

**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 Regional Behavioral Health Authority (RBHA) contracted with the Arizona Department of Health Services Division of Behavioral Health (ADHS/DBHS) for the treatment of behavioral health conditions.

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.

[To enable the State to provide certain dental services \(as described in the Special Terms and Conditions\) up to a cost of \\$1,000 per person annually to persons age 21 or older enrolled in the Arizona Long Term Care System.](#)

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.

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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 1932(a)(3) of the Act in so far as they incorporate 42 CFC 438.52(a) to the extent necessary to allow the state to operate only one managed care plan in urban areas:
 - a. For AACP members with a serious mental illness residing in Maricopa County and Greater Arizona; and
 - b. Outside of Maricopa County to permit the state to limit choice of managed care plans to a single MCO for individuals enrolled in 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.

2. 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.

3. 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.
4. 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.
5. 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.
6. Expenditures for outpatient drugs which are not otherwise allowable under section 1903(i)(10) of the Act.
7. 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.
8. 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.
9. 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."
10. 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.
11. 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

12. 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.

13. 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.
14. 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.
15. 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.
16. 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.
17. Expenditures for demonstration caregiver services provided by spouses of the demonstration participants.
18. [Expenditures to provide certain dental services up to a cost of \\$1,000 per person annually to persons age 21 or older enrolled in the Arizona Long Term Care System.](#)

The following expenditure (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:

- ~~18.~~19. Subject to the overall cap on the Safety Net Care Pool (SNCP), expenditures through December 31, 2015 for payments to Phoenix Children's Hospital 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.
- ~~19.~~20. Expenditures through September 30, 2016 for all state plan and demonstration covered services for pregnant women during their hospital presumptive eligibility period.
- ~~20.~~21. Expenditures through September 30, 2016 for payments to participating IHS and tribal 638 facilities reflecting uncompensated care, limited to categories of care that were previously covered under the State Medicaid plan, furnished in or by such facilities.

The AHCCCS Administration will issue a Director's Decision within 30 calendar days of receipt of the ALJ Decision.

- a) The state will track the Opt-out for Cause requests detailed in paragraph 21, subparagraph (i) including the number of each type of request; the county of each request; and the final result of the request. This information shall be provided to CMS in the quarterly reports.

22) **Arizona Long Term Care System (ALTCS).** The ALTCS program is for individuals who are age 65 and over, blind, disabled, or who need ongoing services at a nursing facility or ICF/MR level of care. ALTCS enrollees do not have to reside in a nursing home and may live in their own homes or an alternative residential setting and receive needed in-home services. The ALTCS package also includes all medical care covered under AACP inclusive of doctor's office visits, hospitalization, prescriptions, lab work, behavioral health services, and rehabilitative services. Rehabilitative services may only be eligible for FFP if these services reduce disability or restore the program enrollee to the best possible level of functionality. [Additionally, ALTCS participants age 21 or older receive dental services up to \\$1,000 per person annually for therapeutic and preventive care, including but not limited to: basic diagnostic services, preventive services, restorative services, periodontics, prosthetic services, and oral surgery.](#)

The ALTCS is administered through a statewide, managed care system which delivers acute, long-term care, home-and-community based, CRS and behavioral health care services through capitated MCOs that AHCCCS calls "Program Contractors." The one exception is ALTCS DES/DDD enrollees eligible under the CRS program receive specialty care for treatment of their CRS and behavioral health conditions through a separate MCO contract. Those enrollees will receive services for all conditions other than behavioral health or CRS related conditions through ALTCS DES/DDD.

With one exception, ALTCS contracts are awarded in the same geographic service areas as AACP are awarded. The exception is for the ALTCS contract with the Arizona DES/DDD to provide coverage on a statewide basis of the full ALTCS benefit package to all eligible individuals with developmental disabilities. Under state law, A.R.S. 36-2940, AHCCCS is required to enter into an intergovernmental agreement (IGA) with DES/DDD to serve as the managed care organization for individuals with developmental disabilities. The DES/DDD ALTCS contract is an at-risk MCO contract that complies with 42 C.F.R. Part 438 and as such is reviewed and approved by CMS. Payments to DES/DDD under the ALTCS contract shall not include any payments other than payments that meet the requirements of 42 C.F.R. 438.6(c) including the requirement that all payments and risk-sharing mechanisms in the contract are actuarially sound. State law, A.R.S. 36-2953, requires DES/DDD to maintain a separate fund to account for all revenues and expenditures under the ALTCS contract and limits use of the fund for the administration of the ALTCS contract. ALTCS enrollees in Maricopa and Pima Counties have a choice of Program Contractors, but ALTCS enrollees in the rest of the state enroll in the Program Contractor for their GSA.

- a) **ALTCS Eligibility Groups** - Individuals as defined in Table 1 requiring health care services at a nursing facility or ICF/MR level of care.

23) **Arizona Long Term Care System (ALTCS).** The ALTCS program is for individuals who are aged (65 and over), blind, or disabled and who need ongoing services at a

- ii. Assurance that the standards of any state licensure or certification requirements are met for services or for individuals furnishing services that are provided under the ALTCS program. The state assures that these requirements will be met on the date that the services are furnished; and
- iii. Assurance that all facilities covered by section 1616 (e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable state standards that meet the requirement of 45 CFR Part 1397 for board and care facilities.
- iv. A formal quality control system which monitors the health and welfare of members served in the ALTCS program.
 - 1. Monitoring will ensure that all provider standards and health and welfare assurances are continually met, and that plans of care are periodically reviewed to ensure that the services furnished are reasonably consistent with the identified needs of the individuals.
 - 2. The state further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

f) ALTCS Benefits and Services

- i. **ALTCS Acute Care** - Enrollees receive the same acute services as defined in paragraph 17(c). [Additionally, ALTCS participants age 21 or older receive certain dental services up to \\$1,000 per person annually.](#)
- ii. **ALTCS Behavioral Health Care** - Enrollees receive behavioral health care services as defined in paragraph 17(c)(iii).
- iii. **Home and Community-Based Services (HCBS)** - ALTCS will provide a comprehensive HCBS package to eligible enrollees in the enrollee's home or in an ALTCS approved Alternative Residential Setting.
 - 1. **Alternative Residential Settings** include:
 - a. Adult foster care.
Assisted living homes, assisted living centers, adult developmental homes, child developmental homes and group homes, hospices, group homes for traumatic brain injured members, and rural substance abuse transitional agencies.
 - b. Behavioral Health Facilities that are licensed to provide behavioral health services in a structured setting with 24-hour supervision. ALTCS covers services, except room and board, that are provided to ALTCS members who have a behavioral