Janice K. Brewer, Governor
Thomas J. Betlach, Director

801 East Jefferson, Phoenix, AZ 85034
PO Box 25520, Phoenix, AZ 85002
Phone: 602-417-4000
www.azahcccs.gov

AHCCCS

Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

December 12, 2013

Cheryl Young
Centers for Medicare & Medicaid Services
Division of Medicaid & Children's Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Dear Ms. Young:

Enclosed is Arizona State Plan Amendment (SPA) #13-015, effective January 1, 2014, which updates the State Plan to reflect the methodology for identification of applicable FMAP rates.

If you have any questions about the enclosed SPA, please contact Theresa Gonzales at (602) 417-4732.

Sincerely,

Monica Coury
Assistant Director
Office of Intergovernmental Relations

Cc: Wakina Scott

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: Centers for Medicare and Medicaid Services**	1. TRANSMITTAL NUMBER: 13-015	2. STATE Arizona
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE January 1, 2014	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

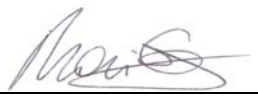
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 433.206(h)	7. FEDERAL BUDGET IMPACT: FFY 2014: $ 0 FFY 2015: $ 0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 18 to Attachment 2.6A pages 1-6 Attachment A Attachment E	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:

Updates the State Plan to reflect the methodology for identification of applicable FMAP rates, effective January 1, 2014.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Monica Coury 801 E. Jefferson, MD#4200 Phoenix, Arizona 85034
13. TYPED NAME: Monica Coury	
14. TITLE: Assistant Director	
15. DATE SUBMITTED: December 12, 2013	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE:

State Plan Under Title XIX of the Social Security Act

State: Arizona

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

Part 1 – Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on 12/03/2013 . In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.

Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

Covered Populations Within New Adult Group		Applicable Population Adjustment			
Population Group	**Relevant Population Group Income Standard** For each population group, indicate the lower of: • The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or • 133% FPL. If a population group was not covered as of 12/1/09, enter "Not covered".	**Resource Proxy**	**Enrollment Cap**	**Special Circumstances**	**Other Adjustments**
		Enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.			
A	B	C	D	E	F
Parents/Caretaker Relatives	**100% FPL = 106% FPL (MAGI)**	No	No	No	No
Disabled Persons, non-institutionalized	**Not covered within new adult group**	N/A	N/A	N/A	N/A
Disabled Persons, institutionalized	**Not covered within new adult group**	N/A	N/A	N/A	N/A
Children Age 19 or 20	**Not covered within new adult group**	N/A	N/A	N/A	N/A
Childless Adults	**100% FPL = 106% FPL (MAGI)**	No	No	No	No

Part 2 – Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances

A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))

1. The state:

   ☐ Applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   ☒ Does NOT apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B).

   Table 1 indicates the group or groups for which the state applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment B.

2. Data source used for resource proxy adjustments:

   The state:

   ☐ Applies existing state data from periods before January 1, 2014.

   ☐ Applies data obtained through a post-eligibility statistically valid sample of individuals.

   Data used in resource proxy adjustments is described in Attachment B.

3. Resource Proxy Methodology: Attachment B describes the sampling approach or other methodology used for calculating the adjustment.

B. Enrollment Cap Adjustment (42 CFR 433.206(e))

1. ☐ An enrollment cap adjustment is applied by the state (complete items 2 through 4).

   ☒ An enrollment cap adjustment is not applied by the state (skip items 2 through 4 and go to Section C).

2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009 that are applicable to populations that the state covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).

3. The state applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:

   ☐ Yes. The combined enrollment cap adjustment is described in Attachment C

   ☒ No.

4. Enrollment Cap Methodology: Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

C. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology

1. The state:

   ☐ Applies a special circumstances adjustment(s).

   ☒ Does not apply a special circumstances adjustment.

2. The state:

   ☐ Applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).

   ☒ Does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).

3. Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group

A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group

☒ Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E, and where applicable, is subject to any special circumstances or other adjustments described in Attachment D.

☐ The state does not have any relevant populations requiring such transitions.

Part 4 - Applicability of Special FMAP Rates

A. Expansion State Designation

The state:

☐ Does NOT meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 5)

☒ Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated 10/30/2013.

B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP.

The state:

☐ Does NOT qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).

☒ Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated 10/30/2013. The state will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

Part 5 - State Attestations

The State attests to the following:

A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.

B. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

ATTACHMENTS

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this SPA:

- ☒ Attachment A – Conversion Plan Standards Referenced in Table 1
- ☐ Attachment B – Resource Criteria Proxy Methodology
- ☐ Attachment C – Enrollment Cap Methodology
- ☐ Attachment D – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology
- ☒ Attachment E – Transition Methodologies

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 4 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Part 2 of Modified Adjusted Gross Income (MAGI) Conversion Plan

This MAGI Conversion Plan is being submitted to CMS by **Arizona** in accordance with the final FMAP rule published in the Federal Register April 2, 2013 (78 FR 19918) and under Section 1902(e)(14)(A) of the Social Security Act.

Purpose of Part 2 Income Conversions

Part 2 of the MAGI Conversion Plan includes income conversions that will be needed for FMAP claiming purposes in the new Medicaid adult group. States that wish to claim newly eligible and/or expansion state FMAP for enrollees in the adult group (42 CFR 435.119) must submit a State Plan Amendment (SPA) to CMS. States will use information from this document to complete the FMAP claiming SPA. It is highly recommended that states not expanding Medicaid in 2014 complete this document for all relevant eligibility groups so that necessary information will be available should the state implement a change in policy.

State Options for Part 2 MAGI Conversions

In its December 28, 2012 State Health Officials' Letter, CMS laid out several MAGI conversion methodology choices for states. Choices that states made during Part 1 of the MAGI conversion process affect their options for this part (Part 2) of the MAGI Conversion Plan. In general, states must use the same method as they used in Part 1, with the exception that states that previously chose to do their own conversions may choose the Standardized MAGI Conversion Methodology with SIPP data for any groups that were not converted in Part 1. The state must provide an explanation of the reason for the change.

Information Provided to States for Part 2 MAGI Conversions

To facilitate the process of completing this document (Part 2 of the Income Conversion Plan), CMS is providing states with information summarized from available sources. CMS will provide each state with the following:

- A detailed list of the new conversions performed using SIPP; and
- A document titled "Summary Information for Part 2 of Modified Adjusted Gross Income (MAGI) Conversion Plan." This document combines information from the state's approved Part 1 conversion plan and the new SIPP conversions performed, which together comprise the information that states will need to:
    - identify the relevant standards,
    - perform the conversions (for those states not using the SIPP conversions),
    - submit this document (Part 2 of the MAGI Conversion Plan) and
    - submit their FMAP claiming State Plan Amendments.

Populating the Relevant Standards in an FMAP Claiming SPA

The information that your state submits, and that CMS approves in this document (Part 2 of the MAGI Conversion Plan), will be recorded in the FMAP Claiming SPA. In the SPA states will provide the converted income standards for each relevant population group.

- For states using **Option 1** (the Standard Method with SIPP data), the information to supply in your SPA appears in column C in the sheet titled "Summary Information for Part 2 of Modified Adjusted Gross Income (MAGI) Conversion Plan."
- For states using **Option 2** (the Standard Method with state data or an alternative method), the information to supply in your SPA appears in column G in Table 1 of this document.

SECTION 1

Instructions

1. **Please indicate the MAGI conversion method chosen by your state and follow the appropriate instructions below. (Reminder: this should be the same as the method your state chose for Part 1 of your Conversion Plan.)**

☐ **Option 1** – Standardized Methodology with SIPP data

☒ **Option 2** – State Data (Standardized Method or Alternative Method): this includes states that chose to do their own conversions for Part 1 and choose to use SIPP data for eligibility groups that were not previously converted.

Please follow the instructions below and submit this plan to incomeconversion@cms.hhs.gov. This document (Conversion Plan Part 2) is due by November 15, 2013 or ten days after receipt of your state's Part 2 SIPP conversion results, whichever is later.

Option 1: FMAP conversions using SIPP data (standardized method	1) Review the sheet titled "Summary Information for Part 2 of Modified Adjusted Gross Income (MAGI) Conversion Plan" that was provided to you by CMS with your Part 2 conversion results. 2) Indicate in step 2 below which option your state is choosing for time-limited disregards, if applicable. 3) Submit Section 1 along with the sheet labeled "Summary Information for Part 2 of Modified Adjusted Gross Income (MAGI) Conversion Plan" to CMS as Part 2 of your MAGI conversion plan.
Option 2: FMAP conversions using State Data (standardized or alternative method)	1) Complete Section 2 of this document. Your state may use a combination of State Data and SIPP data for this submission, but you will need to provide additional explanation. In Table 1, for values that you have previously converted and CMS has approved or for which you are using SIPP you may either insert the state data/SIPP values from the "Summary Information for Part 2 of Modified Adjusted Gross Income (MAGI) Conversion Plan" sheet or insert specific cross references to that sheet.0 2) Submit this document to CMS as Part 2 of your MAGI

	conversion plan.

2. Time-limited disregards:

Select the appropriate option below for how your state chooses to convert standards with time-limited disregards for Part 2 of your MAGI conversion plan:

- ☒ Not applicable, no new conversions of standards with time-limited disregards.
- ☐ Use highest converted standard
- ☐ CMS-supplied conversions with weighting for time-limited disregards
- ☐ State-calculated weights for time-limited disregards (provide a separate attachment detailing the eligibility groups to which this applies, the weights applied, the data used to derive the weights, the formula used to apply the weight, and the converted standard).

SECTION 2

Option 2

For States Using Standardized Methodology with State Data or Alternative Method with State Data

Please provide a state contact who can answer questions about the conversion plan, data, and conversion methods:

Name: Penny Ellis Title: Deputy Assistant Director, DMS

E-mail: Penny.Ellis@azahcccs.gov Phone: (602) 417-4512

Supplemental Information: In addition to the information provided in this document, during the review and approval process, CMS may determine that supplemental information regarding the income conversion results is necessary. If CMS determines that a supplemental review of these results is necessary, your state may be required to submit:

- Descriptive statistics of the data used. Such descriptive statistics could include for each eligibility group converted with state data:
    - Net income statistics and disregard statistics for the full population or sample and for the population used in conversion (e.g., the 25% band) including: Total N, mean net income, mean gross income, and number of individuals with positive net income, number with earned income, mean earned income, number with unearned income, and mean unearned income
- Data files used for conversion
- Annotated programming code used in the analysis

FMAP Claiming Conversions

For States Using
Standardized Methodology with State Data
Or
Alternative Method with State Data

Please fill out Table 1 below to provide CMS with information about how state data were used for FMAP-related conversions. Use the "Summary Information for Part 2 of Modified Adjusted Gross Income (MAGI) Conversion Plan" provided by CMS to identify which standards need to be converted. Column B contains the net standards as of December 1, 2009 for each group.

Alternative Method States: Does the information you supplied about your alternative method in Part 1 of your state's MAGI Conversion Plan also apply to the conversions in Part 2 (summary of method and data source, differences from standardized method, equations, description of how fixed dollar standards are converted, and description of how the method meets the criteria specified in the December 28, 2012 State Health Officials' Letter on MAGI conversion)?

☐ **Yes**

☒ **No:** ***Please attach a separate explanation of how the method for FMAP conversion differs and why the changes to the method were made.***

Instructions for Table 1:

Population group: The population groups listed in column A are the groups that are relevant for FMAP claiming. **Special instructions for children ages 19-20**: this conversion is only needed for FMAP claiming if your state covered the entire population of children; if coverage was limited to specific groups of children 19/20 (e.g., foster children), then you do not need to convert this group for FMAP claiming purposes. If a conversion is needed for the children age 19-20 group, please indicate in Column A which age limit (19 or 20) was applicable in your state as of December 1, 2009.

SIPP results used: In column B, if your state is using SIPP results for any groups, please mark yes in column B of Table 1 and provide the converted standard from those results. Please list the group below (e.g., parents) and an explanation of why the SIPP results are being used for this eligibility group (e.g., state data unavailable). Also, for groups that have time-limited disregards, if the state chooses to provide its own weighting, please provide the state-specific weighting strategy that was used to derive the converted standard. The explanation of the weighting strategy should include the percent assumed to have time limited disregards and the data on which this calculation was based (e.g., 15%: based on analysis of state data for those enrolled in the 1931 group in CY 2012). Attach additional pages if necessary. **Note that for groups that need to be converted both for eligibility and FMAP purposes (e.g., childless adults) the same income conversion method/data source (i.e., SIPP or state data) must be used even if the values are different (i.e., the state had a different standard in 2009 than in 2013).**

Time period: In column C, specify the time period of data that was used, for example: June 2011-May 2012. If a time period other than 12 months was used, please explain why below and summarize the methods used to determine that the time period is unbiased. Attach additional pages if necessary**:**

Sampling: In column D, mark yes or no. If yes (the analysis did not include all records in the eligibility group), please provide a detailed explanation below of the sampling approach that was used (i.e., simple random sample, stratified sample, etc.). Please also provide information about the total population and the number of records sampled. Attach additional pages if necessary.

_____

_____

_____

_____

_____

_____

Net income standard: In column E, specify the net standard that was converted for each eligibility group. This can be located in column B of the document titled "Summary Information for Part 2 of Modified Adjusted Gross Income (MAGI) Conversion Plan."

Income band used in conversion: In column F, specify the income band that was used in conversion. This band should reflect the net standard minus 25 percentage points of FPL (or FBR if relevant).[1] For example, if the net standard was 120% FPL, the income band used in conversion would be 95% FPL to 120% FPL. For standards at or below 25% FPL, the income band will include all records—e.g., for a net standard of 18% FPL, the income band used in conversion should be 0-18% FPL. For conversions of fixed dollar thresholds, please specify the income band (expressed as a percentage of FPL or FBR)[1] for each family size.[2] For states using an alternative method, this column should only be filled out if it is applicable (e.g., if the marginal approach was used).

Converted standard: Fill in the converted standard that resulted from your calculations in column G. If your state is using SIPP results for any group in Table 1, this information can be found in column C of the document titled "Summary Information for Part 2 of

[1] See "Frequently Asked Questions About MAGI Conversions for FMAP Claiming" for an explanation. Available at http://www.shadac.org/content/state-resources-converting-medicaid-eligibility-groups-magi.

[2] See page 14 of *How States Can Implement the Standardized Modified Adjusted Gross Income (MAGI) Conversion Methodology from State Medicaid and CHIP Data* for more information on converting fixed dollar standards to FPL. http://aspe.hhs.gov/health/reports/2013/MAGIHowTo/rb.cfm.

Modified Adjusted Gross Income (MAGI) Conversion Plan." The information in column G will be the values you will use for your FMAP Claiming State Plan Amendment. For the non-institutionalized disabled adult group, indicate in column G whether you used the average or the median disregard from the relevant income band for conversion.[1]

Table 1

Part 2 of MAGI Conversion Plan Using State Data

	Population Group	SIPP results used? (Yes/No)	Time Period selected	Sampling (Yes/No)	Net Income Standard	Income band used in conversion*	Converted Standard
	A	B	C	D	E	F	G
Conversions for FMAP Claiming							
1	Parents/Caretaker Relatives (Expand number of rows for family size as needed for larger family size standards defined by the state)	**No**	**January, April, July 2012**	**No**	**100 FPL%**	**75%-100% FPL**	**106% FPL**
2	Non-institutionalized disabled adults	**N/A****	**N/A****	**N/A****	**N/A****	**N/A****	**N/A****
3	Institutionalized disabled adults (This is a gross income category: fill in column G **only**)						**300% SSI FBR**

	Population Group	SIPP results used? (Yes/No)	Time Period selected	Sampling (Yes/No)	Net Income Standard	Income band used in conversion*	Converted Standard
	A	B	C	D	E	F	G
4	Children age 19 and/or 20 **Specify age limit as of 12/1/09** **(19 or 20):** **_____**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
5	Childless Adults	**No**	**January, April, July 2012**	**No**	**100 FPL%**	**75%-100% FPL**	**105% FPL**

*Alternative method states: only fill out column F if applicable.

**** See Arizona's Alternative FMAP conversion proposal attached**

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 20 per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Attachment 1

Summary

- Arizona is building a fully integrated system (HEAplus) with MAGI and non-MAGI rules. HEAplus will accurately identify newly and non-newly eligible recipients and transmit this information to the MMIS system.
- In December 2009, Arizona covered childless adults and the disabled population at 100% of the FPL. If an applicant had a confirmed disability determination, they were enrolled in the ABD category, if they met the net income test. If they did not meet the ABD income test, but could pass the income test for the Childless Adult program they would be enrolled as a Childless Adult. If they were not disabled (or claimed they were disabled but did not have a formal disability determination), they were enrolled in the childless adult category, if they met the net income test for Childless Adults. If they did not meet the income test for Childless Adults they would be evaluated under the ABD category for a determination of disability and would also need to meet the net income test for ABD. Our approach remains the same in 2014.
- Arizona already runs the full net test for the ABD programs if it is needed. The HEAplus system will run the full net test for ABD just as the legacy system does today. There is no need to approximate it with an income conversion.
- The Arizona Long Term Care System is limited to individuals who need an institutional level of care.

Proposed Solution

Arizona will not convert ABD categories. Consumers who are age 65 or older or have evidence of a confirmed disability determination, if eligible, will be approved for coverage under the ABD category. If they are not eligible under the ABD category they will be considered under the New Adult category. Additionally, if Arizona puts an individual into the adult group but later realizes that the individual was actually disabled when they were put into that group (and we determine a net income standard for the individual using SSI income counting methods that qualifies the individual in the disabled group), Arizona will claim regular match for the period the individual was erroneously in the adult group.

Consumers who are not eligible for the new Adult category, and who indicate they have a disability (that has not been determined yet), will be evaluated under ABD eligibility rules and Arizona will make a determination of disability for these consumers.

Arizona understands that CMS will complete a SIPP income conversion for Arizona's relevant disabled group ("eligible but not receiving cash assistance" 1902(a)(10)(A)(ii)(I)). If Arizona ever changes its income standard for its non-institutionalized disabled group, we understand that Arizona will need to submit a new FMAP SPA and indicate that we are going to use the converted SIPP result as the threshold moving forward.

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

Children and Adults Health Programs Group

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

OCT 15 2013

Dear Mr. Betlach:

On August 23, 2013, your staff submitted a draft transition plan for your section 1115 demonstration, Arizona Health Care Cost Containment (project number 11-W-00275/09 and 21-W-0064/9). We appreciate the cooperation and collaboration your staff has provided during our review of your section 1115 demonstration transition plan.

Please find attached a clean version of your transition plan. CMS has accepted the redline edits you submitted on October 2, 2013. We ask that you review this document carefully and submit your confirmation of your transition plan as described in the enclosed document within 15 days.

Based on the enclosed version of your transition plan, at this time we have no further questions about your 2013 transition plan for your section 1115 demonstration population. Please note that the draft transition notices are still outstanding; we request that you submit the draft notices as soon as possible. Please be aware that we may have additional questions after the submission of the outstanding items.

Please note that we will continue to work with you through the State Operations Technical Assistance (SOTA) process on issues related to overall eligibility and enrollment policies and practices for 2014, such as the grandfathering protections for beneficiaries. Other Centers for Medicare & Medicaid Services (CMS) components will continue to work with you on other Affordable Care Act-related items, such as your systems and data.

If you have any questions, please contact your transition plan project officer, Ms. Angela Britton, at either 410-786-3079 or by email at Angela.Britton@cms.hhs.gov.

We appreciate your cooperation throughout the review process.

Sincerely,

for

Diane T. Gerrits
Director
Division of State Demonstrations & Waivers

Enclosure

cc: Eliot Fishman, Director, Children and Adults Health Programs Group
Gloria Nagle, Associate Regional Administrator, Region IX

Arizona 1115 Demonstration Transition Plan

I. 2013 Renewal Process

For those members that have a renewal coming due between October 1 through December 31, they will go through the current renewal process. Thus, they will not get asked to update their information with the tax relationships in the household as the system will not yet be ready to send that style of renewal yet.

II. Coverage in 2014

For all populations currently served by Arizona's demonstration (this includes mandatory state plan, optional state plan, and expansion populations), you must map their coverage in 2014. Please:

- Identify the current authority for the population;
- Identify the 1/1/2014 authority for the population; and
- For each 1/1/2014 population, specify the benefits the population will receive and the delivery system for those benefits.

Eligibility Category	*Current* Coverage and Authority	*Jan. 1, 2014* Coverage and Authority	Benefits	Delivery System	Transition Required?
Mandatory Coverage Groups					
Infants Age 0-1	140% FPL; Mandatory State Plan (AZ covers FPL above minimum requirement of 133% FPL)	No change	State Plan	Managed Care	No
Children Age 1-5	133% FPL; Mandatory State Plan	No change	State Plan	Managed Care	No
Children Age 6-18	100% FPL; Mandatory State Plan	Increase to 133% FPL	State Plan	Managed Care	Yes – State Plan to State Plan

Pregnant Women	150% FPL; Mandatory State Plan (AZ covers FPL above minimum requirement of 133% FPL)	No change	State Plan	Managed Care	No
Parents and Caretaker Relatives	100% FPL; Mandatory State Plan (AZ covers FPL above 1996 minimum level which averages 21.3% FPL)	No change	State Plan	Managed Care	No
Aged, Blind and Disabled	100% FPL; Mandatory State Plan	No change	State Plan	Managed Care	No
Young Adult Transitional Insurance (YATI)	Mandatory State Plan	Increase of coverage to Age 26	State Plan	Managed Care	Yes – State Plan to State Plan
Adoption Assistance and Foster Care Children	Mandatory State Plan	No change	State Plan	Managed Care	No
Optional Coverage Groups (State Plan)					
SSI-MAO	Income greater than 100% FBR and up to 100% FPL; Optional State Plan	No change	State Plan	Managed Care	No
Breast and Cervical Cancer Treatment Program	Optional State Plan	No change	State Plan	Managed Care	No
Freedom to Work	250% FPL; Optional State Plan	No change	State Plan	Managed Care	No

State Adoption Subsidy	Optional State Plan	No change	State Plan	Managed Care	No
New Adult Group	100-133% FPL; Not currently covered	Coverage begins 1/1/14 at option of the State; State Plan authority	ABP	Managed Care	Yes – New State Plan
Optional Coverage Groups (1115 Waiver)					
Childless Adults	100% FPL; 1115 Waiver (Enrollment currently frozen)	No FPL change; restore coverage 1/1/14; transition authority from 1115 to State Plan	ABP	Managed Care	Yes – expansion to State Plan
Family Planning Extension Program	150% FPL; 1115 Waiver	No change	State plan	Managed Care	No
KidsCare II	100-200% FPL up to age 19; 1115 Waiver (authority expires 12/31/13)	***Transition to Medicaid***: Children with income between 100-133% FPL ***Transition to FFM***: Children with income over 133% FPL up to 200%	N/A	N/A	Yes – Expansion to State Plan; Expansion to FFM
CHIP/KidsCare					
KidsCare I	100-200% FPL up to age 19; Title XXI State Plan (enrollment currently frozen	***Transition to Medicaid***: Children with income between 100-133% FPL	State plan	Managed Care	Yes – Title XXI CHIP State Plan to Title XIX State Plan

		Maintain KidsCare enrollment: Children with income over 133% FPL up to 200%; enrollment remains frozen (no new enrollment)			
Arizona Long Term Care System (ALTCS)					
Elderly & Physically Disabled	300% of FBR; Optional State Plan	No change	State Plan and 1115 Waiver	Managed Care	No
Division of Developmental Disabilities (DDD)	300% of FBR; Optional State Plan	No change	State Plan and 1115 Waiver	Managed Care	No

III. Process for Transition

Describe the state process for transitioning covered groups to appropriate Medicaid eligibility or to the Marketplace under the 2014 coverage options.

- Describe any actions (including proposed dates for those actions) the state will take to transition populations including the process the state will use to screen individuals for coverage under his/her existing category, and for other Medicaid eligibility categories (if he/she is not still eligible under the existing category);
- Describe any actions the beneficiary will need to take for his/her transition; and
- Describe how the state will communicate with and transfer cases to the Marketplace.

AHCCCS Populations Requiring Transition						
Eligibility Category	**Type of Transition**	**Impact to Member**	**State Action**	**Action Needed by AHCCCS Member?**	**Member Notice Needed?**	**Transfer of Case to FFM?**

Children ages 6-18 (100-133% FPL)	State Plan to State Plan to reflect increase in FPL level from current maximum of 100% FPL to new of 133% FPL	None. Current members in this category retain their coverage. Enrollment opens for new members from 100-133% FPL on 10-1-13 for coverage effective 1-1-14.	System change to allow for new enrollment	No.	No.	No.
YATI	State Plan to State Plan to reflect increase in upper age limit for youth transitioning out of foster care from current age limit of 21 to new age limit of 26.	Members in this category will retain their coverage through age 26.	System change to maintain eligibility of member in this category through age 26.	No.	Yes to inform member they will retain coverage in this category through age 26. Notices to be sent 1-1-14.	No.
Childless adults (0-100% FPL)	1115 Waiver to State Plan	Current members retain coverage; enrollment will open to new members beginning 10-1-13 for coverage effective 1-1-14	System change to open enrollment 10-1-13 for coverage effective 1-1-14	None for existing members. Adults not currently enrolled must submit application to be considered for eligibility.	Yes to inform current members that enrollment is no longer frozen, their coverage is not being impacted and coverage is available to all adults from 0-133% FPL effective 1-1-14. Notice to be sent 1-1-14.	No.
New Adults (100-133% FPL)	New State Plan Amendment	None. Coverage category not currently available	System change to open enrollment 10-1-13 for	Yes. Must submit application to be considered for	Yes. This is a new notice to explain final eligibility determination (eligibility	No

			coverage effective 1-1-14	eligibility.	confirmed or denied). Notice sent once eligibility determination is made to inform applicant of disposition of case.	
KidsCare I (children 100-133% FPL)	CHIP State Plan to Medicaid State Plan for children in households with income between 100-133% FPL	Minimal. Coverage and health plan options are the same. Move to Medicaid means household will no longer have to pay premiums for coverage. Some copay requirements may apply.	AHCCCS will determine Medicaid eligibility using income data on file	No.	Yes to inform member they are now Medicaid eligible and impact of change in status regarding premiums. Notice to be sent 11-15-13.	No.
KidsCare II (children 100-133% FPL)	1115 Expansion to Medicaid State Plan for children in households with income between 100-133% FPL	Minimal. Coverage and health plan options are the same. Move to Medicaid means household will no longer have to pay premiums for coverage. Some copay requirements may apply.	AHCCCS will determine Medicaid eligibility using income data on file	No.	Yes to inform member they are now Medicaid eligible and impact of change in status regarding premiums. Notice to be sent 11-15-13.	No.
KidsCare II (children above 133% FPL)	Termination of 1115 Expansion program	Children in households with income above 133% FPL will no longer be eligible for KidsCare II. Household	AHCCCS will review for Medicaid eligibility using income data on file to confirm	Yes. Member will have to work with FFM to complete the application	Yes to inform member their KidsCare coverage is terminating and their case is being transferred to FFM for	Yes. Ideally the State will complete account transfer electroni-cally but is awaiting

		will have to seek coverage on FFM or elsewhere.	household is above 133% FPL	following the account transfer.	disposition and availability of PTC or CSR Notice to be sent 11-15-13.	testing with FFM.

General Transition Information

1. Prepopulated forms will be used in 2014 for the renewal process. The prepopulated form will be used to collect additional income information. Notices will request that additional information be sent if your income has changed.
2. Between November and December 2013 a data conversion will take place to move data to the new system. In 2014, the new system will run household information thru MAGI rules.
3. The state will transfer accounts to the federal facilitated Marketplace.
4. Arizona will check all eligible categories before referring enrollee to the marketplace.

IV. Notification

Please describe the notification process the state will use to communicate with beneficiaries about changes to his/her coverage in 2014. This process description should include:

- A description of the review process used to develop the notices;
- The timing of notices to beneficiaries;
- How the notices will be sent to beneficiaries; and
- How the beneficiaries will be able to ask questions about the notice.

Notices are developed by AHCCCS staff. AHCCCS uses special software to identify base reading level and ease of reading. Also, the staff who complete final reviews have participated in multiple training sessions and webinars by Penny Lane and Maximus, and employ the principles from those sessions in development and review to ensure notices are clear and written at appropriate reading levels.

For those coverage groups whose transition will trigger a notice requirement, the timing of the notice was noted above. Notices will be sent via U.S. Mail to the address of record. A phone number will be provided on the notice for customers to call with questions. The AHCCCS Administration is currently working on a streamline call center targeting a 10-1-13 start date.

V. Content of the Notices

- Please provide drafts of the notices that will be sent to beneficiaries.

- Please provide an example of the draft notice for each type of transition (this should include examples of notices where the only change that will be apparent to a beneficiary is a change in benefits or delivery system).

Please note that all notices must comply with the notice requirements in 42 CFR 431.206, 431.210 and 431.213, and must include information on appeal and hearing rights as outlined in 42 CFR 431.220 and 431.221.

The State is working on its draft notices. The State's first goal is to complete work on the actual eligibility system to conform to required ACA changes for a 10-1-13 start date.

Kids CareII Notice: The state is trying to obtain a list of navigators to provide to the beneficiaries as part of their notice. The notice may reference a list of navigators and/or reference a website to obtain navigator information.

VI. Community Outreach

- Please describe all community outreach activities (such as public forums, webinars, flyers, websites, etc.) the state has or will undertake to inform beneficiaries about the transition and to support them during the transition period.
- This component of the transition plan must include information about tribal consultation activities for all states with federally recognized tribes.

HEA Plus Subscribers

The State has a robust community outreach and education effort. First, the State has 75 organizations with 300 different sites and over 1,000 employees trained as community assistors on the State's current and new eligibility system, Health-e-Arizona Plus (HEA Plus). These HEA Plus subscribers will be able to assist applicants and obtain real time eligibility determinations. The State engages with these subscribers in monthly meetings and has conducted various phases of testing on the new system. These subscribers represent FQHCs, other providers, community organizations and more.

In addition, the State is reaching out to new groups not currently subscribers. The State has a list of 20 new groups that will sign HEA Plus agreements beginning 10-1-13. The number of new subscribers is expected to grow.

Attached is a list of HEA Plus demonstrations and trainings conducted to date.

Website and Community Forums

The State developed a dedicated page on its website called Medicaid Moving Forward to provide updated information on the progress of the State in moving toward 2014. That page can be found here: http://www.azahcccs.gov/publicnotices/MovingForward.aspx .

The State also has developed a listserv that current has 1,366 individuals representing various organizations, Medicaid members or themselves.

The State is also hosting Community Forums across the State that are open to the public. The schedule is below, news of the update was sent via the AHCCCS listserv and is posted to the AHCCCS website here:
http://www.azahcccs.gov/publicnotices/Downloads/MedicaidCoverage/MMFCommunityForums.pdf

GENERAL – Sessions for Families, Advocates and Community Partners	
Tuesday, October 8, 2013 1p.m. – 3p.m. RSVP: ForwardTucson@azahcccs.gov	**Casino del Sol - Conference Center** 5655 W. Valencia Rd. **Tucson**, AZ 85757
Friday, October 11, 2013 1p.m. – 3p.m. RSVP: ForwardFlagstaff@azahcccs.gov	**Flagstaff Medical Center – McGee Auditorium** 1200 N. Beaver Street **Flagstaff**, AZ 86001
Wednesday, October 30, 2013 1p.m. – 3p.m. RSVP: ForwardPhoenix@azahcccs.gov	**The Disability Empowerment Center** 5025 E. Washington Street, Suite 200 **Phoenix**, AZ 85034

*Two additional sessions in Phoenix have been scheduled for October 30, 3:15 – 5:00 and November 4, 1:00-3:00. The website (link above) is updated as new forums are scheduled.

Tribal Consultation Activities

The State has been engaging with its tribal stakeholders throughout this process. Regular updates on HEA Plus and the transition of populations have been provided in tribal consultation. In addition, many tribal organizations are HEA Plus subscribers and have been part of the special trainings and demonstrations. These issues have been discussed as part of tribal consultation on the dates below:

Tribal Consultations and Meetings
2/6/13: Tribal Consultation meeting held in Phoenix
3/21/13: Special Meeting with I/T/U's held in Phoenix
6/25/13: Special ACA SPA Tribal Consultation via teleconference
7/12/13: Meeting with Vice-Chairwoman Catalina Alvarez of Pascua Yaqui Tribe to discuss Restoration Plan
8/5/13: Meeting with White Mountain Apache Tribal leaders and Health Program personnel re: Restoration Plan and HEA Plus
8/13/13: Inter-Tribal Council of Arizona Training: State Health Insurance Assistance Program (included update on restoration plan)
8/15/13: Tribal Consultation meeting off-site on the Hopi Reservation review of HEA Plus and 1115 Transition Plan

9/19/13: Tribal Consultation regarding restoration and expansion implementation, threat of legal challenges to implementation and extension of current supplemental payments waiver authority
9/26/13: Provided overview at Phoenix Indian Medical Center ACA kick-off event
9/30/13: Meeting with Navajo Nation Vice President and Councilmembers

Communications on Expansion/Restoration Updates/Information sent to tribal listserv:
1/15/13: Proposed Expansion of AZ Medicaid Program by Governor Brewer = 205 people
3/19/13: Governor Brewer's Medicaid Coverage Bill = 205
3/22/13: Yuma Public Forum Announcement sent to Colorado River Tribe Leaders, Tribal Council, Tribal Health Programs = 18
4/17/13: AHCCCS Public Forum at Eastern Arizona College in Thatcher sent to San Carlos Apache Tribal Leaders, Tribal Council, Tribal Health Programs = 20
5/1/13: AHCCCS Updates re: Medicaid Restoration = 205
5/2/13: Show Your Support - Rally for Restoration = 205
5/14/13: Rally for Restoration = 183
5/14/13: Rally for Restoration sent to Tribal Leaders = 22
6/14/13: Medicaid Restoration Approval Amendment Announcement = 205
6/14/13: Bill Signing Ceremony sent to Tribal Leaders = 22
6/17/13: AHCCCS Update – Thank you Follow-up to tribal stakeholders = 205

In addition, the schedule for upcoming forums, including dedicated tribal sessions outlined below, was sent to the tribal listserv.

TRIBAL – Sessions for Tribal Stakeholders	
Date	**Location**
Monday, September 16, 2013 and Monday, September 23, 2013 1p.m. – 3p.m. RSVP: ForwardPhoenix@azahcccs.gov	**Native American Community Service Center** 4520 N. Central Ave., 6th Floor Conference Room **Phoenix**, AZ 85012
Tuesday, October 8, 2013 10a.m. – 12p.m. RSVP: ForwardTucson@azahcccs.gov	**Casino del Sol - Conference Center** 5655 W. Valencia Rd. **Tucson**, AZ 85757
Friday, October 11, 2013 10:30a.m. – 12:30p.m. RSVP: ForwardFlagstaff@azahcccs.gov	**Flagstaff Medical Center – McGee Auditorium** 1200 N. Beaver Street **Flagstaff**, AZ 86001

*Additional sessions in Parker, Arizona and Western and Eastern Navajo Nation are being scheduled. The website (link above) is updated as new forums are scheduled.

Additional Outreach Activities

Although the AHCCCS Administration has limited staffing and resources to attend individual meetings, AHCCCS staff has provided or are scheduled to provide updates on these issues to the following groups:
6/11: Healthy Children Arizona Committee
8/11: Arizona Hemophilia Association Statewide Conference

8/13: Alzheimer's Task Force Conference Call
8/20: Arizona Probation Court Administrators Monthly Meeting
9/6: Access Tucson – a panel discussion to be aired on local cable stations in the Tucson area
9/21: Philippine Nurses Association
9/24: Participated in Tele-Town Hall for small business owners and employees hosted by AZ Sen. Steve Farley
9/25: Participated in Tele-Town Hall for small business owners and employees hosted by AZ Sen. Steve Farley
9/27: Hosted two Webinars on implementation of restoration and expansion for HEA and HEAplus community partners and Cover AZ coalition members with over 600 people attending
10/22: Scheduled to speak at conference hosted by Mental Health America of Arizona
11/1: Arizona School Based Health Care Council Board annual meeting

Special communications and information are being provided as well to the hospital community working in cooperation with the Arizona Hospital and Healthcare Association. Additional outreach activities are anticipated throughout the Fall of 2013.