STATE OF ARIZONA

JANICE K. BREWER
GOVERNOR

EXECUTIVE OFFICE

March 31, 2011

The Honorable Kathleen Sebelius
Secretary
United States Department of Health and Human Services
200 Independence Avenue, S.W., Room 120-F
Washington, DC 20201

Dear Secretary Sebelius:

Thank you for meeting with me last month. I appreciated your candor and pledge to help states like Arizona better manage the quality and costs of their Medicaid programs. Your guidance has given my staff and me the opportunity to develop what I believe is a thoughtful and balanced approach to preserving our state's Medicaid program, with consideration for both beneficiaries and taxpayers. However, it cannot be successful without your help and willingness to grant additional flexibility.

Your partnership is critical to my efforts to preserve Medicaid coverage for more than one million Arizonans. My previous correspondence to you and your staff on this matter has clearly outlined the fiscal challenges the State has faced over the past several years. Over the past four years, while we have made unprecedented spending reductions in almost every other area of state government, Medicaid expenditures have increased by over 65 percent. These increases have occurred despite the fact that Arizona's Medicaid program is one of the most innovative in the nation; indeed, we have pursued or are pursuing almost every innovation you have suggested states consider. We must, therefore, have your assistance in making further changes to the program to assure its future sustainability.

In light of your assurance of flexibility, I have modified my initial proposal to preserve existing coverage to the greatest extent possible. But it will not be possible to achieve my proposed reforms – and limit the economic and human impact of necessary reductions – without your support.

Enclosed with this letter please find my amended request for a new Section 1115 Research and Demonstration Waiver ("Demonstration Waiver") for the period of October 1, 2011, through September 30, 2016.

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This Demonstration Waiver will allow the continuation of the Arizona Health Care Cost Containment System (AHCCCS) managed care model, as well as add new innovations to ensure its sustainability for the future.

The details of this new Demonstration Waiver are explained in the attached document. This submittal amends Arizona's package from September 27, 2010, and adds the reforms I have proposed as part of my plan to preserve our Medicaid program for Arizona's most needy while getting a handle on program costs over the long term.

To that end, the new Demonstration Waiver will include efforts to limit enrollment, incentivize personal responsibility and wellness, and modernize Medicaid benefits and payment processes as described below.

Enrollment Reforms

Spend Down Program
As previously submitted to you, the State intends to terminate the Medical Expense Deduction (or "spend down") program on October 1, 2011. A phase-down period (including suspended enrollment for this population) will begin May 1, 2011. Implementation of this change will be achieved through emergency rule authority and will include a 30-day public comment period. We recognize that, in order to implement this component (and others); the State will require a CMS-approved transition plan.

Enrollment Limits
My proposal retains coverage for Arizonans currently on Medicaid, but limits new enrollment of childless adults and higher-income parents (with incomes between 75 and 100 percent of the federal poverty level). For childless adults, the mechanism by which the State will achieve this will be through the termination of its existing childless adult program and an application for a new Demonstration Waiver. This new waiver will operate the program under an enrollment freeze and other amendments as outlined in this letter. The waiver transition will be seamless for those enrolled in the program. Please consider this Arizona's notification of its intent to terminate the existing program.

In order to phase-out the current Demonstration Waiver for childless adults, the State will need to freeze enrollment for childless adults beginning July 1, 2011. The new Demonstration Waiver for childless adults will maintain coverage for individuals already enrolled, while reducing state costs over time and focusing efforts on disease prevention and personal responsibility.

Although we have not received your response to my January 25, 2011, request for you to waive the Maintenance of Effort (MOE) requirements of the Patient Protection and Affordable Care Act, this proposal narrows that request. Specifically, I request you waive the MOE requirements to allow Arizona to implement an enrollment freeze on higher-income parents, as well as the implementation of a shorter redetermination process for parents.

Redeterminations
This proposal ensures that the Medicaid program serves only those who are eligible by employing a six-month redetermination process for childless adults and parents. This is a common-sense change that will not change coverage for anyone who remains eligible for the program and who completes a simplified redetermination process.

Personal Responsibility and Wellness Incentives

My proposal includes requirements and incentive strategies that will encourage individuals to take greater control of their health. It increases personal responsibility through the expansion of mandatory co-payments and the imposition of "no-show" penalties for missed appointments, which have long been commonplace in private commercial coverage. I believe these components are critical to ensuring that enrollees are making decisions that positively impact their health and well-being, and that they have a financial stake in those decisions.

Payment and Benefit Modernization

Payment Innovations
My proposal implements payment reform innovations that focus on quality of care so we can truly begin the hard work of "bending the health care cost curve." For instance, we are pursuing models such as medical/health homes, which will improve the efficiency and quality of health care delivery, but are not feasible for the long-term under Medicaid's current reimbursement structure. The proposal also seeks reimbursement for state Medicaid payments that should have been paid by Medicare, as it is critical to our ongoing state and federal partnership that each party pay its rightful share.

Benefit Changes
I propose new limits upon benefits that are prone to waste and abuse by eliminating non-emergency transportation for non-disabled adults living in urban areas. Benefits for the most needy – children, the disabled and residents of rural areas – would be unaffected.

Other components of my plan will require State Plan Amendments (SPAs), which will be submitted under separate cover. Some of these SPAs will include: (1) limits on inpatient hospital stays; (2) limits on other services, such as office visits; (3) reductions and changes to provider reimbursement.

Finally, I also propose the restoration of optional transplant services that were eliminated as part of the state's FY 2011 budget. I have long said that restoration of these services is only possible through a comprehensive plan that reforms Arizona's Medicaid program and ensures its long-term financial viability. I believe this is that plan. Therefore, I am asking the Legislature to authorize the restoration of optional transplant services. In the absence of state coverage for these services for the past six months, I have been grateful for the private financial support

provided by individual Arizonans and the health care community and I extend to them my deep gratitude.

Other Changes

In addition to the above changes to the Demonstration Waiver, my Medicaid reform plan will include efforts to integrate care in the areas of behavioral health and children with special needs. I also propose continued support of the health care needs of individuals receiving care through Indian Health Services or tribally-owned 638 facilities by exempting benefit and eligibility limits that would simply shift costs to these fragile systems. Finally, I believe it is critical that Arizona continue its vigilant pursuit of fraud, waste and abuse within the Medicaid system, and I affirm continued attention to these vital efforts.

Some parts of this proposal are near-term changes that require immediate action, such as the phase-down and termination of the Medical Expense Deduction program. Other components, like payment reform and the integration of behavioral and physical health services, are longer-term in nature and designed to reduce the rate at which state health care spending increases to ensure affordability.

I am committed to working with you on the implementation of this new Demonstration Waiver. As I believe this plan demonstrates, my priority is to preserve and modernize Arizona's Medicaid program so that it continues to serve as a national model of cost-effective care for the states most vulnerable and continues as a leading example of a successful state-federal partnership. If Arizona is to successfully preserve its Medicaid program for the future, it will require a willingness on the part of the federal government to grant flexibility and freedom. Based on our correspondence and our recent meeting, I believe you share these goals and I am encouraged you will assist Arizona in achieving them.

I will do everything I can to ensure that you and your staff have the data and information you require to give this proposal due consideration. Please do not hesitate to contact me directly for anything you might need to assist in your evaluation.

Thank you again for the time you spent with me and thank you for your service to the nation.

Sincerely,

Janice K. Brewer

Governor Janice K. Brewer

Arizona Waiver and Expenditure Authority Request
Medicaid Reform Plan for Arizona

I. Overview

By way of this document, the State of Arizona's Medicaid program, known as the Arizona Health Care Cost Containment System (AHCCCS), respectfully requests authority for a new five-year 1115 Research and Demonstration Waiver ("Demonstration") to replace its current Demonstration that is set to expire September 30, 2011. This document provides an update to Arizona's notice of intent to apply for new Demonstration authority submitted September 27, 2010[1].

On March 15, 2011, Arizona Governor Jan Brewer released a Medicaid Reform Plan ("Reform Plan")[2]. The Reform Plan is designed to set a course for sustainability while still preserving coverage for the greatest number of Arizonans. The elements of the Reform Plan requiring 1115 Research and Demonstration Waiver authority are laid out in this document. A cover letter accompanying this document includes elements of the Reform Plan that can be achieved through the 1115 Demonstration process as well as State Plan Amendments.

Extensive background has been provided to the Centers for Medicare and Medicaid Services (CMS) regarding Arizona's unprecedented budget crisis, which has necessitated difficult action on the part of the State in order to preserve the core of the Medicaid program. That background can be found on the AHCCCS website as part of the Maintenance of Effort (MOE) Waiver request of January 25, 2011 and briefing materials provided to CMS on February 8, 2011 and is hereby incorporated by reference as part of this request[3].

The goal of the Reform Plan is to preserve coverage by adding flexibilities that will allow the State to manage its Medicaid program within budgetary constraints. The requested flexibilities also include a renewed focus on personal responsibility and partnership between the State and the consumer, payment innovations to support a health care infrastructure that rewards quality over quantity, and authority to exempt Indian Health Services (IHS) and 638 facilities from eligibility and benefit restrictions.

II. Public Process

Arizona first proposed making significant changes in eligibility as part of the FY 2011 budget enacted in March 2010. Shortly after passage of the budget, the Affordable Care Act (ACA) was enacted into law. The MOE provisions of the ACA limited the State's ability to implement eligibility changes enacted as part of the State FY2011 budget. Authority provided as part of the State's budget legislation has served as the basis for implementing some of the initial changes in the Reform Plan.

Authority to pursue an MOE waiver was originally provided in SB 1001, during the First Special Session of the Fiftieth Legislature. SB 1001 included provisions that required AHCCCS to seek a waiver to "reduce eligibility requirements for select Title XIX populations that were previously optional." The legislative process for SB 1001 included hearings in the Appropriations Committees of both chambers of the

[1] http://www.azahcccs.gov/reporting/Downloads/1115waiver/CoverLetterWaiver1-26-11.pdf
[2] http://www.azahcccs.gov/shared/Downloads/News/MedicaidReformPlan.pdf
[3] http://www.azahcccs.gov/reporting/federal/waiver.aspx

legislature where members of the public provided public testimony. AHCCCS posted information about the MOE waiver on its website in January of 2011. Information included the text of SB 1001, Governor Brewer's statement on signing SB 1001, MOE Frequently Asked Questions, the MOE Waiver Request to CMS, the CMS Response regarding the MOE Request and Arizona's authority, and additional information.

AHCCCS also posted information regarding the Phase Out Plan for the Medical Expense Deduction program on its website. In addition, Public Notice was provided in The Arizona Republic, a newspaper circulated statewide, on March 19, 2011. The Notice of Proposed Rulemaking was also published in the Arizona Administrative Register on March 25, 2011, with the opportunity for public comments due on April 18, 2011.

Other items in this proposal were also covered in the public hearings for the original Waiver Renewal submission held on August 9th and September 2nd of 2010. These public hearings were made available by webinar as well.

Tribal consultation was held on January 10, 2011, January 21, 2011 and March 31, 2011[4].

III. Data Analysis- "With Waiver" vs. "Without Waiver"

See attached.

IV. Allotment Neutrality

N/A. The amendment does not impact the Title XXI HIFA population.

V. Details

A. Payment Reforms

1. *Reimbursement Innovations that Allow Medicaid to Reimburse for Quality*

Health care reform legislation and the various demonstration and grant opportunities contained in the ACA are all geared toward achieving certain changes in the delivery of health care for Medicaid members. AHCCCS has already achieved many of these innovations – e.g., moving away from care in institutions to care in the home or the community (80% 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

[4] http://www.azahcccs.gov/tribal/consultations/consultations.aspx

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 piloting a number of different models that incentivize quality. 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 current system structure, which is built around reimbursing for quantity. For instance, 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 or through case managers. Consequently, health plans and hospitals are expending monies out of their own administrative dollars or grant monies to achieve and support these innovations. Clearly, this is not a sustainable model.

Medicaid is a critical partner in the broader health care industry. Transforming the Medicaid reimbursement structure is a key element to encouraging system reform that reimburses for improved health outcomes. Thus, AHCCCS wants to look at opportunities 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:
(a) Allow Medicaid to reimburse for costs not otherwise matchable to recognize the costs incurred by a health plan entering into an ACO arrangement that have not been included as “medical services” as defined 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.
(b) Allow for savings from improved quality to be used to support gain sharing arrangements with ACOs and health plans. The goal is 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 those savings. Medical homes and ACOs will be explored and created in order to achieve this effort, thus fostering 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; interventions through primary and preventive care in more cost-effective settings; compliance with appointments and care. The ultimate outcome is to begin to bend the health care cost curve.

Accordingly, AHCCCS seeks the following authority:

- Expenditure Authority for Expenditures made by the State for a delivery system as described above that would not otherwise be included as matchable expenditures under Section 1903.
- Waiver of section 1903(m) to the extent that the implementing regulation, 42 C.F.R. § 438.6(c)(4), requires that the certification of actuarial soundness is based only on services covered under the State Plan and cost directly related to providing those services.

2. *Cost Effectiveness Reimbursement for the ALTCS DD Program*

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), under contract with AHCCCS as a managed care organization, 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 individual recipient's 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. 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.

The desired outcome is to 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.

Accordingly, AHCCCS seeks the following authority:

- Expenditure Authority for Expenditures associated with the provision of providing Home and Community-Based Services for individuals in the ALTCS DD program to be limited to the cost of care in an appropriate alternative out-of-home placement. Amendments are also needed to STC #34.

B. Medicaid Eligibility

1. *Eliminate Medical Expense Deduction Program*

The Medical Expense Deduction (MED) program is a spend down program for those individuals or households who are over the income threshold to qualify for other Medicaid eligibility categories but, because of a catastrophic event, have spent down to below 40% of the Federal Poverty Level (FPL). The MED program is time-limited with eligibility lasting between three to six months. Enrollment in this program usually is between 5,000 to 6,000 individuals each month.

The State is seeking to terminate this program. Termination of this program necessitates a phase out or enrollment freeze under the current Special Terms and Conditions of Arizona's Demonstration. The State has requested that this phase out begin by May 1, 2011 so that individuals currently enrolled do not lose coverage. However, no new blocks of eligibility will begin after that date. Thus, since a single block of eligibility can last no longer than the remainder of the month of eligibility plus five additional months, a phase out beginning May 1, 2011 would mean that the eligibility period for all individuals currently enrolled would end by October 1, 2011. A phase out plan has been submitted to CMS for review. No enrollment freeze will begin until that phase out plan is approved by CMS[5].

Accordingly, AHCCCS seeks to **discontinue** the following authority:

- Expenditure Authority for Expenditures to provide Medicaid coverage to individuals who have medical bills incurred by the family unit sufficient to reduce the adjusted net countable family income to 40 percent or less of the FPL, and who are not otherwise eligible for Medicaid (CNOM #15).

2. *Eliminate Current Childless Adult Program*

[5] http://www.azahcccs.gov/reporting/federal/waiver.aspx#med

Arizona offers Medicaid coverage to "childless adults" (i.e., persons who are not categorically eligible) from 0 to 100% FPL. This program is currently open-ended and has over 220,000 individuals enrolled.

The State is seeking to terminate this program. Termination of this program necessitates a phase out or enrollment freeze under the current Special Terms and Conditions of Arizona's Demonstration. The State has requested that this phase out begin by July 1, 2011. This means all individuals enrolled under this category as of the begin date of the freeze would retain their coverage (so long as they continue to meet the eligibility standard prior to the freeze), but no new members would be permitted to enroll for childless adult coverage after the date of the freeze. A phase out plan will be submitted to CMS for review and posted to the AHCCCS website once available. No enrollment freeze will begin until that phase out plan is approved by CMS.

Accordingly, AHCCCS seeks to **discontinue** the following authority:

- Expenditure Authority for Expenditures to provide Medicaid coverage to individuals with adjusted net countable family income at or below 100% FPL who are not otherwise eligible for Medicaid (CNOM #16).

3. Authority for New Childless Adult Program

The State is seeking authority to implement a new Demonstration for childless adults. Arizona would maintain coverage of those childless adults from 0 to 100% FPL that are enrolled before July 1, 2011. The program, however, would not be open-ended. Enrollment would remain frozen, and the State would have authority and flexibility to make changes in eligibility to maintain the program within funding limits. While the intent for FY 2012 is to operate the program under a freeze, the State is seeking the ability to manage the population depending on available funds.

In addition to flexibilities to assess eligibility, the State is seeking to pilot penalty and incentive strategies that would assist the State in partnering with the consumers to take responsibility for their own health care. For instance, all smokers enrolled in the childless adult population would be required to pay an annual fee of $50. In addition, childless adults who are obese and/or suffer from a chronic disease, such as diabetes, will need to work with their primary care physician to develop a care plan. Individuals who do not adhere to the plan and meet specified goals will be required to pay an annual fee of $50.

AHCCCS will combine these annual fees with incentive strategies, including those grant opportunities outlined by the Affordable Care Act, to provide appropriate incentives for healthy behaviors and disease management. AHCCCS has solicited input from the public regarding these strategies and will work with stakeholders on an initiative that best meets the agency's goal of improving health outcomes and lowering the cost of care. In addition, the Arizona Department of Health Services has obtained a $400,000 grant from the Centers for Disease Control and National Center for Chronic Disease Prevention and Health Promotion, which will be aimed at wellness initiatives for the Medicaid population.

The State is also seeking to implement six-month redeterminations for the childless adult population. This is considered an important program integrity effort that will help to ensure that only those who are truly eligible and meet the income standard maintain their eligibility. This is a matter of program integrity, not adding administrative layers to eligibility. The State should not make monthly capitation payments for those individuals who are no longer eligible for the program. Thus, the State will offer a simplified redetermination process at the six month marker. Some of the simplified redetermination strategies the State is reviewing include a pre-populated affidavit, which the enrollee must sign and return, or using an online process verifying that there have been no changes in the household's income, composition, etc. The six-month redetermination will not impact eligibility for those individuals who continue to be eligible and complete the simplified requirement.

Finally, the State is seeking to be waived from requirements under Early Periodic Screening Diagnosis and Treatment (EPSDT) for those childless adults age 19 and 20.

Accordingly, AHCCCS seeks the following authority:

- Expenditure Authority for Expenditures to provide Medicaid coverage consistent with the above description to individuals with adjusted net countable family income at or below 100% FPL (or such other lower percentage of FPL as established by the State) who are not otherwise eligible for Medicaid subject to available state matching funds.

AHCCCS is also requesting explicit statements in the Expenditure Authority that the following Medicaid Requirements are Not Applicable to this expansion population:

- EPSDT requirements under § 1902(a)(10)(A) and (a)(43) to enable the State to not provide EPSDT coverage for 19 and 20-year old individuals enrolled in the childless adult program.
- Cost Sharing limitations under §§ 1916 and 1916A.
- Maintenance of effort requirements under § 1902(gg).

4. *Freeze Enrollment for Parents from 75% - 100% FPL*

The State is seeking authority to implement an enrollment freeze for those parents age 18 and older with incomes between 75 and 100% FPL and currently enrolled under Section 1931. This enrollment freeze would begin October 1, 2011. Those parents currently enrolled as part of this income block would retain their coverage and no new individuals falling into this eligibility category would be able to enroll if their income is between 75% to 100% FPL. Currently, the State covers parents from 0 to 100% FPL. The national mean for coverage of parents in Medicaid is 63% FPL. In Arizona, enrollment of 1931 parents with incomes from 0 to 100% FPL is approximately 120,000, with approximately 60,000 represented in the 75% to 100% FPL group. No children would be impacted by this enrollment freeze and AHCCCS will submit a transition plan regarding this freeze to CMS.

The State recognizes this enrollment freeze would require a waiver from MOE Requirements contained in the ACA, which amended Section 1902 of the Social Security Act ("the Act") [42 U.S.C. § 1396] by adding a new paragraph (gg). This

new paragraph requires states to maintain eligibility for Title XIX Medicaid and Title XXI Children's Health Insurance Program (CHIP)[6].

Because the MOE provisions were incorporated as part of Section 1902 of the Act, it is a waivable matter under Section 1115 [42 U.S.C. § 1315]. The Congressional Research Service (CRS) review of this matter reached the same conclusion[7] -- that it is within the Secretary's broad discretion, depending on her interpretation of the statute. Section 1115 provides the Secretary with broad authority to waive any of the requirements of Section 1902 of the Act if the waiver request "is likely to assist in promoting the objectives of title XIX." An enrollment freeze promotes the objectives of Title XIX and of the Secretary in reaching a solution that allows for preservation of coverage to the greatest extent. This enrollment freeze provides the State additional flexibility to assist it in preserving coverage for the childless adult population and to maintain life-saving benefits. Without these flexibilities, legislative proposals like SB 1519 (a bill to opt out of Medicaid that passed out of the State Senate Appropriations Committee) or the Senate Budget Reconciliation Bill eliminating coverage for all childless adults gain momentum.

Accordingly, AHCCCS seeks the following authority:

- Waiver Authority: Waiver from § 1902(gg), to waive MOE requirements in the Affordable Care Act that would allow Arizona to freeze enrollment for parents with incomes between 75% to 100% FPL and implement a six month redetermination process for this population.

5. *Implement Six-Month Redetermination Requirement for Parents*

In an effort to preserve coverage and maintain program integrity, the State is seeking authority to conduct six month redeterminations for parents age 18 and older qualifying under Section 1931. This change will ensure that only those who are truly eligible and meet the appropriate income requirements are maintained on the program. This is particularly important in a capitated managed care model.

This is a matter of program integrity. The State should not make monthly capitation payments for those individuals who are no longer eligible for the program. Thus, the State will offer a simplified redetermination process at the six month marker. Some of the simplified redetermination strategies the State is reviewing include a pre-populated affidavit, which the enrollee must sign and return, or using an online process verifying that there have been no changes in the household's income, composition, etc. The six-month redetermination will not impact eligibility for those individuals who continue to be eligible and complete the simplified requirement.

The State recognizes that this request would require a waiver of MOE requirements in order to implement this change for parents, and accordingly seeks to be waived from those requirements as found in Section 1902(gg) as explained above.

Accordingly, AHCCCS seeks the following authority:

[6] http://www.azahcccs.gov/reporting/Downloads/BudgetProposals/FY2012/AZMOEWaiverAttachment.pdf
[7] http://www.azahcccs.gov/reporting/Downloads/1115waiver/03_16_11_Maintenance_of_Effort_Requirements_CRS_Report.pdf

- Waiver Authority: Waiver from § 1902(gg), to waive MOE requirements in the Affordable Care Act that would allow Arizona implement a six month redetermination process for parents qualifying under Section 1931.

6. *Eliminate Coverage for Federal Emergency Services*

Federal Emergency Services (FES) provides Medicaid coverage only for services necessary to treat an emergency medical condition to those individuals who are otherwise Medicaid eligible but cannot prove citizenship or qualified alien status. This category includes emergency coverage for any nonqualified alien, such as individuals who are legally present in the United States and are legal permanent residents but who have not met the five-year U.S. residency requirement or undocumented immigrants.

The Immigration Act, 8 USC 1611(a)[8], generally prohibits any nonqualified alien from receiving any federal benefit. Subsection (b) of that statute says that the prohibition does not apply to treatment of an emergency medical condition as part of the Medicaid program. In other words, the Immigration Act says that a nonqualified alien can receive those services. However, the exception is not worded in a way that mandates such coverage.

The mandatory language is in the Medicaid Act under a waivable provision. The final unnumbered paragraph of 1902(a) states that "Notwithstanding paragraph (10)(B) or any other provision of this subsection, a State plan shall provide medical assistance with respect to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law only in accordance with section 1903(v) [treatment of emergency medical treatment]." Under Section 1115(a) of the Social Security Act, any provision of 1902 can be waived by the Secretary. The prohibition on FFP for service (other emergency services) to nonqualified aliens – found at section 1903(v) – can also be waived under Section 1115 of the Act.

The State is seeking to be waived from this provision as found in Section 1902(a) and 1903(v) in order to maintain the core of its Medicaid program and preserve coverage to the greatest extent. The State shares the concern of the hospital industry regarding any burden of uncompensated care and is prepared to assist hospitals to explore ways to maximize Disproportionate Share Hospital (DSH)

[8] The relevant text of the Immigration Act provides:

> (a) In general. Notwithstanding any other provision of law and except as provided in subsection (b), an alien who is not a qualified alien (as defined in section 431 [8 USCS § 1641]) is not eligible for any Federal public benefit (as defined in subsection (c)).
>
> (b) Exceptions.
> (1) Subsection (a) shall not apply with respect to the following Federal public benefits:
> (A) Medical assistance under title XIX of the Social Security Act [42 USCS §§ 1396 et seq.] (or any successor program to such title) for care and services that are necessary for the treatment of an emergency medical condition (as defined in section 1903(v)(3) of such Act [42 USCS § 1396b(v)(3)]) of the alien involved and are not related to an organ transplant procedure, if the alien involved otherwise meets the eligibility requirements for medical assistance under the State plan approved under such title...

payments through the opportunities and flexibility established under the previous Demonstration.

Accordingly, AHCCCS seeks the following authority:

- Waiver Authority: Waiver from § 1902(a) and § 1903(v) to waive the requirement to cover this population.

7. *Seek Reimbursement of Medicare Liability*

The State seeks to pursue Demonstration authority in order to be reimbursed by Medicare for eligibility errors. For over three decades, state Medicaid programs, including Arizona, have paid for health care coverage for individuals who were eligible for Medicare but were not covered under Medicare because of errors in the methodology used by the Social Security Administration to determine federal disability benefits. SSA has acknowledged this error and implemented the Special Disability Workload (SDW) project to correct the error. AHCCCS is seeking Demonstration Waiver authority for a payment of $40 million to be made to the State for facilitating the provision of services to SDW cases.

Accordingly, AHCCCS seeks the following authority:

- Expenditure Authority: Costs not otherwise matchable for reimbursement to AHCCCS of $40 million for payments made by the State to providers for Medicare covered services in SDW cases.

8. *Ex Parte Cases*

Section 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 has 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.

The objective is to include language in the waiver that corresponds with what AHCCCS is doing. Specifically, Arizona is requesting expenditure authority for costs

not otherwise matchable under section 1903 and its implementing regulation, 42 CFR 435.1003.

The desired outcome is to maintain continuity of care for members as well as administrative efficiencies given limited resources for operations.

Accordingly, AHCCCS seeks the following authority:

- Expenditure Authority for Expenditures made by the State not in accordance with 42 CFR 435.1003 described above which would not otherwise be included as matchable expenditures under Section 1903.

C. Personal Responsibility

1. *Implement Mandatory Copayments for Adults*

The State is seeking authority to conduct a Demonstration requiring mandatory copayments for all adults, except those in the Arizona Long Term Care System (ALTCS)[9]. The copayment requirements for adults would mirror those established for the TMA population as part of State Plan Amendment (SPA) 10-001[10]. Those co-payments include:

Temporary Medical Assistance (TMA)[11] Copays	
Service	**Copay Amount**
Prescriptions	$2.30
Doctor/provider outpatient office visits for evaluation and management	$4.00
Physical, Occupational and Speech Therapies	$3.00
Outpatient Non-emergency or voluntary surgical procedures	$3.00
Non Emergency Use of the Emergency Room	$25.00[12]

Providers would be permitted to deny services for failure to pay the required co-payment.

The State seeks this waiver authority for a Demonstration project, which, in accordance with Section 1916(f) of the Act would:

- Test a unique and previously untested use of copayments;
- Limit the demonstration to a period of not more than two years;
- Provide benefits to the recipients of medical assistance, which can reasonably be expected to be equivalent to the risks to the recipients;

[9] Copayments for childless adults are covered separately under current 1115 Demonstration authority.
[10] http://www.azahcccs.gov/reporting/Downloads/MedicaidStatePlan/Amendments/2010/SPA10-001_Submittal.pdf
[11] TMA is for families who previously qualified under the Medicaid "1931" category and are no longer eligible for any AHCCCS program due to increased earnings. TMA may be provided for up to 12 consecutive months. Copays can not exceed 5% of the gross family income for a quarter.
[12] Currently, copay requirements for TMA do not include non-emergency use of the emergency room.

- Be based on a reasonable hypothesis that the Demonstration is designed to test in a methodologically sound manner, including the use of control groups or similar recipients of medical assistance in the area; and
- Be voluntary or make provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.

The State is testing the use of mandatory copayments in conjunction with use of incentives to promote health behaviors and disease self-management. This proposal would require copayments for members who smoke, are obese, or who fail to meet steps necessary to manage a chronic disease. AHCCCS will apply funds through incentive grants under the ACA and through a $400,000 grant awarded to the Arizona Department of Health Services to encourage members to meet wellness initiatives and manage chronic illness.
The purpose of this Demonstration is twofold: (1) to test the linkage between copayments, incentive strategies and healthy behaviors and outcomes; and (2) to bring down costs within the program in an effort to preserve coverage to the greatest extent and preserve as many life-saving benefits as possible.

Accordingly, AHCCCS seeks the following authority:

- Waiver Authority- Waiver from §1902(a)(14) and corresponding regulation 42 CFR §§ 447.51 through 447.56, to expand cost sharing.

2. *Implement Mandatory Co-Payments for Children*

The State is seeking authority to conduct a Demonstration requiring mandatory copayments for children. The copayment requirements would mirror those established for the TMA population as part of State Plan Amendment (SPA) 10-001[13]. Those co-payments include:

Temporary Medical Assistance (TMA) Copays	
Service	**Copay Amount**
Prescriptions	$2.30
Doctor/provider outpatient office visits for evaluation and management	$4.00
Physical, Occupational and Speech Therapies	$3.00
Outpatient Non-emergency or voluntary surgical procedures	$3.00
Non Emergency Use of the Emergency Room	$25[14]

Providers would be permitted to deny services for failure to pay the required co-payment.

The State seeks this waiver authority for a Demonstration project, which, in accordance with Section 1916(f) of the Act would:

- Test a unique and previously untested use of copayments;
- Limit the demonstration to a period of not more than two years;

[13] http://www.azahcccs.gov/reporting/Downloads/MedicaidStatePlan/Amendments/2010/SPA10-001_Submittal.pdf
[14] Currently, copay requirements for TMA do not include non-emergency use of the emergency room.

- Provide benefits to the recipients of medical assistance, which can reasonably be expected to be equivalent to the risks to the recipients;
- Be based on a reasonable hypothesis that the Demonstration is designed to test in a methodologically sound manner, including the use of control groups or similar recipients of medical assistance in the area; and
- Be voluntary or make provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.

The State seeks to meet these criteria by requiring copayments for those children who do not meet their well exam requirements or who do not maintain their immunizations current. The State will also provide incentives to those families who ensure their child is up to date on well exams and immunizations. Children who are obese must meet a care plan outlined by their pediatrician and when steps are not taken to address the child's obesity, a copayment will be assessed. If the child shows positive improvements under the guidelines and supervision of the pediatrician, the copayment will be waived and an incentive payment will be considered. Likewise, children who are managing a chronic condition will be excused from copayment requirements if they are managing their disease under the pediatrician's supervision.

The purpose of this Demonstration is twofold: (1) to test the linkage between copayments, incentive strategies and healthy behaviors and outcomes; and (2) to bring down costs within the program in an effort to preserve coverage to the greatest extent and preserve as many life-saving benefits as possible.

Accordingly, AHCCCS seeks the following authority:

- Waiver Authority- Waiver from §1902(a)(14) and corresponding regulation 42 CFR §§447.53 through 447.56, to expand cost sharing.

3. *Implement a Penalty for Missed Appointments*

AHCCCS providers have expressed concerns on numerous occasions regarding member appointment compliance. In an effort to increase member accountability and provider satisfaction during a period of decreased funding for the program, many providers have asked for the ability to seek relief from those individuals who miss their scheduled appointments. This is permitted for those who are uninsured and commercially insured as a matter of personal responsibility and respect for the health care provider's time. Accordingly, the State seeks the authority to test the effectiveness of penalties for missed appointments. CMS policy prohibits providers from charging Medicaid recipients for missed appointments based on the reasoning that a missed appointment is not a distinct reimbursable Medicaid service but part of the overall cost of doing business already covered by the Medicaid rate.

The State recognizes it will not benefit from any monetary savings. By allowing the same flexibilities providers have for beneficiaries enrolled in Medicare and private insurance carriers, addressing the high rate of missed appointments promotes continued provider participation, especially during a time when provider rates are being reduced. Providers would be required to obtain express written acknowledgement from Medicaid enrollees prior to enforcing standard no-show

charges for members who miss scheduled appointments or do not abide by provider cancellation policies. Also as part of this effort, the State will explore opportunities to partner with the provider community and share best practices for reducing no shows among the Medicaid population. Already there are many community health centers that have reduced the rate of no-shows by changing the structure of appointment scheduling. AHCCCS will create a "best practices" page on its website to share these types of success stories.

The goal is to assist members to take personal responsibility for their own healthcare and to offer a tool to providers to better manage their Medicaid clientele.

Accordingly, AHCCCS seeks the following authority:

- Waiver Authority: Waiver from CMS policy prohibiting charges for missed appointments and, to the extent CMS deems it necessary, from §1902(a)(14) and corresponding regulation 42 CFR §§447.53 through 447.56, to expand cost sharing.

D. Benefit Changes

1. *Restrictions on Coverage for Non-Emergency Transportation*

The State seeks to eliminate non-emergency medical transportation (NEMT) for non-disabled childless adults and non-disabled parents in urban Maricopa and Pima counties. The State seeks the authority to impose a co-payment for non-disabled childless adults and non-disabled parents in all other areas.

The State will offer information regarding alternative resources for low cost or no cost transportation.

For Arizona to sustain a cost effective Medicaid program, AHCCCS must continuously examine program costs and benefits so it continues to serve its growing population and preserve medical services for the more traditional (and more vulnerable) population while responding to the State's dire fiscal circumstances. The limit on NEMT aligns with this objective. It is a choice between the provision of actual medical services or the provision of NEMT to non-disabled adults in urban areas. The State believes that greater importance should be placed on the provision of medical services.

However, recognizing that there are concerns regarding potentially limiting access to care, Arizona agrees to conduct a review of the elimination of NEMT to determine the impact on access to care after one-year with a report to be filed with CMS and made available for public comment within one year and six months. If the effect of elimination of NEMT proves deleterious to the consumer, AHCCCS will complete a corrective action plan that must be approved by CMS but that still fits within budgetary constraints. If no appropriate corrective action plan can be constructed, the State agrees to restore the benefit.

AHCCCS would continue to cover NEMT provided through the Indian Health Service or 638 facilities regardless of the enrollee's county or residence and without requiring a copayment for those services.

Accordingly, AHCCCS seeks the following authority:

- Assurance of Transportation: Waiver from §1902(a)(4) to the extent that it is implemented through 42 CFR §431.53, to allow the State to limit transportation to and from providers for certain populations;
- Statewideness: Waiver from §1902(a)(1) and corresponding regulation 42 CFR §431.50, to allow the State to provide different benefits to members who live outside of Maricopa and Pima Counties;
- Comparability: Waiver from §1902(a)(10)(B) and corresponding regulations at 42 CFR §§440.240 and .230, to allow the State to offer NEMT in a different amount, duration and scope as described herein.

AHCCCS is also requesting explicit statements in the Expenditure Authority under Medicaid Requirements Not Applicable that § 1902(a)(4), to the extent that it is implemented through 42 CFR §431.53, does not apply to the expansion population as described herein.

E. Avoid Cost Shift to Indian Health Services and Tribally Owned/Operated 638 Facilities

The State seeks to obtain authority to exempt benefit restrictions and eligibility changes for those services and benefits obtained through Indian Health Services (I.H.S.) or 638 facilities. This exemption would allow I.H.S. and 638s to continue to provide all benefits at their facilities at 100% federal financial participation. This would also maintain eligibility for the childless adult population and parent population under the current open enrollment model.

The objective is to ensure the viability of the I.H.S. and 638 systems for the provision of care to American Indians and avoid shifting the burden of State budget issues on Indian tribes and Indian Health Services. Avoiding this cost shift is particularly important since it is of no savings to the State because services provided to these facilities is 100% federally funded. Moreover, it is the desire of the tribes through several consultation sessions that this fragile healthcare delivery system be protected from State budget cuts so that Medicaid payments can be preserved and members retain adequate health care infrastructure in their community.

In addition to these changes, the State is still seeking similar authority to exempt benefits eliminated on October 1, 2010.

Accordingly, AHCCCS seeks the following authority:

- Comparability: Waiver from §1902(a)(10)(B) and corresponding regulations at 42 CFR §§440.240 and .230, to allow the State to exempt populations and members who receive services provided through the Indian Health Services and 638 facilities from benefit and eligibility limits.
- Amount, Duration, and Scope: Waiver from § 1902(a)(10)(B) to enable the State to offer different or additional services to some categorically eligible or medically needy individuals, than to other eligible individuals, based on where care is received.

F. Other

1. *Medicare Part B*

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.

The State's objective is to obtain expenditure authority for medical assistance in the form of Part B premiums for non-QMB dual eligibles as authorized in two SMD Letters (dated November 24, 1997 and December 14, 2000). This will allow AHCCCS to maintain continuity of care for members as well as administrative efficiencies given limited resources for operations. Without this change, Medicare Part B coverage for approximately 10,000 ALTCS members will be terminated by AHCCCS and will become the member's responsibility.

Accordingly, AHCCCS seeks the following authority:

- Expenditure Authority: Expenditures to provide Medicare Part B premiums for non-QMB dual eligibles, notwithstanding 42 CFR 431.625(d).

VI. Evaluation Design

The State is requesting this waiver authority in addition to the waiver application submitted September 27, 2010 and the same evaluation criteria would be applied. The evaluation would show that since the Demonstration preserves the core of the Medicaid program, the components of the evaluation criteria provided are still valid.

Budget Neutrality
Federal Fiscal Years 2012-2016

This chapter presents information related to budget neutrality. As a condition of waiver approval, the State must demonstrate that federal expenditures under the waiver will not be in excess of federal expenditures without the waiver. The discussion and data that follow is the State's demonstration that the proposed waiver extension will not cause such an expenditure increase and that the State will meet the budget neutrality requirements of the existing waiver.

Through the first five and one-half year waiver, the State demonstrated a $145 million Federal Fund positive variance. Through the current five year waiver (total ten and one-half years) the State projects a positive $1.1 billion Federal Fund variance. For the submitted waiver (total fifteen and one-half years), the State projects a positive $29.8 billion Total Fund variance (projections going forward are made in Total Funds whereas actuals are presented in Federal Funds since the future Federal Matching Assistance Percentages are unknown).

Background

Arizona was first required to demonstrate budget neutrality beginning in April 2001 due to the addition of a large expansion population. Because the expansion population only received acute care services, the budget neutrality requirement was only applied to the acute care program. This waiver ran from April 1, 2001 to September 30, 2006.

During the last waiver renewal, CMS required Arizona to also include the Arizona Long Term Care System (ALTCS or LTC) portion of the AHCCCS program under the budget neutrality requirement. This was the first instance in the 18 year history of the ALTCS program that it had been subject to such a requirement. With the addition of ALTCS, Arizona has over 99% of the total Title XIX program (excluding administration) subject to budget neutrality. The current waiver runs from October 1, 2006 to September 30, 2011.

Current Waiver Budget Neutrality Summary

As previously indicated, the acute care portion of the AHCCCS program was subjected to budget neutrality requirements for the first time under the April 1, 2001 through September 30, 2006 waiver. The agreement for that waiver established: 1) a per capita method of measuring compliance (as opposed to an aggregate method); 2) FFY 1999 as the base year; 3) included the State's DSH allotment as a component of the limit calculation; and 4) provided for trend rates on the base year PMPMs of 9.495% for the TANF/SOBRA eligibility group and 6.88% for the SSI eligibility group. The current waiver (2007-2011) continued the use of the per capita method and DSH treatment, however, the trend rates were adjusted to 7.20% for both the TANF/SOBRA and SSI eligibility groups.

The current waiver added the ALTCS EPD and ALTCS DD eligibility groups to the expenditure limit. The Without Waiver expenditure limit PMPMs for these two

eligibility groups were established with FFY 2005 (adjusted for growth and Medicare Part D) as the base year and provided trend rates on the base PMPMs of 7.20% for both populations.

A summary of the Without Waiver expenditure limit PMPMs and trends is provided in Table 1.

Table 1
Budget Neutrality
Without Waiver Per Member Per Month Costs and Trend Rates
April 1, 2001 to September 30, 2011

	TANF/SOBRA		SSI		ALTCS EPD		ALTCS DD	
	PMPM	Trend	PMPM	Trend	PMPM	Trend	PMPM	Trend
FFY01 (6mo)	250.23	-	473.25	-	-	-	-	-
FFY02	273.98	9.495%	505.81	6.88%	-	-	-	-
FFY03	300.00	9.495%	540.60	6.88%	-	-	-	-
FFY04	328.48	9.495%	577.80	6.88%	-	-	-	-
FFY05	359.67	9.495%	617.55	6.88%	-	-	-	-
FFY06 Oct-Dec	393.82	9.495%	660.04	6.88%	-	-	-	-
FFY06 Jan-Sep	392.97	Note 1	590.02	Note 1	-	-	-	-
FFY07	421.27	7.20%	632.50	7.20%	3,409.91	-	3,516.33	-
FFY08	451.60	7.20%	678.04	7.20%	3,655.42	7.20%	3,769.51	7.20%
FFY09	484.12	7.20%	726.86	7.20%	3,918.61	7.20%	4,040.91	7.20%
FFY10	518.98	7.20%	779.19	7.20%	4,200.75	7.20%	4,331.86	7.20%
FFY11	556.35	7.20%	835.29	7.20%	4,503.20	7.20%	4,643.75	7.20%

Note 1: Adjustments to the without waiver PMPMs were made on January 1, 2006 to account for the implementation of Medicare Part D.
Sources: FFY2001 to FFY2006 from 1115 Waiver Attachment C; FFY2007 to FFY2011 from 1115 Waiver Special Term and Condition #66.

The State has now entered into the tenth year of tracking and reporting budget neutrality pursuant to the waiver's Standard Terms and Conditions. Table 2 on the following page depicts the "to date" status of these filings in terms of federal funds, as claimed on the CMS-64 for the quarter ending September 30, 2010. This table includes the annual Federal Share of Budget Neutrality Limit, the annual Federal Share of Waiver Costs on the CMS-64 and the Annual Variance and Grand Total Variance against the limit. As of September 30, 2010, the State has a positive *cumulative* variance of 2.53% (or $934 million) against the limit.

Budget Neutrality Demonstration Years (BNY) #8 and #9 are not yet complete. In order to have a better estimate of the ultimate result of the current waiver's budget neutrality situation, the State forecasted the remaining expenditures under the waiver. The result is an estimated final federal fund variance to the budget neutrality limit of 2.54% (or $1.1 billion). This is depicted in Table 3 on the following page.

Table 2
Budget Neutrality Tracking Summary
For the Period Ended September 30, 2010
Federal Funds

	Federal Share of Budget Neutrality Limit	Federal Share of Waiver Costs on CMS-64	Annual Variance	As % of Budget Neutrality Limit
DY 01	$ 2,319,463,207	$ 2,409,409,188	$ (89,945,981)	-3.88%
DY 02	2,192,157,747	2,107,943,997	84,213,750	3.84%
DY 03	2,586,542,373	2,480,605,261	105,937,112	4.10%
DY 04	2,938,104,082	2,854,467,813	83,636,269	2.85%
DY 05	3,097,456,715	3,135,621,607	(38,164,892)	-1.23%
Subtotal	13,133,724,124	12,988,047,866	145,676,258	1.11%
DY 06	4,488,538,656	4,516,457,343	(27,918,687)	-0.62%
DY 07	5,029,080,213	5,095,207,582	(66,127,369)	-1.31%
DY08	6,612,677,002	6,581,174,269	31,502,733	0.48%
DY09	7,685,084,578	6,832,794,634	852,289,944	11.09%
DY10	-	1,321,934	(1,321,934)	
Subtotal	23,815,380,449	23,026,955,762	788,424,687	3.31%
Grand Total	$ 36,949,104,573	$ 36,015,003,628	$ 934,100,945	2.53%

Table 3
Budget Neutrality Tracking Summary
Projected Final FFY 2001-2011
Federal Funds

	Federal Share of Budget Neutrality Limit	Federal Share of Waiver Costs	Annual Variance	As % of Budget Neutrality Limit
DY 01	$ 2,319,463,207	$ 2,409,409,188	$ (89,945,981)	-3.88%
DY 02	2,192,157,747	2,107,943,997	84,213,750	3.84%
DY 03	2,586,542,373	2,480,605,261	105,937,112	4.10%
DY 04	2,938,104,082	2,854,467,813	83,636,269	2.85%
DY 05	3,097,456,715	3,135,621,607	(38,164,892)	-1.23%
Subtotal	13,133,724,124	12,988,047,866	145,676,258	1.11%
DY 06	4,488,538,656	4,516,457,343	(27,918,687)	-0.62%
DY 07	5,029,080,213	5,095,207,582	(66,127,369)	-1.31%
DY08	6,612,677,002	6,557,004,169	55,672,833	0.84%
DY09	7,685,084,578	7,175,726,634	509,357,944	6.63%
DY10	7,777,628,900	7,259,824,234	517,804,666	6.66%
Subtotal	31,593,009,349	30,604,219,962	988,789,387	3.13%
Grand Total	$ 44,726,733,473	$ 43,592,267,828	$ 1,134,465,645	2.54%

Current Waiver Economic Anomalies

The conditions of the Arizona and National economies and the Arizona state budget during most of the current waiver period resulted in some irregular population growth and PMPM cost trends. These irregularities, driven by the economic circumstances, make using trends from the current waiver in the waiver renewal budget neutrality analysis unreasonable as explained below.

Population/Member Month Growth

The Arizona unemployment rate bottomed out in April-June 2007 with a rate of 3.7%. Shortly thereafter, the recession took hold and the unemployment rate gradually grew through the rest of 2007, all of 2008, and most of 2009 where it has peaked at a rate of approximately 9.5%. As expected, this increase in unemployment resulted in increased Medicaid enrollment during this same period. Title XIX full benefit enrollment (excluding emergency services only) increased almost 400,000 members (over 45%) from February 2007 to December 2010. Over the last few months, the enrollment growth seems to have stabilized and the AHCCCS forecast for the waiver extension assumes a return to more normal growth levels. Actual Budget Neutrality Member Months and Growth Rates for FFY 2002 to FFY 2010 are shown below in Table 4.

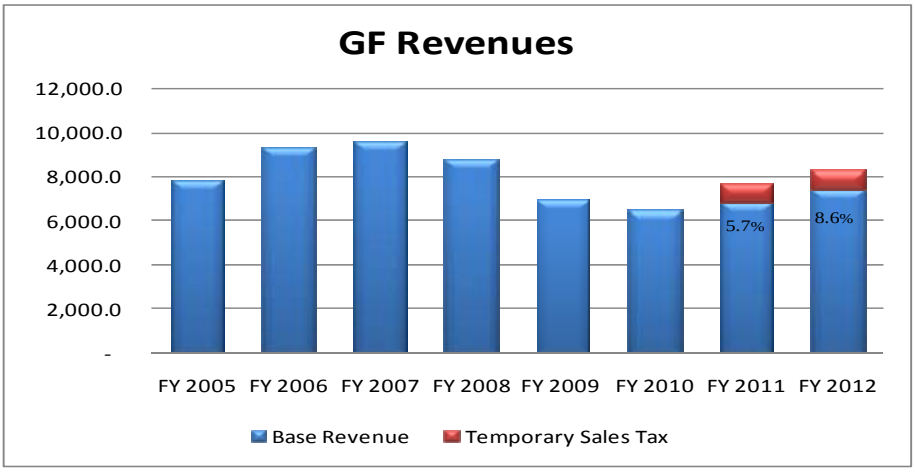
Table 4
Actual Budget Neutrality Member Months and Growth Rates
FFY 2002 - FFY 2010

	TANF/ SOBRA	SSI	AC/MED	EPD	DD	TOTAL
FFY 2002	6,241,010	1,178,552	607,659	256,677	159,533	8,443,431
FFY 2003	7,586,523	1,288,226	869,473	276,122	174,150	10,194,494
FFY 2004	8,167,584	1,407,497	923,012	286,650	188,598	10,973,341
FFY 2005	8,796,238	1,515,440	1,368,708	295,827	201,675	12,177,888
FFY 2006	8,692,374	1,537,744	1,443,780	300,405	213,935	12,188,238
FFY 2007	8,678,327	1,545,391	1,372,369	299,447	227,264	12,122,798
FFY 2008	9,159,965	1,583,168	1,583,168	311,973	242,343	12,880,617
FFY 2009	10,296,147	1,619,489	1,788,017	328,207	258,665	14,290,525
FFY 2010	11,453,120	1,674,184	2,660,853	335,917	271,381	16,395,455
FFY 2003	21.6%	9.3%	43.1%	7.6%	9.2%	20.7%
FFY 2004	7.7%	9.3%	6.2%	3.8%	8.3%	7.6%
FFY 2005	7.7%	7.7%	48.3%	3.2%	6.9%	11.0%
FFY 2006	-1.2%	1.5%	5.5%	1.5%	6.1%	0.1%
FFY 2007	-0.2%	0.5%	-4.9%	-0.3%	6.2%	-0.5%
FFY 2008	5.5%	2.4%	15.4%	4.2%	6.6%	6.3%
FFY 2009	12.4%	2.3%	12.9%	5.2%	6.7%	10.9%
FFY 2010	11.2%	3.4%	48.8%	2.3%	4.9%	14.7%

Note: AC/MED populations are adjusted for HIFA Waiver periods where Title XXI allotment was utilized as match.

With Waiver Expenditure PMPM Growth

During the same time frame, Arizona General Fund revenues have plummeted by 33%. After peaking at $9.6 billion in FY 2007, revenues plunged and the state closed FY 2010 with collections of $6.3 billion. The revenue declines have created a huge structural deficit in the Arizona budget that the state has been dealing with over the past four years and will continue to be challenged with in the future.



In an effort to balance the state budget, Arizona enacted several measures that impacted the With Waiver expenditure PMPMs. The AHCCCS Program in SFY 2011 is $874 million less as a result of the following policy changes:

- $413 million in provider reductions;
- $241 million in institutional rate freezes;
- $121 million in eligibility reductions;
- $39 million in benefit changes;
- $29.5 million in administrative reductions; and
- $28 million in increased member cost sharing.

Provider rates will be reduced 5% on April 1, 2011, and again on October 1, 2011 by another 5%, resulting in an additional $600 million in reductions. These measures have reduced the medical trend beginning in SFY 2009 and continued throughout the remainder of the current waiver period. Table 5 demonstrates the compound growth rates by waiver group for the first two waiver periods and clearly shows the decline in growth after FFY 2008 at well below historical averages.

Table 5
Budget Neutrality
Compound PMPM Growth Trends

	FFY02	FFY03	FFY04	FFY05	FFY06	FFY07	FFY08	FFY09	FFY10	FFY11
TANF	224.41	217.70	232.42	248.26	271.63	293.09	315.28	318.65	319.14	323.56
SSI	504.30	512.06	590.07	638.77	651.84	682.24	734.99	772.74	797.64	811.46
AC/MED	684.20	625.02	674.30	609.56	734.44	799.58	848.41	912.56	835.56	813.90
EPD	2,556.71	2,660.01	2,855.19	2,937.90	3,358.02	3,414.77	3,553.23	3,735.53	3,734.35	3,778.86
DD	2,544.76	2,670.84	2,847.28	3,081.71	3,310.37	3,463.49	3,606.95	3,603.06	3,517.48	3,510.25

TANF	FFY03	FFY04	FFY05	FFY06	FFY07	FFY08	FFY09	FFY10	FFY11
FFY02 base year	-2.99%	1.77%	3.42%	4.89%	5.49%	5.83%	5.14%	4.50%	4.15%
FFY03 base year		6.76%	6.79%	7.66%	7.72%	7.69%	6.56%	5.62%	5.08%
FFY04 base year			6.82%	8.11%	8.04%	7.92%	6.51%	5.43%	4.84%
FFY05 base year				9.41%	8.65%	8.29%	6.44%	5.15%	4.51%
FFY06 base year					7.90%	7.74%	5.47%	4.11%	3.56%
FFY07 base year						7.57%	4.27%	2.88%	2.50%
FFY08 base year							1.07%	0.61%	0.87%
FFY09 base year								0.15%	0.77%
FFY10 base year									1.38%

SSI	FFY03	FFY04	FFY05	FFY06	FFY07	FFY08	FFY09	FFY10	FFY11
FFY02 base year	1.54%	8.17%	8.20%	6.63%	6.23%	6.48%	6.29%	5.90%	5.43%
FFY03 base year		15.23%	11.69%	8.38%	7.44%	7.50%	7.10%	6.54%	5.92%
FFY04 base year			8.25%	5.10%	4.96%	5.64%	5.54%	5.15%	4.66%
FFY05 base year				2.05%	3.35%	4.79%	4.88%	4.54%	4.07%
FFY06 base year					4.66%	6.19%	5.84%	5.18%	4.48%
FFY07 base year						7.73%	6.43%	5.35%	4.43%
FFY08 base year							5.14%	4.17%	3.35%
FFY09 base year								3.22%	2.47%
FFY10 base year									1.73%

AC/MED	FFY03	FFY04	FFY05	FFY06	FFY07	FFY08	FFY09	FFY10	FFY11
FFY02 base year	-8.65%	-0.73%	-3.78%	1.79%	3.17%	3.65%	4.20%	2.53%	1.95%
FFY03 base year		7.88%	-1.24%	5.53%	6.35%	6.30%	6.51%	4.23%	3.36%
FFY04 base year			-9.60%	4.36%	5.85%	5.91%	6.24%	3.64%	2.72%
FFY05 base year				20.49%	14.53%	11.65%	10.61%	6.51%	4.94%
FFY06 base year					8.87%	7.48%	7.51%	3.28%	2.08%
FFY07 base year						6.11%	6.83%	1.48%	0.44%
FFY08 base year							7.56%	-0.76%	-1.37%
FFY09 base year								-8.44%	-5.56%
FFY10 base year									-2.59%

EPD	FFY03	FFY04	FFY05	FFY06	FFY07	FFY08	FFY09	FFY10	FFY11
FFY02 base year	4.04%	5.68%	4.74%	7.05%	5.96%	5.64%	5.57%	4.85%	4.44%
FFY03 base year		7.34%	5.09%	8.08%	6.44%	5.96%	5.82%	4.97%	4.49%
FFY04 base year			2.90%	8.45%	6.15%	5.62%	5.52%	4.58%	4.09%
FFY05 base year				14.30%	7.81%	6.54%	6.19%	4.91%	4.28%
FFY06 base year					1.69%	2.87%	3.62%	2.69%	2.39%
FFY07 base year						4.05%	4.59%	3.03%	2.57%
FFY08 base year							5.13%	2.52%	2.07%
FFY09 base year								-0.03%	0.58%
FFY10 base year									1.19%

DD	FFY03	FFY04	FFY05	FFY06	FFY07	FFY08	FFY09	FFY10	FFY11
FFY02 base year	4.95%	5.78%	6.59%	6.80%	6.36%	5.99%	5.09%	4.13%	3.64%
FFY03 base year		6.61%	7.42%	7.42%	6.71%	6.19%	5.12%	4.01%	3.48%
FFY04 base year			8.23%	7.83%	6.75%	6.09%	4.82%	3.59%	3.04%
FFY05 base year				7.42%	6.01%	5.39%	3.98%	2.68%	2.19%
FFY06 base year					4.63%	4.38%	2.86%	1.53%	1.18%
FFY07 base year						4.14%	1.99%	0.52%	0.34%
FFY08 base year							-0.11%	-1.25%	-0.90%
FFY09 base year								-2.38%	-1.30%
FFY10 base year									-0.21%

Waiver Extension Assumptions

This waiver submittal impacts the budget neutrality model by introducing two significant and inter-related components. First, this model which covers FFY 2012 – FFY 2016 (DY11-DY15), incorporates the impact of the Federal Healthcare Reform effective January 1, 2014. Second, this submittal includes enrollment freezes for childless adults and higher-income parents, the termination of the Medical Expense Deduction (MED) program, and other program changes. The waiver assumes the enrollment freezes will be lifted on January 1, 2014.

Impact of Federal Healthcare Reform

The Medicaid provisions of the Patient Protection and Affordable Care Act of 2010 (ACA) change the eligibility requirements for mandatory Medicaid populations. While this package includes modifications to eligibility achievable through the unique structure and timing of Arizona's Section 1115 Demonstration waiver, as well as a request for a waiver of the ACA Maintenance of Effort requirements for parents, it is envisioned that these are time limited changes through January 1, 2014.

Further, given the fact that these populations will become mandatory Medicaid populations effective January 1, 2014, Arizona strongly believes it should no longer be subject to budget neutrality. Under the new federal law, Arizona will be unable to meaningfully manage enrollment and therefore would have no recourse in the event that it does not maintain budget neutrality. Given that the purpose of budget neutrality is to ensure federal expenditures do not increase more than they would have in the absence of the waiver, and given that in the absence of the waiver, Arizona would still have to cover these populations pursuant to federal law, it is clear that the budget neutrality requirements will no longer accomplish their intended purpose and will simply serve to place additional administrative burdens on both state and federal agencies.

Eligibility Changes

The State is requesting the following changes to its Medicaid eligibility:

1) Medical Expense Deduction (MED) enrollment freeze effective May 1, 2011. Eligibility for this program is six months; therefore, a freeze will result in a full phase-out of this population by October 1, 2011. This population would not be eligible to return January 1, 2014.
2) AHCCCS Care (AC) enrollment freeze effective July 1, 2011. No new childless adult (AC) members may enroll and existing members who lose coverage may not re-enroll. Impacted members of this population would be eligible to return January 1, 2014. This change is achieved through the termination of the existing waiver for AC members and the establishment of a new waiver for AC members that includes coverage for those enrolled in the program as of July 1, 2011, as well as other program modifications.
3) Enrollment freeze effective October 1, 2011 for TANF (1931 parents) coverage from 75% FPL to 100% FPL. Impacted members of this population would be eligible to return January 1, 2014. This change requires a waiver of the ACA Maintenance of Effort provisions.

Table 6
Impact of freezes on select populations

	Members w/o freeze			Members with freeze			Change in Members		
	TANF 75-100% FPL	MED	AC	TANF 75-100% FPL	MED	AC	TANF 75-100% FPL	MED	AC
FFY11 (5 mo)	354,202	32,646	1,170,127	354,202	16,279	1,073,874	-	(16,367)	(96,252)
FFY12	871,308	80,171	2,886,653	643,398	-	1,736,301	(227,910)	(80,171)	(1,150,352)
FFY13	901,849	82,796	2,999,096	384,843	-	1,272,218	(517,005)	(82,796)	(1,726,878)
FFY14 (3 mo)	230,320	21,117	767,616	69,124	-	265,533	(161,195)	(21,117)	(502,082)

Note: Members include Capitated Member Months and IHS enrollees, does not include potential FES impact.

Beginning January 1, 2014, the State projects that 70% of the eliminated populations will return to the program, excluding the MED, which is being completely eliminated (see ACA population impacts in Table 9). Over the course of two years, the State is estimating that this percentage will grow to 80%.

Waiver Extension Budget Neutrality Summary

Using the assumptions outlined above and below, the State is projecting a positive Total Fund cumulative budget neutrality variance of $29.8 billion by the end of DY15 (FFY 2016) on total expenditures of $117.0 billion. The fifteen and one-half year totals are shown in Table 7 below.

Table 7
Projected Budget Neutrality Status

	DY1-DY15 Total
Without Waiver Member Months	199,278,161
Without Waiver Expenditure Limit	144,441,962,000
Disproportionate Share Allotment	2,318,691,000
Total Without Waiver Limit	146,760,653,000
With Waiver Expenditures	114,713,274,600
Disproportionate Share Expenditures	2,290,389,200
Total With Waiver Expenditures	117,003,663,800
Total Budget Neutrality Variance	29,756,989,200

AHCCCS Care Expenditure Limit PMPM

The State proposes that beginning January 1, 2014, the State will receive Without Waiver allowance for the AC (Childless Adults) population since this will now be a mandatory population. Accordingly, beginning in January 2014 the budget neutrality projections include an expenditure limit PMPM of $758.53 that is then grown by the existing trend of 7.2%. The $758.53 is based on the estimated expenditure PMPM for FFY 2013 of $707.58 times the trend of 7.2%. This change provides the state with an additional $7.1

billion in expenditure limit over the final two and three quarter years of the waiver period.

Member Months

As previously described (see Table 4), shortly after the state implemented the current waiver, the AHCCCS program experienced tremendous population growth as the nation entered a period of economic slowdown and recession. As in previous periods of economic slowing, safety net programs like AHCCCS experienced significant caseload growth.

Table 8 provides a summary of the population growth assumptions utilized in the waiver extension budget neutrality model.

Table 8
Waiver Extension Population Growth Assumptions

	FFY12	FFY13	FFY14	FFY15	FFY16
TANF	3.0%	5.0%	5.0%	5.0%	5.0%
TANF (with Freeze 75-100%)	5.0%	1.5%	3.7%	5.0%	5.0%
SSI	4.9%	5.0%	5.0%	5.0%	5.0%
AC/MED	3.0%	5.0%	5.0%	5.0%	5.0%
AC/MED (with Freeze)	-8.4%	-26.7%	-17.9%	0.0%	0.0%
EPD	3.3%	4.0%	4.0%	4.0%	4.0%
DD	5.3%	4.0%	4.0%	4.0%	4.0%
FES	0% or Neg	0.0%	3.0%	3.0%	3.0%

The growth assumptions above apply to the existing Medicaid State Plan populations. The ACA is expected to result in additional populations beginning in January 2014 as Medicaid eligibility is expanded to 133% FPL. Table 9 on the following page provides the estimates for expansion populations (those between 100-133% FPL), currently eligible but not enrolled populations (those between 0-100% FPL), and the return of populations impacted by the population freezes.

Table 9
Estimated Additional Caseloads from ACA

	Expansion Populations (100-133% FPL)			
	Categorical Children	Categorical Adults	Non-Categorical Adults	Total
FFY14 MM	284,130	282,240	120,960	687,330
FFY15 MM	387,240	385,140	165,060	937,440
FFY16 MM	396,480	393,372	168,588	958,440

	Eligible but not Enrolled Populations (0-100% FPL)			
	Categorical Children	Categorical Adults	Non-Categorical Adults	Total
FFY14 MM	373,050	513,450	220,050	1,106,550
FFY15 MM	509,400	700,140	300,060	1,509,600
FFY16 MM	520,200	716,100	306,900	1,543,200

	Enrollment Freezes Returning Populations			
	Categorical Children	Categorical Adults	Non-Categorical Adults	Total
FFY14 MM	-	346,038	1,072,541	1,418,579
FFY15 MM	-	518,895	1,608,813	2,127,708
FFY16 MM	-	581,165	1,801,872	2,383,037

	Total ACA Populations			
	Categorical Children	Categorical Adults	Non-Categorical Adults	Total
FFY14 MM	657,180	1,141,728	1,413,551	3,212,459
FFY15 MM	896,640	1,604,175	2,073,933	4,574,748
FFY16 MM	916,680	1,690,637	2,277,360	4,884,677

	ACA Populations by Waiver Group			
	TANF	SSI	TWG	TOTAL
FFY14 MM	1,485,885	313,023	1,413,551	3,212,459
FFY15 MM	2,065,655	435,160	2,073,933	4,574,748
FFY16 MM	2,153,625	453,692	2,277,360	4,884,677

PMPMs

The State has assumed that the Without Waiver PMPM for the TANF/SOBRA, SSI, ALTCS EPD, and ALTCS DD populations for the extension will be the current Without Waiver PMPM amounts trended forward.

The existing With Waiver PMPMs for all populations are below the Without Waiver PMPM in FFY 2011. The State believes that this is due, in part, to the cost containment features of the demonstration and primarily to the enactment of budget balancing efforts required by the unprecedented state budget deficit due to the recession.

Trend

The current waiver budget neutrality agreement includes a Without Waiver trend rate of 7.2% for all populations. The State requests that this trend rate be retained. While the With Waiver PMPM trends have been lower over the past three years (see Table 5), that trend is due to the budget balancing actions required by the recession. Prior to FFY 2009, the State experienced several years of normal growth in expenditure PMPMs.

The State believes that as the economy improves the actual expenditure trends will increase. Failure to recognize future provider rate growth could limit the State's provider network and potentially reduce the competition that has kept Arizona's costs lower than the national levels. Additionally, with the anticipated influx of members both in the Medicaid and commercial markets in 2014, a strong provider network will be critical.

For the waiver extension, the State is assuming that the expenditure PMPM trends will gradually return to normal as providers seek inflationary increases. Given the two consecutive 5% reductions scheduled for 2011 (in April and October), the State will have fewer options in the future to reduce trends in both provider reimbursement and benefits. The With Waiver PMPM trends for the extension are shown in the Table 10 below:

Table 10
With Waiver Expenditure PMPM Trend Rates

	FFY12	FFY13	FFY14	FFY15	FFY16
TANF (Cap, FFS, RI)	-5.0%	4.5%	5.5%	6.5%	7.5%
SSI (Cap, FFS, RI)	-5.0%	4.5%	5.5%	6.5%	7.5%
AC (Cap, FFS, RI)	-5.0%	4.5%	5.5%	6.5%	7.5%
EPD (Cap, FFS, RI)	-5.0%	4.5%	5.5%	6.5%	7.5%
DD (Cap, FFS, RI)	-5.0%	4.5%	5.5%	6.5%	7.5%
Medicare Premiums	9.0%	9.0%	9.0%	9.0%	9.0%
IHS OMB Rates	7.0%	7.0%	7.0%	7.0%	7.0%
BHS-CRS	-5.0%	4.5%	5.5%	6.5%	7.5%
FQHC	16.9%	8.1%	8.1%	8.1%	8.1%

Disproportionate Share Hospital Allotments

For the purpose of establishing the Without Waiver budget neutrality limit, the State uses the current Disproportionate Share Hospital (DSH) allotment levels as established in federal law. With respect to With Waiver DSH expenditures, the State has assumed that the full DSH allotment will be expended.

Arizona Health Care Cost Containment System
Budget Neutrality Status by Federal Fiscal Year
Total Funds
For the Period April 1, 2001 - September 30, 2016
All Populations

Without Waiver	Actual 2001-2006	Actual 2007	Actual 2008	Estimate 2009	Estimate 2010	Estimate 2011	Estimate 2012	Estimate 2013	Estimate 2014	Estimate 2015	Estimate 2016	
Expenditure Limit Calculation	DY 01-05	DY 06	DY 07	DY 08	DY 09	DY 10	DY 11	DY 12	DY 13	DY 14	DY 15	Total
Member Months												
TANF/SOBRA	41,966,543	8,678,327	9,159,965	10,296,147	11,453,120	11,213,869	11,143,768	11,237,895	13,132,851	14,283,724	14,974,729	157,540,937
SSI	7,469,137	1,545,391	1,583,168	1,619,489	1,674,184	1,724,085	1,794,969	1,876,635	2,283,215	2,503,820	2,625,749	26,699,842
AC/MED	-	-	-	-	-	-	-	-	2,192,892	3,117,390	3,325,997	8,636,279
ALTCS-EPD	-	299,447	311,973	328,207	335,917	333,470	344,731	358,214	372,543	387,444	402,942	3,474,888
ALTCS-DD	-	227,264	242,343	258,665	271,381	287,000	301,684	315,057	327,659	340,766	354,396	2,926,215
Combined	49,435,680	10,750,429	11,297,449	12,502,508	13,734,602	13,558,424	13,585,152	13,787,801	18,309,160	20,633,144	21,683,813	199,278,161
Without Waiver PMPM												
TANF/SOBRA	330.54	421.27	451.60	484.12	518.98	556.35	596.41	639.35	685.38	734.73	787.63	532.90
SSI	566.64	632.50	678.04	726.86	779.19	835.29	895.43	959.90	1,029.01	1,103.10	1,182.52	817.61
AC/MED	-	-	-	-	-	-	-	-	758.53	813.14	871.69	821.82
ALTCS-EPD	-	3,409.91	3,655.42	3,918.61	4,200.75	4,503.20	4,827.43	5,175.00	5,547.60	5,947.03	6,375.22	4,839.87
ALTCS-DD	-	3,516.33	3,769.51	4,040.91	4,331.86	4,643.75	4,978.10	5,336.52	5,720.75	6,132.64	6,574.19	5,038.41
Weighted	366.21	600.31	642.98	679.31	716.08	775.41	840.59	908.15	926.04	978.30	1,046.75	724.83
Without Waiver Expenditure Limit												
TANF/SOBRA	13,871,619,700	3,655,918,800	4,136,640,200	4,984,570,700	5,943,940,200	6,238,836,000	6,646,254,500	7,184,948,000	9,000,993,200	10,494,680,800	11,794,545,500	83,952,947,600
SSI	4,232,307,200	977,459,800	1,073,451,200	1,177,141,800	1,304,507,400	1,440,110,900	1,607,269,200	1,801,382,300	2,349,451,000	2,761,963,400	3,105,000,200	21,830,044,400
AC/MED	-	-	-	-	-	-	-	-	1,663,374,700	2,534,874,100	2,899,238,200	7,097,487,000
ALTCS-EPD	-	1,021,087,300	1,140,392,300	1,286,115,200	1,411,103,300	1,501,682,700	1,664,162,800	1,853,758,500	2,066,718,300	2,304,144,000	2,568,845,600	16,818,010,000
ALTCS-DD	-	799,135,200	913,514,400	1,045,242,000	1,175,584,500	1,332,756,500	1,501,815,000	1,681,307,800	1,874,456,600	2,089,792,800	2,329,868,200	14,743,473,000
Total	18,103,926,900	6,453,601,100	7,263,998,100	8,493,069,700	9,835,135,400	10,513,386,100	11,419,501,500	12,521,396,600	16,954,993,800	20,185,455,100	22,697,497,700	144,441,962,000
DSH Allotment	795,666,700	143,477,400	143,477,400	155,169,200	159,096,900	153,633,900	153,633,900	153,633,900	153,633,900	153,633,900	153,633,900	2,318,691,000
Total Without Waiver Expenditure Limi	18,899,593,600	6,597,078,500	7,407,475,500	8,648,238,900	9,994,232,300	10,667,020,000	11,573,135,400	12,675,030,500	17,108,627,700	20,339,089,000	22,851,131,600	146,760,653,000
With Waiver Expenditures												
TANF/SOBRA	10,035,096,900	2,543,570,700	2,887,946,200	3,280,884,000	3,655,183,000	3,638,253,500	3,488,360,800	3,697,320,900	4,554,812,200	5,261,098,000	5,904,056,100	48,946,582,300
SSI	4,314,478,900	1,054,327,300	1,163,613,900	1,251,445,000	1,335,396,900	1,386,780,500	1,388,359,400	1,516,309,600	1,951,888,400	2,281,884,800	2,569,248,500	20,213,733,200
AC/MED	3,586,333,800	1,097,316,900	1,338,605,900	1,631,680,600	2,223,298,900	2,145,341,900	1,228,135,500	900,192,700	1,839,858,900	2,492,135,900	2,863,018,800	21,345,919,800
ALTCS-EPD	-	1,022,541,700	1,108,511,600	1,226,026,200	1,254,432,800	1,251,375,800	1,236,307,100	1,353,376,400	1,486,854,400	1,648,401,400	1,843,979,000	13,431,806,400
ALTCS-DD	-	787,126,500	874,118,100	931,985,800	954,577,900	1,007,442,900	1,015,116,100	1,110,552,300	1,221,545,400	1,356,359,000	1,516,408,900	10,775,232,900
Expenditure Subtotal	17,935,909,600	6,504,883,100	7,372,795,700	8,322,021,600	9,422,889,500	9,429,194,600	8,356,278,900	8,577,751,900	11,054,959,300	13,039,879,100	14,696,711,300	114,713,274,600
DSH	789,015,700	143,477,300	141,543,300	135,452,600	159,096,900	153,633,900	153,633,900	153,633,900	153,633,900	153,633,900	153,633,900	2,290,389,200
Total With Waiver Expenditures	18,724,925,300	6,648,360,400	7,514,339,000	8,457,474,200	9,581,986,400	9,582,828,500	8,509,912,800	8,731,385,800	11,208,593,200	13,193,513,000	14,850,345,200	117,003,663,800
With Waiver Expenditure PMPMs												
TANF/SOBRA	239.12	293.09	315.28	318.65	319.14	324.44	313.03	329.00	346.83	368.33	394.27	
SSI	577.64	682.24	734.99	772.74	797.64	804.36	773.47	807.99	854.89	911.36	978.48	
AC/MED	672.28	799.58	848.41	912.56	835.56	780.18	707.33	707.58	748.39	799.43	860.80	
ALTCS-EPD	-	3,414.77	3,553.23	3,735.53	3,734.35	3,752.59	3,586.30	3,778.12	3,991.10	4,254.55	4,576.29	
ALTCS-DD	-	3,463.49	3,606.95	3,603.06	3,517.48	3,510.25	3,364.83	3,524.93	3,728.10	3,980.33	4,278.85	
Budget Neutrality Variance	174,668,300	(51,281,900)	(106,863,500)	190,764,700	412,245,900	1,084,191,500	3,063,222,600	3,943,644,700	5,900,034,500	7,145,576,000	8,000,786,400	**29,756,989,200**
Cumulative Variance	174,668,300	123,386,400	16,522,900	207,287,600	619,533,500	1,703,725,000	4,766,947,600	8,710,592,300	14,610,626,800	21,756,202,800	29,756,989,200	
Variance by Waiver Group												
TANF/SOBRA	3,836,522,800	1,112,348,100	1,248,694,000	1,703,686,700	2,288,757,200	2,600,582,500	3,157,893,700	3,487,627,100	4,446,181,000	5,233,582,800	5,890,489,400	35,006,365,300
SSI	(82,171,700)	(76,867,500)	(90,162,700)	(74,303,200)	(30,889,500)	53,330,400	218,909,800	285,072,700	397,562,600	480,078,600	535,751,700	1,616,311,200
AC/MED	(3,586,333,800)	(1,097,316,900)	(1,338,605,900)	(1,631,680,600)	(2,223,298,900)	(2,145,341,900)	(1,228,135,500)	(900,192,700)	(176,484,200)	42,738,200	36,219,400	(14,248,432,800)
ALTCS-EPD	-	(1,454,400)	31,880,700	60,089,000	156,670,500	250,306,900	427,855,700	500,382,100	579,863,900	655,742,600	724,866,600	3,386,203,600
ALTCS-DD	-	12,008,700	39,396,300	113,256,200	221,006,600	325,313,600	486,698,900	570,755,500	652,911,200	733,433,800	813,459,300	3,968,240,100
DSH	6,651,000	100	1,934,100	19,716,600	-	-	-	-	-	-	-	28,301,800
	174,668,300	(51,281,900)	(106,863,500)	190,764,700	412,245,900	1,084,191,500	3,063,222,600	3,943,644,700	5,900,034,500	7,145,576,000	8,000,786,400	29,756,989,200
Exp PMPM Change												
TANF/SOBRA		7.9%	7.6%	1.1%	0.2%	1.7%	-3.5%	5.1%	5.4%	6.2%	7.0%	
SSI		4.7%	7.7%	5.1%	3.2%	0.8%	-3.8%	4.5%	5.8%	6.6%	7.4%	
AC/MED		8.9%	6.1%	7.6%	-8.4%	-6.6%	-9.3%	0.0%	5.8%	6.8%	7.7%	
ALTCS-EPD			4.1%	5.1%	0.0%	0.5%	-4.4%	5.3%	5.6%	6.6%	7.6%	
ALTCS-DD			4.1%	-0.1%	-2.4%	-0.2%	-4.1%	4.8%	5.8%	6.8%	7.5%	

Arizona Health Care Cost Containment System
Budget Neutrality Status by Federal Fiscal Year
Total Funds
For the Period April 1, 2001 - September 30, 2016
Existing (Pre-ACA) Populations

Without Waiver	Actual 2001-2006	Actual 2007	Actual 2008	Estimate 2009	Estimate 2010	Estimate 2011	Estimate 2012	Estimate 2013	Estimate 2014	Estimate 2015	Estimate 2016	
Expenditure Limit Calculation	DY 01-05	DY 06	DY 07	DY 08	DY 09	DY 10	DY 11	DY 12	DY 13	DY 14	DY 15	Total
Member Months												
TANF/SOBRA	41,966,543	8,678,327	9,159,965	10,296,147	11,453,120	11,213,869	11,143,768	11,237,895	11,646,966	12,218,069	12,821,104	151,835,773
SSI	7,469,137	1,545,391	1,583,168	1,619,489	1,674,184	1,724,085	1,794,969	1,876,635	1,970,192	2,068,660	2,172,056	25,497,966
AC/MED	-	-	-	-	-	-	-	-	779,342	1,043,457	1,048,637	2,871,435
ALTCS-EPD	-	299,447	311,973	328,207	335,917	333,470	344,731	358,214	372,543	387,444	402,942	3,474,888
ALTCS-DD	-	227,264	242,343	258,665	271,381	287,000	301,684	315,057	327,659	340,766	354,396	2,926,215
Combined	49,435,680	10,750,429	11,297,449	12,502,508	13,734,602	13,558,424	13,585,152	13,787,801	15,096,701	16,058,396	16,799,136	186,606,278
Without Waiver PMPM												
TANF/SOBRA	330.54	421.27	451.60	484.12	518.98	556.35	596.41	639.35	685.38	734.73	787.63	525.04
SSI	566.64	632.50	678.04	726.86	779.19	835.29	895.43	959.90	1,029.01	1,103.10	1,182.52	803.65
AC/MED	-	-	-	-	-	-	-	-	758.53	813.14	871.69	819.70
ALTCS-EPD	-	3,409.91	3,655.42	3,918.61	4,200.75	4,503.20	4,827.43	5,175.00	5,547.60	5,947.03	6,375.22	4,839.87
ALTCS-DD	-	3,516.33	3,769.51	4,040.91	4,331.86	4,643.75	4,978.10	5,336.52	5,720.75	6,132.64	6,574.19	5,038.41
Weighted	366.21	600.31	642.98	679.31	716.08	775.41	840.59	908.15	963.27	1,027.58	1,100.03	718.77
Without Waiver Expenditure Limit												
TANF/SOBRA	13,871,619,700	3,655,918,800	4,136,640,200	4,984,570,600	5,943,940,200	6,238,836,000	6,646,254,500	7,184,948,000	7,982,597,300	8,976,982,100	10,098,286,200	79,720,593,600
SSI	4,232,307,200	977,459,800	1,073,451,300	1,177,141,800	1,304,507,400	1,440,110,900	1,607,269,200	1,801,382,400	2,027,347,100	2,281,938,300	2,568,500,200	20,491,415,600
AC/MED	-	-	-	-	-	-	-	-	591,150,700	848,476,300	914,086,200	2,353,713,200
ALTCS-EPD	-	1,021,087,300	1,140,392,300	1,286,115,300	1,411,103,400	1,501,682,600	1,664,162,900	1,853,758,500	2,066,718,300	2,304,144,000	2,568,845,600	16,818,010,200
ALTCS-DD	-	799,135,100	913,514,400	1,045,241,900	1,175,584,400	1,332,756,600	1,501,815,000	1,681,307,800	1,874,456,600	2,089,792,900	2,329,868,200	14,743,472,900
Total	18,103,926,900	6,453,601,000	7,263,998,200	8,493,069,600	9,835,135,400	10,513,386,100	11,419,501,600	12,521,396,700	14,542,270,000	16,501,333,600	18,479,586,400	134,127,205,500
DSH Allotment	795,666,700	143,477,400	143,477,400	155,169,200	159,096,900	153,633,900	153,633,900	153,633,900	153,633,900	153,633,900	153,633,900	2,318,691,000
Total Without Waiver Expenditure Limi	18,899,593,600	6,597,078,400	7,407,475,600	8,648,238,800	9,994,232,300	10,667,020,000	11,573,135,500	12,675,030,600	14,695,903,900	16,654,967,500	18,633,220,300	136,445,896,500
With Waiver Expenditures												
TANF/SOBRA	10,035,096,900	2,543,570,700	2,887,946,200	3,280,884,000	3,655,183,000	3,638,253,500	3,488,360,800	3,697,320,900	4,039,462,700	4,500,255,300	5,054,946,500	46,821,280,500
SSI	4,314,478,900	1,054,327,300	1,163,613,900	1,251,445,000	1,335,396,900	1,386,780,500	1,388,359,400	1,516,309,600	1,684,288,000	1,885,297,300	2,125,319,800	19,105,616,600
AC/MED	3,586,333,800	1,097,316,900	1,338,605,900	1,631,680,600	2,223,298,900	2,145,341,900	1,228,135,500	900,192,700	781,971,700	834,171,600	902,667,300	16,669,716,800
ALTCS-EPD	-	1,022,541,700	1,108,511,600	1,226,026,200	1,254,432,800	1,251,375,800	1,236,307,100	1,353,376,400	1,486,854,400	1,648,401,400	1,843,979,000	13,431,806,400
ALTCS-DD	-	787,126,500	874,118,100	931,985,800	954,577,900	1,007,442,900	1,015,116,100	1,110,552,300	1,221,545,400	1,356,359,000	1,516,408,900	10,775,232,900
Expenditure Subtotal	17,935,909,600	6,504,883,100	7,372,795,700	8,322,021,600	9,422,889,500	9,429,194,600	8,356,278,900	8,577,751,900	9,214,122,200	10,224,484,600	11,443,321,500	106,803,653,200
DSH	789,015,700	143,477,300	141,543,300	135,452,600	159,096,900	153,633,900	153,633,900	153,633,900	153,633,900	153,633,900	153,633,900	2,290,389,200
Total With Waiver Expenditures	18,724,925,300	6,648,360,400	7,514,339,000	8,457,474,200	9,581,986,400	9,582,828,500	8,509,912,800	8,731,385,800	9,367,756,100	10,378,118,500	11,596,955,400	109,094,042,400
With Waiver Expenditure PMPMs												
TANF/SOBRA	239.12	293.09	315.28	318.65	319.14	324.44	313.03	329.00	346.83	368.33	394.27	
SSI	577.64	682.24	734.99	772.74	797.64	804.36	773.47	807.99	854.89	911.36	978.48	
AC/MED	672.28	799.58	848.41	912.56	835.56	780.18	707.33	707.58	748.39	799.43	860.80	
ALTCS-EPD	-	3,414.77	3,553.23	3,735.53	3,734.35	3,752.59	3,586.30	3,778.12	3,991.10	4,254.55	4,576.29	
ALTCS-DD	-	3,463.49	3,606.95	3,603.06	3,517.48	3,510.25	3,364.83	3,524.93	3,728.10	3,980.33	4,278.85	
Budget Neutrality Variance	174,668,300	(51,282,000)	(106,863,400)	190,764,600	412,245,900	1,084,191,500	3,063,222,700	3,943,644,800	5,328,147,800	6,276,849,000	7,036,264,900	
Cumulative Variance	174,668,300	123,386,300	16,522,900	207,287,500	619,533,400	1,703,724,900	4,766,947,600	8,710,592,400	14,038,740,200	20,315,589,200	27,351,854,100	
Variance by Waiver Group												
TANF/SOBRA	3,836,522,800	1,112,348,100	1,248,694,000	1,703,686,600	2,288,757,200	2,600,582,500	3,157,893,700	3,487,627,100	3,943,134,600	4,476,726,800	5,043,339,700	32,899,313,100
SSI	(82,171,700)	(76,867,500)	(90,162,600)	(74,303,200)	(30,889,500)	53,330,400	218,909,800	285,072,800	343,059,100	396,641,000	443,180,400	1,385,799,000
AC/MED	(3,586,333,800)	(1,097,316,900)	(1,338,605,900)	(1,631,680,600)	(2,223,298,900)	(2,145,341,900)	(1,228,135,500)	(900,192,700)	(190,821,000)	14,304,700	11,418,900	(14,316,003,600)
ALTCS-EPD	-	(1,454,400)	31,880,700	60,089,100	156,670,600	250,306,800	427,855,800	500,382,100	579,863,900	655,742,600	724,866,600	3,386,203,800
ALTCS-DD	-	12,008,600	39,396,300	113,256,100	221,006,500	325,313,700	486,698,900	570,755,500	652,911,200	733,433,900	813,459,300	3,968,240,000
DSH	6,651,000	100	1,934,100	19,716,600	-	-	-	-	-	-	-	28,301,800
	174,668,300	(51,282,000)	(106,863,400)	190,764,600	412,245,900	1,084,191,500	3,063,222,700	3,943,644,800	5,328,147,800	6,276,849,000	7,036,264,900	27,351,854,100
Exp PMPM Change												
TANF/SOBRA		7.9%	7.6%	1.1%	0.2%	1.7%	-3.5%	5.1%	5.4%	6.2%	7.0%	
SSI		4.7%	7.7%	5.1%	3.2%	0.8%	-3.8%	4.5%	5.8%	6.6%	7.4%	
AC/MED		8.9%	6.1%	7.6%	-8.4%	-6.6%	-9.3%	0.0%	5.8%	6.8%	7.7%	
ALTCS-EPD			4.1%	5.1%	0.0%	0.5%	-4.4%	5.3%	5.6%	6.6%	7.6%	
ALTCS-DD			4.1%	-0.1%	-2.4%	-0.2%	-4.1%	4.8%	5.8%	6.8%	7.5%	

Arizona Health Care Cost Containment System
Budget Neutrality Status by Federal Fiscal Year
Total Funds
For the Period April 1, 2001 - September 30, 2016
ACA Expansion and Woodwork Populations

Without Waiver Expenditure Limit Calculation	Actual 2001-2006 DY 01-05	Actual 2007 DY 06	Actual 2008 DY 07	Estimate 2009 DY 08	Estimate 2010 DY 09	Estimate 2011 DY 10	Estimate 2012 DY 11	Estimate 2013 DY 12	Estimate 2014 DY 13	Estimate 2015 DY 14	Estimate 2016 DY 15	Total
Member Months												
TANF/SOBRA									1,485,885	2,065,655	2,153,625	5,705,164
SSI									313,023	435,160	453,692	1,201,875
AC/MED									1,413,551	2,073,933	2,277,360	5,764,844
ALTCS-EPD												-
ALTCS-DD												-
Combined	-	-	-	-	-	-	-	-	3,212,459	4,574,748	4,884,677	12,671,884
Without Waiver PMPM												
TANF/SOBRA									685.38	734.73	787.63	741.85
SSI									1,029.01	1,103.10	1,182.52	1,113.78
AC/MED									758.53	813.14	871.69	822.88
ALTCS-EPD												
ALTCS-DD												
Weighted									751.05	805.32	863.50	813.99
Without Waiver Expenditure Limit												
TANF/SOBRA									1,018,395,800	1,517,698,600	1,696,259,400	4,232,353,800
SSI									322,104,000	480,025,100	536,500,100	1,338,629,200
AC/MED									1,072,220,700	1,686,397,900	1,985,151,900	4,743,770,500
ALTCS-EPD												-
ALTCS-DD												-
Total	-	-	-	-	-	-	-	-	2,412,720,500	3,684,121,600	4,217,911,400	10,314,753,500
DSH Allotment												-
Total Without Waiver Expenditure Limi	-	-	-	-	-	-	-	-	2,412,720,500	3,684,121,600	4,217,911,400	10,314,753,500
With Waiver Expenditures												
TANF/SOBRA									515,349,500	760,842,700	849,109,600	2,125,301,800
SSI									267,600,400	396,587,500	443,928,700	1,108,116,600
AC/MED									1,057,887,200	1,657,964,300	1,960,351,500	4,676,203,000
ALTCS-EPD												
ALTCS-DD												
Expenditure Subtotal	-	-	-	-	-	-	-	-	1,840,837,100	2,815,394,500	3,253,389,800	7,909,621,400
DSH												-
Total With Waiver Expenditures	-	-	-	-	-	-	-	-	1,840,837,100	2,815,394,500	3,253,389,800	7,909,621,400
With Waiver Expenditure PMPMs												
TANF/SOBRA									346.83	368.33	394.27	
SSI									854.89	911.36	978.48	
AC/MED									748.39	799.43	860.80	
ALTCS-EPD												
ALTCS-DD												
Budget Neutrality Variance									571,883,400	868,727,100	964,521,600	**2,405,132,100**
Cumulative Variance									571,883,400	1,440,610,500	2,405,132,100	
Variance by Waiver Group												
TANF/SOBRA									503,046,300	756,855,900	847,149,800	2,107,052,000
SSI									54,503,600	83,437,600	92,571,400	230,512,600
AC/MED									14,333,500	28,433,600	24,800,400	67,567,500
ALTCS-EPD									-	-	-	-
ALTCS-DD									-	-	-	-
DSH									-	-	-	-
	-	-	-	-	-	-	-	-	571,883,400	868,727,100	964,521,600	2,405,132,100
Exp PMPM Change												
TANF/SOBRA												
SSI												
AC/MED												
ALTCS-EPD												
ALTCS-DD												