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.

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. 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. Expenditures through September 30, 2016 for all state plan and demonstration covered services for pregnant women during their hospital presumptive eligibility period.

20. 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.