

**CENTERS FOR MEDICARE & MEDICAID SERVICES  
WAIVER LIST**

**NUMBERS:** 11-W-00275/09  
21-W-00064/9

**TITLE:** Arizona Medicaid Section 1115 Demonstration

**AWARDEE:** Arizona Health Care Cost Containment System (AHCCCS)

All Medicaid and Children's Health Insurance Program requirements expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in this list, shall apply to the demonstration project beginning October 22, 2011, through September 30, 2016, unless otherwise specified. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

**1. Proper and Efficient Administration**

**Section 1902(a)(4)  
(42 CFR 438.52, 438.56)**

To the extent necessary to permit the State to limit acute care enrollee's and Arizona Long Term Care System (ALTCS) enrollees' choice of managed care plans to a single Managed Care Organization (MCO) -- Children's Rehabilitative Services Program (CRS) -- for the treatment of conditions covered under that program and to permit the State to limit acute care enrollees' choice of managed care plans to a single Prepaid Inpatient Health Plan PIHP -- the Arizona Department of Health Services Division of Behavioral Health -- for the treatment of behavioral health conditions, as long as enrollees in such plans may request change of primary care provider at least at the times described in Federal regulations at 42 CFR 438.56(c).

To the extent necessary to permit the State to automatically reenroll an individual who loses Medicaid eligibility for a period of 90 days or less in the same PIHP in which he or she was previously enrolled.

To the extent necessary to permit the State to restrict beneficiaries' ability to disenroll without cause after an initial 30 day period from a managed care plan.

To the extent necessary to permit the state to restrict beneficiary disenrollment based on 42 CFR 438.56(d)(2)(iv), which provides for disenrollment for causes including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs

**2. Non-Covered Activities**

**Section 1902(a)(10)  
(42 CFR 440.210 and 440.225)**

To the extent necessary to permit the State to not provide coverage of otherwise required or optional services insofar as such coverage is attributable to appointments that the beneficiary misses.

**3. Eligibility Based on Institutional Status**

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

To the extent necessary to relieve the State of the obligation to make eligible individuals who meet the statutory definition of this eligibility group because they are in an acute care hospital for greater than 30 days but who do not meet the level of care standard for long term care services.

**4. Amount, Duration, Scope of Services**

**Section 1902(a)(10)(B)  
(42 CFR 440.240 and 440.230)**

To the extent necessary to enable the State to offer different or additional services to some categorically eligible individuals, than to other eligible individuals, based on differing care arrangements in the Spouses as Paid Caregivers Program.

To the extent necessary to permit the State to offer coverage through managed care organizations (MCOs) and PIHPs that provide additional or different benefits to enrollees, than those otherwise available other eligible individuals.

**5. Disproportionate Share Hospital (DSH) Requirements**

**Section 1902(a)(13) insofar as it incorporates section 1923**

To the extent necessary to relieve the State from the obligation to make payments for inpatient hospital services that take into account the situation of hospitals with a disproportionate share of low-income patients in accordance with the provisions for disproportionate share hospital payments that are described in the STCs.

**6. Cost Sharing**

**Section 1902(a)(14) insofar as it incorporates 1916 (42 CFR 447.51 and 447.52)**

To the extent necessary to enable the State to charge a premium to parents of ALTCS Medicaid qualified disabled children (under 18 years of age) when the parent's annual adjusted gross income is at or exceeds 400 percent of the FPL.

**7. Estate Recovery**

**Section 1902(a)(18)  
(42 CFR 433.36)**

To the extent necessary to enable the State to exempt from estate recovery as required by section 1917(b), the estates of acute care enrollees age 55 or older who receive long-term care services.

**8. Freedom of Choice**

**Section 1902(a)(23)(A)  
(42 CFR 431.51)**

To the extent necessary to enable the State to restrict freedom of choice of providers through mandatory enrollment of eligible individuals in managed care organizations and/or Prepaid Inpatient Health Plans that do not meet the requirements of section 1932 of the Act.

To the extent necessary to enable the State to impose a limitation on providers on charges associated with non-covered activities.

**9. Drug Utilization Review**

**Section 1902(a) (54) insofar as it  
incorporates section 1927(g)  
(42 CFR 456.700 through 456.725)**

To the extent necessary to relieve the State from the requirements of section 1927(g) of the Act pertaining to drug use review.

**The following waiver is authorized for the period beginning October 22, 2011, through December 31, 2013:**

**1. Retroactive Eligibility**

**Section 1902(a) (34)  
(42 CFR 435.914)**

To enable the State to waive the requirement to provide medical assistance for up to 3 months prior to the date that an application for assistance is made for AHCCCS.