STATE OF ARIZONA

JANICE K. BREWER
GOVERNOR

EXECUTIVE OFFICE

September 27, 2010

Secretary Kathleen Sebelius
Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Arizona's Section 1115 Waiver

Dear Secretary Sebelius:

Pursuant to federal requirements, with this letter I submit my request to apply for a new Section 1115 Research and Demonstration Waiver (the "Demonstration Waiver") to continue the Arizona Health Care Cost Containment System (AHCCCS) program, as well as add new innovations to the AHCCCS model, for the period of October 1, 2011 through September 30, 2016.

Before I discuss the great success and continued innovations demonstrated by AHCCCS under the flexibility of the Demonstration Waiver, I must begin by highlighting what I believe is the most pressing issue facing our Medicaid program now and in the foreseeable future. Simply put, the Arizona Medicaid program as it exists today is unsustainable.

Arizona is relatively unique in the combination of circumstances surrounding its program. We are one of a handful of states who expanded Medicaid to cover all low-income residents, including childless adults. Yet we have also been among the hardest hit by the fiscal crisis facing most states. Over the past two years, we have undertaken numerous steps to contain the uncontrolled costs of our Medicaid program. We have reduced provider rates across the board, we have eliminated optional benefits and, prior to the enactment of the maintenance of effort (MOE) requirements of the Affordable Care Act, we had planned to resize the eligibility for our program to parallel that of most other states. Our ability to implement further reductions in provider rates and benefits is essentially limited, so the lack of flexibility to modify Medicaid eligibility severely restricts our cost containment options. As a result of the MOE requirements and upon expiration of the enhanced federal financial participation, Arizona faces a $1 billion shortfall in our Medicaid program in the next fiscal year. Although this waiver document does not yet address the changes necessary to address these fiscal challenges, I believe it is critical to begin discussions on this important issue very soon.

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The attached proposal demonstrates that AHCCCS continues to offer quality care for members while containing costs, and it conforms to new requirements for renewing or applying for a new Demonstration Waiver. Much of the Demonstration Waiver proposal requests to renew existing authority for a model with a long history of providing quality care. The State is also seeking new authority that would allow it to continue to innovate and build upon what is the most mature managed care Medicaid program in the country.

These new proposals are explained in more detail in the attached document and relate to three areas: (1) achieving greater efficiencies and more equitable reimbursement for services provided to members within our Division of Developmental Disabilities; (2) obtaining program integrity improvements by working with the Centers for Medicare and Medicaid Services (CMS) to allow for more targeted data analytics in the area of Medicaid managed care, rather than attempting to use Fee-For-Service program integrity tools and adopt them to a managed care environment; and (3) striving toward true health care reform by working with providers and health plans to implement payment innovations.

AHCCCS has achieved its success through the creation of a solid business model – a true public/private partnership – that controls costs while assuring quality of care. To date, this has been accomplished through a mandatory managed care program. I believe that the AHCCCS program is uniquely positioned to build upon this mature model by building a payment strategy that allows health plans and providers to work together so that payments are being made for quality and not just quantity of care. AHCCCS will need flexibility to explore many different models to attain these payment innovations, including exploring Accountable Care Organizations, Patient Centered Medical Homes, different types of capitation arrangements, bundled payments, and opportunities for shared savings.

I request your approval of our Demonstration Waiver for another five years and I look forward to future discussions that will be necessary regarding the continuation of the AHCCCS program.

Sincerely,

Janice K. Brewer

Janice K. Brewer
Governor

JKB:bkl

a. Demonstration Summary and Objectives:

Requirement: "Demonstration Summary and Objectives: The State must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included."

Historical Summary

In October 1982, after remaining the only state in the nation without a Medicaid program under Title XIX, Arizona launched the Arizona Health Care Cost Containment System (AHCCCS) as a Section 1115 demonstration project. Since that time, AHCCCS has continued to expand and change in accordance with its objectives and the needs of the populations it serves.

10/1982: AHCCCS begins, covering only acute care services and 90-day post-hospital care in a skilled nursing facility.

12/1988: The Arizona Long Term Care System (ALTCS) is added for individuals with Developmental Disabilities (DD).

01/1989: ALTCS is extended to include individuals who are Elderly and Physically Disabled (EPD).

10/1990: Comprehensive behavioral health services phased-in, beginning with coverage of seriously emotionally disturbed children under age 18 who require residential care. Within the next 5 years, behavioral health coverage extended to all Medicaid-eligible individuals.

01/2001: CMS approves the expansion of income criteria for acute care Medicaid eligibility as a result of Proposition 204 to include coverage up to 100% for traditional Temporary Assistance to Needy Families (TANF), Supplemental Security Income (SSI) populations, adults without dependent children, and individuals in the Medical Expense Deduction (MED) program.

12/2001: Title XXI funds used to extend coverage to (1) adults over age 18 without dependent children and with an adjusted family net income at or below 100% of the FPL, and (2) individuals with an adjusted net family income between 100% and 200% of the FPL, who are parents of children enrolled in Arizona's Medicaid or Children's Health Insurance Program (CHIP – also known as KidsCare), but who, themselves, are not eligible for either program.

03/2006: The ALTCS component of the demonstration requires budget neutrality.

04/2008: Statewide premium assistance program for Title XXI CHIP-eligible children with family incomes between 100% and 200% FPL and with access to Employer Sponsored Insurance (ESI) is implemented. The State will subsidize premium assistance on a monthly per-child basis. Children may opt back into CHIP direct coverage at any time.

02/2009: Increase in monthly premiums from four percent to five percent of net household income for parents of Medicaid and CHIP children enrolled in AHCCCS between 151% - 175% FPL.

10/2009: Arizona terminates the HIFA Title XXI parents program (HIFA II) and modifies the federal funding source for childless adults (HIFA I).

Objectives

Operate a managed care service delivery model that facilitates quality care in a cost-efficient manner.

- With over 30% fewer staff, AHCCCS continues to effectively manage a program that has grown by almost 30% since the start of the recession.

- AHCCCS recorded statistically significant increases in quality performance measures despite a state budget crisis, resource limitations, membership increases, and staff reductions.

- According to Kaiser's most recent Medicaid Fact Sheets, Arizona, when compared to all other states, demonstrated the lowest cost per member/per year overall and for prescribed drugs. (http://www.statehealthacts.org/comparetable).

- A comprehensive 2008 survey of the ALTCS population indicated significant satisfaction with all aspects of care and services, despite some limitations to provider choice in rural areas.

- AHCCCS formalized an Agency-wide Program Integrity Plan that reported a 19% increase in recoveries and cost avoidance between State Fiscal Years 2008 and 2009.

- The percentage of ALTCS members receiving Home and Community Based Services (HCBS) has increased from 47% in 2002 to 70% in 2010.

- ALTCS expansion of Home and Community Based Services (HCBS) to include spouses as paid caregivers, has created satisfaction among the 625 members affected and has expanded the caregiver network by availing non-spouse caregivers to other HCBS members.

- AHCCCS has been able to deliver services to waiver-expansion populations (e.g. Proposition 204), and continue to maintain budget neutrality, estimating a positive balance of over $1.13 billion through the end of the waiver period.

- The volume of Managed Care Organizations (MCOs) indicating interest in and willingness to contract with AHCCCS continues to grow.

- When offered an opportunity to change their current MCO, only 2% of the AHCCCS population chooses to do so.

Achieve administrative simplifications, including the expansion of electronic resources for both providers and members.

- Expanded electronic claims processing has led to significant efficiencies i.e. 85% FFS claims submitted electronically; 99% FFS claims paid within 30 days; 17% of claims attachments received electronically despite recent implementation of the capability.

- AHCCCS has created substantial efficiencies for members, providers, and staff through the development and expansion of web-based resources, including:
  - → On-line application opportunities (i.e. Health-e-Arizona)
  - → Member access to individual eligibility information and transaction capabilities (i.e. MyAHCCCS.com)
  - → Provider registration and verification capabilities

- AHCCCS obtained and implemented a new data analytics tool to improve identification of fraud, waste, and abuse.

- The groundwork has been completed to move forward as a partner with other stakeholders in a state-wide solution for Health Information Exchange (HIE), addressing both technical and governance challenges. The PAPD was approved.

- Given the small size of the FFS population and related administrative resources, flexibilities allowed by drug and UPL waivers have lead to operational efficiencies.

- On average, acute care MCOs reported receiving over 60% of claims electronically.

Changes Considered

Arizona's current economic climate will continue to play a major role in shaping the discussion regarding the AHCCCS program. Federal maintenance of effort requirements and reduced federal participation will result in a shortfall of $1billion in State funding for Medicaid alone in State Fiscal Year 2012. Already the State has been forced to implement provider rate reductions, an enrollment freeze on the Title XXI KidsCare program, and implement benefit reductions. In addition, Arizona voters took action to impose a significant new tax increase and tremendous reductions have been made in other important State services as we, in Arizona, live within our means. Given the new paradigm of limited State flexibility in Medicaid, Arizona policymakers will continue to evaluate what options may be available.

Therefore, the majority of the proposed changes included in this document respond to current economic realities. They are innovative solutions developed within the context of an economy that requires an increased need for health services in the face of restricted budgets and resource constraints. Historically, AHCCCS has served as a model for the efficient and effective use of resources in the delivery of health care to those in need. These changes are designed to carry that momentum forward to meet future challenges.

1) Cost Effectiveness Reimbursement for the ALTCS DD Program

Narrative: Arizona's Long Term Care System (ALTCS) for members with developmental disabilities (DD) supports the delivery of care primarily through Home and Community-Based Services (HCBS). The Arizona Department of Economic Security's Division of Developmental Disabilities (DES/DDD) provides necessary supports to ALTCS members under age six at risk of a developmental disability and to ALTCS members age six or older with a diagnosis of epilepsy, cerebral palsy, mental retardation or autism, which was made prior to the age of 18 years. In addition to long-term care and supportive services provided through DES/DDD, these members also receive primary and acute medical services through DES/DDD's subcontracts with three AHCCCS health plans and a private health plan.

Arizona's current expenditure authority to offer HCBS in lieu of institutionalization places no limit (cap) on the number of individuals enrolled. Instead, current limits are based on the cost of institutional care in an ICF-MR. This is unique in that, for people with DD, programs in the majority of states operate under 1915 waivers that include enrollment and financial caps. Another important factor to consider is that AHCCCS has de-institutionalized the delivery of services for members enrolled in the DDD program (99% receive HCBS).

There are very few ICF-MR facilities in Arizona. When a member cannot be served in the home, there is adequate capacity in alternative residential facilities that meet member needs. These services are provided most often in DD group homes (an alternative residential facility); when necessary, a member has access to an ICF-MR but placement in an ICF-MR is rare. Thus, the most appropriate out-of-home placement for the member is the measure by which AHCCCS proposes to compare cost effectiveness in the ALTCS DD program.

Objective: Obtain expenditure authority under Section 1115 to claim federal funds for HCBS provided to members within the DD program that would not exceed the cost of care in an appropriate alternative out-of-home placement (modification of STC 36(d)(3)). Limit reimbursement of HCBS provided in a member's own home to the cost of the most appropriate out-of-home placement (alternative residential facility or ICF-MR), rather than only the cost of institutional care in an ICF-MR for a member enrolled in the DD program.

This objective is consistent with the concept of Money Follows the Person and is a more appropriate cost effectiveness threshold.

Desired Outcome: Sustain the ALTCS DD program over time and not continue to pay more than the cost that is associated with the setting that the member would most appropriately be placed in outside of their own home. Reimbursement limits based on an appropriate level of care lead to cost savings that align with the member's needs and, ultimately more equitable allocation of resources. Without this authority, the sustainability of the DD program is at great risk. As an alternative, Arizona would consider pursuing a 1915(c) waiver to include a dollar and/or service limit.

2) Reimbursement Innovation

Narrative: Health care reform legislation and the various demonstration and grant opportunities contained in the Patient Protection and Affordable Care Act (ACA) are all geared toward achieving certain changes in the delivery of health care for Medicaid members, many of which AHCCCS has already achieved – e.g., moving away from care in institutions to care in the home or the community (70% of AHCCCS long term care members are in the home or community); providing members with a primary care physician as the manager of their care; and using capitated payment arrangements (AHCCCS has a capitated, at-risk managed care model).

AHCCCS believes the heart of reform lies in addressing provider reimbursement through the use of medical home models and Accountable Care Organizations (ACOs). It is in this area that AHCCCS is uniquely positioned among Medicaid programs to adopt wide scale changes in the way care is paid for by Medicaid – that is, moving to a model that pays for quality over quantity. In order to achieve that reform, there must be a redesign of the way Medicaid pays for services. Under the current structure of health care delivery, any model that improves efficiencies will ultimately hurt the bottom line of the provider community as well as participating health plans. For instance, a hospital is not necessarily incentivized to promote a model that ultimately will mean fewer individuals occupying bed space, because that will translate into lost revenues.

AHCCCS, its provider community, and health plans are actively engaged in a number of different models that are driving toward this end. One of these models is located in the Tucson area and is recognized nationally. The other is achieving outstanding results in a short period of time in the Yuma area. Unfortunately, eventually these efforts will be stymied by the fact that health plans and hospitals are expending monies out of their own administrative dollars or grant monies to achieve these innovations. In addition, providers will soon see a loss in profit as hospital admissions/readmissions continue to decrease and members are better equipped to manage their care at home through case managers, etc.

Thus, AHCCCS wants to look at opportunities that allow Medicaid to reimburse for costs not otherwise matchable for those activities in which a health plan needs to engage in order to achieve a model that truly reimburses for value rather than volume. And AHCCCS seeks a system whereby providers who are engaged in this effort can share in the savings of bending the cost curve.

Objectives: (1) Allow Medicaid to reimburse for costs not otherwise matchable, but that also recognize the costs incurred by a health plan entering into an ACO arrangement that have not been included as "medical services" by the Medicaid program but that improve quality and save money by decreasing utilization and readmission. Those costs should be recognized as part of the cost of doing business in Medicaid so that providers, health plans and the Medicaid system are incentivized to achieve greater innovations in quality care that will truly bend the cost curve.

(2) Allow for savings from improved quality to be used to gainshare with ACOs and health plans.

Desired Outcome: To redesign the reimbursement model in a way that pays for quality of care over quantity of care, value over volume. In return, providers and health plans who are actively engaged in this concept should share in that reward through gainsharing opportunities. Medical homes and ACOs will be created in order to achieve this effort, thus creating a more integrated health care delivery system. The return for CMS and the nation will be the reduction of avoidable inpatient admissions and emergency department visits, better patient management and interventions through primary and preventive care in more cost-effective settings, follow up strategies to ensure appointments are kept, etc. In other words, the ultimate outcome is to begin to bend the health care cost curve.

3) Program Integrity Demo

Narrative: In support of the program integrity efforts illustrated throughout Title VI-Transparency and Program Integrity of the ACA, and in view of current fiscal challenges, AHCCCS has developed and implemented a Program Integrity Plan (PIP) that outlines key strategies to promote economy, efficiency, accountability, and integrity in the management and delivery of services. A Program Integrity Committee, comprised of executive staff and chaired by the Director, ensures ongoing coordination and evaluation of PIP activities.

Title VI, Section 6411, of the ACA requires states to establish contracts with one or more Medicare Recovery Audit Contractors (RACs) to identify underpayments and overpayments and recoup overpayments for services provided under State Medicaid plans and waivers. In addition, CMS has established Medicaid Integrity Contractors (MICs) that conduct program review and perform audit functions.

Currently AHCCCS participates in a state-wide RAC contract with Recovery Audit Specialists (RAS). RAS will work with AHCCCS to identify and recover overpayments. Ultimately AHCCCS will discuss with RAS the identification of underpayments as well.

Objective: In large part, however, new RAC initiatives appear to be designed primarily for a fee-for-service system. Therefore, AHCCCS will seek funding for a demonstration in which AHCCCS serves as its own RAC, leveraging the State's managed care experience to establish a process that targets a managed care model. AHCCCS recently contracted with EDI-Watch, a software solutions vendor that supports program integrity activities. AHCCCS would use regular reports generated by EDI-Watch to identify potential fraud and/or abuse and, with the support of funding, employ staff to review results and ensure recoupment. At the same time, AHCCCS would provide CMS with the same data to analyze with its own algorithms for comparison purposes. Finally, after 24 months, AHCCCS would evaluate results and compare with previous metrics. In accordance with 42 CFR 1007.19, AHCCCS will also seek 90% federal reimbursement for start-up costs.

In accordance with 42 USC 1396b(a)(6), AHCCCS will seek 75% federal funding for its Office of Inspector General (OIG) to combat fraud and abuse. The AHCCCS OIG has a similar mission and works in concert with the Medicaid Fraud Control Unit (MFCU), assigned to the Arizona Attorney General's Office (AGO), to prosecute provider fraud. Whereas the MFCU is limited in scope to provider fraud, the AHCCCS OIG also aggressively investigates and actively participates in the prosecution of recipient fraud.

Outcomes: A successful process could lead to a more cost-effective recovery audit model that is specific to Medicaid managed care and suitable for use by other state Medicaid agencies.

4) Ex parte cases

Narrative: 42 CFR § 435.1003 provides that when the Social Security Administration (SSA) notifies the agency that a recipient has been determined ineligible for SSI, federal dollars continue to be available for a short period to allow for an ex parte determination of eligibility. The time frames for continued funds are: Through the end of the month of notification if the agency receives SSA notice by the 10th day of the month, and through the end of the following month if the agency receives SSA notice after the 10th day of the month, unless the recipient requests a hearing. AHCCCS currently does not begin to make an eligibility determination until after the SSI eligibility end date and does not take action to discontinue eligibility until a determination can be made.

The processing requirement under 42 CFR 435.1003 is inefficient considering:

- Approximately 50% of persons who lose SSI eligibility are reinstated and receiving SSI again before the SSI eligibility end date.
- 42 CFR 435.930 states the agency must continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible. AHCCCS staff have to contact the individual and obtain verification of most eligibility factors. This includes documentation of US citizenship or qualified alien status as well as information about other members of the household.
- The State's economic down turn has increased the AHCCCS caseload at the same time that AHCCCS' resources have been reduced.

Objective: Include language in the waiver that corresponds with what AHCCCS is doing. Specifically, Arizona is requesting expenditure authority for costs not otherwise matchable under 42 CFR 435.1003.

Desired Outcome: Maintain continuity of care for members as well as administrative efficiencies given limited resources for operations.

5) Medicare Part B

Narrative: In the Spring of 2010, the Department of Health and Human Services, Office of Inspector General conducted an audit of Arizona's buy-in of Medicare Part B premiums for beneficiaries that are dually eligible for Medicare and Medicaid to determine whether AHCCCS complied with Federal requirements. The OIG is questioning whether Arizona has the authority to draw down Federal dollars for the premiums of non-QMB dual eligibles. A non-QMB dual is eligible for Medicare Part A or Part B and is also eligible for Medicaid at an income level that exceeds 100% of the FPL.

Arizona has relied on the guidance provided in two State Medicaid Director (SMD) Letters dated November 24, 1997 and December 14, 2000, stating that, at the State's option, FFP is available for the cost of Part B premiums for non-QMB dual eligibles. For years, AHCCCS has relied upon the most recent and formal direction from the Administrator of CMS in making its claim for federal reimbursement.

Objective: Expenditure authority for medical assistance in the form of Part B premiums for non-QMB dual eligibles as authorized in two SMD Letters (dated 11/24/97 and 12/14/00).

Desired Outcome: Maintain continuity of care for members as well as administrative efficiencies given limited resources for operations.

6) Maintenance of Effort Requirements

Narrative: Arizona is one of six states that extended coverage to populations not traditionally covered under Medicaid. In 2000, Arizonans approved Proposition 204 to provide health care coverage for all residents up to 100% of the Federal Poverty Level (FPL), including parents and childless adults. Additional Prop 204 expansion populations that most states currently do not cover include individuals with income above 100% FPL but who have

incurred medical debt that has lowered their income to 40% FPL (known as the Medical Expense Deduction/MED program), and individuals who are aged, blind or disabled with income at or below 100% of the Federal Benefit Rate (FBR) (knows as SSI).

Arizona continues to face the most significant budget deficit in the history of the State. AHCCCS is requesting Section 1115 Waiver authority to make reductions to eligibility necessary to preserve Arizona's Title XIX program. Specifically, beginning October 1, 2011, Arizona is requesting to reduce eligibility for the following expansion groups known as Prop 204 eligibility groups:

(1) the elimination of coverage to childless adults;
(2) the elimination of coverage to the MED population; and
(3) the reduction of coverage to TANF families from 100% FPL to approximately 50% FPL.

Objective: To preserve Arizona's Medicaid program and ensure those who represent the core of Medicaid's mission in serving the most vulnerable – the aged, blind, disabled, pregnant women and children, are served.

Desired Outcome: Continue to serve over 1 million members without jeopardizing the quality or increasing the cost of their care.

Changes Pending CMS Review

1) Disproportionate Share Hospital Funding- Attachment D

On April 2, 2010, AHCCCS requested an amendment to Exhibit 3 of Attachment D to update FY 2010 DSH funding amounts. While working through the amendment, Arizona's legislature passed legislation that allows political subdivisions, tribes and state universities to use their funding as local match to draw down federal dollars and designate those dollars to go to specific hospitals for purposes of supporting DSH programs. AHCCCS is currently working with interested stakeholders by providing information regarding these opportunities.

AHCCCS has been working with CMS to implement legislatively mandated changes to the Disproportionate Share Hospital (DSH) Payment methodology. As part of the FY 2011 budget, the legislature eliminated pool 3 from DSH funding. The FY 2011 budget authorized a total of $9.3 million for Pool 1, 1A, 2 and 2A. The proposed waiver language also includes $16 million in DSH funding that can be allocated if local dollars are voluntarily made available.

2) Benefits

In response to significant fiscal challenges facing the State and substantial recent growth in the Medicaid population, AHCCCS implemented several changes to the adult benefit package for optional services effective October 1, 2010. Pending before CMS is the outstanding request to exempt services provided through the Indian Health Services (I.H.S.) and 638 facilities paid with 100% Federal dollars from the benefit reductions. If granted, members who receive services through the I.H.S. and 638 facilities would continue to receive the benefits being eliminated or limited in SPA #10-006.

b. Special Terms and Conditions Compliance:

Requirement: The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

List of Waivers (in order)			
STC #	**Title**	**AZ Compliance**	**Documentation**
1.	Compliance w/ Federal Non-Discrimination Statutes	Yes	N/A
2.	Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy	Yes	N/A
3.	Changes in Medicaid and CHIP Law, Regulation, and Policy	Yes	During the period, AHCCCS has implemented provisions of DRA, CHIPRA, ARRA and is in the process of implementing ACA
4.	Impact on Demonstration of Changes in Federal Law, Regulation, and Policy	Yes	Examples include: rescission of 6 month redetermination policy; restoration of the KidsCare program, and expansion populations
5.	State Plan Amendments	Yes	SPA table
6.	Changes Subject to the Amendment Process	Yes	List of waiver changes
7.	Amendment Process	Yes	List of waiver changes
8.	Extension of the Demonstration	Yes	
9.	Demonstration Phase-Out	N/A	N/A
10.	Enrollment Limitation During Demonstration Phase-Out	N/A	N/A
11.	CMS Right to Terminate or Suspend	N/A	N/A
12.	Finding of Non-Compliance	N/A	N/A
13.	Withdrawal of Waiver Authority	N/A	N/A
14.	Adequacy of Infrastructure	Yes	Org Chart; List Health Plans
15.	Public Notice, Tribal Consultation, and Consultation with Interested Parties	Yes	News and A/I website Public Hearings and comments
16.	FFP	N/A	N/A
17.	General Financial Requirements	Yes	CMS 64
18.	Reporting Requirements Relating to Budget and Allotment Neutrality	Yes	Regular updates provided
19.	Budget Neutrality Information	Yes	Quarterly Report

List of Waivers (in order)			
STC #	**Title**	**AZ Compliance**	**Documentation**
20.	Encounter Data	Yes	DHCM
21.	Encounter Data Validation Study for New MCOs or PIHPs	Yes	SCAN 2007 study
22.	Submission of Encounter Data	Yes	DHCM; DBF
23.	Monthly Calls	Yes	Calendar appts
24.	Quarterly Reports	Yes	Website
25.	Annual Report	Yes	Submitted
26.	Final Report	yes	forthcoming
27.	Contractor Reviews	Yes	See Section d
28.	Contractor Quality	Yes	See Section d
29.	Contractor Disclosure of Ownership	Yes	
30.	Eligibility	N/A	N/A
31.	Arizona Acute Care Program	N/A	N/A
32.	Children in Foster Care	Yes	
33.	Children Rehabilitative Services	Yes	
34.	Arizona Long Term Care System	N/A	N/A
35.	ALTCS Transitional Program	N/A	N/A
36.	Arizona Health Insurance Flexibility and Accountability	Yes	
37.	Family Planning Extension Program	Yes	
38.	Contracts	Yes	
39.	Health Services to Native American Populations	Yes	
40.	State Must Separately Evaluate Components of the Demonstration	Yes	Draft Eval design
41.	Final Evaluation Design and Implementation	Yes	Draft Eval design
42.	Cooperation with Federal Evaluators	N/A	N/A
43.	Quarterly Expenditure Reports	Yes	Quarterly Report
44.	Reporting Expenditures in the Demonstration	Yes	CMS Report
45.	Reporting of Member Months	Yes	Quarterly Report
46.	Standard Medicaid Funding Process	Yes	

List of Waivers (in order)			
STC #	**Title**	**AZ Compliance**	**Documentation**
47.	Extent of Federal Financial Participation for the Demonstration	N/A	N/A
48.	Medicare Part D Drugs	N/A	N/A
49.	Sources of Non-Federal Share	Yes	Certifications
50.	Certification of Public Expenditures	Yes	Certifications
51.	Applicability of Fee for Service Upper Payment Limits	Yes	CMS report submitted
52.	Proper and Efficient Administration of the Plan	Yes	Submitted to CMS 3/31/07
53.	Institutions for Mental Disease (IMD) Phase Down	Yes	
54.	Fraud and Abuse Recoveries	Yes	
55.	Quarterly CHIP Expenditure Reports	Yes	CMS Report submitted
56.	Tracking CHIP Expenditures	Yes	CMS Report submitted
57.	Limit on Title XXI Funding	Yes	CMS Report submitted
58.	Drawdown of Title XIX Funds	Yes	Notice to CMS submitted
59.	Compliance with Federal Rules	N/A	N/A
60.	Monitoring Demonstration Funding Flows	Yes	
61.	Limit on Title XIX Funding	N/A	N/A
62.	Risk	N/A	N/A
63.	Demonstration Populations and Programs Subject to the Budget Neutrality Agreement	Yes	BN agreement
64.	Budget Neutrality Expenditure Cap	Yes	BN agreement
65.	Enforcement of Budget Neutrality.	N/A	N/A
66.	Exceeding Budget Neutrality	N/A	N/A

c. Waiver and Expenditure Authorities:

Requirement: The State must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

STC Reference	Title	Brief Description	Renew (Y/N)
29,35 CRS 36 ALTCS 29 BHS --- 27, 33 CRS 34 ALTCS 27 BHS	Proper and Efficient Administration	a) Limit choice for CRS and BHS b) Auto enroll members who lose eligibility w/in 90 days to PIHP previously enrolled c) restrict ability to disenroll w/out cause after 30 days d) restrict disenrollment for cause	Y
36(e) --- 34(g) DD	Cost Sharing	Charge premiums to parents of ALTCS disabled children <18 from household with income 400%-500% FPL	Y
52(b) --- 50(b)	DSH Requirements	Relieves AZ from making payments for inpatient hospital services that take into account disproportionate share of low income patients	Y
36 --- 34	Freedom of Choice	Restricts freedom of choice of providers by furnishing benefits through MCOs and PIHPs (Title V, foster care and SSI children; A/Is, FP, QMBs and Medicare beneficiaries);	Y
NA	Drug Rebate	Exempts AHCCCS from drug rebate and review	Y
N/A	Retroactive Eligibility	Eliminates 3 month prior period coverage	Y
36(d)(iv) --- 34(f)(iv) 36(d)(iv) --- 34(f)(iv)	Amount, Duration and Scope of Services	Allows AZ to offer different/additional services based on different care arrangements for members receiving spousal caregiver services. Also allows MCOs and PIHPs to provide additional or different benefits.	Y Y
N/A	Estate Recovery	Relieves AHCCCS from creating an estate recovery program for acute care (55+).	Y
N/A	Eligibility Based on Institutional Status	Allows AZ to exclude hospitalized individuals and others in medical institutions not requiring LTC from automatically becoming eligible for LTC services.	Y
41 AI 36 ALTCS 35 CRS 34 CMDP --- 39 AI 34 ALTCS 33 CRS 32 CMDP	MCOs do not have to meet certain requirements	a) American Indians have the choice of IHS or an AHCCCS health plan* b) Restricts enrollees from disenrolling from their health plan without cause beyond 30 days c) Restricts freedom of choice of MCOs for ALTCS (except for Maricopa County) and CMDP d) AHCCCS can automatically reenroll member into same health plan as was previously enrolled if the member lost eligibility within 90 days (vs. 60 day standard)	Y Y Y Y
N/A	MEQC Findings	Enable AHCCCS to use an MEQC process that is different than what is required under 1903(u).	Y
N/A* double check; see Waiver #5	Outpatient Drugs (10)	Companion to waiver; FFP for FFS outpatient drug costs since state does not participate in the Drug Rebate Program	Y
N/A	Outpatient drugs (23)	Requirement to use Tamper Resistant Drug Pads for prescription	Y
N/A	Direct payments to	State can't make supplemental payment except for	Y

STC Reference	Title	Brief Description	Renew (Y/N)
	CAH	GME and DSH	
53, Att. D 51, Att D	FFS UPL	FFP authority is companion to waived sections on UPL. Allows for flexibilities for FFS in institutional rate setting and development. Also relates to drugs and DSH.	Y
52(b)(iii), Att. D 50(b)(iii), Att. D	DSH Payments	Relieves AZ from making payments for inpatient hospital services that take into account disproportionate share of low income patients	Y
	ALTCS Disregard of income 1612(b)	Standardize the treatment of income disregards b/t income and the share of cost calculation	Y
32 (Table 1) 36(b)(4) 30(Table 1) 34(b)(4)	300% FBR	Applies the PAS to determine ALTCS eligibility Need authority to expend funds for HCBS program that we use a PAS (substitutes for disability determination) and apply regardless if in an institution or not. See "old" language. Allow benefit of 300% FBR regardless of institutionalize 30 day requirement.	Y
NA	Children or Spouses in Separation	Allow a dependent child or institutionalized spouse to qualify for ALTCS one month earlier by disregarding the income of parents and spouses in the month of separation.	Y
NA	QMB, SLMB, QI-1, SSI MAO, ISM	Disregard in-kind support/maintenance as income for QMB, SLMB, QI-1 and SSI-MAO.	Y
32 (Table 1) 30 (Table 1)	SSI-MAO (1924)	Change the budget process for ALTCS and SSI-MAO applicants/recipients in situations where there is an eligible or ineligible spouse or if the applicant/recipient is living with a minor dependent child.	Y
32 (Table 1) 30 (Table 1)	SSI-MAO (resources)	Simplify the resource determination for SSI-MAO groups by disregarding assets that an individual has irrevocably assigned to fund a burial or life insurance, household goods, mineral oil and timber rights and personal effects	Y
32 (Table 1) 30 (Table 1)	Resources	Disregard excess interest and dividends from resources for disabled adult children, widows and widowers and Pickle category.	Y
NA	Post-eligibility	Disregard interest and dividend from post-eligibility calculations.	Y
NA	Pickle Amendment	Disregard excess resources under Pickle Amendment, sec 503, PL 94-566, Sec 1634(c)	Y
NA	$20 Quarterly income	Allows AHCCCS to disregard quarterly income that is less than $20 in the post-eligibility determination process for the ALTCS program.	Y
36 34	ALTCS PAS	Extends ALTCS eligibility to individuals under 65 using the PAS as a substitute disability standard.	Y
36(d)(iii) 34(f)(iii)	HCBS	Authorizes HCBS under ALTCS (including transitional program)	Y
39, Att. C 37, Att. C	Family Planning	Provides family planning services for up to 24 months to women who lose eligibility at 60 days post-partum.	Y
55 53	IMD	FFP for services provided to 21-64 year olds in an IMD for the first 30 days with an annual limit of 60 days.	N
36(d)(iv) 34(f)(iv)	Spouses as Paid Caregivers	FFP to reimburse spouses as paid caregivers	Y
38(b)	ESI	FFP to provide coverage through ESI to employees	N

STC Reference	Title	Brief Description	Renew (Y/N)
36(b)		of small business w/ family income under 200% FPL	
32 (Table 1) 30 (Table 1)	MED Expansion population	FFP to provide coverage to individuals w/ medical bills that reduce the adjusted net countable income to 40% FPL or less	N
38(a)(i) 32 (Table 1) 36(a)(i) 30 (Table 1)	Prop 204 Population 100% FPL	FFP to provide coverage to individuals w/ adjusted net countable income at or below 100% FPL	N
38(a)(ii) 32 (Table 1) 36(a)(ii) 30 (Table 1)	Parents up to 200% FPL	FFP to provide coverage to parents of Medicaid and CHIP kids w/ adjusted net countable income between 100-200% FPL	N
33(d) 38(e) 32 (Table 1) 31(d) 36(e) 30 (Table 1)	Cost Sharing	Enable cost-sharing for parents of Medicaid or CHIP 100-200% FPL, for ESI individuals without dependent children between 0% - 100% FPL, and for MED expansion group.	Yes, except ESI and parents b/t 100-200% FPL which the state does not wish to renew
38(b) 36(b)	Amount Duration and Scope	Enable modification of Medicaid benefits pkg. for ESI individuals in order to offer a different pkg. than would otherwise be offered under State Plan.	N
N/A	Retroactive Coverage	ESI individuals, parents of Medicaid or CHIP children at100% - 200% FPL, individuals without dependent children between 0 - 100% FPL, & MED expansion group won't be retroactively eligible.	Yes, but delete reference to ESI and parents 100-200% FPL
N/A	Providing Medical Assistance	Parents of Medicaid or CHIP children at 100%-200% FPL who voluntarily terminate health insurance coverage during 3 mo, pre- application period, can be denied for medical assistance	N
39 37	Amount, Duration and Scope	Allows State to offer demonstration population a benefit pkg. consisting only of CMS-approved family planning services.	Yes, but amend to include related services
	EPSDT	State will not furnish or arrange for EPSDT services for demonstration population	Yes
	Retroactive Eligibility	Individuals in Family Planning program will not be retro-actively eligible.	Yes
	Prospective Pymt for FQHCs/RHCs	Enables State to establish reimbursement levels for FQHCs	Yes
	Eligibility Re-determination	Exempts FP women from reporting changes in income during their 12-mo eligibility period	Yes
38(a)(i) 36(a)(i)	Childless Adults HIFA I	FFP for coverage of uninsured childless adults over 18 at 40% - 100% FPL and not eligible for other coverage.	N
38(a)(ii) 36(a)(ii)	Parents HIFA II	FFP for coverage of uninsured parents of enrolled children at 100% - 200% FPL and not eligible for other coverage.	No
38(b)(ii)	ESI	Title XXI funds for coverage of CHIP-eligible children	No

STC Reference	Title	Brief Description	Renew (Y/N)
36(b)(ii)		to 19 at 100% - 200% FPL, who meet definition of targeted low-income child, and elect coverage via ESI rather than State CHIP program. Not subject to Title XXI requirements.	
	General Requirements, Eligibility, Outreach	Requires State to do eligibility screenings to ensure CHIP eligibles are not eligible for other health insurance (does not require State Plan to reflect the demo population and eligibility standards are not limited by §2102(b).	Yes
	FMAP and family coverage	FFP for demonstration populations outside the 10% admin cap [2105(c)(2)] Does not waive cap for XXI expenditures.	Yes
	Annual Report	Waives SARTS submission but requires reporting on issues related to demonstration populations via qtrly and annual reports, and enrollment data via Statistical Enrollment Data Systems (SEDS).	Yes
	Cost Sharing	Rules governing cost-sharing under Sec. 2103(c) of the Act shall not apply to demonstration populations to the extent necessary to impose cost-sharing for parents, childless adults, and ESI individuals.	Yes, except delete parents and ESI reference
	Restrictions on Coverage and eligibility to low income children	Coverage and eligibility for demonstration populations not restricted to targeted low-income children.	No
	Benefit Package Requirements	Permits State to offer benefit package for ESI program that does not meet requirements of Sec 2103 of the Act (42CFR 457.410(b)(1))	No
	DD Services	Limit services cost effectiveness not be compared to ICFMR but rather alternative residential setting (true average cost of DD home); including autism related services.	Yes, NEW
	Payment Reform	Allow the State to reimburse for costs not otherwise matchable and permit contracted health plans and providers to share in savings	Yes, NEW
	Program Integrity	Allow the State to serve as its own RAC, leveraging the State's managed care experience to establish a process that targets a managed care model, and seek 75% federal funding to combat fraud and abuse.	Yes, NEW
	Ex parte cases	Allow State to provide 60 days from the time a recipient has been determined ineligible for SSI	Yes, NEW
	Medicare Part B premium authority	Waiver from 431 CFR 625 to be consistent w/ SMDL	Yes, NEW
	MOE Waiver	Reduce eligibility for expansion groups known as Prop 204 eligibility groups	Yes, NEW
	DSH FY 2011 funding	Updates Att. D to reflect FY 2011 funding amounts	Pending
	Benefit Exemption	Exempts benefit reductions for services provided through IHS and 638 facilities	Pending

d. Quality:

Requirement: "Quality: The State must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and State quality assurance monitoring, and any other documentation of the quality of care provided under the demonstration."

Performance Measures: AHCCCS has established a number of performance measures to monitor the utilization of preventative health care services amongst members enrolled in the contracted health plans. AHCCCS uses the results of these measurements to identify areas for improvement and implement interventions to increase the utilization of preventative services. Contractors are expected to meet the AHCCCS Minimum Performance Standard for a particular measure and should try to achieve higher goals established by the agency. AHCCCS requires corrective action plans from Contractors that do not meet the Minimum Performance Standard for any measure, or that show a statistically significant decline, even if they met the minimum standard. Contractors that fail to show improvement may be subject to sanctions.

Below, please find a summary of the various performance measures by program or service category. Complete detail related to performance measures and related reports may be found at http://www.azahcccs.gov/reporting/quality/performancemeasures.aspx.

Acute Care

- Children's Access to PCPs
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
- Adolescent Well-Care Visits
- Annual Dental Visits
- Adult Access to Preventative/Ambulatory Health Services
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening
- Timeliness of Prenatal Care
- Low Birth Weight Deliveries
- Prenatal Care in the First Trimester
- Initiation of Prenatal Care
- Childhood Immunizations

ALTCS

- EPD
  - Diabetes Management Measures
  - Influenza and Pneumococcal Vaccination Rates
  - Prevalence of Pressure Ulcers
  - EPSDT Rates
- Performance Measures for the Arizona Department of Economic Security's Division of Developmental Disabilities
  - EPSDT Rates
  - Immunization of Two Year Olds
  - Adolescent Immunizations
  - Children's Access to PCPs
  - Well Child Visits in the Third, Fourth, Fifth and Sixth Year of Life
  - Annual Dental Visit
  - Adolescent Well Visits
- Initiation of Home and Community Based Services within 30 Days

BHS

Access to Care

Behavioral Health Service Plan
Behavioral Health Service Provision
Coordination of Care
Follow-up After Hospitalization of Mental Illness 7 and 30 Days
Treatment of Depression

CRS

Timeliness of Eligibility Determinations
Timeliness of Initial Service Plan Development
First CRS Service

Performance Improvement Projects: Recognizing that there are a number of critical health care issues facing both AHCCCS and the larger community, the Agency has also initiated a number of Performance Improvement Projects. A listing of the most recent AHCCCS Performance Improvement Projects may be found below. To view the full text of these reports, please visit http://www.azahcccs.gov/reporting/quality/PIPs.aspx.

Performance Improvement Projects

Acute

Asthma Management
Adolescent Well Care Visits
Care Coordination with Behavioral Health

ALTCS

Advance Directives
Influenza Vaccines
Re-Admission Within 30 Days

DDD

Advance Directives
Adolescent Well Care Visits

BHS

Supported Employment
Care Coordination with Acute Care

CRS

Enrollment and Access to Services
Electronic Health Record Use

- Diabetes Management
- Childhood Immunizations
- Children's Oral Health
- Vaccination Reporting to the Arizona State Immunization Information System (ASIIS)

AHCCCS Quality Assessment & Performance Improvement Strategy:

In accordance with 42 CFR 438.202, AHCCCS created the AHCCCS Quality Assessment and Performance Improvement Strategy. The 2010 revision includes requirements under Section 401(c)(1) of CHIPRA. The AHCCCS Quality Strategy is a coordinated, comprehensive, and pro-active approach to drive quality throughout the AHCCCS system by utilizing creative initiatives, monitoring, assessment, and outcome-based performance improvement. It is designed to ensure that services provided to members meet or exceed established standards for access to care, clinical quality of care, and quality of service. In addition, it leads to identification and documentation of issues related to those standards, and encourages improvement through incentives, or where necessary, through corrective actions. The document offers information related to progress on current projects; current Agency successes and future Agency endeavors. To view this document, please visit http://www.azahcccs.gov/reporting/quality/strategy.aspx.

Quarterly Progress Reports: AHCCCS includes a summary of its Quality Assurance/Monitoring activities in each of its Quarterly Progress Reports. These summaries include updates on implementation of the AHCCCS Quality Assessment and Performance Improvement Strategy, in accordance with Balanced Budget Act (BBA) requirements. To view the Quarterly Progress Reports, please visit: http://www.azahcccs.gov/reporting/reports/quarterly.aspx

External Review Organization Reports: The External Quality Review Organization Reports were conducted by an external review organization on an annual basis in accordance with the requirements of the Balanced Budget Act of 1997 to assure compliance with federal managed care regulations. To view these reports, please visit http://www.azahcccs.gov/reporting/reports/EQR.aspx

e. Compliance with Budget Neutrality Cap:

Requirement: The State must provide financial data (as set forth in the current STCs) demonstrating the State's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In addition, the State must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.

Forthcoming

f. Draft report with Evaluation Status and Findings:
The State must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

Attached