DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

AHCCCS/RECEIVED
DIRECTOR'S OFFICE
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Ms. Phyllis Biedess
Director
Arizona Health Care Cost
Containment System
801 East Jefferson
Phoenix, AZ 85034

Dear Ms. Biedess:

I am pleased to inform you that we have approved your requests to amend the section 1115 demonstration authority for the Arizona Health Care Cost Containment System (AHCCCS) (11-W-00032/09). This approval permits the State to be exempted from estate recovery requirements for acute care enrollees age 55 and older who receive long-term care (LTC) services. In addition, we have approved your requests to make your Medicaid Eligibility Quality Control (MEQC) pilot a permanent part of the Arizona demonstration and to exclude resources from the eligibility determination for the Supplemental Security Income-Medical Assistance Only groups. Approval is under the authority of section 1115 of the Social Security Act (the Act) and covers the same period as your overall demonstration (i.e., through September 30, 2006).

The following limited waiver is granted under the authority of section 1115(a)(1) of the Act:

> To enable the State to exempt from recovery the estates of acute care program enrollees age 55 or older who receive LTC services.
>
> Section 1902(a)(18) of the Act.

The following expenditure authority is granted for the latter two amendments:

Under the authority of section 1115(a)(2) of the Act, expenditures made by the State for the items identified below (which would not otherwise be included as matchable expenditures under section 1903) shall, for the period of this project, be regarded as matchable expenditures under the State's Medicaid State plan:

> Expenditures that would have been disallowed under section 1903(u) of the Act based on MEQC findings.
>
> Expenditures for medical assistance provided to individuals who are determined to be eligible for Medicaid as SSI recipients under: the "Pickle Amendment," section 503 of Public Law Number 94-566; section 1634(c) of the Act (disabled adult children); and section 1634(b) of the Act (disabled widows and widowers), who because of excess resources actually do not qualify for this status.

The cumulative list of waivers and expenditure authorities for the overall AHCCCS demonstration is enclosed. Notification to our office of your acceptance of this award must be received within 30 days after you receive this letter.

Your project officer continues to be Ms. Joan Peterson, who may be reached at (410) 786-0621. Communications regarding program matters should be sent to the project officer at the following address: Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations, Family and Children's Health Programs Group, Division of Integrated Health Systems, Mail Stop S2-01-16, 7500 Security Boulevard, Baltimore, Maryland, 21244-1850. Administrative correspondence concerning the project should also be submitted to Ms. Peterson.

We look forward to working with you on the continued success of the AHCCCS program.

Sincerely,

Tom Scully

Thomas A. Scully

Enclosure

03/02

Cumulative List of Waivers and Expenditure Authorities
for the Arizona Health Care Cost Containment System (AHCCCS) Demonstration

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), waivers of the following provisions of the Act (and its implementing regulations) are granted through September 30, 2006, to enable the State to carry out the demonstration, consistent with the accompanying special terms and conditions:

1. To enable the State to impose cost sharing on mandatory services and to individuals enrolled in a health maintenance organization.

   Section 1902(a)(14), (42 CFR 447.50 and 447.53)

2. To enable the State to restrict freedom of choice of provider. Among other things, this waiver will allow the State to restrict the freedom of choice of provider upon re-enrollment for individuals who lose eligibility and then become eligible again within 90 days.

   Section 1902(a)(23), (42 CFR 431.51)

3. To enable the State to obtain flexibility in arranging reimbursement agreements with health care providers.

   Section 1902(a)(13), (42 CFR 447.250 - 447.371) (except for the public notice provisions in 1902(a)(13)(A)); Section 1902(a)(30), insofar as it is implemented by the regulations cited above and by 42 CFR 434.23; Section 1902(a)(4), insofar as it is implemented by 42 CFR 434.23.

4. To enable the State to exclude hospitalized individuals and others not requiring long-term care (LTC) services from the optional institutionalized eligibility categories.

   Section 1902(a)(10)(A)(ii)(V), (42 CFR 435.217 and 435.236)

5. To enable the State to receive payment for outpatient drugs without complying with the requirements of the Omnibus Budget Reconciliation Act of 1990 pertaining to drug rebate and drug use review.

   Section 1902(a)(54), (42 CFR 456.700 - 456.725)

6. To enable the State to provide supported employment services to certain developmentally-disabled HCBS services clients.

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

7. To enable the State to disregard quarterly income totaling less than $20 from the post-eligibility income determination.

   Section 1902(a)(17), (42 CFR 435.725 and 435.726)

8. To the extent necessary to permit the State to offer different benefits to managed care organization enrollees that are not offered to Medicaid beneficiaries not enrolled.

   Section 1902(a)(10)(B)(i)

9. 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.

   Section 1902(a)(34)

10. To enable the State to exempt from recovery the estates of acute care enrollees age 55 or older who receive LTC services.

    Section 1902(a)(18)

Under the authority of section 1115(a)(2) of the Act, expenditures made by the State for the items identified below (which would not otherwise be included as matchable expenditures under section 1903) shall, for the period of this project, be regarded as matchable expenditures under the State's Medicaid State plan:

1. Expenditures for hospital services that would not otherwise be federally matchable due to the limits on matching in section 1903(i)(3).

2. Expenditures under contracts with managed care entities that do not meet the requirements in section 1903(m)(2)(A) specified below. AHCCCS' managed care plans participating in the demonstration will have to meet all the requirements of section 1903(m) except the following:

   --1903(m)(2)(A)(i), but only insofar as the provisions of 1903(m)(1)(A)(i) would otherwise preclude Native Americans from having a choice to enroll in either Indian Health Service facilities or AHCCCS plans;

   --1903(m)(2)(A)(vi) insofar as it requires compliance with the requirements in section 1932(a)(4) - that enrollees be permitted an initial 90-day period within which they can disenroll without cause.

   --1903(m)(2)(A)(viii) and 1903(m)(4)(A) and (B), but only insofar as these provisions relate to disclosure of transactions between AHCCCS plans and parties in interest.

3. Expenditures associated with the provision of HCBS to individuals determined to be eligible and for services specified in the program. Those expenditures include, but are not limited to, the establishment of ALTCS eligibility for all individuals with income levels up to 300 percent of the SSI income level, whether institutionalized or non-institutionalized, as well as individuals enrolled in the ALTCS Transitional program; waiving parental income for children up to age 18; and imposing the share of cost and personal needs allowance requirements.

4. Expenditures for outpatient drugs which would otherwise be excluded by virtue of section 1903(i)(10).

5. Expenditures to extend ALTCS eligibility to individuals under the age of 65 using the preadmission screening instrument as a substitute disability standard.

6. Expenditures to provide continued medical coverage to children who meet the initial eligibility requirement as a deemed newborn without consideration of the mother's continued Medicaid eligibility.

7. Expenditures to provide family planning services for up to 24 months to AHCCCS-eligible women who subsequently lose eligibility at 60 days postpartum.

8. Expenditures for services to an AHCCCS enrollee age 21-64 residing in an IMD for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days. Enrollees who were residing in an IMD as of the date of the award letter, but who were admitted prior to the date of this letter, will not be eligible for title XIX reimbursement for that stay. Enrollees who are admitted on or after the date of the award letter will be eligible for title XIX reimbursement, subject to the 30/60 limits.

9. In determining the eligibility of ALTCS applicants and recipients, expenditures associated with excluding from the 300 percent of SSI test and post-eligibility calculations the income currently excluded from the 100 percent of SSI test listed in section 1612(b) of the Act.

10. Expenditures associated with eliminating the 30-day wait for use of 300 percent of SSI as the income limit in determining eligibility for new ALTCS applicants.

11. Expenditures associated with allowing some dependent children or spouses to qualify for ALTCS one month earlier than usual by disregarding the income and resources of responsible relatives or spouses in the month of separation.

12. Expenditures associated with disregarding in-kind support and maintenance (ISM) as income in determining eligibility for QMB, SLMB, QI 1, QI 2, or SSI-MAO benefits.

13. Expenditures associated with changing the budgeting process for ALTCS and SSI-MAO income eligibility determinations when there is an eligible or ineligible spouse (if the spousal impoverishment requirements of section 1924 of the Act do not apply) or when the applicant/recipient is living with a minor dependent child.

14. Expenditures associated with simplifying the life insurance and burial funds policy in the eligibility determination process for the SSI-MAO groups.

15. Expenditures associated with excluding the value of household goods and personal effects in the eligibility determination process for the SSI-MAO groups.

16. Expenditures associated with excluding the value of mineral rights, oil rights, and timber rights in the eligibility determination process for the SSI-MAO groups.

17. Expenditures associated with allowing resource determinations to be made based on resource verifications produced for any date during a calendar month, making the individual resource eligible for the entire month.

18. Expenditures to provide Medicaid coverage to individuals with adjusted net countable income at or below 100 percent of the Federal Poverty Level (FPL) who are not otherwise eligible for Medicaid.

19. Expenditures to provide Medicaid coverage to individuals who have medical bills incurred by the family unit sufficient to reduce their adjusted net countable family income to 40 percent or less of the FPL and who are not otherwise eligible for Medicaid.

20. Expenditures that would have been disallowed under section 1903(u) of the Act based on MEQC findings.

21. Expenditures for medical assistance provided to individuals who are determined to be eligible for Medicaid as SSI recipients under: the "Pickle Amendment," section 503 of Public Law Number 94-566; section 1634(c) of the Act (disabled adult children); and section 1634(b) of the Act (disabled widows and widowers), who because of excess resources actually do not qualify for this status.

Under the authority of section 1115(a)(2) of the Act, as incorporated into title XXI by section 2107(e)(2)(A), State expenditures described below (which would not otherwise be included as matchable expenditures under title XXI) shall, for the period of this project 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:

22. Expenditures to provide Medicaid coverage to individuals over age 18 with adjusted net countable family income at or below 100 percent of the FPL, who are single adults and childless couples, and who are not otherwise eligible for such coverage, except through

the demonstration project amendment approved January 18, 2001.

23. Expenditures to provide demonstration coverage consistent with the requirements of section 2103 to individuals whose adjusted net countable family income exceeds 100 percent of the FPL, but does not exceed 200 percent of the FPL, who are parents of children enrolled in the Arizona Medicaid or title XXI programs, and who are not otherwise eligible for Medicaid or title XXI coverage.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center For Medicaid and State Operations

FEB 1 2002

Ms. Phyllis Biedess
Director
Arizona Health Care Cost
Containment System
801 East Jefferson
Phoenix, Arizona 85034

Dear Ms. Biedess:

As part of the December 12, 2001, approval of Arizona's Health Insurance Flexibility and Accountability (HIFA) amendment, the Centers for Medicare & Medicaid Services (CMS) approved the State's request to extend your Medicaid section 1115 demonstration from October 1, 2002, through September 30, 2006.

The Administration's policy is to include a budget neutrality agreement with all section 1115 demonstrations to limit demonstration costs to those that would be incurred under current law. Your current section 1115 demonstration includes a budget neutrality agreement only for your acute care program. As CMS has approved the extension of Arizona's underlying demonstration through September 30, 2006, this letter is to inform you that future requests to amend the Arizona Long Term Care System (ALTCS) affecting program spending will only be approved after successful negotiation of a budget neutrality agreement for ALTCS.

Sincerely,

Charlene Burn
for Dennis G. Smith
Director

SPECIAL TERMS AND CONDITIONS

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

MEDICAID SECTION 1115 DEMONSTRATION

NUMBER: 11-W-00032/09

TITLE: Arizona Health Care Cost Containment System -- AHCCCS, A Statewide Approach of Cost Effective Health Care Financing

AWARDEE: Arizona Health Care Cost Containment System

The following special terms and conditions apply to the project:

1. The State of Arizona will continue to provide access to Arizona Long Term Care System (ALTCS) services to American Indians on the reservation as it does to other citizens of the State.

2. The State will conduct a comprehensive medical audit of all plans between October 1 and September 30 of each year and prepare a report to be submitted to the Centers for Medicare and Medicaid Services (CMS) by July 31 of the following year.

3. The State will not deny Medicaid eligibility for any potentially disabled individual based on using PAS criteria in lieu of the SSI-disability determination. Prior to rendering a final decision of ineligibility based on disability, the State will use the SSI criteria as required under section 1902(a)(10) interpreted through Federal regulations at sections 435.120 and 435.601.

4. Effective October 1, 1999, the provision of home- and community-based services (HCBS) to the elderly and physically disabled (EPD) will no longer be capped. In the absence of a limit, AHCCCS will report annually on current placements and ongoing activities for expanding HCB services and settings. The report will be due by March 31 of each year.

5. The State will submit quarterly progress reports on the encounter data collection process as well as on the quality improvement initiative. These reports are due 60 calendar days after the end of each quarter.

   AHCCCS will submit all identified reports for the Quality Improvement Initiative, based on agreements between CMS and AHCCCS regarding report content, reporting frames, and submission schedules.

6. The State will submit quarterly progress reports, which are due 60 calendar days after the end of each quarter. The reports should include a discussion of events occurring during the quarter that affect health care delivery, quality of care, access, financial results, and other operational issues. The report should also include proposals for addressing any problems identified in the quarterly report. The intent of the report is to present the State's analysis and status of the various operational areas.

7. The Department of Economic Security/Developmental Disabilities Division (DES/DDD) will comply with all contractual and reporting requirements as specified in the Request for Proposal (RFP) between AHCCCS and DES/DDD and in any subsequent amendments. DES/DDD will be sanctioned as specified in the RFP if DES/DDD fails to comply with the stated contractual and reporting requirements. All comparable requirements will apply to the relationship between AHCCCS and the Department of Health Services/Behavioral Health Services (ADHS/BHS).

8. The State will enforce financial penalties on individual health plans and on LTC program contractors that are not complying with data collection requirements.

9. The State will take appropriate action to correct deficiencies identified in the collection of 100 percent encounter data. Steps to be taken will include, at a minimum, data validation studies to determine problems that exist at health plans, technical assistance to plans to correct problems, and sanctioning plans for failure to meet the allowable error rates imposed by CMS. Failure to undertake these activities will result in CMS withholding up to 0.25 percent of Federal matching funds for the current contract year. CMS will inform AHCCCS in writing that it did not carry out the encounter data requirement, specifying what needs to be done, and giving AHCCCS 90 days to correct the deficiency before payments are reduced by 0.25 percent in matching funds for the year. For FY 2002, the effectiveness of AHCCCS' actions will be determined based on the error rates for acute care data and LTC data for the period October 1, 1999 through September 30, 2000, and on the error rates for behavioral health data for the period October 1, 1999 through September 30, 2000. For FY 2003 through FY 2006, these baseline years will advance by one year for each year. AHCCCS' actions will be considered ineffective if error rates exceed the following, over all plans:

ERROR RATES

Criterion	Institutional	Professional
Omission	6.9%	11.9%
Timeliness		12.8%*
Correctness		12.9%*

* Does not include hospital or LTC data.

If AHCCCS' actions are ineffective, CMS may immediately invoke the withhold. Failure to conduct and complete the data validation studies on schedule will also be the basis for invoking the withhold.

10. The allowable error rate for encounter data for all AHCCCS contractors will be 5 percent. Penalty sanctions will be imposed by AHCCCS on all contractors that exceed this error rate.

11. By January 15 of each year, the State will submit a draft annual report, documenting accomplishments, project status, quantitative and case study findings, and policy and administrative difficulties for the fiscal year ended the previous September 30, and a revised annual report incorporating CMS's comments within 30 days of receipt of these comments.

12. AHCCCS will submit to CMS a summary of financial and operational reviews of AHCCCS Health Plans and ALTCS Program Contractors immediately upon completion. In addition, AHCCCS will submit separate summaries of financial and operational reviews that it conducts of DES/DDD and of ADHS/BHS.

13. The State will forward summaries of the financial and operational reviews that ADHS/BHS completes on the Regional Behavioral Health Authorities (RBHAs), as well as summaries of any reviews AHCCCS conducts of ADHS/BHS. The State will also forward summaries of any comparable information prepared by or pertaining to DES/DDD.

14. AHCCCS will require the same level of quality reporting for DES/DDD and ADHS/BHS as for Health Plans and Program Contractors, subject to the same time lines and penalties.

15. Each year, AHCCCS will monitor and ensure that for each contract year, the DES/DDD and the ADHS/BHS have provided the appropriate State match necessary to draw down the FMAP for title XIX services provided, respectively, to ALTCS eligible persons and to AHCCCS eligible persons enrolled with ADHS/BHS. Specifically, AHCCCS and DES/DDD entered into an Intergovernmental Agreement, effective July 1, 1998, whereby DES/DDD transfers to AHCCCS the total amount appropriated for the State match for title XIX ALTCS expenditures. Likewise, AHCCCS and ADHS/BHS entered into an Intergovernmental Agreement, effective July 1, 1999, whereby ADHS/BHS transfers to AHCCCS the total amount appropriated for the State match for title XIX expenditures. AHCCCS deposits the monies transferred into an Intergovernmental Fund from which AHCCCS has sole disbursement authority.

16. AHCCCS will report on a comparison of revenues and costs associated with the DES Interagency Agreement, including how any excess revenues are spent. AHCCCS will also report this information for ADHS/BHS. Both reports will be due by January 15 of each year for the State fiscal year ending the previous June 30.

17. Before contracting with any provider of service, the State will obtain from the provider full disclosure of ownership and control and related party transactions, as specified in

sections 1124 and 1902(a)(38) of the Act. No Federal financial participation (FFP) will be available for providers that fail to provide this information.

18. CMS will utilize the rate-setting method specified below.

    The Federal match for acute-care and ALTCS services will be based on the actual capitation rates AHCCCS negotiates with each provider. Thirty days before the effective date, the acute-care rates and ALTCS rates that AHCCCS negotiates with each provider should be submitted to CMS for review and approval.

19. CMS retains the right to renegotiate rate-setting methodologies used by the AHCCCS and ALTCS programs during the period of the award if the assumptions or projections used in the methodologies are not in reasonable alignment with national projections or with any uniform restriction on Federal matching that applies to all title XIX programs.

20. At any phase of the project, including at the project's conclusion, AHCCCS, if so requested by the project officer, must submit to CMS analytic data file(s), with appropriate documentation, representing the data developed/used in end-product analyses generated under this award. The analytic file(s) may include primary data collected, acquired, or generated under the award and/or data furnished by CMS. The content, format, documentation, and schedule for production of the data file(s) will be agreed upon by AHCCCS and the CMS project officer. The negotiated format(s) could include both file(s) that would be limited to CMS internal use and file(s) that CMS could make available to the general public.

21. At any phase of the project, including at the project's conclusion, AHCCCS, if so requested by the project officer, must deliver to CMS any materials, systems, or other items developed, refined, or enhanced in the course of or under the award. AHCCCS agrees that CMS shall have royalty-free, nonexclusive, and irrevocable rights to reproduce, publish, or otherwise use and authorize others to use the items for Federal Government purposes.

22. In order to track expenditures under this demonstration, the State must submit the following forms for the demonstration on a quarterly basis:

HCFA-64.9	HCFA-64.9a
HCFA-64.9p	HCFA-64.9o
HCFA 64.10	HCFA-64 Certification
HCFA-64.10p	HCFA-64 Summary

    The State must report all administrative and service expenditures allowed under the waivers approved for this demonstration.

23. If the State anticipates that continued enrollment at 100 percent of the Federal Poverty Level (FPL) as part of the acute care eligibility expansion would compromise budget neutrality for the State or Federal government, the State will notify CMS in writing at least 60 days before the intended action to reduce eligibility levels. At the time of the

request, the State will provide previously agreed-upon data to support the request for a reduction. CMS will review the request to reduce eligibility levels for the expansion population and act upon the request within 60 days from receipt of the request. Eligibility levels for the title XIX categorically-eligible population will not be reduced lower than the mandatory Medicaid eligibility levels.

HIFA AMENDMENT

24. The State will establish a monitoring process to ensure that expenditures for the HIFA amendment do not exceed available title XXI funding (i.e., the title XXI allotment or reallocated funds) and the appropriated state match. The State will use title XXI funds to cover services for the SCHIP and HIFA populations in the following priority order:

    1) Individuals eligible under the title XXI State plan.
    2) Beginning on or before October 1, 2002, individuals with adjusted net countable family income above 100 percent of the FPL and at or below 200 percent FPL who are parents of children enrolled in the Arizona Medicaid or SCHIP programs but who themselves are not eligible for either program.
    3) Beginning November 1, 2001, single adults and childless couples with income at or below 100 percent of the FPL who are also eligible under the Medicaid section 1115 eligibility expansion. For purposes of this amendment, these are defined as individuals over age 18 without dependent children.

    If the State determines that title XXI funding will be exhausted, available title XXI funding will first be used to cover costs associated with the title XXI State plan population. The State will not close enrollment, institute waiting lists, or decrease eligibility standards with respect to the children covered under its title XXI State plan while the HIFA amendment is in effect.

    For the purpose of administering the priority system, no distinction will be made between parents of Medicaid children and parents of SCHIP children. The State may also, for the Medicaid or SCHIP parents

    - Lower the federal poverty level used to determine eligibility, and/or
    - Suspend eligibility determination and/or intake into the program, or
    - Discontinue coverage

    Before taking any of the above actions related to the priority system, Arizona will provide 60-day notice to CMS. Subject to legislative approval and the Governor's signature, the expansion to parents of Medicaid and SCHIP children will be implemented on or before October 1, 2002. If this expansion is not implemented, Arizona will no longer receive title XXI funding for single adults and childless couples.

    For the single adults and childless couples, title XIX federal matching funds will be provided if title XXI funding is exhausted, to the extent these individuals are otherwise eligible under the Medicaid demonstration authority approved on January 18, 2001 or any

other approved Medicaid expenditure authority.

25. Information on the HIFA populations will be included in a separate section of the quarterly progress report. AHCCCS will monitor and report on progress toward agreed-upon goals for reducing the rate of uninsurance. From data that are readily available, AHCCCS will also monitor the private insurance market (e.g., changes in employer contribution levels (if possible, among employers with low-income populations), trends in sources of insurance, etc.) and other related information in order to provide a context for interpreting progress toward reducing uninsurance. AHCCCS will also continue to monitor substitution of coverage (i.e., participants dropping private coverage). In addition, data on the HIFA populations will be separately identified in the monthly Eligibility and Enrollment Reports.

26. AHCCCS will explore the feasibility of implementing a pilot program for employer-sponsored insurance (ESI) coverage. The State's assessment will be completed by May 1, 2002, at which time AHCCCS will advise CMS of its findings and conclusions. If CMS and the State mutually agree that it is feasible, AHCCCS will implement an ESI pilot within six months after receiving CMS approval. As part of any pilot, AHCCCS will monitor aggregate costs for participants to ensure that costs are not significantly higher than they would be in the absence of the pilot.

ATTACHMENT A

GENERAL FINANCIAL REQUIREMENTS FOR THE ACUTE CARE PROGRAM

1. The State will submit quarterly expenditure reports using the HCFA-64 to report total expenditures for services provided under the budget neutrality agreement, including those provided to enrollees in the current acute care program as well as those provided through the expansion of the acute care program. CMS will provide Federal Financial Participation (FFP) only for allowable acute care expenditures that do not exceed the pre-defined limits as specified in Attachment C (Monitoring Budget Neutrality for the AHCCCS Acute Care Program).

2. The following describes the reporting of expenditures subject to the budget neutrality cap:

a) In order to track expenditures under this eligibility expansion, the State will report acute care program expenditures through the Medicaid Budget and Expenditure System (MBES), as part of the routine HCFA-64 reporting process. Expenditures subject to the budget neutrality cap will be reported on separate HCFA-64.9s/HCFA-64.9ps, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the budget neutrality agreement year in which services were rendered). The term "expenditures subject to the budget neutrality cap" is defined below in item 2.c.

b) For each year of the budget neutrality agreement, a separate HCFA-64.9/HCFA-64.9p will be submitted reporting expenditures subject to the budget neutrality cap. This form will contain the total of all expenditures for acute care program enrollees (i.e., both those in the current program and those in the expansion).

c) For the purpose of this section, the term "expenditures subject to the budget neutrality cap" will include all Federal Medicaid expenditures made on behalf of acute care enrollees, including those in the current program and those in the expansion. The expansion population will consist of individuals made eligible through amendments to the Arizona State plan using section 1931(b) and section 1902(r)(2) authority as well as individuals made eligible through section 1115(a)(2) authority. "Expenditures subject to the budget neutrality cap" will also include both capitation payments and FFS expenditures. The following expenditures are excluded from the cap: expenditures for the reimbursement of Medicaid services associated with the Medicaid in the Schools program, Arizona Long Term Care System (ALTCS) expenditures, and all administrative expenditures. The State may request, and CMS reserves the right to re-examine, exclusions of expenditures from the budget neutrality cap. The State may also request, and CMS reserves the right to make, prospective adjustments to the budget neutrality cap for changes in current law services from those provided by AHCCCS in the base year specified in Attachment C, 4 c).

d) All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within two years after the calendar quarter in which the State

made the expenditures. During the period following the conclusion or termination of the budget neutrality agreement, the State must continue to separately identify expenditures subject to the budget neutrality cap, using the procedures addressed above.

3. The following describes the reporting of member months subject to the budget neutrality cap:

a) For the purpose of calculating the budget neutrality expenditure cap described in Attachment C, the State will provide to CMS on a quarterly basis the actual number of eligible member months (as defined in 3.b.). These will include member months only for individuals enrolled in the current acute care program and individuals made eligible for the expansion through amendments to the Arizona State plan using section 1931(b) and section 1902(r)(2) authority. This information should be provided to CMS 30 days after the end of each quarter as part of the HCFA-64 submission under the narrative section of the MBES or as a stand-alone report.

b) The term "eligible member months" will refer to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member months.

4. The procedures related to the reporting of expenditures and member months will be described in an operational protocol to be submitted by the State to CMS no later than 30 days prior to implementation of the eligibility expansion. CMS will respond within 30 days of receipt of the operational protocol regarding any issues or areas it believes require clarification. During the duration of the budget neutrality agreement, subsequent changes to the operational protocol that are the result of major changes in policy or operating procedures should be submitted no later than 30 days prior to the date of implementation of the change(s) for approval by CMS. The State will assure and monitor compliance with the operational protocol.

5. The standard Medicaid funding process will be used during the duration of the budget neutrality agreement. Arizona must estimate matchable Medicaid expenditures on the quarterly Form HCFA-37. The State must submit supplemental schedules that provide estimates of expenditures for the entire acute care population (both current and expansion groups combined). CMS will make Federal funds available each quarter based upon the State's estimates, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form HCFA-64 quarterly Medicaid expenditure report, showing Medicaid expenditures for the quarter just ended. CMS will reconcile expenditures reported on the Form HCFA-64 with Federal funding previously made available to the State for that quarter, and include the reconciling adjustment in the finalization of the grant award to the State.

6. CMS will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in Attachment C:

a) Administrative costs of the entire acute care program (including current and expansion);

b) Net expenditures of the Medicaid program and prior period adjustments that are paid in accordance with the current acute care program (including Disproportionate Share Hospital payments); and

c) Net medical assistance expenditures made in conjunction with the acute care expansion.

7. The State will certify State/local monies used as matching funds for the Arizona acute care program and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

ATTACHMENT B

LEGISLATION

1. All requirements of the Medicaid program expressed in laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter of which these amended Special Terms and Conditions are part, will apply to the Arizona acute care eligibility expansion. To the extent the enforcement of such laws, regulations, and policy statements would have affected State spending in the absence of a budget neutrality agreement in ways not explicitly anticipated in this agreement, CMS will incorporate such effects into a modified budget limit for Arizona. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement. CMS will have two years after the amendment award date to notify the State that it intends to take action. The growth rates for the budget neutrality baseline are not subject to this Special Term and Condition. If the law, regulation, or policy statement cannot be linked specifically with program components that are or are not affected by the Arizona acute care eligibility expansion (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the State's budget limit will be proportional to the size of the Arizona budget neutrality agreement in comparison to the State's entire Medicaid program (as measured in aggregate medical assistance payments).

2. The State will, within the time frame specified in law, come into compliance with any changes in Federal law, regulation or policy affecting the Medicaid program that take effect after the amendment award date. To the extent that a change in Federal law, regulation or policy that does not exempt State section 1115 demonstrations would affect State Medicaid spending in the absence of the demonstration, CMS will incorporate such changes into a modified budget limit for the Arizona acute care eligibility expansion. The modified budget limit will be effective upon implementation of the change in Federal law, as specified in law. If the new law cannot be linked specifically with program components that are or are not affected by the Arizona acute care eligibility expansion (e.g., laws affecting sources of Medicaid funding), the State will submit its methodology to CMS for complying with the change in law. If the methodology is consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law in Arizona, CMS would approve the methodology. Should CMS and the State, working in good faith to ensure State flexibility, fail to develop within 90 days a methodology to revise the without waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments will be made according to the method applied in non-demonstration States.

3. The State may submit to CMS a request for an amendment to request exemption from changes in law taking effect after the amendment award date. The cost to the Federal government of such an amendment must be offset to ensure that total projected expenditures under a modified Arizona budget neutrality agreement do not exceed projected expenditures in the absence of the Arizona demonstration (assuming full compliance with the change in law).

ATTACHMENT C

MONITORING BUDGET NEUTRALITY FOR THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ACUTE CARE PROGRAM

1. Arizona will be subject to a limit on the amount of Federal title XIX funding that the State may receive on expenditures for its acute care program during the duration of the budget neutrality agreement. This limit will be determined using a per capita cost method. In this way, Arizona will be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles in the acute care program, but not for the number of Medicaid eligibles in the acute care program. By providing FFP for all Medicaid eligibles in the acute care program, CMS will not place Arizona at risk for changing economic conditions. However, by placing Arizona at risk for the per capita costs of Medicaid eligibles in the acute care program, CMS assures that the expenditures for the acute care program do not exceed the levels that would have been realized had there been no budget neutrality agreement.

2. The budget neutrality (i.e., overall expenditure) limit for the acute care program will be the sum of two components: the projected medical assistance payments and the Disproportionate Share Hospital (DSH) allotments.

3. For the purpose of calculating the budget neutrality limit for the acute care program, the State will provide to CMS on a quarterly basis the actual number of eligible member months for enrollees in the current acute care program and that portion of the expansion authorized through State plan amendments only. This information should be provided to CMS 30 days after the end of each quarter as part of the HCFA-64 submission under the narrative section of the MBES or as a stand-alone report. The State will report eligible member months for enrollees in the current acute care program and that portion of the expansion authorized through State plan amendments only for each quarter beginning April 1, 2001, until the end of the budget neutrality agreement (September 30, 2006).

4. The following describes the method for calculating the budget neutrality limit:

   a) For each year of the budget neutrality agreement, a separate annual limit is calculated.

   b) The annual limit for the medical assistance payments component will be calculated as the product of the number of eligible member months reported by the State for enrollees in the current acute care program plus those enrolled in that portion of the expansion authorized through State plan amendments times the appropriate estimated per member/per month (PMPM) cost from the table in item 4.c. below.

c) The base year for budget neutrality purposes will be FFY 1999. The following are the estimated PMPM costs for the calculation of the budget neutrality limit for the medical assistance payments component:

FFY	Overall AFDC/SOBRA	SSI
2001 (April-September)	$250.23	$473.25
2002	$273.98	$505.81
2003	$300.00	$540.60
2004	$328.48	$577.80
2005	$359.67	$617.55
2006	$393.82	$660.04

d) The DSH component of the budget neutrality agreement will be the published allotment for each year of the budget neutrality agreement.

e) The annual limit will be the sum of the medical assistance payments component and the DSH allotment, as described above. The overall budget neutrality limit is the sum of the annual limits for the 5 1/2 years of the budget neutrality agreement. The actual Federal share of the budget neutrality limit represents the maximum amount of FFP that the State may receive during the 5 1/2 years of the budget neutrality agreement (April 1, 2001 through September 30, 2006) for Medicaid expenditures. For each FFY, the Federal share will be calculated using the effective FMAP rate for that year.

5. The budget neutrality limit calculated above will be applied to actual expenditures for medical services, as reported by the State under Attachment A. If at the end of the 5 1/2-year period of the budget neutrality agreement the limit has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients, program categories, services and provider types not listed. If the demonstration is terminated prior to the end of the 5 1/2-year budget neutrality agreement, the budget neutrality test will be based on the time elapsed through the termination date.

6. If any health care-related tax that was in effect during the base period, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care-related tax provisions of section 1903(w) of the Social Security Act, CMS reserves the right to make adjustments to the budget neutrality limit.

7. CMS will enforce budget neutrality over the 5 1/2-year period of the agreement, rather than on an annual basis. However, no later than 6 months after the end of each year (or 18-month period in the case of FFY 2001-FFY 2002) of the budget neutrality agreement, HCFA will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide, if the State exceeds the cumulative

target, it will submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

FFY	Cumulative target definition	Percentage
2001-2002*	FFYs 2001 and 2002 budget neutrality caps plus	8 percent
2003	FFYs 2001 through 2003 budget neutrality caps plus	3 percent
2004	FFYs 2001 through 2004 budget neutrality caps plus	1 percent
2005	FFYs 2001 through 2005 budget neutrality cap plus	0.5 percent
2006	FFYs 2001 through 2006 budget neutrality cap plus	0 percent

* 4/1/01-9/30/02

ATTACHMENT D

FINANCIAL REQUIREMENTS FOR THE HIFA 1115 AMENDMENT

1. The State will provide quarterly expenditure reports using the Form HCFA-21 to report total expenditures for services provided under the approved SCHIP State plan and through the Arizona HIFA amendment approved under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide Federal Financial Participation (FFP) only for allowable Arizona HIFA amendment expenditures that do not exceed the State's available title XXI funding.

2. a. In order to track expenditures under the demonstration, the State will report expenditures for the HIFA amendment through the Medicaid Budget and Expenditure System (MBES), as part of the routine quarterly HCFA-21 reporting process. Title XXI amendment expenditures will be reported for each HIFA eligibility group on separate Forms HCFA-21 Waiver/HCFA-21P Waiver, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made).

   b. All claims for expenditures related to the HIFA amendment (including any cost settlements) must be made within two years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During this two-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form HCFA-21.

   c. The standard SCHIP funding process will be used during the demonstration. Arizona must estimate matchable SCHIP expenditures on the quarterly Form HCFA-21B. On a separate HCFA-21B, the State will provide updated estimates of expenditures for the HIFA amendment populations. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form HCFA-21 quarterly SCHIP expenditure report. CMS will reconcile expenditures reported on the Form HCFA-21 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

d. The State will certify State/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other federal grant or contract, except as permitted by federal law.

3. Arizona will be subject to a limit on the amount of federal title XXI funding that the State may receive for HIFA amendment expenditures during the demonstration period. Federal title XXI funding available for HIFA amendment expenditures is limited to the State's available allotment, including current reallocated funds. For the purpose of administering the priority system, no distinction will be made between parents of Medicaid children and parents of SCHIP children. Should the State expend its available title XXI funding, no further enhanced federal matching funds will be available for costs of the separate child health program and HIFA amendment populations until the next allotment becomes available. Title XIX federal matching funds will be provided for the single adults and childless couples if title XXI funding is exhausted.

4. Total Federal title XXI funds for the State's SCHIP program (i.e., the approved title XXI State plan and the HIFA amendment) are restricted to the State's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with the State plan population. HIFA amendment expenditures are limited to remaining funds.

5. Total expenditures for outreach and other reasonable costs to administer the title XXI State plan and the HIFA amendment may not exceed ten percent of total title XXI expenditures.

03/02

Cumulative List of Waivers and Expenditure Authorities
for the Arizona Health Care Cost Containment System (AHCCCS) Demonstration

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), waivers of the following provisions of the Act (and its implementing regulations) are granted through September 30, 2006, to enable the State to carry out the demonstration, consistent with the accompanying special terms and conditions:

1. To enable the State to impose cost sharing on mandatory services and to individuals enrolled in a health maintenance organization.

   Section 1902(a)(14), (42 CFR 447.50 and 447.53)

2. To enable the State to restrict freedom of choice of provider. Among other things, this waiver will allow the State to restrict the freedom of choice of provider upon re-enrollment for individuals who lose eligibility and then become eligible again within 90 days.

   Section 1902(a)(23), (42 CFR 431.51)

3. To enable the State to obtain flexibility in arranging reimbursement agreements with health care providers.

   Section 1902(a)(13), (42 CFR 447.250 - 447.371) (except for the public notice provisions in 1902(a)(13)(A)); Section 1902(a)(30), insofar as it is implemented by the regulations cited above and by 42 CFR 434.23; Section 1902(a)(4), insofar as it is implemented by 42 CFR 434.23.

4. To enable the State to exclude hospitalized individuals and others not requiring long-term care (LTC) services from the optional institutionalized eligibility categories.

   Section 1902(a)(10)(A)(ii)(V), (42 CFR 435.217 and 435.236)

5. To enable the State to receive payment for outpatient drugs without complying with the requirements of the Omnibus Budget Reconciliation Act of 1990 pertaining to drug rebate and drug use review.

   Section 1902(a)(54), (42 CFR 456.700 - 456.725)

6. To enable the State to provide supported employment services to certain developmentally-disabled HCBS services clients.

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

7. To enable the State to disregard quarterly income totaling less than $20 from the post-eligibility income determination.

   Section 1902(a)(17), (42 CFR 435.725 and 435.726)

8. To the extent necessary to permit the State to offer different benefits to managed care organization enrollees that are not offered to Medicaid beneficiaries not enrolled.

   Section 1902(a)(10)(B)(i)

9. 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.

   Section 1902(a)(34)

10. To enable the State to exempt from recovery the estates of acute care enrollees age 55 or older who receive LTC services.

    Section 1902(a)(18)

Under the authority of section 1115(a)(2) of the Act, expenditures made by the State for the items identified below (which would not otherwise be included as matchable expenditures under section 1903) shall, for the period of this project, be regarded as matchable expenditures under the State's Medicaid State plan:

1. Expenditures for hospital services that would not otherwise be federally matchable due to the limits on matching in section 1903(i)(3).

2. Expenditures under contracts with managed care entities that do not meet the requirements in section 1903(m)(2)(A) specified below. AHCCCS' managed care plans participating in the demonstration will have to meet all the requirements of section 1903(m) except the following:

   --1903(m)(2)(A)(i), but only insofar as the provisions of 1903(m)(1)(A)(i) would otherwise preclude Native Americans from having a choice to enroll in either Indian Health Service facilities or AHCCCS plans;

   --1903(m)(2)(A)(vi) insofar as it requires compliance with the requirements in section 1932(a)(4) - that enrollees be permitted an initial 90-day period within which they can disenroll without cause.

   --1903(m)(2)(A)(viii) and 1903(m)(4)(A) and (B), but only insofar as these provisions relate to disclosure of transactions between AHCCCS plans and parties in interest.

3. Expenditures associated with the provision of HCBS to individuals determined to be eligible and for services specified in the program. Those expenditures include, but are not limited to, the establishment of ALTCS eligibility for all individuals with income levels up to 300 percent of the SSI income level, whether institutionalized or non-institutionalized, as well as individuals enrolled in the ALTCS Transitional program; waiving parental income for children up to age 18; and imposing the share of cost and personal needs allowance requirements.

4. Expenditures for outpatient drugs which would otherwise be excluded by virtue of section 1903(i)(10).

5. Expenditures to extend ALTCS eligibility to individuals under the age of 65 using the preadmission screening instrument as a substitute disability standard.

6. Expenditures to provide continued medical coverage to children who meet the initial eligibility requirement as a deemed newborn without consideration of the mother's continued Medicaid eligibility.

7. Expenditures to provide family planning services for up to 24 months to AHCCCS-eligible women who subsequently lose eligibility at 60 days postpartum.

8. Expenditures for services to an AHCCCS enrollee age 21-64 residing in an IMD for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days. Enrollees who were residing in an IMD as of the date of the award letter, but who were admitted prior to the date of this letter, will not be eligible for title XIX reimbursement for that stay. Enrollees who are admitted on or after the date of the award letter will be eligible for title XIX reimbursement, subject to the 30/60 limits.

9. In determining the eligibility of ALTCS applicants and recipients, expenditures associated with excluding from the 300 percent of SSI test and post-eligibility calculations the income currently excluded from the 100 percent of SSI test listed in section 1612(b) of the Act.

10. Expenditures associated with eliminating the 30-day wait for use of 300 percent of SSI as the income limit in determining eligibility for new ALTCS applicants.

11. Expenditures associated with allowing some dependent children or spouses to qualify for ALTCS one month earlier than usual by disregarding the income and resources of responsible relatives or spouses in the month of separation.

12. Expenditures associated with disregarding in-kind support and maintenance (ISM) as income in determining eligibility for QMB, SLMB, QI 1, QI 2, or SSI-MAO benefits.

13. Expenditures associated with changing the budgeting process for ALTCS and SSI-MAO income eligibility determinations when there is an eligible or ineligible spouse (if the spousal impoverishment requirements of section 1924 of the Act do not apply) or when the applicant/recipient is living with a minor dependent child.

14. Expenditures associated with simplifying the life insurance and burial funds policy in the eligibility determination process for the SSI-MAO groups.

15. Expenditures associated with excluding the value of household goods and personal effects in the eligibility determination process for the SSI-MAO groups.

16. Expenditures associated with excluding the value of mineral rights, oil rights, and timber rights in the eligibility determination process for the SSI-MAO groups.

17. Expenditures associated with allowing resource determinations to be made based on resource verifications produced for any date during a calendar month, making the individual resource eligible for the entire month.

18. Expenditures to provide Medicaid coverage to individuals with adjusted net countable income at or below 100 percent of the Federal Poverty Level (FPL) who are not otherwise eligible for Medicaid.

19. Expenditures to provide Medicaid coverage to individuals who have medical bills incurred by the family unit sufficient to reduce their adjusted net countable family income to 40 percent or less of the FPL and who are not otherwise eligible for Medicaid.

20. Expenditures that would have been disallowed under section 1903(u) of the Act based on MEQC findings.

21. Expenditures for medical assistance provided to individuals who are determined to be eligible for Medicaid as SSI recipients under: the "Pickle Amendment," section 503 of Public Law Number 94-566; section 1634(c) of the Act (disabled adult children); and section 1634(b) of the Act (disabled widows and widowers), who because of excess resources actually do not qualify for this status.

Under the authority of section 1115(a)(2) of the Act, as incorporated into title XXI by section 2107(e)(2)(A), State expenditures described below (which would not otherwise be included as matchable expenditures under title XXI) shall, for the period of this project 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:

22. Expenditures to provide Medicaid coverage to individuals over age 18 with adjusted net countable family income at or below 100 percent of the FPL, who are single adults and childless couples, and who are not otherwise eligible for such coverage, except through

the demonstration project amendment approved January 18, 2001.

23. Expenditures to provide demonstration coverage consistent with the requirements of section 2103 to individuals whose adjusted net countable family income exceeds 100 percent of the FPL, but does not exceed 200 percent of the FPL, who are parents of children enrolled in the Arizona Medicaid or title XXI programs, and who are not otherwise eligible for Medicaid or title XXI coverage.