

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST**

NUMBERS: **11-W-00275/09**
 21-W-00064/9

TITLE: **Arizona Medicaid Section 1115 Demonstration**

AWARDEE: **Arizona Health Care Cost Containment System (AHCCCS)**

All Medicaid and Children’s Health Insurance Program requirements expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in this list, shall apply to the demonstration project beginning October 22, 2011, through September 30, 2016, unless otherwise specified. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

1. Proper and Efficient Administration

Section 1902(a)(4)
(42 CFR 438.52, 438.56)

To the extent necessary to permit the state to limit Arizona Long Term Care System (ALTCS) DES/DDD enrollees’ choice of managed care plans to a single Managed Care Organization (MCO) -- Children’s Rehabilitative Services Program (CRS) – for the treatment of CRS and behavioral health conditions and to permit the state to limit choice of managed care plans for acute care enrollees with a CRS condition to a single MCO – the CRS program – for acute care as well as the treatment of CRS and behavioral health conditions.

To the extent necessary to permit the state to limit choice of managed care plans to a single MCO for individuals enrolled in the ALTCS and Comprehensive Medical and Dental Program (CMDP) programs so long as enrollees in such plans have a choice of at least two primary care providers, and may request change of primary care provider at least at the times described in 42 CFR 438.56(c). Notwithstanding this authority, the state must offer a choice of at least two MCOs to elderly and physically disabled individuals in Maricopa County.

To the extent necessary to permit the State to limit acute care enrollees’ choice of managed care plans to a single Prepaid Inpatient Health Plan PIHP – the Arizona Department of Health Services Division of Behavioral Health (ADHS/DBHS) – for the treatment of behavioral health conditions, and to permit the state to limit choice of managed care plans for acute care enrollees with a serious mental illness residing in Maricopa County to a single PIHP – the ADHS/DBHS – for acute care as well as for the treatment of behavioral health conditions, as long as enrollees in such plans may request change of primary care provider at least at the times described in Federal regulations at 42 CFR 438.56(c).

To the extent necessary to permit the State to automatically reenroll an individual who loses Medicaid eligibility for a period of 90 days or less in the same PIHP in which he or she was previously enrolled.

To the extent necessary to permit the State to restrict beneficiaries' ability to disenroll without cause after an initial 30 day period from a managed care plan.

To the extent necessary to permit the state to restrict beneficiary disenrollment based on 42 CFR 438.56(d)(2)(iv), which provides for disenrollment for causes including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs

2. Eligibility Based on Institutional Status **Section 1902(a)(10)(A)(ii)(V)**
(42 CFR 435.217 and 435.236)

To the extent necessary to relieve the State of the obligation to make eligible individuals who meet the statutory definition of this eligibility group because they are in an acute care hospital for greater than 30 days but who do not meet the level of care standard for long term care services.

3. Amount, Duration, Scope of Services **Section 1902(a)(10)(B)**
(42 CFR 440.240 and 440.230)

To the extent necessary to enable the State to offer different or additional services to some categorically eligible individuals, than to other eligible individuals, based on differing care arrangements in the Spouses as Paid Caregivers Program.

To the extent necessary to permit the State to offer coverage through managed care organizations (MCOs) and PIHPs that provide additional or different benefits to enrollees, than those otherwise available other eligible individuals.

5. Disproportionate Share Hospital (DSH) Requirements **Section 1902(a)(13) insofar as it incorporates section 1923**

To the extent necessary to relieve the State from the obligation to make payments for inpatient hospital services that take into account the situation of hospitals with a disproportionate share of low-income patients in accordance with the provisions for disproportionate share hospital payments that are described in the STCs.

6. Cost Sharing **Section 1902(a)(14) insofar as it incorporates 1916 (42 CFR 447.51 and 447.52)**

To the extent necessary to enable the State to charge a premium to parents of ALTCS Medicaid qualified disabled children (under 18 years of age) when the parent's annual adjusted gross income is at or exceeds 400 percent of the FPL.

7. Estate Recovery

**Section 1902(a)(18)
(42 CFR 433.36)**

To the extent necessary to enable the State to exempt from estate recovery as required by section 1917(b), the estates of acute care enrollees age 55 or older who receive long-term care services.

8. Freedom of Choice

**Section 1902(a)(23)(A)
(42 CFR 431.51)**

To the extent necessary to enable the State to restrict freedom of choice of providers through mandatory enrollment of eligible individuals in managed care organizations and/or Prepaid Inpatient Health Plans that do not meet the requirements of section 1932 of the Act. No waiver of freedom of choice is authorized for family planning providers.

To the extent necessary to enable the State to impose a limitation on providers on charges associated with non-covered activities.

9. Drug Utilization Review

**Section 1902(a) (54) insofar as it
incorporates section 1927(g)
(42 CFR 456.700 through 456.725)**

To the extent necessary to relieve the State from the requirements of section 1927(g) of the Act pertaining to drug use review.

The following waiver is authorized for the period beginning October 22, 2011, through December 31, 2013:

1. Retroactive Eligibility

**Section 1902(a) (34)
(42 CFR 435.914)**

To enable the State to waive the requirement to provide medical assistance for up to 3 months prior to the date that an application for assistance is made for AHCCCS.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBERS: **11-W-00275/09**
 21-W-00064/9

TITLE: **Arizona Medicaid Section 1115 Demonstration**

AWARDEE: **Arizona Health Care Cost Containment System (AHCCCS)**

Medicaid Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below (which would not otherwise be included as matchable expenditures under section 1903 of the Act) shall, for the period beginning October 22, 2011, through September 30, 2016, unless otherwise specified, be regarded as matchable expenditures under the state's Medicaid state plan:

I. Expenditures Related to Administrative Simplification and Delivery Systems

1. Expenditures under contracts with managed care entities that do not meet the requirements in section 1903(m)(2)(A) of the Act specified below. AHCCCS's managed care plans participating in the demonstration will have to meet all the requirements of section 1903(m) except the following:
 - a. Section 1903(m)(2)(A)(vi) of the Act insofar as it requires compliance with requirements in section 1932(a)(4) of the Act and 42 CFR 438.56(c)(2)(i) that enrollees be permitted an initial period after enrollment that would be longer than 30 days to disenroll without cause.
 - b. Section 1903(m)(2)(H) of the Act and 42 CFR 438.56(g), but only insofar as to allow the State to automatically reenroll an individual who loses Medicaid eligibility for a period of 90 days or less in the same managed care plan from which the individual was previously enrolled.
2. Expenditures under contracts with managed care entities that do not provide for payment for Indian health care providers as specified in section 1932(h) of the Act, when the State pays Indian health providers for covered services furnished to AHCCCS managed care plan enrollees at the State plan rate.
3. Expenditures for State payments for services furnished to managed care enrollees by Indian health providers, when those payments are offset from the managed care capitation payment.

4. Expenditures that would have been disallowed under section 1903(u) of the Act and 42 CFR 431.865 based on Medicaid Eligibility Quality Control (MEQC) findings.
5. Expenditures for outpatient drugs which are not otherwise allowable under section 1903(i)(10) of the Act.
6. Expenditures for outpatient drugs which are not otherwise allowable under section 1903(i)(23) of the Act. This expenditure authority will expire on November 1, 2012.
7. Expenditures for direct payments to Critical Access Hospitals (CAH) for services provided to AHCCCS enrollees in the Acute Care and ALTCS managed care programs that are not consistent with the requirements of 42 CFR 438.60.
8. Expenditures for inpatient hospital and long-term care facility services, other institutional and non-institutional services (including drugs) provided to AHCCCS fee-for-service beneficiaries, that exceed the amounts allowable under section 1902(a)(30)(A) of the Act (42 CFR 447.250 through 447.280, 447.300 through 447.334) but are in accordance with Special Term and Condition (STC) #52 entitled “Applicability of Fee-for-Service Upper Payment Limit.”
9. Expenditures for inpatient hospital services that take into account the situation of hospitals with a disproportionate share of low-income patients but are not allowable under sections 1902(a)(13)(A) and 1923 of the Act, but are in accordance with the provisions for disproportionate share hospital (DSH) payments that are described in the STCs.
10. Expenditures for medical assistance including Home and Community Based Services furnished through ALTCS for individuals over age 18 who reside in Alternative Residential Settings classified as residential Behavioral Health Facilities.

II. Expenditures Related to Expansion of Existing Eligibility Groups based on Eligibility Simplification

11. Expenditures related to:
 - a. Medical assistance furnished to ALTCS enrollees who are eligible only as a result of the disregard from eligibility of income currently excluded under section 1612(b) of the Act, and medical assistance that would not be allowable for some of those enrollees but for the disregard of such income from post-eligibility calculations.
 - b. Medical assistance furnished to ALTCS enrollees who are financially eligible with income equal to or less than 300 percent of the Federal Benefit Rate and who are eligible for ALTCS based on the functional, medical, nursing, and social needs of the individual.
 - c. Medical assistance furnished to some dependent children or spouses who qualify for ALTCS based on a disregard of income and resources of legally responsible

relatives or spouses during the month of separation from those relatives or spouses.

- d. Medical assistance furnished to individuals who are eligible as Qualified Medicare Beneficiary (QMB), Special Low Income Beneficiary (SLMB), Qualified Individuals-1(QI-1), or Supplemental Security Income Medical Assistance Only (SSI MAO) beneficiaries based only on a disregard of in-kind support and maintenance (ISM).
 - e. Medical assistance furnished to individuals who are eligible based only on an alternate budget calculation for ALTCS and SSI-MAO income eligibility determinations when spousal impoverishment requirements of section 1924 of the Act do not apply or when the applicant/recipient is living with a minor dependent child.
 - f. Medical assistance furnished to individuals who are eligible only based on the disregard of interest and dividend from resources, and are in the following eligibility groups:
 - i. The Pickle Amendment Group under 42 CFR 435.135;
 - ii. The Disabled Adult Child under section 1634(c) of the Act;
 - iii. Disabled Children under section 1902(a)(10)(A)(i)(II) of the Act; and
 - iv. The Disabled Widow/Widower group under section 1634(d) of the Act.
 - g. Medical assistance furnished to ALTCS enrollees under the eligibility group described in section 1902(a)(10)(A)(ii)(V) of the Act that exceeds the amount that would be allowable except for a disregard of interest and dividend from the post-eligibility calculations.
 - h. Medical assistance provided to individuals who would be eligible but for excess resources under the “Pickle Amendment,” section 503 of Public Law 94-566; section 1634(c) of the Act (disabled adult children); or section 1634(b) of the Act (disabled widows and widowers).
 - i. Medical assistance that would not be allowable but for the disregard of quarterly income totaling less than \$20 from the post-eligibility determination.
12. Expenditures to extend eligibility past the timeframes specific in 42 CFR §435.1003 for demonstration participants who lose SSI eligibility for a period of up to 2-months from the SSI termination effective date.
13. Expenditures to provide Medicare Part B premiums on behalf of individuals enrolled in ALTCS with income up to 300 percent of the FBR who are also eligible for Medicare, but do not qualify as a QMB, SLMB or QI; are eligible for Medicaid under a mandatory or optional Title XIX coverage group for the aged, blind, or disabled (SSI-MAO); are eligible for continued coverage under 42 CFR 435.1003; or are in the guaranteed enrollment period described in 42 CFR 435.212 and the State was paying their Part B premium before eligibility terminated.
14. Expenditures to extend ALTCS eligibility to individuals under the age of 65 who meet the applicable financial criteria but are not disabled, but who are found to be at risk of

needing nursing facility services based on medical illness or mental retardation on the preadmission screening instrument.

15. Expenditures associated with the provision of Home & Community-Based Services (HCBS) to individuals enrolled in the Arizona Long Term Care system with income levels up to 300 percent of the SSI income level, as well as individuals enrolled in the ALTCS Transitional program.
16. Expenditures for demonstration caregiver services provided by spouses of the demonstration participants.

The following expenditures (which would not otherwise be included as matchable expenditures under section 1903 of the Act) shall be regarded as matchable expenditures under the state's Medicaid state plan through December 31, 2013:

17. Expenditures to provide coverage through employer-sponsored insurance for eligible employees of small businesses and with family income below 200 percent of the FPL that would not otherwise be allowable because it is not cost effective.
18. Expenditures to provide medical assistance for adults without children who were enrolled in the AHCCCS under Demonstration project #11-W-00032/9 and #21-W-00009/9 as of July 8, 2011, as long as they continue to meet the State's eligibility criteria and redetermination requirements.
19. Expenditures to provide medical assistance to adults without children with adjusted net countable family income at or below 100 percent of the FPL who are not otherwise eligible for Medicaid.
20. Expenditures to provide medical assistance for individuals who applied for the Medical Expense Deduction (MED) program (under Expenditure Authority 16 of Demonstration project #11-W-00032/9 and #21-W-00009/9) prior to May 1, 2011, and were determined eligible for that population for a 6-month guaranteed eligibility period after that date, until the end of that 6-month period.
21. Expenditures for family planning and family planning-related services for up to 24 months for women losing Medicaid pregnancy coverage at the conclusion of their 60-day postpartum period, and who are not otherwise eligible for Medicare, Medicaid (including other components of this section 1115 demonstration), Children's Health Insurance Program (CHIP), or health insurance coverage that provides family planning services, and who have a family income at or below 150 percent of the Federal poverty level (FPL) at the time of annual redetermination. (Family Planning Extension Program).

22. Expenditures for payments to participating IHS and tribal facilities reflecting uncompensated care, limited to categories of care that were previously covered under the State Medicaid plan, furnished in or by such facilities to Medicaid-eligible individuals, and other individuals, with family income at or below 100 percent of the FPL.
23. Subject to the overall cap on the Safety Net Care Pool (SNCP), expenditures for payments to certain hospitals and other providers reflecting uncompensated costs of medical services that are within the scope of the definition of “medical assistance” under 1905(a) of the Act, that are provided to Medicaid eligible or uninsured individuals, and that exceed the amounts paid to the hospitals pursuant to section 1923 of the Act.
24. Expenditures for uncompensated care payments made under the Proposition 202 Trauma/Emergency Room Designated State Health Program, which is otherwise a State-funded program, as specified in the reimbursement protocol for the SNCP.

Medicaid Requirements Not Applicable

Medicaid populations made eligible by virtue of the expenditure authorities expressly granted in this Demonstration are not subject to Medicaid laws or regulations except as specified in the STCs and waiver and expenditure authorities for this Demonstration. The following Medicaid requirements will not apply to such demonstration populations, and will expire on December 31, 2013 (sections refer to the Social Security Act):

1. **Cost Sharing** **Section 1902(a)(14) insofar as it incorporates section 1916 (42 CFR 447.50 through 447.56)**

To enable the State to impose cost sharing, to the extent necessary, for those in the employer-sponsored insurance program, and individuals without dependent children with family income up to 100 percent of the FPL

2. **Amount, Duration, Scope of Services** **Section 1902(a)(10)(B) (42 CFR 440.210)**

To enable the State to modify the Medicaid benefits package for those in the employer-sponsored insurance program in order to offer a different benefit package than would otherwise be required under the State plan. This authority is granted only to the extent necessary to allow those in the employer-sponsored insurance plan to receive coverage through a private or employer-sponsored insurance plan, which may offer a different benefit package than that available through the State plan.

3. Retroactive Coverage

**Section 1902(a)(34)
(42 CFR 435.914)**

Individuals who enroll in the employer-sponsored insurance program and individuals without dependent children with family income up to 100 percent of the FPL.

4. Early and Periodic Screening, Diagnostic, Treatment (EPSDT)

**Section 1902(a)(43)(A) and
(42 CFR 440.40 and 441.50
through 441.62)**

To enable the State to not provide or arrange for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to adults without dependent children with family income up to 100 percent of FPL ages 19 and 20 years old.

Medicaid Requirements Not Applicable to the Family Planning Extension Program

All Medicaid requirements apply to the Family Planning Extension Program, with the exception of the following:

1. Amount, Duration, and Scope (Comparability)

**Section 1902(a)(10)(B)
(42 CFR 440.240)**

To the extent necessary to allow the State to offer the family planning demonstration population a benefit package consisting only of family planning and family planning-related services.

2. Eligibility Redetermination

**Section 1902(a)(19)
(42 CFR 435.916)**

To enable the State to exempt women, who are eligible for the family planning program by virtue of losing Medicaid eligibility at the conclusion of their 60-day postpartum period (SOBRA women), from reporting changes in income during their 12-month eligibility period.

3. Retroactive Eligibility

**Section 1902(a)(34)
(42 CFR 435.914)**

To the extent necessary to enable the State to not provide medical assistance to the Demonstration population for any time prior to when an application for the Demonstration is made.

4. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

**Section 1902(a)(43)(A)
(42 CFR 440.40 and 441.50
through 441.62)**

To the extent necessary to enable the State to not furnish or arrange for EPSDT services to the demonstration population.

CHIP Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act as incorporated into title XXI by section 2107(e)(2)(A) of the Act, State expenditures described below, shall, for the period through December 31, 2013, and to the extent of the State's available allotment under section 2104 of the Act; be regarded as matchable expenditures under the State's title XXI plan. All requirements of title XXI will be applicable to such expenditures for the demonstration population described below, except those specified below as not applicable to these expenditure authorities.

- 1. Employer-Sponsored Insurance.** Expenditures to provide coverage to CHIP-eligible children up to age 19 with incomes above 100 percent of the FPL up to and including 200 percent of the FPL, who meet the definition of a targeted low-income child and who elect to receive coverage through the State's Employer-Sponsored Insurance (ESI) program rather than coverage under the CHIP State plan. Such children are no longer subject to the title XXI requirements listed below.
- 2. KidsCare II Program.** Expenditures to provide coverage to children up to age 19 with family income up to 175 percent of the FPL not otherwise eligible for Medicaid.

CHIP Requirements Not Applicable to CHIP Expenditure Authorities

(Sections refer to the Social Security Act.)

1. General Requirements, Eligibility, and Outreach

**Section 2102
(42 CFR 457.90)**

Only to the extent that the State child health plan would be required to reflect the demonstration population.

2. Annual Reporting Requirements

**Section 2108
(42 CFR 457.700 through
457.750)**

To the extent that the State would have to meet the annual reporting requirements with respect to the demonstration populations (the submission of an annual report into the CHIP Annual Report Template System/CARTS). The State will report on issues related

to the demonstration populations in quarterly and annual reports and enrollment data through the Statistical Enrollment Data System (SEDS).

3. Cost Sharing

**Section 2103(e)
(42 CFR 457.530 through
457.560)**

Rules governing cost sharing under section 2103(e) of the Act shall not apply to the demonstration populations.

4. Benefit Package Requirements

Section 2103

To the extent necessary to permit the State to offer a benefit package for the ESI program that does not meet the requirements of section 2103 of the Act, outlined at 42 CFR 457.410(b)(1).