



OCT 21 2011

Administrator  
Washington, DC 20201

Mr. Thomas Betlach  
Director  
Arizona Health Care Cost Containment System  
801 East Jefferson Street  
Phoenix, AZ 85034

Dear Mr. Betlach:

The Centers for Medicare & Medicaid Services (CMS) has approved the State of Arizona's request for a new section 1115 Demonstration (project number 11-W-00275/09 and 21-W-00064/9), "Arizona Health Care Cost Containment System" (AHCCCS). This Demonstration is approved for a 5-year period, from October 22, 2011, through September 30, 2016. The new section 1115 demonstration will continue many aspects of the State's expired Demonstration (project number 11-W-00032/09 and 21-W-00009/9)," such as eligibility for all populations except as expressly changed in the list below, mandatory enrollment in managed care, benefits, and cost-sharing requirements for the childless adults. In addition, the following is a summary of the requests from the State's March 31, 2011, proposal that are included in the approval of the State's new section 1115 demonstration with the specific details outlined in the Special Terms and Conditions (STCs):

1. Expenditure authority to claim Federal financial participation (FFP) for the payment of Medicare Part B premiums for non-Qualified Medicare Beneficiary (QMB) dual eligibles with income up to 300 percent of the Federal Benefit Rate (FBR);
2. Expenditure authority to provide an additional 2-month period of eligibility for beneficiaries after losing Supplemental Security Income (SSI) eligibility;
3. Authority to not provide the early, periodic screening, diagnostic and treatment (EPSDT) services requirement for childless adults ages 19 and 20;
4. Mandatory co-payments for the childless adult population;
5. Authority under the conditions outlined to impose \$4 copayments (roundtrip) on taxi rides for certain childless adults residing in Maricopa and Pima counties; and
6. Authority under the conditions outlined to permit providers to charge a \$3 fee for parents and childless adults outside of Maricopa and Pima counties who miss scheduled appointments without providing 24 hour advance notice of any cancellation.

Approval of the new Demonstration will provide for authorities that enable the State to provide health care services through a capitated managed care delivery model that operates statewide for Medicaid State plan groups and the Demonstration expansion group. The new Demonstration also will continue to provide the State authority to cover groups not currently covered under its

Medicaid State plan, including individuals who lose SSI and certain low-income individuals eligible for both Medicaid and Medicare (dual eligibles) who otherwise would not qualify for Medicaid payment of Part B premiums. With the expiration of the State's previous section 1115 Demonstration (project number 11-W-00032/09 and 21-W-00009/9), the State elected to freeze enrollment for the childless adult eligibility group on July 8, 2011. This Demonstration will continue to provide the State authority to cover the childless adults who were enrolled prior to the July 8<sup>th</sup> enrollment freeze.

Maintaining as much of the current coverage of the childless adult population as possible is an important feature of the Demonstration as it furthers the coverage objectives of the Medicaid program. As such, we understand from the State that the imposition of the mandatory copayments on this population is necessary in order to prevent the State from implementing alternatives, such as covering this population at a lower percentage of the Federal poverty level (FPL), a result that would jeopardize current coverage levels or result in diminished benefits for this population. Additionally, as your submissions reflect, the imposition of these co-payments is only one element of the Demonstration and is tied to other elements. As a result, the co-payments are not viewed in isolation, but are considered in the context of the Demonstration as a whole, which is intended to increase access to care and improve quality of care for the State's population as a whole and for expansion populations in particular.

The State will test several hypotheses related to the impact of these copayments on access, outcomes, and costs of care, including the impact of the copayment on non-emergency medical transportation on access to care and the selection of transportation alternatives and the missed appointment fee on the rate of missed appointments, access to care and outcomes, as outlined in our October 7, 2011, letter. The testing of these hypotheses will further the access and quality of care objectives of the Medicaid program. In testing these hypotheses, CMS will work with the State to develop a robust evaluation design plan by April 1, 2012, and the broad parameters of this plan is outlined in the attached STCs. The evaluation design plan will describe how Arizona will assess the impact of the copayments on participating beneficiaries based on these hypotheses and any additional hypotheses developed during the evaluation design process.

CMS has not approved, and did not incorporate, the following State requests from the March 31, 2011, proposal into the section 1115 demonstration:

1. Waiver to permit the elimination of coverage for 60,000 parents with family income between 75 and 100 percent of the FPL;
2. Authority to further reduce the enrollment level of the childless adult population based on available funding;
3. Authority to permit a change in eligibility procedures that would provide for eligibility redetermination every six months for the childless adult and parent populations, rather than the current 12-month schedule;
4. Mandatory co-payments on children, pregnant women and Temporary Assistance for Needy Families (TANF) parents;
5. Waiver of the Emergency Services to individuals who do not qualify for Medicaid based on their immigration status; and
6. Authority to impose a \$50 annual assessment on childless adults who smoke.

At this time, the following State requests are not being approved, but CMS will continue to work with Arizona on these matters:

1. Safety Net Care Pool (SNCP);
2. Arizona Health System Improvement Pool (AHSIP); and
3. Authority to exempt American Indian/Alaskan Natives (AI/AN) from benefit and eligibility changes.

On July 29, 2011, the State added two additional proposals to its request for a new Demonstration, requesting the establishment of a Safety Net Care Pool (SNCP), which would serve as an uncompensated care pool, and for an Arizona Health System Improvement Pool (AHSIP). CMS is not approving the creation of a SNCP at this time. We agree that it is important to address the need to maintain access to emergency room and other hospital care, but we do not find a clear basis to determine that dedicating new resources to an uncompensated care pool in the context of a demonstration that otherwise contracts and limits coverage is consistent with the objectives of the Medicaid program. However, as we expressed in our October 7, 2011, letter, we will seriously review and consider the proposal for the systems improvement pool and continue to work with the State on these requests.

As noted in our October 7<sup>th</sup> letter, the State's request for authority to exempt American Indian/Alaskan Natives (AI/AN) from recent benefit and eligibility changes raises a number of complex issues. This request is important to us as well as to the State and to the Arizonan tribes. We have been very actively engaged in working through these issues and expect to have a decision in the near future.

Approval of this section 1115 Demonstration is contingent upon the State's agreement to the enclosed STCs and the corresponding waiver and expenditure authorities. The STCs set forth in detail the nature, character, and extent of Federal involvement in this project. The award is subject to our receiving your written acceptance of the award within 30 days of the date of this letter.

Your project officer is Ms. Jessica Schubel. She is available to answer any questions concerning your section 1115 Demonstration. Ms. Schubel's contact information is as follows:

Centers for Medicare & Medicaid Services  
Center for Medicaid, CHIP and Survey & Certification  
7500 Security Boulevard  
Mailstop S2-01-06  
Baltimore, MD 21244-1850  
Telephone: (410) 786-3032  
Facsimile: (410) 786-8534  
E-mail: [Jessica.schubel@cms.hhs.gov](mailto:Jessica.schubel@cms.hhs.gov)

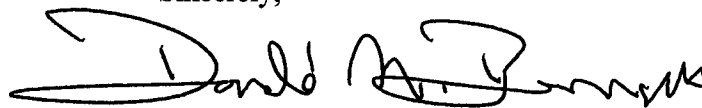
Official communications regarding program matters should be sent simultaneously to Ms. Schubel and to Ms. Gloria Nagle, Associate Regional Administrator for the Division of Medicaid and Children's Health in our San Francisco Regional Office. Ms. Nagle's contact information is as follows:

Ms. Gloria Nagle  
Associate Regional Administrator  
Division of Medicaid and Children Health Operations  
90 Seventh Street, Suite 5-300 (5W)  
San Francisco, CA 94103 -6706

If you have questions regarding this approval, please contact Ms. Victoria Wachino, Director, Children and Adults Health Programs Group, Center for Medicaid and CHIP and Services, at (410)786-5647.

Congratulations on the approval of this section 1115 Demonstration.

Sincerely,

A handwritten signature in black ink, appearing to read "Donald M. Berwick". The signature is stylized with a large, sweeping initial "D" and a long horizontal line extending to the left.

Donald M. Berwick, M.D.

Enclosures

cc: Cindy Mann, Director, CMCS  
Victoria A. Wachino, CMCS  
Gloria Nagle, Associate Regional Administrator, Region IX  
Jessica Schubel, CMCS

**SPECIAL TERMS AND CONDITIONS**  
**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)**  
**MEDICAID SECTION 1115 DEMONSTRATION**  
**NUMBER: 11-W00275/9**  
**21-W-00064/9**

**(For Counties outside of Maricopa and Pima)**

**Final STCs**

**Page 13**

**V. Demonstration Programs**

**17. Arizona Acute Care Programs (ACCP)**

**e) ACCP Permissible Provider Fee for Missed Appointments.**

i. The State may permit a provider to impose a \$3 fee on the TANF parent and adults without dependent children population for the non-covered activity of reserving an appointment that an individual misses provided that:

1) Beneficiaries are notified in easily understood, plain language at the time of scheduling their appointment of the consequences of missing appointments without cancelling 24 hours prior to the appointment. This includes, but is not limited to notification of the \$3 fee, and the possibility of the provider refusing future service until the \$3 fee has been paid. In addition, the provider must present its missed appointment policy to a beneficiary on an annual basis and obtain a signed acknowledgment of such policy from the beneficiary;

2) Participating providers have a mechanism in place that notifies beneficiaries 48 hours in advance of their scheduled appointment time. The provider shall make available to the beneficiary a choice from among two or more different notice mechanisms (such as a telephone call, a text message to a mobile device, and/or an email) and permit the beneficiary to utilize whichever method of communication is preferable to the beneficiary. The provider shall keep a record of such notifications;

3) Beneficiaries receive written confirmation of his/her scheduled appointment. This could include, but is not limited to, a postcard given to the beneficiary at the time the appointment is scheduled, a mailed letter, an email, or a text message to a mobile device. The times and dates of individual appointments, and a record of the date and time that confirmation was delivered, should be recorded and maintained by the provider.

4) Providers develop a mechanism by which they can track, and subsequently report to the State on a quarterly basis, the following information through claims data:

a. The number of missed appointment fees in the reporting period;

b. The number of individuals assessed the missed appointment fee;

c. The number of individuals who have been assessed the fee more than once during the reporting period, including the average number of times the fee has been assessed for this subpopulation; and

d. The reason for missing the scheduled appointment (if provided by the beneficiary).

5) The State, after reviewing the quarterly reports submitted by the providers as specified in subparagraph 4, monitors providers that it has identified as having an above average rate of beneficiaries assessed the missed appointment fee and identifies the reasons for this higher rate. This may include conducting outreach to the providers to ensure that they are in compliance with the requirements specified in subparagraphs 1 – 4, as well as providing any necessary corrective action.

6) The State includes in its quarterly report to CMS, as specified in STC #34, the information required in subparagraphs 4 and 5. In addition, the State must report to the CMS the number of providers with a high volume of missed appointment copayments, clearly identifying those that have been reported on a previous quarterly report. The State should also supply its assessment of the reasons for these missed appointments.

ii. A missed appointment occurs when a beneficiary is more than 20 minutes late to his/her scheduled appointment time.

iii. Missed appointments cannot not be considered in any utilization limits as specified in the Medicaid State plan as the service has not been rendered.

iv. Providers who elect to impose the \$3 missed appointment fee on beneficiaries must submit to the State a plan assuring that they can comply with the requirements in paragraphs 1 – 4 as well as a process by which a beneficiary would be exempt from the fee, such as lack of adequate transportation, an appointment scheduled by a third party, or a disability or mental illness.

v. The authority to impose the \$3 missed appointment fee on the TANF parent and adults without dependent children populations is time-limited, and will expire on January 1, 2013. On November 1, 2012, as specified in STC# 26(d), the State must submit an independent evaluation for CMS review and approval documenting the effectiveness of the missed appointment copayment in reducing the number of missed appointments. **Upon concluding the review of the evaluation and at the request of the State, CMS may extend this authority to December 31, 2013.**

---

Other Info—

For Counties **outside** of Maricopa and Pima