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

**Children and Adults Health Programs Group**

October 15, 2013

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

Dear Mr. Betlach:

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

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

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

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

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

We appreciate your cooperation throughout the review process.

Sincerely,

/s/

Diane T. Gerrits
Director
Division of State Demonstrations & Waivers

Enclosure

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

**Arizona 1115 Demonstration Transition Plan**

## I. 2013 Renewal Process

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

## II. Coverage in 2014

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

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

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

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

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

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

## III. Process for Transition

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

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

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

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

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

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

General Transition Information

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

## IV. Notification

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

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

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

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

## V. Content of the Notices

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

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

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

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

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

## VI. Community Outreach

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

***HEA Plus Subscribers***

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

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

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

***Website and Community Forums***

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

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

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

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

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

***Tribal Consultation Activities***

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

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

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

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

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

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

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

### *Additional Outreach Activities*

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

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

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

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

April 17, 2013

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

Dear Mr. Betlach:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving your request to amend Arizona's Medicaid section 1115 demonstration, the Arizona Health Care Cost Containment (AHCCCS) demonstration (11-W-00275/09 and 21-W-00064/9). Approval of the amendment to this demonstration is under the authority of section 1115(a) of the Social Security Act and is effective from the date of this letter through December 31, 2013.

This award approves the state's request to expand the Safety Net Care Pool (SNCP) to add nine new hospitals from the City of Phoenix as participating providers, which allows the state to make payments to these hospitals to reflect the burden of uncompensated care costs. The SNCP expansion will also provide additional funding to the KidsCare II program which will help expand coverage through the program. This award also permits the state to increase the KidsCare II program's maximum income level from 175 to 200 percent of the federal poverty level (FPL) in addition to increasing enrollment in the KidsCare II Program by an additional 33,000 children. Finally, this award permits the state, through the SNCP expansion, to continue coverage for parents previously eligible for Medicaid under section 1931 of the Social Security Act who, because of a lack of a dependent child, would otherwise lose coverage due to the state's prior determination to stop enrolling additional individuals into the childless adult population. Maintaining coverage to these adults as well as expanding coverage to children in the KidsCare II program are important features of the demonstration as they further the objectives of both the Medicaid and CHIP programs.

The CMS approval of the AHCCCS demonstration amendment is conditioned upon continued compliance with the enclosed set of Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

A copy of the revised STCs and expenditure authorities are enclosed. The waivers for the demonstration are unchanged by this amendment, and remain in force.

Your project officer for this demonstration is Ms. Wakina Scott. She is available to answer any questions concerning your section 1115 demonstration and this amendment. Ms. Scott's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-0921
Facsimile: (410) 786-8534
E-mail: Wakina.Scott@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Scott and to Ms. Gloria Nagle, Associate Regional Administrator for the Division of Medicaid and Children's Health in our San Francisco Regional Office. Ms. Nagle's contact information is as follows:

Ms. Gloria Nagle
Associate Regional Administrator
Division of Medicaid and Children Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103 -6706

If you have questions regarding this approval, please contact Ms. Jennifer Ryan, Acting Director, Children and Adults Health Programs Group, Center for Medicaid and CHIP and Services, at (410) 786-5647.

Sincerely,

/s/

Cindy Mann
Director

Enclosures

cc: Jennifer Ryan, CMCS
Gloria Nagle, Associate Regional Administrator, Region IX
Wakina Scott, CMCS

**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 Arizona Long Term Care System (ALTCS) DES/DDD enrollees' choice of managed care plans to a single Managed Care Organization (MCO) -- Children's Rehabilitative Services Program (CRS) – for the treatment of CRS and behavioral health conditions and to permit the state to limit choice of managed care plans for acute care enrollees with a CRS condition to a single MCO – the CRS program – for acute care as well as the treatment of CRS and behavioral health conditions.

To the extent necessary to permit the state to limit choice of managed care plans to a single MCO for individuals enrolled in the ALTCS and Comprehensive Medical and Dental Program (CMDP) programs so long as enrollees in such plans have a choice of at least two primary care providers, and may request change of primary care provider at least at the times described in 42 CFR 438.56(c). Notwithstanding this authority, the state must offer a choice of at least two MCOs to elderly and physically disabled individuals in Maricopa County.

To the extent necessary 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 (ADHS/DBHS) – for the treatment of behavioral health conditions, and to permit the state to limit choice of managed care plans for acute care enrollees with a serious mental illness residing in Maricopa County to a single PIHP – the ADHS/DBHS – for acute care as well as 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. 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.

**3. 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. No waiver of freedom of choice is authorized for family planning providers.

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.

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**EXPENDITURE AUTHORITY**

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

**TITLE:** **Arizona Medicaid Section 1115 Demonstration**

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

**Medicaid Costs Not Otherwise Matchable**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below (which would not otherwise be included as matchable expenditures under section 1903 of the Act) shall, for the period beginning October 22, 2011, through September 30, 2016, unless otherwise specified, be regarded as matchable expenditures under the state's Medicaid state plan:

## I. Expenditures Related to Administrative Simplification and Delivery Systems

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

    a. Section 1903(m)(2)(A)(vi) of the Act insofar as it requires compliance with requirements in section 1932(a)(4) of the Act and 42 CFR 438.56(c)(2)(i) that enrollees be permitted an initial period after enrollment that would be longer than 30 days to disenroll without cause.

    b. Section 1903(m)(2)(H) of the Act and 42 CFR 438.56(g), but only insofar as to allow the State to automatically reenroll an individual who loses Medicaid eligibility for a period of 90 days or less in the same managed care plan from which the individual was previously enrolled.

2. Expenditures under contracts with managed care entities that do not provide for payment for Indian health care providers as specified in section 1932(h) of the Act, when the State pays Indian health providers for covered services furnished to AHCCCS managed care plan enrollees at the State plan rate.

3. Expenditures for State payments for services furnished to managed care enrollees by Indian health providers, when those payments are offset from the managed care capitation payment.

4. Expenditures that would have been disallowed under section 1903(u) of the Act and 42 CFR 431.865 based on Medicaid Eligibility Quality Control (MEQC) findings.

5. Expenditures for outpatient drugs which are not otherwise allowable under section 1903(i)(10) of the Act.

6. Expenditures for outpatient drugs which are not otherwise allowable under section 1903(i)(23) of the Act. This expenditure authority will expire on November 1, 2012.

7. Expenditures for direct payments to Critical Access Hospitals (CAH) for services provided to AHCCCS enrollees in the Acute Care and ALTCS managed care programs that are not consistent with the requirements of 42 CFR 438.60.

8. Expenditures for inpatient hospital and long-term care facility services, other institutional and non-institutional services (including drugs) provided to AHCCCS fee-for-service beneficiaries, that exceed the amounts allowable under section 1902(a)(30)(A) of the Act (42 CFR 447.250 through 447.280, 447.300 through 447.334) but are in accordance with Special Term and Condition (STC) #52 entitled "Applicability of Fee-for-Service Upper Payment Limit."

9. Expenditures for inpatient hospital services that take into account the situation of hospitals with a disproportionate share of low-income patients but are not allowable under sections 1902(a)(13)(A) and 1923 of the Act, but are in accordance with the provisions for disproportionate share hospital (DSH) payments that are described in the STCs.

10. Expenditures for medical assistance including Home and Community Based Services furnished through ALTCS for individuals over age 18 who reside in Alternative Residential Settings classified as residential Behavioral Health Facilities.

**II. Expenditures Related to Expansion of Existing Eligibility Groups based on Eligibility Simplification**

11. Expenditures related to:

    a. Medical assistance furnished to ALTCS enrollees who are eligible only as a result of the disregard from eligibility of income currently excluded under section 1612(b) of the Act, and medical assistance that would not be allowable for some of those enrollees but for the disregard of such income from post-eligibility calculations.
    b. Medical assistance furnished to ALTCS enrollees who are financially eligible with income equal to or less than 300 percent of the Federal Benefit Rate and who are eligible for ALTCS based on the functional, medical, nursing, and social needs of the individual.
    c. Medical assistance furnished to some dependent children or spouses who qualify for ALTCS based on a disregard of income and resources of legally responsible

relatives or spouses during the month of separation from those relatives or spouses.

d. Medical assistance furnished to individuals who are eligible as Qualified Medicare Beneficiary (QMB), Special Low Income Beneficiary (SLMB), Qualified Individuals-1(QI-1), or Supplemental Security Income Medical Assistance Only (SSI MAO) beneficiaries based only on a disregard of in-kind support and maintenance (ISM).
e. Medical assistance furnished to individuals who are eligible based only on an alternate budget calculation for ALTCS and SSI-MAO income eligibility determinations when spousal impoverishment requirements of section 1924 of the Act do not apply or when the applicant/recipient is living with a minor dependent child.
f. Medical assistance furnished to individuals who are eligible only based on the disregard of interest and dividend from resources, and are in the following eligibility groups:

    i. The Pickle Amendment Group under 42 CFR 435.135;
    ii. The Disabled Adult Child under section 1634(c) of the Act;
    iii. Disabled Children under section 1902(a)(10)(A)(i)(II) of the Act; and
    iv. The Disabled Widow/Widower group under section 1634(d) of the Act.

g. Medical assistance furnished to ALTCS enrollees under the eligibility group described in section 1902(a)(10)(A)(ii)(V) of the Act that exceeds the amount that would be allowable except for a disregard of interest and dividend from the post-eligibility calculations.
h. Medical assistance provided to individuals who would be eligible but for excess resources under the "Pickle Amendment," section 503 of Public Law 94-566; section 1634(c) of the Act (disabled adult children); or section 1634(b) of the Act (disabled widows and widowers).
i. Medical assistance that would not be allowable but for the disregard of quarterly income totaling less than $20 from the post-eligibility determination.

12. Expenditures to extend eligibility past the timeframes specific in 42 CFR §435.1003 for demonstration participants who lose SSI eligibility for a period of up to 2-months from the SSI termination effective date.

13. Expenditures to provide Medicare Part B premiums on behalf of individuals enrolled in ALTCS with income up to 300 percent of the FBR who are also eligible for Medicare, but do not qualify as a QMB, SLMB or QI; are eligible for Medicaid under a mandatory or optional Title XIX coverage group for the aged, blind, or disabled (SSI-MAO); are eligible for continued coverage under 42 CFR 435.1003; or are in the guaranteed enrollment period described in 42 CFR 435.212 and the State was paying their Part B premium before eligibility terminated.

14. Expenditures to extend ALTCS eligibility to individuals under the age of 65 who meet the applicable financial criteria but are not disabled, but who are found to be at risk of

needing nursing facility services based on medical illness or mental retardation on the preadmission screening instrument.

15. Expenditures associated with the provision of Home & Community-Based Services (HCBS) to individuals enrolled in the Arizona Long Term Care system with income levels up to 300 percent of the SSI income level, as well as individuals enrolled in the ALTCS Transitional program.

16. Expenditures for demonstration caregiver services provided by spouses of the demonstration participants.

**The following expenditures (which would not otherwise be included as matchable expenditures under section 1903 of the Act) shall be regarded as matchable expenditures under the state's Medicaid state plan through December 31, 2013:**

17. Expenditures to provide coverage through employer-sponsored insurance for eligible employees of small businesses and with family income below 200 percent of the FPL that would not otherwise be allowable because it is not cost effective.

18. Expenditures to provide medical assistance for adults without children who were enrolled in the AHCCCS under Demonstration project #11-W-00032/9 and #21-W-00009/9 as of July 8, 2011, as long as they continue to meet the State's eligibility criteria and redetermination requirements.

19. Expenditures to provide medical assistance to adults without children with adjusted net countable family income at or below 100 percent of the FPL who are not otherwise eligible for Medicaid.

20. Expenditures to provide medical assistance for individuals who applied for the Medical Expense Deduction (MED) program (under Expenditure Authority 16 of Demonstration project #11-W-00032/9 and #21-W-00009/9) prior to May 1, 2011, and were determined eligible for that population for a 6-month guaranteed eligibility period after that date, until the end of that 6-month period.

21. Expenditures for family planning and family planning-related services for up to 24 months for women losing Medicaid pregnancy coverage at the conclusion of their 60-day postpartum period, and who are not otherwise eligible for Medicare, Medicaid (including other components of this section 1115 demonstration), Children's Health Insurance Program (CHIP), or health insurance coverage that provides family planning services, and who have a family income at or below 150 percent of the Federal poverty level (FPL) at the time of annual redetermination. (Family Planning Extension Program).

22. Expenditures for payments to participating IHS and tribal facilities reflecting uncompensated care, limited to categories of care that were previously covered under the State Medicaid plan, furnished in or by such facilities to Medicaid-eligible individuals, and other individuals, with family income at or below 100 percent of the FPL.

23. Subject to the overall cap on the Safety Net Care Pool (SNCP), expenditures for payments to certain hospitals and other providers reflecting uncompensated costs of medical services that are within the scope of the definition of "medical assistance" under 1905(a) of the Act, that are provided to Medicaid eligible or uninsured individuals, and that exceed the amounts paid to the hospitals pursuant to section 1923 of the Act.

24. Expenditures for uncompensated care payments made under the Proposition 202 Trauma/Emergency Room Designated State Health Program, which is otherwise a State-funded program, as specified in the reimbursement protocol for the SNCP.

**Medicaid Requirements Not Applicable**

Medicaid populations made eligible by virtue of the expenditure authorities expressly granted in this Demonstration are not subject to Medicaid laws or regulations except as specified in the STCs and waiver and expenditure authorities for this Demonstration. The following Medicaid requirements will not apply to such demonstration populations, and will expire on December 31, 2013 (sections refer to the Social Security Act):

**1. Cost Sharing** — **Section 1902(a)(14) insofar as it incorporates section 1916 (42 CFR 447.50 through 447.56)**

To enable the State to impose cost sharing, to the extent necessary, for those in the employer-sponsored insurance program, and individuals without dependent children with family income up to 100 percent of the FPL

**2. Amount, Duration, Scope of Services** — **Section 1902(a)(10)(B) (42 CFR 440.210)**

To enable the State to modify the Medicaid benefits package for those in the employer-sponsored insurance program in order to offer a different benefit package than would otherwise be required under the State plan. This authority is granted only to the extent necessary to allow those in the employer-sponsored insurance plan to receive coverage through a private or employer-sponsored insurance plan, which may offer a different benefit package than that available through the State plan.

**3. Retroactive Coverage** **Section 1902(a)(34) (42 CFR 435.914)**

Individuals who enroll in the employer-sponsored insurance program and individuals without dependent children with family income up to 100 percent of the FPL.

**4. Early and Periodic Screening, Diagnostic, Treatment (EPSDT)** **Section 1902(a)(43)(A)and (42 CFR 440.40 and 441.50 through 441.62**

To enable the State to not provide or arrange for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to adults without dependent children with family income up to 100 percent of FPL ages 19 and 20 years old.

**Medicaid Requirements Not Applicable to the Family Planning Extension Program**

All Medicaid requirements apply to the Family Planning Extension Program, with the exception of the following:

**1. Amount, Duration, and Scope (Comparability)** **Section 1902(a)(10)(B) (42 CFR 440.240)**

To the extent necessary to allow the State to offer the family planning demonstration population a benefit package consisting only of family planning and family planning-related services.

**2. Eligibility Redetermination** **Section 1902(a)(19) (42 CFR 435.916)**

To enable the State to exempt women, who are eligible for the family planning program by virtue of losing Medicaid eligibility at the conclusion of their 60-day postpartum period (SOBRA women), from reporting changes in income during their 12-month eligibility period.

**3. Retroactive Eligibility** **Section 1902(a)(34) (42 CFR 435.914)**

To the extent necessary to enable the State to not provide medical assistance to the Demonstration population for any time prior to when an application for the Demonstration is made.

| | |
|---|---|
| **4. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)** | **Section 1902(a)(43)(A) (42 CFR 440.40 and 441.50 through 441.62)** |

To the extent necessary to enable the State to not furnish or arrange for EPSDT services to the demonstration population.

## CHIP Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act as incorporated into title XXI by section 2107(e)(2)(A) of the Act, State expenditures described below, shall, for the period through December 31, 2013, and to the extent of the State's available allotment under section 2104 of the Act; be regarded as matchable expenditures under the State's title XXI plan. All requirements of title XXI will be applicable to such expenditures for the demonstration population described below, except those specified below as not applicable to these expenditure authorities.

1. **Employer-Sponsored Insurance**. Expenditures to provide coverage to CHIP-eligible children up to age 19 with incomes above 100 percent of the FPL up to and including 200 percent of the FPL, who meet the definition of a targeted low-income child and who elect to receive coverage through the State's Employer-Sponsored Insurance (ESI) program rather than coverage under the CHIP State plan. Such children are no longer subject to the title XXI requirements listed below.
2. **KidsCare II Program**. Expenditures to provide coverage to children up to age 19 with family income up to 200 percent of the FPL not otherwise eligible for Medicaid.

## CHIP Requirements Not Applicable to CHIP Expenditure Authorities

(Sections refer to the Social Security Act.)

| | |
|---|---|
| **1. General Requirements, Eligibility, and Outreach** | **Section 2102 (42 CFR 457.90)** |

Only to the extent that the State child health plan would be required to reflect the demonstration population.

| | |
|---|---|
| **2. Annual Reporting Requirements** | **Section 2108 (42 CFR 457.700 through 457.750)** |

To the extent that the State would have to meet the annual reporting requirements with respect to the demonstration populations (the submission of an annual report into the CHIP Annual Report Template System/CARTS).The State will report on issues related

to the demonstration populations in quarterly and annual reports and enrollment data through the Statistical Enrollment Data System (SEDS).

**3. Cost Sharing** **Section 2103(e) (42 CFR 457.530 through 457.560)**

Rules governing cost sharing under section 2103(e) of the Act shall not apply to the demonstration populations.

**4. Benefit Package Requirements** **Section 2103**

To the extent necessary to permit the State to offer a benefit package for the ESI program that does not meet the requirements of section 2103 of the Act, outlined at 42 CFR 457.410(b)(1).

**SPECIAL TERMS AND CONDITIONS**
**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)**

**MEDICAID SECTION 1115 DEMONSTRATION**

**NUMBER:** 11-W00275/9
21-W-00064/9

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

**AWARDEE:** Arizona Health Care Cost Containment System

## I. PREFACE

The following are the Special Terms and Conditions (STCs) for Arizona's section 1115(a) Medicaid demonstration extension (hereinafter "Demonstration"). The parties to this agreement are the State of Arizona and the Centers for Medicare & Medicaid Services (CMS). This Demonstration is approved for a 5-year period, from October 22, 2011, through September 30, 2016. The STCs set forth below and the lists of waivers and expenditure authorities are incorporated in their entirety into the letter approving the Demonstration. The STCs are effective as of October 22, 2011, unless otherwise specified.

The STCs have been arranged into the following subject areas:

I. Preface;
II. Program Overview and Historical Context;
III. General Program Requirements;
IV. Eligibility;
V. Demonstration Programs;
VI. Funding Pools Under the Demonstration;
VII. Delivery Systems;
VIII. Evaluation;
IX. General Reporting Requirements;
X. General Financial Requirements under Title XIX;
XI. General Financial Requirements under Title XXI;
XII. Monitoring Budget Neutrality; and
XIII. Schedule of State Deliverables During the Demonstration.

## II. PROGRAM OVERVIEW AND HISTORICAL CONTEXT

Until 1982, Arizona was the only State that did not have a Medicaid program under title XIX of the Social Security Act. In October 1982, Arizona implemented the AHCCCS in the State's first section 1115 demonstration project. AHCCCS initially covered only acute care services, however, by 1989, the program was expanded to include the Arizona Long Term Care System (ALTCS), the State's capitated long term care (LTC) program for the elderly and physically disabled (EPD) and the developmentally disabled (DD) populations. In 2000, the State also expanded coverage to adults without dependent children with family income up to and including 100 percent of the Federal poverty level (FPL) as well as established the Medical Expense Deduction (MED) program for adults with income in excess of 100 percent of the FPL who have qualifying healthcare costs that reduce their income at or below 40 percent of the FPL. On March 31, 2011, Arizona requested to terminate its initial section 1115 demonstration in order to eliminate the MED program and implement an enrollment freeze on the adults without dependent children population. On April 30, 2011, and July 1, 2011, CMS approved the State's required phase-out plans for the MED program and the adults without dependent children population, respectively.

The new Demonstration provides health care services through a prepaid, capitated managed care delivery model that operates statewide for both Medicaid State plan groups as well as Demonstration expansion groups. The goal of the Demonstration is to test health care delivery systems to provide organized and coordinated health care for both acute and long term care that include pre-established provider networks and payment arrangements, administrative and clinical systems for utilization review, quality improvement, patient and provider services, and management of health services. The Demonstration will also test the extent to which health outcomes in the overall population are improved by expanding coverage to additional needy groups.

The Demonstration affects coverage for certain specified mandatory State plan eligibles by requiring enrollment in coordinated, cost effective, health care delivery systems. In this way, the Demonstration will test the use of managed care entities to provide cost effective care coordination, including two pilot projects that will test the effect of integrating behavioral and physical health services for two populations – individuals residing in Maricopa county with serious mental illness and children participating in the Children's Rehabilitative Services program. The Demonstration also provides coverage to limited groups the State does not currently cover under its Medicaid State plan, including adults without dependent children, and a limited number of children with incomes above the levels under the Medicaid State plan and at or below 200 percent of the FPL, which will show the benefits of such coverage using these approaches to a wider population. In addition, the Demonstration will provide for payments to IHS and tribal 638 facilities to address the fiscal burden of uncompensated care for services provided in or by such facilities to individuals with income up to 100 percent of the FPL. This authority will enable the State to evaluate how this approach impacts the financial viability of IHS and 638 facilities and ensures the continued availability of a robust health care delivery network for current and future Medicaid beneficiaries.

Finally, the Demonstration will allow the State to also test the effects of increasing personal

financial responsibility on utilization and health outcomes on some populations by permitting cost sharing. Specifically, the Demonstration will test the effects of the imposition of mandatory co-payments on adults without dependent children in the following areas:

1. Utilization of needed preventive, primary care, and treatment services;
2. Appropriate utilization of emergency room care, and appropriate, cost and clinically effective use of generic and brand name drugs;
3. State and Federal expenditures (per enrollee) in the short and long term; and
4. Physician participation, including physician willingness to accept appointments from the adults without dependent children population.

In order to evaluate these hypotheses, the Demonstration will review utilization and cost data and quality measures related to the adults without dependent children enrolled under the Demonstration as specified in paragraph 29(c).

## III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program, or the Children's Health Insurance Program (CHIP) for the separate CHIP population, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the Demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid program that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

   a) To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

   b) If mandated changes in the Federal law require State legislation, the changes must

take effect on the earlier of the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State will not be required to submit title XIX and XXI State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid State plan is affected by a change to the Demonstration, a conforming amendment to the State Plan is required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must include, but are not limited to, the following:

    a) An explanation of the public process used by the State, consistent with the requirements of paragraph 14 to reach a decision regarding the requested amendment;

    b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

    c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

    d) If applicable, a description of how the evaluation designs will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the Demonstration, the chief executive officer of the State must submit to CMS either a

Demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

As part of the Demonstration extension request, the state must provide documentation of compliance with the public notice requirements outlined in paragraph 14 as well as include the following supporting documentation:

a) Demonstration Summary and Objectives: The State must provide a summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met.

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

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

d) Compliance with the Budget Neutrality Cap: The State must provide financial data (as set forth in the current STCs) demonstrating that the State has maintained and will maintain budget neutrality for the requested period of extension. CMS will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension.

e) Interim Evaluation Report: The State must provide an evaluation report reflecting the hypotheses being tested and any results available.

9. **Demonstration Phase-Out.** The State may only suspend or terminate this Demonstration in whole, or in part, consistent with the following requirements.

a) Notification of Suspension or Termination: The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The State must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the Demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the State must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the State must

provide a summary of each public comment received, the State's response to the comment and how the State incorporated the received comment into the revised phase-out plan.

The State must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

b) Phase-out Plan Requirements: The State must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c) Phase-out Procedures: The State must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2010, State Health Official Letter #10-008.

d) Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge CMS' finding that the State materially failed to comply.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is

limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** The State will ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The State must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the State's approved State plan, when any program changes to the Demonstration, including (but not limited to) those referenced in STC 6, are proposed by the State.

    In States with Federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the State's approved Medicaid State plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

    In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any Demonstration proposal and/or renewal of this Demonstration (42 C.F.R. §431.408(b)(3)).

    The State must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

15. **FFP.** Federal funds are not available for expenditures for this Demonstration until the effective date identified in the Demonstration approval letter.

## IV. ELIGIBILITY

16. **Eligibility.** The Demonstration affects all of the mandatory Medicaid eligibility groups set forth in Arizona's approved State plan, 14 optional groups set forth in the State plan, and 5 expansion groups made eligible under this Demonstration. Mandatory and optional State plan groups described below are subject to all applicable Medicaid laws and regulations except as expressly waived. Expansion populations are defined as those groups made eligible by virtue of the expenditure authorities expressly granted in this Demonstration and are subject to Medicaid and CHIP laws or regulations except as

specified in the STCs and waiver and expenditure authorities for this Demonstration. These cited documents generally provide that all requirements of Medicaid and CHIP laws and regulations do apply, except to the extent waived or specified as not applicable. The criteria for Arizona eligibility groups are as follows (Table 1):

**Table 1 –** State Plan and Expansion Populations Affected by the Demonstration

| Description | Program | Social Security Act Cite | 42CFR Cite |
|---|---|---|---|
| **STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS**<br>**Families and Children** | | | |
| 1931 (Title IV A program that was in place in July 1996) including:<br>• pregnant women with no other eligible children (coverage for third trimester)<br>• persons 18 years of age, if a full-time student<br>• family with unemployed parent | AACP | 1902(a)(10)(A)(i)(I) | 435.110 |
| Twelve months continued coverage (transitional medical assistance) 1931 ineligible due to increase in income from employment or work hours or loss of "income disregard." | AACP | 1902(a)(52)<br>1902(e)(l)<br>1925(a)(b)(c) | 435.112 |
| 1931 Extension-Extension of MA when child or spousal support collection results in 1931 ineligibility. (4 months continued coverage) | AACP | 408(a)(11)(B)<br>1902 (a) (10) (A) (i) (I)<br>1931 (c) | 435.115 |
| **STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS**<br>**Pregnant Women, Children, and Newborns** | | | |
| Qualified pregnant women who:<br>• would be AFDC eligible if child were born and<br>• meet AFDC income & resource criteria | AACP | 1902(a)(10)(A)(i)III<br>1905(n) | 435.116 |
| "S.O.B.R.A. WOMEN & INFANTS"<br>Pregnant women & infants under age 1 with incomes less than or equal to 133% FPL. (optional group extends coverage up to 140% FPL for infants under age 1) | AACP<br>ALTCS | 1902(a)(10)(A)(i)(IV)<br>1902(l)(1)(A) | |
| "S.O.B.R.A. CHILDREN"<br>Children age 1+ but not yet 6 with incomes at or below 133% FPL. | AACP<br>ALTCS | 1902(a)(10)(A)(i)(VI)<br>1902(l)(1)(C) | |
| "S.O.B.R.A. CHILDREN"<br>Children age 6+ but not yet 19, born after 9-30-83, with income less than or equal to 100% FPL. | AACP<br>ALTCS | 1902(a)(10)(A)(i)(VII)<br>1902(l)(1)(D) | |
| "DEEMED CATEGORICAL NEWBORNS"<br>Children born to a woman who was eligible and received Medicaid on the date of the child's birth. Children living with their mothers are eligible for 1 year as long as mothers are eligible or would be eligible if pregnant.* | AACP | 1902(e)(4) | 435.117 |
| **STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS**<br>**Qualified Family Members** | | | |
| Qualified members of family with unemployed principal wage earner (persons who would be eligible if state did not limit number of months AFDC-UP cash was available). | AACP | 1902(a)(10)(A)(i)<br>1905(m)(l) | 435.119 |

| Description | Program | Social Security Act Cite | 42CFR Cite |
|---|---|---|---|
| **STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS**<br>**Aged, Blind, and Disabled** | | | |
| All SSI cash recipients: aged, blind or disabled persons | AACP<br>ALTCS | 1902(a)(10)(A)(i)(II) | 435.120 |
| Qualified severely impaired working blind or disabled persons < 65 who were: a) receiving Title XIX, SSI or State supplement under 1619(a); or b) eligible for Medicaid under 1619(b) in 6/87 | AACP | 1902(a)(10)(A)(i)(II)<br>1905(q) | 435.120 |
| "DAC" Disabled adult child (age 18+) who lost SSI by becoming OASDI eligible (i.e., due to blindness or disability that began before age 22) or due to increase in amount of child's benefits. | AACP | 1634(c) | |
| SSI cash or state supplement ineligible for reasons prohibited by Title XIX. | AACP<br>ALTCS | | 435.122 |
| SSA Beneficiaries who lost SSI or state supplement cash benefits due to cost of living adjustment (COLA) increase in Title II benefits | AACP | | 435.135 |
| Disabled widow/widower who lost SSI or State supplement due to 1984 increase in OASDI caused by elimination of reduction factor in PL 98-21. (person must apply for this by 7/88) | AACP | 1634(b) | 435.137 |
| Disabled widow/widower (age 60-64 and ineligible for Medicare Part A) who lost SSI or State supplement due to early receipt of Social Security benefits. | AACP | 1634(d) | 435.138 |
| "DC Children" Children under the age of 18 who were receiving SSI Cash on 8/26/96 and would continue to be eligible for SSI Cash if their disability met the childhood definition of disability that was in effect prior to 8/26/96. | AACP | 1902(a)(10)(A)(i)(II) | |
| **STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS**<br>**Adoption Assistance and Foster Care Children** | | | |
| Children in adoption subsidy/foster care Title IV-E programs | AACP<br>ALTCS | 473(b)(l)<br>1902(a)(10)(A)(i)(I) | 435.145 |
| **STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS**<br>**Special Groups** | | | |
| "POSTPARTUM"<br>Title XIX eligible women who apply on or before pregnancy ends, (continuous coverage through the month in which the 60th day postpartum period ends) | AACP | 1902(e)(5)<br>1902(e)(6) | 435.170 |
| **STATE PLAN OPTIONAL TITLE XIX COVERAGE GROUPS** | | | |
| **Description** | **Program** | **Social Security Act Cite** | **42CFR Cite** |
| "210 GROUP" Persons who meet AFDC, SSI or State supplement income & resource criteria. | AACP<br>ALTCS Case Management | 1902(a)(10)(A)(ii)(I) | 435.210 |
| “211 GROUP" Persons who would be eligible for cash assistance except for their institutional status. | ALTCS | 1902(a)(10)(A)(ii)(IV) | 435.211 |
| "GUARANTEED ENROLLMENT" Continuous coverage for persons enrolled in AHCCCS Health Plans who lose categorical eligibility prior to 6 months from enrollment. (5 full months plus month of enrollment) | AACP | 1902(e)(2) | 435.212 |
| "S.O.B.R.A. Infants” infants with incomes between the 133% FPL mandatory group maximum and a 140% FPL optional State maximum. | AACP<br>ALTCS | 1902(a)(10)(A)(ii)(IX) | |
| Pregnant women, including postpartum, who maintain eligibility without regard to changes in income. | AACP | 1902(e)(6) | |

| Description | Program | Social Security Act Cite | 42CFR Cite |
|---|---|---|---|
| "HCBS GROUP" Persons receiving HCBS under a waiver with incomes < or equal to 300% of the Federal benefit rate (FBR). | ALTCS | 1902(a)(10)(A)(ii)(VI) | 435.217 |
| "State Adoption Subsidy" Children who receive a state adoption subsidy payment. | AACP | 1902(a)(10)(ii)(VIII) | 435.227 |
| "236 GROUP" Persons in medical institutions for 30 consecutive days who meet state-set income level of < or equal to 300% of FBR. | ALTCS | 1902(a)(10)(A)(ii)(V) | 435.236 |
| "Freedom to Work" Basic Coverage Group – individuals aged 16-64 with a disability who would be eligible, except for earnings, for SSI up to and including 250% of FPL. | AACP<br>ALTCS | 1902(a)(10)(A)(ii)(XV) | |
| "Freedom to Work" Medical Improvement Group – employed individuals aged 16-64 with a medically improved disability up to and including 250% of FPL. | AACP<br>ALTCS | 1902(a)(10)(A)(ii)(XVI) | |
| Women under 65 who need treatment for breast or cervical cancer, and not otherwise eligible for Medicaid. | AACP | 1902(a)(10)(A)(ii)(XVIII) | |
| Children who have aged out of foster care at 18 up to age 21 | AACP | 1902(a)(10)(A)(ii)(XVII) | |
| 1931 Expansion-Income Greater than 36% FPL and less than or equal to 100% FPL. | AACP | | |
| SSI-MAO Expansion (Optional 210 Group)- aged, blind, or disabled individuals with income greater than 100% FBR and less than or equal to 100% FPL. | AACP | Arizona State Plan | |
| **TITLE XIX AND XXI EXPANSION GROUPS UNDER THE DEMONSTRATION** | | | |
| Adults without dependent children who were enrolled in the AHCCCS under Demonstration project #11-W-00032/9 and #21-W-00009/9 as of July 8, 2011 as long as they continue to meet the State's eligibility criteria and redetermination requirements. | AACP | ARS 36-2901.01 | |
| To the extent the State gives notice to CMS described in 17.b below, adults without dependent children with adjusted net countable income at or below 100% FPL who are not otherwise eligible for Medicaid. | AACP | ARS 36-2901.01 | |
| Individuals who applied for the Medical Expense Deduction (MED) program (under Expenditure Authority 16 of Demonstration project #11-W-00032/9 and #21-W-00009/9) prior to May 1, 2011 and were determined eligible for that population for a 6-month guaranteed eligibility period after that date, until the end of that 6-month period. | AACP | ARS 36-2901.04 | |
| Women who lose Medicaid pregnancy coverage at the conclusion of 60 days postpartum, and who are not otherwise eligible for Medicare, Medicaid, Children's Health Insurance Program (CHIP) or health insurance coverage that provides family planning services, and who have a family income at or below 150 percent of the FPL at the time of annual redetermination (up to 24 months following the postpartum period). | Family Planning Extension Program | ARS 36-2907.04 | |
| Children up to age 19 with incomes above 100 percent of the FPL up to and including 200 percent of the FPL who meet the definition of a targeted low-income child and who have access to ESI coverage | ESI | | |
| Children with family income at or below 200 percent of the FPL who are not otherwise eligible for Medicaid, subject to available funding. | KidsCare II | | |

*Arizona's 1115 Demonstration provides the authority to waive some of the provisions.

## V. DEMONSTRATION PROGRAMS

17. **Arizona Acute Care Program (AACP)**. The AACP is a statewide, managed care system which delivers acute care services through prepaid, capitated MCOs that AHCCCS calls "Health Plans." Most Health Plan contracts are awarded by Geographic Service Area (GSA), which is a specific county or defined grouping of counties designated by AHCCCS within which a Contractor provides, directly or through subcontract, covered health care to members enrolled with that Contractor. AACP enrollees receive most Medicaid-covered services through the Health Plans, but receive, on a "carve out" basis, behavioral health services through a separate PIHP contract. The one exception to the behavioral health carve out is for AACP members with a serious mental illness residing in Maricopa County who receive their acute care and behavioral health services through the PIHP. In addition, AACP members with a CRS condition receive all of their care – acute care and treatment for CRS and behavioral health care conditions – through a separate MCO contract.

a) **AACP Eligibility –** Those Groups identified in Table 1.

b) **Enrollment** - The Arizona DES processes applications and determines acute care Medicaid eligibility for children, pregnant women, families and non-disabled adults under the age of 65 years. The Social Security Administration (SSA) determines eligibility for the Supplemental Security Income (SSI) cash-related groups, and AHCCCS determines eligibility for the SSI- related aged and disabled groups, Medicare Savings Programs, women diagnosed with breast or cervical cancer, and Freedom to Work recipients. Individuals determined eligible must then select and enroll in a Health Plan, or they will be auto-assigned by the AHCCCS administration.

   i. Except as specified in subparagraph (iv) below, the State will not make individuals eligible based on applications received on and/or after July 8, 2011, for AHCCCS benefits from adults without dependent children with family income up to 100 percent of the FPL. Adults without dependent children who were enrolled in the AHCCCS under Demonstration project #11-W-00032/9 and #21-W-00009/9 as of July 8, 2011, will continue to receive AHCCCS benefits under this Demonstration as long as such individuals continue to meet the State's eligibility criteria and redetermination requirements.

   ii. The State may open new enrollment for the adults without dependent children population. The State must notify CMS prior to re-opening enrollment, and must include a process by which it will notify the public, such as the use of public forums, tribal consultations, and community stakeholder meetings.

iii. The State must maintain eligibility for individuals who were enrolled in AHCCCS under Demonstration #11-W-00032/9 and #21-W-00009/9 as of July 8, 2011 in the adults without dependent children population unless the individuals no longer meet the eligibility criteria.

iv. Subject to available funding provided by governmental entities pursuant to an IGT agreement as specified in paragraph 26(j), and the notification described above in subparagraph (ii), the state will open enrollment to state plan eligible 1931 parents who, because of a lack of a dependent child, would otherwise lose coverage due to the state's determination to close enrollment to new childless adults. This would include allowing state plan eligible 1931 parents to transition to childless adult coverage in the event that their children age out of Medicaid or enter the foster care system. The AHCCCS Administration will, upon notice of loss of a dependent child, change the beneficiary's eligibility status to that of childless adult administratively, and will not require the beneficiary to reapply for coverage under the demonstration. The affected 1931 parents will maintain their AHCCCS coverage through December 31, 2013, assuming all other eligibility criteria is met (e.g., income), and will be notified of their change in eligibility designation from 1931 parent to childless adult. Funding is anticipated to support enrollment of a target number of 13,000 adults.

c) **Benefits** – Benefits for AACP and the expansion population authorized by the 1115 Demonstration will consist of all acute care benefits covered under the Medicaid State plan (see Attachment G), unless otherwise noted within these STCs.

i. **Notice -** The State must include the CMS Central Office when submitting a State plan amendment (SPA) to the CMS Regional Office that would impact the expansion population authorized by the 1115 Demonstration inclusive of:
   a. The proposed date of implementation;
   b. The date the State plans to submit the SPA; and
   c. Revised budget neutrality projections.

ii. **Demonstration Amendment.** CMS reserves the right to require the State to submit an amendment if it is determined that it is warranted.

iii. Behavioral health services are outlined in Table 2 and subject to limitations set forth in the existing State plan.

Table 2 – AACP Behavioral Management

| **Benefit** | **Title XIX** | | **Title XXI** |
|---|---|---|---|
| Age | < 21 yrs | ≥ 21 yrs | < 19 yrs |
| | | | |
| Behavioral Management | X | X | X |
| Case Management | X | X | X |
| Emergency Behavioral Health Care | X | X | X |
| Evaluation | X | X | X |

| Benefit | Title XIX | | Title XXI |
|---|---|---|---|
| Therapeutic Residential Support (in home, excluding room and board ) | X | X | X |
| Inpatient Services | | | |
| Inpatient Hospital | X | X | X |
| Inpatient Psychiatric Facilities | X | X | X |
| Lab & X – Ray | X | X | X |
| Medications (Psychotropic) | X | X | X |
| Medication Adjustment & Monitoring | X | X | X |
| Methadone / IAAM | X | X | X |
| Partial Care | X | X | X |
| Professional Services | | | |
| Individual | X | X | X |
| Group & Family | X | X | X |
| Psychosocial Rehabilitation | X | X | X |
| Respite (with limits) | X | X | X |
| Screening | X | X | X |
| Transportation – Emergency | X | X | X |
| Transportation – Non Emergency | X | X | X |

d) **AACP Cost Sharing** – Cost sharing shall be imposed as specified in the Medicaid State plan for all populations, except for the adults without dependent children with income up to 100 percent of the FPL which are as follows:

Table 3 – Adults without Dependent Children Copayments

| Service | Copayment Amount | Geographic Applicability |
|---|---|---|
| Generic prescription, or brand name prescription if generic is not available | $4 | Statewide |
| Brand name prescription when generic is available | $10 | Statewide |
| Non-emergency use of the emergency room | $30 | Statewide |
| Physician office visit | $5 | Statewide |
| Non-emergency medical transportation (NEMT) (taxi rides only) | $2 per trip ($4 roundtrip maximum) | Only in Maricopa and Pima counties |

i. The NEMT copayment shall be imposed only on taxi rides for adults without dependent children who reside in Maricopa and Pima counties. Adults without dependent children residing in all other counties within the State are exempt from the NEMT copayment. The American Indian/Alaskan Native (AI/AN) population is also exempt.

ii. The copayments referenced in the Table 3 above are subject to the evaluation requirements in STC# 29(c).

18. **Children in Foster Care** – Services for Arizona's children in foster care are provided through an MCO contract between AHCCCS and the Arizona DES/CMDP. CMDP operates in the same manner as other AACP Health Plans, but children in foster care who

receive acute care services will be enrolled in CMDP instead of other Health Plans. Children in foster care who are eligible for or receive ALTCS will be enrolled or remain with the Program Contractor. Case Management services provided and reimbursed through this contractual relationship must be provided consistent with Federal policy, regulations and law. Children in foster care who are also eligible for CRS receive treatment for their CRS and behavioral health care conditions through the separate MCO contract for the CRS program. CRS eligible foster children will receive services for all conditions other than behavioral health or CRS related conditions through CMDP.

a) **FFP**. FFP will not be available for:

i. Duplicate payments made to public agencies or private entities under other program authorities for case management services or other Medicaid services for the same purpose; or

ii. Activities integral to the administration of the foster care program excluding any health care related activities.

19. **Children Rehabilitative Services (CRS)**. AHCCCS contracts on a sole-source, capitated basis for the CRS program. Acute Care enrolled children with qualifying conditions receive their CRS specialty care, behavioral health care and acute care through the CRS contractor. Children enrolled in ALTCS DES/DDD who also have a CRS condition will receive care for their CRS and behavioral health conditions through the CRS contractor. Children with a CRS condition who are enrolled in CMDP will receive treatment for their CRS and behavioral health care conditions through the CRS contractor.

a) **Transition of Care.** When individuals transition to the CRS contractor from an AACP health plan, children in active treatment (including but not limited to chemotherapy, pregnancy, drug regime or a scheduled procedure) with a CRS non-participating provider shall be allowed to continue receiving treatment from the non-participating provider through the duration of their prescribed treatment.

b) **Choice of Primary Care Physician (PCP).** The CRS contractor is required to assure that members have a choice of PCPs. Specifically, beneficiaries will have a choice of at least two primary care providers, and may request change of primary care provider at least at the times described in 42 CFR 438.56(c). In addition, the CRS contractor will offer contracts to primary and specialist physicians who have established relationships with beneficiaries including specialists who may also serve as PCPs to encourage continuity of provider. For children who have an established relationship with a PCP that does not participate in the CRS contractor's provider network, the CRS contractor will provide, at a minimum, a 90-day transition period in which the child may continue to seek care from their established PCP while the child and child's parents and/or guardian, the CRS contractor, and/or case manager finds an alternative PCP within the CRS contractor's provider network.

c) **Readiness Review of Health Plan.** The state will submit to CMS for review a copy of its readiness review report of the health plan selected to provide the integrated services to the CRS population to ensure the selected health plan's provider network, both in terms of primary and specialty care providers, is adequate and would not result in access to care issues for the affected population.

20. **Individuals with Serious Mental Illness (SMI).** Individuals who are AACP members residing in Maricopa County and who are diagnosed with a serious mental illness will receive their acute care services and behavioral health services through a separate PIHP.

    a) **Transition Period.** When individuals transition to the PIHP for their physical health from an AACP health plan, members in active treatment (including but not limited to chemotherapy, pregnancy, drug regime or a scheduled procedure) with a non-participating/non-contracted provider shall be allowed to continue receiving treatment from the non-participating/non-contracted provider through the duration of their prescribed treatment.

    b) **Choice of Primary Care Physician (PCP).** The PIHP is required to assure that members have a choice of PCPs. Specifically, beneficiaries will have a choice of at least two primary care providers, and may request change of primary care provider at least at the times described in 42 CFR 438.56(c). In addition, the PIHP, through the Regional Behavioral Health Authorities (RBHA), will offer contracts to primary and specialist physicians who have established relationships with beneficiaries including specialists who may also serve as PCPs to encourage continuity of provider. For individuals who have an established relationship with a PCP that does not participate in the PIHP/RBHA's provider network, the PIHP will provide, at a minimum, a 90-day transition period in which the individual may continue to seek care from their established PCP while the individual, the PIHP, RBHA and/or case manager finds an alternative PCP within the PIHP/RBHA's provider network.

    c) **Readiness Review of Health Plan.** The state will submit to CMS for review a copy of its readiness review report of the health plan selected to provide the integrated services to the SMI population to ensure the selected health plan's provider network, both in terms of primary and specialty care providers, is adequate and would not result in access to care issues for the affected population.

21. **Arizona Long Term Care System (ALTCS).** The ALTCS program is for individuals who are age 65 and over, blind, disabled, or who need ongoing services at a nursing facility or ICF/MR level of care. ALTCS enrollees do not have to reside in a nursing home and may live in their own homes or an alternative residential setting and receive needed in-home services. The ALTCS package also includes all medical care covered under AACP inclusive of doctor's office visits, hospitalization, prescriptions, lab work, behavioral health services, and rehabilitative services. Rehabilitative services may only

be eligible for FFP if these services reduce disability or restore the program enrollee to the best possible level of functionality.

The ALTCS is administered through a statewide, managed care system which delivers acute, long-term care, home-and-community based, CRS and behavioral health care services through capitated MCOs that AHCCCS calls "Program Contractors." The one exception is ALTCS DES/DDD enrollees eligible under the CRS program receive specialty care for treatment of their CRS and behavioral health conditions through a separate MCO contract. Those enrollees will receive services for all conditions other than behavioral health or CRS related conditions through ALTCS DES/DDD.

With one exception, ALTCS contracts are awarded in the same geographic service areas as AACP are awarded. The exception is for the ALTCS contract with the Arizona DES/DDD to provide coverage on a statewide basis of the full ALTCS benefit package to all eligible individuals with developmental disabilities. Under State law, A.R.S. 36-2940, AHCCCS is required to enter into an intergovernmental agreement (IGA) with DES/DDD to serve as the managed care organization for individuals with developmental disabilities. The DES/DDD ALTCS contract is an at-risk MCO contract that complies with 42 C.F.R. Part 438 and as such is reviewed and approved by CMS. Payments to DES/DDD under the ALTCS contract shall not include any payments other than payments that meet the requirements of 42 C.F.R. 438.6(c) including the requirement that all payments and risk-sharing mechanisms in the contract are actuarially sound. State law, A.R.S. 36-2953, requires DES/DDD to maintain a separate fund to account for all revenues and expenditures under the ALTCS contract and limits use of the fund for the administration of the ALTCS contract. ALTCS enrollees in Maricopa and Pima Counties have a choice of Program Contractors, but ALTCS enrollees in the rest of the State enroll in the Program Contractor for their GSA.

a) **ALTCS Eligibility Groups -** Individuals as defined in Table 1 requiring health care services at a nursing facility or ICF/MR level of care.

b) **ALTCS Financial Eligibility -** Individuals must be financially eligible for ALTCS with income equal to or less than 300 percent of the Federal Benefit Rate (FBR), as used by SSA to determine eligibility for SSI.

    i. The State may disregard income in excess of the FBR for persons with AHCCCS approved income-only trusts.

    ii. The resource (cash, bank accounts, stocks, bonds, etc.) limit is $2,000 for a single individual. Resources, such as a person's home, vehicle, and irrevocable burial plan are not counted toward the resource limit.

    iii. When the applicant has a spouse who resides in the community, the spouse can retain one-half of the couple's resources, up to the Federal maximum as specified in section 1924(f)(2) of the Act. Resources, such as a person's

home, vehicle, and irrevocable burial plan are not counted toward the resource limit.

iv. The total gross income for a married couple is combined and divided by 2. The resulting income may not exceed 300 percent of the single FBR. If the resulting income exceeds 300 percent of the single FBR, the income of the applicant only (name on check) is compared to 300 percent of the single FBR.

c) **Pre-Admission Screening (PAS) -** Once financial eligibility has been established, a PAS will be conducted by a registered nurse or social worker to determine if the individual is at immediate risk of institutionalization in either a nursing facility or an ICF/MR. The PAS must be used to determine if the applicant is eligible for ALTCS based on functional, medical, nursing, and social needs of the individual.

d) **Written Plan of Care** - An individual written plan of care will be developed by qualified providers for ALTCS enrollees under this demonstration. This plan of care will describe the medical and other services to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the review of AHCCCS.

i. **FFP** - will not be claimed for Demonstration services furnished prior to the development of the plan of care. FFP will not be claimed for Demonstration services which are not included in the individual written plan of care.

e) **ALTCS Safeguards** – AHCCCS will take the following necessary safeguards to protect the health and welfare of persons receiving HCBS services under the ALTCS program. Those safeguards include:

i. Adequate standards for all types of providers that furnish services under the ALTCS program;

ii. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the ALTCS program. The State assures that these requirements will be met on the date that the services are furnished; and

iii. Assurance that all facilities covered by section 1616 (e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirement of 45 CFR Part 1397 for board and care facilities.

iv. A formal quality control system which monitors the health and welfare of members served in the ALTCS program.

1) Monitoring will ensure that all provider standards and health and welfare assurances are continually met, and that plans of care are

periodically reviewed to ensure that the services furnished are reasonably consistent with the identified needs of the individuals.

2) The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

f) **ALTCS Benefits and Services**

i. **ALTCS Acute Care -** Enrollees receive the same acute services as defined in paragraph 17(c).

ii. **ALTCS Behavioral Health Care -** Enrollees receive behavioral health care services as defined in paragraph 17(c)(iii).

iii. **Home and Community-Based Services (HCBS) -** ALTCS will provide a comprehensive HCBS package to eligible enrollees in the enrollee's home or in an ALTCS approved Alternative Residential Setting.

1) **Alternative Residential Settings** include:

a. Adult foster care.
Assisted living homes, assisted living centers, adult developmental homes, child developmental homes and group homes, hospices, group homes for traumatic brain injured members, and rural substance abuse transitional agencies.

b. Behavioral Health Facilities that are licensed to provide behavioral health services in a structured setting with 24-hour supervision. ALTCS covers services, except room and board, that are provided to ALTCS members who have a behavioral health disorder and are residing in one of the following behavioral health facilities:

i. Level II behavioral health facility – Licensed by ADHS. An HCBS alternative residential behavioral health treatment setting for individuals who do not require the intensity of services or onsite medical services found in a Level I facility.

ii. Level III behavioral health facility - Licensed by ADHS. An HCBS alternative residential behavioral health treatment setting with 24-hour supervision and supportive, protective oversight. These services are excluded for individuals involuntarily living in the

secure custody of law enforcement, judicial, or penal systems.

2) **HCBS Services** – Services provided to ALTCS enrollees receiving HCBS are enumerated in Table 4.

Table 4 – ALTCS HCBS

| Service | Title XIX | |
|---|---|---|
| | EPD | DD |
| Acute Hospital Admission | X | X |
| Adult Day Health Services | X | N/A |
| Attendant Care | X | X |
| Behavioral Health Services | X | X |
| Community Transition Services* | X | X |
| DME / Medical Supplies | X | X |
| Emergency Alert | X | X |
| Habilitation | X | X |
| Home Delivered Meals | X | n/a |
| Home Health Agency Services | X | X |
| Home Modifications | X | X |
| Home Maker Services | X | X |
| Hospice Services (HCBS & Institutional) | X | X |
| ICF / MR | n/a | X |
| Medical Care Acute Services | X | X |
| Nursing Facility Services | X | X |
| Personal Care | X | X |
| Respite Care (in home) | X | X |
| Respite Care (Institutional) | X | X |
| Therapies | X | X |
| Transportation | X | X |

*As Defined in State Medicaid Director Letter #02-008 (Attachment D)

3) **HCBS Expenditures**- Expenditures for individual members are limited to an amount that does not exceed the cost of providing care to the eligible individual in an institutional setting. Exceptions are permitted including when the need for additional services is due to a change in condition that is not expected to last more than 6 months.

iv. **Spouses As Paid Care Givers**. AHCCCS may implement a voluntary program for spouses as paid caregivers. The program will provide reimbursement to spouses who elect to provide needed in-home care for eligible ALTCS enrollees. Spouses providing care to eligible enrollees will be employed by an ALTCS network contractor, or registered with AHCCCS as an ALTCS independent provider when providing services to an ALTCS FFS Native American or developmentally disabled member. In order for the State to receive FFP from CMS for Paid Caregiver Spouses of Medicaid beneficiaries, the personal care service or support must meet the following criteria and monitoring provisions.

1) Services provided by the Spouse as Paid Caregiver must meet the definition of a "service/support" for personal care or similar services that are rendered by a Paid Caregiver when such services are deemed extraordinary care.
    a. Personal care or similar services – Is defined as assistance with the Activities of Daily Living (ADLs), or Instrumental Activities of Daily Living (IADLs), whether furnished in the home or the community, including personal assistance, attendant care, and closely related services such as home health aide, homemaker, chore, and companion services which may include improving and maintaining mobility and physical functioning, promoting health and personal safety, preparation with meals and snacks, accessing and using transportation, and participating in community experiences and activities.
    b. Extraordinary care - Is defined as care that exceeds the range of activities that a spouse would ordinarily perform in the household on behalf of the recipient spouse, if he/she did not have a disability or chronic illness, and which are necessary to assure the health and welfare of the beneficiary, and avoid institutionalization.

2) The Spouse as Paid Caregiver must be a service/support that is specified in a plan of care prepared on behalf of the enrollee.

3) The enrollee who selects the Spouse as Paid Caregiver is not eligible to receive like services from another attendant caregiver.

4) The enrollee will remain eligible to receive other HCBS such as skilled/professional type services, home modifications, respite care, and other services that are not within the scope of the personal/attendant care services prescribed in the provider's plan of care.

5) The Services must be provided by a Spouse as Paid Caregiver who meets specified provider qualifications and training standards prepared by the State for a Paid Caregiver.

6) The Spouse as Paid Caregiver must be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the State Medicaid Agency (SMA) for the payment of personal care/attendant services; and

7) The Spouse as Paid Caregiver will comply with the following conditions.

a. A Spouse as Paid Caregiver may not be paid for more than 40 hours of services in a 7-day period;
b. The Spouse as Paid Caregiver must maintain and submit time sheets and other required documentation for hours worked/paid;
c. The Spouse as Paid Caregiver may only submit claims for services that have been authorized by the Program Contractor or ALTCS FFS case manager;
d. The ALTCS enrollee must be offered a choice of providers, other than his/her spouse. The enrollee's choice of a Paid Caregiver Spouse as provider must be recorded in his/her plan of care, at least annually.

8) AHCCCS and its Program Contractors must comply with the following monitoring requirements:
   a. Require Program Contractors and FFS case managers to make an on-site case management visit at least every 90 days to reassess a beneficiary's need for services, including the health, safety, and welfare status of the beneficiary serviced by the Spouse as Paid Caregiver;
   b. Require Program Contractors to provide quarterly financial statements that include separate authorized hours and expenditure information for Paid Caregiver Spouses; and
   c. Require AHCCCS to perform quarterly financial analysis that includes authorized hours and expenditure information for ALTCS FFS Spouses as Paid Caregivers.

v. **Institutional Care** ALTCS will provide institutional care in facilities appropriate to their needs that hold State licenses and Medicaid provider agreements indicating compliance with Medicaid requirements.

g) **Cost Sharing.**

i. Monthly Premiums for ALTCS. The AHCCCS may implement a monthly premium on ALTCS eligible households with an adjusted gross income at or above 400 percent of the FPL that have children under the age of 18 years with developmental disabilities enrolled in ALTCS.

ii. The total of all monthly premiums will be 2 percent of the annual adjusted gross income for households with income between 400 percent and 500 percent of the FPL, and 4 percent for households with income at and above 500 percent the FPL. There will be no distinction between institutional or non-institutional placements.

iii. AHCCCS will compute the premium amount using annual adjusted gross income from the parent's most recent Federal income tax return.

1) Premiums will be billed monthly on the 1st and due on the 15th.
2) AHCCCS will establish a grievance and appeal process allowing families to dispute the initial amount of the premium based on annual income or family size, increases in premiums and discontinuances for failure to pay the monthly premiums or deductibles.
    a. Premiums will continue to be billed and incurred during an eligibility appeal period and failure to pay the premium during the appeal period could mean a loss of eligibility.
    b. If the appeal is based on an increase in the premium amount, the premium increase will not be imposed until after an appeal decision.

h) **Other ALTCS Requirements**

i. The State of Arizona will continue to provide access to ALTCS services to American Indians on the reservation as it does to other citizens of the State.

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

iii. In the absence of a limit, AHCCCS will report annually on current placements and ongoing activities for expanding HCB services and settings. The report will be due by March 31 of each year.

iv. The DES/DDD will comply with all contractual and reporting requirements as specified in the contract between AHCCCS and DES/DDD and in any subsequent amendments. DES/DDD will be sanctioned as specified in the contract if DES/DDD fails to comply with the stated contractual and reporting requirements.

22. **ALTCS Transitional Program**. AHCCCS will complete a second scoring of the PAS for members who are enrolled in ALTCS, but fail to be at "immediate risk of institutionalization" based on the PAS conducted at the time of the re-determination.

    If determined eligible for the ALTCS Transitional Program, AHCCCS will transfer the member to the ALTCS Transitional Program which limits institutional services to 90-days per admission and provides the member with medically necessary acute care services, HCBS, behavioral health services and case management services as prescribed in paragraph #20.

23. **Medicare Part B Premiums.** The State of Arizona will continue to pay the Medicare Part B premiums on behalf of individuals enrolled in ALTCS with income up to 300

percent of the FBR who are also eligible for Medicare, but do not qualify as a QMB, SLMB or QI; eligible for Medicaid under a mandatory or optional Title XIX coverage group for the aged, blind, or disabled (SSI-MAO); eligible for continued coverage under 42 CFR 435.1003; or are in the guaranteed enrollment period described in 42 CFR 435.212 and the State was paying their Part B premium before eligibility terminated. Once the State has received the Medicare Part B premium invoice, it will automatically make an electronic payment on behalf of the beneficiary.

24. **Title XXI Programs under the Demonstration.**

a) **Employer-Sponsored Insurance (ESI)**

i. **Eligibility.** Children who are eligible for KidsCare or KidsCare II whose family income is between 100 percent up to and including 200 percent of FPL, and who have access to a qualifying employer sponsored insurance (ESI) plan, as described in (iv) and (v) below.

ii. **Enrollment Process.** Prior to enrollment in the ESI, children (either directly or through their parents or guardians) must specify that they are declining enrollment into KidsCare or KidsCare II and instead requesting enrollment in the ESI. Before such a request is accepted, the individual must receive information/counseling in order to ensure that enrollment is an informed choice. ESI enrollees will have the choice to opt back into direct coverage, if available, at any time.

iii. **Premium Assistance Benefits**: The State will subsidize premium assistance through a monthly per child subsidy that will not exceed the per capita cost of direct CHIP coverage for the child. This monthly subsidy does not need to be allocated between eligible and ineligible family members.

iv. **Minimum Employer Contribution.** Qualifying ESI must include employer contributions of at least 30 percent of the total premium or cost under the employer plan.

v. **Minimum Benefit package.** Qualifying ESI will include coverage that provides a basic primary care package of inpatient hospital services, outpatient services, laboratory and x-ray services, pharmacy services, and behavioral health services. Coverage may be provided through any commercial group package or self-insurance program offered by the employer to all employees in a class. Within these parameters, benefits may vary between employers. Wrap-around services are not provided.

vi. **Choice of ESI Plans.** To the extent that premium assistance is extended to individuals, the individuals must agree not to exercise choice among available ESI plans without obtaining State concurrence. The State will not, however, deny coverage based on a prior exercise of such choice.

vii. **Cost Sharing.** Enrollees in the ESI program will have cost sharing set by their employer-based coverage.

viii. **Enrollment Data.** Each quarter, the State will provide CMS with end of quarter actual and unduplicated ever-enrolled figures. These enrollment data will be entered into the Statistical Enrollment Data System within 30 days after the end of each quarter. The data will also be referenced in the quarterly reports described in paragraph 37. In addition, the State will provide monthly enrollment data as specified by CMS in the monthly Eligibility and Enrollment Reports.

b) **Kids Care II Program.** This program is authorized, subject to the available funding as specified in paragraph 25(i), from May 1, 2012 through December 31, 2013.

i. **Eligibility.** Targeted low-income children defined in 42 CFR 457.310 with family income from 100 percent of the FPL up to and including 200 percent of the FPL who are not otherwise eligible for Medicaid but are otherwise eligible for the Arizona CHIP State Plan, except for the enrollment cap and/ or waiting period.

ii. **Enrollment Process.** Eligible children will enroll into the KidsCare II program as outlined in the sub-paragraphs below. Attachment H provides further operational details with respect to the enrollment process.

1) **Children "Aging Out" of Medicaid.** Beginning April 6, 2012, the State will conduct an administrative renewal for a child turning age 6 to determine if the child is eligible for Medicaid under a different eligibility category, or if the child is eligible for the KidsCare II program. If the child is no longer eligible for Medicaid, the State will automatically transfer the child from the AACP program into the KidsCare II program if they meet KidsCare II eligibility requirements. These children will remain enrolled if otherwise eligible, until the KidsCare II program ends on December 31, 2013, at which time they will seamlessly transition to other forms of coverage. These children are not subject to the waiting list as described in subparagraph (vi) below, and will continue to be automatically transitioned to KidsCare II.

2) **KidsCare Waiting List**. Families with children on the KidsCare waiting list who are notified by the State will have the opportunity to apply for the KidsCare II program. In order to be determined eligible for KidsCare II coverage, children must have income at or below200 percent of the FPL, and have no outstanding KidsCare premiums and must meet all other eligibility requirements. KidsCare premiums must be paid before a child can enroll in the KidsCare II program. Once

determined eligible, a child will remain in the KidsCare II program if otherwise eligible until the program ends on December 31, 2013.

3) **Open Enrollment**. Subject to available program funding and notification to all the families with children on the KidsCare waiting list as described above in subparagraph (2) and in Attachment H, the State will open enrollment to the KidsCare II program to all eligible children up to 19 years old with family income at or below 200 percent of the FPL. The State must notify CMS prior to opening enrollment, and must include a process by which it will notify the public, such as the use of public forums, tribal consultations, and community stakeholder meetings.

iii. **Enrollment Threshold.** Enrollment for the KidsCare II program is subject to the available funding provided by (a) the Safety Net Hospital Systems as specified in paragraph 25(i), in order to enroll a target number of 21,700 children, and (b) the City of Phoenix as specified in paragraph 25(j), in order to enroll a target number of 33,191 additional children. The State will seek to maintain full enrollment in the program. If the enrollment drops below 19,000 children, the State shall conduct additional outreach activities as outlined in Attachment H in order to increase enrollment.

iv. **Benefits.** Children enrolled in the KidsCare II program will be offered the same benefit package provided under Arizona's CHIP State plan.

v. **Cost Sharing.** Children in the KidsCare II program will be subject to cost sharing requirements, including monthly premiums, specified in Arizona's CHIP State Plan. Cost sharing for children in KidsCare II must meet the same requirements as those for children receiving coverage under the CHIP State plan, consistent with the requirements at section 2103(e). Cost sharing for families at or below 150 percent of the Federal poverty level (FPL), must be "nominal" in accordance with 42 CFR 457.540 - 457.555and total charges may not exceed 5 percent of the family's income for children of all income levels, in accordance with 42 CFR 457.560.

vi. **Wait List.** Upon reaching the target enrollment of 21,700 children, the state is authorized to maintain a wait list for the KidsCare II program. Children will be placed on the wait list in chronological order of the state's receipt of their application. The state will continue to conduct a Medicaid eligibility determination upon receipt of a KidsCare II application before placing the child onto the wait list. The state will monitor enrollment on a monthly basis in order to determine if enrollment has dropped to 19,000 children. Once enrollment has dropped to 19,000, or if enrollment has decreased by 3,000 in a single month, the state will notify families on the KidsCare II wait list, beginning with the oldest application, informing them to electronically verify the information the state has on file in its Health-e-Arizona system in order to

enroll into the KidsCare II program. If the application is less than two months old, the state will automatically approve the applicant for KidsCare II without requiring the family to re-verify their information on Health-e-Arizona. Subject to available funding and notification of all families on the KidsCare II wait list, the state will open enrollment to the KidsCare II program to all eligible children up to 19 years old with family income at or below 200 percent of the FPL.

Children "aging out" of Medicaid will continue to automatically transition from Medicaid into the KidsCare II program following the enrollment process set forth in subparagraph (ii)(1) and will not be subject to the wait list.

c) **Funding for Title XXI Programs.** The State will establish a monitoring process to ensure that expenditures do not exceed available title XXI funding (i.e., the title XXI allotment or reallocated funds) and the appropriated State match. The State will use title XXI funds to cover services for the CHIP, ESI and KidsCare II populations in the following priority order:

i. Title XXI State plan eligibles, as well as children that opt for ESI, who are children up to age 19 years with family incomes up to and including 200 percent of the FPL.
ii. KidsCare II program participants who are children up to age 19 years with family incomes above 100 percent of the FPL up to and including 175 percent of the FPL.
iii. If the State determines that title XXI funding will be exhausted, available title XXI funding will first be used to cover costs associated with the title XXI State plan population.

25. **Family Planning Extension Program.** Family planning and family planning related services are provided, for a period of up to 24 months, to eligible recipients who lose Medicaid pregnancy coverage at the conclusion of 60 days postpartum, and who are not otherwise eligible for Medicare, Medicaid, CHIP, or health insurance coverage that provides family planning services, and who have a family income at or below 150 percent of the FPL at the time of annual redetermination.

a) **Benefits.**

i. Family planning services and supplies described in section 1905(a)(4)(c) and are limited to those services and supplies whose primary purpose is family planning and which are provided in a family planning setting. Family planning services and supplies are reimbursable at the 90 percent matching rate, including:
   1) Approved methods of contraception;

2) Sexually transmitted infection (STI)/sexually transmitted disease (STD) testing, Pap smears and pelvic exams;
    i. Note: The laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs/STDs, blood count and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.
3) Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the State's provider enrollment requirements (subject to the national drug rebate program requirements); and
4) Contraceptive management, patient education, and counseling.

ii. Family planning-related services and supplies are defined as those services provided as part of or as follow-up to a family planning visit and are reimbursable at the State's regular Federal Medical Assistance Percentage (FMAP) rate. Such services are provided because a "family planning-related" problem was identified and/or diagnosed during a routine or periodic family planning visit. Examples of family planning-related services and supplies include[1]:
1) Colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit.
2) Drugs for the treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is identified/ diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered.
3) Drugs/treatment for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, where these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/ drugs may also be covered.
4) Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.

[1] For more information on which of these family planning-related services is covered, see the AHCCCS Medical Policy Manual at: http://ahcccsnew/shared/MedicalPolicyManual/MedicalPolicyManual.aspx?ID=policymanuals

5) Treatment of major complications arising from a family planning procedure such as:
    i. Treatment of a perforated uterus due to an intrauterine device insertion;
    ii. Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or
    iii. Treatment of surgical or anesthesia-related complications during a sterilization procedure.

b) **Primary Care Referral.** Primary care referrals to other social service and health care providers as medically indicated are provided; however, the costs of those primary care services are not covered for enrollees of this program. The State must facilitate access to primary care services for participants in the Family Planning Extension Program and must assure CMS that written materials concerning access to primary care are distributed to participants. The written materials must explain to the participants how they can access primary care services.

c) **Eligibility Re-determinations.** The State must ensure that redeterminations of eligibility for the Demonstration are conducted at least every 12 months. At the State's option, redeterminations may be administrative in nature. The State must notify CMS within the previous quarterly or annual report, described in STCs 38 and 39, if it chooses to utilize administrative redeterminations.

d) **Disenrollment.** If a woman becomes pregnant while enrolled in the Demonstration, she may be determined eligible for Medicaid under the State plan. The State must not submit claims under the Demonstration for any woman who is found to be eligible under the Medicaid State plan. In addition, women who receive a sterilization procedure and complete all necessary follow-up procedures will be disenrolled from the Demonstration.

## VI. Funding Pools and Payments under the Demonstration.

26. **Safety Net Care Pool (SNCP).** Payments from this pool will assist hospitals and other eligible providers that have high levels of uncompensated care related to medical assistance provided to Medicaid eligibles or to individuals who have no source of third party coverage. In each Demonstration Year (DY), the annual SNCP will be distributed to each provider based on its proportionate share of projected uncompensated care (based on prior period data). Furthermore, payments to each provider in each DY will be subject to a limit computed based on the provider's uncompensated care costs incurred for a 12-month period covered by the DY, except in DY 3 where the limit will be computed based on uncompensated care costs incurred up to December 31, 2013. The total computable amount for the SNCP is $332 million per DY for eligible uncompensated care costs of providers identified in sections A through C of Attachment J (Safety Net Hospital Systems), and $385 million per DY beginning with DY 2 for eligible uncompensated care costs of providers identified in section D of Attachment J (City of Phoenix Hospitals). Any unspent cap amount cannot be transferred to the following DY in order to increase the annual cap amount.

a) **SNCP Payments.** Funds may be used to assist providers with high levels of uncompensated care related to medical services that meet the definition of "medical assistance" contained in section 1905(a) of the Act, that are provided to Medicaid eligible or uninsured individuals incurred by hospitals, clinics, or by other provider types, as agreed upon by CMS and the State and identified in Attachment J. Expenditures must be claimed in accordance with CMS-approved claiming protocols in Attachment I for each provider type. FFP claiming for payments made from the SNCP will begin upon CMS approval of the claiming protocol as identified in sub-paragraph (c). For any provider receiving SNCP payments, the total Medicaid payments, Disproportionate Share Hospital (DSH) payments, SNCP payments, and any other payments for medical services furnished to Medicaid eligible and uninsured individuals cannot exceed the actual cost of providing services to Medicaid eligibles and the uninsured as defined in the claiming protocol. SNCP payments will be made directly from the State to the eligible providers as defined in subparagraph (d), who incurred uncompensated care costs.

b) **Prohibited Use of SNCP Funds.** SNCP funds cannot be used to pay for costs associated with non-emergency services provided to non-qualified aliens. The State must develop a methodology as part of the claiming protocol to exclude such costs from eligible uncompensated care costs.

c) **Uncompensated Care Cost Limit** The aggregate amount of SNCP payments made to Safety Net Hospital Systems and their affiliated providers pursuant to sections A through C of Attachment J will not exceed the SNCP amount of $332 million per DY (the "Safety Net Hospital System Limit"). The aggregate amount of SNCP payments made to the City of Phoenix High Uncompensated Care Hospitals and their affiliated providers pursuant to section D of Attachment J will not exceed the amount of $385 million per DY (the "Phoenix Hospital Limit"). The annual SNCP payment distributed to each individual provider will not exceed its uncompensated care costs for providing section 1905(a) medical services to Medicaid eligible and uninsured individuals for the period.

The State must submit to CMS for approval and incorporation into Attachment I a claiming protocol for each provider type to provide for the computation of a provider's uncompensated care costs. No FFP is available for SNCP payments until the associated claiming protocol is approved by CMS. Such protocols must take into consideration:

i. The cost reporting tool (i.e., the CMS-2552 cost report for hospital providers, and other cost reports for non-hospital providers as approved by CMS) to be used to determine a provider's allowable patient care costs, consistent with Medicare cost principles and OMB Circular A-87, for a specific service period.

ii. A methodology to apportion allowable patient care costs to Section 1905(a) services furnished to Medicaid eligible and uninsured individuals.

iii. An offset of all payments received for the services furnished to Medicaid eligible and uninsured individuals, including all Medicaid payments, third party payments, and payments by or on behalf of the patients, to arrive at the provider's uncompensated care cost.

iv. A carve-out of costs associated with non-emergency services provided to non-qualified aliens, which is a prohibited use of SNCP funds.

v. A payment methodology to allow the State to distribute SNCP payments to providers based on projected uncompensated care costs.

vi. Reconciliations of payments to the provider's uncompensated care cost limits as computed based on the provider's as-filed and finalized cost reports for the actual service period.

The uncompensated care cost limit is computed and SNCP payments are made on a DY basis. To the extent that a provider's cost reporting period does not coincide with the DY, the cost protocol will provide for an allocation of uncompensated care costs to the DY.

Any SNCP payments made in excess of the individual provider's uncompensated care cost limit for a demonstration period will be recouped from the provider, and the Federal share of the overpayment will be returned to CMS.

d) **Eligible Providers.** The eligible providers for SNCP payments are those identified in Attachment J. The State must seek prior approval from CMS to amend the list of eligible providers. The State must also submit to CMS for review and approval any additional claiming protocol needed due to the expansion of the eligible provider list.

The State will consider providers which meet the following criteria for SNCP participation:

i. Safety Net Hospital Systems which are defined as the health systems in each of the State's two largest metropolitan statistical areas that (a) are providing the highest percentage of care (measured in terms of discharges) within their MSA for adult AHCCCS and low-income uninsured patients and (b) sponsor multiple adult residency programs.

ii. Rural Hospitals which are defined as (a) Arizona hospitals that are not in Pima or Maricopa Counties; or (b) Arizona hospitals that are in counties of 500,000 or fewer persons.

iii. Critical Access Hospitals, which are defined as rural community hospitals that meet defined criteria outlined in the Conditions of Participation at 42 C.F.R. 485, Subpart F and 42 C.F.R. 440.170(g).

iv. Hospitals that qualify for a disproportionate share hospitals (DSH) payment as outlined in Attachment D.

v. City of Phoenix High Uncompensated Care Hospitals which are certain acute care hospitals located within the City of Phoenix as identified in Attachment J.

vi. Any provider affiliated with the hospitals outlined in the above subparagraphs (i-v).

e) **DSH and SNCP.** All applicable inpatient hospital and outpatient hospital SNCP payments received by a hospital provider must be included as offsetting revenue in the State's annual DSH audit reports. Hospitals cannot receive total payments, including DSH and SNCP payments, related to inpatient and outpatient hospital services furnished to Medicaid eligible and uninsured individuals that exceed the hospital's total eligible inpatient hospital and outpatient hospital uncompensated care costs.

**f) Intergovernmental Transfers (IGTs).** The non-Federal share of the SNCP payments will be funded by IGTs by eligible governmental entities, which may include IGTs derived from permissible provider taxes levied by a local government. The State will submit to CMS for review and approval all IGT agreements to ensure compliance with Section 1903(w)(6)(A) of the Act and Part X of these STCs. Such agreements should specify the amount and source of the IGT money, including funds to provide the non-federal share of expenditures for KidsCare II beneficiaries referenced in subparagraph (i) and AHCCCS coverage for adults referenced in subparagraph (j). The agreements shall ensure that the IGT is not derived from an impermissible source, including recycled Medicaid payments, Federal money precluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. The agreements shall also ensure that providers will retain the SNCP payments.

**g) Annual Reporting Requirements for SNCP Payments**. The State will submit to CMS an annual report specifically related to the amount of payments made from the SNCP per DY. The reporting requirements are as follows:

Within ninety (90) days after the end of each DY, the State shall provide the following information to CMS:

1) Actual SNCP payments to each provider for each DY, including the interim payments and any reconciliation payments;

2) The uncompensated care cost limit computed for each provider for each DY, including the projected uncompensated care costs used for interim payment

purposes, the uncompensated care costs based on the as-filed cost reports, and the uncompensated care costs based on the finalized cost reports.

h) **SNCP Designated State Health Program (DSHP**). In addition to the $332 million uncompensated care cost payments outlined above, the State may claim FFP for the Trauma and Emergency Services Fund Payments as authorized by Arizona State Proposition 202 for DY 1 and DY 2. The total program amount eligible for FFP cannot exceed $20 million total computable per DY, and expenditures must be claimed in accordance with a CMS-approved claiming protocol. Claiming of FFP cannot begin until the protocol is approved by CMS and incorporated into Attachment I. Any unspent funds cannot be transferred to the following DY in order to increase the annual amount.

i) **Contribution to the KidsCare II Program.** The eligible governmental entities in subparagraph (f) funding the non-federal share of SNCP payments to Safety Net Hospital Systems identified in sections A through C of Attachment J will provide IGTs to fund the non-federal share of KidsCare II Program expenditures for 21,700 children, estimated at up to $76,991,169 total computable. In addition, the eligible governmental entities in subparagraph (f) funding the non-federal share of SNCP payments to City of Phoenix providers identified in section D of Attachment J will provide IGTs to fund the non-federal share of KidsCare II Program expenditures for an additional 33,191 children estimated at up to $64,361,700 total computable.

j) **Contribution to AHCCCS Coverage Expansion for Certain Adults without Dependent Children**. The eligible governmental entities in subparagraph (f) funding the non-Federal share of SNCP payments to City of Phoenix providers will provide IGTs to fund the non-federal share of AHCCCS expenditures described in 17(b)(iii) for the projected 13,000 adults that will lose Medicaid eligibility under 1931 state plan authority due to lack of a dependent child, estimated at up to $43,063,000 total computable.

27. **Payments to IHS and 638 Facilities.** The State is authorized under the expenditure authorities of this Demonstration to make payments to IHS and tribal 638 facilities that take in to account their uncompensated costs in furnishing specified types of care furnished by IHS and tribal 638 facilities to Medicaid-eligible individuals and other individuals with family income at or below 100 percent of the FPL.

Facilities will have the option to elect one of two approved methodologies, as further outlined in Attachment K, to calculate and receive payment for their uncompensated care costs. The facilities will notify AHCCCS of their selection by April 30, 2012, and will have the option to switch their methodology election only once. If a facility elects to switch the methodology by which their uncompensated care payment is calculated, the facility must notify the State by December 15, 2012. The new methodology will be utilized to calculate the facility's uncompensated care payment effective January 1, 2013.

## VII. DELIVERY SYSTEMS

28. **Contracts.** All contracts and modifications of existing contracts between the State and MCOs must be prior approved by CMS. The State will provide CMS with a minimum of 30 days to review and approve changes.

## VIII. EVALUATION

29. **State Must Separately Evaluate Components of the Demonstration.** As outlined in subparagraphs (a) - (e) the outcomes from each evaluation component must be integrated into one programmatic summary that describes whether the State met the Demonstration goal, with recommendations for future efforts regarding all components. The evaluation must outline and address evaluation questions for all of the following components:

    a) **Evaluation Design Plan.** The State must submit to CMS for approval a draft evaluation design no later April 1, 2012. At a minimum, the draft design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those outlined in subparagraphs (c) and (d), as well as those that focus specifically on the target populations within the Acute Care, ALTCS, ESI program and the Family Planning Extension Program within the demonstration. The draft design plan must also include a separate section discussing the AACP cost sharing, the missed appointment fee evaluation requirements, the uncompensated care payments to IHS and 638 facilities and the CRS and SMI integration programs as described further in subparagraphs (c) - (f). The draft design shall discuss the outcome measures that must be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes (Attachment C – Evaluation Design Guidelines). The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration are isolated from other initiatives occurring in the State.

    The State must submit a revised draft evaluation design plan by April 1, 2013, in order to include the specific hypotheses outlined in subparagraph (e).

    b) **ESI Evaluation**. Arizona must conduct an evaluation of the ESI demonstration as described in paragraph 24(a). The State shall report on its progress in the quarterly and annual reports. AHCCCS will monitor the private insurance market as it relates to the ESI program (e.g., changes in employer contribution levels, trends in sources of insurance, etc.). AHCCCS will also continue to monitor substitution of coverage (i.e., participants dropping private coverage to enroll in the Demonstration).

    c) **AACP Cost Sharing Evaluation.** Arizona must conduct an independent

evaluation of the AACP cost sharing requirements as described in paragraph 17(d). The evaluation must test the following specific hypotheses related to the mandatory copayments assessed on the adults without dependent children population:

i. How will utilization of needed preventive, primary care, and treatment services be affected;
ii. To what extent will the imposition of the pharmacy co-payments and copayments related to non-emergent use of emergency rooms ensure appropriate utilization of emergency room care and appropriate utilization of cost and clinically effective generic and brand name drugs; and
iii. Will the mandatory co-payments affect State and federal expenditures (per enrollee) in the short and long term; and
iv. Will there be an impact on physician participation, or physician willingness to accept appointments from the adults without dependent children population.

Methods by which the State can evaluate these hypotheses include evaluating the relative utilization of, and access to, services provided to the adults without dependent children population compared to a similar population of parents (who are not subject to the copayment requirements), as well as, comparing selected access, utilization and quality indicators, across the pre-copayment adults without dependent children population with those of the post-co-payment adults without dependent children population, as well as across the adults without dependent children populations Measures could include examining the impact of the copayments on rates of emergency department utilization, rates of inpatient readmission, and selected evidence-based measures indicating management of chronic conditions (such as diabetes and asthma).

In addition, the State will evaluate how the NEMT copayment on adults without dependent children residing in Maricopa and Pima counties has affected access compared to the same population residing in all other counties.

Finally, the State shall report on the evaluation's progress in the State's quarterly and annual reports.

d) **Permissible Provider Fee for Missed Appointments Evaluation.** The state must submit an independent evaluation of the missed appointment fee on the TANF parents and adults without dependent children residing in all counties except for Maricopa and Pima counties that was in effect from October 22, 2011 through January 1, 2013. . In addition to the other hypotheses that the state has developed to test this fee, the state must evaluate the following to determine the fee's impact on:

i. Reducing the number of missed appointments;
ii. Beneficiaries seeking more care from walk-in clinics, urgent care centers, and/or emergency rooms, and any resulting impact on costs;
iii. Denial of service as a result of the fee;
iv. Subgroups within the adults without dependent children population, i.e., were there variations by income level, age, gender, etc.;
v. Program integrity;
vi. Compliance with the provisions for missed appointment fees;
vii. Administrative feasibility and cost to the provider; and
viii. The rate of missed appointment fees assessed by provider type and region of the state.

e) **Uncompensated Care Payments to IHS and 638 Facilities.** Arizona must conduct an independent evaluation of the uncompensated care payments provided to IHS and 638 facilities as described in paragraph 27 and Attachment K. The evaluation must test the following specific hypotheses related to the uncompensated care payments:

i. What is the effect on service utilization as a result of the uncompensated care payments broken down by type of service as well as the population served?
ii. Are the affected facilities able to maintain and/or increase their current staffing levels?

Methods by which the state can evaluate these hypotheses include evaluating staffing levels as well as the relative utilization of, and access to, services provided to adults pre-uncompensated care payment period to services with those of the post-uncompensated care payment period. Measures could include examining selected evidence-based measures indicating management of chronic conditions (such as diabetes and asthma).

f) **Integration of Physical and Behavioral Health Services for the CRS and SMI populations.** Arizona must contract with an independent evaluator in order to conduct an evaluation of the integration of physical and behavioral health services for the CRS and SMI populations as described in paragraphs 19 and 20. The evaluation will focus on two components – integration of care and health outcomes. As part of the state's revised evaluation design plan, as specified in subparagraph (a), the state must use baseline data from October 1, 2012 through September 30, 2013, and must begin the evaluation of the integration projects by October 1, 2013. The state must submit to CMS a written report of its finding no later than March 31, 2016.

i. Integration of Care. This component of the evaluation must test the following hypotheses as they relate to both populations affected by the integration projects:

1) Did this care model provide the same or an improved level of physical and behavioral health care quality as non-integrated care model? Health care quality includes improved access, utilization, health care outcomes and patient experience.

2) Did this care model improve how physical and behavioral health is integrated for the target population in a way that is different than the care they would have received if they had remained in the traditional care model?

The baseline period, as reflected in the revised evaluation design, must include information detailing the characteristics of the fragmented delivery system that is being replaced with the integrated system of care, such as the prevalence of multiple care plans, the number of primary care provider not connected with case managers, the number of duplicated tests and/or treatment, and the number of beneficiaries making and keeping appointments post discharge.

ii. Health Outcomes. This component of the evaluation will broken down by each target population.

1) CRS Population. The evaluation must test the following specific hypotheses related to the integration of services for the CRS population:

a. What is the effect on health outcomes as a result of the integration of services, including but not limited to improving:

i. Emergency department visit rates with a primary diagnosis of asthma;

ii. Hospital readmissions rates with a primary diagnosis of asthma diabetes, congestive heart failure and behavioral health as well as all-cause hospital readmissions rates.

b. How will the integration of services affect access to care and the utilization of needed preventive, primary care, and treatment services, such as immunization rates?

c. For foster children enrolled in the CRS integrated plan, how will the integration of services improve the appropriateness of prescribing patterns and utilization of psychotropic prescription drugs?

2) SMI Population. The evaluation must test the following specific hypotheses related to the integration of services for the SMI population in Maricopa county:

a. Did the integration project improve care coordination for the target population (as measured by patient experience improved access to specialty care, appropriate medications, etc.)?

b. Does the integration of services result in an increase in access to and utilization of primary and specialty care?

c. What is the effect on health outcomes as a result of the integration of services, including but not limited to improving chronic disease management, diabetes and cardiovascular conditions such as congestive heart failure?

d. How is this model providing more appropriate care for this population as measured by: inpatient utilization for asthma, congestive heart failure and COPD conditions; hospital readmissions with a primary diagnosis of asthma, diabetes, congestive heart failure and behavioral health as well as all-cause hospital readmissions; and emergency room visits with a primary diagnosis of asthma and diabetes, broken down by diagnosis?

Measures by which the state can evaluate these hypotheses include, but are not limited to, primary care and preventive services utilization (as applicable), emergency room utilization, inpatient hospital utilization and rate of readmissions, screenings and testing associated with diabetes, cardiovascular disease, and HIV/AIDS. In addition to the above measures, the state must use data from beneficiary satisfaction surveys and grievance and appeals data to assist in the evaluation. As the demonstration progresses, the state may include additional measures and data sources working in coordination with CMS, such as body mass index assessments and integration of electronic health records as penetration increases.

30. **Final Evaluation Design and Implementation.** CMS must provide comments on the draft design, within 60 days of receipt, and the State must submit a final design within 60-days of receipt of CMS comments. The State must implement the evaluation design, and submit to CMS a draft of the evaluation 120 days after the expiration of the demonstration. CMS shall provide comments within 60 days of receipt of the draft evaluation. Within 60 days of receipt of comments from CMS, a revised final report must be submitted.

31. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the Demonstration, the State must fully cooperate with Federal evaluators' and their contractors' efforts to conduct an independent, federally funded evaluation of the Demonstration program.

## IX. GENERAL REPORTING REQUIREMENTS

32. **General Financial Requirements.** The State shall comply with all general financial requirements under title XIX and title XXI.

33. **Reporting Requirements Relating to Budget and Allotment Neutrality.** The State

shall comply with all reporting requirements for monitoring budget and allotment neutrality set forth in this Agreement.

34. **Budget Neutrality Information.** For each quarter, the State will correctly report expenditures and member months that are subject to budget neutrality. Where data are incorrect and upon the request of CMS, the State must submit corrected budget neutrality data.

35. **Monthly Calls.** CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost sharing, employer-sponsored insurance progress, family planning issues, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, health plan financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers, or State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

36. **Monthly Childless Adult Enrollment Reports.** As required in the July 1, 2011, childless adult phase-out plan (Attachment A), the State must submit a monthly enrollment report for the childless adult populations by the 15th of each month until December 31, 2013. The enrollment report must contain the following:

    a) Population, including the percent change from the previous month;

    b) Beneficiaries transferred from the childless adult eligibility category to the SSI-MAO eligibility category;

    c) Beneficiaries who did not meet the SSI-MAO eligibility requirements and were transferred back to the childless adult eligibility category; and

    d) Beneficiaries who were transferred to the SSI-MAO eligibility and were discontinued because they did not comply with the State's redetermination requirements.

37. **KidsCare II Monthly Reports.** The State must submit a monthly report for the KidsCare II population by the 15th of each month until December 31, 2013. The monthly report must contain the following the information:

    a) **Enrollment.** The monthly report must contain the following enrollment information broken down by the number of children enrolled through the application process and the number of title XIX children transferred from the AACP:

        i. Number of children newly enrolled in KidsCare II;

ii. Number of children enrolled to date; and
iii. Current enrollment at end of each quarter with an annual total.

b) **Applications.** Of the total number of families who received notices, the number of children applying with a breakdown of the number who are eligible for Medicaid, eligible for KidsCare II and those that are ineligible for KidsCare II.

For those determined to be ineligible for KidsCare II, the reason for ineligibility, including, but not limited to following reasons:

i. Over income limit;
ii. Did not pay outstanding KidsCare premiums; and
iii. Did not provide required documentation during application process.

c) **KidsCare II PCAP Dedicated Hotline.** This section of the monthly report must contain the following information:

i. Number of calls;
ii. Where did callers hear about the helpline? (letter, TV/radio/newspaper, family/friend, community organization);
iii. Number of callers who said they received a notice;
iv. Number of callers for whom address must be updated;
v. Number of callers referred to subscriber for application assistance;
vi. Number of calls in other categories; and
vii. Time of day helpline most busy.

38. **Quarterly Reports.** The State shall submit progress reports in a format agreed upon by CMS and the State no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports shall include, but not be limited to (Attachment B – Quarterly Report Guidelines):

a) A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, enrollment, quality of care, access, health plan financial performance that is relevant to the Demonstration, the benefit package, and other operational issues, including the transition of SMI and CRS individuals;

b) Action plans for addressing any policy and administrative issues identified;

c) The quarterly reports must also include at least enrollment data, member month data, and budget neutrality monitoring tables;

d) The number of IHS and 638 facilities receiving uncompensated care payments, broken down by the methodology selected in which the uncompensated care

payment is calculated as well as a discussion on how the payments are affecting the financial viability of the facilities, using metrics that the State will develop in consultation with IHS and tribal programs, and the impact on service utilization broken down by type of service and by populations served.

e) The number of complaints and grievances filed on behalf of beneficiaries participating in the SMI and CRS integration projects, broken down by access to care, health plan and provider satisfaction.

f) The number of individuals enrolled in the Family Planning Extension Program at the end of the quarter, as well as the number of participants served during the prior quarter (participants include all individuals who obtain one or more covered family planning or family planning-related services through the Demonstration);

g) Notification of any changes in enrollment and/or participation to the Family Planning Extension Program that fluctuate 10 percent or more in relation to the previous quarter within the same Demonstration Year (DY) and the same quarter in the previous DY; and

Any issues which arise in conjunction with the Employer Sponsored Insurance (ESI) portion of the program, including but not limited to enrollment, quality of care, grievances, and other operational issues; and evaluation activities.

39. **Annual Report.** The State shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, the status of the collection and verification of encounter data and policy and administrative difficulties in the operation of the Acute Care, ALTCS, ESI, KidsCare II, SNCP/DSHP, IHS and 638 facilities uncompensated care payments, and Family Planning components of the Demonstration. The State shall submit the draft annual report no later than 120-days after the end of each operational year. Within 30-days of receipt of comments from CMS, a final annual report shall be submitted.

For the Family Planning Extension Program, the annual report must include the following:

a) The number of actual births that occur to Family Planning Extension Program participants (participants include all individuals who obtain one or more covered medical family planning services through the Family Planning Extension Program each year);

b) Total number of individuals enrolled at the end of the demonstration year;

c) Total number of participants enrolled at the end of the demonstration year; and

d) The average total Medicaid expenditures for a Medicaid-funded birth each year. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth up to age 1 (the services should be limited to the services

that are available to women who are eligible for Medicaid because of their pregnancy and their infants.)

40. **Transition Plan**. On or before July 1, 2012, the State is required to submit a draft, and incrementally revise, a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the Demonstration. This plan will address how the State plans to coordinate the transition of these individuals, including children enrolled in the KidsCare II program, to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The plan must contain the required elements and milestones described in paragraphs 40(a)-(f) outlined below. In addition, the Plan will include a schedule of implementation activities that the State will use to operationalize the Transition Plan.

a) Seamless Transitions: Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the State plans to obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the Demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. Specifically, the State must:

i. Determine eligibility under all January 1, 2014, eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL.

ii. Identify Demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014.

iii. Implement a process for considering, reviewing, and making preliminarily determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility.

iv. Conduct an analysis that identifies populations in the Demonstration that may not be eligible for or affected by the Affordable Care Act and the authorities the State identifies that may be necessary to continue coverage for these individuals.

v. Develop a modified adjusted gross income (MAGI) conversion for program eligibility.

b) KidsCare II Transition: The Plan must include the State's process to seamlessly transition children enrolled in the KidsCare II program to other forms of coverage once the program expires December 31, 2013. The State must include the

information outlined in subparagraph (a) as applied to the KidsCare II program.

c) Cost-sharing Transition: The Plan must include the State's process to come into compliance with all applicable Federal cost-sharing requirements, including the section 1916(f) requirements that apply to the adults without dependent children population when it becomes a mandatory State plan population on January 1, 2014.

d) Access to Care and Provider Payments and System Development or Remediation: The State should assure adequate provider supply for the State plan and Demonstration populations affected by the Demonstration on December 31, 2013. Additionally, the Transition Plan for the Demonstration is expected to expedite the State's readiness for compliance with the requirements of the Affordable Care Act and other Federal legislation.

e) Pilot Programs: Progress towards developing and testing, when feasible, pilot programs that support Affordable Care Act activities, such as the State's Medicare-Medicaid integration project to allow for more efficient and effective management of dually eligible ALTCS EPD beneficiaries.

f) Progress Updates: After submitting the initial Transition Plan for CMS approval, the State must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed.

g) Implementation:

i. By October 1, 2013, the State must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the Demonstration to Medicaid, the Exchange or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the State plan, the State will not require these individuals to submit a new application.

ii. On or before December 31, 2013, the State must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

41. **Final Report.** The State shall submit a final report pursuant to the requirements of section 1115 of the Act.

42. **Contractor Reviews**. The State will forward summaries of the financial and operational reviews that:

a) The Arizona Department of Health Services/ Behavioral Health Services (ADHS/BHS) completes on the Regional Behavioral Health Authorities (RBHAs).

b) The Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD) performs on its subcontracting MCOs.

c) The State will also forward summaries of the financial and operational reviews that AHCCCS completes on the Children's Rehabilitative Services Program (CRS) contractor; and the Comprehensive Medical and Dental Program (CMDP) at the Arizona DES.

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

44. **Contractor Disclosure of Ownership**. Before contracting with any provider of service, the State will obtain from the provider full disclosure of ownership and control and related party transactions, as specified in sections 1124 and 1902(a)(38) of the Act. No FFP will be available for providers that fail to provide this information.

## X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

45. **Quarterly Expenditure Reports.** Effective with the quarter beginning October 1, 2011, the State shall provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in this Agreement.

46. **Reporting Expenditures in the Demonstration**. The following describes the reporting of expenditures subject to the budget neutrality cap:

a) **Tracking Expenditures.** In order to track expenditures under this Demonstration, Arizona shall report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap shall be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this Demonstration), the adjustments should be reported on lines 9 or 10.C through 10.F, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is

defined below.

b) **Use of Forms**. For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the Demonstration, subject to the budget neutrality cap. The State must complete separate forms for the following categories:

i. AFDC/SOBRA
ii. SSI
iii. AC
iv. MED
v. ALTCS-DD
vi. ALTCS-EPD
vii. Family Planning Extension
viii. Uncompensated Care Payments to IHS and 638 Facilities
ix. SNCP/DSHP
x. DSH and Critical Access Hospital Payments (CAHP)**

**Critical Access Hospital Payments as defined in Attachment F

c) **Expenditures Subject to the Budget Neutrality Cap**. For purposes of section X, the term "expenditures subject to the budget neutrality cap" shall include all Medicaid expenditures except those as described below, on behalf of the individuals who are enrolled in this Demonstration. Expenditures excluded from this Demonstration and the budget neutrality cap are Direct Services Claiming program expenditures for Medicaid in the public schools, Breast and Cervical Cancer Treatment program expenditures, Freedom to Work program expenditures, and all administrative expenditures.

d) **Premium and Cost Sharing Adjustment**. Premiums and other applicable cost sharing contributions from enrollees that are collected by the State from enrollees under the Demonstration shall be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that the Demonstration is properly credited with premium collections, premium collections (both total computable and Federal share) should also be reported on the CMS-64 Narrative. The State should include these section 1115 premium collections as a manual adjustment (decrease) to the Demonstration's actual expenditures on a quarterly basis.

e) **Administrative Costs.** Administrative costs shall not be included in the budget neutrality limit. All administrative costs shall be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

f) **Claiming Period**. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be

made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

g) **Pharmacy Rebates.** The State may propose a methodology for assigning a portion of pharmacy rebates to the Demonstration. The proposed methodology must determine, in a way that reasonably reflects actual rebate-eligible pharmacy utilization, the amounts of rebate that are attributable to pharmacy utilization under the Demonstration *vs.* outside the Demonstration, and appropriate subtotals by EG and DY. The methodology (and any subsequent changes to the methodology) must be approved in advance by the CMS Regional Office prior to use. Rebate amounts assigned to the Demonstration must be reported on the appropriate Forms CMS-64.9 or 64.9P Waiver, and not on any other CMS-64.9 form (to avoid double-counting). In the absence of an approved methodology, all pharmacy rebates must be reported on Forms CMS-64.9 or 64.9P Base.

47. **Reporting of Member Months.** The following describes the reporting of member months in the Demonstration.

a) Member months subject to the budget neutrality cap include:

i. For the purpose of calculating the budget neutrality expenditure cap described in this Agreement, the State shall provide to CMS on a quarterly basis the actual number of eligible member months for:

1) Eligibility Group 1:AFDC / SOBRA
2) Eligibility Group 2: SSI
3) Eligibility Group 3: AC
4) Eligibility Group 4 ALTCS-DD
5) Eligibility Group 5: ALTCS–EPD
6) Eligibility Group 6: Family Planning Extension Program

ii. This information shall be provided to CMS 30 days after the end of each quarter as part of the CMS-64 submission, either under the narrative section of the MBES/CBES or as a stand-alone report.

iii. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member months.

iv. For the purposes of this Demonstration, the term "Demonstration eligibles" refers to all individuals covered by Arizona Medicaid with the exception of individuals in the Freedom to Work and Breast and Cervical Cancer Treatment programs

b) Demonstration Member Months subject to reporting on the CMS 64-Narrative includes the MED Group – described in paragraph 16 as:

i. MED - Individuals who applied for the MED program (under Expenditure Authority 20 of Demonstration project #11-W-00032/9 and #21-W-00009/9) prior to May 1, 2011 and were determined eligible for that population for a 6-month guaranteed eligibility period after that date, until the end of that 6-month period.

48. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

49. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the following, subject to the limits described in this Agreement.

a) Administrative costs, including those associated with the administration of the Demonstration;

b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan; and

c) Net expenditures and prior period adjustments made with dates of service during the operation of the Demonstration.

d) CMS shall provide FFP for family planning and family planning-related services and supplies at the applicable Federal matching rates described in STC 24(a)(i) and (ii), subject to the limits and processes described below:

i. For family planning services, reimbursable codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service;
ii. Allowable family planning expenditures eligible for reimbursement at the

enhanced family planning match rate, described in STC 24(a)(i), should be entered in Column (D) of the Forms CMS-64.9 Waiver.

iii. Allowable family planning-related expenditures eligible for reimbursement at the FMAP rate, as described in STC 24(a)(ii), should be entered in Column (B) on the Forms CMS-64.9 Waiver.

iv. FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. For example, in the instance of testing for STIs as part of a family planning visit, FFP will be available at the 90 percent Federal matching rate. The match rate for the subsequent treatment would be paid at the applicable Federal matching rate for the State. For testing or treatment not associated with a family planning visit, no FFP will be available.

v. Pursuant to 42 CFR 433.15(b)(2), FFP is available at the 90 percent administrative match rate for administrative activities associated with administering the family planning services provided under the Demonstration including the offering, arranging, and furnishing of family planning services. These costs must be allocated in accordance with OMB Circular A-87 cost allocation requirements. The processing of claims is reimbursable at the 50 percent administrative match rate.

50. **Medicare Part D Drugs.** No FFP is available for this Demonstration for Medicare Part D drugs.

51. **Sources of Non-Federal Share**. The State certifies that the source of the non-Federal share of funds for the Demonstration is State/local monies. The State further certifies that such funds shall not be used as the non-Federal share for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with Title XIX of the Social Security Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

a) CMS shall review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b) The State shall provide information to CMS regarding all sources of the non-Federal share of funding for any amendments that impact the financial status of the program.

c) Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as Demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State and/or local government to return and/or redirect any portion of the Medicaid or Demonstration payments. This confirmation of Medicaid and Demonstration payment retention is made with the understanding that payments that are the normal operating expenses of conducting

business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid or the Demonstration and in which there is no connection to Medicaid or Demonstration payments) are not considered returning and/or redirecting a Medicaid or Demonstration payment.

52. **Certification of Public Expenditures.** The State must certify that the following conditions for non-Federal share of Demonstration expenditures are met:

a) Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-Federal share of funds under the Demonstration.

b) To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

i. To the extent that Arizona institutes the use of CPEs, the requirements of this term and condition fully apply. The State is subject to any policy guidance or regulation released by CMS regarding the use of CPEs.

ii. The disproportionate share hospital (DSH) payment methodology for Arizona State Hospital (ASH) and the Maricopa Medical Center will be cost reimbursement and will utilize CPEs as the funding system. The methodology and the cost identification/reconciliation process, as approved by CMS, is included as an amendment to the DSH methodology in Attachment D.

c) To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration to non-governmental providers, the governmental entity appropriating funds to the provider must certify to the State the amount of such tax revenue (State or local) appropriated to the non-governmental provider used to satisfy demonstration expenditures. The non-governmental provider that incurred the cost must also provide cost documentation to support the State's claim for Federal match.

d) The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of

Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

53. **Applicability of Fee for Service Upper Payment Limits.** If expenditures (excluding expenditures for members enrolled with the Indian Health Service for inpatient hospital and long-term-care facility services, other institutional and non-institutional services (including drugs) provided to AHCCCS fee-for-service beneficiaries equal or exceed 5 percent of the State's total Medical Assistance expenditures, the expenditure authority will be terminated and the State shall submit a demonstration amendment that includes a plan to comply with the administrative requirements of section 1902(a)(30)(A). The State shall submit documentation to CMS on an annual basis that shows the percentage AHCCCS fee-for-service beneficiary expenditures as compared to total Medical Assistance expenditures.

54. **Fraud and Abuse Recoveries**: The State must improve fraud and abuse recoveries by:

    a) Submitting for CMS review an action plan by April 1, 2012, to enhance Medicaid fraud and abuse recoveries by the end of the Demonstration period ending September 30, 2016.

    b) Submitting to CMS an annual report of the State's implementation of its action plan as required in paragraph 38.

    c) Demonstrating by September 30, 2016, that its level of recoveries is equal to, or greater than, the level anticipated in the action report approved by CMS.

## XI. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

55. **Quarterly CHIP Expenditure Reports.** The State shall provide quarterly expenditure reports using the Form CMS-21 to report total expenditures for services provided to all Demonstration populations receiving title XXI funds under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS will provide FFP only for allowable Demonstration title XXI expenditures that do not exceed the State's available title XXI funding.

56. **Tracking CHIP Expenditures.** In order to track title XXI expenditures under this Demonstration, the State will report Demonstration expenditures, excluding KidsCare II, through the MBES/CBES, following routine CMS-21 reporting instructions. Title XXI Demonstration expenditures will be reported on separate Forms CMS-21 Waiver and/or CMS-21P Waiver identified by the Demonstration project number assigned by CMS

(including project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). Expenditures for the KidsCare II program will be reported on the CMS-21 with the state plan population in the MBES/CBES._Separate KidsCare II reporting will be provided in the CMS-21 Narrative using a proportion of KidsCare II to the total KidsCare population based on date of payments.

a) **CHIP Claiming.** All claims for expenditures related to the Demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the Form CMS-21.

b) **Standard CHIP Funding Process.** The standard CHIP funding process will be used during the Demonstration. Arizona must estimate matchable CHIP expenditures on the quarterly Form CMS-21B. On a separate CMS-21B, the State shall provide updated estimates of expenditures for the Demonstration population. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

c) **Sources of CHIP Non-Federal Share.** The State will certify State/local monies used as matching funds for the Demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law. All sources of non-Federal share of funding and distribution of monies involving Federal match are subject to CMS approval. Upon review of the sources of the non-Federal share of funding and distribution methodologies of funds under the Demonstration, all funding sources and distribution methodologies deemed unacceptable by CMS shall be addressed within the timeframes set by CMS. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding

57. **Limit on Title XXI Funding**. Arizona will be subject to a limit on the amount of Federal title XXI funding that the State may receive for Demonstration expenditures during the Demonstration period. Federal title XXI funding available for Demonstration expenditures is limited to the State's available allotment, including currently available reallocated funds. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the Demonstration until the next allotment becomes available.

58. **Compliance with Federal Rules.** All Federal rules shall continue to apply during the period of the Demonstration if title XXI Federal funds are not available and the State

decides to continue the program.

## XII. MONITORING BUDGET NEUTRALITY

59. **Monitoring Demonstration Funding Flows.** The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

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

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

60. **Limit on Title XIX Funding.** The State shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. The data supplied by the State to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

61. **Risk.** The State shall be at risk for the per capita cost (as determined by the method described below) for Demonstration eligibles under this budget neutrality agreement, but not for the number of Demonstration eligibles in each of the groups. By providing FFP for all Demonstration eligibles, the State shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing the State at risk for the per capita costs for Demonstration eligibles under this agreement, CMS assures that Federal Demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration.

62. **Demonstration Populations and Programs Subject to the Budget Neutrality Cap.** The following Demonstration populations are subject to the budget neutrality cap and are incorporated into the following eligibility groups:

a) Eligibility Group 1: AFDC / SOBRA

b) Eligibility Group 2: SSI

c) Eligibility Group 3: AC

d) Eligibility Group 4: ALTCS-DD

e) Eligibility Group 5: ALTCS–EPD

f) Eligibility Group 6: Family Planning Extension Program

g) Program Group 1: DSH

h) Program Group 2: Uncompensated Care Payments to IHS and Tribal Facilities

i) Program Group 3: SNCP/DSHP

j) Program Group 4: KidsCare II

63. **Budget Neutrality Expenditure Cap:** The following describes the method for calculating the budget neutrality expenditure cap for the Demonstration:

a) For each year of the budget neutrality agreement an annual budget neutrality expenditure cap is calculated for each eligibility group described in paragraph 61 as follows:

i. An annual eligibility group expenditure cap must be calculated as a product of the number of eligible member months reported by the State under paragraph 46 for each eligibility group, times the appropriate estimated per member per month (PM/PM) costs from the table in subparagraph (iii) below.

ii. The PM/PM costs in subparagraph (iii) below are net of premiums paid by Demonstration eligibles.

iii. The PM/PM costs for the calculation of the annual budget neutrality expenditure cap for the eligibility groups subject to the budget neutrality agreement under this Demonstration are specified below. In addition, the PM/PM cost for each eligibility group in DY 1 has been increased by the appropriate growth rate included in the President's Federal fiscal year 2012 budget for DYs 2, 3, 4 and 5, as outlined below. The AC and Family Planning Extension Program populations are structured as a "pass-through" or a "hypothetical State plan population" beginning in DY 1. Therefore, the State may not derive savings from these populations.

| Eligibility Group | Trend Rate | DY 1<br>FFY 2012 | DY 2<br>FFY 2013 | DY 3<br>FFY 2014 | DY 4<br>FFY 2015 | DY 5<br>FFY 2016 |
|---|---|---|---|---|---|---|
| **AFDC / SOBRA** | 5.2% | $585.28 | $615.71 | $647.73 | $681.41 | $716.85 |
| **SSI** | 6.0% | $885.41 | $938.53 | $994.84 | $1054.53 | $1117.81 |
| **AC** | 0.0% | $707.33 | $707.58 | $707.58 | $0 | $0 |
| **ALTCS - EPD** | 5.2% | $4737.37 | $4983.71 | $5242.86 | $5515.49 | $5802.30 |
| **ALTCS - DD** | 6.0% | $4922.38 | $5217.72 | $5530.78 | $5862.63 | $6214.39 |
| **Family Planning Extension Program** | 5.8% | $30.06 | $31.80 | $33.65 | $35.60 | $37.66 |

iv. The annual budget neutrality expenditure cap for the Demonstration as a whole is the sum of DSH allotment, the uncompensated care payments to IHS and tribal facilities, expenditures for the SNCP/DSHP and KidsCare II program plus the annual expenditure caps for each eligibility group calculated in subparagraph 62(a)(i) above.

b) The overall budget neutrality expenditure cap for the 5-year demonstration period is the sum of the annual budget neutrality expenditure caps calculated in subparagraph 62(a)(iv) above for each of the 5 years. The Federal share of the overall budget neutrality expenditure cap represents the maximum amount of FFP that the State may receive for expenditures on behalf of Demonstration populations and expenditures described in paragraph 48 during the Demonstration period.

c) Apply the effective FMAP, or enhanced 90 percent match for family planning services, that is determined from the MBES/CBES Schedule C report.

64. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State exceeds the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the DYs, the State must submit a corrective action plan to CMS for approval.

| Cumulative Demonstration Years | Cumulative Expenditure Cap Definition | Percentage |
|---|---|---|
| Year 1 | Budget neutrality expenditure cap plus Year 1 Budget Cap | 1.0 % |
| Year 2 | Combined budget neutrality expenditure caps plus Year 1 through 2 Budget Cap | 0.75 % |
| Year 3 | Combined budget neutrality expenditure caps plus Year 1 through 3 Budget Cap | 0.5 % |
| Year 4 | Combined budget neutrality expenditure caps plus Year 1 through 4 Budget Cap | 0.25 % |
| Year 5 | Combined budget neutrality expenditure caps plus Year 1 through 5 Budget Cap | 0.0 % |

65. **Exceeding Budget Neutrality.** If, at the end of this Demonstration period the overall budget neutrality expenditure cap has been exceeded, the excess Federal funds must be returned to

CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

## XIII. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

| **Date** | **Deliverable** |
|---|---|
| April 1, 2012 | Submission of draft Evaluation Design STC # 28(a) |
| July 1, 2012 | Submission of revised Evaluation Design STC # 28(a) |
| July 1, 2012 | Transition Plan. |
| March 1, 2013 | Submission of draft Evaluation Design STC # 28(a) |
| September 30, 2015 | Written Notice of State's Intent to Extend the Demonstration Under 1115 |
| March 31, 2016 | Complete Demonstration Extension Application (1115) and CRS and SMI Integration Evaluation Report (STC #28(f)) |
| January 1, 2017 | Submit Draft Evaluation Report - STC # 29 |
| March 1, 2017 | Final Evaluation Report - STC #29. Final Report - STC# 40. End of Demonstration Period. |
| **Monthly Deliverables** | Monthly call - STC# 34 |
| | Monthly Childless Adult Enrollment Report – STC # 35 |
| **Quarterly Deliverables** | Requirements for Quarterly Reports – STC # 37 |
| | Quarterly Budget Neutrality Reports – STC # 33 |
| | Expenditure Reports CMS 64 and CMS21 - STC# 44 and STC# 53 |
| | Member Months Report - STC# 46 |
| | SEDS Enrollment Data - STC# 23(h) |
| **Annual Deliverables** | Requirement for Annual Report - STC# 38 |
| | Requirement for annual HCBS Report on March 31st - STC# 20 (f)(iv) |
| | Comparison of Costs for the DES Interagency Agreement, including how any excess revenues are spent, and for ADHS/BHS. Both reports will be due by January 15 – STC # 58 (b) |

**Attachment A – Approved Childless Adult Phase-out Plan under Demonstration #11-W-0003/09 and 21-W-0009/9**

# Childless Adults Freeze Implementation Milestones
# Phase Out Plan and Corresponding Enrollment Freeze

## Effective July 8, 2011

### 1. Summary of Childless Adults

Childless adults is a waiver program for adults who have not been determined Medicaid eligible under a categorical link (aged, blind, disabled, pregnant, under 18 or parent of a deprived child). Childless adults have open ended eligibility with redeterminations every 12 months. An asset test is not required and they have income under 100% of the Federal Poverty Level (FPL).

Eligibility for the Childless Adult program is determined primarily by DES. DES also determines eligibility for Medicaid programs for children, pregnant women, families and the MED program.

AHCCCS determines eligibility for CHIP, long term care, aged, blind, disabled populations, the Breast and Cervical Cancer Treatment Program and Medicare Savings Programs. AHCCCS also determines eligibility under Medicaid programs for children, pregnant women, families and the Childless Adult program for family members of KidsCare (CHIP) eligible members.

As of March 1, 2011 AHCCCS had about 2,800 Childless Adults in KidsCare households. Although the KidsCare program has been frozen since January 1, 2010, AHCCCS still processes renewals and changes for the active KidsCare population and their families, sometimes resulting in applications for Childless Adults. When KidsCare was open to new enrollment, AHCCCS processed KidsCare and Medicaid applications for everyone in the household. Even though enrollment in KidsCare is now frozen, AHCCCS still manages the entire household, including any category of Medicaid under which a household member qualifies. AHCCCS processes the renewals for the entire household. KidsCare children who age out of KidsCare will be processed by AHCCCS for Childless Adult coverage.

Below is an example of a KidsCare household with AHCCCS Care parents:

| | | |
|---|---|---|
| Mother | no income | eligible for AC |
| Father | 3050.00 earnings | eligible for AC |
| Child 15 yrs old | no income | eligible for KidsCare |
| Child 6 yrs old | no income | eligible for KidsCare |
| Child 10 yrs old | no income | eligible for KidsCare |

- Total household income: $3050.00
- KidsCare income limit for family of 5: $4362.00
- The children are ineligible for SOBRA because of their share of their father's income but they are eligible for KidsCare.
- The mother and father are eligible for AHCCCS Care because when the father's income is allocated between the members, their share of the income is $610.00 which is under the $613.00 income limit.

**2. Applications submitted prior to 7/8/11**

Applications that are received prior to July 8, 2011 will be processed, even if DES or AHCCCS cannot complete the eligibility determination until after July 8, 2011. If household members meet all eligibility requirements, before July 8, 2011, they will be approved for Childless Adults, even if the determination cannot be made until after July 8, 2011. If household members do not meet eligibility requirements until July 8, 2011 or later, the household member will not be approved for Childless Adults.

**3. Potential Consumer Notices:**

- Notice #1: In the first week of July 2011, AHCCCS will notify all Childless Adult members that on July 8, 2011 enrollment into the Childless Adult program will be frozen. If they want to retain Medicaid coverage under the Childless Adult program they will need to comply with redetermination requirements and continue to meet the eligibility requirements for that program.

  The first group of Childless Adult members who are SMI, aged 65 and older, under age 65 and have Medicare, and AHCCCS Care members who have HIV/AIDS and have lost coverage for AHCCCS Care because they failed to comply with the redetermination will have been already transferred to SSI MAO before this notice is generated.

  See Attachment #1

- Notice #2: In the month of July 2011, AHCCCS will send a notice to all AHCCCS eligible members, who are not on MED or the Childless Adult program, explaining to all remaining populations that they are not impacted by the elimination of the MED program or the freeze of the Childless Adult Program.

  See Attachment #2

- Notice #3 Beginning June 28 2011, and every month thereafter, AHCCCS will notify all Childless Adults who are age 65 and older, and all Childless Adults, who are under age 65 and who have Medicare, that they are being transferred to the SSI MAO program. The SSI MAO program will not be frozen and SSI MAO staff will contact these individuals for a redetermination of their eligibility under SSI MAO rules.

  Every month AHCCCS will identify Childless Adults who are age 65 or older, or under age 65 and have Medicare, and transfer them to SSI MAO. AHCCCS will notify these individuals that they are being transferred shortly after their eligibility category has changed from AHCCCS Care to SSI MAO. This transfer will occur when the member turns 65, or when the member obtains Medicare if under age 65, and is not based on their redetermination date. AHCCCS will give these individuals the same redetermination date that they had in AHCCCS Care.

  See Attachment #3

- Notice #4: Beginning June 28, 2011, and every month thereafter, Childless Adults who lose coverage for the Childless Adult program, because they failed to comply with the redetermination process AND they have a diagnosis of HIV/AIDS and/or take antiretroviral drugs, will receive a notice that they are being transferred to the SSI MAO program. The SSI MAO program will not be frozen and SSI MAO staff will contact these individuals for a redetermination of their eligibility under SSI MAO rules. These individuals will be indentified every month and will be transferred to the SSI MAO program. They will be notified that they are being transferred to SSI MAO shortly after their eligibility category has changed from AHCCCS Care to SSI MAO. They will have a redetermination shortly after they are transferred since they failed to comply with their Childless Adult redetermination requirements.

  See Attachment #4

- Notice #5: Beginning June 28, 2011, and every month thereafter, AHCCCS will notify all Childless Adults, who are identified in the AHCCCS PMMIS system as Seriously Mentally Ill (SMI) by the Arizona Department of Health Services (ADHS), that they will be transferred to the SSI MAO program. The SSI MAO program will not be frozen and SSI MAO staff will contact these individuals for a redetermination of their eligibility under SSI MAO rules. Every month AHCCCS will identify Childless Adults who are seriously mentally ill and transfer them to the SSI MAO program. The timing of the transfer occurs upon a member's designation as being SMI. They will be notified that they are being transferred to SSI MAO shortly after their eligibility category has changed from AHCCCS Care to SSI MAO. We will give these individuals the same redetermination date that they had in AHCCCS Care.

See Attachment #5

- Notice #6: Childless Adults who lose coverage for the Childless Adult program (and they are not SMI, HIV/AIDS, over 65 or under 65 with Medicare), because they failed to comply with the redetermination process will receive a third and final notice from AHCCCS beginning June 25, 2011, and each month thereafter. The notice will tell them that they cannot get back into the Childless Adult program, but if they comply with redetermination requirements before the effective date of their discontinuance they can remain on AHCCCS Care.

See Attachment #6

- Notice #7: Childless Adults who lose coverage for the Childless Adult program (and they are not SMI, HIV/AIDS, over 65 or under 65 with Medicare), because they failed to comply with the redetermination process will receive a discontinuance notice from the eligibility agency. The notice will tell them that they cannot get back into the Childless Adult program, they can file an appeal if they believe the discontinuance was made in error, if they appeal timely they can request continued benefits and that they can reapply for AHCCCS (but not Childless Adults). If they reapply they will need to demonstrate that they have a categorical link, including: pregnancy, parent of a deprived child, disability, or being age 65 or older.

See Attachment #7

- Notice #8: Childless Adults whose redetermination is due by June 30, 2011 will receive a notice from AHCCCS in June letting them know that AHCCCS is planning to freeze Childless Adults effective July 1, 2011, pending approval from CMS. The notice will also let them know that if they do not comply with the redetermination process by June 30, 2011 they will lose AHCCCS coverage under the Childless Adult category and may not be able to get back onto AHCCCS, unless they are eligible under a categorical link such as: age 65 or older, blind, disabled, pregnant or the parent of a deprived child.

  This notice will also be sent in July to Childless Adults whose redetermination is due July 31, 2011, letting them know that AHCCCS will freeze enrollment for Childless Adults effective July 8, 2011, pending approval from CMS. The notice will also let them know that if they do not comply with the redetermination process by July 31, 2011, they will lose AHCCCS coverage under the Childless Adult category and may not be able to get back onto AHCCCS, unless they are eligible under a categorical link such as: age 65 or older, blind, disabled, pregnant

or the parent of a deprived child.

See Attachment #8

- Notice #9: Children who are aging out of the 1931, SOBRA Child, YATI (Young Adult Transitional Insurance for children 18-21 years old who aged out of foster care) and KidsCare programs will receive Notice #9 if they are aging out in the month in which their redetermination is due. The notice will advise them that if they comply with the redetermination requirements, they may be redetermined under the Childless Adults program. If they do not comply with the redetermination requirements, and their eligibility ends, they cannot apply for coverage under the Childless Adult program while enrollment is frozen.

  This notice will be sent June 22, 2011, and then every subsequent month. Additionally, the notice will be sent early in the month that the renewal is due. Note that Notice #9 is only triggered when an individual both ages out AND has a redetermination in the same month. This will occur each month for a small sub-set of children who are aging out of the 1931, SOBRA Child, YATI and KidsCare programs.

- Notice #10: Children who aged out of the 1931, SOBRA Child, YATI and KidsCare programs will receive Notice #10 to notify them that they have been determined eligible for Childless Adults, and that they will need to comply with the redetermination process in order to remain eligible. Children who age out will be transferred to Childless Adults at the time of their birth date, and will be notified shortly after their eligibility category has changed. They will keep their same redetermination date.

**4. Ex Parte Determinations and other Processes:**
**After 7-1-11 for Childless Adult Members Who Are No Longer Eligible as Childless Adults and for Children Aging Out of 1931, SOBRA Child, YATI and KidsCare**

- On June 28, 2011, and every month thereafter, any Childless Adult who is age 65 and older, or who is under age 65 and has Medicare, who is eligible as a Childless Adult for the following month will be transferred to the SSI MAO program and will be redetermined under that category. These members will be identified in our PMMIS system and their eligibility key codes will be changed from Childless Adult to SSI MAO-Aged or SSI MAO-Disabled. We have an automated process from PMMIS to post this change back into DES' AZTECS system and AHCCCS' ACE system to close the Childless Adult case. There will be no break in coverage

for these members. If they lose coverage for Childless Adults for any other eligibility reason, i.e., excess income, loss of residency, etc, they will not be moved to SSI MAO. AHCCCS and DES may become aware of these other reasons for losing eligibility for the Childless Adults program through a variety of means, such as, redetermination, self reporting (all Medicaid members are required to report changes in their circumstances), or PARIS updates (which is a data system that allows state Medicaid agencies across the country to share data regarding state residency and other issues).
AHCCCS will look for individuals who are age 65 and older, and for individuals under age 65 with Medicare every month subsequent to June 28, 2011. This process will ensure that individuals turning 65 or individuals under age 65 receiving Medicare are moved to SSI MAO. The same process described for June 28, 2011 will be followed each month. By transferring these individuals prior to our month end processing, we will get them into the correct capitation rate category prior to paying monthly capitation to our contractors for the following month.

These individuals will be scheduled for a redetermination based on their next redetermination due date for AHCCCS Care.

AHCCCS makes a file available monthly to all of its contracted health plans, Indian Health Services and 638 tribal contractors that identifies AHCCCS members with redeterminations due in the next 60 days. This file can be sorted by zip code and eligibility category.
The 270/271 eligibility and enrollment verification will include redetermination due dates for each member effective June 19, 2011. The 270/271 file is available on line (AHCCCS On Line), through Interactive Voice Response (a phone bank) and through batch processing. Batch processing allows the registered provider to access information on multiple members at one time. Batch processing will be updated effective October 1, 2011.

Members age 65 and older or under age 65 with Medicare, who are moved to SSI MAO and subsequently determined to be ineligible under the requirements for that program, will be returned to the Childless Adult program without a break in coverage.

- On June 28, 2011, and every month thereafter, any Seriously Mentally Ill (SMI) adult, who is eligible under the Childless Adult program for the following month will be moved into the SSI MAO program and will be redetermined under that category. If they lose coverage for Childless Adults for any other eligibility reason, e.g., excess income, loss of residency, etc, they will not be moved to SSI MAO. AHCCCS and DES may become aware of these other reasons for losing eligibility (e.g., excess income, loss of residency) for the Childless Adults program through a variety of means, such as, redetermination, self reporting (all

Medicaid members are required to report changes in their circumstances), or PARIS updates.

SMI members are identified by the Arizona Department of Health Services (ADHS) through their Regional Behavioral Health Authorities (RBHAs) and their behavioral health provider network. This information is posted in the AHCCCS PMMIS system.

AHCCCS will look for individuals who are SMI every month subsequent to June 28, 2011. This process will ensure that individuals diagnosed as SMI are moved to SSI MAO. The same process described for June 28, 2011 will be followed each month. By transferring these individuals prior to our month end processing, we will get them into the correct capitation rate category prior to paying monthly capitation to our contractors for the following month.

These individuals will be scheduled for a redetermination based on their next redetermination due date for AHCCCS Care. AHCCCS will share a listing of transferred SMI members who are due for renewal within 60 days with each Regional Behavioral Health Authority (RHBA) on a monthly basis. The RBHAs work with their providers; application assistor staff use Health-e-Arizona to complete the renewal application, including submission of any necessary documentation. Application assistors are individuals employed by a Health-e-Arizona facility who are trained in using the Health-e-Arizona product and helping individuals complete the application process. Using Health-e-Arizona will allow the RBHA providers to track and follow up with the renewal process, and ensure members have support in completing the process.

In addition, AHCCCS has reached agreement with the Disability Determination Service Administration (DDSA) to significantly streamline the process of collecting and submitting documentation for the disability determination, if one is required. Typically, the disability determination through DDSA requires a lot of documentation. AHCCCS is working with DDSA to allow RHBA providers to submit data that is essential to the disability determination directly to DDSA. This way, DDSA can coordinate with providers to obtain the required documentation rather than rely solely on the individual.

AHCCCS makes a file available monthly to all of its contracted health plans, Indian Health Services and 638 tribal contractors that identifies AHCCCS members with redeterminations due in the next 60 days. This file can be sorted by zip code and eligibility category.
The 270/271 eligibility and enrollment verification will include redetermination due dates for each member effective June 19, 2011. The 270/271 file is available on line (AHCCCS On Line), through IVR and through batch processing. Batch processing will be updated effective October 1, 2011.

SMI members who are moved to SSI MAO and subsequently determined to be

ineligible under the requirements for that program will be returned to the Childless Adult program without a break in coverage.

- Effective June 28, 2011, and every month thereafter, Childless Adults who have a diagnosis of HIV/AIDs and/or take antiretrovirals, and lose coverage under the Childless Adults program, because they did not comply with the redetermination process, will be moved into the SSI MAO program and will be redetermined under the rules of that category. If the adult with HIV/AIDS does not meet the requirements for SSI MAO, that individual's eligibility ends.

  Adults with HIV/AIDS, who are moved to SSI MAO, because they did not comply with the Childless Adult redetermination process, will not have a break in coverage when they are transferred from the Childless Adults program to SSI MAO.

  Adults with HIV/AIDS, who are moved to SSI MAO, will be scheduled for a redetermination as soon as possible, since they lost AHCCCS Care for failure to comply with the redetermination process.

  If the adult with HIV/AIDS loses coverage for Childless Adults for any other eligibility reason, i.e., excess income or loss of residency, they will not be moved to SSI MAO.

  AHCCCS will identify these individuals based on the diagnosis code of 042 and/or antiretrovirals for which there are encounters and claims in the PMMIS system. AHCCCS will look for these individuals every month before our month end processing, starting June 28, 2011.

  AHCCCS makes a file available monthly to health plans, Indian Health Services and 638 tribal contractors that identifies AHCCCS members with redeterminations due in the next 60 days. This file can be sorted by zip code and eligibility category.
  The 270/271 eligibility and enrollment verification will include redetermination due dates for each member effective June 19, 2011. The 270/271 file is available on line (AHCCCS On Line), through IVR and through batch processing. Batch processing will be updated effective October 1, 2011.

- Other Childless Adults who lose coverage because they did not comply with the redetermination process, will be advised by the eligibility agency using Notice #7 that they are no longer eligible for AHCCCS Care, that they can file an appeal if they believe their eligibility was discontinued in error and that they can apply for Medicaid, if they believe they are aged, blind, disabled, pregnant, or the parent of a deprived child. They will receive a final notification from AHCCCS using Notice #6 that their eligibility is ending and advising them to complete their renewal prior to the effective date of their discontinuance.

AHCCCS makes a file available monthly to health plans, Indian Health Services and 638 tribal contractors that identifies AHCCCS members with redeterminations due in the next 60 days. This file can be sorted by zip code and eligibility category.
The 270/271 eligibility and enrollment verification will include redetermination due dates for each member effective June 19, 2011. The 270/271 file is available on line (AHCCCS On Line), through IVR and through batch processing. Batch processing will be updated effective October 1, 2011.

- Children who are aging out of the 1931, SOBRA Child, YATI and KidsCare programs, and meet the qualifications for Childless Adults, can continue to be determined eligible for Childless Adults after the enrollment freeze is in effect. Children who have a redetermination due the month they are aging out of the 1931, SOBRA Child, YATI and KidsCare programs must comply with the redetermination process. If they do not comply with the redetermination, and as a result, lose coverage, and then reapply after the effective date of the discontinuance of their coverage, they cannot be determined eligible for Childless Adults.

  AHCCCS makes a file available monthly to health plans, Indian Health Services and 638 tribal contractors that identifies AHCCCS members with redeterminations due in the next 60 days. This file can be sorted by zip code and eligibility category.
  The 270/271 eligibility and enrollment verification will include redetermination due dates for each member effective June 19, 2011. The 270/271 file is available on line (AHCCCS On Line), through IVR and through batch processing. Batch processing will be updated effective October 1, 2011.

  DES and AHCCCS staff will automatically determine eligibility for children aging out of the 1931, SOBRA Child, YATI and KidsCare programs, who do not have a redetermination due. If DES and AHCCCS staff are unable to complete the eligibility determination for the child before the child ages out, the child will be transferred to Childless Adults and will remain eligible for Childless Adults if they meet all other eligibility criteria. The child's redetermination date will remain the same as it was under his or her previous eligibility category.

- Households are advised that they can submit a paper application or can use the Health-e-Arizona on line application at www.healthearizona.org.

- All households that have not submitted a renewal application by the second week of the renewal month receive an automated reminder call, if they have a phone number.

**5. Examples of Childless Adult Members:**

- **CASE SCENARIO 1 –** Childless Adult member is SMI and is transferred from the Childless Adult program to SSI MAO effective July 1, 2011. AHCCCS has a unique identifier for SMI members in our PMMIS system. This information is supplied by the Arizona Department of Health Services (ADHS), who is responsible for diagnosing and serving this population.

  Household consists of John Smith, age 55, who has been identified by the Department of Health Services as SMI.

  John earns $400 monthly. A notice is sent to John in June 2011 informing him that his eligibility has been transferred from the Childless Adult program to SSI MAO. John will be contacted by SSI MAO staff to complete a redetermination for that program, based on the redetermination date he would have had in Childless Adults.

  On November 1, 2011 an SSI MAO eligibility specialist tries to contact John to start the redetermination process. The Eligibility Specialist phones John and his phone has been disconnected. John is sent a redetermination notice to complete the redetermination process, and is informed that he has until January 31, 2012 to respond. The redetermination notice is returned by the U.S. Post Office as undeliverable. His SSI MAO eligibility is discontinued effective February 1, 2012. John is ineligible for SSI MAO.

- **CASE SCENARIO 2** – Childless Adult member fails to comply with the redetermination process after the freeze is in effect and is diagnosed with HIV/AIDs. (We will identify and track these individuals before they lose coverage)

  John earns $400 monthly. A notice requiring John to send a renewal application was sent to John on November 1, 2011. John was required to respond by December 31, 2011. No renewal application was received from John. His Childless Adult eligibility is discontinued effective January 1, 2012. But John is transferred to SSI MAO effective January 1, 2012 and will be contacted by SSI MAO staff to complete a redetermination for that program.

  John is sent a notice that he has been transferred to SSI MAO and that he will need to complete the redetermination process and meet the requirements for SSI MAO in order to remain eligible for that program.

  On February 1, 2012 an SSI MAO eligibility specialist telephones John to start

the redetermination process. The eligibility specialist then sends John a disability packet to complete and answers questions for John after he reviews it. John returns the requested information and the disability packet is sent to the DES Disability Determination Service Administration (DDSA).

On June 15, 2012 DDSA determines that John meets the requirements for disability and returns that information to the eligibility specialist. The eligibility specialist updates the eligibility system, ACE, with the DDSA information and completes the redetermination. John is eligible for SSI MAO.

- **Case Scenario #3 -** Childless adult member is age 66 on July 8, 2011 when the Childless Adult program is frozen. These members will be identified in our PMMIS system and their eligibility key codes will be changed from Childless Adult to SSI MAO-Aged.

  Household consists of John Smith, aged 66, who has been identified in our MMIS system as being over age 65.

  We change his eligibility category to SSI MAO aged in our PMMIS system and the system sends a message to the DES AZTECS system to discontinue his Childless Adult eligibility. We notify the SSI MAO Office to add him to the ACE eligibility system and conduct a redetermination based on the redetermination date he would have had in Childless Adults.

  On September 1, 2011 an SSI MAO eligibility specialist contacts John by telephone to start the redetermination process. John provides requested information by September 15, 2011 and the eligibility specialist updates the eligibility system, ACE with John's information and completes the redetermination. John is eligible for SSI MAO.

- **Case Scenario #4 –** Childless adult member fails to comply with the redetermination process after the freeze is in effect and is pregnant.

  Household consists of Jane Smith, age 35. Jane earns $400 monthly. A notice requiring Jane to send a renewal application was sent to Jane on November 1, 2011. Jane was required to respond by December 31, 2011. No renewal application was received from Jane.

  A discontinuance notice is sent to Jane on December 19, 2011 advising her that her Childless Adult eligibility will be discontinued effective January 1, 2012.

  The discontinuance notice advises Jane that she no longer qualifies for the Childless Adult program, but she can file an appeal if she feels this

discontinuance was made in error and advises her that she can reapply for AHCCCS. Her Childless Adult eligibility is discontinued effective January 1, 2012.

Jane reapplied for AHCCCS on January 5, 2012 and indicates that she is pregnant. An eligibility determination is made under SOBRA Pregnant Woman and on January 18, 2012 she is approved for AHCCCS effective January 1, 2012. Jane is eligible as a SOBRA Pregnant Woman.

- **Case Scenario #5: -** Childless adult member fails to comply with the redetermination process after the freeze is in effect and is disabled.

  Household consists of Jane Smith, age 35. Jane earns $400 monthly. A notice requiring Jane to send a renewal application was sent to Jane on November 1, 2011. Jane was required to respond by December 31, 2011. No renewal application was received from Jane.

  A discontinuance notice is sent to Jane on December 19, 2011 advising her that her Childless Adult eligibility will be discontinued effective January 1, 2012. No renewal application was received from Jane. The discontinuance notice advises Jane that she no longer qualifies for the Childless Adult program, but she can file an appeal if she feels this discontinuance was made in error and advises her that she can reapply for AHCCCS. The notice tells her that she will need a categorical link to AHCCCS such as pregnancy, disability, being the parent of a deprived child or being over age 65. Her Childless Adult eligibility is discontinued effective January 1, 2012.

  Jane reapplied for AHCCCS on January 5, 2012 and indicates that she is disabled. An application for SSI MAO is entered into the ACE eligibility system and Jane is asked to complete a disability determination packet. A disability determination is made by the DES Disability Determination Service Administration (DDSA) and Jane is determined to have a disability on April 1, 2012. Jane is approved for SSI MAO on April 10, 2012, effective January 1, 2012. Jane is eligible for SSI MAO.

- **Case Scenario #6:** Child ages out of SOBRA Child after the freeze is in effect.

  Household consists of Jane Smith, age 35 and Jimmy Smith, who turns age nineteen in August. Jane earns $775 monthly. Jimmy earns $500. Jimmy's scheduled redetermination under SOBRA Child is in March. An alert is generated in July notifying eligibility staff that Jimmy is turning 19. On July 25th, eligibility is redetermined for Jimmy using the most current information in the file.

Jimmy does not have a deprived, dependent child and is not disabled. He is determined eligible for the Childless Adult program effective September 1st without a break in coverage. Jimmy will receive Notice #10 informing him of his transfer to Childless Adults. Jimmy will then complete his redetermination under Childless Adults in March as scheduled. Jane remains eligible for the Childless Adult program.

**6. System Changes:**

- Changes to the Department of Economic Security AZTECS eligibility system: AZTECS will not approve Childless Adults for applications dated July 8, 2011 or later. It will approve Childless Adults for applications dated prior to July 8, 2011, if all eligibility criteria were met prior to July 8, 2011. AZTECS will generate Notice #7. It will allow children aging out of the 1931, SOBRA Child, and YATI programs to move into Childless Adults if they meet the eligibility requirements.

- Changes to the AHCCCS ACE eligibility system: ACE will not approve Childless Adults for applications dated July 8, 2011 or later. It will approve Childless Adults for applications dated prior to July 8, 2011, if all eligibility criteria were met prior to July 8, 2011. ACE will generate Notice #7. It will allow children aging out of the 1931, SOBRA Child, and KidsCare programs to move into Childless Adults if they meet the eligibility requirements.

- Changes to the AHCCCS PMMIS system: On July 8, 2011 PMMIS will stop accepting Childless Adults for eligibility effective July 8, 2011 or later. It will accept Childless Adults eligibility from children aging out of the 1931, SOBRA Child, YATI, and KidsCare programs. It will permit manual update of Childless Adults for cases closed in error. It will produce notices #1, #2, #3, #4, #5, #6, #8, #9 and #10.

  PMMIS will move members age 65 and older, and members under age 65 with Medicare to SSI MAO. PMMIS will post a file of those members in the DES AZTECS system and the AHCCCS ACE system to close their Childless Adult cases. PMMIS will produce a file of these members so they can be added into the ACE system as SSI MAO eligibles. AHCCCS will run this process every month effective June 28, 2011.

  AHCCCS will identify individuals from the PMMIS Claims and Encounters systems, who have a diagnosis code of 042 (HIV/AIDS) and/or who have a pharmacy claim or encounter for an antiretroviral. We will create an electronic file of these individuals monthly and run it against our PMMIS Recipient system monthly to ensure their Childless Adult cases remains active. If a future termination date is sent for these members, PMMIS can identify through the

coding if the case is being closed because they did not comply with the redetermination process. If it is, the member will be transferred to SSI MAO and scheduled for a redetermination, without a break in their coverage. AHCCCS will run this process every month, effective June 28, 2011.

AHCCCS will identify individuals from the PMMIS Recipient System, who have been identified as SMI. We will transfer all of these individuals to SSI MAO on July 1, 2011 and schedule them for a redetermination, without a break in their coverage. AHCCCS will run this process every month.

The 270/271 process for eligibility and enrollment verification will be updated to include redetermination dates for each member effective June 19, 2011. This process includes web based and IVR tools. Batch 270/271 will be updated effective October 1, 2011.

- Changes to the AHCCCS/DES Health-e-Arizona on line application and renewal system: Effective July 8, 2011 Health-e-Arizona will stop screening for Childless Adults.

**7. Eligibility Appeals:**

The Department of Economic Security has an Office of Appeals, which hears eligibility appeals for eligibility determinations made by DES employees. Eligibility appeals for eligibility determinations made by AHCCCS employees are heard by a separate agency, the Office of Administrative Hearings (OAH). Other than the two different offices the eligibility appeals process are essentially the same. Any differences are noted below.

If a Childless Adult loses eligibility for any reason, they have 30 calendar days from the date the decision notice is mailed to request an appeal of the decision. A request for appeal can be submitted either verbally or in writing. The member may request to withdraw the hearing request at any time.

Benefits will continue if the request for appeal is received within 10 calendar days from the date the decision notice is mailed. Benefits will not be continued if the action appealed is due solely to a change required by a change in federal or state law.

Within 7 days from receipt of the appeal request at DES and within 10 days at AHCCCS, the DES or AHCCCS eligibility office schedules a pre-hearing conference and sends copies of the budget calculations, income screens, notices, and case notes to the member. The conference may be conducted by telephone at the request of the member.

Within 10 calendar days of receipt of the appeal request, a DES or AHCCCS

supervisor reviews the results of the pre-hearing conference and documents in the appeal packet the accuracy of the eligibility decision.

When the pre-hearing conference may result in an informal resolution of the dispute at DES, a request to withdraw from the appeal is sent to the member. An informal resolution may happen when the decision is discussed with the member directly and the member agrees that the agency made the correct decision. A request to withdraw from the appeal is not sent to the member when the decision requires correction. When the review of the circumstances indicates that the case needs correction, DES sends the Request to Vacate and Remand (FAA-1389A) form to the Office of Appeals. The case is not corrected until a response is received from the Office of Appeals or the Office of Administrative Hearings that indicates that the matter was vacated and remanded to the local office for correction.

At AHCCCS, when the pre-hearing conference may result in an informal resolution of the dispute, a request to withdraw from the appeal is sent to the member. If a correction is needed, AHCCCS takes the action necessary to correct the adverse action being appealed. When the completed Voluntary Withdrawal from Appeal form is received, it is sent electronically to OAH with a request to vacate the appeal.

When a resolution is not reached during the pre-hearing conference, DES or AHCCCS continues processing the request for appeal.

Appeals are scheduled to allow for a decision to be rendered within 90 days from the request for appeal. Appeals are scheduled not fewer than 20, nor more than 45, calendar days from the date the request is filed. The member may request less than 20 calendar days notice in order to expedite the appeal.

Appeals may be conducted by phone when mutually agreed on by the member and the Office of Appeals for DES or the Office of Administrative Hearings for AHCCCS. The member is afforded the same rights as members who attend face-to-face hearings.

The member presents the facts and knowledge of the case, and has an opportunity to address witnesses, present evidence, advance arguments, refute testimony or evidence, and examine evidence introduced by any party at the hearing.

The Office of Appeals for DES or the AHCCCS Director, for AHCCCS appeals, notifies the member of the appeal decision. If the appeal decision is unfavorable to the member, he/she may request an appeals board review of the decision. If the Appeals Board decision is unfavorable to the member, he/she may request a Judicial Review of the Appeals Board decision.

For AHCCCS, OAH makes a written recommended decision within 20 days from the day of the hearing. The AHCCCS Director reviews the recommendation and issues a written decision to the member within 30 days. If the decision is unfavorable to the

member, the member may request a re-hearing.

Local eligibility offices are required to take action to implement all appeal decisions and remands within 10 days. Based on historical appeals data relating to changes in eligibility, copayments, etc., the State has seen a minimal increase in the number of appeals. Given the other elements in the phase out plan, such as specific community outreach, the ex parte process and exceptions made to target particular groups, DES does not expect a heavy influx of appeal requests. There is a significant amount of variation regarding total number of appeals received in any one month. Thus, DES is staffed in such a way as to deal with peak highs and lows.

Eligibility appeals are given priority and appeals from providers and others are secondary. Also, DES provides a quarterly report on number of hearing requests, number of decisions and timeliness that AHCCCS monitors. The State does not shift staff to address high/low peaks. The Arizona Office of Administrative Hearings conducts hearings on a number of different subjects, in addition to eligibility appeals. The State has a longstanding agreement that eligibility appeals are given priority. This agreement – that eligibility cases are a priority for the State to remain in compliance with federal law – is included in AHCCCS' Intergovernmental Agreement with the Office of Administrative Hearings. In the event that the State receives a significant increase of appeals in a given month, the State is aware of its responsibilities to process eligibility appeals timely and would appropriately allocate resources to that end.

**8. Other Communication:**

- Web
  - The AHCCCS website, www.azahcccs.gov will be updated continually to reflect program changes as decisions are made.
  - The Childless Adults phase out plan will be posted on the AHCCCS website, www.azahcccs.gov.
  - The AHCCCS website will provide opportunity for the public to electronically submit comment. Those comments will be posted on the website.
  - Information for members will be posted on the AHCCCS website member portal, www.azahcccs.gov/members, the Health-e-Arizona website, www.healthearizona.org and the DES website, https://egov.azdes.gov/dbme/faa/myFamilyBenefits.
  - Members can access information about the status of their eligibility at www.azahcccs.gov/members/myahcccs.
  - Providers can verify the status of member eligibility at https://azweb.statemedicaid.us/Home.asp.

- Legislative and Rule Making Process

- Should this plan require legislative action, it will go through the normal public process at the Legislature where there is public notice, a hearing and opportunity to be heard.
- Notice will also be published statewide through the Secretary of State and/or newspaper publication and a 30-day public comment period will be provided. Public comment can be submitted electronically via the AHCCCS website or by mail. Comments received electronically will be posted on the AHCCCS website.

- Providers/Health Plans

  - AHCCCS will distribute information regarding program changes to all of its contracted health plans.
  - Providers will receive information regarding program changes through the monthly AHCCCS electronic newsletter for providers, "Claims Clues."
  - The health plans will disseminate information as a component of their normal member outreach tools. AHCCCS health plans have community and provider relations staff that will be able to assist AHCCCS in its efforts to inform members and the public.
  - AHCCCS makes a file available monthly to health plans, Indian Health Services and 638 tribal contractors that identifies AHCCCS members with redeterminations due in the next 60 days. This file can be sorted by zip code and eligibility category.
  - The 270/271 eligibility and enrollment verification will include redetermination due dates for each member effective June 19, 2011. The 270/271 is available on line (AHCCCS On Line), through IVR and through batch processing. Batch processing will be updated effective October 1, 2011.

- Stakeholders/Community Partners

  - AHCCCS will send mass emails to stakeholders and community partners to notify them when the AHCCCS website has been updated with new information.
  - AHCCCS will distribute information about program changes to its Health-e-Arizona subscribers. Health-e-Arizona subscribers have 220 located across the state and are very dedicated to assisting people in applying for or renewing coverage. They will receive complete information about this phase out plan and how they can assist.
  - Although AHCCCS has already held tribal consultation on this matter, AHCCCS will ensure specific communication to the tribes, I.H.S. and 638 facilities and host any consultation or information session as needed. As a result AHCCCS has modified its monthly renewal file which provides the names of members whose renewal dates are due in the next 60 days. As of May 4, 2011 IHS and 638 contractors can sort this file by zip code and eligibility category.

- AHCCCS will work with the Health-e-Arizona Steering Committee to develop an outreach plan for AHCCCS Care households. The plan will include notification to community partners of the change to the AHCCCS Care program and ideas for assisting AHCCCS Care members. See Attachment #9
- In addition, AHCCCS will host two one-hour training sessions for community partners and stakeholders that assist the AHCCCS Care population. The training will focus on walking through the steps of the Childless Adult Phase out Plan.

- News Entities

  - AHCCCS may also provide information through news entities.

**9. Consideration of Public Comment:**

AHCCCS has received numerous comments from the public, including individual members, family members, organizations and providers. Many of these comments were part of the Community Forum held on June 1, 2011. A summary of this forum can be found on the AHCCCS website at: http://www.azahcccs.gov/publicnotices/Downloads/ChildlessAdultsForumFromJune1_2011_SummaryFINAL.pdf

Other comments have been submitted electronically via the AHCCCS website or email. Some of these comments were submitted through the comment portal on the 1115 Waiver section of the AHCCCS website and will be addressed individually. Some comments were received as part of the formal administrative rules process.

In addition, AHCCCS staff have attended meetings with community groups where there has been discussion of the childless adult phase out plan. In addition, the phase out plan has been discussed with Health-e-Arizona Steering Committee partners who have assisted in developing fact sheets and alternative resources materials for community health centers and other organizations who regularly assist consumers that may fall into the childless adult category.

AHCCCS has considered all public comments and incorporated the public comments in the following ways:

- Transitioning all members who are designated SMI to the SSI MAO category;
- Transitioning members with HIV/AIDS in the childless adult category who fall off for failure to comply with their annual renewal to the SSI MAO category;
- Transitioning children who age out of SOBRA, 1931, YATI and KidsCare to the childless adult category;
- Updating the provider portal and the myahcccs.com site by providing specific redetermination dates by June 17 to assist providers in reaching out to members;
- Providing specific outreach to I.H.S. and 638 facilities with a review file so that these facilities can obtain redetermination dates;

- Developing a fact sheet for organizations who assist consumers;
- Developing a list of alternative resources for individuals;
- Including a notice specifically for those individuals whose redetermination is June 30 and may not be aware of the potential enrollment freeze in childless adults eligibility category;
- Facilitating the process for public input via the AHCCCS website and community forums.

**10. Health-e-Arizona:**

Health-e-Arizona (HEA) is our online system for public assistance applications. A consortium of Federally Qualified Health Centers (FQHCs) brought the original model to Arizona in June 2002. We call the original model (still in place) the subscription model and it is used by community partners, such as FQHCs and hospitals, who pay a subscription fee to use it. Today we have 70 Subscribers at 220 locations statewide.

When patients come into a subscriber's facility, facility staff assists them with the completion of the application online, get an electronic signature and use fax or scanning to associate necessary documentation with the application. When the application is complete, the system screens it and identifies potential eligibility for Medicaid, CHIP, SNAP and TANF. An application can be submitted even if the applicant does not screen potentially eligible. The application is sent to the correct location electronically and is automatically entered into the eligibility systems of AHCCCS and DES. The facility can track workloads, communicate with the eligibility agency and get a final determination from the eligibility agency. Facilities who build a consistent process around this product are much more successful in getting their patients enrolled in Medicaid or CHIP and getting reimbursement for services to uninsured patients.

When an application is initiated, HEA interfaces with the AHCCCS PMMIS system to see if the applicant is already Medicaid eligible. If the applicant is known to PMMIS two things will happen:

1. HEA will pull name, date of birth (DOB) and SSN from PMMIS and will compare it to the name, DOB and SSN entered by the applicant. If there are discrepancies between PMMIS and the data that the applicant entered, HEA will require the applicant to resolve the discrepancy. This will significantly reduce problems pushing the data into the AHCCCS and DES eligibility systems.

2. Once HEA knows that the applicant is an active Medicaid recipient, it will treat their application as a renewal and ask questions appropriate for renewals.

   If the applicant has entered data into HEA on a previous occasion, HEA will pre-populate that data into the application or renewal.

In December 2008, AHCCCS implemented a public access version of Health-e-Arizona. Because this was a new feature, AHCCCS set a modest first-year goal of 17,000 Medicaid and CHIP applicants. Instead AHCCCS received 170,000 applicants using the public access version of Health-e-Arizona. In the last 12 months, AHCCCS has received 500,000 applications through the public and subscription models. Health-e-Arizona now represents nearly 40% of all Medicaid, Medicare Savings Programs and CHIP applications received each month in Arizona.

**11. Reports:**

AHCCCS will produce the following reports every month regarding the Childless Adult Freeze:

- Report #1: The number of members enrolled in the Childless Adult program as of the 1st of each month and the percentage of change from the previous month.

- Report #2: The number of SMI members transferred from Childless adults to SSI MAO effective the first of each month and the total number of SMI members transferred to date.

- Report #3: The number of members age 65 and older transferred from Childless Adults to SSI MAO effective the first of each month and the total number transferred to date.

- Report #4: The number of members under age 65, with Medicare transferred from Childless Adults to SSI MAO effective the first of each month and the total number transferred to date.

- Report #5: The number of members identified with HIV/AIDS transferred from Childless Adults to SSI MAO effective the first of each month and the total number transferred to date.

- Report #6: The number of SMI members who did not meet SSI MAO requirements and were transferred back into the Childless Adults program.

- Report #7: The number of members with HIV/AIDS who did not meet SSI MAO requirements and were discontinued because they did not qualify for any Medicaid category.

- Report #8: The number of individuals aged 65 and older or under age 65 with Medicare who do not meet the eligibility requirements for SSI MAO and are transferred back to Childless Adults.

**Attachment #1: Notice #1**

AHCCCS is Arizona's Medical Assistance

# ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

You get AHCCCS Health Insurance through the AHCCCS Care program. Due to the current budget crisis in Arizona, the State will "freeze" new enrollment in the AHCCCS Care program beginning July 8, 2011. This means that no new applications for the AHCCCS Care program will be accepted after July 7, 2011.

**People who are already on the AHCCCS Care program will still receive medical services from AHCCCS, but only as long as they stay eligible for AHCCCS.**

**If you lose coverage for the AHCCCS Care program because you no longer meet eligibility requirements, you will not be able to get back on the AHCCCS Care Program.**

**To keep your AHCCCS Care benefits, you must:**

- **Continue to meet the eligibility requirements of the AHCCCS Care program;**
- **Cooperate with all requests you receive from the Department of Economic Security (DES) or AHCCCS staff; and**
- **Complete your renewal when notified.**

This change only applies to the AHCCCS Care program. Please quickly answer any requests that you may receive from DES or AHCCCS about your AHCCCS Care benefits. If you have family members on other AHCCCS programs, their benefits are not affected at this time.

If you do lose coverage for AHCCCS Care, you may be eligible under another AHCCCS program if you are:

- Pregnant,
- The parent of a deprived child under 18,
- Age 65 and older or
- Have a disability.

If you do lose coverage for AHCCCS Care, DES and AHCCCS will let you know how to apply for other programs. If you have specific questions, please contact your AHCCCS office or call DES at 602-542-9935 or 1-800-352-8401

If you do lose coverage for AHCCCS and you are employed and your employer offers health insurance, under new federal law you may be able to enroll in your employer's insurance plan within 60 days of losing coverage under AHCCCS. You should contact your employer immediately if you lose your AHCCCS Care benefits. Listed below are some other health care programs that may also be able to help you afford health care services if your AHCCCS Care benefits end.

**SEE IMPORTANT INFORMATION ON THE OTHER SIDE OF THIS NOTICE**

**Here are some other health care programs that may also be able to help you afford health**

**care services if your AHCCCS Care benefits end:**

Community Health Centers
Phone: 602-253-0090
On the Web: www.aachc.org/associatemembersl.php

Health Care Connect
Maricopa County
Phone: 602-288-7564
On the Web: www.healthcareconnect.org/contactus.php

Pima Community Access Program (PCAP)
Pima and Santa Cruz County
Phone: 520-694-0418
On the Web: www.pcap.cc

Community Access Programs of Arizona and Mexico (CAPAZ-MEX)
Yuma County
Phone: 928-627-9222
On the Web: www.rcfbh.org/programCAPAZMEX

Pre-existing Condition Insurance Plan
Phone: 1-866-717-5826
On the Web: http://www.healthcare.gov/law/provisions/preexisting/states/az.html

**If you need free legal advice, call the following numbers:** Phoenix at 602-258-3434 (800-852-9075); Tucson at 520-623-9461 (800-248-6789); and Flagstaff at 928-774-0653 (800-789-5781). For persons in other parts of the state, call 1-866-637-5341 to find the nearest legal services office in your area.

Additional sources of free legal service can be found at these web sites:

http://apps.americanbar.org/legalservices/probono/directory/arizona.html

http://www.acdl.com/gettinghelp.html

If you have specific questions, please contact your Eligibility Specialist in your local DES or AHCCCS office.

**Attachment #2: Notice #2**

AHCCCS is Arizona's Medical Assistance

AHCCCS

# ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

## V.

## VI.

## VII. IMPORTANT NOTICE ABOUT CHANGES TO THE MEDICAL EXPENSE DEDUCTION (MED) PROGRAM AND THE AHCCCS CARE PROGRAM

You may have heard that enrollment in some AHCCCS programs is being frozen or may end due to the current budget crisis in Arizona.

At this time, only the Medical Expense Deduction (MED) program and the AHCCCS Care Program have been affected.

### What is MED and AHCCCS Care?

MED is an AHCCCS program administered by the Department of Economic Security (DES). MED provides AHCCCS benefits to people who have income too high to qualify for other programs, but who have high medical expenses. Enrollment in the MED program was frozen on May 1, 2011 and the program will end on October 1, 2011.

AHCCCS Care provides AHCCCS benefits to people whose income is not too high, but they do not meet some other requirements for the rest of the AHCCCS programs. Enrollment in the AHCCCS Care Program was frozen on July 8, 2011. Effective July 8, 2011 no one can be added to this program.

### Does This Change Affect Me?

**If you are not on MED or the AHCCCS Care Program, these changes do not affect you.** These changes do not affect AHCCCS coverage under any other programs at this time. However, if you or other family members receive AHCCCS coverage under the MED or AHCCCS Care programs, you or other family members have already received a separate letter describing the changes in more detail.

**This letter is sent only for your information so that you will know that if you are not on the MED or AHCCCS Care programs, you are not affected by the changes for the MED and AHCCCS Care programs. If you have specific questions, please contact your AHCCCS office or call DES at 602-542-9935 or 1-800-352-8401.**

**Attachment #3: Notice #3**

AHCCCS is Arizona's Medical Assistance

AHCCCS

# ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

## IMPORTANT NOTICE ABOUT YOUR AHCCCS ELIGIBILITY

You get AHCCCS Health Insurance through the AHCCCS Care program.

Due to the current budget crisis in Arizona, the State will "freeze" new enrollment in the AHCCCS Care program beginning July 8, 2011. This means that no new applications for the AHCCCS Care program will be accepted after July 7, 2011.

**Because you are over age 65 or are under age 65 and have Medicare, your case has been sent to the AHCCCS SSI MAO office, which provides AHCCCS health insurance to people who are aged, blind or disabled. There is not a freeze on enrollment for this program. The SSI MAO office will contact you when your redetermination is due to determine your eligibility for the SSI MAO program.**

The SSI MAO office is located at:

801 E. Jefferson Street, MD 3800
Phoenix, AZ 85034

To stay eligible for SSI MAO benefits, you must:

- Meet the eligibility requirements of the SSI MAO program;
- Let AHCCCS know if you move;
- Cooperate with all requests you receive from AHCCCS staff; and
- Complete your renewal when requested.

If you have any questions or need to report a change, call the SSI MAO office at a phone number listed below:

602-417-5010 (Area Codes 602, 480 and 623)
Toll Free: 1-800-528-0142FAX: 602-258-4619

For information about SSI MAO eligibility go to:

http://www.azahcccs.gov/community/Downloads/resources/Description_of_AHCCCS_Programs.pdf

**Attachment #4: Notice #4**

AHCCCS is Arizona's Medical Assistance

# ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

## IMPORTANT NOTICE ABOUT YOUR AHCCCS ELIGIBILITY

You were getting AHCCCS Health Insurance through the AHCCCS Care program with the Department of Economic Security (DES) or through AHCCCS, but your benefits ended when you failed to complete your annual renewal.

Due to the current budget crisis in Arizona, the State will "freeze" new enrollment in the AHCCCS Care program beginning July 8, 2011. This means that you will not be able to get back on the AHCCCS Care program.

**However, your case has been sent to the AHCCCS SSI MAO office, which provides AHCCCS health insurance to people who are aged, blind or disabled. There is no freeze on enrollment for this program.**

**The SSI MAO office will contact you soon to determine your eligibility under the SSI MAO program.**

**In order to be eligible, you must:**

- Meet the eligibility requirements of the SSI MAO program; and
- Cooperate with all requests you receive from AHCCCS staff.
- Complete your renewal when requested.

The SSI MAO office is located at:

801 E. Jefferson Street, MD 3800
Phoenix, AZ 85034

If you have any questions or need to report a change, call the SSI MAO office at a phone number listed below:

Ph: 602-417-5010 (Area Codes 602, 480 and 623)
Toll Free: 1-800-528-0142

FAX: 602-258-4619

For information about SSI MAO eligibility go to:

http://www.azahcccs.gov/community/Downloads/resources/Description_of_AHCCCS_Programs.pdf

**Attachment #5: Notice #5**

AHCCCS is Arizona's Medical Assistance

AHCCCS

# ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

## IMPORTANT NOTICE ABOUT YOUR AHCCCS ELIGIBILITY

You get AHCCCS Health Insurance through the AHCCCS Care program.

Due to the current budget crisis in Arizona, the State will "freeze" new enrollment in the AHCCCS Care program beginning July 8, 2011. This means that no new applications for the AHCCCS Care program will be accepted after July 7, 2011.

**Your case has been sent to the AHCCCS SSI MAO office. The AHCCCS SSI MAO program provides AHCCCS health insurance to people who are aged, blind or disabled. There is no freeze on enrollment for this program.**

**The SSI MAO office will contact you at your redetermination time to do a determination of your eligibility under the SSI MAO program.**

**In order to be eligible, you must:**

- Complete an SSI MAO eligibility redetermination;
- Meet the eligibility requirements of the SSI MAO program; and
- Cooperate with all requests you receive from AHCCCS staff.

The SSI MAO office is located at:

801 E. Jefferson Street, MD 3800
Phoenix, AZ 85034

If you have any questions or need to report a change, call the SSI MAO office at a phone number listed below:

Ph: 602-417-5010 (Area Codes 602, 480 and 623)
Toll Free: 1-800-528-0142

FAX: 602-258-4619

For information about SSI MAO eligibility go to:

**http://www.azahcccs.gov/community/Downloads/resources/Description_of_AHCCCS_Programs.pdf**

**Attachment #6: Notice #6**

AHCCCS is Arizona's Medical Assistance

AHCCCS

# ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

## XII. IMPORTANT NOTICE ABOUT YOUR AHCCCS ELIGIBILITY

You are on AHCCCS Care and you recently received a letter from DES or AHCCCS telling you that your AHCCCS Health Insurance will stop June 30, 2011 because you did not complete the renewal process.

Due to the current budget crisis in Arizona, the State will "freeze" new enrollment in the AHCCCS Care program beginning July 8, 2011. This means that you will not be able to get back on the AHCCCS Care program after your eligibility ends.

If you contact your eligibility worker before your AHCCCS Health Insurance stops and provide needed information, you may still be eligible.

If you do lose coverage for AHCCCS Care, you may be eligible under another AHCCCS program if you are:

- Pregnant,
- The parent of a deprived child under 18,
- Age 65 and older or
- Have a disability including serious mental illness or HIV/AIDS.

If you do lose coverage for AHCCCS Care, DES and AHCCCS will let you know how to apply for other programs.

If you do lose coverage for AHCCCS and you are employed and your employer offers health insurance, under new federal law you may be able to enroll in your employer's insurance plan within 60 days of losing coverage under AHCCCS. You should contact your employer immediately if you lose your AHCCCS Care benefits.

If you have specific questions, please contact your AHCCCS office or call DES at 602-542-9935 or 1-800-352-8401. They can answer questions and help you complete your renewal for AHCCCS Care.

**SEE IMPORTANT INFORMATION ON THE OTHER SIDE OF THIS NOTICE**

**Here are some other health care programs that may also be able to help you afford health care services if your AHCCCS benefits end:**

Community Health Centers
Phone: 602-253-0090
On the Web: www.aachc.org/associatemembersl.php

Health Care Connect
Maricopa County
Phone: 602-288-7564
On the Web: www.healthcareconnect.org/contactus.php

Pima Community Access Program (PCAP)
Pima and Santa Cruz County
Phone: 520-694-0418
On the Web: www.pcap.cc

Community Access Programs of Arizona and Mexico (CAPAZ-MEX)
Yuma County
Phone: 928-627-9222
On the Web: www.rcfbh.org/programCAPAZMEX

Pre-existing Condition Insurance Plan
Phone: 1-866-717-5826
On the Web: http://www.healthcare.gov/law/provisions/preexisting/states/az.html

**If you need free legal advice, call the following numbers:** Phoenix at 602-258-3434 (800-852-9075); Tucson at 520-623-9461 (800-248-6789); and Flagstaff at 928-774-0653 (800-789-5781). For persons in other parts of the state, call 1-866-637-5341 to find the nearest legal services office in your area.

Additional sources of free legal service can be found at these web sites:

http://apps.americanbar.org/legalservices/probono/directory/arizona.html

http://www.acdl.com/gettinghelp.html

If you have specific questions, please contact your Eligibility Specialist in your local DES or AHCCCS office.

Attachment #7 Notice #7
NOTICE: X051
TITLE: MISSED REVIEW NOTICE

Si necesita esta noticia traducida en espanol, llame a la oficina
local al numero que aparece arriba, o al numero de Servicio al Cliente
al (602) 542-9935 o 1-800-352-8401.@@
>>
**********@@
* IMPORTANT INFORMATION ABOUT YOUR CASH ASSISTANCE *@@
* AND AHCCCS HEALTH INSURANCE *@@
**********@@
>>
Your Cash Assistance and/or AHCCCS Health Insurance will be stopped
without further notice beginning %%%%%%%%%%%%%%%%%%%%. The item listed
below applies to you.@@
//@@
|##|A. You failed to report to your local office for an interview to@@
renew your Cash Assistance and/or AHCCCS Health Insurance@@
eligibility.@@
||@@
|##|B. You failed to turn in an application for an interview to@@
renew your Cash Assistance and/or AHCCCS Health Insurance@@
eligibility.||@@
\\@@
If you want your benefits to continue you need to fill out an
application and complete an interview by %%%%%%%%%%%%%%%%%%.@@
>>
If you need a special appointment time, day or location (for example:
home visit, phone interview, before 8:00 AM or after 5:00 PM) due to
work, school, distance to a DES local office, or other reasons, please
let us know when you turn in your application.@@
>>
Even if you are employed, you may continue to be eligible for AHCCCS
Health Insurance. Please call us for details.@@

If you do lose coverage for AHCCCS Care, you may be eligible under another AHCCCS program if you are:

- Pregnant,
- The parent of a deprived child under 18,
- Age 65 and older or
- Have a disability including serious mental illness or HIV/AIDS.

If you do lose coverage for AHCCCS Care, DES and AHCCCS will let you know how to apply for other programs.

>>
If you have a child who was born in the past 12 months while you were
receiving AHCCCS Health Insurance, the child(ren) may continue to be

eligible. If you have not called us, please do so immediately.@@
>>
This action is based on 42 Code of Federal Regulations (CFR) 435.916
and 45 CFR 206.10 and Arizona Administrative Code R9-22-1414. The CFR
references are available through public libraries.@@
>>
If you think your benefits should not be stopped, ask for a hearing by
filling out the form on the back now.@@
>>
NOTE: If you are interested in registering to VOTE or making changes
to your voter registration, contact your local DES office.@@
>>
If you have questions or need help, please call us at %%%%%%%%%%%%%%.
You can also get information from our 24 hour Interactive Voice
Response (IVR) System at (602) 542-9935 (If calling from area code
602, 480 or 623) or 1-800-352-8401 (for all other area codes). To
apply for free legal help, call %%%%%%%%%%%%%%. Fair Hearing rights
are explained on the back of this notice.@@

Attachment #8

## XIII. IMPORTANT NOTICE: YOU MUST COMPLETE YOUR RENEWAL FOR AHCCCS BY JUNE 30, 2011

You get AHCCCS Health Insurance through the AHCCCS Care program. Your current coverage period will end on June 30, 2011 unless you renew your coverage on time. Your deadline to renew your coverage is June 30, 2011.

Due to the current budget crisis in Arizona, the State is planning to "freeze" new enrollment in the AHCCCS Care program beginning July 1, 2011. This means that no new applications for the AHCCCS Care program will be accepted after June 30, 2011.

**If you do not return your completed renewal application by the June 30, 2011 deadline, your coverage will end on July 1, 2011. You will be discontinued from the AHCCCS Care program, and if the program is "frozen" on July 1st, you will not be able to get back on the program.**

**To keep your AHCCCS Care benefits, you must**:

- **Turn in a renewal application by June 30, 2011;**
- **Meet the eligibility requirements of the AHCCCS Care program; and**
- **Cooperate with all requests you receive from the Department of Economic Security (DES) or AHCCCS staff.**

If you have already turned in a renewal application, please be sure to reply to any mail you get from DES or AHCCCS, and provide any proof requested.

This change only applies to the AHCCCS Care program. If you have family members on other AHCCCS programs, they still need to complete their renewal applications. However, if they lose their AHCCCS coverage because they do not complete a renewal application, they may still be able to get back on other AHCCCS programs.

If you do lose coverage for AHCCCS Care, you may be eligible under another AHCCCS program if you are:

- Pregnant;
- The parent of a deprived child under 18;
- Age 65 and older; or
- Have a disability.

If you lose eligibility for AHCCCS Care, DES and AHCCCS will let you know how to apply for other AHCCCS programs. If you have specific questions, please contact your AHCCCS office or call DES at 602-542-9935 or 1-800-352-8401.

If you do lose coverage for AHCCCS and you are employed and your employer offers health insurance, under new federal law you may be able to enroll in your employer's insurance plan within 60 days of losing coverage under AHCCCS. You should contact your employer immediately if you lose your AHCCCS Care benefits.

### SEE IMPORTANT INFORMATION ON THE OTHER SIDE OF THIS NOTICE

**Note:** This notice was already sent to AHCCCS Care members in this group and so reflects the original proposed July 1, 2011, effective date. This notice will be sent to AHCCCS Care members with a July 31, 2011, redetermination date, and will reflect the revised July 8, 2011, AHCCCS Care enrollment freeze effective date.

**Here are some other health care programs that may also be able to help you afford health care services if your AHCCCS Care benefits end:**

Community Health Centers
Phone: 602-253-0090
On the Web: www.aachc.org/associatemembersl.php

Health Care Connect
Maricopa County
Phone: 602-288-7564
On the Web: www.healthcareconnect.org/contactus.php

Pima Community Access Program (PCAP)
Pima and Santa Cruz County
Phone: 520-694-0418
On the Web: www.pcap.cc

Community Access Programs of Arizona and Mexico (CAPAZ-MEX)
Yuma County
Phone: 928-627-9222
On the Web: www.rcfbh.org/programCAPAZMEX

Pre-existing Condition Insurance Plan
Phone: 1-866-717-5826
On the Web: http://www.healthcare.gov/law/provisions/preexisting/states/az.html

**If you need free legal advice, call the following numbers:** Phoenix at 602-258-3434 (800-852-9075); Tucson at 520-623-9461 (800-248-6789); and Flagstaff at 928-774-0653 (800-789-5781). For persons in other parts of the state, call 1-866-637-5341 to find the nearest legal services office in your area.

Additional sources of free legal service can be found at these web sites:

http://apps.americanbar.org/legalservices/probono/directory/arizona.html

http://www.acdl.com/gettinghelp.html

If you have specific questions, please contact your Eligibility Specialist in your local DES or AHCCCS

office.

**Attachment #9**

**AHCCCS Care (Childless Adults) Phase out Plan**
**Fact Sheet**
**June 1, 2011**

**Eligibility for the AHCCCS Care program will be frozen July 8, 2011 until additional funds become available to reopen enrollment into the program. No one will be approved for AHCCCS Care for the month of July 2011 and ongoing, except children aging out of their eligibility group because they turned 19 or 21. The phase out plan is waiting for approval from the Centers for Medicare and Medicaid Services (CMS), and the enrollment freeze will not be implemented until federal approval is granted.**

**What is the AHCCCS Care program?**
AHCCCS Care or Childless Adults, as it is sometimes known, is a waiver program for adults who have not been determined eligible under one of the regular Medicaid groups (aged, blind, disabled, pregnant, under 18 or parent of a deprived child). An asset test is not required and they must have income under 100% of the Federal Poverty Level (FPL). Eligibility must be renewed every 12 months.

**How many people are on AHCCCS Care?**
As of June 1, 2011 there are nearly 225,000 AHCCCS Care members.

**What will happen to those already on AHCCCS Care?**
All AHCCCS Care members with eligibility that began before July 8, 2011 will remain eligible for the program, unless they lose eligibility because they no longer meet the requirements. This includes the requirement to comply with the renewal process.

AHCCCS will make an administrative change from AHCCCS Care to SSI MAO – a program for people who are aged, blind or disabled (SSI MAO enrollment will not be frozen) – if the member is over age 65, under age 65 and has Medicare or is diagnosed as seriously mentally ill (SMI) by the Department of Health Services. AHCCCS Care members who are diagnosed with HIV/AIDS will be administratively changed to SSI MAO, if they lose eligibility for AHCCCS Care for failure to complete the renewal process. Most SMI and HIV/AIDS members under the age of 65 will have to later be determined disabled under federal requirements by the Disability Determination Service Administration (DDSA), Department of Economic Security. If an SMI member does not meet the federally defined criteria of disabled for Medicaid under the SSI MAO category, AHCCCS will continue their coverage under the AHCCCS Care category, as long as they meet all other required eligibility criteria, such as income.

Although AHCCCS will make every effort, using information already available to the state, to identify people who are age 65 or older, disabled, pregnant, or the parent of a deprived child to ensure that their coverage continues under other categories, we may not identify all of these individuals. If an individual's coverage in the Childless Adult program is being terminated and the individual believes that they may be covered under one of these other groups, they can notify their eligibility worker, who can help them apply for coverage under these categories. AHCCCS is also working with DDSA to streamline the process of collecting and submitting documentation for the disability determination. RBHA providers can also assist individuals in submitting documentation to DDSA.

**What can AHCCCS Care members do?**

AHCCCS Care members should do everything in their power to complete their renewal on time. They can complete a paper renewal form or complete an electronic renewal on line at www.healthearizona.org. They should also report any changes in address to their eligibility worker to insure no loss of contact.

**How will AHCCCS Care members know their renewal date?**
**1st Notice:** All AHCCCS Care members will be notified 60 days before the due date of their renewal and given information about how to comply.
**2nd Notice:** If they have not complied they will receive a notice telling them their benefits will stop, the date they will stop and giving them appeal rights.
**3rd Notice:** AHCCCS will send another notice on the 25th of each month as a 3rd warning that AHCCCS Care members have until the end of that month to comply with the renewal process.

AHCCCS members can find their renewal dates on www.myahcccs.com. AHCCCS registered providers can obtain an AHCCCS Care members' renewal date through the provider portal on the AHCCCS website.

**What appeal rights will AHCCCS Care members have?**
If AHCCCS Care members lose their eligibility and they believe their eligibility was not determined correctly, they can ask for a hearing. If they request a hearing within 10 days their eligibility can be continued until the final decision is made.

**Alternative resources**
See: http://www.azahcccs.gov/community for ideas about helping people who are not eligible for AHCCCS Care or other AHCCCS programs.

**Attachment 10**

Comparison of SSI MAO Budgeting Methodology to AHCCCS Care

| | **AHCCCS Care** | **SSI-MAO** |
|---|---|---|
| Cash Program methodology | Title IV-A | Title XVI |
| Categorical link | No categorical link requirement. | Must be aged, blind or disabled. |
| Monthly income calculation | Income received more often than monthly is averaged and converted to a monthly amount.<br>Weekly income is multiplied by 4.3<br>Bi-weekly income is multiplied by 2.15 | Monthly income is based on actual income received and not converted. |
| Deductions | • $90 earned income deduction (per wage earner)<br>• Up to $200 per dependent for dependent care expenses. "Dependent" includes a minor child or incapacitated spouse. | <u>FBR Test (100% FBR)</u><br>• $20 General deduction<br>• $65 standard earned income deduction<br>• **1/2 earned income deduction**<br>• Child allocation*<br>• Student earned income deduction**<br><br><u>FPL Test (100% FPL)</u><br>• $20 General deduction<br>• $65 standard earned income deduction<br>• Child allocation*<br>• Student earned income deduction**<br><br>* Deduction per child of *up to* $337. If the child has countable income of his/her own, the deduction is reduced by the child's countable income.<br>** Deduction per student under age 22 of $1640 per month, up to a maximum of $6600 per year. |
| Due to different Cash Program methodologies, a few income types count differently | Examples:<br>• In-kind income – Counted<br>• Interest/dividends (if withdrawn) – Counted<br>• TANF payments - Excluded | Examples:<br>• In-kind income – Excluded<br>• Interest/dividends (if withdrawn) – Excluded<br>• TANF payments - Counted |
| Budgeting Methodology | <u>Sneede v. Kizer methodology</u><br>Net income after deductions is divided equally and allocated based on financial responsibility (spouse to spouse; parent to child).<br>Allocated income is compared to the income limit for a single person, or if married, to ½ the 2-person income limit. | Net income after deductions is compared to the income limit for a single person or couple as appropriate. |

**Attachment 11 Notice #9**

AHCCCS is Arizona's Medical Assistance

AHCCCS

# ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

## XIV. IMPORTANT NOTICE: YOU MUST COMPLETE YOUR RENEWAL FOR AHCCCS BY JUNE 30, 2011

You get AHCCCS Health Insurance through an AHCCCS program with an age limit of 19 or 21. You have reached the program's age limit. Your eligibility must be redetermined to see if you qualify for any other AHCCCS programs. One of these programs is AHCCCS Care. Due to the current budget crisis in Arizona, the State is planning to "freeze" new enrollment in the AHCCCS Care program beginning July 1, 2011. This means no new applications for the AHCCCS Care program will be accepted after July 1, 2011.

**To make sure that the AHCCCS Care program is available to you, you must complete your renewal application by June 30, 2011. If you do not complete your renewal application by June 30, 2011, and the program is "frozen" on July 1st, you will not be able to get on the AHCCCS Care program, even if you do not qualify for any other AHCCCS program.**

**To be able to get on AHCCCS Care, if you do not qualify for any other AHCCCS program, you must**:

- **Turn in a renewal application by June 30, 2011;**
- **Meet the eligibility requirements of the AHCCCS Care program; and**
- **Cooperate with all requests you receive from Department of Economic Security (DES) or AHCCCS staff.**

If you have already turned in a renewal application, please be sure to reply to any mail you get from DES or AHCCCS, and provide any proof requested.

This change only applies to the AHCCCS Care program. If you have family members on other AHCCCS programs, they still need to complete their renewal application. However, if they lose their AHCCCS coverage because they do not complete a renewal application, they may still be able to get back on other AHCCCS programs.

If you do not qualify for AHCCCS Care, you may be eligible under another AHCCCS program if you are:

- pregnant
- the parent of a deprived child under 18
- age 65 and older or
- have a disability.

If you lose coverage for AHCCCS Care, DES and AHCCCS will let you know how to apply for other AHCCCS programs. If you have specific questions, please contact your AHCCCS office or call DES at 602-542-9935 or 1-800-352-8401.

If you do lose coverage for AHCCCS and you are employed and your employer offers health insurance, under new federal law you may be able to enroll in your employer's insurance plan within 60 days of losing coverage under AHCCCS. You should contact your employer immediately if you lose your AHCCCS Care benefits.

**SEE IMPORTANT INFORMATION ON THE OTHER SIDE OF THIS NOTICE**

**Note:** This notice was already sent and reflects the original proposed enrollment freeze effective date of July 1, 2011. This notice will be sent every month to children whose redetermination date and birth date fall in the same month.

**Here are some other health care programs that may also be able to help you afford health care services if your AHCCCS Care benefits end:**

Community Health Centers
Phone: 602-253-0090
On the Web: www.aachc.org/associatemembersl.php

Health Care Connect
Maricopa County
Phone: 602-288-7564
On the Web: www.healthcareconnect.org/contactus.php

Pima Community Access Program (PCAP)
Pima and Santa Cruz County
Phone: 520-694-0418
On the Web: www.pcap.cc

Community Access Programs of Arizona and Mexico (CAPAZ-MEX)
Yuma County
Phone: 928-627-9222
On the Web: www.rcfbh.org/programCAPAZMEX

Pre-existing Condition Insurance Plan
Phone: 1-866-717-5826
On the Web: http://www.healthcare.gov/law/provisions/preexisting/states/az.html

**If you need free legal advice, call the following numbers:** Phoenix at 602-258-3434 (800-852-9075); Tucson at 520-623-9461 (800-248-6789); and Flagstaff at 928-774-0653 (800-789-5781). For persons in other parts of the state, call 1-866-637-5341 to find the nearest legal services office in your area.

Additional sources of free legal service can be found at these web sites:

http://apps.americanbar.org/legalservices/probono/directory/arizona.html

http://www.acdl.com/gettinghelp.html

If you have specific questions, please contact your Eligibility Specialist in your local DES or AHCCCS

office.

**Attachment #12 Notice #10**

AHCCCS is Arizona's Medical Assistance

AHCCCS

# ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

## XV. IMPORTANT NOTICE ABOUT YOUR AHCCCS ELIGIBILITY

You were getting AHCCCS Health Insurance through an AHCCCS program with an age limit of 19 or 21. When you reached that program's age limit, you were made eligible for the AHCCCS Care program.

Due to the current budget crisis in Arizona, the State has "frozen" new enrollment in the AHCCCS Care program beginning July 8, 2011. This means no new applications for the AHCCCS Care program will be accepted after July 8, 2011.

**People who are already on the AHCCCS Care program will still receive medical services from AHCCCS, but only as long as they stay eligible for the program.**

**If you lose coverage for the AHCCCS Care program because you no longer meet eligibility requirements, you will not be able to get back on the AHCCCS Care Program.**

**To keep your AHCCCS Care benefits, you must:**

- **Continue to meet the eligibility requirements of the AHCCCS Care program;**
- **Cooperate with all requests you receive from the Department of Economic Security (DES)or AHCCCS staff; and**
- **Complete your renewal when notified.**

If you do not qualify for AHCCCS Care, you still may be eligible for coverage under another AHCCCS program if you are:

- Pregnant;
- The parent of a deprived child under 18; or
- Have a disability.

If you lose coverage for AHCCCS Care, DES and AHCCCS will let you know how to apply for other AHCCCS programs. If you have specific questions, please contact your AHCCCS office or call DES at 602-542-9935 or 1-800-352-8401.

If you do lose coverage for AHCCCS and you are employed, and your employer offers health insurance, under new federal law you may be able to enroll in your employer's insurance plan within 60 days of losing coverage under AHCCCS. You should contact your employer immediately if you lose your AHCCCS Care benefits.

**SEE IMPORTANT INFORMATION ON THE OTHER SIDE OF THIS NOTICE**

**Here are some other health care programs that may also be able to help you afford health care services if your AHCCCS Care benefits end:**

Community Health Centers
Phone: 602-253-0090
On the Web: www.aachc.org/associatemembersl.php

Health Care Connect
Maricopa County
Phone: 602-288-7564
On the Web: www.healthcareconnect.org/contactus.php

Pima Community Access Program (PCAP)
Pima and Santa Cruz County
Phone: 520-694-0418
On the Web: www.pcap.cc

Community Access Programs of Arizona and Mexico (CAPAZ-MEX)
Yuma County
Phone: 928-627-9222
On the Web: www.rcfbh.org/programCAPAZMEX

Pre-existing Condition Insurance Plan
Phone: 1-866-717-5826
On the Web: http://www.healthcare.gov/law/provisions/preexisting/states/az.html

**If you need free legal advice, call the following numbers:** Phoenix at 602-258-3434 (800-852-9075); Tucson at 520-623-9461 (800-248-6789); and Flagstaff at 928-774-0653 (800-789-5781). For persons in other parts of the state, call 1-866-637-5341 to find the nearest legal services office in your area.

Additional sources of free legal service can be found at these web sites:

http://apps.americanbar.org/legalservices/probono/directory/arizona.html

http://www.acdl.com/gettinghelp.html

If you have specific questions, please contact your Eligibility Specialist in your local DES or AHCCCS office.

## Attachment B - Quarterly Report Guidelines

As written in STC paragraph 34, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 30 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include the budget neutrality monitoring workbook. An electronic copy of the report narrative and the Microsoft Excel budget neutrality monitoring workbook is provided.

**NARRATIVE REPORT FORMAT:**

**TITLE**

**Title Line One** – Arizona Health Care Cost Containment System -- AHCCCS, A Statewide Approach of Cost Effective Health Care Financing

**Title Line Two - Section 1115 Quarterly Report**

**Demonstration/Quarter Reporting Period:**

Example:
Demonstration Year: 5 (5/01/04 - 4/30/05)
Federal Fiscal Quarter: 4/2004 (7/04 - 9/04)

**INTRODUCTION:**

Information describing the goal of the Demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

**ENROLLMENT INFORMATION:**

Please complete the following table that outlines all enrollment activity under the Demonstration. The State should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by "0".

**Note:** Enrollment counts should be person counts, not participant months.

| **Population Groups (as hard coded in the CMS 64)** | **Current Enrollees** (to date) | **No. Voluntary Disenrolled in current Quarter** | **No. Involuntary Disenrolled in current Quarter** |
|---|---|---|---|
| **Population 1 – AFDC / SOBRA** | | | |
| **Population 2 - SSI** | | | |
| **Population 3 – ALTCS DD** | | | |
| **Etcetera** | | | |

Voluntary Disenrollments:
Cumulative Number of Voluntary Disenrollments Within Current Demonstration Year:
Reasons for Voluntary Disenrollments:

Involuntary Disenrollments:
Cumulative Number of Involuntary Disenrollments Within Current Demonstration Year:
Reasons for Involuntary Disenrollments:

**Outreach/Innovative Activities:**

Summarize outreach activities and/or promising practices for the current quarter.

**Operational/Policy Developments/Issues:**

Identify all significant program developments/issues/problems that have occurred in the current quarter.

**Financial/Budget Neutrality Developments/Issues:**

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the State's actions to address these issues.

**Consumer Issues:**

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken, or to be taken, to prevent other occurrences.

**Quality Assurance/Monitoring Activity:**

Identify any quality assurance/monitoring activity in current quarter.

**ESI Issues:**
Identify all significant program developments/issues/problems that have occurred in the current quarter.

**Family Planning Extension Program:**
Identify all significant program developments/issues/problems that have occurred in the current quarter, including the required data and information included in STC 34(d) and (e), including enrollment data requested that is not represented in the formatted tables.

**Enclosures/Attachments:**

Identify by title any attachments along with a brief description of what information the document contains.

**State Contact(s):**

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

***The State may also add additional program headings as applicable.***

**Date Submitted to CMS:**

## Attachment C – Evaluation Guidelines

Section 1115 demonstrations are valued for information on health services, health services delivery, health care delivery for uninsured populations, and other innovations that would not otherwise be part of Medicaid programs. CMS encourages States with demonstration programs to conduct or arrange for evaluations of the design, implementation, and/or outcomes of their demonstrations. The CMS also conducts evaluation activities.

The CMS believes that all parties to demonstrations; States, Federal Government, and individuals benefit from State conducted self-evaluations that include process and case-study evaluations—these would include, but are not limited to: 1) studies that document the design, development, implementation, and operational features of the demonstration, and 2) studies that document participant and applicant experiences that are gathered through surveys, quality assurance activities, grievances and appeals, and in-depth investigations of groups of participants and applicants and/or providers (focus groups, interviews, other). These are generally studies of short-term experiences and they provide value for quality assurance and quality improvements programs (QA/QI) that are part of quality assurance activities and/or demonstration refinements and enhancements.

Benefit also derives from studies of intermediate and longer-term investigations of the impact of the demonstration on health outcomes, self-assessments of health status, and/or quality of life. Studies such as these contribute to State and Federal formation and refinements of policies, statutes, and regulations.

States are encouraged to conduct short-term studies that are useful for QA/QI that contribute to operating quality demonstration programs. Should States have resources available after conducting these studies, they are encouraged to conduct outcome studies.

The following are criteria and content areas to be considered for inclusion in Evaluation Design Reports.

- Evaluation Plan Development - Describe how plan was or will be developed and maintained:
    - Use of experts through technical contracts or advisory bodies;
    - Use of techniques for determining interest and concerns of stakeholders (funding entities, administrators, providers, clients);
    - Selection of existing indicators or development of innovative indicators;
    - Types of studies to be included, such as Process Evaluations, Case-Studies and Outcome investigations;
    - Types of data collection and tools that will be used – for instance, participant and provider surveys and focus groups; collection of health service utilization; employment data; or, participant purchases of other sources of health care coverage; and, whether the data collection instruments will be existing or newly developed tools;
    - Incorporation of results through QA/QI activities into improving health service delivery; and

- Plans for implementation and consideration of ongoing refinement to the evaluation plan.

- Study Questions – Discuss:
  - Hypothesis or research questions to be investigated;
  - Goals, such as:
    - Increase Access
    - Cost Effectiveness
    - Improve Care Coordination
    - Increase Family Satisfaction and Stability
  - Outcome Measures, Indicators, and Data Sources

- Control Group and/or Sample Selection Discussion:
  - The type of research design(s) to be included -
    - Pre/Post Methodology
    - Quasi-Experimental
    - Experimental
  - Plans for Base-line Measures and Documentation – time period, outcome measures, indicators, and data sources that were used or will be used

- Data Collection Methods – Discuss the use of data sources such as:
  - Enrollment and outreach records;
  - Medicaid claims data;
  - Vital statistics data;
  - Provide record reviews;
  - School record reviews; and
  - Existing or custom surveys

- Relationship of Evaluation to Quality Assessment and Quality Improvement Activities– Discuss:
  - How evaluation activities and findings are shared with program designers, administrators, providers, outreach workers, etc., in order to refine or redesign operations;
  - How findings will be incorporated into outreach, enrollment and education activities;
  - How findings will be incorporated into provider relations such as provider standards, retention, recruitment, and education; and
  - How findings will be incorporated into grievance and appeal proceedings.

- Discuss additional points as merited by interest of the State and/or relevance to nuances of the demonstration intervention.

**ATTACHMENT D**
**AHCCCS DISPROPORTIONATE SHARE HOSPITAL PROGRAM**
**DSH 102**

Congress established the Medicaid Disproportionate Share Hospital (DSH) program in 1981 to provide financial support to hospitals that serve a significant number of low-income patients with special needs.

This document sets forth the criteria by which Arizona defines DSH hospitals and the methodology through which DSH payments are calculated and distributed. The document is divided into the following major topics:

- Hospital eligibility requirements
- Data on a State Plan Year Basis
- Timing of eligibility determination
- Medicaid Inpatient Utilization Rate (MIUR) calculation (Overall and Group 1 eligibility)
- Low Income Utilization Rate (LIUR) calculation (Group 2 eligibility)
- Governmentally-operated hospitals (Group 4 eligibility)
- Obstetrician Requirements
- Payment
- Aggregate Limits
- Reconciliations
- Certified Public Expenditures (CPEs)
- Grievances and appeals
- Other provisions

**Eligibility Requirements**

In order to be considered a DSH hospital in Arizona, a hospital must be located in the state of Arizona, must submit the information required by AHCCCS by the specified due date, must satisfy one (1) of the conditions in Column A, AND must satisfy one (1) of the conditions in Column B, AND must satisfy the condition in Column C.

| COLUMN A | COLUMN B | COLUMN C |
|---|---|---|
| 1. The hospital has a Medicaid Inpatient Utilization Rate (MIUR) which is at least one standard deviation above the mean MIUR for all hospitals receiving a Medicaid payment in the state (“Group 1”) | 1. The hospital has at least two (2) obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid patients<br>2. The hospital is outside a Metropolitan Statistical | The hospital has an MIUR of at least 1 percent |

| | | |
|---|---|---|
| 1.A. The hospital meets all of the requirements of 1 above (Group 1) and is a privately owned or privately operated hospital licensed by the State of Arizona ("Group 1A")<br>2. The hospital has a Low Income Utilization Rate (LIUR) that exceeds 25% ("Group 2")<br>2.A. The hospital meets all of the requirements of 2 above (Group 2) and is a privately owned or privately operated hospital licensed by the State of Arizona ("Group 2A")<br>3. The hospital is a governmentally-operated hospital ("Group 4") | Area and has at least two (2) physicians with staff privileges to perform non-emergency obstetric procedures<br>3. The patients of the hospital are predominantly under 18 years of age<br>4. The hospital was in existence on December 22, 1987 but did not offer non-emergency obstetric services as of that date | |

Notice that within Column A, there are six group numbers assigned. Group 1 and Group 2 contain those hospitals that are "deemed" to be DSH hospitals under federal Medicaid law. Group 1A, Group 2A, and Group 4 contain additional hospitals that the state has designated to be DSH hospitals within its federal authority to do so. The criteria listed in Columns B and C are federal eligibility requirements which apply regardless of whether or not the hospital is deemed or designated as a DSH hospital.

- In Group 4, the term "governmentally-operated hospital" refers to a hospital provider which under federal law is able to participate in the financing of the non-federal portion of medical assistance expenditures. A governmentally-operated hospital is differentiated herein from "non-governmental", "non-public", "private", "privately operated" or "privately owned" hospitals as well as IHS or tribal or 638 hospitals and facilities as well as other federally owned or operated facilities.

Medicare Certification

In addition to the eligibility requirements outlined above, in order to receive payment under Medicaid, hospitals must meet the requirements for participation as a hospital in Medicare (except in the case of medical supervision of nurse-midwife services). Therefore, for purposes of DSH, the facility must be Medicare-certified during the state plan rate year for which the initial

DSH payment is made.

If a facility is Medicare-certified for the full state plan rate year for which the initial DSH payment is made, but subsequently loses that certification, the facility remains eligible to receive the payment (together with any payment adjustments). If a hospital is only Medicare-certified for part of the state plan rate year for which the initial DSH payment is made, the eligibility and the payment will be calculated based on the period for which the hospital was Medicare-certified.

**Data on a State Plan Year Basis**

DSH payments are made based on the State Plan Rate Year. The State Plan Rate Year (or State Plan Year or SPY) is equivalent to the Federal Fiscal Year and runs from October 1 to September 30 of each year. The calculations to determine eligibility for, and the amount of, DSH payments, will be made on the basis of the State Plan Year. This requirement will impact the information collected and submitted by all hospitals that do not have a fiscal year and/or CMS 2552 Report year that runs from 10/1 to 9/30.

In order to make the necessary calculations to determine eligibility and payments on a State Plan Year basis, hospitals that do not have a fiscal/CMS Report year that runs from 10/1 to 9/30 will have to submit cost reports and other data elements for each of the fiscal/CMS Report years that encompass the State Plan Year. For example, for SPY 2008 (10/1/07 to 9/30/08), for a hospital that has a CMS 2552 Report year that runs from 7/1 to 6/30, the hospital will have to submit the CMS 2552 Report and other data elements for the fiscal/CMS Report year that ends on 6/30/08 and the same information for the fiscal/CMS Report year that ends 6/30/09.[2]

As discussed later in this Attachment, AHCCCS will extract all Title XIX (Medicaid) claims and encounters from the PMMIS system on the basis of each hospital's CMS 2552 Report year and these data will serve as the basis for all Medicaid days, charges and payments. Similarly, AHCCCS will collect and distribute to hospitals all Medicaid supplemental payments (e.g. GME, Critical Access Hospitals (CAH), Rural Inpatient Payments) and Non-Title XIX payments (for Children Rehabilitative Services, the Comprehensive Medical and Dental Program, Behavioral Health Services and Payments for Trauma and Emergency Departments) on the basis of each hospital's CMS 2552 Report year.

All data compiled by the hospitals (e.g. total, uninsured and charity days; charges and payments; and state and local subsidy payment information not provided by AHCCCS) will be compiled on a CMS 2552 Report year basis.

---

[2] Note however that the use of the 2008 and 2009 reports and information referred to in this paragraph is for the determination of *final* DSH payments. For the initial 2008 DSH payments, reports and information for 2006 and 2007 will be submitted. For a discussion of initial payments, final payments and data sources, see the discussions that follow.

Except in the case where a hospital's fiscal year is identical to the State Plan Year – the calculations to determine eligibility for, and the amount of, DSH payments, will be performed separately for each hospital's fiscal year and these results will be prorated based on the distribution of months from each of the two years that encompass the SPY. For example, for SPY 2008 (10/1/07 to 9/30/08), for a hospital that has a CMS 2552 Report year that runs from 7/1 to 6/30, the proration of the results of the calculations will be derived by summing:

1. 9/12th of the result of the calculations performed for the fiscal/CMS Report year ending 6/30/08, and
2. 3/12th of the result of the calculations performed for the fiscal/CMS Report year ending 6/30/09.

**Timing of Eligibility Determination**

The eligibility determination calculations will be performed annually for all hospitals located in the State of Arizona that are registered as providers with AHCCCS. Eligibility calculations will be performed only with and for hospitals that have submitted the information required by this document and/or as otherwise requested by AHCCCS. In order to be considered "submitted", the information must be received by AHCCCS by the due date specified in a request for information communicated to the Chief Financial Officer of the hospital. The calculations will be performed with the information submitted by, or available to AHCCCS on the due date specified as the deadline for the submission of information.

The eligibility determination will be made in at least two steps:

1. The first step of the eligibility process will occur in the state plan rate year of the initial DSH payment. To determine initial eligibility, AHCCCS will:
    a. Extract from the PMMIS system all inpatient and outpatient hospital claims and encounters by date of service for each registered hospital for that hospital's fiscal years that encompass the state plan rate year two years prior to the state plan year of the initial DSH payment.
    b. Based on the extracted claims and encounters data and data provided by the hospitals, determine for each hospital whether or not that hospital has a Medicaid Inpatient Utilization Rate (MIUR) of at least 1%. For hospitals that qualify under this criteria, determine if the hospital:
        i. Meets the criteria for Group 1
        ii. Meets the criteria for Group 1A
        iii. Meets the criteria for Group 2
        iv. Meets the criteria for Group 2A
        v. Meets the criteria for Group 4
    c. Based on certifications filed by each hospital, determine if the hospital satisfies the criteria in Column B above.

2. The second step of the eligibility process will occur in the state plan rate year two years after the state plan rate year of the initial DSH payment. To determine final eligibility, AHCCCS will:
    a. Extract from the PMMIS system all inpatient and outpatient hospital claims and encounters by date of service for each registered hospital for that hospital's fiscal years that encompass the state plan rate year of the initial DSH payment.
    b. Based on the extracted claims and encounters data and data provided by the hospitals determine for each hospital whether or not that hospital has a MIUR of at least 1%. For hospitals that qualify under this criteria, determine if the hospital:
        i. Meets the criteria for Group 1
        ii. Meets the criteria for Group 1A
        iii. Meets the criteria for Group 2
        iv. Meets the criteria for Group 2A
        v. Meets the criteria for Group 4
    c. Based on certifications filed by each hospital, determine if the hospital satisfies the criteria in Column B above.

3. AHCCCS may redetermine any hospital's eligibility for any DSH payment should the agency become aware of any information that may prove that the hospital was not eligible for a DSH payment.

**MIUR Calculation (Overall Eligibility Criteria and Group 1 and Group 1A Eligibility)**

A hospital's Medicaid Inpatient Utilization Rate (MIUR) will determine the hospital's overall eligibility for DSH (Column C above) as well as the hospital's eligibility for Group 1 and Group 1A. A hospital's MIUR is calculated using the following equation:

$$\boxed{MIUR = \frac{Total\ Medicaid\ Inpatient\ Days}{Total\ Number\ of\ Inpatient\ Days}}$$

The calculation will be performed based on the state plan rate year. In order to find each hospital's MIUR for the state plan year, AHCCCS will calculate a MIUR separately for each hospital fiscal/CMS Report year that encompasses the relevant State Plan Year and then prorate the results from the two hospital fiscal/CMS Report years as described in the discussion above entitled "Data on a State Plan Year Basis".

If a hospital has a MIUR of at least 1%, and the obstetrical criteria of Column B above are satisfied, it will meet the overall eligibility criteria. If a hospital has a MIUR which is at least one standard deviation above the mean MIUR for all Arizona hospitals receiving a Medicaid payment in that State Plan Year, it will meet the eligibility for Group 1. If a hospital meets the eligibility criteria for Group 1 and is a privately owned or privately operated hospital licensed by the State of Arizona, it will meet the eligibility for Group 1A. NOTE that meeting overall eligibility criteria does not ensure that a hospital will meet the eligibility criteria for any Group.

In performing the calculations:

1. "Inpatient Days" includes:
    a. Fee-for-service and managed care days, and
    b. Each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward, and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

2. "Medicaid Inpatient Days" includes:
    a. All adjudicated inpatient days for categorically eligible Title XIX clients including days paid by Medicare except as noted below
    b. All adjudicated inpatient days for Demonstration eligible Title XIX clients – that is clients that are eligible for Title XIX including days paid by Medicare and days funded by Title XXI except as noted below

3. "Medicaid Inpatient Days" does not include:
    a. Inpatient days in which a categorically or Demonstration eligible Title XIX client was in an Institution for Mental Disease (IMD) and the client was between 21 and 65 years of age

*Data Sources for MIUR Calculations*

1. For "Medicaid Inpatient Days" the PMMIS claims and encounters
    a. For the initial determination of a hospital's MIUR, extracted based on date of service for the hospital's fiscal/CMS Report years that encompass the state plan rate year that ends two years prior to the state plan rate year of the initial DSH payment.
    b. For the second determination of a hospital's MIUR, extracted based on date of service for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.

2. For "Total Number of Inpatient Days" the CMS 2552-96
    a. For the initial determination of a hospital's MIUR, the cost report (or reports) for the hospital that encompass the state plan rate year two years prior to the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet S-3, Lines 1 and 6 through 11, Column 6 plus Line 14, Column 6 for hospital subprovider days. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.
    b. For the second determination of a hospital's MIUR, the cost report(s) for the hospital that encompass the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet S-3, Lines 1 and 6 through 11, Column 6 plus Line 14, Column 6 for hospital subprovider days. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-

96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.

*Calculation of the mean MIUR and the Standard Deviation*

In calculating the mean MIUR, the MIUR calculated for the state plan year for all Arizona hospitals that have received a Medicaid payment will be used. The mean MIUR – the average of the individual MIURs – will be calculated based on all the individual state plan year MIURs greater than zero (i.e. including the MIURs that are less than 1%). The standard deviation will be calculated based on the same list of individual hospital MIURs.

**LIUR Calculation (Group 2 Eligibility)**

A hospital's Low Income Utilization Rate (LIUR) will determine the hospital's eligibility for Group 2. A hospital's LIUR is calculated by summing the following two equations:

$$\boxed{LIUR = \frac{Total\ Medicaid\ Patient\ Services\ Charges + Total\ State\ and\ Local\ Cash\ Subsidies\ for\ Patient\ Services}{Total\ Charges\ for\ Patient\ Services}}$$

$$+$$

$$\boxed{\frac{Total\ Inpatient\ Charges\ Attributable\ to\ Charity\ Care - Cash\ Subsidies\ Portion\ Attributable\ to\ Inpatient}{Total\ Inpatient\ Charges}}$$

The calculation will be performed based on the state plan rate year. In order to find each hospital's LIUR for the state plan year, AHCCCS will calculate a LIUR separately for each hospital fiscal/CMS Report year that encompasses the relevant State Plan Year and then prorate the results from the two hospital fiscal/CMS Report years as described in the discussion above entitled "Data on a State Plan Year Basis".

If a hospital has a LIUR that exceeds 25% it will meet the eligibility for Group 2. If a hospital meets the eligibility criteria for Group 2 and is a privately owned or privately operated hospital licensed by the State of Arizona, it will meet the eligibility for Group 2A.

In performing the calculations:

1. "Total Medicaid Patient Services Charges" includes Title XIX charges for inpatient and outpatient services (both fee-for-service and managed care)

2. "Total Medicaid Patient Services Charges" does not include DSH payments or payments made for GME, Critical Access Hospitals, Rural Inpatient Payments or any other TXIX supplemental payments authorized by the Legislature as these amounts are effectively included in charges

3. "Total State and Local Cash Subsidies for Patient Services" includes payments made with state-only or local-only funds and includes, but is not limited to
    a. Payments made for:
        i. Non-Title XIX and Non-Title XXI enrollees in the DES Comprehensive Medical and Dental Program
        ii. Non-Title XIX and Non-Title XXI enrollees in the DHS Children's Rehabilitative Services program
        iii. Non-Title XIX and Non-Title XXI enrollees in the DHS Behavioral Health Services Program (note that these payments are typically made through Regional Behavioral Health Authorities)
        iv. The support of trauma centers and emergency departments
    b. Payments made by:
        i. An appropriation of state-only funds
        ii. The Arizona State Hospital
        iii. Local governments including (but not limited to):
            (1) Tax levies dedicated to support a governmentally-operated hospital
            (2) Tax levies from a hospital district organized pursuant to A.R.S. § 48-1901 et seq.
            (3) Subsidies for the general support of a hospital

4. "Total State and Local Cash Subsidies for Patient Services" does not include payments for or by:
    a. Inpatient or outpatient services for employees of state or local governments
    b. Governmentally-operated AHCCCS health plans or program contractors
    c. Tax reductions or abatements

5. "Total Charges for Patient Services" includes total gross patient revenue for hospital services (including hospital subprovider charges).

6. "Total Inpatient Charges Attributable to Charity Care" includes the amount of inpatient services – stated as charges – that is provided free to individuals who cannot afford health care due to inadequate resources as determined by the hospital's charity care policy and do not otherwise qualify for government subsidized insurance. In order to qualify as charity care, payment may neither be received nor expected.

7. "Total Inpatient Charges Attributable to Charity Care" does not include bad debt expense or contract allowances and discounts offered to third party payors or self pay patients that do not qualify for charity care pursuant to the hospital's charity care policy.

8. "Cash Subsidies Portion Attributable to Inpatient" means that portion of "Total State and Local Cash Subsidies for Patient Services" that is attributable to inpatient services.

9. "Total Inpatient Charges" includes total inpatient and hospital subprovider charges without any deductions for contract allowances or discounts offered to third party payors or self pay patients.

*Data Sources for LIUR Calculations*

1. For "Total Medicaid Patient Services Charges":
    a. For the initial determination of a hospital's LIUR:
        i. The PMMIS claims and encounters extracted based on date of service for each registered hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the year of the initial DSH payment.
    b. For the second determination of a hospital's LIUR:
        i. The PMMIS claims and encounters extracted based on date of service for each registered hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.

2. For the portion of "Total State and Local Cash Subsidies for Patient Services" and "Cash Subsidies Portion Attributable to Inpatient" attributed to Non-Title XIX and Non-Title XXI payments for the CMDP, CRS or Behavioral Health programs and for the payments in support of trauma centers and emergency departments:
    a. For the initial determination of a hospital's LIUR:
        i. AHCCCS will provide to hospitals the amounts of such payments made during the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the year of the initial DSH payment based on data from its financial records or from the financial records of the state agencies making the payments.
    b. For the second determination of a hospital's LIUR:
        i. AHCCCS will provide to hospitals the amounts of such payments made during the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment based on data from its financial records or from the financial records of the state agencies making the payments.
    c. In the case of CRS payments, if AHCCCS does not provide a breakdown of inpatient and outpatient payments, the hospital shall allocate the CRS payments between outpatient and inpatient based on the percentage of total inpatient charges to total charges for patient services

3. For all other "Total State and Local Cash Subsidies for Patient Services" and "Cash Subsidies Portion Attributable to Inpatient":
    a. For the initial determination of a hospital's LIUR:
        i. The hospital financial records for the payments received during the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the year of the initial DSH payment.
    b. For the second determination of a hospital's LIUR:
        i. The hospital financial records for the payments received during the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.

c. In the case of "Cash Subsidies Portion Attributable to Inpatient", if the hospital receives subsidies for the general operation of the hospital, allocation between outpatient and inpatient should be based on the percentage of total inpatient charges to total charges from patient services.

4. For "Total Inpatient Charges Attributable to Charity Care":
    a. For the initial determination of a hospital's LIUR:
        i. The hospital claims and financial records for the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the year of the initial DSH payment.
    b. For the second determination of a hospital's LIUR:
        i. The hospital claims and financial records for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.

5. For "Total Inpatient Charges":
    a. For the initial determination of a hospital's LIUR, the cost report (or reports) for the hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet C Part 1, Column 6 Line 101 less Lines 34 to 36, less Lines 63.5 to 63.99, and less Lines 64 to 68. If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted from Line 101. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.
    b. For the second determination of a hospital's LIUR, the cost report(s) for the hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet C Part 1, Column 6 Line 101 less Lines 34 to 36, less Lines 63.5 to 63.99, and less Lines 64 to 68. If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted from Line 101. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.

6. For "Total Charges for Patient Services":
    a. For the initial determination of a hospital's LIUR, the cost report (or reports) for the hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet C Part 1, Column 8 Line 101 less Lines 34 to 36, less Lines 63.5 to 63.99, and less Lines 64 to 68.

If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted from Line 101. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.

b. For the second determination of a hospital's LIUR, the cost report(s) for the hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet C Part 1, Column 8 Line 101 less Lines 34 to 36, less Lines 63.5 to 63.99, and less Lines 64 to 68. If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted from Line 101. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.

**Group 4 Eligibility Determination – Governmentally-operated Hospitals**

Because the state has designated all governmentally-operated hospitals (represented in Group 4) as DSH hospitals, no eligibility calculations are required.

**Obstetrician Requirements**

In order to ensure that hospitals receiving DSH payments meet requirements related to obstetricians, all hospitals that are determined to have a MIUR of at least 1% must file a completed certification statement indicating their compliance with the requirements. Any hospital that fails to return the certification statement by the date specified by AHCCCS will not be eligible to receive DSH payments for the state plan rate year of the initial DSH payment.

For the determination of a hospital's compliance with the obstetrician requirement, the certification will be based on the state plan rate year of the initial DSH payment from the start of the state plan rate year to the date of certification.

The certification statement shall incorporate the following language:

> I certify that the hospital indicated below currently has and has had since the beginning of the current state plan year at least two (2) obstetricians with staff privileges who have agreed to provide obstetric services to individuals eligible for Medicaid, OR
>
> I certify that the hospital indicated below is located in a rural area and currently has and

has had since the beginning of the current state plan year at least two (2) qualified physicians with staff privileges who have agreed to provide non-emergency obstetric services to individuals eligible for Medicaid, OR

I certify that the hospital indicated below did not offer non-emergency obstetric services to the general population as of December 22, 1987, or that the inpatients of the hospital are predominantly individuals under 18 years of age.

**Payment**

Pools and Changing Payment Levels

The DSH program in Arizona is funded through a six pool system. Each of the pools correlates to one of the hospital eligibility Groups. Therefore, there are five non-governmental hospital pools and one governmental hospital pool. The non-governmental hospital pool amounts are set by AHCCCS as authorized by the Arizona Legislature; the governmental pool amount is established by the Arizona Legislature. The amounts of funding for the pools for the current state plan year are contained in Exhibit 3.

If a non-governmental hospital qualifies for pool 1A it will be removed from pool 1. Similarly, if a non-governmental hospital qualifies for pool 2A it will be removed from pool 2. The non-governmental hospitals in pool 1 and pool 2 will be considered as a group and if a non-governmental hospital qualifies for more than one pool, the hospital will be categorized into the pool that maximizes its DSH payment. The non-governmental hospitals in pool 1A and 2A will be considered as a group, and if a non-governmental hospital qualifies for more than one pool, the hospital will be categorized into the pool that maximizes its DSH payment. The payment amount to each non-governmental hospital will be determined based on the maximization process performed during the state plan rate year of the initial DSH payment. The maximization process will be performed separately for 1) the non-governmental hospitals that qualify for pools 1 and 2, and; 2) the non-governmental hospitals that qualify for pools 1A and 2A.

There are five instances where the initial DSH payment to one or more non-governmental hospitals may change:

1. A hospital is found on the second eligibility determination (or any subsequent eligibility check) to not be eligible for a DSH payment in the state plan rate year of the initial DSH payment. In this instance, the amount of payment to the hospital will be recouped and the recouped amount will be distributed proportionately based on the initial DSH payments to the eligible hospitals remaining in the pool in which the ineligible hospital was placed in the state plan rate year of the initial DSH payment, up to each hospital's OBRA limit (see discussion below).

2. A hospital is found to have exceeded its finalized OBRA limit (see discussions below). In this instance, the amount of payment to the hospital in excess of its finalized OBRA limit will be recouped, and the recouped amount will be distributed proportionately based

on the initial DSH payments to the eligible hospitals remaining in the pool in which the hospital was placed in the state plan rate year of the initial DSH payment, up to each hospital's finalized OBRA limit.

3. In the event of a recoupment of an initial DSH payment and as a result of the process of distributing the recoupment to the pool to which the recouped payment was originally made, the distribution would result in all the hospitals in the pool receiving a total DSH payment in excess of their finalized OBRA limit, the amount of recoupment will be proportionately allocated among the remaining non-governmental hospital pools based on the initial DSH payments and distributed proportionately based on the initial DSH payments to the hospitals in the remaining pools up to each hospital's finalized OBRA limit.

4. In the event that litigation (either by court order or settlement), or a CMS audit, financial review, or proposed disallowance requires AHCCCS to issue DSH payment amounts to one or more hospitals in a pool in excess of the initial DSH payment amount, AHCCCS will proportionately recoup funds based on the initial DSH payments from the remaining hospitals in the pool or pools effected to satisfy the requirement. This process will be followed to ensure that the annual federal DSH allotment is not exceeded.

5. In the event that a hospital qualifies for a DSH payment in the second (or any subsequent) eligibility determination that did not qualify in the initial eligibility determination, that hospital will receive the minimum payment under the DSH program which is $5,000.

The payment amount to each governmentally-operated hospital will be determined during the state plan rate year of the initial DSH payment. The payment amount will only change if the total DSH payment to a hospital in the pool would be in excess of its finalized OBRA limit (see discussion below). To the extent that the excess amount recouped from a governmentally-operated hospital can be distributed to other hospitals in the pool without exceeding the interim or finalized OBRA limits of the remaining governmentally-operated hospitals, the excess amount will be distributed to the other governmentally-operated hospitals.

<u>Determination of Payment Amounts</u>

The amount that each non-governmental hospital receives as an initial DSH payment from the pool for which it qualifies is determined by a weighting method that considers both the amounts/points over the Group threshold and the volume of services. The volume of services is either measured by Title XIX days or net inpatient revenue, depending upon the group being considered.

*Hospitals that only qualify for Group 1 or Group 2*

There are ten steps to determining the DSH payment amount for non-governmental hospitals that only qualify for Group 1 or Group 2 (and not Group 1A or 2A). After determining the initial DSH payment amount through the ten step process, there is a final adjustment that may be made depending on the result of the hospital's OBRA limit.

1. Determine Points Exceeding Threshold.
   Each of the Groups 1 and 2 has thresholds established for qualification of the hospital. For Group 1 it is one standard deviation above the mean MIUR; for Group 2 it is greater than 25% LIUR. Step 1 merely determines the difference between each hospital's "score" for the Group measure and that Group's threshold.

2. Convert Points Exceeding Threshold into a Value.
   Each of the Groups 1 and 2 are measuring a value: for Group 1 the value is Medicaid days; for Group 2 it is revenue. Step 2 multiplies the Points Exceeding Threshold by the value of the associated Group.

3. Determine Relative Weight of Each Hospital in Each Group.
   The relative weight of each hospital in each Group is determined by dividing each hospital's value for a Group determined in Step 2 by the total of all hospital values for that Group.

4. Initial Allocation of Dollars to Each Hospital in Each Group.
   The amount of funds available to each of the Groups 1 and 2 is determined by AHCCCS as authorized by the Legislature. The funding amount for the current state plan year is contained in Exhibit 3. The initial allocation to each hospital in each group is determined by multiplying each hospital's relative weight in a Group (determined in Step 3) by the amount of funds available for that Group.

5. Maximize Allocation of Dollars Between Group 1 and Group 2.
   This step selects the greater of the allocation to each hospital between Group 1 and Group 2.

6. Recalculating the Relative Weights of Each Hospital in Group 1 and Group 2.
   Since Step 5 eliminated hospitals from both Group 1 and Group 2, it is necessary to redetermine the weight for each remaining hospital. This is accomplished by dividing the value of each hospital remaining in Group 1 and Group 2 after Step 5 by the total of the remaining hospitals.

7. Second Allocation of Dollars Within Group 1 and Group 2.
   The second allocation to each hospital remaining in Group 1 and Group 2 is determined by multiplying each hospital's recalculated relative weight pursuant to Step 6 by the amount of funds available for that Group.

8. Identifying Minimum Payment.
   It is policy that the minimum payment made to any hospital qualifying for DSH is $5,000. This step identifies any amount thus far determined for any hospital that is less than $5,000.

9. Ensuring Minimum Payment.
   This step replaces any amount thus far determined for any hospital that is less than

$5,000 with a $5,000 amount.

10. Determining Penultimate Payment Amount.
    With the replacement of values with the $5,000 minimum amounts, it is necessary to recalculate and redistribute the values within any Group where the minimum payment amount was imposed in order to ensure that the total funding for a Group is not exceeded. Step 10 accomplishes this.

After determining the penultimate initial DSH payment amount for each non-governmental hospital that only qualifies for Group 1 or Group 2 (and not Group 1A or 2A) a check of the determined amount is made against the hospital's initial OBRA limit. The description of that limit follows in a subsequent section. If the initial DSH payment amount exceeds the initial OBRA limit, the initial DSH amount is set to the OBRA limit and the excess amount is distributed to the remaining hospitals in the group, with a recheck of the initial DSH amounts against the OBRA limit. This process is repeated until all amounts are distributed or all hospitals in the group are at their OBRA limit.

*Hospitals that qualify for Group 1A or Group 2A*

There are thirteen steps to determining the DSH payment amount for non-governmental hospitals that qualify for Group 1A or 2A . After determining the initial DSH payment amount through the thirteen step process, there is a final adjustment that may be made depending on the result of the hospital's OBRA limit.

1. Determine Points Exceeding Threshold.
   Each of the Groups 1A or 2A has thresholds established for qualification of the hospital. For Group 1A it is one standard deviation above the mean MIUR; for Group 2A it is greater than 25% LIUR. Step 1 merely determines the difference between each hospital's "score" for the Group measure and that Group's threshold.

2. Convert Points Exceeding Threshold into a Value.
   Each of the Groups 1A and 2A are measuring a value: for Group 1A the value is Medicaid days; for Group 2A it is revenue.; Step 2 multiplies the Points Exceeding Threshold by the value of the associated Group.

3. Determine Relative Weight of Each Hospital in Each Group.
   The relative weight of each hospital in each Group is determined by dividing each hospital's value for a Group determined in Step 2 by the total of all hospital values for that Group.

4. Initial Allocation of Dollars to Each Hospital in Each Group.
   The amount of funds available to each of the Groups 1A and 2A is determined by AHCCCS as authorized by the Legislature. The funding amount for the current state plan year is contained in Exhibit 3. The initial allocation to each hospital in each group is determined by multiplying each hospital's relative weight in a Group (determined in Step 3) by the amount of funds available for that Group.

5. Maximize Allocation of Dollars Between Group 1A and Group 2A.
   This step selects the greater of the allocation to each hospital between Group 1A and Group 2A.

6. Recalculating the Relative Weights of Each Hospital in Group 1A and Group 2A.
   Since Step 5 eliminated hospitals from both Group 1A and Group 2A, it is necessary to redetermine the weight for each remaining hospital. This is accomplished by dividing the value of each hospital remaining in Group 1A and Group 2A after Step 5 by the total of the remaining hospitals.

7. Second Allocation of Dollars Within Group 1A and Group 2A.
   The second allocation to each hospital remaining in Group 1A and Group 2A is determined by multiplying each hospital's recalculated relative weight pursuant to Step 6 by the amount of funds available for that Group.

8. Identifying Minimum Payment.
   It is policy that the minimum payment made to any hospital qualifying for DSH is $5,000. This step identifies any amount thus far determined for any hospital that is less than $5,000.

9. Ensuring Minimum Payment.
   This step replaces any amount thus far determined for any hospital that is less than $5,000 with a $5,000 amount.

10. Determining Penultimate Payment Amount.
    With the replacement of values with the $5,000 minimum amounts, it is necessary to recalculate and redistribute the values within any Group where the minimum payment amount was imposed in order to ensure that the total funding for a Group is not exceeded.

After determining the penultimate initial DSH payment amount for each non-governmental hospital that qualifies for Group 1A or 2A a check of the determined amount is made against the hospital's initial OBRA limit. The description of that limit follows in the next section. If the initial DSH payment amount exceeds the initial OBRA limit, the initial DSH amount is set to the OBRA limit and the excess amount is distributed to the remaining hospitals in the group, with a recheck of the initial DSH amounts against the OBRA limit. This process is repeated until all amounts are distributed or all hospitals in the group are at their OBRA limit.

*Hospitals that qualify for Group 4*

To determine the initial DSH payment amount for each governmentally-operated hospital, the relative allocation percentage for each hospital is computed based on the lesser of the hospital's CPE and the amount of funding specified by the Legislature. The funding amount for the current state plan year is contained in Exhibit 3.

OBRA Limits

The DSH payment ultimately received by qualifying non-governmental hospitals is the *lesser* of the amount calculated pursuant to the above-described methodologies or the hospital's OBRA limit. The DSH payment ultimately received by governmentally-operated hospitals is the *lesser* of the amount funded and specified by the Legislature or the hospital's finalized OBRA limit. All DSH payments are subject to the federal DSH allotment.

The OBRA limit is calculated using the following equation:

$$\boxed{\begin{array}{l} \textit{Uncompensated Care Costs Incurred Serving Medicaid Recipients} + \\ \textit{Uncompensated Care Costs Incurred Serving the Uninsured} \end{array}}$$

Pursuant to the above equation, the OBRA limit is comprised of two components:

1. The amount of uncompensated care costs associated with providing inpatient and outpatient hospital services to Medicaid individuals (the Medicaid shortfall), and
2. The amount of uncompensated care costs associated with providing inpatient and outpatient hospital services to individuals with no source of third party coverage for the inpatient and outpatient hospital services they received (uninsured costs).

The OBRA limit for the state plan rate year of the initial DSH payment will be computed for each hospital up to three times:

1. The OBRA limit will be calculated in the state plan rate year of the initial DSH payment for all eligible hospitals based on the cost report(s) and days and charges and other program data for the state plan rate year two years prior to the state plan rate year of the initial DSH payment
2. For governmentally-operated hospitals, the OBRA limit will be recalculated when the cost report for the state plan rate year of the initial DSH payment is filed
3. The final calculation of each hospital's OBRA limit will be performed when the cost report for the state plan rate year of the initial DSH payment is finalized

The steps to computing the OBRA limit are[3]:

1. The hospital shall prepare its CMS 2552 Report (cost report(s)). Each hospital must complete the cost report to determine per diems (for inpatient routine services) and ratios of cost to charges (RCC) (for ancillary services). The cost reports must be completed

[3] Note: The following discussion applies to hospitals that do not have a per diem ancillary allocation methodology approved by Medicare. For the steps to calculate the OBRA limit for governmental hospitals that do have such approval, see Exhibit 2 to this Attachment D. Non-governmental hospitals that have such approval should contact AHCCCS for further information.

based on Medicare cost principles and Medicare cost allocation process as specified in the CMS 2552 instructions and the CMS Provider Reimbursement Manual, volumes 15-1 and 15-2, including updates.

2. Medicaid shortfall will be calculated based on information available from PMMIS, other AHCCCS financial systems, and the cost report.
3. Uninsured costs will be calculated based on uninsured days and charges and other program data collected by each hospital from its claims and financial records, other systems, and the cost report.

The sum of each hospital's Medicaid shortfall (whether positive or negative) and uninsured costs (whether positive or negative) is that hospital's OBRA limit.

The Medicaid Shortfall

The data used to calculate the Medicaid shortfall is extracted from the cost report(s) as well as from the AHCCCS PMMIS system and other AHCCCS financial reporting systems. The Medicaid shortfall will be calculated for each hospital for each fiscal/CMS Report year that encompasses the state plan year. The resulting Medicaid shortfall for each fiscal/CMS Report year will be prorated to derive the state plan year Medicaid shortfall according to the above discussion entitled "Data on a State Plan Year Basis".

The information from AHCCCS will include, but not be limited to:

1. The number of Medicaid fee for service (FFS) inpatient hospital days (for governmentally-operated hospitals this will be accumulated for each inpatient routine service cost center on the cost report)
2. The number of Medicaid managed care inpatient hospital days (for governmentally-operated hospitals this will be accumulated for each inpatient routine service cost center on the cost report)
3. The Medicaid inpatient and outpatient hospital FFS charges for ancillary cost centers (for governmentally-operated hospitals this will be accumulated separately for each ancillary cost center on the cost report)
4. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital FFS services
5. The amounts of Medicaid payments made by AHCCCS for inpatient and outpatient hospital FFS services
6. The Medicaid inpatient and outpatient hospital managed care charges for ancillary cost centers (for governmentally-operated hospitals this will be accumulated separately for each ancillary cost center on the cost report)
7. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services for health plans and program contractors
8. The amounts of Medicaid payments made by health plans and program contractors for inpatient and outpatient hospital services for health plans and program contractors
9. Other amounts of Medicaid payments for Medicaid inpatient and outpatient services furnished during the Medicaid state plan rate year under review (e.g. GME, CAH, etc.)

For each hospital, the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report will be applied to the data extracted from PMMIS (days and charges) to determine the cost of providing inpatient and outpatient Medicaid services. Inpatient and outpatient Medicaid services will not include services reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services. The per diem amounts will be calculated by dividing:

- The individual amounts on Worksheet B Part 1 Column 25 Lines (and where applicable Subscript Lines) 25 to 33
- By
- The corresponding day totals on Lines (and where applicable Subscript Lines) 5 through 11 and Line 14 (for inpatient hospital subproviders) from Worksheet S-3 Part I Column 6.

Note: when calculating the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 25, Line 25 should have deducted the amounts appearing on Worksheet D-1, Part I, Lines 26 and 36 and the amount on Worksheet S-3, Part I, Column 6, Line 5 should have added the amount appearing on Line 26 (observation bed days).

The ancillary RCCs will be calculated by dividing:

1. The individual Line and Subscript amounts for each of the Lines 37 to 63 taken from Worksheet B Part 1 Column 25
2. By
3. The individual Line and Subscript amounts for each of the Lines 37 to 63 taken from Worksheet C Part 1 Column 8

Costs will be offset by the payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services as well as payments made by AHCCCS including FFS payments, payments by health plans and program contractors, and supplemental payments (such as GME, Rural Hospital Payments and CAH) made during the hospital's fiscal/CMS Report years that encompass the state plan rate year.

Uninsured Costs

Each hospital will collect uninsured days and charges and program data for the hospital's fiscal/CMS Report years that encompass the state plan year from the hospital's claims and auditable financial records. Only hospital inpatient and outpatient days and charges and program data for medical services that would otherwise be eligible for Medicaid should be included in the DSH calculation. Inpatient and outpatient uninsured services will not include services that would be reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services if the patient were eligible for Medicaid. The uninsured days, charges and program information provided to the state is subject to the same audit standards and procedures as the data included in the cost report.

When providing uninsured days, charges and program information hospitals should be guided by the following:

The Uninsured are defined as:

- Self pay and self insured patients
- Individuals with no source of third party coverage for inpatient and outpatient hospital services
- Third party coverage does not include state and local government subsidized care (i.e. individuals covered by indigent programs without other forms of third party coverage are uninsured)
- Payments made by state or local government are not considered a source of third party payment
- It is permissible to include in the Uninsured individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.
- Individuals with AHCCCS coverage (either Medicaid or KidsCare) are not considered uninsured
- Individuals participating in a Ryan White HIV/AIDS Program that have no source of third party coverage for the services provided other than the Ryan White program are considered uninsured. However, the funding provided under the program must be considered payments received from or on behalf of patients or payments received from third parties.

When submitting uninsured days, charges and program information hospitals should accompany the submission with:

- A listing of all payor types that are included in the uninsured data compilation, and
- A CD or DVD that contains sufficient claims or other information (e.g. ICNs) to enable an auditor to tie the amounts submitted to the financial records of the hospital

The uninsured costs will be calculated for each hospital for each fiscal/CMS Report year that encompasses the state plan year. The resulting uninsured costs for each fiscal/CMS Report year will be prorated to derive the state plan year uninsured costs according to the above discussion entitled “Data on a State Plan Year Basis”.

The information to be collected will include, but not be limited to:

1. The number of uninsured inpatient hospital days (for governmentally-operated hospitals this will be accumulated for each inpatient routine service cost center on the cost report)
2. The uninsured inpatient and outpatient hospital ancillary charges (for governmentally-operated hospitals this will be accumulated for each ancillary cost center on the cost report)
3. The amounts of payments received during the hospital’s fiscal/CMS Report years that encompass the state plan year made by or on behalf of patients and payments made by third parties related to uninsured inpatient and outpatient hospital services. The information collected shall:

a. Include payments received during the hospital's fiscal/CMS Report years that encompass the state plan year under Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, of the MMA,
b. Not include payments, funding and subsidies made by the state or a unit of local governments (e.g., state-only, local-only or state-local health program)

For each hospital the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report (as determined for Medicaid) will be applied to the data collected by the hospital to determine the uninsured costs.

Costs will be offset by the payments received during the state plan year from or on behalf of patients and payments received during the hospital's fiscal/CMS Report years that encompass the state plan year from third parties related to all uninsured inpatient and outpatient hospital services. Payments made by state or local government are not considered a source of third party payment.

The OBRA Limit

The summation of the Medicaid shortfall (whether positive or negative) and the uninsured costs (whether positive or negative) is the hospital's OBRA limit.

**Group 5 Eligibility Determination**

Any Arizona hospital that qualifies for funding in Groups 1 and 2 (Group 1, 1A, 2, or 2A) is eligible for funding through Group 5. Group 5 is created to enable DSH-eligible hospitals to get qualifying DSH payments matched via voluntary intergovernmental agreements (IGAs). Per State Medicaid Director Letter #10-010, the State will require the appropriate documentation that the funding has been voluntarily provided. Group 5 DSH payments are on top of the Groups 1 and 2 DSH payments, but no individual hospital will receive aggregate DSH payments that exceed its OBRA limit.

Funding for any hospital in Group 5 must be arranged via a voluntary intergovernmental agreement with a political subdivision, tribal government or public university, using public funds not derived from impermissible sources, such as impermissible provider-related donations or impermissible health care-related taxes, as a match to draw down DSH payments. Political subdivisions, tribal governments and public universities will notify AHCCCS of the hospitals designated to receive funds and of the amount of matching funds that are available through their IGAs.
For hospitals that qualify for Group 5, a "LOM" score will be calculated by multiplying the hospital's LIUR times the hospital's full OBRA limit, times the hospital's MIUR.

Example:
Hospital A
OBRA = $54,734,467, MIUR = 0.3542, LIUR = 0.2946
Group 5 LOM score for Hospital A = $54,734,467 x 0.3542 x 0.2946 = $5,711,394

For the first round of distributions, each hospital's percentage of the total group LOM score will be calculated using the hospital's LOM score as the numerator and the total of all eligible hospitals' LOM

scores as the denominator. The total amount of DSH available as a result of the IGAs (Group 5 DSH funds) will be multiplied by each hospital's LOM percentage of this first round. If any allocation from this round is higher than a hospital's OBRA limit (remaining after Group 1 and 2 DSH distributions) or higher than the matching funds (in total computable) for that hospital, the lower of those two limits will be recorded as the allocation for round one.

For subsequent rounds, only the hospitals that have not hit their OBRA limit or matching fund limit will be considered in that round. The LOM score for only those hospitals will be totaled. Each hospital's percentage of the total LOM score for that round will be calculated. The total amount of Group 5 DSH funds remaining for that round will be multiplied by each hospital's LOM percentage for that round. If any allocation from any round is higher than a hospital's remaining OBRA limit or higher than the remaining total computable matching funds for that hospital, the lower of those two limits will be recorded as the allocation for that round.

Distribution rounds will continue until all Group 5 DSH funds are distributed, or all Group 5 qualifying hospitals have received the maximum distribution identified in the IGAs or reached their individual OBRA limits, whichever comes first. All excess IGA funds not used for Group 5 DSH distributions, due to application of the above limits, will be returned to the originating political subdivisions, tribal governments or public universities and will not be retained by AHCCCS for other uses.

The Group 5 DSH distribution for any hospital will consist of that hospital's total of allocations from all rounds.

## Aggregate Limits

*IMD Limit*

Federal law provides that aggregate DSH payments to Institutions for Mental Diseases (IMDs) in Arizona is confined to the *lesser* of $28,474,900 or the amount equal to the product of Arizona's current year total computable DSH allotment and 23.27%. Therefore, DSH payment to IMDs will be reduced proportionately to the extent necessary to ensure that the aggregate IMD limit is not exceeded.

"Institutions for Mental Diseases" includes hospitals that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

*Overall Total Limit*

The federal government shares in the cost of Medicaid DSH expenditures based on the Federal Medical Assistance Percentage (FMAP) for each state. However, for each fiscal year, the amount of federal funds available to states for DSH payment is fixed. As such, the total amount of DSH payments for a state plan rate year will not exceed the federal allotment divided by the FMAP.

**Reconciliation**

The initial DSH payment issued to a hospital by AHCCCS is considered "interim" and is subject to different reconciliation methodologies depending upon whether the hospital is non-governmental or governmentally-operated. The payments to hospitals are generally made as a single lump sum payment that is made once the calculations of the payment amounts are completed. The purpose of the interim DSH payment is to provide reimbursement that approximates the Medicaid and uninsured inpatient hospital and outpatient hospital uncompensated care costs eligible for Federal Financial Participation (FFP).

The reasons for a change in the initial (or interim) DSH payment for both non-governmental and governmentally-operated hospitals are outlined above under "Pools and Changing Payment Levels".

If it is determined that the total amount of payments made to non-governmental hospitals under the methodology outlined in the "Pools and Changing Payment Levels" exceeds the amount of all finalized non-governmental hospital OBRA limits, the amount in excess will be recouped by AHCCCS and any associated federal funding claimed will be properly credited to the federal government.

If it is determined that the total amount of payments made to governmentally-operated hospitals under the methodology outlined in the "Pools and Changing Payment Levels" exceeds the amount of either:

1. All governmentally-operated hospital OBRA limits calculated based on the "finalized" cost report, or
2. The total amount of certified public expenditures of governmentally-operated hospitals, then
3. The amount in excess will be recouped by AHCCCS and any associated federal funding claimed will be properly credited to the federal government.

**Certified Public Expenditures**

Expenditures by governmentally-operated hospitals shall be used by AHCCCS in claiming FFP for DSH payments to the extent that the amount of funds expended are certified by the appropriate officials at the governmentally-operated hospital.

The method for determining a governmentally-operated hospital's allowable uncompensated care costs eligible for DSH reimbursement when such costs are funded through the certified public expenditure (CPE) process will be the same as the method for calculating and reconciling the OBRA limit for governmentally-operated hospitals set forth above.

However, because governmentally-operated hospitals are certifying expenditures for the state plan year of the initial DSH payment and final expenditures may not be known at the time of initial certification of public expenditures, governmentally owned hospitals may certify an amount of expenditures for the initial DSH payment based on an estimate of the OBRA limit for

the state plan year of the initial DSH payment.

In certifying estimates of public expenditure for the initial DSH payment, the governmentally operated hospital will first calculate its expenditures based on the methodology for calculating the OBRA limit for the state plan year two years before the state plan year of the initial payment (as specified in the protocols in Exhibit 1 or Exhibit 2) and then provide for adjustments to such OBRA limit. The adjustments may increase or decrease the days, costs, charges or payments reflected on the cost reports, Medicaid and/or uninsured information used to calculate the OBRA limit. The adjustments will reflect increases and decreases resulting from changes in operations or circumstances that are not reflected in the information from the state plan year two years prior to the state plan year of the initial payment, but will be reflected in the final information for the state plan year of the initial payment. All adjustments must be supported by adequate explanation/justification and is subject to review by AHCCCS and CMS.

In order to use CPE, the certifying governmentally-operated hospital must follow the protocol in Exhibit 1 or Exhibit 2 and provide a certification as to the amount of allowable uncompensated care costs eligible for DSH reimbursement. If CPE is used, the amount of expenditures used to determine the FFP will not exceed the amount of the CPE.

The payment of FFP to governmentally-operated hospitals is subject to legislative appropriation.

## Grievances and Appeals

The state considers a hospital's DSH eligibility and DSH payment amount to be appealable issues. A DSH eligibility list along with the initial DSH payment amounts that eligible hospitals have been calculated to receive will be distributed. Hospitals will be permitted thirty (30) days from distribution to appeal their DSH eligibility and payment amounts. Because the total amount of DSH funds is fixed, the successful appeal of one DSH hospital will reduce DSH payment amounts to all other providers. Once the final reconciliation process is completed, no additional DSH payment will be issued.

## Other Provisions

Ownership

DSH payment will only be issued to the entity which is currently registered with AHCCCS as a participating hospital provider. Therefore, it is expected that facilities will consider this information when negotiating ownership changes.

**Attachment D - AHCCCS Disproportionate Share Hospital (DSH) Payments Exceptions (Revised May 29, 2009)**

**An exception to the use of the Medicare Cost Report (Form CMS 2552-96) as a data source shall apply to:**

I. **Hospitals that:**

- Serve patients that are predominantly under 18 years of age, and
- Are licensed for fewer than 50 beds, and
- Do not file a comprehensive Form CMS 2552-96 (Medicare Cost Report), and
- Receive an acceptance letter from the CMS fiscal intermediary for the portion of the CMS 2552-96 (Medicare Cost Report) that the hospital does file with the fiscal intermediary, and
- Receive written permission from AHCCCS to invoke the provisions of this exception.

Such hospitals may extract data from their financial records in lieu of extracting data from the Form CMS 2552-96 (Medicare Cost Report) as provided in this Attachment D.

The method of extracting and compiling the data from the hospital's financial records shall conform to the instructions for the Form CMS 2552-96. All other non-Medicare Cost Report data and documentation as described in this Attachment D shall be required from such hospitals.

**II. Indian Health Service (IHS) Hospitals** and tribally-operated 638 hospitals who do not file a full Form CMS 2552-96 Medicare Cost Report but rather file an abbreviated Medicare cost report in accordance with Medicare Provider Reimbursement Manual, Part I, Section 2208.1.E (Method E cost report).

Such IHS Hospitals and tribally-operated 638 hospitals can submit a Private Facility Information Sheet (PFIS) to AHCCCS using data from the IHS Method E report that is filed with CMS as well as supporting hospital financial reports, as necessary.

The method of extracting and compiling the data from the hospital's financial records shall conform to the instructions for the Form CMS 2552-96. All other non-Medicare Cost Report data and documentation as described on the PFIS cover sheet will be required by such hospitals.

**EXHIBIT 1 to ATTACHMENT D**

**AHCCCS**
**Disproportionate Share Hospital Payment Methodology**
**Calculation of OBRA Limits for**
**Governmentally-Operated Hospitals for the Purpose of**
**Certified Public Expenditures**

Each governmentally-operated hospital certifying its expenditures for Disproportionate Share Hospital (DSH) payments shall compute and report its OBRA limit as prescribed by this Exhibit. The governmentally-operated hospital's OBRA limit is comprised of two components:

1. The amount of uncompensated care costs associated with providing inpatient and outpatient hospital services to Medicaid individuals (the Medicaid shortfall), and
2. The amount of uncompensated care costs associated with providing inpatient and outpatient hospital services to individuals with no source of third party coverage for the inpatient and outpatient hospital services they received (uninsured costs).

The steps to computing the governmentally-operated hospital's OBRA limit are[4]:

1. The hospital shall prepare its CMS 2552 Report (cost report(s)). Each hospital must complete the cost report to determine per diems (for inpatient routine services) and ratios of cost to charges (RCC) (for ancillary services). The cost reports must be completed based on Medicare cost principles and Medicare cost allocation process as specified in the CMS 2552 instructions and the CMS Provider Reimbursement Manual, volumes 15-1 and 15-2, including updates.
2. Medicaid shortfall will be calculated based on information available from PMMIS, other AHCCCS financial systems, and the cost report.
3. Uninsured costs will be calculated based on uninsured days and charges and other program data collected by the hospital from its claims and financial records, other systems, and the cost report.
4. Finally, the governmentally-operated hospital will compile and summarize the calculations on The OBRA Limit and CPE Schedule. In compiling and summarizing the OBRA calculations, the governmentally-operated hospital may make adjustments to the calculated OBRA limit to estimate the OBRA limit for a future state plan year. The adjustments may increase or decrease the days, costs, charges or payments reflected on the cost reports, Medicaid and/or uninsured information used to calculate the OBRA limit. The adjustments will reflect increases and decreases resulting from changes in operations or circumstances that are not reflected in the information from the state plan

[4] Note: The following discussion applies to hospitals that do not have a per diem ancillary allocation methodology approved by Medicare. For the steps to calculate the OBRA limit for governmental hospitals that do have such approval, see Exhibit 2 to this Attachment D.

year two years prior to the state plan year of the initial payment, but will be reflected in the final information for the state plan year of the initial payment. All adjustments must be supported by adequate explanation/justification and is subject to review by AHCCCS and CMS. The Schedule will be submitted to AHCCCS, with backup documentation, for the cost reporting period(s) covered by the Medicaid state plan rate year(s) under review.

The Medicaid Shortfall

AHCCCS will provide each governmentally-operated hospital with a report from the PMMIS system and other agency financial reporting systems to assist each governmentally-operated hospital in completing required schedules. The information to be provided by AHCCCS will include, but not be limited to:

1. The number of Medicaid fee for service (FFS) inpatient hospital days (for each inpatient routine service cost center on the cost report)
2. The number of Medicaid managed care inpatient hospital days (for each inpatient routine service cost center on the cost report)
3. The Medicaid inpatient and outpatient hospital FFS charges (separately for each ancillary cost center on the cost report). Inpatient and outpatient Medicaid charges will not include charges reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services.
4. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital FFS services
5. The amounts of Medicaid payments made by AHCCCS for inpatient and outpatient hospital FFS services
6. The Medicaid inpatient and outpatient hospital managed care charges (for each ancillary cost center on the cost report). Inpatient and outpatient Medicaid charges will not include charges reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services.
7. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services for health plans and program contractors
8. The amounts of Medicaid payments made by health plans and program contractors for inpatient and outpatient hospital services for health plans and program contractors
9. Other amounts of Medicaid payments for Medicaid inpatient and outpatient services furnished during the Medicaid state plan rate year under review (e.g. GME, CAH, etc.)

Each governmentally-operated hospital will use the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report and the data extracted from PMMIS (days and charges) to determine the cost of providing inpatient and outpatient Medicaid services. Inpatient and outpatient Medicaid services will not include services reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services. The Medicaid shortfall will be calculated for each hospital for each fiscal/CMS Report year that encompasses the state plan year. The resulting Medicaid shortfall for each fiscal/CMS Report year will be prorated to derive the state plan year Medicaid shortfall according to the discussion entitled “Data on a State Plan Year Basis”.

The per diem amounts will be calculated by dividing:

- The individual amounts on Worksheet B Part 1 Column 25 Lines (and where applicable Subscript Lines) 25 to 33
- By
- The corresponding day totals on Lines (and where applicable Subscript Lines) 5 through 11 and Line 14 (for inpatient hospital subproviders) from Worksheet S-3 Column 6.

Note: when calculating the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 25, Line 25 should have deducted the amounts appearing on Worksheet D-1, Part I, Lines 26 and 36 and the amount on Worksheet S-3, Part I, Column 6, Line 5 should have added the amount appearing on Line 26 (observation bed days).

The ancillary RCCs will be calculated by dividing:

1. The individual Line and Subscript amounts for each of the Lines 37 to 63 taken from Worksheet B Part 1 Column 25
2. By
3. The individual Line and Subscript amounts for each of the Lines 37 to 63 taken from Worksheet C Part 1 Column 8

Each governmentally-operated hospital will use the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report and the data supplied by AHCCCS to compile the Medicaid Schedule of Costs on the OBRA Limit and CPE Schedule. The Medicaid Schedule of Costs depicts:

1. The governmentally-operated hospital specific Medicaid inpatient and outpatient cost data,
2. The payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services,
3. The Medicaid inpatient and outpatient net cost data,
4. Payments made by AHCCCS including FFS and payments by health plans and program contractors
5. The amount of supplemental Medicaid payments related to inpatient and outpatient hospital services (e.g., GME and CAH)
6. The Medicaid shortfall
7. Adjustments to the calculated Medicaid shortfall to estimate a Medicaid shortfall for a future state plan year.

Uninsured Costs

Each governmentally-operated hospital will collect uninsured days and charges and program data for the hospital's fiscal/CMS Report years that encompass the state plan year from the hospital's claims and auditable financial records. Only hospital inpatient and outpatient days and charges and program data for medical services that would otherwise be eligible for Medicaid should be included in the calculation. Inpatient and outpatient uninsured services will not include services that would be reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services if the patient were eligible for Medicaid. The uninsured days, charges and program information

provided to the state is subject to the same audit standards and procedures as the data included in the cost report.

When providing uninsured days, charges and program information hospitals should be guided by the following:

The Uninsured are defined as:

- Self pay and self insured patients
- Individuals with no source of third party coverage for inpatient and outpatient hospital services
- Third party coverage does not include state and local government subsidized care (i.e. individuals covered by indigent programs without other forms of third party coverage are uninsured)
- Payments made by state or local government are not considered a source of third party payment
- It is permissible to include in the Uninsured individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.
- Individuals with AHCCCS coverage (either Medicaid or KidsCare) are not considered uninsured
- Individuals participating in a Ryan White HIV/AIDS Program that have no source of third party coverage for the services provided other than the Ryan White program are considered uninsured. However, the funding provided under the program must be considered payments received from or on behalf of patients or payments received from third parties.

When submitting uninsured days, charges and program information hospitals should accompany the submission with:

- A listing of all payor types that are included in the uninsured data compilation, and
- A CD or DVD that contains sufficient claims or other information (e.g. ICNs) to enable an auditor to tie the amounts submitted to the financial records of the hospital

The information to be collected will include, but not be limited to:

1. The number of uninsured inpatient hospital days (for each inpatient routine service cost center on the cost report)
2. The uninsured inpatient and outpatient hospital ancillary charges (for each ancillary cost center on the cost report)
3. The amounts of payments received during the hospital's fiscal/CMS Report years that encompass the state plan year made by or on behalf of patients and payments made by third parties related to uninsured inpatient and outpatient hospital services. The information collected shall:
    a. Include payments received during the hospital's fiscal/CMS Report years that encompass the state plan year under Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, of the MMA,

b. Not include payments, funding and subsidies made by the state or a unit of local governments (e.g., state-only, local-only or state-local health program)

Each governmentally-operated hospital will use the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report (as determined for Medicaid), the uninsured days and charges, and other program data collected by the governmentally-operated hospital to compile the Uninsured Schedule of Costs on the OBRA Limit and CPE Schedule. The Uninsured Schedule of Costs depicts:

1. The governmentally-operated hospital specific uninsured inpatient and outpatient cost data,
2. The payments made by or on behalf of patients and payments made by third parties related to uninsured inpatient and outpatient hospital services, and
3. The uninsured inpatient and outpatient cost.
4. Adjustments to the calculated uninsured inpatient and out patient cost to estimate the uninsured inpatient and outpatient cost for a future state plan year.

The Governmentally-Operated Hospital OBRA Limit

The summation of the Medicaid shortfall (whether positive or negative) and the uninsured costs (whether positive or negative) is the hospital's OBRA limit and is depicted on the Calculation of OBRA Limit and CPE on the OBRA Limit and CPE Schedule.

The summation of the estimated Medicaid shortfall (whether positive or negative) and the estimated uninsured costs (whether positive or negative) is the hospital's OBRA limit for a future state plan year and is depicted on the Calculation of OBRA Limit and CPE on the OBRA Limit and CPE Schedule.

Certification

The appropriate official of the governmentally-operated hospital will sign the certification statement on the Governmentally-Operated Hospital OBRA Limit and CPE Schedule. A certification will be signed for each of the three times the OBRA limit for the state plan rate year of the initial DSH payment is calculated as described below under "Reconciliation".

Reconciliation

The OBRA limit for the state plan rate year of the initial DSH payment will be computed for each governmentally-operated hospital three times:

1. The OBRA limit will be calculated in the state plan rate year of the initial DSH payment based on the cost report(s) and days and charges and other program data for the state plan rate year two years prior to the state plan rate year of the initial DSH payment. This calculation may include an adjustment to the calculated OBRA limit of the state plan rate year two years prior to the state plan rate year of the initial DSH payment in order to estimate the OBRA limit of the state plan rate year of the initial DSH payment.

2. The OBRA limit will be recalculated when the cost report(s) for the state plan rate year of the initial DSH payment are filed. In recalculating the OBRA limit the cost data from the as-filed cost report(s) and program data (days, charges, and payments) from the actual cost reporting period(s) will be used in the calculation. This calculation may not include any adjustment to the calculated OBRA limit of the state plan rate year of the initial DSH.
3. The final calculation of each governmentally-operated hospital's OBRA limit will be performed when the cost report(s) for the state plan rate year of the initial DSH payment are finalized. In finalizing the OBRA limit the cost data from the finalized cost report(s) and program data (days, charges, and payments) from the actual cost reporting period(s) will be used in the calculation.

**EXHIBIT 2 to ATTACHMENT D**

**AHCCCS**
**Disproportionate Share Hospital Payment Methodology**
**Calculation of OBRA Limits for**
**Arizona State Hospital**
**A Hospital with a Per Diem Ancillary Cost Allocation Method**
**Approved by Medicare**

Arizona State Hospital (ASH), a governmentally-operated hospital that is an all-inclusive rate provider under Medicare, shall compute, report and certify its OBRA limit as prescribed by this Exhibit. Because ASH only provides inpatient services, the OBRA limit will by calculated based only on inpatient information. ASH's OBRA limit is comprised of two components:

1. The amount of uncompensated care costs associated with providing inpatient hospital services to Medicaid individuals (the Medicaid shortfall), and
2. The amount of uncompensated care costs associated with providing inpatient hospital services to individuals with no source of third party coverage for the inpatient hospital services they received (uninsured costs).

The steps to computing ASH's OBRA limit are:

1. The hospital shall prepare its CMS 2552 Report (cost report(s)). The hospital must complete the cost report to determine per diems (for inpatient routine services and for ancillary services). The cost reports must be completed based on Medicare cost principles and Medicare cost allocation process as specified in the CMS 2552 instructions and the CMS Provider Reimbursement Manual, volumes 15-1 and 15-2, including updates.
2. Medicaid shortfall will be calculated based on information available from PMMIS, other AHCCCS financial systems, and the cost report.
3. Uninsured costs will be calculated based on uninsured days and other program data collected by the hospital from its claims and financial records, other systems, and the cost report.
4. Finally, ASH will compile and summarize the calculations on The OBRA Limit and CPE Schedule. In compiling and summarizing the OBRA calculations, ASH may make adjustments to the calculated OBRA limit to estimate the OBRA limit for a future state plan year. The adjustments may increase or decrease the days, costs, charges or payments reflected on the cost reports, Medicaid and/or uninsured information used to calculate the OBRA limit. The adjustments will reflect increases and decreases resulting from changes in operations or circumstances that are not reflected in the information from the state plan year two years prior to the state plan year of the initial payment, but will be reflected in the final information for the state plan year of the initial payment. All adjustments must be supported by adequate explanation/justification and is subject to review by AHCCCS and CMS. The Schedule will be submitted to AHCCCS, with backup documentation, for the cost reporting period(s) covered by the Medicaid state plan rate year(s) under review.

The Medicaid Shortfall

AHCCCS will provide ASH with a report from the PMMIS system and other agency financial reporting systems to assist ASH in completing required schedules. The information to be provided by AHCCCS will include, but not be limited to:

1. The number of Medicaid fee for service (FFS) inpatient hospital days (for the single inpatient routine service cost center on the cost report)
2. The number of Medicaid managed care inpatient hospital days (for the single inpatient routine service cost center on the cost report)
3. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient hospital FFS services
4. The amounts of Medicaid payments made by AHCCCS for inpatient hospital FFS services
5. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient hospital services for health plans and program contractors
6. The amounts of Medicaid payments made by health plans and program contractors for inpatient hospital services for health plans and program contractors
7. Other amounts of Medicaid payments for Medicaid inpatient services furnished during the Medicaid state plan rate year under review (e.g. GME, CAH, etc.)

ASH will use a single total per diem calculated from the cost report and the inpatient days extracted from PMMIS to determine the cost of providing inpatient Medicaid services. The Medicaid shortfall will be calculated for ASH for each fiscal/CMS Report year that encompasses the state plan year. The resulting Medicaid shortfall for each fiscal/CMS Report year will be prorated to derive the state plan year Medicaid shortfall according to the discussion entitled "Data on a State Plan Year Basis".

The single total per diem amount will be calculated by summing the inpatient per diem amount and the ancillary per diem amount.

The inpatient per diem amount will be found by dividing the amounts on Worksheet B Part 1 Column 25 Line 25 by the day total on Line 5 from Worksheet S-3 Column 6. Note: when calculating the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 25, Line 25 should have deducted the amounts appearing on Worksheet D-1, Part I, Lines 26 and 36 and the amount on Worksheet S-3, Part I, Column 6, Line 5 should have added the amount appearing on Line 26 (observation bed days).

The ancillary per diem amount will be calculated by:

1. Summing the Line and Subscript amounts for each of the Lines 37 to 63 (but excluding Subscript Lines 63.5 to 63.99) taken from Worksheet B Part 1 Column 25
2. Dividing the amount determined in step 1 above by the amount determined in step 3 below

3. Summing the Lines 5 and 17 from Worksheet S-3 Column 6

ASH will use the single total per diem calculated from the cost report and the data supplied by AHCCCS to compile the Medicaid Schedule of Costs on the OBRA Limit and CPE Schedule. The Medicaid Schedule of Costs depicts:

1. The governmentally-operated hospital specific Medicaid inpatient cost data (determined by multiplying the single total per diem by the number of inpatient Medicaid days),
2. The payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient hospital services,
3. The Medicaid inpatient net cost data,
4. Payments made by AHCCCS including FFS and payments by health plans and program contractors
5. The amount of supplemental Medicaid payments (e.g., GME and CAH)
6. The Medicaid shortfall
7. Adjustments to the calculated Medicaid shortfall to estimate a Medicaid shortfall for a future state plan year.

Uninsured Costs

ASH will collect uninsured days and program data for the hospital's fiscal/CMS Report years that encompass the state plan year from the hospital's claims and auditable financial records. Only hospital inpatient days and program data for medical services that would otherwise be eligible for Medicaid should be included in the calculation. Inpatient uninsured services will not include services that would be reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services if the patient were eligible for Medicaid. The uninsured days and program information provided to the state is subject to the same audit standards and procedures as the data included in the cost report.

When collecting uninsured days and program information ASH should be guided by the following:

The Uninsured are defined as:

- Self pay and self insured patients
- Individuals with no source of third party coverage for inpatient hospital services
- Third party coverage does not include state and local government subsidized care (i.e. individuals covered by indigent programs without other forms of third party coverage are uninsured)
- Payments made by state or local government are not considered a source of third party payment
- It is permissible to include in the Uninsured individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.
- Individuals with AHCCCS coverage (either Medicaid or KidsCare) are not considered uninsured
- Individuals participating in a Ryan White HIV/AIDS Program that have no source of third party coverage for the services provided other than the Ryan White program are

considered uninsured. However, the funding provided under the program must be considered payments received from or on behalf of patients or payments received from third parties.

The uninsured costs will be calculated for ASH for each fiscal/CMS Report year that encompasses the state plan year. The resulting uninsured costs for each fiscal/CMS Report year will be prorated to derive the state plan year uninsured costs according to the discussion entitled "Data on a State Plan Year Basis".

The information to be collected will include, but not be limited to:

1. The number of uninsured inpatient hospital days (for the single inpatient routine service cost center on the cost report)
2. The amounts of payments received during the hospital's fiscal/CMS Report years that encompass the state plan year made by or on behalf of patients and payments made by third parties related to uninsured inpatient hospital services. The information collected shall:
    a. Include payments received during the hospital's fiscal/CMS Report years that encompass the state plan year under Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, of the MMA,
    b. Not include payments, funding and subsidies made by the state or a unit of local governments (e.g., state-only, local-only or state-local health program)

ASH will use the total inpatient per diem calculated from the cost report (as determined for Medicaid), the uninsured days, and other program data collected by ASH to compile the Uninsured Schedule of Costs on the OBRA Limit and CPE Schedule. The Uninsured Schedule of Costs depicts:

1. The ASH specific uninsured inpatient cost data (determined by multiplying the single total per diem by the number of uninsured inpatient days),
2. The payments made by or on behalf of patients and payments made by third parties related to uninsured inpatient hospital services, and
3. The uninsured inpatient cost.
4. Adjustments to the calculated uninsured inpatient and out patient cost to estimate the uninsured inpatient and outpatient cost for a future state plan year.

The Governmentally-Operated Hospital OBRA Limit

The summation of the Medicaid shortfall (whether positive or negative) and the uninsured costs (whether positive or negative) is the hospital's OBRA limit and is depicted on the OBRA Limit and CPE Schedule.

The summation of the estimated Medicaid shortfall (whether positive or negative) and the estimated uninsured costs (whether positive or negative) is the hospital's OBRA limit for a future state plan year and is depicted on the Calculation of OBRA Limit and CPE on the OBRA Limit and CPE Schedule.

Certification

The appropriate official of ASH will sign the certification statement on the OBRA Limit and CPE Schedule. A certification statement will be signed for each of the three times the OBRA limit for the state plan year of the initial DSH payment is calculated as described below under "Reconciliation".

Reconciliation

The OBRA limit for the state plan rate year of the initial DSH payment will be computed for ASH three times:

1. The OBRA limit will be calculated in the state plan rate year of the initial DSH payment based on the cost report(s) and days and other program data for the state plan rate year two years prior to the state plan rate year of the initial DSH payment. This calculation may include an adjustment to the calculated OBRA limit of the state plan rate year two years prior to the state plan rate year of the initial DSH payment in order to estimate the OBRA limit of the state plan rate year of the initial DSH payment.
2. The OBRA limit will be recalculated when the cost report(s) for the state plan rate year of the initial DSH payment are filed. In recalculating the OBRA limit the cost data from the as-filed cost report(s) and program data (days and payments) from the actual cost reporting period(s) will be used in the calculation. This calculation may not include any adjustment to the calculated OBRA limit of the state plan rate year of the initial DSH.
3. The final calculation of ASH's OBRA limit will be performed when the cost report(s) for the state plan rate year of the initial DSH payment are finalized. In finalizing the OBRA limit the cost data from the finalized cost report(s) and program data (days and payments) from the actual cost reporting period(s) will be used in the calculation.

**EXHIBIT 3 to ATTACHMENT D**

**AHCCCS**
**Disproportionate Share Hospital Payment Methodology**
**Pool Funding Amount for SPY 2013**

This Exhibit contains the amount of funding for six pools in the Arizona DSH pool methodology.

For State Plan Year (SPY) 2008 and 2009, funding will be allocated among six pools (pools 1, 1A, 2, 2A, 3, and 4). For SPY 2010, funding will be allocated among seven pools (pools 1, 1A, 2, 2A, 3, 4, and 5). For SPY 2011, SPY 2012, and 2013 the funding will be allocated among six pools (pools 1, 1A, 2, 2A, 4, and 5).

Pools 1, 1A, 2, 2A, and 3 - Non-governmentally-operated hospitals
The funding for pools 1 and 2 will be sufficient to provide an average payment amount of $6,000 for all hospitals qualifying for both of the two pools. No hospital in pools 1 or 2 will receive less than $5,000. Therefore, the amount of funding for pools 1 and 2 will be determined by multiplying the number of hospitals qualifying for pools 1 and 2 by $6,000.

The funding for pools 1A, 2A and 3 (if applicable) will be derived by subtracting the total amount allocated for pools 1 and 2 from the amount of DSH authorized by the Legislature for non-governmentally operated hospitals. Beginning SPY 2011, these remaining funds will be split with 15% for Pool 1A and 85% for Pool 2A.

For SPY 2008, the funding for pools 1, 2, 1A, and 2A and 3 will be $26,147,700.
For SPY 2009, the funding for pools 1, 2, 1A, and 2A and 3 will be $26,147,700.
For SPY 2010, the funding for pools 1, 2, 1A, and 2A and 3 will be $500,000.
For SPY 2011, the funding for pools 1, 2, 1A, and 2A will be $9,284,800.
For SPY 2012, the funding for pools 1, 2, 1A, and 2A will be $9,284,800.
For SPY 2013, the funding for pools 1, 2, 1A, and 2A will be $9,284,800.

Pool 4 – Governmentally-operated hospitals
The funding for pool 4 is the amount authorized by the Legislature for governmentally operated hospitals.

For SPY 2008, the funding for pool 4 is $117,914,800.
For SPY 2009, the funding for pool 4 is $128,427,000.
For SPY 2010, the funding for pool 4 is $132,596,900.
For SPY 2011, the funding for pool 4 is $128,637,400.
For SPY 2012, the funding for pool 4 is $119,784,246
For SPY 2013, the funding for pool 4 is $118,352,300

For SPY 2009, any excess DSH funding in pool 4 not allocated due to OBRA limits may be reallocated and distributed to DSH-qualifying hospitals in pools 1, 1A, 2, 2A or 3 until September 30, 2011. AHCCCS shall notify CMS prior to the distribution of any pool 4

reallocated DSH funds.

For SPY 2010, funding will be reallocated first to pools 1, 1A, 2, 2A, and 3, should the State make available matching funds. This reallocation to the pools will be based proportionately on the SPY 2009 pool allocations. For each pool, the distribution of the reallocated DSH funding to the hospitals within the pool will be based on each hospital's 2010 relative weights as described in the "Determination of Payment Amounts" section of this Attachment D. SPY 2010 payments made from reallocated funds will be added to the hospital's original SPY 2010 payments with the total SPY payments subject to each hospital's OBRA limit. For SPY 2010, any excess DSH funding in pool 4 not allocated due to OBRA limits may be reallocated to DSH pools 1, 1A, 2, 2A, 3, and 5 until September 30, 2012. A determination will be made by June 30, 2012, by the Administration if any reallocation will occur. AHCCCS shall notify CMS prior to the distribution of any pool 4 reallocated DSH funds.

For SPY 2011, funding will be reallocated first to pools 1, 1A, 2, and 2A should the State make available matching funds. This reallocation to the pools will be based proportionately on the SPY 2011 pool allocation For each pool, the distribution of the reallocated DSH funding to the hospitals within the pool will be based on each hospital's 2011 relative weights as described in the "Determination of Payment Amounts" section of this Attachment D. SPY 2011 payments made from reallocated funds will be added to the hospital's original SPY 2011 payments with the total SPY payments subject to each hospital's OBRA limit. For SPY 2011, any excess DSH funding in pool 4 not allocated due to OBRA limits may be reallocated to DSH pools 1, 1A, 2, 2A, and 5 until September 30, 2013. A determination will be made by June 30, 2013, by the Administration if any reallocation will occur. AHCCCS shall notify CMS prior to the distribution of any pool 4 reallocated DSH funds.

For SPY 2012, funding will be reallocated first to pools 1, 1A, 2, and 2A should the State make available matching funds. This reallocation to the pools will be based proportionately on the SPY 2012 pool allocation For each pool, the distribution of the reallocated DSH funding to the hospitals within the pool will be based on each hospital's 2012 relative weights as described in the "Determination of Payment Amounts" section of this Attachment D. SPY 2012 payments made from reallocated funds will be added to the hospital's original SPY 2012 payments with the total SPY payments subject to each hospital's OBRA limit. For SPY 2012, any excess DSH funding in pool 4 not allocated due to OBRA limits may be reallocated to DSH pools 1, 1A, 2, 2A, and 5 until September 30, 2014. A determination will be made by June 30, 2014, by the Administration if any reallocation will occur. AHCCCS shall notify CMS prior to the distribution of any pool 4 reallocated DSH funds.

For SPY 2013, funding will be reallocated first to pools 1, 1A, 2, and 2A should the State make available matching funds. This reallocation to the pools will be based proportionately on the SPY 2013 pool allocation For each pool, the distribution of the reallocated DSH funding to the hospitals within the pool will be based on each hospital's 2013 relative weights as described in the "Determination of Payment Amounts" section of this Attachment D. SPY 2013 payments made from reallocated funds will be added to the hospital's original SPY 2013 payments with the total SPY payments subject to each hospital's OBRA limit. For SPY 2013, any excess DSH funding in pool 4 not allocated due to OBRA limits may be reallocated to DSH pools 1, 1A, 2,

2A, and 5 until September 30, 2015. A determination will be made by June 30, 2015, by the Administration if any reallocation will occur. AHCCCS shall notify CMS prior to the distribution of any pool 4 reallocated DSH funds.

Additionally, for SPY 2010 forward, any remaining excess funding may be reallocated to pool 5. Additional DSH payments from Pool 5 are funded by transfers per IGAs. If more than one hospital has available voluntary match, the reallocation will be allocated based proportionately according to the hospital's LOM scores, subject to the lower of each hospital's remaining OBRA limit or the total computable matching fund amount designated for each hospital per the applicable IGA. AHCCCS shall notify CMS prior to the distribution of any pool 4 reallocated DSH funds. Any additional payments will be limited to a hospital's overall OBRA limit.

Pool 5 – Voluntary Intergovernmental Agreements
The funding for pool 5 will be provided through voluntary intergovernmental transfers to hospitals designated by political subdivisions, universities, and tribal governments. Political subdivisions, public universities, and tribal governments will notify AHCCCS of the hospitals that will be designated to receive funds and of the amount of matching funds that will be available through their intergovernmental agreements (IGAs). AHCCCS will provide CMS with a list of designated pool 5 hospitals as soon as it becomes available.

For SPY 2010, the funding for pool 5 is $26,000,000
For SPY 2011, the funding for Pool 5 is $16,000,000.
For SPY 2012, the funding for Pool 5 is $25,000,000.
For SPY 2013, the funding for Pool 5 is $ is $34,178,795.

Upon reconciliation, the non-federal portion of any Pool 5 funds that has to be recouped due to changes in hospital qualification or payment limits will be returned to the local match entity. The resulting federal funds will be returned to CMS.

**[To Be Placed on Public Hospital Letter Head]**

**State Plan Year _____**

☐ Initial

☐ Final

**CERTIFICATION STATEMENT**
**DISPROPORTIONATE SHARE HOSPITAL PAYMENT**

As the of Maricopa Medical Center, I certify that:

- Maricopa Medical Center has expended local funds in an amount equal to the OBRA Limit(s) indicated below.

- The local funds were not obligated to match other federal funds for any federal program and these funds are not federal funds.

- The attached Maricopa Medical Center OBRA Limit and CPE Schedule is true, accurate and complete to the best of my knowledge and belief and the information presented thereon is either identified and supported in the Hospital's accounting system, has been supplied to me by AHCCCS, or is supported by the attached documentation. I understand that the information presented on the Schedule is subject to audit.

- Maricopa Medical Center and I understand that the Disproportionate Share Hospital Payment received by the hospital will be from Federal funds, that any overpayment of those funds to the hospital will be recovered by AHCCCS, and that any falsification or concealment of a material fact made to receive payment of those funds may be prosecuted under Federal and/or State laws.

The estimated OBRA Limit Calculation for State Plan Year _____ is $ _____.

(Another line to certify a finalized amount will be added in the future)

_____ _____
Signature of CEO or CFO Printed Name

_____ _____
Title Date

**[To Be Placed on Public Hospital Letter Head]**

**State Plan Year 2008**

☐ Initial
☐ Final

**CERTIFICATION STATEMENT**
**DISPROPORTIONATE SHARE HOSPITAL PAYMENT**

As the of Arizona State Hospital, I certify that:

- Arizona State Hospital has expended State funds in an amount equal to the OBRA Limit(s) indicated below.

- The State funds were not obligated to match other federal funds for any federal program and these funds are not federal funds.

- The attached Arizona State Hospital OBRA Limit and CPE Schedule is true, accurate and complete to the best of my knowledge and belief and the information presented thereon is either identified and supported in the Hospital's accounting system, has been supplied to me by AHCCCS, or is supported by the attached documentation. I understand that the information presented on the Schedule is subject to audit.

- Arizona State Hospital and I understand that the Disproportionate Share Hospital Payment received by the hospital will be from Federal funds, that any overpayment of those funds to the hospital will be recovered by AHCCCS, and that any falsification or concealment of a material fact made to receive payment of those funds may be prosecuted under Federal and/or State laws.

The estimated OBRA Limit Calculation for State Plan Year _____ is $ _____.

(Another line to certify a finalized amount will be added in the future)

_____ _____
Signature of CEO or CFO Printed Name

_____ _____
Title Date

Spreadsheets – Excel Files

**Attachment E**

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

## Center for Medicaid and State Operations

### Letter Summary

*This letter clarifies some methods by which HCBS waivers under section 1915(c) may aid in the transitioning of individuals from institutional settings to their own home in the community through coverage of one-time transitional expenses. This clarification was promised in the HHS New Freedom Report to the President.*

---

SMDL #02-008

May 9, 2002

Dear State Medicaid Director:

Medicaid home and community-based services (HCBS) waivers are the statutory alternative to institutional care. Many states have found in HCBS waivers a cost-effective means to implement a comprehensive plan to provide services in the most integrated setting appropriate to the needs of individuals with disabilities.

However, individuals seeking a return to the community from institutions are faced with many one-time expenses, and many states are unclear about the extent to which waivers cover transition costs. Examples of those expenses include the cost of furnishing an apartment, the expense of security deposits, utility set-up fees, etc. Other states have expressed interest in having the waivers pay for apartment/housing rent. This letter is designed to answer such questions.

Federal funding under Medicaid HCBS waivers is not available to cover the cost of rent. States may offset rental expenses from state-only funds that augment federal HCBS resources, but federal financial participation (FFP) for such a purpose is not available for any apartment/housing rental expenses.

As the HHS Report for the President's *New Freedom Initiative* stated, however, states may secure federal matching funds under HCBS waivers for one-time, set-up expenses for individuals who make the transition from an institution to their own home or apartment in the community, such as security deposits, that do not constitute payment for housing rent.

States may pay the reasonable costs of *community transition services*, including some or all of the following components:

- Security deposits that are required to obtain a lease on an apartment or home;
- Essential furnishings and moving expenses required to occupy and use a community domicile;
- Set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating);
- Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy.

By reasonable costs, we mean necessary expenses in the judgment of the state for an individual to establish his or her basic living arrangement. For example, essential furnishings in the above context would refer to necessary items for an individual to establish his or her basic living arrangement, such a bed, a table, chairs, window blinds, eating utensils, and food preparation items. We would not consider essential furnishings to include diversional or recreational items such as televisions, cable TV access or VCRs.

States that choose to include community transition services in their HCBS waivers must demonstrate that this service, in combination with other services furnished under the waiver, would be cost-neutral to the Medicaid program. (In the streamlined HCBS waiver format, this cost neutrality is demonstrated in appendix G.) To be eligible for FFP, the service must be included in the individual's written plan of care (service plan) and fit within the service definitions established by the state.

For more than three years CMS has awarded "Nursing Facility Transition Grants" to states in which transition costs have been paid from grant funds. Those states found that coverage of transition expenses has been manageable, cost-effective and has greatly facilitated the expeditious integration of individuals into their communities from prior institutional living arrangements. Contacts and other relevant information about those states may be found on the CMS website.

Any questions concerning this letter may be referred to Mary Jean Duckett at (410) 786-3294.

Sincerely,

/s/

Dennis G. Smith
Director

cc:

CMS Regional Administrators
CMS Associate Regional Administrators
for Medicaid and State Operations

Lee Partridge
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Brent Ewig
Senior Director, Access Policy
Association of State and Territorial Health Officials

Jim Frogue
Acting Director, Health and Human Services Task Force
American Legislative Exchange Council

Trudi Matthews
Senior Health Policy Analyst
Council of State Governments

## Attachment F
## REIMBURSEMENT FOR CRITICAL ACCESS HOSPITALS

**Subject to the availability of state funds**, beginning May 1, 2002, supplemental payments will be made to non-I.H.S., non-638 facility in-state hospitals, certified by Medicare as Critical Access Hospitals (CAHs) under 42 CFR 485, Subpart F and 42CFR 440.170(g). These supplemental CAH payments shall be made in addition to the other payments described in Attachments 4.19-A (inpatient hospital) and 4.19-B (outpatient hospital). Supplemental payments shall be made based on each CAH designated hospital's percentage of total inpatient and outpatient Title XIX reimbursement paid relative to other CAH designated hospitals for the time period from July 1 through June 30 of the previous year.

AHCCCS will allocate the amount available through legislative appropriation in the following manner:

(1) Gather all adjudicated claims/encounters with dates of service from July 1 through June 30 of the prior year for each CAH-designated hospital.

(2) Sum the AHCCCS payments for inpatient and outpatient services for the year to establish a hospital-specific hospital paid amount.

(3) Total all AHCCCS payments for inpatient and outpatient services for the year to establish a total paid amount.

(4) Divide the hospital paid amount by the total paid amount to establish the hospital's utilization percentage.

(5) Divide the annual CAH appropriation by twelve to get the monthly CAH allocation.

(6) Multiply each hospital's monthly relative utilization by the monthly CAH allocation to establish each hospital's monthly payment.

Funding will be distributed based on the number of CAH-designated hospitals in each month and their Medicaid utilization. Because there may be a different number of CAH-designated hospitals each month, the hospital-specific weightings and payments may fluctuate from month to month. The calculations will be computed monthly and the distribution of the CAH dollars to the CAH-designated hospitals will be made twice a year.

**Attachment G**

**AACP** Acute Care and Behavioral Health Services

The following chart summarizes the services available to expansion populations covered under the Demonstration. It is not intended to be a detailed or comprehensive statement of benefit coverage. Except as specifically noted in the chart or elsewhere in the List of Waivers, CNOM's, and/or the Special Terms and Conditions, the scope of services for the expansion populations are as set forth in the Arizona State Plan.

| **Benefit** | **Title XIX** | | **Title XXI** |
|---|---|---|---|
| Age | < 21 yrs | ≥ 21 yrs | < 19 yrs |
| Inpatient Hospital Services | X | X | X |
| Outpatient Hospital Services and Rural Health Clinic Services | X | X | X |
| Other Lab and X-ray Services | X | X | X |
| Nursing Facility Services for Individuals 21 age or older other than services in an institution for mental disease | X | X | X |
| EPSDT- medical services and other services covered by Title XXI | X | | X |
| Family Planning Services and Supplies | X | X | |
| Physician Services | X | X | X |
| Medical and surgical services of a dentist | X | X | X |
| Medical or other remedial care provided by licensed practitioners | X | X | X |
| Home Health Services | X | X | X |
| Private Duty Nursing Services | X | X | X |
| Clinic Services | X | X | X |
| Dental Services | X | X | X |
| Physical Therapy and Related Services | X | X | X |
| Occupational Therapy | X | X | X |
| Services for individuals with speech hearing and language disorders | X | X | X |
| Prescribed Drugs | X | X | X |
| Prosthetic Devices | X | X | X |
| Eyeglasses | X | X | X |
| Diagnostic Services | X | X | X |
| Screening Services | X | X | X |
| Preventive Services | X | X | X |
| Rehabilitative services | | | |
| Inpatient hospital services, nursing facility services and intermediate care facility services for individuals age 65 or older in institutions for mental disease | X | X | X |
| Inpatient psychiatric facility services for individuals under 21 years of age | X | | X |
| Nurse mid-wife services | X | X | X |
| Hospice Care | | X | |
| Case Management and Tuberculosis related services | X | X | X |
| Respiratory care services | X | X | X |
| Certified Pediatric or family nurse practitioners' services | X | X | X |
| Transportation | X | X | X |
| Services of nurses in Religious Non-Medical Health Care Institutions | X | X | X |
| Nursing facility services for patients under 21 years of age | X | | X |
| Emergency hospital services | X | X | X |
| Personal Care Services | X | X | X |
| Behavioral Health | See Table 2 in STC #17 | | |
| | | | |

**Attachment H**

KidsCare II Operational Protocol

The following protocol provides operational specifics with respect to the opening of the KidsCare II program.

**Eligibility**

Children who were on the KidsCare waiting list and have income at or below 200 percent of the FPL, are not otherwise eligible for Medicaid, and meet all other requirements for the KidsCare II program are eligible for the KidsCare II program, based on available funding. Children who are on the KidsCare waiting list must pay outstanding KidsCare premiums before they can enroll into the KidsCare II program. In addition, children age 6 with income at or below 200 percent of the FPL who were Medicaid beneficiaries but who no longer qualify for Medicaid, will automatically be transferred to the KidsCare II program, if eligible.

**Enrollment Process**

Notices will be sent to households on the waiting list in the order in which they joined the waiting list, starting with the children who have been on the waiting list the longest. Households will have 30 days to respond and apply for KidsCare II. If a household does not respond within that 30 day period, it will be removed from the waiting list. However, households who respond after the 30 day response period has ended will be reviewed on a case-by-case basis if enrollment slots are still available. Notices will direct people to apply through Health-e-Arizona, the online application. The notices will provide locations and contact information for community assistors, including Health-e-Arizona subscriber sites and other community groups engaged in the statewide outreach effort. The notices will also include the telephone numbers for the Pima County Access Program (PCAP) hotline. Technical assistance will be available to households who request it.

AHCCCS will mail notices to 20,000 households in two initial phases of 10,000 mailings each, one week apart. In addition to the notices, AHCCCS will also use email addresses it has on file as another mechanism to contact households on the waiting list notifying them that they can apply for KidsCare II. The timing of these emails will correspond to the date when the notices described above are mailed.

In the event that less than 5,000 applications have been received for KidsCare II after the first two mailings, AHCCCS will have the next batch of notices to 20,000 households ready to go within two weeks after the date of the first mailing as an “on-deck” approach. AHCCCS will also ensure that the corresponding group of emails is also ready to be sent in tandem with the regular mail notices. AHCCCS will, on a weekly basis, monitor the caseload size/take-up rate, and adjust the size and timing of future mailings accordingly. The size and frequency of future mailings (e.g., lower to 5,000 or maintain at 20,000) will be based on actual application return rate, approval rate, and attrition. Should enrollment in KidsCare II drop below 15,000 children, AHCCCS will prepare additional mailings and utilize the same approach as described above.

Once a household has applied for the KidsCare II program through the Health-e-Arizona system, applications will be routed to the Department of Economic Security (DES) for Medicaid and KidsCare II determination. These applications will, in turn, be routed directly to a centralized office for Health-e-Arizona for processing. DES also has its own customer support line where KidsCare II applicants can call to determine the status of their application, but DES will refer applicants to the AHCCCS call center in order to receive information with respect to whether they are on the KidsCare waiting list, and if they are included in one of the "active" notice batches, i.e., the caller will be able to inquire if AHCCCS had sent them a notice informing them that they are eligible to apply for the KidsCare II program.

For Kids Care II enrollment funded by the City of Phoenix High Uncompensated Care Hospitals, AHCCCS will first notify any families remaining on the KidsCare wait list that may not have previously been eligible for KidsCare II as their income may have exceeded 175 percent of the FPL, the upper income limit established when KidsCare II opened. Once all families on the KidsCare wait list have been notified, following the procedures set forth in this Attachment, the state will open KidsCare II enrollment to the public and conduct stakeholder outreach, as well as continue its partnership with the third party hotline described below.

AHCCCS/DES will conduct specialized training for Health-e-Arizona staff, the State-operated customer service staff, and AHCCCS Office of the Client Advocate to ensure appropriate understanding of the KidsCare II program so that staff can more effectively assist beneficiary and applicant inquiries.

**Community Outreach**

Letters will be sent to Health-e-Arizona subscribers (representing about 220 community groups and facilities statewide) to educate about the new KidsCare II program. Once CMS approval is obtained, special training will be conducted for Health-e-Arizona subscribers, and additional training will be provided to the public through an AHCCCS Community Forum. Information regarding eligibility and process of the KidsCare II program will be posted to the AHCCCS website.

A third-party hotline will be established by PCAP that will operate during extended business hours during the week for a limited period. The hotline will work in coordination with AHCCCS to provide information about the KidsCare II waitlist to families. AHCCCS will provide PCAP access to the KidsCare waiting list as well as information on the children that have been sent notices to apply for the KidsCare II program in a manner that ensures the protection of hotline callers' and waitlist families' personal information.

For the KidsCare II expansion funded by the City of Phoenix High Uncompensated Care Hospitals, letters will be sent to Health-e-Arizona subscribers (representing about 220 community groups and facilities statewide) to educate about the expanded enrollment in the KidsCare II program. Once CMS approval is obtained, special training will be conducted for Health-e-Arizona subscribers, and additional training will be provided to the public through an AHCCCS Community Forum. Information regarding eligibility and process of the expanded KidsCare II

program will be posted to the AHCCCS website.

**Attachment I**
**Safety Net Care Pool Claiming Protocol**

In accordance with the Special Terms and Conditions (STC) Section VI, this Attachment I serves as the claiming protocol for Arizona's Safety Net Care Pool (SNCP) uncompensated care payments. The protocol provides for the computation of the uncompensated care cost limit for each provider type that is authorized to receive uncompensated care payments in accordance with Section VI and identified in Attachment J. For each Demonstration Year (DY), aggregate uncompensated care payments will be a distribution of the SNCP pool established in Section VI for each DY, and payments to each individual provider cannot exceed the uncompensated care cost limit as determined by this cost claiming protocol for each DY.

Generally, the uncompensated care cost limit is determined based on each provider's uncompensated costs pertaining to Section 1905(a) medical services furnished to Medicaid eligible and uninsured individuals. Allowable patient care costs, consistent with Medicare and Medicaid cost principles and OMB Circular A-87, A-121, and A-122 where applicable, are identified using a CMS-approved cost report. Such costs are apportioned to the eligible Medicaid and uninsured services and then offset by all applicable revenues. SNCP payments made based on interim computation of the uncompensated care cost limit (using prior period cost data) must be subsequently reconciled to a recomputation of the uncompensated care costs using the provider's as-filed and audited cost reports for the actual service period covered by the DY.

If a provider is eligible under both section A, B and/or C (Safety Net Hospital Systems) and under section D (City of Phoenix Hospitals) of Attachment J, payments to the provider will first be credited against the Phoenix Hospital Limit described in STC Paragraph 25(c), and any remaining eligible uncompensated costs for that provider will be credited against the Safety Net Hospital System Limit described in STC Paragraph 25(c). Under no circumstances will total SNCP payments to any provider, including payments credited against the Phoenix Hospital Limit and the Safety Net Hospital Limit as well as any disproportionate share hospital payments or other supplemental payments, exceed the provider’s uncompensated costs, as described in STC Paragraph 25(a) and in this Attachment I. In the instance that a provider first receives an allocation from the Phoenix Hospital Limit pool, the prior period uncompensated care cost data used as the allocation basis from the Safety Net Hospital System Limit pool will be that provider's prior period uncompensated care cost reduced by the Phoenix Hospital Limit pool distribution already made to the provider.

Additionally, this Attachment also provides for the claiming protocol for Arizona Designated State Health Program (DSHP) approved for federal matching in accordance with STC Section VI.

**<u>Hospital Inpatient and Outpatient Uncompensated Care Costs</u>**

To be eligible for Federal financial participation (FFP), SNCP uncompensated care payments to each individual hospital cannot exceed the uncompensated care costs as computed by the following steps:

*Interim Computation of Uncompensated Care Costs*

SNCP uncompensated care payments will be made to eligible providers and claimed for FFP in quarterly installments per DY (beginning with DY 2 for City of Phoenix hospitals). Each DY's SNCP will be distributed based on the provider's proportionate share of projected uncompensated care among all hospitals subject to the same Limit (either the Safety Net Hospital System Limit or the Phoenix Hospital Limit), to the extent that sufficient local matching funds are available. This interim computation of uncompensated care costs will be used as the basis for SNCP distribution and will also serve as the uncompensated care cost limit for SNCP payments made to the provider in each demonstration year.

1. The process of determining the hospital's interim uncompensated care cost limit begins with the use of each hospital's CMS 2552(s) filed with its Medicare contractor. For hospitals eligible pursuant to Section A of Attachment J, the most recent CMS 2552 filed the with hospital's Medicare contractor will be utilized. For hospitals eligible pursuant to Section D of Attachment J, any 2552s that overlap the base state fiscal year will be prorated based on the overlapping dates and utilized. The base state fiscal year is 2010.

2. Per diem amount for each hospital routine cost center is computed by dividing:
   - The individual amounts on Worksheet B, Part I, Column 25, Lines (and where applicable subscripted lines) 25 to 33 of CMS 2552-96 or Worksheet B, Part I, Column 24, Lines (and where applicable subscripted lines) 30-43 of CMS 2552-10
   - by
   - For hospitals eligible pursuant to Section A of Attachment J, the corresponding day totals on Lines (and where applicable subscripted lines) 5 through 11 and Line 14 (for inpatient hospital subproviders) from Worksheet S-3, Part I, Column 6 of CMS 2552-96 or Lines 7 through 13 and Lines 16-18 (for inpatient hospital subproviders) from Worksheet S-3, Part I, Column 8 of CMS 2552-10 consistent with the instructions below regarding observation bed days. For hospitals eligible pursuant to Section D of Attachment J, the corresponding day totals on Lines (and where applicable subscripted lines) 38 through 47 from Worksheet D-1, Part II. The days from Worksheet D-1 should equal to the days reported on Worksheet S-3 for each routine cost center, except that the Adults & Pediatrics days are adjusted for inclusion of observation bed days.

Note when computing the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 24, Line 25 of CMS 2552-96 (Worksheet B, Part I, Column 25, Line 30 of CMS 2552-10) should have deducted the amounts appearing on Worksheet D-1, Part I, Lines 26 and 36 (for swing bed and private room differential adjustments, respectively) of CMS 2552-96 and CMS 2552-10, and the amount on Worksheet S-3, Part I, Column 6, Line 5 of CMS 2552-96 (Worksheet S-3, Part I, Column 8, Line 7 of CMS 2552-10) should have added the amount appearing on Line 26 (observation bed days) of CMS 2552-96 (Line 28 of CMS 2552-10).

Ancillary ratio of cost-to-charges (RCC) for each hospital ancillary cost center is computed by dividing:

- The individual line and subscript amounts for each of the Lines 37 to 63, taken from Worksheet B, Part I, Column 25 of CMS 2552-96 or the individual line and subscript amounts for each of the Lines 50 to 93, taken from Worksheet B, Part I, Column 24 of CMS 2552-10.
- by
- The individual line and subscript amounts for each of the Lines 37 to 63, taken from Worksheet C, Part I, Column 8 of CMS 2552-96 or the individual line and subscript amounts for each of the Lines 50 to 93, taken from Worksheet C, Part I, Column 8 of CMS 2552-10.

(Note that the above cost report references are based on the CMS-2552-96 and CMS 2552-10. For later versions of the CMS-2552, the equivalent worksheets, columns and lines should be identified.)

3. For each hospital routine cost center, the per diem amount computed in Step #2 is applied to the number of Medicaid and uninsured hospital inpatient days for the service period as defined in Step #1. Only hospital inpatient days are to be included; all days pertaining to long term care units or any other non-hospital units must be excluded. The number of Medicaid and uninsured hospital inpatient days must be derived from auditable sources, including the State's PMMIS, managed care encounter data, and provider patient accounting records. Hospital Medicaid and uninsured days are identified for each hospital routine cost center. The result is the facility's Medicaid and uninsured hospital routine cost.

For each hospital ancillary cost center, the RCC computed in Step #2 is applied to the Medicaid and uninsured hospital inpatient and hospital outpatient ancillary charges for the service period as defined in Step #1. Only hospital ancillary charges are to be included; all charges pertaining to non-hospital units, including Rural Health Clinics, Federally Qualified Health Centers, and clinics that are not recognized as hospital outpatient departments, must be excluded. The Medicaid and uninsured hospital ancillary charges must be derived from auditable sources, including the State's PMMIS, managed care encounter data, and provider patient accounting records. Hospital Medicaid and uninsured ancillary charges are identified for each hospital ancillary cost center. The result is the facility's Medicaid and uninsured hospital inpatient and hospital outpatient ancillary cost.

4. The Medicaid and uninsured costs computed in Step #3 will be offset by all revenues received by the hospital for the Medicaid and uninsured hospital inpatient and hospital outpatient services, including but not limited to Medicaid FFS and supplemental payments made by AHCCCS; Medicaid payments made by health plans and program contractors; payments made by or on behalf of patients; payments made by third parties; and any other payments received by for uninsured services that are not excluded from offset under Section 1923(g)(1)(A) of the Social Security Act as State-only or local-only indigent care program payments.

5. The computed Medicaid and uninsured uncompensated care costs based on a prior period may be inflated to the current period using CMS market basket. Furthermore, the State may apply trending factors to account for changes in utilization (e.g., due to changes in Medicaid eligibility criteria) and Medicaid payment rates to ensure that interim uncompensated care costs

approximate final uncompensated care costs for the current service period as closely as possible. Such trending factors must account for both increases and decreases affecting a provider's uncompensated care costs.

6. The hospital's Medicaid and uninsured costs must be further adjusted to remove costs related to non-emergency services furnished to unqualified aliens. For this purpose, the hospital's uncompensated care costs will be reduced by 12.88% to the extent that such unqualified alien non-emergency service costs are not fully reimbursed by DSH dollars.

7. For any Phoenix High Uncompensated Care Hospital with a hospital-based inpatient facility located outside of Phoenix, the hospital’s Medicaid and uninsured costs will be further adjusted to remove costs related to the non-Phoenix facility. For this purpose, the costs will be adjusted by an estimate of the percentage of costs related to the Phoenix facility. This percentage will be calculated as the ratio of Medicaid revenues of the Phoenix facility to total Medicaid revenues for the Phoenix and non-Phoenix facilities.

8. For SNCP uncompensated care payments, the State must ensure that the payments made to hospitals are accounted for in the facility's disproportionate share hospital (DSH) OBRA 93 hospital-specific limit. There cannot be any duplication of payments for the same hospital uncompensated care costs under the SNCP and under DSH.

9. For hospitals eligible pursuant to Section A of Attachment J (Safety Net Hospital Systems), the interim computation of hospital uncompensated care cost limit as described above uses the same prior period cost report and other relevant data as that used by the State in its initial OBRA 93 hospital-specific limit computation for DSH payments for the current DSH State Plan Rate Year. For hospitals eligible pursuant to Section D of Attachment J (City of Phoenix Hospitals), the interim computation of hospital uncompensated care cost limit as described above uses cost reports that overlap the base state fiscal year of 2010.

*Interim Reconciliation*

Each hospital's uncompensated care costs must be recomputed based on the hospital's as-filed cost report for the actual service period. The cost report is filed with the Medicare contractor five months after the close of the cost reporting period. SNCP uncompensated care payments made to the hospital for a DY cannot exceed the recomputed uncompensated care cost limit. If, at the end of the interim reconciliation process, it is determined that expenditures claimed exceeded the individual hospital's uncompensated care cost limit, the overpayment will be recouped from the hospital, and the federal share will be properly credited to the federal government.

The interim reconciliation follows the same computation as outlined above in the Interim Computation of Uncompensated Care Costs steps, except that the per diems and RCCs, Medicaid and uninsured days and charges, and payment offset amounts used will pertain to the actual service period (rather than the prior period). Per diems and RCCs will be derived from the as-filed cost report; and Medicaid and uninsured days, charges and payments will be derived from the latest available auditable data for the service period. No trending factor will be applied. The

uncompensated care costs must again be adjusted to remove costs related to non-emergency services furnished to unqualified aliens. The State must ensure that there is no duplication of payments for the same hospital uncompensated care costs under the SNCP and under DSH; SNCP payments must be accounted for in the hospital's OBRA 93 hospital-specific limit.

A hospital's uncompensated care cost limit is determined for the twelve month period in each DY (beginning with DY 2 for City of Phoenix hospitals eligible pursuant to Section D of Attachment J), except for DY 3 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2013. Where a hospital's cost reporting period does not coincide with the DY (or partial DY in DY3), the uncompensated care costs computed for a cost reporting period can be allocated to the DY (or partial DY) based on the number of cost reporting months that overlap with the DY (or partial DY). This is consistent with the methodology for the computation of the OBRA 93 hospital-specific limit for a given DSH State plan rate year.

The interim reconciliation described above will be performed and completed within six months after the filing of the hospital Medicare cost report(s).

*Final Reconciliation*

Each hospital's uncompensated care costs must be recomputed based on the hospital's audited cost report for the actual service period. The cost report is audited and settled by the Medicare contractor to determine final allowable costs and reimbursement amounts as recognized by Medicare. SNCP uncompensated care payments made to the hospital for a DY cannot exceed the recomputed uncompensated care cost limit. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual hospital's uncompensated care cost limit, the overpayment will be recouped from the hospital, and the federal share will be properly credited to the federal government.

The final reconciliation follows the same computation as outlined above in the Interim Computation of Uncompensated Care Costs steps, except that the per diems and RCCs, Medicaid and uninsured days and charges, and payment offset amounts used will pertain to the actual service period (rather than the prior period). Per diems and RCCS will be derived from the audited cost report, and Medicaid and uninsured days, charges and payments will be updated with the latest available auditable data for the service period. No trending factor will be applied. The uncompensated care costs must again be adjusted to remove costs related to non-emergency services furnished to unqualified aliens. The State must ensure that there is no duplication of payments for the same hospital uncompensated care costs under the SNCP and under DSH; SNCP payments must be accounted for in the hospital's OBRA 93 hospital-specific limit.

A hospital's uncompensated care cost limit is determined for the twelve month period in each DY (beginning with DY 2 for City of Phoenix hospitals), except for DY 3 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2013. Where a hospital's cost reporting period does not coincide with the DY (or partial DY in DY3), the uncompensated care costs computed for a cost reporting period can be allocated to the DY (or partial DY) based on the number of cost reporting months that overlap with the DY (or

partial DY). This is consistent with the methodology for the computation of the OBRA 93 hospital-specific limit for a given DSH State plan rate year.

The final reconciliation described above will be performed and completed within six months after the audited hospital Medicare cost report(s) are made available.

The final computation of hospital uncompensated care cost limit as described above uses the same final cost report and other relevant data as that used by the State in its final OBRA 93 hospital-specific limit computation for DSH payments for the given DSH State Plan Rate Year.

**Federally Qualified Health Center Lookalike (FQHC-LA) Uncompensated Care Costs**

To be eligible for Federal financial participation (FFP), SNCP uncompensated care payments to each individual FQHC-LA cannot exceed the uncompensated care cost limit as computed by the following steps:

*Interim Computation of Uncompensated Care Costs*

SNCP uncompensated care payments will be made to eligible providers and claimed for FFP in quarterly installments per DY. Each DY's SNCP will be distributed based on the provider's proportionate share of projected uncompensated care, to the extent that sufficient local matching funds are available. This interim computation of uncompensated care costs will be used as the basis for SNCP distribution and will also serve as the uncompensated care cost limit for SNCP payments made to the provider in each demonstration year.

1. The process of determining the FQHC-LA's interim uncompensated care cost limit begins with the use of each clinic's most recently available average cost per visit used for Medicaid reimbursement, as computed under the FQHC Alternative Payment Methodology in the Arizona State plan Attachment 4.19-B.

The average cost per visit is derived from FQHC-LA cost reports filed with AHCCCS. (The State plan provides that this average cost per visit is computed based on costs and visits for two consecutive cost reporting periods.) The State must ensure that the FQHC-LA cost report accounts for only allowable costs related to FQHC health care services, including staff and other healthcare costs and allocable overhead; removes any costs related to non-FQHC services and any overhead allocable to non-reimbursable activities; allows only for costs that are consistent with Medicare and Medicaid cost principles and applicable OMB Circulars; and defines a visit consistent with the State plan definition of an FQHC visit.

2. The average cost per visit is multiplied by the number of uninsured visits pertaining to the most recently available cost reporting period. The number of uninsured FQHC-LA visits must be derived from auditable sources. The result is the facility's uninsured cost.

Note that for interim computation of uncompensated care costs, Medicaid visits are not included, as these Medicaid visits are reimbursed at the average cost per visit being used to estimate current period actual cost per visit.

3. The uninsured costs computed in Step #2 will be offset by all revenues received by the FQHC-LA for the uninsured services, including but not limited to payments made by or on behalf of patients and any other payments received for uninsured services including applicable grants.

5. The average cost per visit has already been trended to the current period. However, the State can apply trending factors to account for known changes in uninsured utilization to ensure that interim uncompensated care costs approximate final uncompensated care costs for the

current service period as closely as possible. Such trending factors must account for both increases and decreases affecting a provider's uncompensated care costs.

6. The FQHC-LA's uninsured costs must be further adjusted to remove costs related to non-emergency services furnished to unqualified aliens. For this purpose, the clinic's uncompensated care costs will be reduced by 12.88.

*Interim Reconciliation*

Each FQHC-LA's uncompensated care costs must be recomputed based on the actual as-filed cost report for the actual service period. The cost report is filed with AHCCCS covering the federal fiscal year (ending September 30) by April of the following year. SNCP uncompensated care payments made to the FQHC-LA for a DY cannot exceed the recomputed uncompensated care cost limit. If, at the end of the interim reconciliation process, it is determined that expenditures claimed exceeded the individual clinic's uncompensated care cost limit, the overpayment will be recouped from the clinic, and the federal share will be properly credited to the federal government.

The interim reconciliation follows the same computation as outlined above in the Interim Computation of Uncompensated Care Costs steps, except that:

- The cost per visit is computed based on allowable FQHC-LA cost and total visits pertaining to the actual service period cost report.
- Both Medicaid visits and uninsured visits furnished during the service period are applied to the actual cost per visit to determine the clinic's Medicaid and uninsured costs. Medicaid and uninsured visits must be derived from auditable sources, including the State's PMMIS, managed care encounter data, and provider patient accounting records.
- Both Medicaid and uninsured revenues, applicable to actual service period and derived from auditable sources, are offset against Medicaid and uninsured costs to arrive at the clinic's uncompensated care costs.
- No trending factor will be applied.

The uncompensated care costs must again be adjusted to remove costs related to non-emergency services furnished to unqualified aliens.

An FQHC-LA's uncompensated care cost limit is determined for the twelve month period in each DY, except for DY 3 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2013. Where a clinic's cost reporting period does not coincide with the DY (or partial DY in DY3), the uncompensated care costs computed for a cost reporting period can be allocated to the DY (or partial DY) based on the number of cost reporting months that overlap with the DY (or partial DY).

The interim reconciliation described above will be performed and completed within six months after the filing of the FQHC-LA cost report(s).

*Final Reconciliation*

Each FQHC-LA's uncompensated care costs must be recomputed based on the actual audited cost report for the actual service period. The cost report is audited to ensure costs are allowable consistent with Medicare and Medicaid cost principles and applicable OMB Circulars; and that FQHC services and visits are recognized consistent with the Medicaid State plan. SNCP uncompensated care payments made to the FQHC-LA for a DY cannot exceed the recomputed uncompensated care cost limit. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual clinic's uncompensated care cost limit, the overpayment will be recouped from the clinic, and the federal share will be properly credited to the federal government.

The final reconciliation follows the same computation as outlined above in the Interim Computation of Uncompensated Care Costs steps, except that:

- The cost per visit is computed based on audited allowable FQHC-LA cost and total visits pertaining to the actual service period cost report.
- Both Medicaid visits and uninsured visits furnished during the service period are applied to the audited cost per visit to determine the clinic's Medicaid and uninsured costs. Medicaid and uninsured visits must be derived from the latest available auditable sources, including the State's PMMIS, managed care encounter data, and provider patient accounting records.
- Both Medicaid and uninsured revenues, applicable to actual service period and derived from the latest available auditable sources, are offset against Medicaid and uninsured costs to arrive at the clinic's uncompensated care costs.
- No trending factor will be applied.

The uncompensated care costs must again be adjusted to remove costs related to non-emergency services furnished to unqualified aliens.

An FQHC-LA's uncompensated care cost limit is determined for the twelve month period in each DY, except for DY 3 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2013. Where a clinic's cost reporting period does not coincide with the DY (or partial DY in DY3), the uncompensated care costs computed for a cost reporting period can be allocated to the DY (or partial DY) based on the number of cost reporting months that overlap with the DY (or partial DY).
The final reconciliation described above will be performed and completed within eighteen months after the filing of FQHC-LA cost report(s).

**Physician Professional Service Uncompensated Care Costs**

To be eligible for Federal financial participation (FFP), SNCP uncompensated care payments to each provider cannot exceed the uncompensated care costs as computed by the following steps. The eligible providers include hospitals that employ and contract for physician services and incur physician professional service costs (whether the professional services are billed by the hospital or by the physicians) and physician practice groups that provide physician services in hospital and other settings and incur the physician professional service costs directly.

*Interim Computation of Uncompensated Care Costs*

SNCP uncompensated care payments will be made to eligible providers and claimed for FFP in quarterly installments per DY (beginning with DY 2 for City of Phoenix providers eligible pursuant to Section D of Attachment J). Each DY's SNCP will be distributed based on the provider's proportionate share of projected uncompensated care among all providers subject to the same Limit (either the Safety Net Hospital System Limit or the Phoenix Hospital Limit), to the extent that sufficient local matching funds are available. This interim computation of uncompensated care costs will be used as the basis for SNCP distribution and will also serve as the uncompensated care cost limit for SNCP payments made to the provider in each demonstration year.

1. Steps for hospitals incurring physician professional service costs

a. The professional component of physician costs are identified from each hospital's CMS 2552 cost report Worksheet A-8-2, Column 4. For providers eligible pursuant to Section C of Attachment J, the most recent CMS 2552 filed the with hospital's Medicare contractor will be utilized. For providers eligible pursuant to Section D of Attachment J, any 2552s that overlap the base state fiscal year will be prorated and utilized. For payments made in DY 2 and DY 3, the base state fiscal year is 2010. These professional costs are:

1. Limited to allowable and auditable physician compensations that have been incurred by the hospital;
2. For the professional, direct patient care furnished by the hospital's physicians;
3. Identified as professional costs on Worksheet A-8-2, Column 4 of the cost report of the hospital claiming payment (or, for registry physicians only, Worksheet A-8, if the physician professional compensation cost is not reported by the hospital on Worksheet A-8-2 because the registry physicians are contracted solely for direct patient care activities (i.e., no administrative, teaching, research, or any other provider component or non-patient care activities). Registry physicians are excluded from the cost determination for hospitals eligible for payment pursuant to Section D of Attachment J.);
4. Supported by a time study, accepted by Medicare for Worksheet A-8-2 reporting purposes, that identified the professional, direct patient care activities of the physicians (not applicable to registry physicians discussed above); and
5. Removed from hospital costs on Worksheet A-8.

b. The professional costs on Worksheet A-8-2, Column 4 (or Worksheet A-8 for registry physicians) are subject to further adjustments and offsets, including any necessary adjustment to bring the costs in line with Medicare and Medicaid cost principles and applicable OMB Circulars. However, Medicare physician reasonable compensation equivalents are not applied for physician professional cost determination purposes. The professional costs are further subject to offsets to account for any applicable non-patient care revenues that were not previously offset or accounted for by the application of time study. The resulting costs represent the net allowable professional service costs incurred by the hospitals.

c. Reimbursement for other professional practitioner service costs that have also been identified and removed from hospital costs on the Medicare cost report. The practitioner types to be included are:

Certified Registered Nurse Anesthetists
Nurse Practitioners
Physician Assistants
Dentists
Certified Nurse Midwives
Clinical Social Workers
Clinical Psychologists
Optometrists

d. To the extent these practitioners' professional compensation costs are not included in Worksheet A-8-2, Column 4, but are removed from hospital costs through an A-8 adjustment on the Medi-Cal cost report, these costs may be recognized if they meet the following criteria:

the practitioners must engage in the direct provision of care in addition to being Medicaid-qualified practitioners for whom the services are billable under Medicaid separate from hospital services;
for all non physician practitioners there must be an identifiable and auditable data source by practitioner type;
a CMS-approved time study must be employed to allocate practitioner compensation between clinical and non-clinical costs; and
the clinical costs resulting from the CMS-approved time study are subject to further adjustments and offsets, including adjustments to bring the costs in line with Medicare cost principles and offset of applicable non-patient care revenues that were not previously offset or accounted for by the application of CMS-approved time study.

The resulting net clinical non-physician practitioner compensation costs are allowable costs. The compensation costs for each non-physician practitioner type are identified separately.

e. Professional costs incurred for freestanding clinics (clinics that are not recognized as hospital outpatient departments on the 2552) are not included in this protocol.

f. Hospitals eligible for payment pursuant to Section C of Attachment J may additionally include physician support staff compensation, data processing, and patient accounting costs as physician-related costs to the extent that:

1. These costs are removed from hospital inpatient and outpatient costs because they have been specifically identified as costs related to physician professional services;
2. They are directly identified on ws A-8 as adjustments to hospital costs;
3. They are otherwise allowable and auditable provider costs; and
4. They are further adjusted for any non-patient-care activities such as research based on physician time studies.

If these are removed as A-8 adjustments to the hospital's general service cost centers, these costs should be stepped down to the physician cost centers based on the accumulated physician professional compensation costs. Other than the physician and non-physician practitioner compensation costs and the A-8 physician-related adjustments discussed above, no other costs are allowed.

g. Total billed professional charges by cost center related to physician services are identified from auditable provider records. Similarly, for each non-physician practitioner type, the total billed professional charges are identified from provider records. Charges must be identified for all professional services for which the hospital incurred its cost (whether salaried or contracted). Where the professional services are not billed by the hospital directly, the hospital must obtain those professional charges from the billing party. If hospitals eligible for payment pursuant to Section D of Attachment J, cannot identify total billed Medicaid and uninsured professional charges by cost center related to physician services from auditable provider records, total billed departmental charges by cost center are identified from auditable provider records.

h. A physician cost to charge ratio for each cost center is calculated by dividing the total costs for each cost center as established in paragraphs a-f of subsection 1 by the total billed professional charges for each cost center as established in paragraph g of subsection 1. For each non-physician practitioner type, a cost to charge ratio is calculated by dividing the total costs for each practitioner type as established in paragraphs a-f of subsection 1 by the total billed professional charges for each practitioner type as established in paragraph g of subsection 1. If hospitals eligible for payment pursuant to Section D of Attachment J cannot identify total billed Medicaid and uninsured professional charges for each cost center, a physician cost to departmental charge ratio for each cost center is calculated by dividing the total costs for each cost center as established in paragraphs a-d of subsection 1 by the total departmental charges for each cost center as established in paragraph e of subsection 1.

i. The total professional charges for each cost center related to eligible Medicaid and uninsured physician services are identified using auditable records. Hospitals must map the charges to their cost centers. Each charge may only be mapped to one cost center to prevent duplicate mapping and claiming. These charges must be associated with services furnished during the period defined by paragraph a of subsection 1. For hospitals eligible for payment pursuant to Section D of Attachment J, if total professional charges for each cost center related to eligible Medicaid and uninsured physician services are unidentifiable using auditable records,

total departmental charges for each cost center related to eligible Medicaid and uninsured physician services are identified using auditable records.

For each non-physician practitioner type, the eligible Medicaid and uninsured professional charges are identified using auditable records. Hospitals must map the charges to non-physician practitioner type. Each charge may only be mapped to one practitioner type to prevent duplicate mapping and claiming. These charges must be associated with services furnished during the period covered by the latest as-filed cost report.

Auditable records include the State's PMMIS, managed care encounter data, and hospital records.

j. The total Medicaid and uninsured costs related to physician practitioner professional services are determined for each cost center by multiplying total Medicaid and uninsured charges as established in paragraph i of subsection 1 by the respective cost to charge ratio for the cost center as established in paragraph h of subsection 1.

For each non-physician practitioner type, the total Medicaid and uninsured costs related to non-physician practitioner professional services are determined by multiplying total Medicaid and uninsured charges as established in paragraph i of subsection 1 by the respective cost to charge ratios as established in paragraph h of subsection 1.

k. The total Medicaid and uninsured uncompensated care costs are determined by subtracting all revenues received for the Medicaid and uninsured physician/practitioner services from the Medicaid and uninsured costs as established in paragraph j of subsection 1. The revenues are derived from auditable records. All revenues received for the Medicaid and uninsured professional services will be offset against the computed cost; these revenues include but are not limited to all Medicaid payments from the State or its program contractors, payments from or on behalf of patients, and payments from any other third party payer. The total professional service uncompensated care costs as computed above should be reduced by 12.88% to account for non-emergency care furnished to unqualified aliens.

l. The Medicaid and uninsured physician/practitioner amount computed in paragraph k of subsection 1 above can be trended to current period to account for cost inflation based on CMS market basket update factor. Furthermore, the State may apply trending factors to account for changes in utilization (e.g., due to changes in Medicaid eligibility criteria) and Medicaid payment rates to ensure that interim uncompensated care costs approximate final uncompensated care costs for the current service period as closely as possible. Such trending factors must account for both increases and decreases affecting a provider's uncompensated care costs.

2. Steps for physician practice group incurring physician professional service costs

a. The physician compensation costs are identified from the physician practice group's trial balance or other auditable financial records and reported on a CMS-approved physician practice group cost report for the latest available cost reporting period. These professional compensation

costs are limited to identifiable and auditable costs that have been incurred by the physician practice group for the professional patient care furnished in all applicable sites of service, including services rendered at non-hospital physician office sites operated by the practice groups and at sites not owned or operated by the practice group for which the practice group bills for and collects payment.

The physician compensation costs are reduced by National Institute of Health (NIH) grants to the extent the research activities component is not removed via physician time studies.

b. On the physician practice group cost report, these physician compensation costs net of NIH grants as applicable, reported by cost centers/departments, are then allocated between clinical and non-clinical activities using a CMS-approved time-study tool. The result of the CMS-approved time study tool is the physician compensation costs pertaining only to clinical, patient care activities. SNCP dollars allocated for physician professional service costs incurred by a physician practice group cannot be claimed for FFP until such a time study tool is approved by CMS. For DYs 1-3, a CMS-approved benchmark RVU methodology can be used in lieu of a CMS-approved time study. The benchmark RVU methodology will determine a direct patient care percentage for each cost center/department based on a ratio of actual direct patient care work RVUs for the period to benchmark RVUs for the department which would have been produced if the physicians were working 100% in direct patient care. Where the physician's compensation is first incurred by another entity and the physician practice group then reimburses the entity for the physician direct patient care costs, the physician clinical costs recognized is the lower of 1) the total physician's total compensation multiplied by the direct paitnet care percentage; or 2) the amount incurred by the physician practice group in paying for physician direct patient care costs.

c. The physician clinical costs are subject to further adjustments and offsets, including any necessary adjustment to bring the costs in line with Medicare and Medicaid cost principles and applicable OMB Circulars. However, Medicare physician reasonable compensation equivalents are not applied for professional cost determination purposes. The professional costs are further subject to offsets to account for any applicable non-patient care revenues that were not previously offset or accounted for by the application of time study. The resulting costs represent the net allowable professional service costs incurred by the physician practice group.

d. The above physician compensation costs must not be duplicative of any costs claimed on the hospital cost reports.

e. Additional costs that can be recognized as professional direct costs are costs for non-capitalized medical supplies and equipment used in the furnishing of direct patient care.

f. Indirect costs incurred by the physician practice group and allocable to the physicians' direct patient care will be also recognized. Where a cognizant agency-approved indirect cost rate is available for the physician practice group, the indirect rate will be applied to the total direct cost, calculated above, based on each center/department's physician compensation costs determined to be eligible for Medicaid reimbursement and identifiable medical supply/equipment costs to arrive at total allowable costs for each cost center If an indirect rate is not available, then

actual indirect costs incurred will be identified using auditable financial records including the general ledger. The indirect costs claimed must be allowable under Medicare and Medicaid cost principles and applicable OMB Circulars. The indirect costs may include indirect costs incurred by the physician practice group (including physician group practice clinical support staff salaries and benefits, physician department administrative and office staff salaries and benefits, and other non-salary costs incurred by each physician department) or by its home office as reported on a Medicare-approved home office cost statement and allocated in the cost statement to the physician practice group by approved Medicare allocation methodology. Adjustments to the indirect costs must be made to arrive at allowable indirect costs consistent with the applicable cost principles. The allowable indirect costs must either then be directly assigned or allocated (using accumulated costs as an allocation basis) to each physician department/cost center of the physician practice group.

To determine the additional costs that is allocable to direct patient care, the direct patient care percentage from step 2.b above (resulting from the time study or the time study proxy tool) will be applied the costs identified in steps 2.e and 2.f above at a departmental/cost center level.

g. Total billed professional charges by cost center related to physician services are identified from auditable provider records. Charges must be identified for all professional services for which the physician practice group incurred its cost.

h. A physician cost to charge ratio for each cost center is calculated by dividing the total costs for each cost center as established in paragraphs a-f of subsection 2 by the total billed professional charges for each cost center as established in paragraph g of subsection 2.

i. The total professional charges for each cost center related to eligible Medicaid and uninsured physician services are identified using auditable records. The physician practice group must map the claims to their cost centers. Each charge must be mapped to only one cost center to prevent duplicate mapping and claiming. These charges must be associated with services furnished during the period covered by the latest as-filed cost report.

Auditable records include the State's PMMIS, managed care encounter data, and hospital records.

j. The total Medicaid and uninsured costs related to physician practitioner professional services are determined for each cost center by multiplying total Medicaid and uninsured charges as established in paragraph i of subsection 2 by the respective cost to charge ratio for the cost center as established in paragraph h of subsection 2.

k. The total Medicaid and uninsured professional service uncompensated care costs are determined by subtracting all revenues received for Medicaid and uninsured physician practitioner services from the Medicaid and uninsured costs as established in paragraph j of subsection 2. The revenues are derived from auditable records. All revenues received for the

Medicaid and uninsured professional services will be offset against the computed cost; these revenues include but are not limited to all Medicaid payments from the State or its program contractors, payments from or on behalf of patients, and payments from any other third party payer. The total professional service uncompensated care costs as computed above should be reduced by 12.88% to account for non-emergency care furnished to unqualified aliens.

l. The uninsured physician amount computed in paragraph k above can be trended to current year to account for cost inflation based on CMS market basket update factor. Furthermore, the State can apply trending factors to account for changes in utilization (e.g., due to changes in Medicaid eligibility criteria) and Medicaid payment rates to ensure that interim uncompensated care costs approximate final uncompensated care costs for the current service period as closely as possible. Such trending factors must account for both increases and decreases affecting a provider's uncompensated care costs.

(Note that the above cost report references are based on the CMS-2552-96 and CMS 2552-10. For later versions of the CMS-2552, the equivalent worksheets and columns should be identified.)

*Interim Reconciliation*

Each hospital's or physician practice group's uncompensated care costs must be recomputed based on the as-filed cost report for the actual service period. The hospital cost report is filed with the Medicare contractor five months after the close of the cost reporting period. The physician practice group cost report is filed with the State also five months after the close of the cost reporting period. SNCP uncompensated care payments made to the hospital or the physician practice group for a DY cannot exceed the recomputed uncompensated care cost limit. If, at the end of the interim reconciliation process, it is determined that expenditures claimed exceeded the individual hospital's or physician practice group's uncompensated care cost limit, the overpayment will be recouped, and the federal share will be properly credited to the federal government.

The interim reconciliation follows the same computation as outlined above in the Interim Computation of Uncompensated Care Costs steps, except that the RCCs, Medicaid and uninsured charges, payment offset amounts and any other relevant statistics such as time study or time study proxy data used will pertain to the actual service period (rather than the prior period). RCCs will be derived from the as-filed cost report; and Medicaid and uninsured charges and payments will be derived from the latest available auditable data for the service period. No trending factor will be applied. The uncompensated care costs must again be adjusted to remove costs related to non-emergency services furnished to unqualified aliens.

Note that for those hospitals eligible for payment pursuant to Section D of Attachment J who were unable to readily identify physician professional charges and instead used departmental charges in Interim Computation of Uncompensated Care Costs steps 1.g-i above, physician professional charges must be used in the computation of uncompensated care cost limit in the Interim Reconciliation here and the Final Reconciliation below.

A hospital's or physician practice group's uncompensated care cost limit is determined for the twelve month period in each DY (beginning with DY 2 for providers eligible pursuant to Section D of Attachment J), except for DY 3 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2013. Where a hospital's or physician practice group's cost reporting period does not coincide with the DY (or partial DY in DY3), the uncompensated care costs computed for a cost reporting period can be allocated to the DY (or partial DY) based on the number of cost reporting months that overlap with the DY (or partial DY).

The interim reconciliation described above will be performed and completed within six months after the filing of the cost report(s).

*Final Reconciliation*

Each hospital's or physician practice group's uncompensated care costs must be recomputed based on the audited cost report for the actual service period. The hospital cost report is audited and settled by the Medicare contractor to determine final allowable costs and reimbursement amounts as recognized by Medicare. The physician practice group's cost report is also audited to ensure costs are allowable consistent with Medicare and Medicaid cost principles and applicable OMB Circulars. SNCP uncompensated care payments made to the hospital or physician practice group for a DY cannot exceed the recomputed uncompensated care cost limit. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual hospital's or physician practice group's uncompensated care cost limit, the overpayment will be recouped, and the federal share will be properly credited to the federal government.

The final reconciliation follows the same computation as outlined above in the Interim Computation of Uncompensated Care Costs steps, except that the RCCs, Medicaid and uninsured charges, payment offset amounts, and other relevant statistics such as time study or time study proxy data used will pertain to the actual service period (rather than the prior period). RCCs will be derived from the audited cost report, and Medicaid and uninsured charges and payments will be updated with the latest available auditable data for the service period. No trending factor will be applied. The uncompensated care costs must again be adjusted to remove costs related to non-emergency services furnished to unqualified aliens.

Note that for those hospitals eligible for payment pursuant to Section D of Attachment J who were unable to readily identify physician professional charges and instead used departmental charges in Interim Computation of Uncompensated Care Costs steps 1.g-i above, physician professional charges must be used in the computation of uncompensated care cost limit in the Interim Reconciliation above and the Final Reconciliation here.

A hospital's or physician practice group's uncompensated care cost limit is determined for the twelve month period in each DY (beginning with DY 2 for providers eligible pursuant to Section D of Attachment J), except for DY 3 in which the uncompensated care cost limit is computed for

the three month period ending December 31, 2013. Where a hospital's or physician practice group's cost reporting period does not coincide with the DY (or partial DY in DY3), the uncompensated care costs computed for a cost reporting period can be allocated to the DY (or partial DY) based on the number of cost reporting months that overlap with the DY (or partial DY).

For hospital-incurred professional service uncompensated care costs, the final reconciliation described above will be performed and completed within six months after the audited hospital Medicare cost report(s) are made available. For the physician practice group-incurred professional service uncompensated care costs, the final reconciliation described above will be performed and completed within eighteen months after the filing of physician practice group cost report(s).

**Designated State Health Program (DSHP) - Trauma and Emergency Services Fund**

Arizona State Proposition 202 authorizes the use of State tribal gaming revenues for the Trauma and Emergency Services Fund. The fund, administered by AHCCCS, provides payments to Arizona hospitals to offset trauma center readiness costs and emergency services costs.

The fund, as it is currently operated, distributes 90% of available funds to Arizona hospitals that qualify as Level 1 Trauma Centers and 10% of available funds to Arizona hospitals that operate an emergency department. The 90% Level I Trauma Center amount is distributed proportionally to qualifying hospitals based upon each hospital's total of Injury Severity Score times the number of cases at that level. Hospitals report trauma scores and case volume on an Acuity-Adjusted Volume worksheet that uses hospital utilization from a twelve-month period that ends on June 30 of the previous Federal Fiscal Year. The 10% Emergency Department amount is distributed proportionately to qualifying hospitals based on each hospital's emergency department costs, as reported on its Medicare cost report, Worksheet B, Part I, Column 0, Line 61. In DY1, cost report data for the period July 2010 through June 2011 will be used. In DY2, cost report data for the period July 2011 through June 2012 will be used. When a hospital has two cost reports that span this reporting period, data from the two hospital cost reports that span that period will be allocated based upon each cost report's proportion of the reporting period.

Section VI of these STCs allows the Trauma and Emergency Services Fund to be recognized as a DSHP eligible for SNCP claiming in DY 1 and DY 2. The maximum amount per each Demonstration year that would qualify for SNCP claiming is $20 million total computable.

For each demonstration year, the State should document its computation and distribution of its Trauma and Emergency Services Fund payments to each qualifying hospital. Upon distribution of payments to the hospitals, the State would be allowed to claim FFP of the actual paid amounts as part of the SNCP claims, subject to the $20 million total computable limit. The State should include a schedule of the payment amounts made to each qualifying hospital in its annual DY SNCP reporting to CMS.

**Attachment J**

Participating Providers in the SNCP

A. Hospital Uncompensated Care Cost Payments

- Phoenix Children's Hospital
- University Medical Center
- University Physicians Healthcare Hospital at Kino Campus
- Maricopa Medical Center
- Little Colorado Medical Center (Winslow Memorial Hospital) - effective DYs 2 and 3 only
- Southeast Arizona Medical Center - effective DYs 2 and 3 only
- White Mountain Regional Medical Center - effective DYs 2 and 3 only
- Copper Queen Hospital – effective DYs 2 and 3 only

B. Federally Qualified Health Center Lookalike (FQHC-LA) Uncompensated Care Cost Payments

**Avondale Family Health Center**
950 E. Van Buren, Avondale 85323
623.344.6800

**El Mirage Family Health Center**
12428 W. Thunderbird, El Mirage 85335
623.344.6500

**Glendale Family Health Center**
5141 W. Lamar St., Glendale 85301
623.344.6700

**Maryvale Family Health Center**
4011 N. 51st Ave., Phoenix 85031
623.344.6900

**Chandler Family Health Center**
811 S. Hamilton, Chandler 85225
480.344.6100

**Guadalupe Family Health Center**
5825 E. Calle Guadalupe, Guadalupe 85283
480.344.6000

**Mesa Family Health Center**
59 S. Hibbert, Mesa 85210
480.344.6200

**Comprehensive Healthcare Center**
2525 E. Roosevelt St., Phoenix 85008
602.344.1015

**McDowell Healthcare Center**
1144 E. McDowell Rd., Phoenix 85006
602.344.6550

**7th Avenue Family Health Center**
1205 S. 7th Ave., Phoenix 85007
602.344.6600

**South Central Family Health Center**
33 W. Tamarisk St., Phoenix 85041
602.344.6400

**Sunnyslope Family Health Center**
934 W. Hatcher, Phoenix 85021
602.344.6300

**7th Avenue Walk In Clinic**
1201 S. 7th Ave.
Phoenix 85007
**Phone:** (602) 344-6655

C. Physician Professional Service Uncompensated Care Cost Payments
- Phoenix Children's Hospital
- Maricopa Medical Center
- University Physician's Healthcare

Non-Physician Practitioner Professional Service Uncompensated Care Cost Payments - effective DYs 2 and 3
- Maricopa Medical Center

D. City of Phoenix High Uncompensated Care Hospital Cost Payments: Hospital and Physician Professional Service Costs
- Banner Estrella Medical Center
- Banner Good Samaritan Medical Center
- John C Lincoln-Deer Valley Hospital
- John C. Lincoln North Mountain Hospital
- Maryvale Hospital Medical Center- Paradise Valley Hospital
- Phoenix Baptist Hospital
- Phoenix Children's Hospital
- St Joseph's Hospital-Phoenix
- St Luke's Medical Center

**Attachment K**

IHS and 638 Facilities Uncompensated Care Payment Methodologies

The two methodologies outlined below have been approved for structuring a payment that will be made to IHS and 638 facilities that take in to account their uncompensated costs in furnishing specified types of care furnished by IHS and tribal 638 facilities, to Medicaid-eligible individuals, and other individuals with net family income at or below 100 percent of the Federal poverty level (FPL).

Participating facilities must select one of the two possible options as described below in determining these payments to the facilities:

**Option 1 – Encounter Based Approach**

1. On a monthly basis, facilities will track services provided to individuals with net family income up to 100 percent of the FPL using the appropriate family size and income level limit as specified in the annual Federal Poverty Level tables issued by the U.S. Department of Health & Human Services. These services would include those that are no longer covered for Medicaid eligible individuals under the Arizona Medicaid State plan as well as services provided to individuals who are no longer Medicaid eligible, but under the 100 percent income threshold.
2. The facilities will utilize the attached tracking documents in Exhibits 1 – 3 to record the service provided, the unit of service, the all-inclusive rate, and if the service was provided to an American Indian/Alaskan Native (AI/AN) or to a non-native.
3. The facility will conduct a high-level income determination, which can include, but is not limited to self-attestation or the use of a recent pay stub.
4. The tracking document, along with the cover letter signed by the facility CEO or CFO facility director certifying that the information contained in the tracking document is accurate, will be sent to AHCCCS which will pay the facility the rate AHCCCS would have otherwise paid for the recorded services and draw down the correct FMAP based on the facility's breakdown of AI/AN versus non-native services.

**Option 2 – Historical Data Approach**

This approach is comprised of the following two steps that will be used to calculate the total dollar amount of uncompensated care that will be paid to IHS and 638 facilities on a prospective basis. The steps are as follows:

1) The State will calculate a per member per month (PMPM) rate for AI/AN childless adults enrolled in AHCCCS Acute Care Plan (AACP) using historical utilization data (July 1, 2010 through June 30, 2011) for the services that were furnished in or by IHS/tribal 638 facilities to the childless adult population (who are no longer covered under AHCCCS). This rate is multiplied by the total number of AI/AN childless adults that have been disenrolled from the program in that month since July 2011. This PMPM will be adjusted on an annual basis to mirror the medical inflation adjustment applied to the all-inclusive rate.

2) The State will calculate a second PMPM, using historical data, to reflect the services that it removed from the Medicaid State plan effective October 1, 2010, that were furnished in or by IHS/tribal 638 facilities to AHCCCS-enrolled individuals, and would multiply this rate by the total number of adult AI/ANs currently enrolled in the AHCCCS program. This PMPM will be adjusted on an annual basis to mirror the medical inflation adjustment applied to the all-inclusive rate.

Once this aggregate dollar amount has been computed using the steps 1 and 2 as outlined above, the State will disburse payments to the IHS and 638 facilities based on payments made to each facility for care provided to AI/AN childless adults from July 1, 2010 through June 30, 2011.

In addition, the State will annually review whether the PMPMs calculated in steps 1 and 2 above were accurate within a reasonable margin of error by comparing them to actual claims submitted under approach 1 by one or more facilities or, if no facilities elect approach 1, by reviewing actual records of services furnished by one or more facilities. If the PMPM is not validated, the State will apply an adjustment factor for the following year.

As part of this option, the non-Federal share for services provided to non-natives would be calculated based on the following.

1. After analyzing claims data from 2009-10, the State calculated a ratio of claims paid for currently covered Arizona Medicaid State plan services that were provided at IHS and 638 facilities to non-natives to the total number of paid claims to IHS and 638 facilities. Using this ratio, the State calculated that approximately $2 million out of total claims paid to IHS facilities was for services provided to non-natives. As such, the State will pay the non-Federal share of the $2 million. The State will review the claims data on an annual basis and will adjust the non-Federal share amount accordingly.
2. The State will apply the ratio that was calculated of non-native costs to total IHS costs as described above to calculate the non-Federal portion of the eligibility and service PMPM payments as described above.

**Calculation for Cost of Services to Persons Ineligible for AHCCCS**

| | |
|---|---|
| FY 2011 Total Paid | 90,000,000 |
| Average monthly membership | 22,996 |
| per member per month (pmpm) | $326 |

**Monthly Payment Calculation – Ineligible Individuals**

| | |
|---|---|
| March - Decrease in Native American Childless Adult coverage since Freeze | 9,391 |
| March Eligibility Payment (PMPM * 9,391) | $3,061,466 |

**Monthly Payment Calculation – Services**

| | |
|---|---|
| Adult Per Member Per Month Service Funding | $15.11 |
| Total Number of AI/AN Adults Enrolled with AHCCCS | 56,851 |
| May Services Payment | $859,018.61 |
| Total May Payment to I.H.S and 638 Facilities (Eligibility + Services) | $3,920,484.61 |
| Facility A - Allocation - 1% | $39,204.85 |
| Facility B - Allocation - 5% | $196,024.23 |

**Exhibit 1 to Attachment K**
**Option 1 Encounter Based Approach Cover Letter**

# Summary of the Monthly Report to AHCCCS for the Option 1 Supplemental Payment

Reporting Month: _____

Facility Name:_____

# of Adults under 100% FPL who are not Medicaid eligible to whom covered services was provided:

_____

# of visits that were provided to the above individuals for AHCCCS covered services:

_____

# of Medicaid individuals to whom services were provided that were eliminated from the Medicaid program in the 2010 & 2011 benefit reductions:

_____

# of visits that were provided to the Medicaid individuals for services that were eliminated from the Medicaid program in the 2010 & 2011 benefit reductions:

_____

I hereby attest that the information submitted is prepared in compliance with the Option 1 payment methodology Desk Level Procedures and is current, complete, and accurate to the best of my knowledge and belief. The expenditures included in this report are based on the accounting records of actual recorded expenditures, and are not based on estimates. I understand that payment of these claims will be from federal funds and whoever knowingly and willfully makes or causes to be made a false statement or representation on the reports may be prosecuted under the applicable federal and state laws.

CEO or CFO Signature:_____

**Exhibit 2 to Attachment K**
**Option 1 Encounter Based Approach Tracking Sheet**

The spreadsheet below will be used in tracking uncompensated care costs associated with services provided to individuals who have net family income up to 100 percent of the FPL, but are not enrolled in the AHCCCS program.

**Facility Name:** _____

| Name of Individual Receiving Services | Income verified | American Indian Y/N | Service Date | Service Provided | Inpatient or Outpatient | Service Rate | Patient Account Number |
|---|---|---|---|---|---|---|---|

DRAFT

**Exhibit 3 to Attachment K**
**Option 1 Encounter Based Approach Tracking Sheet**

The spreadsheet below will be used in tracking uncompensated care costs associated with services provided to AHCCCS beneficiaries that are no longer covered under the Arizona Medicaid State plan.

**Facility Name:** _____

| AHCCCS ID | American Indian Y/N | Service Date | Service Provided | Inpatient or Outpatient | Service Rate | Patient Account Number |
|---|---|---|---|---|---|---|

DRAFT

# Arizona Health Care Cost Containment System
# Medicaid Section 1115 Demonstration Amendment Request
# Safety Net Care Pool and Coverage Expansions

## I. Summary

The Arizona Health Care Cost Containment System (AHCCCS) is requesting an amendment to the Section 1115 Research and Demonstration Waiver (the Demonstration) with respect to the Safety Net Care Pool approved in 2012 and an expansion of coverage prior to 2014.

In a waiver amendment approved in April 2012, CMS permitted Arizona to establish a new funding mechanism under the authority of its Section 1115 waiver—the Safety Net Care Pool (SNCP)—to help offset rising uncompensated care costs borne by certain safety net providers and to re-open enrollment into the KidsCare program. The program has been successfully operating for nine months. Building on this success, we now propose to expand the pool to additional Phoenix-area hospitals with high uncompensated care burdens and to further expand coverage by opening KidsCare enrollment to additional children, supporting their transition to Medicaid coverage in 2014, and opening AHCCCS coverage for certain uninsured adult populations. The proposal will be funded by the City of Phoenix through intergovernmental transfers (IGTs) financed by a locally-imposed provider assessment on certain Phoenix hospitals.

## II. Amendments to the Safety Net Care Pool

*Background on the SNCP*

As approved in April 2012, the SNCP authorizes payments to designated providers to assist with the uncompensated costs of medical services that meet the definition of "medical assistance" provided to Medicaid eligible or uninsured individuals. Expenditures must be claimed in accordance with a CMS-approved claiming protocol, which is contained in Attachment I to the Demonstration Special Terms and Conditions (STCs). The annual SNCP payment distributed to each individual provider cannot exceed its uncompensated care costs for providing medical services to Medicaid eligible and uninsured individuals for the period, taking into account its total Medicaid payments, Disproportionate Share Hospital (DSH) payments, SNCP payments, and any other payments for medical services furnished to Medicaid eligible and uninsured individuals, and offsetting costs attributable to non-emergency services provided to non-qualified aliens. The aggregate amount of SNCP payments to the providers currently identified in the waiver cannot exceed $332 million per demonstration year.

Paragraph 25 of the STCs specifies categories of providers potentially eligible for the SNCP, including Safety Net Hospital Systems, Rural Hospitals, Critical Access Hospitals and Disproportionate Share Hospitals. Specific eligible providers are listed in Attachment J. Currently, only certain hospitals in the Safety Net Hospital Systems category and their affiliated providers are

eligible. The State is required to seek prior approval from CMS to amend the list of eligible providers. The program terminates December 31, 2013.

*Request for Amendment to Expand the SNCP to Additional Eligible Providers*

The State proposes to expand the SNCP to hospitals in the City of Phoenix experiencing increased uncompensated care costs, and their affiliated physician professionals. In doing so, the State proposes to add to the SNCP an additional amount for payments not to exceed $385 million per demonstration year that would be directed to the new category of eligible Phoenix acute care hospitals.[1] SNCP payments to the Phoenix hospitals would be subject to all existing SNCP requirements, including the existing claiming protocol (subject to minor modifications summarized at the end of this section) and the requirement that the annual SNCP payment distributed to each provider not exceed its uncompensated care costs for providing medical services to Medicaid-eligible and uninsured individuals for the period.

The following eligible Phoenix providers would be added to the list in Attachment J of the waiver:

- Banner Estrella Medical Center
- Banner Good Sam Medical Center
- John C Lincoln-Deer Valley Hospital
- John C. Lincoln North Mountain Hospital
- Maryvale Hospital Med Center
- Paradise Valley Hospital
- Phoenix Baptist Hospital
- Phoenix Children's Hospital
- St Joseph's Hospital-Phoenix
- St Luke's Medical Center

Note that Phoenix Children's Hospital (PCH) is also among the category of "Safety Net Hospital Systems" that are currently eligible for SNCP payments, funded through IGTs from governmental providers or governmental funding partners. Under this proposal, PCH would primarily participate in the City of Phoenix portion of the pool, funded through the City of Phoenix provider assessment revenues, although it would also retain its eligibility as a Safety Net Hospital System. To the extent any of PCH's costs remain uncompensated after it is paid through the City of Phoenix portion of the pool, PCH would be eligible to receive additional funds through the Safety Net Hospital portion financed with IGTs from a governmental funding partner.[2] Payments under the City of Phoenix portion of the pool will be made prior to any claim under the existing Safety Net Health Systems

[1] The aggregate uncompensated costs for eligible Phoenix hospitals is $385 million, which is the basis for the proposed cap. Based on projected assessment revenues, and accounting for the estimated commitment of funds to coverage expansion and to support MIHS, payments under the City of Phoenix portion of the pool will likely amount to roughly $295 million, or 76.54% of eligible uncompensated care costs.

[2] As described in note 1, current projections estimate 23.46% of eligible costs for hospitals in the City of Phoenix portion of the pool will remain uncompensated.

pool. As specified in the proposed revisions to the STCs, under no circumstances would PCH be paid more than its uncompensated cost limit (to be confirmed upon reconciliation).

The proposed modifications to the SNCP claiming protocol do not include substantive changes to either the interim or final cost reconciliation. The revisions are intended to reflect the expanded eligibility to the Phoenix hospitals listed above, to update the cost report references for use of the CMS 2552-10 reports where appropriate, and to reflect the initial cost calculation methodology used for the Phoenix area hospitals, which follows the existing initial cost calculation closely. The main difference in the methodology is in the base period used for the initial cost calculation. The existing methodology uses the most recently available Medicare cost report for each eligible hospital, while the Phoenix hospital methodology uses any Medicare cost reports that overlap the base state fiscal year (state fiscal year 2010), prorated based on the overlapping dates. This adjustment to measure all costs over a common base period was made in order to maintain consistency with the cost calculations described under the federal DSH audit reconciliation.

The State does not propose to change the termination date for the SNCP of January 1, 2014.

## III. KidsCare and AHCCCS Expansion

In January, 2010, enrollment into KidsCare was frozen due to a lack of funding. Through the SNCP waiver amendment, however, the State was able to establish KidsCare II, a program identical to KidsCare in most respects, except that the eligibility requirements vary and the coverage is temporary, ending January 1, 2014.

Through this requested waiver amendment to expand the SNCP to Phoenix hospitals, the State also proposes to expand the KidsCare II program to an estimated additional 19,250 children, using IGTs from the City of Phoenix. The IGTs from the City would be funded by a portion of the proceeds of the City of Phoenix Access to Care assessment, described in detail in Section IV below. The additional children enrolled through this proposal would be subject to the same eligibility requirements as KidsCare II, except that the federal poverty level requirement would increase to 200% (requiring additional expenditure authority for populations between 175% and 200% federal poverty level). As is true of the entire KidsCare II program, coverage would be temporary to 2014, but the State will be responsible for coordinating the seamless transition of enrolled children to other forms of coverage to the maximum extent possible. To ease this transition, IGTs from the City of Phoenix would also fund Medicaid coverage for a portion of KidsCare II enrollees for the first six months of 2014.

In addition to opening KidsCare II enrollment, the State also seeks to open AHCCCS enrollment for certain adults under 100% federal poverty level without dependent children. Specifically, the State would target 1931 parents who, because of a lack of a deprived child, would otherwise lose coverage due to the childless adult enrollment freeze. This would include allowing 1931 parents to transition to childless adult coverage whose children age out of Medicaid or enter the foster care system. The requested waiver amendment would open AHCCCS enrollment to an estimated additional 13,000

adults, again using IGTs from the City of Phoenix finance by a portion of the proceeds of the City of Phoenix Access to Care assessment.

## IV. Phoenix Provider Assessment

Under the existing Demonstration, SNCP payments may be funded with any permissible source of non-federal share funding as defined in federal regulation. Payments for the Section D Phoenix acute care hospitals will be funded using revenues from a hospital assessment levied by the City of Phoenix and transferred to AHCCCS. Consistent with use of IGTs as the source of non-federal share of other payments under the SNCP, AHCCCS and the City of Phoenix will have an IGT agreement in place specifying the terms of the transfer and payment. To support the City in funding the non-federal share of SNCP payments to these Phoenix hospitals as uncompensated care increases, the City is establishing a provider assessment which has been structured to meet federal Medicaid requirements.

At no time should any authority within the SNCP terms of the waiver be interpreted as an obligation on the state legislature or AHCCCS to fund payments using state general revenue.

*City of Phoenix Access to Care Assessment*

On December 11, 2012, the City of Phoenix adopted an assessment on designated Phoenix acute care hospitals which would be implemented upon CMS approval of this amendment.

The assessment would be levied at a uniform rate of six percent of the hospitals' net inpatient hospital revenues. The proceeds of the assessment (save for a small amount to cover the City's administrative costs) would be transferred to AHCCCS and designated for three purposes:

- The KidsCare II and AHCCCS coverage expansion (approximately 18 percent of assessment funds would be used for coverage);
- SNCP payments to the eligible Phoenix hospitals; and,
- A portion of the cost of SNCP payments for Maricopa Integrated Health System (MIHS), a governmental hospital within the City of Phoenix whose SNCP payments are otherwise funded by MIHS' own governmental funds.

Certain hospitals would be exempt from the assessment:

- Governmental hospitals (specifically MIHS and the Arizona State Hospital);
- Specialty hospitals (psychiatric hospitals, inpatient rehabilitation facilities, long term care hospitals, and orthopedic and surgical specialty hospitals);
- Children's hospitals with less than 30 beds; and,
- Hospitals in which on average at least 50 percent of the inpatient days are for Medicare beneficiaries, and 15 percent of the inpatients are from out-of-state..

Due to their special nature and unique patient populations, the City has determined that imposing the assessment on these facilities would unduly burden access to the specialized care they provide to those populations. Moreover, even with these facilities excluded, the assessment is nonetheless redistributive as

defined under federal law. AHCCCS is therefore requesting a waiver of the broad based requirement at section 1903(w)(3) of the Social Security Act, codified at 42 C.F.R. 433.68(c)(3).

Pursuant to 42 C.F.R. 433.68(e)(1)(ii), CMS will automatically approve such a waiver request if the State demonstrates that the assessment meets the "P1/P2" test, where P1 is the proportion of the assessment revenue applicable to Medicaid if the assessment were broad based and P2 is the proportion of the assessment revenue applicable to Medicaid under the proposed assessment program. If the value of P1/P2 is at least 1, the waiver request will be approved. The value of the P1/P2 for the Phoenix assessment is 1.0001.

The assessment meets all other federal law requirements applicable to permissible health care-related taxes. It will be uniformly proposed on all net inpatient hospital revenues. It meets the hold harmless test because there is no hold harmless arrangement in place and the assessment does not produce revenues in excess of 6 percent of the net inpatient hospital revenues received by the hospitals as required by 42 C.F.R. 433.68(f)(i)(A).

Therefore, the proposed Phoenix assessment is a permissible health care-related tax under federal law and a permissible source for the City's IGT to fund the expanded SNCP payments and expanded coverage.

January 31, 2013

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

Dear Mr. Betlach:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving your request to amend Arizona's Medicaid section 1115 demonstration, the Arizona Health Care Cost Containment (AHCCCS) demonstration (11-W-00275/09 and 21-W-00064/9). Approval of the amendment to this demonstration is under the authority of section 1115(a) of the Social Security Act and is effective from the date of this letter through the end of the demonstration.

This award approves the state's request to integrate physical and behavioral health services provided to children enrolled in the state's Children's Rehabilitative Services (CRS) program as well as to adults residing in Maricopa County who are diagnosed with a serious mental illness (SMI). The objectives of the integration projects are to reduce the fragmentation of care that these populations currently experience as they navigate the multiple systems of care in order to receive their physical and behavioral health services. The demonstration will test the effect of integrating behavioral and physical health services for the two populations by measuring the improvements in health outcomes for these populations as compared to the state's current structure.

CMS is also approving clarifying language outlining the procedures needed to operationalize the KidsCare II program wait list as well as technical changes to the demonstration's Disproportionate Share Hospital (DSH) methodology to reflect the 2013 DSH amounts and to the Safety Net Care Pool (SNCP) protocols to include three new hospitals and mid-level practitioner costs to the SNCP.

The CMS approval of the AHCCCS demonstration amendment is conditioned upon continued compliance with the enclosed set of STCs defining the nature, character, and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

A copy of the revised STCs, waivers and expenditure authorities are enclosed.

Your project officer for this demonstration is Ms. Jessica Schubel. She is available to answer any questions concerning your section 1115 demonstration and this amendment. Ms. Schubel's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-3032
Facsimile: (410) 786-5882
E-mail: Jessica.Schubel@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Schubel and to Ms. Gloria Nagle, Associate Regional Administrator for the Division of Medicaid and Children's Health in our San Francisco Regional Office. Ms. Nagle's contact information is as follows:

Ms. Gloria Nagle
Associate Regional Administrator
Division of Medicaid and Children Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103 -6706

If you have questions regarding this approval, please contact Ms. Jennifer Ryan, Acting Director, Children and Adults Health Programs Group, Center for Medicaid and CHIP Services, at (410) 786-5647.

Sincerely,

/s/

Marilyn Tavenner
Acting Administrator

Enclosures

cc: Cindy Mann, Director, CMCS
Jennifer Ryan, CMCS
Gloria Nagle, ARA, San Francisco Regional Office

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**EXPENDITURE AUTHORITY**

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

**TITLE:** **Arizona Medicaid Section 1115 Demonstration**

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

**Medicaid Costs Not Otherwise Matchable**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below (which would not otherwise be included as matchable expenditures under section 1903 of the Act) shall, for the period beginning October 22, 2011, through September 30, 2016, unless otherwise specified, be regarded as matchable expenditures under the state's Medicaid state plan:

## I. Expenditures Related to Administrative Simplification and Delivery Systems

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

    a. Section 1903(m)(2)(A)(vi) of the Act insofar as it requires compliance with requirements in section 1932(a)(4) of the Act and 42 CFR 438.56(c)(2)(i) that enrollees be permitted an initial period after enrollment that would be longer than 30 days to disenroll without cause.

    b. Section 1903(m)(2)(H) of the Act and 42 CFR 438.56(g), but only insofar as to allow the State to automatically reenroll an individual who loses Medicaid eligibility for a period of 90 days or less in the same managed care plan from which the individual was previously enrolled.

2. Expenditures under contracts with managed care entities that do not provide for payment for Indian health care providers as specified in section 1932(h) of the Act, when the State pays Indian health providers for covered services furnished to AHCCCS managed care plan enrollees at the State plan rate.

3. Expenditures for State payments for services furnished to managed care enrollees by Indian health providers, when those payments are offset from the managed care capitation payment.

4. Expenditures that would have been disallowed under section 1903(u) of the Act and 42 CFR 431.865 based on Medicaid Eligibility Quality Control (MEQC) findings.

5. Expenditures for outpatient drugs which are not otherwise allowable under section 1903(i)(10) of the Act.

6. Expenditures for outpatient drugs which are not otherwise allowable under section 1903(i)(23) of the Act. This expenditure authority will expire on November 1, 2012.

7. Expenditures for direct payments to Critical Access Hospitals (CAH) for services provided to AHCCCS enrollees in the Acute Care and ALTCS managed care programs that are not consistent with the requirements of 42 CFR 438.60.

8. Expenditures for inpatient hospital and long-term care facility services, other institutional and non-institutional services (including drugs) provided to AHCCCS fee-for-service beneficiaries, that exceed the amounts allowable under section 1902(a)(30)(A) of the Act (42 CFR 447.250 through 447.280, 447.300 through 447.334) but are in accordance with Special Term and Condition (STC) #52 entitled "Applicability of Fee-for-Service Upper Payment Limit."

9. Expenditures for inpatient hospital services that take into account the situation of hospitals with a disproportionate share of low-income patients but are not allowable under sections 1902(a)(13)(A) and 1923 of the Act, but are in accordance with the provisions for disproportionate share hospital (DSH) payments that are described in the STCs.

10. Expenditures for medical assistance including Home and Community Based Services furnished through ALTCS for individuals over age 18 who reside in Alternative Residential Settings classified as residential Behavioral Health Facilities.

**II. Expenditures Related to Expansion of Existing Eligibility Groups based on Eligibility Simplification**

11. Expenditures related to:

    a. Medical assistance furnished to ALTCS enrollees who are eligible only as a result of the disregard from eligibility of income currently excluded under section 1612(b) of the Act, and medical assistance that would not be allowable for some of those enrollees but for the disregard of such income from post-eligibility calculations.
    b. Medical assistance furnished to ALTCS enrollees who are financially eligible with income equal to or less than 300 percent of the Federal Benefit Rate and who are eligible for ALTCS based on the functional, medical, nursing, and social needs of the individual.
    c. Medical assistance furnished to some dependent children or spouses who qualify for ALTCS based on a disregard of income and resources of legally responsible

relatives or spouses during the month of separation from those relatives or spouses.

d. Medical assistance furnished to individuals who are eligible as Qualified Medicare Beneficiary (QMB), Special Low Income Beneficiary (SLMB), Qualified Individuals-1(QI-1), or Supplemental Security Income Medical Assistance Only (SSI MAO) beneficiaries based only on a disregard of in-kind support and maintenance (ISM).
e. Medical assistance furnished to individuals who are eligible based only on an alternate budget calculation for ALTCS and SSI-MAO income eligibility determinations when spousal impoverishment requirements of section 1924 of the Act do not apply or when the applicant/recipient is living with a minor dependent child.
f. Medical assistance furnished to individuals who are eligible only based on the disregard of interest and dividend from resources, and are in the following eligibility groups:

    i. The Pickle Amendment Group under 42 CFR 435.135;
    ii. The Disabled Adult Child under section 1634(c) of the Act;
    iii. Disabled Children under section 1902(a)(10)(A)(i)(II) of the Act; and
    iv. The Disabled Widow/Widower group under section 1634(d) of the Act.

g. Medical assistance furnished to ALTCS enrollees under the eligibility group described in section 1902(a)(10)(A)(ii)(V) of the Act that exceeds the amount that would be allowable except for a disregard of interest and dividend from the post-eligibility calculations.
h. Medical assistance provided to individuals who would be eligible but for excess resources under the "Pickle Amendment," section 503 of Public Law 94-566; section 1634(c) of the Act (disabled adult children); or section 1634(b) of the Act (disabled widows and widowers).
i. Medical assistance that would not be allowable but for the disregard of quarterly income totaling less than $20 from the post-eligibility determination.

12. Expenditures to extend eligibility past the timeframes specific in 42 CFR §435.1003 for demonstration participants who lose SSI eligibility for a period of up to 2-months from the SSI termination effective date.

13. Expenditures to provide Medicare Part B premiums on behalf of individuals enrolled in ALTCS with income up to 300 percent of the FBR who are also eligible for Medicare, but do not qualify as a QMB, SLMB or QI; are eligible for Medicaid under a mandatory or optional Title XIX coverage group for the aged, blind, or disabled (SSI-MAO); are eligible for continued coverage under 42 CFR 435.1003; or are in the guaranteed enrollment period described in 42 CFR 435.212 and the State was paying their Part B premium before eligibility terminated.

14. Expenditures to extend ALTCS eligibility to individuals under the age of 65 who meet the applicable financial criteria but are not disabled, but who are found to be at risk of

needing nursing facility services based on medical illness or mental retardation on the preadmission screening instrument.

15. Expenditures associated with the provision of Home & Community-Based Services (HCBS) to individuals enrolled in the Arizona Long Term Care system with income levels up to 300 percent of the SSI income level, as well as individuals enrolled in the ALTCS Transitional program.

16. Expenditures for demonstration caregiver services provided by spouses of the demonstration participants.

**The following expenditures (which would not otherwise be included as matchable expenditures under section 1903 of the Act) shall be regarded as matchable expenditures under the state's Medicaid state plan through December 31, 2013:**

17. Expenditures to provide coverage through employer-sponsored insurance for eligible employees of small businesses and with family income below 200 percent of the FPL that would not otherwise be allowable because it is not cost effective.

18. Expenditures to provide medical assistance for adults without children who were enrolled in the AHCCCS under Demonstration project #11-W-00032/9 and #21-W-00009/9 as of July 8, 2011, as long as they continue to meet the State's eligibility criteria and redetermination requirements.

19. Expenditures to provide medical assistance to adults without children with adjusted net countable family income at or below 100 percent of the FPL who are not otherwise eligible for Medicaid.

20. Expenditures to provide medical assistance for individuals who applied for the Medical Expense Deduction (MED) program (under Expenditure Authority 16 of Demonstration project #11-W-00032/9 and #21-W-00009/9) prior to May 1, 2011, and were determined eligible for that population for a 6-month guaranteed eligibility period after that date, until the end of that 6-month period.

21. Expenditures for family planning and family planning-related services for up to 24 months for women losing Medicaid pregnancy coverage at the conclusion of their 60-day postpartum period, and who are not otherwise eligible for Medicare, Medicaid (including other components of this section 1115 demonstration), Children's Health Insurance Program (CHIP), or health insurance coverage that provides family planning services, and who have a family income at or below 150 percent of the Federal poverty level (FPL) at the time of annual redetermination. (Family Planning Extension Program).

22. Expenditures for payments to participating IHS and tribal facilities reflecting uncompensated care, limited to categories of care that were previously covered under the State Medicaid plan, furnished in or by such facilities to Medicaid-eligible individuals, and other individuals, with family income at or below 100 percent of the FPL.

23. Subject to the overall cap on the Safety Net Care Pool (SNCP), expenditures for payments to certain hospitals and other providers reflecting uncompensated costs of medical services that are within the scope of the definition of "medical assistance" under 1905(a) of the Act, that are provided to Medicaid eligible or uninsured individuals, and that exceed the amounts paid to the hospitals pursuant to section 1923 of the Act.

24. Expenditures for uncompensated care payments made under the Proposition 202 Trauma/Emergency Room Designated State Health Program, which is otherwise a State-funded program, as specified in the reimbursement protocol for the SNCP.

**Medicaid Requirements Not Applicable**

Medicaid populations made eligible by virtue of the expenditure authorities expressly granted in this Demonstration are not subject to Medicaid laws or regulations except as specified in the STCs and waiver and expenditure authorities for this Demonstration. The following Medicaid requirements will not apply to such demonstration populations, and will expire on December 31, 2013 (sections refer to the Social Security Act):

**1. Cost Sharing** — **Section 1902(a)(14) insofar as it incorporates section 1916 (42 CFR 447.50 through 447.56)**

To enable the State to impose cost sharing, to the extent necessary, for those in the employer-sponsored insurance program, and individuals without dependent children with family income up to 100 percent of the FPL

**2. Amount, Duration, Scope of Services** — **Section 1902(a)(10)(B) (42 CFR 440.210)**

To enable the State to modify the Medicaid benefits package for those in the employer-sponsored insurance program in order to offer a different benefit package than would otherwise be required under the State plan. This authority is granted only to the extent necessary to allow those in the employer-sponsored insurance plan to receive coverage through a private or employer-sponsored insurance plan, which may offer a different benefit package than that available through the State plan.

**3. Retroactive Coverage** **Section 1902(a)(34) (42 CFR 435.914)**

Individuals who enroll in the employer-sponsored insurance program and individuals without dependent children with family income up to 100 percent of the FPL.

**4. Early and Periodic Screening, Diagnostic, Treatment (EPSDT)** **Section 1902(a)(43)(A)and (42 CFR 440.40 and 441.50 through 441.62**

To enable the State to not provide or arrange for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to adults without dependent children with family income up to 100 percent of FPL ages 19 and 20 years old.

**Medicaid Requirements Not Applicable to the Family Planning Extension Program**

All Medicaid requirements apply to the Family Planning Extension Program, with the exception of the following:

**1. Amount, Duration, and Scope (Comparability)** **Section 1902(a)(10)(B) (42 CFR 440.240)**

To the extent necessary to allow the State to offer the family planning demonstration population a benefit package consisting only of family planning and family planning-related services.

**2. Eligibility Redetermination** **Section 1902(a)(19) (42 CFR 435.916)**

To enable the State to exempt women, who are eligible for the family planning program by virtue of losing Medicaid eligibility at the conclusion of their 60-day postpartum period (SOBRA women), from reporting changes in income during their 12-month eligibility period.

**3. Retroactive Eligibility** **Section 1902(a)(34) (42 CFR 435.914)**

To the extent necessary to enable the State to not provide medical assistance to the Demonstration population for any time prior to when an application for the Demonstration is made.

| | |
|---|---|
| **4. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)** | **Section 1902(a)(43)(A) (42 CFR 440.40 and 441.50 through 441.62)** |

To the extent necessary to enable the State to not furnish or arrange for EPSDT services to the demonstration population.

## CHIP Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act as incorporated into title XXI by section 2107(e)(2)(A) of the Act, State expenditures described below, shall, for the period through December 31, 2013, and to the extent of the State's available allotment under section 2104 of the Act; be regarded as matchable expenditures under the State's title XXI plan. All requirements of title XXI will be applicable to such expenditures for the demonstration population described below, except those specified below as not applicable to these expenditure authorities.

1. **Employer-Sponsored Insurance**. Expenditures to provide coverage to CHIP-eligible children up to age 19 with incomes above 100 percent of the FPL up to and including 200 percent of the FPL, who meet the definition of a targeted low-income child and who elect to receive coverage through the State's Employer-Sponsored Insurance (ESI) program rather than coverage under the CHIP State plan. Such children are no longer subject to the title XXI requirements listed below.
2. **KidsCare II Program**. Expenditures to provide coverage to children up to age 19 with family income up to 175 percent of the FPL not otherwise eligible for Medicaid.

## CHIP Requirements Not Applicable to CHIP Expenditure Authorities

(Sections refer to the Social Security Act.)

| | |
|---|---|
| **1. General Requirements, Eligibility, and Outreach** | **Section 2102 (42 CFR 457.90)** |

Only to the extent that the State child health plan would be required to reflect the demonstration population.

| | |
|---|---|
| **2. Annual Reporting Requirements** | **Section 2108 (42 CFR 457.700 through 457.750)** |

To the extent that the State would have to meet the annual reporting requirements with respect to the demonstration populations (the submission of an annual report into the CHIP Annual Report Template System/CARTS).The State will report on issues related

to the demonstration populations in quarterly and annual reports and enrollment data through the Statistical Enrollment Data System (SEDS).

**3. Cost Sharing** **Section 2103(e) (42 CFR 457.530 through 457.560)**

Rules governing cost sharing under section 2103(e) of the Act shall not apply to the demonstration populations.

**4. Benefit Package Requirements** **Section 2103**

To the extent necessary to permit the State to offer a benefit package for the ESI program that does not meet the requirements of section 2103 of the Act, outlined at 42 CFR 457.410(b)(1).

**SPECIAL TERMS AND CONDITIONS**
**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)**

**MEDICAID SECTION 1115 DEMONSTRATION**

**NUMBER:** 11-W00275/9
21-W-00064/9

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

**AWARDEE:** Arizona Health Care Cost Containment System

## I. PREFACE

The following are the Special Terms and Conditions (STCs) for Arizona's section 1115(a) Medicaid demonstration extension (hereinafter "Demonstration"). The parties to this agreement are the State of Arizona and the Centers for Medicare & Medicaid Services (CMS). This Demonstration is approved for a 5-year period, from October 22, 2011, through September 30, 2016. The STCs set forth below and the lists of waivers and expenditure authorities are incorporated in their entirety into the letter approving the Demonstration. The STCs are effective as of October 22, 2011, unless otherwise specified.

The STCs have been arranged into the following subject areas:

I. Preface;
II. Program Overview and Historical Context;
III. General Program Requirements;
IV. Eligibility;
V. Demonstration Programs;
VI. Funding Pools Under the Demonstration;
VII. Delivery Systems;
VIII. Evaluation;
IX. General Reporting Requirements;
X. General Financial Requirements under Title XIX;
XI. General Financial Requirements under Title XXI;
XII. Monitoring Budget Neutrality; and
XIII. Schedule of State Deliverables During the Demonstration.

## II. PROGRAM OVERVIEW AND HISTORICAL CONTEXT

Until 1982, Arizona was the only State that did not have a Medicaid program under title XIX of the Social Security Act. In October 1982, Arizona implemented the AHCCCS in the State's first section 1115 demonstration project. AHCCCS initially covered only acute care services, however, by 1989, the program was expanded to include the Arizona Long Term Care System (ALTCS), the State's capitated long term care (LTC) program for the elderly and physically disabled (EPD) and the developmentally disabled (DD) populations. In 2000, the State also expanded coverage to adults without dependent children with family income up to and including 100 percent of the Federal poverty level (FPL) as well as established the Medical Expense Deduction (MED) program for adults with income in excess of 100 percent of the FPL who have qualifying healthcare costs that reduce their income at or below 40 percent of the FPL. On March 31, 2011, Arizona requested to terminate its initial section 1115 demonstration in order to eliminate the MED program and implement an enrollment freeze on the adults without dependent children population. On April 30, 2011, and July 1, 2011, CMS approved the State's required phase-out plans for the MED program and the adults without dependent children population, respectively.

The new Demonstration provides health care services through a prepaid, capitated managed care delivery model that operates statewide for both Medicaid State plan groups as well as Demonstration expansion groups. The goal of the Demonstration is to test health care delivery systems to provide organized and coordinated health care for both acute and long term care that include pre-established provider networks and payment arrangements, administrative and clinical systems for utilization review, quality improvement, patient and provider services, and management of health services. The Demonstration will also test the extent to which health outcomes in the overall population are improved by expanding coverage to additional needy groups.

The Demonstration affects coverage for certain specified mandatory State plan eligibles by requiring enrollment in coordinated, cost effective, health care delivery systems. In this way, the Demonstration will test the use of managed care entities to provide cost effective care coordination, including two pilot projects that will test the effect of integrating behavioral and physical health services for two populations – individuals residing in Maricopa county with serious mental illness and children participating in the Children's Rehabilitative Services program. The Demonstration also provides coverage to limited groups the State does not currently cover under its Medicaid State plan, including adults without dependent children, and a limited number of children with incomes above the levels under the Medicaid State plan and at or below 175 percent of the FPL, which will show the benefits of such coverage using these approaches to a wider population. In addition, the Demonstration will provide for payments to IHS and tribal 638 facilities to address the fiscal burden of uncompensated care for services provided in or by such facilities to individuals with income up to 100 percent of the FPL. This authority will enable the State to evaluate how this approach impacts the financial viability of IHS and 638 facilities and ensures the continued availability of a robust health care delivery network for current and future Medicaid beneficiaries.

Finally, the Demonstration will allow the State to also test the effects of increasing personal

financial responsibility on utilization and health outcomes on some populations by permitting cost sharing. Specifically, the Demonstration will test the effects of the imposition of mandatory co-payments on adults without dependent children in the following areas:

1. Utilization of needed preventive, primary care, and treatment services;
2. Appropriate utilization of emergency room care, and appropriate, cost and clinically effective use of generic and brand name drugs;
3. State and Federal expenditures (per enrollee) in the short and long term; and
4. Physician participation, including physician willingness to accept appointments from the adults without dependent children population.

In order to evaluate these hypotheses, the Demonstration will review utilization and cost data and quality measures related to the adults without dependent children enrolled under the Demonstration as specified in paragraph 28(c).

## III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program, or the Children's Health Insurance Program (CHIP) for the separate CHIP population, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the Demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid program that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

   a) To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

b) If mandated changes in the Federal law require State legislation, the changes must take effect on the earlier of the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State will not be required to submit title XIX and XXI State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid State plan is affected by a change to the Demonstration, a conforming amendment to the State Plan is required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must include, but are not limited to, the following:

   a) An explanation of the public process used by the State, consistent with the requirements of paragraph 14 to reach a decision regarding the requested amendment;

   b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

   c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

   d) If applicable, a description of how the evaluation designs will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the

Demonstration, the chief executive officer of the State must submit to CMS either a Demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

As part of the Demonstration extension request, the state must provide documentation of compliance with the public notice requirements outlined in paragraph 14 as well as include the following supporting documentation:

a) Demonstration Summary and Objectives: The State must provide a summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met.

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

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

d) Compliance with the Budget Neutrality Cap: The State must provide financial data (as set forth in the current STCs) demonstrating that the State has maintained and will maintain budget neutrality for the requested period of extension. CMS will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension.

e) Interim Evaluation Report: The State must provide an evaluation report reflecting the hypotheses being tested and any results available.

9. **Demonstration Phase-Out.** The State may only suspend or terminate this Demonstration in whole, or in part, consistent with the following requirements.

a) Notification of Suspension or Termination: The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The State must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the Demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the State must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation in accordance with its approved tribal consultation State Plan

Amendment. Once the 30-day public comment period has ended, the State must provide a summary of each public comment received, the State's response to the comment and how the State incorporated the received comment into the revised phase-out plan.

The State must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

b) Phase-out Plan Requirements: The State must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c) Phase-out Procedures: The State must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2010, State Health Official Letter #10-008.

d) Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge CMS' finding that the State materially failed to comply.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination

prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** The State will ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The State must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the State's approved State plan, when any program changes to the Demonstration, including (but not limited to) those referenced in STC 6, are proposed by the State.

    In States with Federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the State's approved Medicaid State plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

    In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any Demonstration proposal and/or renewal of this Demonstration (42 C.F.R. §431.408(b)(3)).

    The State must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

15. **FFP.** Federal funds are not available for expenditures for this Demonstration until the effective date identified in the Demonstration approval letter.

## IV. ELIGIBILITY

16. **Eligibility.** The Demonstration affects all of the mandatory Medicaid eligibility groups set forth in Arizona's approved State plan, 14 optional groups set forth in the State plan, and 5 expansion groups made eligible under this Demonstration. Mandatory and optional State plan groups described below are subject to all applicable Medicaid laws and regulations except as expressly waived. Expansion populations are defined as those groups made eligible by virtue of the expenditure authorities expressly granted in this

Demonstration and are subject to Medicaid and CHIP laws or regulations except as specified in the STCs and waiver and expenditure authorities for this Demonstration. These cited documents generally provide that all requirements of Medicaid and CHIP laws and regulations do apply, except to the extent waived or specified as not applicable. The criteria for Arizona eligibility groups are as follows (Table 1):

**Table 1 –** State Plan and Expansion Populations Affected by the Demonstration

| Description | Program | Social Security Act Cite | 42CFR Cite |
|---|---|---|---|
| **STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS**<br>**Families and Children** | | | |
| 1931 (Title IV A program that was in place in July 1996) including:<br>• pregnant women with no other eligible children (coverage for third trimester)<br>• persons 18 years of age, if a full-time student<br>• family with unemployed parent | AACP | 1902(a)(10)(A)(i)(I) | 435.110 |
| Twelve months continued coverage (transitional medical assistance) 1931 ineligible due to increase in income from employment or work hours or loss of "income disregard." | AACP | 1902(a)(52)<br>1902(e)(l)<br>1925(a)(b)(c) | 435.112 |
| 1931 Extension-Extension of MA when child or spousal support collection results in 1931 ineligibility. (4 months continued coverage) | AACP | 408(a)(11)(B)<br>1902 (a) (10) (A) (i) (I)<br>1931 (c) | 435.115 |
| **STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS**<br>**Pregnant Women, Children, and Newborns** | | | |
| Qualified pregnant women who:<br>• would be AFDC eligible if child were born and<br>• meet AFDC income & resource criteria | AACP | 1902(a)(10)(A)(i)III<br>1905(n) | 435.116 |
| "S.O.B.R.A. WOMEN & INFANTS"<br>Pregnant women & infants under age 1 with incomes less than or equal to 133% FPL. (optional group extends coverage up to 140% FPL for infants under age 1) | AACP<br>ALTCS | 1902(a)(10)(A)(i)(IV)<br>1902(l)(1)(A) | |
| "S.O.B.R.A. CHILDREN"<br>Children age 1+ but not yet 6 with incomes at or below 133% FPL. | AACP<br>ALTCS | 1902(a)(10)(A)(i)(VI)<br>1902(l)(1)(C) | |
| "S.O.B.R.A. CHILDREN"<br>Children age 6+ but not yet 19, born after 9-30-83, with income less than or equal to 100% FPL. | AACP<br>ALTCS | 1902(a)(10)(A)(i)(VII)<br>1902(l)(1)(D) | |
| "DEEMED CATEGORICAL NEWBORNS"<br>Children born to a woman who was eligible and received Medicaid on the date of the child's birth. Children living with their mothers are eligible for 1 year as long as mothers are eligible or would be eligible if pregnant.* | AACP | 1902(e)(4) | 435.117 |
| **STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS**<br>**Qualified Family Members** | | | |

| Description | Program | Social Security Act Cite | 42CFR Cite |
|---|---|---|---|
| Qualified members of family with unemployed principal wage earner (persons who would be eligible if state did not limit number of months AFDC-UP cash was available). | AACP | 1902(a)(10)(A)(i)<br>1905(m)(l) | 435.119 |
| **STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS**<br>**Aged, Blind, and Disabled** | | | |
| All SSI cash recipients: aged, blind or disabled persons | AACP<br>ALTCS | 1902(a)(10)(A)(i)(II) | 435.120 |
| Qualified severely impaired working blind or disabled persons < 65 who were: a) receiving Title XIX, SSI or State supplement under 1619(a); or b) eligible for Medicaid under 1619(b) in 6/87 | AACP | 1902(a)(10)(A)(i)(II)<br>1905(q) | 435.120 |
| "DAC" Disabled adult child (age 18+) who lost SSI by becoming OASDI eligible (i.e., due to blindness or disability that began before age 22) or due to increase in amount of child's benefits. | AACP | 1634(c) | |
| SSI cash or state supplement ineligible for reasons prohibited by Title XIX. | AACP<br>ALTCS | | 435.122 |
| SSA Beneficiaries who lost SSI or state supplement cash benefits due to cost of living adjustment (COLA) increase in Title II benefits | AACP | | 435.135 |
| Disabled widow/widower who lost SSI or State supplement due to 1984 increase in OASDI caused by elimination of reduction factor in PL 98-21. (person must apply for this by 7/88) | AACP | 1634(b) | 435.137 |
| Disabled widow/widower (age 60-64 and ineligible for Medicare Part A) who lost SSI or State supplement due to early receipt of Social Security benefits. | AACP | 1634(d) | 435.138 |
| "DC Children" Children under the age of 18 who were receiving SSI Cash on 8/26/96 and would continue to be eligible for SSI Cash if their disability met the childhood definition of disability that was in effect prior to 8/26/96. | AACP | 1902(a)(10)(A)(i)(II) | |
| **STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS**<br>**Adoption Assistance and Foster Care Children** | | | |
| Children in adoption subsidy/foster care Title IV-E programs | AACP<br>ALTCS | 473(b)(l)<br>1902(a)(10)(A)(i)(I) | 435.145 |
| **STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS**<br>**Special Groups** | | | |
| "POSTPARTUM"<br>Title XIX eligible women who apply on or before pregnancy ends, (continuous coverage through the month in which the 60th day postpartum period ends) | AACP | 1902(e)(5)<br>1902(e)(6) | 435.170 |
| **STATE PLAN OPTIONAL TITLE XIX COVERAGE GROUPS** | | | |
| **Description** | **Program** | **Social Security Act Cite** | **42CFR Cite** |
| "210 GROUP" Persons who meet AFDC, SSI or State supplement income & resource criteria. | AACP<br>ALTCS Case Management | 1902(a)(10)(A)(ii)(I) | 435.210 |
| “211 GROUP" Persons who would be eligible for cash assistance except for their institutional status. | ALTCS | 1902(a)(10)(A)(ii)(IV) | 435.211 |
| "GUARANTEED ENROLLMENT" Continuous coverage for persons enrolled in AHCCCS Health Plans who lose categorical eligibility prior to 6 months from enrollment. (5 full months plus month of enrollment) | AACP | 1902(e)(2) | 435.212 |

| Description | Program | Social Security Act Cite | 42CFR Cite |
|---|---|---|---|
| "S.O.B.R.A. Infants" infants with incomes between the 133% FPL mandatory group maximum and a 140% FPL optional State maximum. | AACP<br>ALTCS | 1902(a)(10)(A)(ii)(IX) | |
| Pregnant women, including postpartum, who maintain eligibility without regard to changes in income. | AACP | 1902(e)(6) | |
| "HCBS GROUP" Persons receiving HCBS under a waiver with incomes < or equal to 300% of the Federal benefit rate (FBR). | ALTCS | 1902(a)(10)(A)(ii)(VI) | 435.217 |
| "State Adoption Subsidy" Children who receive a state adoption subsidy payment. | AACP | 1902(a)(10)(ii)(VIII) | 435.227 |
| "236 GROUP" Persons in medical institutions for 30 consecutive days who meet state-set income level of < or equal to 300% of FBR. | ALTCS | 1902(a)(10)(A)(ii)(V) | 435.236 |
| "Freedom to Work" Basic Coverage Group – individuals aged 16-64 with a disability who would be eligible, except for earnings, for SSI up to and including 250% of FPL. | AACP<br>ALTCS | 1902(a)(10)(A)(ii)(XV) | |
| "Freedom to Work" Medical Improvement Group – employed individuals aged 16-64 with a medically improved disability up to and including 250% of FPL. | AACP<br>ALTCS | 1902(a)(10)(A)(ii)(XVI) | |
| Women under 65 who need treatment for breast or cervical cancer, and not otherwise eligible for Medicaid. | AACP | 1902(a)(10)(A)(ii)(XVIII) | |
| Children who have aged out of foster care at 18 up to age 21 | AACP | 1902(a)(10)(A)(ii)(XVII) | |
| 1931 Expansion-Income Greater than 36% FPL and less than or equal to 100% FPL. | AACP | | |
| SSI-MAO Expansion (Optional 210 Group)- aged, blind, or disabled individuals with income greater than 100% FBR and less than or equal to 100% FPL. | AACP | Arizona State Plan | |
| **TITLE XIX AND XXI EXPANSION GROUPS UNDER THE DEMONSTRATION** | | | |
| Adults without dependent children who were enrolled in the AHCCCS under Demonstration project #11-W-00032/9 and #21-W-00009/9 as of July 8, 2011 as long as they continue to meet the State's eligibility criteria and redetermination requirements. | AACP | ARS 36-2901.01 | |
| To the extent the State gives notice to CMS described in 17.b below, adults without dependent children with adjusted net countable income at or below 100% FPL who are not otherwise eligible for Medicaid. | AACP | ARS 36-2901.01 | |
| Individuals who applied for the Medical Expense Deduction (MED) program (under Expenditure Authority 16 of Demonstration project #11-W-00032/9 and #21-W-00009/9) prior to May 1, 2011 and were determined eligible for that population for a 6-month guaranteed eligibility period after that date, until the end of that 6-month period. | AACP | ARS 36-2901.04 | |
| Women who lose Medicaid pregnancy coverage at the conclusion of 60 days postpartum, and who are not otherwise eligible for Medicare, Medicaid, Children's Health Insurance Program (CHIP) or health insurance coverage that provides family planning services, and who have a family income at or below 150 percent of the FPL at the time of annual redetermination (up to 24 months following the postpartum period). | Family Planning Extension Program | ARS 36-2907.04 | |

| Description | Program | Social Security Act Cite | 42CFR Cite |
|---|---|---|---|
| Children up to age 19 with incomes above 100 percent of the FPL up to and including 200 percent of the FPL who meet the definition of a targeted low-income child and who have access to ESI coverage | ESI | | |
| Children with family income at or below 175 percent of the FPL who are not otherwise eligible for Medicaid, subject to available funding. | KidsCare II | | |

*Arizona's 1115 Demonstration provides the authority to waive some of the provisions.

## V. DEMONSTRATION PROGRAMS

17. **Arizona Acute Care Program (AACP)**. The AACP is a statewide, managed care system which delivers acute care services through prepaid, capitated MCOs that AHCCCS calls "Health Plans." Most Health Plan contracts are awarded by Geographic Service Area (GSA), which is a specific county or defined grouping of counties designated by AHCCCS within which a Contractor provides, directly or through subcontract, covered health care to members enrolled with that Contractor. AACP enrollees receive most Medicaid-covered services through the Health Plans, but receive, on a "carve out" basis, behavioral health services through a separate PIHP contract. The one exception to the behavioral health carve out is for AACP members with a serious mental illness residing in Maricopa County who receive their acute care and behavioral health services through the PIHP. In addition, AACP members with a CRS condition receive all of their care – acute care and treatment for CRS and behavioral health care conditions – through a separate MCO contract.

a) **AACP Eligibility –** Those Groups identified in Table 1.

b) **Enrollment** - The Arizona DES processes applications and determines acute care Medicaid eligibility for children, pregnant women, families and non-disabled adults under the age of 65 years. The Social Security Administration (SSA) determines eligibility for the Supplemental Security Income (SSI) cash-related groups, and AHCCCS determines eligibility for the SSI- related aged and disabled groups, Medicare Savings Programs, women diagnosed with breast or cervical cancer, and Freedom to Work recipients. Individuals determined eligible must then select and enroll in a Health Plan, or they will be auto-assigned by the AHCCCS administration.

   i. The State will not make individuals eligible based on applications received on and/or after July 8, 2011, for AHCCCS benefits from adults without dependent children with family income up to 100 percent of the FPL. Adults without dependent children who were enrolled in the AHCCCS under Demonstration project #11-W-00032/9 and #21-W-00009/9 as of July 8, 2011, will continue to receive AHCCCS benefits under this Demonstration as long as such individuals continue to meet the State's eligibility criteria and redetermination requirements.

ii. The State may open new enrollment for the adults without dependent children population. The State must notify CMS prior to re-opening enrollment, and must include a process by which it will notify the public, such as the use of public forums, tribal consultations, and community stakeholder meetings.

iii. The State must maintain eligibility for individuals who were enrolled in AHCCCS under Demonstration #11-W-00032/9 and #21-W-00009/9 as of July 8, 2011 in the adults without dependent children population unless the individuals no longer meet the eligibility criteria.

c) **Benefits** – Benefits for AACP and the expansion population authorized by the 1115 Demonstration will consist of all acute care benefits covered under the Medicaid State plan (see Attachment G), unless otherwise noted within these STCs.

i. **Notice -** The State must include the CMS Central Office when submitting a State plan amendment (SPA) to the CMS Regional Office that would impact the expansion population authorized by the 1115 Demonstration inclusive of:
   a. The proposed date of implementation;
   b. The date the State plans to submit the SPA; and
   c. Revised budget neutrality projections.

ii. **Demonstration Amendment.** CMS reserves the right to require the State to submit an amendment if it is determined that it is warranted.

iii. Behavioral health services are outlined in Table 2 and subject to limitations set forth in the existing State plan.

Table 2 – AACP Behavioral Management

| **Benefit** | **Title XIX** | | **Title XXI** |
|---|---|---|---|
| Age | < 21 yrs | ≥ 21 yrs | < 19 yrs |
| | | | |
| Behavioral Management | X | X | X |
| Case Management | X | X | X |
| Emergency Behavioral Health Care | X | X | X |
| Evaluation | X | X | X |
| Therapeutic Residential Support (in home, excluding room and board ) | X | X | X |
| Inpatient Services | | | |
| Inpatient Hospital | X | X | X |
| Inpatient Psychiatric Facilities | X | X | X |
| Lab & X – Ray | X | X | X |
| Medications (Psychotropic) | X | X | X |
| Medication Adjustment & Monitoring | X | X | X |
| Methadone / IAAM | X | X | X |
| Partial Care | X | X | X |
| Professional Services | | | |
| Individual | X | X | X |
| Group & Family | X | X | X |

| Benefit | Title XIX | | Title XXI |
|---|---|---|---|
| Psychosocial Rehabilitation | X | X | X |
| Respite (with limits) | X | X | X |
| Screening | X | X | X |
| Transportation – Emergency | X | X | X |
| Transportation – Non Emergency | X | X | X |

d) **AACP Cost Sharing** – Cost sharing shall be imposed as specified in the Medicaid State plan for all populations, except for the adults without dependent children with income up to 100 percent of the FPL which are as follows:

Table 3 – Adults without Dependent Children Copayments

| Service | Copayment Amount | Geographic Applicability |
|---|---|---|
| Generic prescription, or brand name prescription if generic is not available | $4 | Statewide |
| Brand name prescription when generic is available | $10 | Statewide |
| Non-emergency use of the emergency room | $30 | Statewide |
| Physician office visit | $5 | Statewide |
| Non-emergency medical transportation (NEMT) (taxi rides only) | $2 per trip ($4 roundtrip maximum) | Only in Maricopa and Pima counties |

i. The NEMT copayment shall be imposed only on taxi rides for adults without dependent children who reside in Maricopa and Pima counties. Adults without dependent children residing in all other counties within the State are exempt from the NEMT copayment. The American Indian/Alaskan Native (AI/AN) population is also exempt.

ii. The copayments referenced in the Table 3 above are subject to the evaluation requirements in STC# 28(c).

18. **Children in Foster Care** – Services for Arizona's children in foster care are provided through an MCO contract between AHCCCS and the Arizona DES/CMDP. CMDP operates in the same manner as other AACP Health Plans, but children in foster care who receive acute care services will be enrolled in CMDP instead of other Health Plans. Children in foster care who are eligible for or receive ALTCS will be enrolled or remain with the Program Contractor. Case Management services provided and reimbursed through this contractual relationship must be provided consistent with Federal policy, regulations and law. Children in foster care who are also eligible for CRS receive treatment for their CRS and behavioral health care conditions through the separate MCO contract for the CRS program. CRS eligible foster children will receive services for all conditions other than behavioral health or CRS related conditions through CMDP.

a) **FFP**. FFP will not be available for:

i. Duplicate payments made to public agencies or private entities under other program authorities for case management services or other Medicaid services for the same purpose; or

ii. Activities integral to the administration of the foster care program excluding any health care related activities.

19. **Children Rehabilitative Services (CRS)**. AHCCCS contracts on a sole-source, capitated basis for the CRS program. Acute Care enrolled children with qualifying conditions receive their CRS specialty care, behavioral health care and acute care through the CRS contractor. Children enrolled in ALTCS DES/DDD who also have a CRS condition will receive care for their CRS and behavioral health conditions through the CRS contractor. Children with a CRS condition who are enrolled in CMDP will receive treatment for their CRS and behavioral health care conditions through the CRS contractor.

a) **Transition of Care.** When individuals transition to the CRS contractor from an AACP health plan, children in active treatment (including but not limited to chemotherapy, pregnancy, drug regime or a scheduled procedure) with a CRS non-participating provider shall be allowed to continue receiving treatment from the non-participating provider through the duration of their prescribed treatment.

b) **Choice of Primary Care Physician (PCP).** The CRS contractor is required to assure that members have a choice of PCPs. Specifically, beneficiaries will have a choice of at least two primary care providers, and may request change of primary care provider at least at the times described in 42 CFR 438.56(c). In addition, the CRS contractor will offer contracts to primary and specialist physicians who have established relationships with beneficiaries including specialists who may also serve as PCPs to encourage continuity of provider. For children who have an established relationship with a PCP that does not participate in the CRS contractor's provider network, the CRS contractor will provide, at a minimum, a 90-day transition period in which the child may continue to seek care from their established PCP while the child and child's parents and/or guardian, the CRS contractor, and/or case manager finds an alternative PCP within the CRS contractor's provider network.

c) **Readiness Review of Health Plan.** The state will submit to CMS for review a copy of its readiness review report of the health plan selected to provide the integrated services to the CRS population to ensure the selected health plan's provider network, both in terms of primary and specialty care providers, is adequate and would not result in access to care issues for the affected population.

20. **Individuals with Serious Mental Illness (SMI).** Individuals who are AACP members residing in Maricopa County and who are diagnosed with a serious mental illness will receive their acute care services and behavioral health services through a separate PIHP.

    a) **Transition Period.** When individuals transition to the PIHP for their physical health from an AACP health plan, members in active treatment (including but not limited to chemotherapy, pregnancy, drug regime or a scheduled procedure) with a non-participating/non-contracted provider shall be allowed to continue receiving treatment from the non-participating/non-contracted provider through the duration of their prescribed treatment.

    b) **Choice of Primary Care Physician (PCP).** The PIHP is required to assure that members have a choice of PCPs. Specifically, beneficiaries will have a choice of at least two primary care providers, and may request change of primary care provider at least at the times described in 42 CFR 438.56(c). In addition, the PIHP, through the Regional Behavioral Health Authorities (RBHA), will offer contracts to primary and specialist physicians who have established relationships with beneficiaries including specialists who may also serve as PCPs to encourage continuity of provider. For individuals who have an established relationship with a PCP that does not participate in the PIHP/RBHA's provider network, the PIHP will provide, at a minimum, a 90-day transition period in which the individual may continue to seek care from their established PCP while the individual, the PIHP, RBHA and/or case manager finds an alternative PCP within the PIHP/RBHA's provider network.

    c) **Readiness Review of Health Plan.** The state will submit to CMS for review a copy of its readiness review report of the health plan selected to provide the integrated services to the SMI population to ensure the selected health plan's provider network, both in terms of primary and specialty care providers, is adequate and would not result in access to care issues for the affected population.

21. **Arizona Long Term Care System (ALTCS).** The ALTCS program is for individuals who are age 65 and over, blind, disabled, or who need ongoing services at a nursing facility or ICF/MR level of care. ALTCS enrollees do not have to reside in a nursing home and may live in their own homes or an alternative residential setting and receive needed in-home services. The ALTCS package also includes all medical care covered under AACP inclusive of doctor's office visits, hospitalization, prescriptions, lab work, behavioral health services, and rehabilitative services. Rehabilitative services may only be eligible for FFP if these services reduce disability or restore the program enrollee to the best possible level of functionality.

The ALTCS is administered through a statewide, managed care system which delivers acute, long-term care, home-and-community based, CRS and behavioral health care services through capitated MCOs that AHCCCS calls "Program Contractors." The one exception is ALTCS DES/DDD enrollees eligible under the CRS program receive

specialty care for treatment of their CRS and behavioral health conditions through a separate MCO contract. Those enrollees will receive services for all conditions other than behavioral health or CRS related conditions through ALTCS DES/DDD.

With one exception, ALTCS contracts are awarded in the same geographic service areas as AACP are awarded. The exception is for the ALTCS contract with the Arizona DES/DDD to provide coverage on a statewide basis of the full ALTCS benefit package to all eligible individuals with developmental disabilities. Under State law, A.R.S. 36-2940, AHCCCS is required to enter into an intergovernmental agreement (IGA) with DES/DDD to serve as the managed care organization for individuals with developmental disabilities. The DES/DDD ALTCS contract is an at-risk MCO contract that complies with 42 C.F.R. Part 438 and as such is reviewed and approved by CMS. Payments to DES/DDD under the ALTCS contract shall not include any payments other than payments that meet the requirements of 42 C.F.R. 438.6(c) including the requirement that all payments and risk-sharing mechanisms in the contract are actuarially sound. State law, A.R.S. 36-2953, requires DES/DDD to maintain a separate fund to account for all revenues and expenditures under the ALTCS contract and limits use of the fund for the administration of the ALTCS contract. ALTCS enrollees in Maricopa and Pima Counties have a choice of Program Contractors, but ALTCS enrollees in the rest of the State enroll in the Program Contractor for their GSA.

a) **ALTCS Eligibility Groups** - Individuals as defined in Table 1 requiring health care services at a nursing facility or ICF/MR level of care.

b) **ALTCS Financial Eligibility** - Individuals must be financially eligible for ALTCS with income equal to or less than 300 percent of the Federal Benefit Rate (FBR), as used by SSA to determine eligibility for SSI.

    i. The State may disregard income in excess of the FBR for persons with AHCCCS approved income-only trusts.

    ii. The resource (cash, bank accounts, stocks, bonds, etc.) limit is $2,000 for a single individual. Resources, such as a person's home, vehicle, and irrevocable burial plan are not counted toward the resource limit.

    iii. When the applicant has a spouse who resides in the community, the spouse can retain one-half of the couple's resources, up to the Federal maximum as specified in section 1924(f)(2) of the Act. Resources, such as a person's home, vehicle, and irrevocable burial plan are not counted toward the resource limit.

    iv. The total gross income for a married couple is combined and divided by 2. The resulting income may not exceed 300 percent of the single FBR. If the resulting income exceeds 300 percent of the single FBR, the income of the applicant only (name on check) is compared to 300 percent of the single FBR.

c) **Pre-Admission Screening (PAS) -** Once financial eligibility has been established, a PAS will be conducted by a registered nurse or social worker to determine if the individual is at immediate risk of institutionalization in either a nursing facility or an ICF/MR. The PAS must be used to determine if the applicant is eligible for ALTCS based on functional, medical, nursing, and social needs of the individual.

d) **Written Plan of Care** - An individual written plan of care will be developed by qualified providers for ALTCS enrollees under this demonstration. This plan of care will describe the medical and other services to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the review of AHCCCS.

   i. **FFP -** will not be claimed for Demonstration services furnished prior to the development of the plan of care. FFP will not be claimed for Demonstration services which are not included in the individual written plan of care.

e) **ALTCS Safeguards** – AHCCCS will take the following necessary safeguards to protect the health and welfare of persons receiving HCBS services under the ALTCS program. Those safeguards include:

   i. Adequate standards for all types of providers that furnish services under the ALTCS program;

   ii. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the ALTCS program. The State assures that these requirements will be met on the date that the services are furnished; and

   iii. Assurance that all facilities covered by section 1616 (e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirement of 45 CFR Part 1397 for board and care facilities.

   iv. A formal quality control system which monitors the health and welfare of members served in the ALTCS program.

      1) Monitoring will ensure that all provider standards and health and welfare assurances are continually met, and that plans of care are periodically reviewed to ensure that the services furnished are reasonably consistent with the identified needs of the individuals.

      2) The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

f) **ALTCS Benefits and Services**

i. **ALTCS Acute Care -** Enrollees receive the same acute services as defined in paragraph 17(c).

ii. **ALTCS Behavioral Health Care -** Enrollees receive behavioral health care services as defined in paragraph 17(c)(iii).

iii. **Home and Community-Based Services (HCBS) -** ALTCS will provide a comprehensive HCBS package to eligible enrollees in the enrollee's home or in an ALTCS approved Alternative Residential Setting.

1) **Alternative Residential Settings** include:

a. Adult foster care.
Assisted living homes, assisted living centers, adult developmental homes, child developmental homes and group homes, hospices, group homes for traumatic brain injured members, and rural substance abuse transitional agencies.

b. Behavioral Health Facilities that are licensed to provide behavioral health services in a structured setting with 24-hour supervision. ALTCS covers services, except room and board, that are provided to ALTCS members who have a behavioral health disorder and are residing in one of the following behavioral health facilities:

i. Level II behavioral health facility – Licensed by ADHS. An HCBS alternative residential behavioral health treatment setting for individuals who do not require the intensity of services or onsite medical services found in a Level I facility.

ii. Level III behavioral health facility - Licensed by ADHS. An HCBS alternative residential behavioral health treatment setting with 24-hour supervision and supportive, protective oversight. These services are excluded for individuals involuntarily living in the secure custody of law enforcement, judicial, or penal systems.

2) **HCBS Services** – Services provided to ALTCS enrollees receiving HCBS are enumerated in Table 4.

Table 4 – ALTCS HCBS

| Service | Title XIX | |
|---|---|---|
| | EPD | DD |
| Acute Hospital Admission | X | X |
| Adult Day Health Services | X | N/A |
| Attendant Care | X | X |
| Behavioral Health Services | X | X |
| Community Transition Services* | X | X |
| DME / Medical Supplies | X | X |
| Emergency Alert | X | X |
| Habilitation | X | X |
| Home Delivered Meals | X | n/a |
| Home Health Agency Services | X | X |
| Home Modifications | X | X |
| Home Maker Services | X | X |
| Hospice Services (HCBS & Institutional) | X | X |
| ICF / MR | n/a | X |
| Medical Care Acute Services | X | X |
| Nursing Facility Services | X | X |
| Personal Care | X | X |
| Respite Care (in home) | X | X |
| Respite Care (Institutional) | X | X |
| Therapies | X | X |
| Transportation | X | X |

*As Defined in State Medicaid Director Letter #02-008 (Attachment D)

3) **HCBS Expenditures**- Expenditures for individual members are limited to an amount that does not exceed the cost of providing care to the eligible individual in an institutional setting. Exceptions are permitted including when the need for additional services is due to a change in condition that is not expected to last more than 6 months.

iv. **Spouses As Paid Care Givers**. AHCCCS may implement a voluntary program for spouses as paid caregivers. The program will provide reimbursement to spouses who elect to provide needed in-home care for eligible ALTCS enrollees. Spouses providing care to eligible enrollees will be employed by an ALTCS network contractor, or registered with AHCCCS as an ALTCS independent provider when providing services to an ALTCS FFS Native American or developmentally disabled member. In order for the State to receive FFP from CMS for Paid Caregiver Spouses of Medicaid beneficiaries, the personal care service or support must meet the following criteria and monitoring provisions.

1) Services provided by the Spouse as Paid Caregiver must meet the definition of a "service/support" for personal care or similar services that are rendered by a Paid Caregiver when such services are deemed extraordinary care.
   a. Personal care or similar services – Is defined as assistance with the Activities of Daily Living (ADLs), or Instrumental

Activities of Daily Living (IADLs), whether furnished in the home or the community, including personal assistance, attendant care, and closely related services such as home health aide, homemaker, chore, and companion services which may include improving and maintaining mobility and physical functioning, promoting health and personal safety, preparation with meals and snacks, accessing and using transportation, and participating in community experiences and activities.

b. Extraordinary care - Is defined as care that exceeds the range of activities that a spouse would ordinarily perform in the household on behalf of the recipient spouse, if he/she did not have a disability or chronic illness, and which are necessary to assure the health and welfare of the beneficiary, and avoid institutionalization.

2) The Spouse as Paid Caregiver must be a service/support that is specified in a plan of care prepared on behalf of the enrollee.

3) The enrollee who selects the Spouse as Paid Caregiver is not eligible to receive like services from another attendant caregiver.

4) The enrollee will remain eligible to receive other HCBS such as skilled/professional type services, home modifications, respite care, and other services that are not within the scope of the personal/attendant care services prescribed in the provider's plan of care.

5) The Services must be provided by a Spouse as Paid Caregiver who meets specified provider qualifications and training standards prepared by the State for a Paid Caregiver.

6) The Spouse as Paid Caregiver must be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the State Medicaid Agency (SMA) for the payment of personal care/attendant services; and

7) The Spouse as Paid Caregiver will comply with the following conditions.
   a. A Spouse as Paid Caregiver may not be paid for more than 40 hours of services in a 7-day period;
   b. The Spouse as Paid Caregiver must maintain and submit time sheets and other required documentation for hours worked/paid;

c. The Spouse as Paid Caregiver may only submit claims for services that have been authorized by the Program Contractor or ALTCS FFS case manager;
d. The ALTCS enrollee must be offered a choice of providers, other than his/her spouse. The enrollee's choice of a Paid Caregiver Spouse as provider must be recorded in his/her plan of care, at least annually.

8) AHCCCS and its Program Contractors must comply with the following monitoring requirements:
   a. Require Program Contractors and FFS case managers to make an on-site case management visit at least every 90 days to reassess a beneficiary's need for services, including the health, safety, and welfare status of the beneficiary serviced by the Spouse as Paid Caregiver;
   b. Require Program Contractors to provide quarterly financial statements that include separate authorized hours and expenditure information for Paid Caregiver Spouses; and
   c. Require AHCCCS to perform quarterly financial analysis that includes authorized hours and expenditure information for ALTCS FFS Spouses as Paid Caregivers.

v. **Institutional Care** ALTCS will provide institutional care in facilities appropriate to their needs that hold State licenses and Medicaid provider agreements indicating compliance with Medicaid requirements.

g) **Cost Sharing.**

i. Monthly Premiums for ALTCS. The AHCCCS may implement a monthly premium on ALTCS eligible households with an adjusted gross income at or above 400 percent of the FPL that have children under the age of 18 years with developmental disabilities enrolled in ALTCS.

ii. The total of all monthly premiums will be 2 percent of the annual adjusted gross income for households with income between 400 percent and 500 percent of the FPL, and 4 percent for households with income at and above 500 percent the FPL. There will be no distinction between institutional or non-institutional placements.

iii. AHCCCS will compute the premium amount using annual adjusted gross income from the parent's most recent Federal income tax return.
   1) Premiums will be billed monthly on the 1st and due on the 15th.
   2) AHCCCS will establish a grievance and appeal process allowing families to dispute the initial amount of the premium based on annual income or family size, increases in premiums and discontinuances for failure to pay the monthly premiums or deductibles.

a. Premiums will continue to be billed and incurred during an eligibility appeal period and failure to pay the premium during the appeal period could mean a loss of eligibility.
b. If the appeal is based on an increase in the premium amount, the premium increase will not be imposed until after an appeal decision.

h) **Other ALTCS Requirements**

i. The State of Arizona will continue to provide access to ALTCS services to American Indians on the reservation as it does to other citizens of the State.

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

iii. In the absence of a limit, AHCCCS will report annually on current placements and ongoing activities for expanding HCB services and settings. The report will be due by March 31 of each year.

iv. The DES/DDD will comply with all contractual and reporting requirements as specified in the contract between AHCCCS and DES/DDD and in any subsequent amendments. DES/DDD will be sanctioned as specified in the contract if DES/DDD fails to comply with the stated contractual and reporting requirements.

22. **ALTCS Transitional Program**. AHCCCS will complete a second scoring of the PAS for members who are enrolled in ALTCS, but fail to be at "immediate risk of institutionalization" based on the PAS conducted at the time of the re-determination.

    If determined eligible for the ALTCS Transitional Program, AHCCCS will transfer the member to the ALTCS Transitional Program which limits institutional services to 90-days per admission and provides the member with medically necessary acute care services, HCBS, behavioral health services and case management services as prescribed in paragraph #20.

23. **Medicare Part B Premiums.** The State of Arizona will continue to pay the Medicare Part B premiums on behalf of individuals enrolled in ALTCS with income up to 300 percent of the FBR who are also eligible for Medicare, but do not qualify as a QMB, SLMB or QI; eligible for Medicaid under a mandatory or optional Title XIX coverage group for the aged, blind, or disabled (SSI-MAO); eligible for continued coverage under 42 CFR 435.1003; or are in the guaranteed enrollment period described in 42 CFR 435.212 and the State was paying their Part B premium before

eligibility terminated. Once the State has received the Medicare Part B premium invoice, it will automatically make an electronic payment on behalf of the beneficiary.

24. **Title XXI Programs under the Demonstration.**

a) **Employer-Sponsored Insurance (ESI)**

i. **Eligibility.** Children who are eligible for KidsCare or KidsCare II whose family income is between 100 percent up to and including 200 percent of FPL, and who have access to a qualifying employer sponsored insurance (ESI) plan, as described in (iv) and (v) below.

ii. **Enrollment Process.** Prior to enrollment in the ESI, children (either directly or through their parents or guardians) must specify that they are declining enrollment into KidsCare or KidsCare II and instead requesting enrollment in the ESI. Before such a request is accepted, the individual must receive information/counseling in order to ensure that enrollment is an informed choice. ESI enrollees will have the choice to opt back into direct coverage, if available, at any time.

iii. **Premium Assistance Benefits**: The State will subsidize premium assistance through a monthly per child subsidy that will not exceed the per capita cost of direct CHIP coverage for the child. This monthly subsidy does not need to be allocated between eligible and ineligible family members.

iv. **Minimum Employer Contribution.** Qualifying ESI must include employer contributions of at least 30 percent of the total premium or cost under the employer plan.

v. **Minimum Benefit package.** Qualifying ESI will include coverage that provides a basic primary care package of inpatient hospital services, outpatient services, laboratory and x-ray services, pharmacy services, and behavioral health services. Coverage may be provided through any commercial group package or self-insurance program offered by the employer to all employees in a class. Within these parameters, benefits may vary between employers. Wrap-around services are not provided.

vi. **Choice of ESI Plans.** To the extent that premium assistance is extended to individuals, the individuals must agree not to exercise choice among available ESI plans without obtaining State concurrence. The State will not, however, deny coverage based on a prior exercise of such choice.

vii. **Cost Sharing.** Enrollees in the ESI program will have cost sharing set by their employer-based coverage.

viii. **Enrollment Data.** Each quarter, the State will provide CMS with end of quarter actual and unduplicated ever-enrolled figures. These enrollment data will be entered into the Statistical Enrollment Data System within 30 days after the end of each quarter. The data will also be referenced in the quarterly reports described in paragraph 37. In addition, the State will provide monthly enrollment data as specified by CMS in the monthly Eligibility and Enrollment Reports.

b) **Kids Care II Program.** This program is authorized, subject to the available funding as specified in paragraph 25(i), from May 1, 2012 through December 31, 2013.

i. **Eligibility.** Targeted low-income children defined in 42 CFR 457.310 with family income from 100 percent of the FPL up to and including 175 percent of the FPL who are not otherwise eligible for Medicaid but are otherwise eligible for the Arizona CHIP State Plan, except for the enrollment cap and/ or waiting period.

ii. **Enrollment Process.** Eligible children will enroll into the KidsCare II program as outlined in the sub-paragraphs below. Attachment H provides further operational details with respect to the enrollment process.

1) **Children "Aging Out" of Medicaid.** Beginning April 6, 2012, the State will conduct an administrative renewal for a child turning age 6 to determine if the child is eligible for Medicaid under a different eligibility category, or if the child is eligible for the KidsCare II program. If the child is no longer eligible for Medicaid, the State will automatically transfer the child from the AACP program into the KidsCare II program if they meet KidsCare II eligibility requirements. These children will remain enrolled if otherwise eligible, until the KidsCare II program ends on December 31, 2013, at which time they will seamlessly transition to other forms of coverage. These children are not subject to the waiting list as described in subparagraph (vi) below, and will continue to be automatically transitioned to KidsCare II.

2) **KidsCare Waiting List**. Families with children on the KidsCare waiting list who are notified by the State will have the opportunity to apply for the KidsCare II program. In order to be determined eligible for KidsCare II coverage, children must have income at or below 175 percent of the FPL, and have no outstanding KidsCare premiums and must meet all other eligibility requirements. KidsCare premiums must be paid before a child can enroll in the KidsCare II program. Once determined eligible, a child will remain in the KidsCare II program if otherwise eligible until the program ends on December 31, 2013.

3) **Open Enrollment**. Subject to available program funding and notification to all the families with children on the KidsCare waiting list

as described above in subparagraph (2) and in Attachment H, the State will open enrollment to the KidsCare II program to all eligible children up to 19 years old with family income at or below 175 percent of the FPL. The State must notify CMS prior to opening enrollment, and must include a process by which it will notify the public, such as the use of public forums, tribal consultations, and community stakeholder meetings.

iii. **Enrollment Threshold.** Enrollment for the KidsCare II program is subject to the available funding as specified in paragraph 25(i), in order to enroll a target number of 21,700 children. The State will seek to maintain full enrollment in the program. If the enrollment drops below 15,000 children, the State shall conduct additional outreach activities as outlined in Attachment H in order to increase enrollment.

iv. **Benefits.** Children enrolled in the KidsCare II program will be offered the same benefit package provided under Arizona's CHIP State plan.

v. **Cost Sharing.** Children in the KidsCare II program will be subject to cost sharing requirements, including monthly premiums, specified in Arizona's CHIP State Plan. Cost sharing for children in KidsCare II must meet the same requirements as those for children receiving coverage under the CHIP State plan, consistent with the requirements at section 2103(e). Cost sharing for families at or below 150 percent of the Federal poverty level (FPL), must be "nominal" in accordance with 42 CFR 457.540 - 457.555and total charges may not exceed 5 percent of the family's income for children of all income levels, in accordance with 42 CFR 457.560.

vi. **Wait List.** Upon reaching the target enrollment of 21,700 children, the state is authorized to maintain a wait list for the KidsCare II program. Children will be placed on the wait list in chronological order of the state's receipt of their application. The state will continue to conduct a Medicaid eligibility determination upon receipt of a KidsCare II application before placing the child onto the wait list. The state will monitor enrollment on a monthly basis in order to determine if enrollment has dropped to 19,000 children. Once enrollment has dropped to 19,000, or if enrollment has decreased by 3,000 in a single month, the state will notify families on the KidsCare II wait list, beginning with the oldest application, informing them to electronically verify the information the state has on file in its Health-e-Arizona system in order to enroll into the KidsCare II program. If the application is less than two months old, the state will automatically approve the applicant for KidsCare II without requiring the family to re-verify their information on Health-e-Arizona. Subject to available funding and notification of all families on the KidsCare II wait list, the state will open enrollment to the KidsCare II program to all

eligible children up to 19 years old with family income at or below 175 percent of the FPL.

Children "aging out" of Medicaid will continue to automatically transition from Medicaid into the KidsCare II program following the enrollment process set forth in subparagraph (ii)(1) and will not be subject to the wait list.

c) **Funding for Title XXI Programs.** The State will establish a monitoring process to ensure that expenditures do not exceed available title XXI funding (i.e., the title XXI allotment or reallocated funds) and the appropriated State match. The State will use title XXI funds to cover services for the CHIP, ESI and KidsCare II populations in the following priority order:

i. Title XXI State plan eligibles, as well as children that opt for ESI, who are children up to age 19 years with family incomes up to and including 200 percent of the FPL.
ii. KidsCare II program participants who are children up to age 19 years with family incomes above 100 percent of the FPL up to and including 175 percent of the FPL.
iii. If the State determines that title XXI funding will be exhausted, available title XXI funding will first be used to cover costs associated with the title XXI State plan population.

24. **Family Planning Extension Program.** Family planning and family planning related services are provided, for a period of up to 24 months, to eligible recipients who lose Medicaid pregnancy coverage at the conclusion of 60 days postpartum, and who are not otherwise eligible for Medicare, Medicaid, CHIP, or health insurance coverage that provides family planning services, and who have a family income at or below 150 percent of the FPL at the time of annual redetermination.

a) **Benefits.**

i. Family planning services and supplies described in section 1905(a)(4)(c) and are limited to those services and supplies whose primary purpose is family planning and which are provided in a family planning setting. Family planning services and supplies are reimbursable at the 90 percent matching rate, including:
   1) Approved methods of contraception;
   2) Sexually transmitted infection (STI)/sexually transmitted disease (STD) testing, Pap smears and pelvic exams;
      i. Note: The laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs/STDs, blood count and pregnancy test. Additional screening

tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.

3) Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the State's provider enrollment requirements (subject to the national drug rebate program requirements); and
4) Contraceptive management, patient education, and counseling.

ii. Family planning-related services and supplies are defined as those services provided as part of or as follow-up to a family planning visit and are reimbursable at the State's regular Federal Medical Assistance Percentage (FMAP) rate. Such services are provided because a "family planning-related" problem was identified and/or diagnosed during a routine or periodic family planning visit. Examples of family planning-related services and supplies include[1]:

1) Colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit.
2) Drugs for the treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is identified/ diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered.
3) Drugs/treatment for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, where these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/ drugs may also be covered.
4) Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.
5) Treatment of major complications arising from a family planning procedure such as:
    i. Treatment of a perforated uterus due to an intrauterine device insertion;
    ii. Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or

[1] For more information on which of these family planning-related services is covered, see the AHCCCS Medical Policy Manual at: http://ahcccsnew/shared/MedicalPolicyManual/MedicalPolicyManual.aspx?ID=policymanuals

iii. Treatment of surgical or anesthesia-related complications during a sterilization procedure.

b) **Primary Care Referral.** Primary care referrals to other social service and health care providers as medically indicated are provided; however, the costs of those primary care services are not covered for enrollees of this program. The State must facilitate access to primary care services for participants in the Family Planning Extension Program and must assure CMS that written materials concerning access to primary care are distributed to participants. The written materials must explain to the participants how they can access primary care services.

c) **Eligibility Re-determinations.** The State must ensure that redeterminations of eligibility for the Demonstration are conducted at least every 12 months. At the State's option, redeterminations may be administrative in nature. The State must notify CMS within the previous quarterly or annual report, described in STCs 34 and 35, if it chooses to utilize administrative redeterminations.

d) **Disenrollment.** If a woman becomes pregnant while enrolled in the Demonstration, she may be determined eligible for Medicaid under the State plan. The State must not submit claims under the Demonstration for any woman who is found to be eligible under the Medicaid State plan. In addition, women who receive a sterilization procedure and complete all necessary follow-up procedures will be disenrolled from the Demonstration.

## VI. Funding Pools and Payments under the Demonstration.

25. **Safety Net Care Pool (SNCP).** Payments from this pool will assist hospitals and other eligible providers that have high levels of uncompensated care related to medical assistance provided to Medicaid eligibles or to individuals who have no source of third party coverage. In each Demonstration Year (DY), the annual SNCP will be distributed to each provider based on its proportionate share of projected uncompensated care (based on prior period data). Furthermore, payments to each provider in each DY will be subject to a limit computed based on the provider's uncompensated care costs incurred for a 12-month period covered by the DY, except in DY 3 where the limit will be computed based on uncompensated care costs incurred up to December 31, 2013. The total computable amount for the SNCP is $332 million per DY. Any unspent cap amount cannot be transferred to the following DY in order to increase the annual cap amount.

a) **SNCP Payments.** Funds may be used to assist providers with high levels of uncompensated care related to medical services that meet the definition of "medical assistance" contained in section 1905(a) of the Act, that are provided to Medicaid eligible or uninsured individuals incurred by hospitals, clinics, or by other provider types, as agreed upon by CMS and the State and identified in Attachment J. Expenditures must be claimed in accordance with CMS-approved claiming protocols in Attachment I for each provider type. FFP claiming for payments made from the SNCP will begin upon CMS approval of the claiming protocol as identified in sub-paragraph (c). For any provider receiving SNCP payments, the total Medicaid

payments, Disproportionate Share Hospital (DSH) payments, SNCP payments, and any other payments for medical services furnished to Medicaid eligible and uninsured individuals cannot exceed the actual cost of providing services to Medicaid eligibles and the uninsured as defined in the claiming protocol. SNCP payments will be made directly from the State to the eligible providers as defined in subparagraph (d), who incurred uncompensated care costs.

b) **Prohibited Use of SNCP Funds.** SNCP funds cannot be used to pay for costs associated with non-emergency services provided to non-qualified aliens. The State must develop a methodology as part of the claiming protocol to exclude such costs from eligible uncompensated care costs.

c) **Uncompensated Care Cost Limit** The aggregate amount of SNCP payments to the providers identified in Attachment J will not exceed the SNCP amount of $332 million per DY. The annual SNCP payment distributed to each individual provider will not exceed its uncompensated care costs for providing section 1905(a) medical services to Medicaid eligible and uninsured individuals for the period.

The State must submit to CMS for approval and incorporation into Attachment I a claiming protocol for each provider type to provide for the computation of a provider's uncompensated care costs. No FFP is available for SNCP payments until the associated claiming protocol is approved by CMS. Such protocols must take into consideration:

i. The cost reporting tool (i.e., the CMS-2552 cost report for hospital providers, and other cost reports for non-hospital providers as approved by CMS) to be used to determine a provider's allowable patient care costs, consistent with Medicare cost principles and OMB Circular A-87, for a specific service period.

ii. A methodology to apportion allowable patient care costs to Section 1905(a) services furnished to Medicaid eligible and uninsured individuals.

iii. An offset of all payments received for the services furnished to Medicaid eligible and uninsured individuals, including all Medicaid payments, third party payments, and payments by or on behalf of the patients, to arrive at the provider's uncompensated care cost.

iv. A carve-out of costs associated with non-emergency services provided to non-qualified aliens, which is a prohibited use of SNCP funds.

v. A payment methodology to allow the State to distribute SNCP payments to providers based on projected uncompensated care costs.

vi. Reconciliations of payments to the provider's uncompensated care cost limits as computed based on the provider's as-filed and finalized cost reports for the actual service period.

The uncompensated care cost limit is computed and SNCP payments are made on a DY basis. To the extent that a provider's cost reporting period does not coincide with the DY, the cost protocol will provide for an allocation of uncompensated care costs to the DY.

Any SNCP payments made in excess of the individual provider's uncompensated care cost limit for a demonstration period will be recouped from the provider, and the Federal share of the overpayment will be returned to CMS.

d) **Eligible Providers.** The eligible providers for SNCP payments are those identified in Attachment J. The State must seek prior approval from CMS to amend the list of eligible providers. The State must also submit to CMS for review and approval any additional claiming protocol needed due to the expansion of the eligible provider list.

The State will consider providers which meet the following criteria for SNCP participation:

i. Safety Net Hospital Systems which are defined as the health systems in each of the State's two largest metropolitan statistical areas that (a) are providing the highest percentage of care (measured in terms of discharges) within their MSA for adult AHCCCS and low-income uninsured patients and (b) sponsor multiple adult residency programs.

ii. Rural Hospitals which are defined as (a) Arizona hospitals that are not in Pima or Maricopa Counties; or (b) Arizona hospitals that are in counties of 500,000 or fewer persons.

iii. Critical Access Hospitals, which are defined as rural community hospitals that meet defined criteria outlined in the Conditions of Participation at 42 C.F.R. 485, Subpart F and 42 C.F.R. 440.170(g).

iv. Hospitals that qualify for a disproportionate share hospitals (DSH) payment as outlined in Attachment D.

v. Any provider affiliated with the hospitals outlined in the above subparagraphs (i-iv).

e) **DSH and SNCP.** All applicable inpatient hospital and outpatient hospital SNCP payments received by a hospital provider must be included as offsetting revenue in the State's annual DSH audit reports. Hospitals cannot receive total payments, including

DSH and SNCP payments, related to inpatient and outpatient hospital services furnished to Medicaid eligible and uninsured individuals that exceed the hospital's total eligible inpatient hospital and outpatient hospital uncompensated care costs.

f) **Intergovernmental Transfers (IGTs).** The non-Federal share of the SNCP payments will be funded by IGTs by eligible governmental entities. The State will submit to CMS for review and approval all IGT agreements to ensure compliance with Section 1903(w)(6)(A) of the Act and Part X of these STCs. Such agreements should specify the amount and source of the IGT money, including funds to provide the non-federal share of KidsCare II referenced in subparagraph (i). The agreements shall ensure that the IGT is not derived from an impermissible source, including recycled Medicaid payments, Federal money precluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. The agreements shall also ensure that providers will retain the SNCP payments.

g) **Annual Reporting Requirements for SNCP Payments**. The State will submit to CMS an annual report specifically related to the amount of payments made from the SNCP per DY. The reporting requirements are as follows:

Within ninety (90) days after the end of each DY, the State shall provide the following information to CMS:

1) Actual SNCP payments to each provider for each DY, including the interim payments and any reconciliation payments;

2) The uncompensated care cost limit computed for each provider for each DY, including the projected uncompensated care costs used for interim payment purposes, the uncompensated care costs based on the as-filed cost reports, and the uncompensated care costs based on the finalized cost reports.

h) **SNCP Designated State Health Program (DSHP**). In addition to the $332 million uncompensated care cost payments outlined above, the State may claim FFP for the Trauma and Emergency Services Fund Payments as authorized by Arizona State Proposition 202 for DY 1 and DY 2. The total program amount eligible for FFP cannot exceed $20 million total computable per DY, and expenditures must be claimed in accordance with a CMS-approved claiming protocol. Claiming of FFP cannot begin until the protocol is approved by CMS and incorporated into Attachment I. Any unspent funds cannot be transferred to the following DY in order to increase the annual amount.

i) **Contribution to the KidsCare II Program.** The eligible governmental entities in subparagraph (f) will provide IGTs to fund the non-federal share of KidsCare II Program expenditures. The funding amount is estimated at up to $76,991,169 total computable.

26. **Payments to IHS and 638 Facilities.** The State is authorized under the expenditure authorities of this Demonstration to make payments to IHS and tribal 638 facilities that take in to account their uncompensated costs in furnishing specified types of care furnished by IHS and tribal 638 facilities to Medicaid-eligible individuals and other individuals with family income at or below 100 percent of the FPL.

    Facilities will have the option to elect one of two approved methodologies, as further outlined in Attachment K, to calculate and receive payment for their uncompensated care costs. The facilities will notify AHCCCS of their selection by April 30, 2012, and will have the option to switch their methodology election only once. If a facility elects to switch the methodology by which their uncompensated care payment is calculated, the facility must notify the State by December 15, 2012. The new methodology will be utilized to calculate the facility's uncompensated care payment effective January 1, 2013.

## VII. DELIVERY SYSTEMS

27. **Contracts.** All contracts and modifications of existing contracts between the State and MCOs must be prior approved by CMS. The State will provide CMS with a minimum of 30 days to review and approve changes.

## VIII. EVALUATION

28. **State Must Separately Evaluate Components of the Demonstration.** As outlined in subparagraphs (a) - (e) the outcomes from each evaluation component must be integrated into one programmatic summary that describes whether the State met the Demonstration goal, with recommendations for future efforts regarding all components. The evaluation must outline and address evaluation questions for all of the following components:

    a) **Evaluation Design Plan.** The State must submit to CMS for approval a draft evaluation design no later April 1, 2012. At a minimum, the draft design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those outlined in subparagraphs (c) and (d), as well as those that focus specifically on the target populations within the Acute Care, ALTCS, ESI program and the Family Planning Extension Program within the demonstration. The draft design plan must also include a separate section discussing the AACP cost sharing, the missed appointment fee evaluation requirements, the uncompensated care payments to IHS and 638 facilities and the CRS and SMI integration programs as described further in subparagraphs (c) - (f). The draft design shall discuss the outcome measures that must be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes (Attachment C – Evaluation Design Guidelines). The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration are isolated from other

initiatives occurring in the State.

The State must submit a revised draft evaluation design plan by April 1, 2013, in order to include the specific hypotheses outlined in subparagraph (e).

b) **ESI Evaluation**. Arizona must conduct an evaluation of the ESI demonstration as described in paragraph 23(a). The State shall report on its progress in the quarterly and annual reports. AHCCCS will monitor the private insurance market as it relates to the ESI program (e.g., changes in employer contribution levels, trends in sources of insurance, etc.). AHCCCS will also continue to monitor substitution of coverage (i.e., participants dropping private coverage to enroll in the Demonstration).

c) **AACP Cost Sharing Evaluation.** Arizona must conduct an independent evaluation of the AACP cost sharing requirements as described in paragraph 17(d). The evaluation must test the following specific hypotheses related to the mandatory copayments assessed on the adults without dependent children population:

   i. How will utilization of needed preventive, primary care, and treatment services be affected;
   ii. To what extent will the imposition of the pharmacy co-payments and copayments related to non-emergent use of emergency rooms ensure appropriate utilization of emergency room care and appropriate utilization of cost and clinically effective generic and brand name drugs; and
   iii. Will the mandatory co-payments affect State and federal expenditures (per enrollee) in the short and long term; and
   iv. Will there be an impact on physician participation, or physician willingness to accept appointments from the adults without dependent children population.

Methods by which the State can evaluate these hypotheses include evaluating the relative utilization of, and access to, services provided to the adults without dependent children population compared to a similar population of parents (who are not subject to the copayment requirements), as well as, comparing selected access, utilization and quality indicators, across the pre-copayment adults without dependent children population with those of the post-co-payment adults without dependent children population, as well as across the adults without dependent children populations Measures could include examining the impact of the copayments on rates of emergency department utilization, rates of inpatient readmission, and selected evidence-based measures indicating management of chronic conditions (such as diabetes and asthma).

In addition, the State will evaluate how the NEMT copayment on adults without dependent children residing in Maricopa and Pima counties has affected access compared to the same population residing in all other counties.

Finally, the State shall report on the evaluation's progress in the State's quarterly and annual reports.

d) **Permissible Provider Fee for Missed Appointments Evaluation.** The state must submit an independent evaluation of the missed appointment fee on the TANF parents and adults without dependent children residing in all counties except for Maricopa and Pima counties that was in effect from October 22, 2011 through January 1, 2013. . In addition to the other hypotheses that the state has developed to test this fee, the state must evaluate the following to determine the fee's impact on:

i. Reducing the number of missed appointments;
ii. Beneficiaries seeking more care from walk-in clinics, urgent care centers, and/or emergency rooms, and any resulting impact on costs;
iii. Denial of service as a result of the fee;
iv. Subgroups within the adults without dependent children population, i.e., were there variations by income level, age, gender, etc.;
v. Program integrity;
vi. Compliance with the provisions for missed appointment fees;
vii. Administrative feasibility and cost to the provider; and
viii. The rate of missed appointment fees assessed by provider type and region of the state.

e) **Uncompensated Care Payments to IHS and 638 Facilities.** Arizona must conduct an independent evaluation of the uncompensated care payments provided to IHS and 638 facilities as described in paragraph 26 and Attachment K. The evaluation must test the following specific hypotheses related to the uncompensated care payments:

i. What is the affect on service utilization as a result of the uncompensated care payments broken down by type of service as well as the population served?
ii. Are the affected facilities able to maintain and/or increase their current staffing levels?

Methods by which the state can evaluate these hypotheses include evaluating staffing levels as well as the relative utilization of, and access to, services provided to adults pre-uncompensated care payment period to services with those of the post-uncompensated care payment period. Measures could include examining selected evidence-based measures indicating management of chronic conditions (such as diabetes and asthma).

f) **Integration of Physical and Behavioral Health Services for the CRS and SMI populations.** Arizona must contract with an independent evaluator in order to conduct an evaluation of the integration of physical and behavioral health services for the CRS and SMI populations as described in paragraphs 19 and 20. The evaluation will focus on two components – integration of care and health outcomes. As part of the state's revised evaluation design plan, as specified in subparagraph (a), the state must use baseline data from October 1, 2012 through September 30, 2013, and must begin the evaluation of the integration projects by October 1, 2013. The state must submit to CMS a written report of its finding no later than March 31, 2016.

i. Integration of Care. This component of the evaluation must test the following hypotheses as they relate to both populations affected by the integration projects:

1) Did this care model provide the same or an improved level of physical and behavioral health care quality as non-integrated care model? Health care quality includes improved access, utilization, health care outcomes and patient experience.

2) Did this care model improve how physical and behavioral health is integrated for the target population in a way that is different than the care they would have received if they had remained in the traditional care model?

The baseline period, as reflected in the revised evaluation design, must include information detailing the characteristics of the fragmented delivery system that is being replaced with the integrated system of care, such as the prevalence of multiple care plans, the number of primary care provider not connected with case managers, the number of duplicated tests and/or treatment, and the number of beneficiaries making and keeping appointments post discharge.

ii. Health Outcomes. This component of the evaluation will broken down by each target population.

1) CRS Population. The evaluation must test the following specific hypotheses related to the integration of services for the CRS population:

a. What is the effect on health outcomes as a result of the integration of services, including but not limited to improving:

i. Emergency department visit rates with a primary diagnosis of asthma;

ii. Hospital readmissions rates with a primary diagnosis of asthma diabetes, congestive heart failure and behavioral health as well as all-cause hospital readmissions rates.

b. How will the integration of services affect access to care and the utilization of needed preventive, primary care, and treatment services, such as immunization rates?

c. For foster children enrolled in the CRS integrated plan, how will the integration of services improve the appropriateness of prescribing patterns and utilization of psychotropic prescription drugs?

2) SMI Population. The evaluation must test the following specific hypotheses related to the integration of services for the SMI population in Maricopa county:

a. Did the integration project improve care coordination for the target population (as measured by patient experience improved access to specialty care, appropriate medications, etc.)?

b. Does the integration of services result in an increase in access to and utilization of primary and specialty care?

c. What is the effect on health outcomes as a result of the integration of services, including but not limited to improving chronic disease management, diabetes and cardiovascular conditions such as congestive heart failure?

d. How is this model providing more appropriate care for this population as measured by: inpatient utilization for asthma, congestive heart failure and COPD conditions; hospital readmissions with a primary diagnosis of asthma, diabetes, congestive heart failure and behavioral health as well as all-cause hospital readmissions; and emergency room visits with a primary diagnosis of asthma and diabetes, broken down by diagnosis?

Measures by which the state can evaluate these hypotheses include, but are not limited to, primary care and preventive services utilization (as applicable), emergency room utilization, inpatient hospital utilization and rate of readmissions, screenings and testing associated with diabetes, cardiovascular disease, and HIV/AIDS. In addition to the above measures, the state must use data from beneficiary satisfaction surveys and grievance and appeals data to assist in the evaluation. As the demonstration progresses, the state may include additional measures and data sources working in coordination with CMS, such as body mass index assessments and integration of electronic health records as penetration increases.

29. **Final Evaluation Design and Implementation.** CMS must provide comments on the draft design, within 60 days of receipt, and the State must submit a final design within 60-days of receipt of CMS comments. The State must implement the evaluation design, and submit to CMS a draft of the evaluation 120 days after the expiration of the demonstration. CMS shall provide comments within 60 days of receipt of the draft evaluation. Within 60 days of receipt of comments from CMS, a revised final report must be submitted.

30. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the Demonstration, the State must fully cooperate with Federal evaluators' and their contractors' efforts to conduct an independent, federally funded evaluation of the Demonstration program.

## IX. GENERAL REPORTING REQUIREMENTS

31. **General Financial Requirements.** The State shall comply with all general financial requirements under title XIX and title XXI.

32. **Reporting Requirements Relating to Budget and Allotment Neutrality.** The State shall comply with all reporting requirements for monitoring budget and allotment neutrality set forth in this Agreement.

33. **Budget Neutrality Information.** For each quarter, the State will correctly report expenditures and member months that are subject to budget neutrality. Where data are incorrect and upon the request of CMS, the State must submit corrected budget neutrality data.

34. **Monthly Calls.** CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost sharing, employer-sponsored insurance progress, family planning issues, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, health plan financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers, or State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

35. **Monthly Childless Adult Enrollment Reports.** As required in the July 1, 2011, childless adult phase-out plan (Attachment A), the State must submit a monthly enrollment report for the childless adult populations by the 15th of each month until December 31, 2013. The enrollment report must contain the following:

    a) Population, including the percent change from the previous month;

b) Beneficiaries transferred from the childless adult eligibility category to the SSI-MAO eligibility category;

c) Beneficiaries who did not meet the SSI-MAO eligibility requirements and were transferred back to the childless adult eligibility category; and

d) Beneficiaries who were transferred to the SSI-MAO eligibility and were discontinued because they did not comply with the State's redetermination requirements.

36. **KidsCare II Monthly Reports.** The State must submit a monthly report for the KidsCare II population by the 15th of each month until December 31, 2013. The monthly report must contain the following the information:

a) **Enrollment.** The monthly report must contain the following enrollment information broken down by the number of children enrolled through the application process and the number of title XIX children transferred from the AACP:

i. Number of children newly enrolled in KidsCare II;
ii. Number of children enrolled to date; and
iii. Current enrollment at end of each quarter with an annual total.

b) **Applications.** Of the total number of families who received notices, the number of children applying with a breakdown of the number who are eligible for Medicaid, eligible for KidsCare II and those that are ineligible for KidsCare II.

For those determined to be ineligible for KidsCare II, the reason for ineligibility, including, but not limited to following reasons:

i. Over income limit;
ii. Did not pay outstanding KidsCare premiums; and
iii. Did not provide required documentation during application process.

c) **KidsCare II PCAP Dedicated Hotline.** This section of the monthly report must contain the following information:

i. Number of calls;
ii. Where did callers hear about the helpline? (letter, TV/radio/newspaper, family/friend, community organization);
iii. Number of callers who said they received a notice;
iv. Number of callers for whom address must be updated;
v. Number of callers referred to subscriber for application assistance;
vi. Number of calls in other categories; and
vii. Time of day helpline most busy.

37. **Quarterly Reports.** The State shall submit progress reports in a format agreed upon by CMS and the State no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports shall include, but not be limited to (Attachment B – Quarterly Report Guidelines):

    a) A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, enrollment, quality of care, access, health plan financial performance that is relevant to the Demonstration, the benefit package, and other operational issues, including the transition of SMI and CRS individuals;

    b) Action plans for addressing any policy and administrative issues identified;

    c) The quarterly reports must also include at least enrollment data, member month data, and budget neutrality monitoring tables;

    d) The number of IHS and 638 facilities receiving uncompensated care payments, broken down by the methodology selected in which the uncompensated care payment is calculated as well as a discussion on how the payments are affecting the financial viability of the facilities, using metrics that the State will develop in consultation with IHS and tribal programs, and the impact on service utilization broken down by type of service and by populations served.

    e) The number of complaints and grievances filed on behalf of beneficiaries participating in the SMI and CRS integration projects, broken down by access to care, health plan and provider satisfaction.

    f) The number of individuals enrolled in the Family Planning Extension Program at the end of the quarter, as well as the number of participants served during the prior quarter (participants include all individuals who obtain one or more covered family planning or family planning-related services through the Demonstration);

    g) Notification of any changes in enrollment and/or participation to the Family Planning Extension Program that fluctuate 10 percent or more in relation to the previous quarter within the same Demonstration Year (DY) and the same quarter in the previous DY; and

    h)

    Any issues which arise in conjunction with the Employer Sponsored Insurance (ESI) portion of the program, including but not limited to enrollment, quality of care, grievances, and other operational issues; and evaluation activities.

38. **Annual Report.** The State shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, the

status of the collection and verification of encounter data and policy and administrative difficulties in the operation of the Acute Care, ALTCS, ESI, KidsCare II, SNCP/DSHP, IHS and 638 facilities uncompensated care payments, and Family Planning components of the Demonstration. The State shall submit the draft annual report no later than 120-days after the end of each operational year. Within 30-days of receipt of comments from CMS, a final annual report shall be submitted.

For the Family Planning Extension Program, the annual report must include the following:

a) The number of actual births that occur to Family Planning Extension Program participants (participants include all individuals who obtain one or more covered medical family planning services through the Family Planning Extension Program each year);

b) Total number of individuals enrolled at the end of the demonstration year;

c) Total number of participants enrolled at the end of the demonstration year; and

d) The average total Medicaid expenditures for a Medicaid-funded birth each year. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth up to age 1 (the services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants.)

39. **Transition Plan**. On or before July 1, 2012, the State is required to submit a draft, and incrementally revise, a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the Demonstration. This plan will address how the State plans to coordinate the transition of these individuals, including children enrolled in the KidsCare II program, to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The plan must contain the required elements and milestones described in paragraphs 39(a)-(f) outlined below. In addition, the Plan will include a schedule of implementation activities that the State will use to operationalize the Transition Plan.

    a) Seamless Transitions: Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the State plans to obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the Demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. Specifically, the State must:

        i. Determine eligibility under all January 1, 2014, eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the

FPL.

ii. Identify Demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014.

iii. Implement a process for considering, reviewing, and making preliminarily determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility.

iv. Conduct an analysis that identifies populations in the Demonstration that may not be eligible for or affected by the Affordable Care Act and the authorities the State identifies that may be necessary to continue coverage for these individuals.

v. Develop a modified adjusted gross income (MAGI) conversion for program eligibility.

b) KidsCare II Transition: The Plan must include the State's process to seamlessly transition children enrolled in the KidsCare II program to other forms of coverage once the program expires December 31, 2013. The State must include the information outlined in subparagraph (a) as applied to the KidsCare II program.

c) Cost-sharing Transition: The Plan must include the State's process to come into compliance with all applicable Federal cost-sharing requirements, including the section 1916(f) requirements that apply to the adults without dependent children population when it becomes a mandatory State plan population on January 1, 2014.

d) Access to Care and Provider Payments and System Development or Remediation: The State should assure adequate provider supply for the State plan and Demonstration populations affected by the Demonstration on December 31, 2013. Additionally, the Transition Plan for the Demonstration is expected to expedite the State's readiness for compliance with the requirements of the Affordable Care Act and other Federal legislation.

e) Pilot Programs: Progress towards developing and testing, when feasible, pilot programs that support Affordable Care Act activities, such as the State's Medicare-Medicaid integration project to allow for more efficient and effective management of dually eligible ALTCS EPD beneficiaries.

f) Progress Updates: After submitting the initial Transition Plan for CMS approval, the State must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed.

g) Implementation:

i. By October 1, 2013, the State must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the Demonstration to Medicaid, the Exchange or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the State plan, the State will not require these individuals to submit a new application.

ii. On or before December 31, 2013, the State must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

40. **Final Report.** The State shall submit a final report pursuant to the requirements of section 1115 of the Act.

41. **Contractor Reviews**. The State will forward summaries of the financial and operational reviews that:

    a) The Arizona Department of Health Services/ Behavioral Health Services (ADHS/BHS) completes on the Regional Behavioral Health Authorities (RBHAs).

    b) The Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD) performs on its subcontracting MCOs.

    c) The State will also forward summaries of the financial and operational reviews that AHCCCS completes on the Children's Rehabilitative Services Program (CRS) contractor; and the Comprehensive Medical and Dental Program (CMDP) at the Arizona DES.

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

43. **Contractor Disclosure of Ownership**. Before contracting with any provider of service, the State will obtain from the provider full disclosure of ownership and control and related party transactions, as specified in sections 1124 and 1902(a)(38) of the Act. No FFP will be available for providers that fail to provide this information.

## X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

44. **Quarterly Expenditure Reports.** Effective with the quarter beginning October 1, 2011, the State shall provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall

provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in this Agreement.

45. **Reporting Expenditures in the Demonstration**. The following describes the reporting of expenditures subject to the budget neutrality cap:

    a) **Tracking Expenditures.** In order to track expenditures under this Demonstration, Arizona shall report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap shall be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this Demonstration), the adjustments should be reported on lines 9 or 10.C through 10.F, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below.

    b) **Use of Forms**. For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the Demonstration, subject to the budget neutrality cap. The State must complete separate forms for the following categories:

        i. AFDC/SOBRA
        ii. SSI
        iii. AC
        iv. MED
        v. ALTCS-DD
        vi. ALTCS-EPD
        vii. Family Planning Extension
        viii. Uncompensated Care Payments to IHS and 638 Facilities
        ix. SNCP/DSHP
        x. DSH and Critical Access Hospital Payments (CAHP)**

        **Critical Access Hospital Payments as defined in Attachment F

    c) **Expenditures Subject to the Budget Neutrality Cap**. For purposes of section X, the term “expenditures subject to the budget neutrality cap” shall include all Medicaid expenditures except those as described below, on behalf of the individuals who are enrolled in this Demonstration. Expenditures excluded from this Demonstration and the budget neutrality cap are Direct Services Claiming program expenditures for Medicaid in the public schools, Breast and Cervical Cancer Treatment program expenditures, Freedom to Work program expenditures, and all administrative

expenditures.

d) **Premium and Cost Sharing Adjustment**. Premiums and other applicable cost sharing contributions from enrollees that are collected by the State from enrollees under the Demonstration shall be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that the Demonstration is properly credited with premium collections, premium collections (both total computable and Federal share) should also be reported on the CMS-64 Narrative. The State should include these section 1115 premium collections as a manual adjustment (decrease) to the Demonstration's actual expenditures on a quarterly basis.

e) **Administrative Costs.** Administrative costs shall not be included in the budget neutrality limit. All administrative costs shall be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

f) **Claiming Period**. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

g) **Pharmacy Rebates.** The State may propose a methodology for assigning a portion of pharmacy rebates to the Demonstration. The proposed methodology must determine, in a way that reasonably reflects actual rebate-eligible pharmacy utilization, the amounts of rebate that are attributable to pharmacy utilization under the Demonstration *vs.* outside the Demonstration, and appropriate subtotals by EG and DY. The methodology (and any subsequent changes to the methodology) must be approved in advance by the CMS Regional Office prior to use. Rebate amounts assigned to the Demonstration must be reported on the appropriate Forms CMS-64.9 or 64.9P Waiver, and not on any other CMS-64.9 form (to avoid double-counting). In the absence of an approved methodology, all pharmacy rebates must be reported on Forms CMS-64.9 or 64.9P Base.

46. **Reporting of Member Months.** The following describes the reporting of member months in the Demonstration.

a) Member months subject to the budget neutrality cap include:

i. For the purpose of calculating the budget neutrality expenditure cap described in this Agreement, the State shall provide to CMS on a quarterly basis the actual

number of eligible member months for:

1) Eligibility Group 1:AFDC / SOBRA
2) Eligibility Group 2: SSI
3) Eligibility Group 3: AC
4) Eligibility Group 4 ALTCS-DD
5) Eligibility Group 5: ALTCS–EPD
6) Eligibility Group 6: Family Planning Extension Program

ii. This information shall be provided to CMS 30 days after the end of each quarter as part of the CMS-64 submission, either under the narrative section of the MBES/CBES or as a stand-alone report.

iii. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member months.

iv. For the purposes of this Demonstration, the term "Demonstration eligibles" refers to all individuals covered by Arizona Medicaid with the exception of individuals in the Freedom to Work and Breast and Cervical Cancer Treatment programs

b) Demonstration Member Months subject to reporting on the CMS 64-Narrative includes the MED Group – described in paragraph 16 as:

i. MED - Individuals who applied for the MED program (under Expenditure Authority 20 of Demonstration project #11-W-00032/9 and #21-W-00009/9) prior to May 1, 2011 and were determined eligible for that population for a 6-month guaranteed eligibility period after that date, until the end of that 6-month period.

47. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

48. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the

applicable Federal matching rates for the following, subject to the limits described in this Agreement.

a) Administrative costs, including those associated with the administration of the Demonstration;

b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan; and

c) Net expenditures and prior period adjustments made with dates of service during the operation of the Demonstration.

d) CMS shall provide FFP for family planning and family planning-related services and supplies at the applicable Federal matching rates described in STC 24(a)(i) and (ii), subject to the limits and processes described below:

   i. For family planning services, reimbursable codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service;
   ii. Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate, described in STC 24(a)(i), should be entered in Column (D) of the Forms CMS-64.9 Waiver.
   iii. Allowable family planning-related expenditures eligible for reimbursement at the FMAP rate, as described in STC 24(a)(ii), should be entered in Column (B) on the Forms CMS-64.9 Waiver.
   iv. FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. For example, in the instance of testing for STIs as part of a family planning visit, FFP will be available at the 90 percent Federal matching rate. The match rate for the subsequent treatment would be paid at the applicable Federal matching rate for the State. For testing or treatment not associated with a family planning visit, no FFP will be available.
   v. Pursuant to 42 CFR 433.15(b)(2), FFP is available at the 90 percent administrative match rate for administrative activities associated with administering the family planning services provided under the Demonstration including the offering, arranging, and furnishing of family planning services. These costs must be allocated in accordance with OMB Circular A-87 cost allocation requirements. The processing of claims is reimbursable at the 50 percent administrative match rate.

49. **Medicare Part D Drugs.** No FFP is available for this Demonstration for Medicare Part D drugs.

50. **Sources of Non-Federal Share**. The State certifies that the source of the non-Federal share of funds for the Demonstration is State/local monies. The State further certifies that such

funds shall not be used as the non-Federal share for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with Title XIX of the Social Security Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

a) CMS shall review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b) The State shall provide information to CMS regarding all sources of the non-Federal share of funding for any amendments that impact the financial status of the program.

c) Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as Demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State and/or local government to return and/or redirect any portion of the Medicaid or Demonstration payments. This confirmation of Medicaid and Demonstration payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid or the Demonstration and in which there is no connection to Medicaid or Demonstration payments) are not considered returning and/or redirecting a Medicaid or Demonstration payment.

51. **Certification of Public Expenditures.** The State must certify that the following conditions for non-Federal share of Demonstration expenditures are met:

a) Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-Federal share of funds under the Demonstration.

b) To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

i. To the extent that Arizona institutes the use of CPEs, the requirements of this term and condition fully apply. The State is subject to any policy guidance or regulation released by CMS regarding the use of CPEs.

ii. The disproportionate share hospital (DSH) payment methodology for Arizona State Hospital (ASH) and the Maricopa Medical Center will be cost

reimbursement and will utilize CPEs as the funding system. The methodology and the cost identification/reconciliation process, as approved by CMS, is included as an amendment to the DSH methodology in Attachment D.

c) To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration to non-governmental providers, the governmental entity appropriating funds to the provider must certify to the State the amount of such tax revenue (State or local) appropriated to the non-governmental provider used to satisfy demonstration expenditures. The non-governmental provider that incurred the cost must also provide cost documentation to support the State's claim for Federal match.

d) The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

52. **Applicability of Fee for Service Upper Payment Limits.** If expenditures (excluding expenditures for members enrolled with the Indian Health Service for inpatient hospital and long-term-care facility services, other institutional and non-institutional services (including drugs) provided to AHCCCS fee-for-service beneficiaries equal or exceed 5 percent of the State's total Medical Assistance expenditures, the expenditure authority will be terminated and the State shall submit a demonstration amendment that includes a plan to comply with the administrative requirements of section 1902(a)(30)(A). The State shall submit documentation to CMS on an annual basis that shows the percentage AHCCCS fee-for-service beneficiary expenditures as compared to total Medical Assistance expenditures.

53. **Fraud and Abuse Recoveries**: The State must improve fraud and abuse recoveries by:

a) Submitting for CMS review an action plan by April 1, 2012, to enhance Medicaid fraud and abuse recoveries by the end of the Demonstration period ending September 30, 2016.

b) Submitting to CMS an annual report of the State's implementation of its action plan as required in paragraph 38.

c) Demonstrating by September 30, 2016, that its level of recoveries is equal to, or greater than, the level anticipated in the action report approved by CMS.

## XI. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

54. **Quarterly CHIP Expenditure Reports.** The State shall provide quarterly expenditure reports using the Form CMS-21 to report total expenditures for services provided to all Demonstration populations receiving title XXI funds under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS will provide FFP only for allowable Demonstration title XXI expenditures that do not exceed the State's available title XXI funding.

55. **Tracking CHIP Expenditures.** In order to track title XXI expenditures under this Demonstration, the State will report Demonstration expenditures, excluding KidsCare II, through the MBES/CBES, following routine CMS-21 reporting instructions. Title XXI Demonstration expenditures will be reported on separate Forms CMS-21 Waiver and/or CMS-21P Waiver identified by the Demonstration project number assigned by CMS (including project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). Expenditures for the KidsCare II program will be reported on the CMS-21 with the state plan population in the MBES/CBES. Separate KidsCare II reporting will be provided in the CMS-21 Narrative using a proportion of KidsCare II to the total KidsCare population based on date of payments.

    a) **CHIP Claiming.** All claims for expenditures related to the Demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the Form CMS-21.

    b) **Standard CHIP Funding Process.** The standard CHIP funding process will be used during the Demonstration. Arizona must estimate matchable CHIP expenditures on the quarterly Form CMS-21B. On a separate CMS-21B, the State shall provide updated estimates of expenditures for the Demonstration population. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

    c) **Sources of CHIP Non-Federal Share.** The State will certify State/local monies used as matching funds for the Demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as

permitted by Federal law. All sources of non-Federal share of funding and distribution of monies involving Federal match are subject to CMS approval. Upon review of the sources of the non-Federal share of funding and distribution methodologies of funds under the Demonstration, all funding sources and distribution methodologies deemed unacceptable by CMS shall be addressed within the timeframes set by CMS. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding

56. **Limit on Title XXI Funding**. Arizona will be subject to a limit on the amount of Federal title XXI funding that the State may receive for Demonstration expenditures during the Demonstration period. Federal title XXI funding available for Demonstration expenditures is limited to the State's available allotment, including currently available reallocated funds. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the Demonstration until the next allotment becomes available.

57. **Compliance with Federal Rules.** All Federal rules shall continue to apply during the period of the Demonstration if title XXI Federal funds are not available and the State decides to continue the program.

## XII. MONITORING BUDGET NEUTRALITY

58. **Monitoring Demonstration Funding Flows.** The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

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

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

59. **Limit on Title XIX Funding.** The State shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost

method, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. The data supplied by the State to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

60. **Risk.** The State shall be at risk for the per capita cost (as determined by the method described below) for Demonstration eligibles under this budget neutrality agreement, but not for the number of Demonstration eligibles in each of the groups. By providing FFP for all Demonstration eligibles, the State shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing the State at risk for the per capita costs for Demonstration eligibles under this agreement, CMS assures that Federal Demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration.

61. **Demonstration Populations and Programs Subject to the Budget Neutrality Cap.** The following Demonstration populations are subject to the budget neutrality cap and are incorporated into the following eligibility groups:

    a) Eligibility Group 1: AFDC / SOBRA

    b) Eligibility Group 2: SSI

    c) Eligibility Group 3: AC

    d) Eligibility Group 4: ALTCS-DD

    e) Eligibility Group 5: ALTCS–EPD

    f) Eligibility Group 6: Family Planning Extension Program

    g) Program Group 1: DSH

    h) Program Group 2: Uncompensated Care Payments to IHS and Tribal Facilities

    i) Program Group 3: SNCP/DSHP

    j) Program Group 4: KidsCare II

62. **Budget Neutrality Expenditure Cap:** The following describes the method for calculating the budget neutrality expenditure cap for the Demonstration:

    a) For each year of the budget neutrality agreement an annual budget neutrality expenditure cap is calculated for each eligibility group described in paragraph 61 as follows:

        i. An annual eligibility group expenditure cap must be calculated as a product of the

number of eligible member months reported by the State under paragraph 46 for each eligibility group, times the appropriate estimated per member per month (PM/PM) costs from the table in subparagraph (iii) below.

ii. The PM/PM costs in subparagraph (iii) below are net of premiums paid by Demonstration eligibles.

iii. The PM/PM costs for the calculation of the annual budget neutrality expenditure cap for the eligibility groups subject to the budget neutrality agreement under this Demonstration are specified below. In addition, the PM/PM cost for each eligibility group in DY 1 has been increased by the appropriate growth rate included in the President's Federal fiscal year 2012 budget for DYs 2, 3, 4 and 5, as outlined below. The AC and Family Planning Extension Program populations are structured as a "pass-through" or a "hypothetical State plan population" beginning in DY 1. Therefore, the State may not derive savings from these populations.

| Eligibility Group | Trend Rate | DY 1<br>FFY 2012 | DY 2<br>FFY 2013 | DY 3<br>FFY 2014 | DY 4<br>FFY 2015 | DY 5<br>FFY 2016 |
|---|---|---|---|---|---|---|
| **AFDC / SOBRA** | 5.2% | $585.28 | $615.71 | $647.73 | $681.41 | $716.85 |
| **SSI** | 6.0% | $885.41 | $938.53 | $994.84 | $1054.53 | $1117.81 |
| **AC** | 0.0% | $707.33 | $707.58 | $707.58 | $0 | $0 |
| **ALTCS - EPD** | 5.2% | $4737.37 | $4983.71 | $5242.86 | $5515.49 | $5802.30 |
| **ALTCS - DD** | 6.0% | $4922.38 | $5217.72 | $5530.78 | $5862.63 | $6214.39 |
| **Family Planning Extension Program** | 5.8% | $30.06 | $31.80 | $33.65 | $35.60 | $37.66 |

iv. The annual budget neutrality expenditure cap for the Demonstration as a whole is the sum of DSH allotment, the uncompensated care payments to IHS and tribal facilities, expenditures for the SNCP/DSHP and KidsCare II program plus the annual expenditure caps for each eligibility group calculated in subparagraph 62(a)(i) above.

b) The overall budget neutrality expenditure cap for the 5-year demonstration period is the sum of the annual budget neutrality expenditure caps calculated in subparagraph 62(a)(iv) above for each of the 5 years. The Federal share of the overall budget neutrality expenditure cap represents the maximum amount of FFP that the State may receive for expenditures on behalf of Demonstration populations and expenditures described in paragraph 48 during the Demonstration period.

c) Apply the effective FMAP, or enhanced 90 percent match for family planning services, that is determined from the MBES/CBES Schedule C report.

63. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State exceeds the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the DYs, the State must submit a corrective action plan to CMS for approval.

| Cumulative Demonstration Years | Cumulative Expenditure Cap Definition | Percentage |
|---|---|---|
| Year 1 | Budget neutrality expenditure cap plus Year 1 Budget Cap | 1.0 % |
| Year 2 | Combined budget neutrality expenditure caps plus Year 1 through 2 Budget Cap | 0.75 % |
| Year 3 | Combined budget neutrality expenditure caps plus Year 1 through 3 Budget Cap | 0.5 % |
| Year 4 | Combined budget neutrality expenditure caps plus Year 1 through 4 Budget Cap | 0.25 % |
| Year 5 | Combined budget neutrality expenditure caps plus Year 1 through 5 Budget Cap | 0.0 % |

64. **Exceeding Budget Neutrality.** If, at the end of this Demonstration period the overall budget neutrality expenditure cap has been exceeded, the excess Federal funds must be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

## XIII. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

| **Date** | **Deliverable** |
|---|---|
| April 1, 2012 | Submission of draft Evaluation Design STC # 28(a) |
| July 1, 2012 | Submission of revised Evaluation Design STC # 28(a) |
| July 1, 2012 | Transition Plan. |
| March 1, 2013 | Submission of draft Evaluation Design STC # 28(a) |
| September 30, 2015 | Written Notice of State's Intent to Extend the Demonstration Under 1115 |
| March 31, 2016 | Complete Demonstration Extension Application (1115) and CRS and SMI Integration Evaluation Report (STC #28(f)) |
| January 1, 2017 | Submit Draft Evaluation Report - STC # 29 |
| March 1, 2017 | Final Evaluation Report - STC #29. Final Report - STC# 40. End of Demonstration Period. |
| **Monthly Deliverables** | Monthly call - STC# 34 |
| | Monthly Childless Adult Enrollment Report – STC # 35 |
| **Quarterly Deliverables** | Requirements for Quarterly Reports – STC # 37 |
| | Quarterly Budget Neutrality Reports – STC # 33 |
| | Expenditure Reports CMS 64 and CMS21 - STC# 44 and STC# 53 |
| | Member Months Report - STC# 46 |
| | SEDS Enrollment Data - STC# 23(h) |
| **Annual Deliverables** | Requirement for Annual Report - STC# 38 |

| Date | Deliverable |
|---|---|
| | Requirement for annual HCBS Report on March 31st - STC# 20 (f)(iv) |
| | Comparison of Costs for the DES Interagency Agreement, including how any excess revenues are spent, and for ADHS/BHS. Both reports will be due by January 15 – STC # 58 (b) |

**Attachment A – Approved Childless Adult Phase-out Plan under Demonstration #11-W-0003/09 and 21-W-0009/9**

# Childless Adults Freeze Implementation Milestones
# Phase Out Plan and Corresponding Enrollment Freeze

## Effective July 8, 2011

### 1. Summary of Childless Adults

Childless adults is a waiver program for adults who have not been determined Medicaid eligible under a categorical link (aged, blind, disabled, pregnant, under 18 or parent of a deprived child). Childless adults have open ended eligibility with redeterminations every 12 months. An asset test is not required and they have income under 100% of the Federal Poverty Level (FPL).

Eligibility for the Childless Adult program is determined primarily by DES. DES also determines eligibility for Medicaid programs for children, pregnant women, families and the MED program.

AHCCCS determines eligibility for CHIP, long term care, aged, blind, disabled populations, the Breast and Cervical Cancer Treatment Program and Medicare Savings Programs. AHCCCS also determines eligibility under Medicaid programs for children, pregnant women, families and the Childless Adult program for family members of KidsCare (CHIP) eligible members.

As of March 1, 2011 AHCCCS had about 2,800 Childless Adults in KidsCare households. Although the KidsCare program has been frozen since January 1, 2010, AHCCCS still processes renewals and changes for the active KidsCare population and their families, sometimes resulting in applications for Childless Adults. When KidsCare was open to new enrollment, AHCCCS processed KidsCare and Medicaid applications for everyone in the household. Even though enrollment in KidsCare is now frozen, AHCCCS still manages the entire household, including any category of Medicaid under which a household member qualifies. AHCCCS processes the renewals for the entire household. KidsCare children who age out of KidsCare will be processed by AHCCCS for Childless Adult coverage.

Below is an example of a KidsCare household with AHCCCS Care parents:

| | | |
|---|---|---|
| Mother | no income | eligible for AC |
| Father | 3050.00 earnings | eligible for AC |
| Child 15 yrs old | no income | eligible for KidsCare |
| Child 6 yrs old | no income | eligible for KidsCare |
| Child 10 yrs old | no income | eligible for KidsCare |

- Total household income: $3050.00
- KidsCare income limit for family of 5: $4362.00
- The children are ineligible for SOBRA because of their share of their father's income but they are eligible for KidsCare.
- The mother and father are eligible for AHCCCS Care because when the father's income is allocated between the members, their share of the income is $610.00 which is under the $613.00 income limit.

## 2. Applications submitted prior to 7/8/11

Applications that are received prior to July 8, 2011 will be processed, even if DES or AHCCCS cannot complete the eligibility determination until after July 8, 2011. If household members meet all eligibility requirements, before July 8, 2011, they will be approved for Childless Adults, even if the determination cannot be made until after July 8, 2011. If household members do not meet eligibility requirements until July 8, 2011 or later, the household member will not be approved for Childless Adults.

## 3. Potential Consumer Notices:

- Notice #1: In the first week of July 2011, AHCCCS will notify all Childless Adult members that on July 8, 2011 enrollment into the Childless Adult program will be frozen. If they want to retain Medicaid coverage under the Childless Adult program they will need to comply with redetermination requirements and continue to meet the eligibility requirements for that program.

  The first group of Childless Adult members who are SMI, aged 65 and older, under age 65 and have Medicare, and AHCCCS Care members who have HIV/AIDS and have lost coverage for AHCCCS Care because they failed to comply with the redetermination will have been already transferred to SSI MAO before this notice is generated.

  See Attachment #1

- Notice #2: In the month of July 2011, AHCCCS will send a notice to all AHCCCS eligible members, who are not on MED or the Childless Adult program, explaining to all remaining populations that they are not impacted by the elimination of the MED program or the freeze of the Childless Adult Program.

  See Attachment #2

- Notice #3 Beginning June 28 2011, and every month thereafter, AHCCCS will notify all Childless Adults who are age 65 and older, and all Childless Adults, who are under age 65 and who have Medicare, that they are being transferred to the SSI MAO program. The SSI MAO program will not be frozen and SSI MAO staff will contact these individuals for a redetermination of their eligibility under SSI MAO rules.

  Every month AHCCCS will identify Childless Adults who are age 65 or older, or under age 65 and have Medicare, and transfer them to SSI MAO. AHCCCS will notify these individuals that they are being transferred shortly after their eligibility category has changed from AHCCCS Care to SSI MAO. This transfer will occur when the member turns 65, or when the member obtains Medicare if under age 65, and is not based on their redetermination date. AHCCCS will give these individuals the same redetermination date that they had in AHCCCS Care.

  See Attachment #3

- Notice #4: Beginning June 28, 2011, and every month thereafter, Childless Adults who lose coverage for the Childless Adult program, because they failed to comply with the redetermination process AND they have a diagnosis of HIV/AIDS and/or take antiretroviral drugs, will receive a notice that they are being transferred to the SSI MAO program. The SSI MAO program will not be frozen and SSI MAO staff will contact these individuals for a redetermination of their eligibility under SSI MAO rules. These individuals will be indentified every month and will be transferred to the SSI MAO program. They will be notified that they are being transferred to SSI MAO shortly after their eligibility category has changed from AHCCCS Care to SSI MAO. They will have a redetermination shortly after they are transferred since they failed to comply with their Childless Adult redetermination requirements.

  See Attachment #4

- Notice #5: Beginning June 28, 2011, and every month thereafter, AHCCCS will notify all Childless Adults, who are identified in the AHCCCS PMMIS system as Seriously Mentally Ill (SMI) by the Arizona Department of Health Services (ADHS), that they will be transferred to the SSI MAO program. The SSI MAO program will not be frozen and SSI MAO staff will contact these individuals for a redetermination of their eligibility under SSI MAO rules. Every month AHCCCS will identify Childless Adults who are seriously mentally ill and transfer them to the SSI MAO program. The timing of the transfer occurs upon a member's designation as being SMI. They will be notified that they are being transferred to SSI MAO shortly after their eligibility category has changed from AHCCCS Care to SSI MAO. We will give these individuals the same redetermination date that they had in AHCCCS Care.

See Attachment #5

- Notice #6: Childless Adults who lose coverage for the Childless Adult program (and they are not SMI, HIV/AIDS, over 65 or under 65 with Medicare), because they failed to comply with the redetermination process will receive a third and final notice from AHCCCS beginning June 25, 2011, and each month thereafter. The notice will tell them that they cannot get back into the Childless Adult program, but if they comply with redetermination requirements before the effective date of their discontinuance they can remain on AHCCCS Care.

See Attachment #6

- Notice #7: Childless Adults who lose coverage for the Childless Adult program (and they are not SMI, HIV/AIDS, over 65 or under 65 with Medicare), because they failed to comply with the redetermination process will receive a discontinuance notice from the eligibility agency. The notice will tell them that they cannot get back into the Childless Adult program, they can file an appeal if they believe the discontinuance was made in error, if they appeal timely they can request continued benefits and that they can reapply for AHCCCS (but not Childless Adults). If they reapply they will need to demonstrate that they have a categorical link, including: pregnancy, parent of a deprived child, disability, or being age 65 or older.

See Attachment #7

- Notice #8: Childless Adults whose redetermination is due by June 30, 2011 will receive a notice from AHCCCS in June letting them know that AHCCCS is planning to freeze Childless Adults effective July 1, 2011, pending approval from CMS. The notice will also let them know that if they do not comply with the redetermination process by June 30, 2011 they will lose AHCCCS coverage under the Childless Adult category and may not be able to get back onto AHCCCS, unless they are eligible under a categorical link such as: age 65 or older, blind, disabled, pregnant or the parent of a deprived child.

  This notice will also be sent in July to Childless Adults whose redetermination is due July 31, 2011, letting them know that AHCCCS will freeze enrollment for Childless Adults effective July 8, 2011, pending approval from CMS. The notice will also let them know that if they do not comply with the redetermination process by July 31, 2011, they will lose AHCCCS coverage under the Childless Adult category and may not be able to get back onto AHCCCS, unless they are eligible under a categorical link such as: age 65 or older, blind, disabled, pregnant

or the parent of a deprived child.

See Attachment #8

- Notice #9: Children who are aging out of the 1931, SOBRA Child, YATI (Young Adult Transitional Insurance for children 18-21 years old who aged out of foster care) and KidsCare programs will receive Notice #9 if they are aging out in the month in which their redetermination is due. The notice will advise them that if they comply with the redetermination requirements, they may be redetermined under the Childless Adults program. If they do not comply with the redetermination requirements, and their eligibility ends, they cannot apply for coverage under the Childless Adult program while enrollment is frozen.

  This notice will be sent June 22, 2011, and then every subsequent month. Additionally, the notice will be sent early in the month that the renewal is due. Note that Notice #9 is only triggered when an individual both ages out AND has a redetermination in the same month. This will occur each month for a small sub-set of children who are aging out of the 1931, SOBRA Child, YATI and KidsCare programs.

- Notice #10: Children who aged out of the 1931, SOBRA Child, YATI and KidsCare programs will receive Notice #10 to notify them that they have been determined eligible for Childless Adults, and that they will need to comply with the redetermination process in order to remain eligible. Children who age out will be transferred to Childless Adults at the time of their birth date, and will be notified shortly after their eligibility category has changed. They will keep their same redetermination date.

**4. Ex Parte Determinations and other Processes:**
**After 7-1-11 for Childless Adult Members Who Are No Longer Eligible as Childless Adults and for Children Aging Out of 1931, SOBRA Child, YATI and KidsCare**

- On June 28, 2011, and every month thereafter, any Childless Adult who is age 65 and older, or who is under age 65 and has Medicare, who is eligible as a Childless Adult for the following month will be transferred to the SSI MAO program and will be redetermined under that category. These members will be identified in our PMMIS system and their eligibility key codes will be changed from Childless Adult to SSI MAO-Aged or SSI MAO-Disabled. We have an automated process from PMMIS to post this change back into DES' AZTECS system and AHCCCS' ACE system to close the Childless Adult case. There will be no break in coverage

for these members. If they lose coverage for Childless Adults for any other eligibility reason, i.e., excess income, loss of residency, etc, they will not be moved to SSI MAO. AHCCCS and DES may become aware of these other reasons for losing eligibility for the Childless Adults program through a variety of means, such as, redetermination, self reporting (all Medicaid members are required to report changes in their circumstances), or PARIS updates (which is a data system that allows state Medicaid agencies across the country to share data regarding state residency and other issues).
AHCCCS will look for individuals who are age 65 and older, and for individuals under age 65 with Medicare every month subsequent to June 28, 2011. This process will ensure that individuals turning 65 or individuals under age 65 receiving Medicare are moved to SSI MAO. The same process described for June 28, 2011 will be followed each month. By transferring these individuals prior to our month end processing, we will get them into the correct capitation rate category prior to paying monthly capitation to our contractors for the following month.

These individuals will be scheduled for a redetermination based on their next redetermination due date for AHCCCS Care.

AHCCCS makes a file available monthly to all of its contracted health plans, Indian Health Services and 638 tribal contractors that identifies AHCCCS members with redeterminations due in the next 60 days. This file can be sorted by zip code and eligibility category.
The 270/271 eligibility and enrollment verification will include redetermination due dates for each member effective June 19, 2011. The 270/271 file is available on line (AHCCCS On Line), through Interactive Voice Response (a phone bank) and through batch processing. Batch processing allows the registered provider to access information on multiple members at one time. Batch processing will be updated effective October 1, 2011.

Members age 65 and older or under age 65 with Medicare, who are moved to SSI MAO and subsequently determined to be ineligible under the requirements for that program, will be returned to the Childless Adult program without a break in coverage.

- On June 28, 2011, and every month thereafter, any Seriously Mentally Ill (SMI) adult, who is eligible under the Childless Adult program for the following month will be moved into the SSI MAO program and will be redetermined under that category. If they lose coverage for Childless Adults for any other eligibility reason, e.g., excess income, loss of residency, etc, they will not be moved to SSI MAO. AHCCCS and DES may become aware of these other reasons for losing eligibility (e.g., excess income, loss of residency) for the Childless Adults program through a variety of means, such as, redetermination, self reporting (all

Medicaid members are required to report changes in their circumstances), or PARIS updates.

SMI members are identified by the Arizona Department of Health Services (ADHS) through their Regional Behavioral Health Authorities (RBHAs) and their behavioral health provider network. This information is posted in the AHCCCS PMMIS system.

AHCCCS will look for individuals who are SMI every month subsequent to June 28, 2011. This process will ensure that individuals diagnosed as SMI are moved to SSI MAO. The same process described for June 28, 2011 will be followed each month. By transferring these individuals prior to our month end processing, we will get them into the correct capitation rate category prior to paying monthly capitation to our contractors for the following month.

These individuals will be scheduled for a redetermination based on their next redetermination due date for AHCCCS Care. AHCCCS will share a listing of transferred SMI members who are due for renewal within 60 days with each Regional Behavioral Health Authority (RHBA) on a monthly basis. The RBHAs work with their providers; application assistor staff use Health-e-Arizona to complete the renewal application, including submission of any necessary documentation. Application assistors are individuals employed by a Health-e-Arizona facility who are trained in using the Health-e-Arizona product and helping individuals complete the application process. Using Health-e-Arizona will allow the RBHA providers to track and follow up with the renewal process, and ensure members have support in completing the process.

In addition, AHCCCS has reached agreement with the Disability Determination Service Administration (DDSA) to significantly streamline the process of collecting and submitting documentation for the disability determination, if one is required. Typically, the disability determination through DDSA requires a lot of documentation. AHCCCS is working with DDSA to allow RHBA providers to submit data that is essential to the disability determination directly to DDSA. This way, DDSA can coordinate with providers to obtain the required documentation rather than rely solely on the individual.

AHCCCS makes a file available monthly to all of its contracted health plans, Indian Health Services and 638 tribal contractors that identifies AHCCCS members with redeterminations due in the next 60 days. This file can be sorted by zip code and eligibility category.
The 270/271 eligibility and enrollment verification will include redetermination due dates for each member effective June 19, 2011. The 270/271 file is available on line (AHCCCS On Line), through IVR and through batch processing. Batch processing will be updated effective October 1, 2011.

SMI members who are moved to SSI MAO and subsequently determined to be

ineligible under the requirements for that program will be returned to the Childless Adult program without a break in coverage.

- Effective June 28, 2011, and every month thereafter, Childless Adults who have a diagnosis of HIV/AIDs and/or take antiretrovirals, and lose coverage under the Childless Adults program, because they did not comply with the redetermination process, will be moved into the SSI MAO program and will be redetermined under the rules of that category. If the adult with HIV/AIDS does not meet the requirements for SSI MAO, that individual's eligibility ends.

  Adults with HIV/AIDS, who are moved to SSI MAO, because they did not comply with the Childless Adult redetermination process, will not have a break in coverage when they are transferred from the Childless Adults program to SSI MAO.

  Adults with HIV/AIDS, who are moved to SSI MAO, will be scheduled for a redetermination as soon as possible, since they lost AHCCCS Care for failure to comply with the redetermination process.

  If the adult with HIV/AIDS loses coverage for Childless Adults for any other eligibility reason, i.e., excess income or loss of residency, they will not be moved to SSI MAO.

  AHCCCS will identify these individuals based on the diagnosis code of 042 and/or antiretrovirals for which there are encounters and claims in the PMMIS system. AHCCCS will look for these individuals every month before our month end processing, starting June 28, 2011.

  AHCCCS makes a file available monthly to health plans, Indian Health Services and 638 tribal contractors that identifies AHCCCS members with redeterminations due in the next 60 days. This file can be sorted by zip code and eligibility category.
  The 270/271 eligibility and enrollment verification will include redetermination due dates for each member effective June 19, 2011. The 270/271 file is available on line (AHCCCS On Line), through IVR and through batch processing. Batch processing will be updated effective October 1, 2011.

- Other Childless Adults who lose coverage because they did not comply with the redetermination process, will be advised by the eligibility agency using Notice #7 that they are no longer eligible for AHCCCS Care, that they can file an appeal if they believe their eligibility was discontinued in error and that they can apply for Medicaid, if they believe they are aged, blind, disabled, pregnant, or the parent of a deprived child. They will receive a final notification from AHCCCS using Notice #6 that their eligibility is ending and advising them to complete their renewal prior to the effective date of their discontinuance.

AHCCCS makes a file available monthly to health plans, Indian Health Services and 638 tribal contractors that identifies AHCCCS members with redeterminations due in the next 60 days. This file can be sorted by zip code and eligibility category.
The 270/271 eligibility and enrollment verification will include redetermination due dates for each member effective June 19, 2011. The 270/271 file is available on line (AHCCCS On Line), through IVR and through batch processing. Batch processing will be updated effective October 1, 2011.

- Children who are aging out of the 1931, SOBRA Child, YATI and KidsCare programs, and meet the qualifications for Childless Adults, can continue to be determined eligible for Childless Adults after the enrollment freeze is in effect. Children who have a redetermination due the month they are aging out of the 1931, SOBRA Child, YATI and KidsCare programs must comply with the redetermination process. If they do not comply with the redetermination, and as a result, lose coverage, and then reapply after the effective date of the discontinuance of their coverage, they cannot be determined eligible for Childless Adults.

  AHCCCS makes a file available monthly to health plans, Indian Health Services and 638 tribal contractors that identifies AHCCCS members with redeterminations due in the next 60 days. This file can be sorted by zip code and eligibility category.
  The 270/271 eligibility and enrollment verification will include redetermination due dates for each member effective June 19, 2011. The 270/271 file is available on line (AHCCCS On Line), through IVR and through batch processing. Batch processing will be updated effective October 1, 2011.

  DES and AHCCCS staff will automatically determine eligibility for children aging out of the 1931, SOBRA Child, YATI and KidsCare programs, who do not have a redetermination due. If DES and AHCCCS staff are unable to complete the eligibility determination for the child before the child ages out, the child will be transferred to Childless Adults and will remain eligible for Childless Adults if they meet all other eligibility criteria. The child's redetermination date will remain the same as it was under his or her previous eligibility category.

- Households are advised that they can submit a paper application or can use the Health-e-Arizona on line application at www.healthearizona.org.

- All households that have not submitted a renewal application by the second week of the renewal month receive an automated reminder call, if they have a phone number.

5. **Examples of Childless Adult Members:**

- **CASE SCENARIO 1** – Childless Adult member is SMI and is transferred from the Childless Adult program to SSI MAO effective July 1, 2011. AHCCCS has a unique identifier for SMI members in our PMMIS system. This information is supplied by the Arizona Department of Health Services (ADHS), who is responsible for diagnosing and serving this population.

  Household consists of John Smith, age 55, who has been identified by the Department of Health Services as SMI.

  John earns $400 monthly. A notice is sent to John in June 2011 informing him that his eligibility has been transferred from the Childless Adult program to SSI MAO. John will be contacted by SSI MAO staff to complete a redetermination for that program, based on the redetermination date he would have had in Childless Adults.

  On November 1, 2011 an SSI MAO eligibility specialist tries to contact John to start the redetermination process. The Eligibility Specialist phones John and his phone has been disconnected. John is sent a redetermination notice to complete the redetermination process, and is informed that he has until January 31, 2012 to respond. The redetermination notice is returned by the U.S. Post Office as undeliverable. His SSI MAO eligibility is discontinued effective February 1, 2012. John is ineligible for SSI MAO.

- **CASE SCENARIO 2** – Childless Adult member fails to comply with the redetermination process after the freeze is in effect and is diagnosed with HIV/AIDs. (We will identify and track these individuals before they lose coverage)

  John earns $400 monthly. A notice requiring John to send a renewal application was sent to John on November 1, 2011. John was required to respond by December 31, 2011. No renewal application was received from John. His Childless Adult eligibility is discontinued effective January 1, 2012. But John is transferred to SSI MAO effective January 1, 2012 and will be contacted by SSI MAO staff to complete a redetermination for that program.

  John is sent a notice that he has been transferred to SSI MAO and that he will need to complete the redetermination process and meet the requirements for SSI MAO in order to remain eligible for that program.

  On February 1, 2012 an SSI MAO eligibility specialist telephones John to start

the redetermination process. The eligibility specialist then sends John a disability packet to complete and answers questions for John after he reviews it. John returns the requested information and the disability packet is sent to the DES Disability Determination Service Administration (DDSA).

On June 15, 2012 DDSA determines that John meets the requirements for disability and returns that information to the eligibility specialist. The eligibility specialist updates the eligibility system, ACE, with the DDSA information and completes the redetermination. John is eligible for SSI MAO.

- **Case Scenario #3 -** Childless adult member is age 66 on July 8, 2011 when the Childless Adult program is frozen. These members will be identified in our PMMIS system and their eligibility key codes will be changed from Childless Adult to SSI MAO-Aged.

  Household consists of John Smith, aged 66, who has been identified in our MMIS system as being over age 65.

  We change his eligibility category to SSI MAO aged in our PMMIS system and the system sends a message to the DES AZTECS system to discontinue his Childless Adult eligibility. We notify the SSI MAO Office to add him to the ACE eligibility system and conduct a redetermination based on the redetermination date he would have had in Childless Adults.

  On September 1, 2011 an SSI MAO eligibility specialist contacts John by telephone to start the redetermination process. John provides requested information by September 15, 2011 and the eligibility specialist updates the eligibility system, ACE with John's information and completes the redetermination. John is eligible for SSI MAO.

- **Case Scenario #4 –** Childless adult member fails to comply with the redetermination process after the freeze is in effect and is pregnant.

  Household consists of Jane Smith, age 35. Jane earns $400 monthly. A notice requiring Jane to send a renewal application was sent to Jane on November 1, 2011. Jane was required to respond by December 31, 2011. No renewal application was received from Jane.

  A discontinuance notice is sent to Jane on December 19, 2011 advising her that her Childless Adult eligibility will be discontinued effective January 1, 2012.

  The discontinuance notice advises Jane that she no longer qualifies for the Childless Adult program, but she can file an appeal if she feels this

discontinuance was made in error and advises her that she can reapply for AHCCCS. Her Childless Adult eligibility is discontinued effective January 1, 2012.

Jane reapplied for AHCCCS on January 5, 2012 and indicates that she is pregnant. An eligibility determination is made under SOBRA Pregnant Woman and on January 18, 2012 she is approved for AHCCCS effective January 1, 2012. Jane is eligible as a SOBRA Pregnant Woman.

- **Case Scenario #5: -** Childless adult member fails to comply with the redetermination process after the freeze is in effect and is disabled.

  Household consists of Jane Smith, age 35. Jane earns $400 monthly. A notice requiring Jane to send a renewal application was sent to Jane on November 1, 2011. Jane was required to respond by December 31, 2011. No renewal application was received from Jane.

  A discontinuance notice is sent to Jane on December 19, 2011 advising her that her Childless Adult eligibility will be discontinued effective January 1, 2012. No renewal application was received from Jane. The discontinuance notice advises Jane that she no longer qualifies for the Childless Adult program, but she can file an appeal if she feels this discontinuance was made in error and advises her that she can reapply for AHCCCS. The notice tells her that she will need a categorical link to AHCCCS such as pregnancy, disability, being the parent of a deprived child or being over age 65. Her Childless Adult eligibility is discontinued effective January 1, 2012.

  Jane reapplied for AHCCCS on January 5, 2012 and indicates that she is disabled. An application for SSI MAO is entered into the ACE eligibility system and Jane is asked to complete a disability determination packet. A disability determination is made by the DES Disability Determination Service Administration (DDSA) and Jane is determined to have a disability on April 1, 2012. Jane is approved for SSI MAO on April 10, 2012, effective January 1, 2012. Jane is eligible for SSI MAO.

- **Case Scenario #6:** Child ages out of SOBRA Child after the freeze is in effect.

  Household consists of Jane Smith, age 35 and Jimmy Smith, who turns age nineteen in August. Jane earns $775 monthly. Jimmy earns $500. Jimmy's scheduled redetermination under SOBRA Child is in March. An alert is generated in July notifying eligibility staff that Jimmy is turning 19. On July 25th, eligibility is redetermined for Jimmy using the most current information in the file.

Jimmy does not have a deprived, dependent child and is not disabled. He is determined eligible for the Childless Adult program effective September 1st without a break in coverage. Jimmy will receive Notice #10 informing him of his transfer to Childless Adults. Jimmy will then complete his redetermination under Childless Adults in March as scheduled. Jane remains eligible for the Childless Adult program.

**6. System Changes:**

- Changes to the Department of Economic Security AZTECS eligibility system: AZTECS will not approve Childless Adults for applications dated July 8, 2011 or later. It will approve Childless Adults for applications dated prior to July 8, 2011, if all eligibility criteria were met prior to July 8, 2011. AZTECS will generate Notice #7. It will allow children aging out of the 1931, SOBRA Child, and YATI programs to move into Childless Adults if they meet the eligibility requirements.

- Changes to the AHCCCS ACE eligibility system: ACE will not approve Childless Adults for applications dated July 8, 2011 or later. It will approve Childless Adults for applications dated prior to July 8, 2011, if all eligibility criteria were met prior to July 8, 2011. ACE will generate Notice #7. It will allow children aging out of the 1931, SOBRA Child, and KidsCare programs to move into Childless Adults if they meet the eligibility requirements.

- Changes to the AHCCCS PMMIS system: On July 8, 2011 PMMIS will stop accepting Childless Adults for eligibility effective July 8, 2011 or later. It will accept Childless Adults eligibility from children aging out of the 1931, SOBRA Child, YATI, and KidsCare programs. It will permit manual update of Childless Adults for cases closed in error. It will produce notices #1, #2, #3, #4, #5, #6, #8, #9 and #10.

  PMMIS will move members age 65 and older, and members under age 65 with Medicare to SSI MAO. PMMIS will post a file of those members in the DES AZTECS system and the AHCCCS ACE system to close their Childless Adult cases. PMMIS will produce a file of these members so they can be added into the ACE system as SSI MAO eligibles. AHCCCS will run this process every month effective June 28, 2011.

  AHCCCS will identify individuals from the PMMIS Claims and Encounters systems, who have a diagnosis code of 042 (HIV/AIDS) and/or who have a pharmacy claim or encounter for an antiretroviral. We will create an electronic file of these individuals monthly and run it against our PMMIS Recipient system monthly to ensure their Childless Adult cases remains active. If a future termination date is sent for these members, PMMIS can identify through the

coding if the case is being closed because they did not comply with the redetermination process. If it is, the member will be transferred to SSI MAO and scheduled for a redetermination, without a break in their coverage. AHCCCS will run this process every month, effective June 28, 2011.

AHCCCS will identify individuals from the PMMIS Recipient System, who have been identified as SMI. We will transfer all of these individuals to SSI MAO on July 1, 2011 and schedule them for a redetermination, without a break in their coverage. AHCCCS will run this process every month.

The 270/271 process for eligibility and enrollment verification will be updated to include redetermination dates for each member effective June 19, 2011. This process includes web based and IVR tools. Batch 270/271 will be updated effective October 1, 2011.

- Changes to the AHCCCS/DES Health-e-Arizona on line application and renewal system: Effective July 8, 2011 Health-e-Arizona will stop screening for Childless Adults.

**7. Eligibility Appeals:**

The Department of Economic Security has an Office of Appeals, which hears eligibility appeals for eligibility determinations made by DES employees. Eligibility appeals for eligibility determinations made by AHCCCS employees are heard by a separate agency, the Office of Administrative Hearings (OAH). Other than the two different offices the eligibility appeals process are essentially the same. Any differences are noted below.

If a Childless Adult loses eligibility for any reason, they have 30 calendar days from the date the decision notice is mailed to request an appeal of the decision. A request for appeal can be submitted either verbally or in writing. The member may request to withdraw the hearing request at any time.

Benefits will continue if the request for appeal is received within 10 calendar days from the date the decision notice is mailed. Benefits will not be continued if the action appealed is due solely to a change required by a change in federal or state law.

Within 7 days from receipt of the appeal request at DES and within 10 days at AHCCCS, the DES or AHCCCS eligibility office schedules a pre-hearing conference and sends copies of the budget calculations, income screens, notices, and case notes to the member. The conference may be conducted by telephone at the request of the member.

Within 10 calendar days of receipt of the appeal request, a DES or AHCCCS

supervisor reviews the results of the pre-hearing conference and documents in the appeal packet the accuracy of the eligibility decision.

When the pre-hearing conference may result in an informal resolution of the dispute at DES, a request to withdraw from the appeal is sent to the member. An informal resolution may happen when the decision is discussed with the member directly and the member agrees that the agency made the correct decision. A request to withdraw from the appeal is not sent to the member when the decision requires correction. When the review of the circumstances indicates that the case needs correction, DES sends the Request to Vacate and Remand (FAA-1389A) form to the Office of Appeals. The case is not corrected until a response is received from the Office of Appeals or the Office of Administrative Hearings that indicates that the matter was vacated and remanded to the local office for correction.

At AHCCCS, when the pre-hearing conference may result in an informal resolution of the dispute, a request to withdraw from the appeal is sent to the member. If a correction is needed, AHCCCS takes the action necessary to correct the adverse action being appealed. When the completed Voluntary Withdrawal from Appeal form is received, it is sent electronically to OAH with a request to vacate the appeal.

When a resolution is not reached during the pre-hearing conference, DES or AHCCCS continues processing the request for appeal.

Appeals are scheduled to allow for a decision to be rendered within 90 days from the request for appeal. Appeals are scheduled not fewer than 20, nor more than 45, calendar days from the date the request is filed. The member may request less than 20 calendar days notice in order to expedite the appeal.

Appeals may be conducted by phone when mutually agreed on by the member and the Office of Appeals for DES or the Office of Administrative Hearings for AHCCCS. The member is afforded the same rights as members who attend face-to-face hearings.

The member presents the facts and knowledge of the case, and has an opportunity to address witnesses, present evidence, advance arguments, refute testimony or evidence, and examine evidence introduced by any party at the hearing.

The Office of Appeals for DES or the AHCCCS Director, for AHCCCS appeals, notifies the member of the appeal decision. If the appeal decision is unfavorable to the member, he/she may request an appeals board review of the decision. If the Appeals Board decision is unfavorable to the member, he/she may request a Judicial Review of the Appeals Board decision.

For AHCCCS, OAH makes a written recommended decision within 20 days from the day of the hearing. The AHCCCS Director reviews the recommendation and issues a written decision to the member within 30 days. If the decision is unfavorable to the

member, the member may request a re-hearing.

Local eligibility offices are required to take action to implement all appeal decisions and remands within 10 days. Based on historical appeals data relating to changes in eligibility, copayments, etc., the State has seen a minimal increase in the number of appeals. Given the other elements in the phase out plan, such as specific community outreach, the ex parte process and exceptions made to target particular groups, DES does not expect a heavy influx of appeal requests. There is a significant amount of variation regarding total number of appeals received in any one month. Thus, DES is staffed in such a way as to deal with peak highs and lows.

Eligibility appeals are given priority and appeals from providers and others are secondary. Also, DES provides a quarterly report on number of hearing requests, number of decisions and timeliness that AHCCCS monitors. The State does not shift staff to address high/low peaks. The Arizona Office of Administrative Hearings conducts hearings on a number of different subjects, in addition to eligibility appeals. The State has a longstanding agreement that eligibility appeals are given priority. This agreement – that eligibility cases are a priority for the State to remain in compliance with federal law – is included in AHCCCS' Intergovernmental Agreement with the Office of Administrative Hearings. In the event that the State receives a significant increase of appeals in a given month, the State is aware of its responsibilities to process eligibility appeals timely and would appropriately allocate resources to that end.

**8. Other Communication:**

- Web
  - The AHCCCS website, www.azahcccs.gov will be updated continually to reflect program changes as decisions are made.
  - The Childless Adults phase out plan will be posted on the AHCCCS website, www.azahcccs.gov.
  - The AHCCCS website will provide opportunity for the public to electronically submit comment. Those comments will be posted on the website.
  - Information for members will be posted on the AHCCCS website member portal, www.azahcccs.gov/members, the Health-e-Arizona website, www.healthearizona.org and the DES website, https://egov.azdes.gov/dbme/faa/myFamilyBenefits.
  - Members can access information about the status of their eligibility at www.azahcccs.gov/members/myahcccs.
  - Providers can verify the status of member eligibility at https://azweb.statemedicaid.us/Home.asp.

- Legislative and Rule Making Process

- Should this plan require legislative action, it will go through the normal public process at the Legislature where there is public notice, a hearing and opportunity to be heard.
- Notice will also be published statewide through the Secretary of State and/or newspaper publication and a 30-day public comment period will be provided. Public comment can be submitted electronically via the AHCCCS website or by mail. Comments received electronically will be posted on the AHCCCS website.

- Providers/Health Plans

  - AHCCCS will distribute information regarding program changes to all of its contracted health plans.
  - Providers will receive information regarding program changes through the monthly AHCCCS electronic newsletter for providers, "Claims Clues."
  - The health plans will disseminate information as a component of their normal member outreach tools. AHCCCS health plans have community and provider relations staff that will be able to assist AHCCCS in its efforts to inform members and the public.
  - AHCCCS makes a file available monthly to health plans, Indian Health Services and 638 tribal contractors that identifies AHCCCS members with redeterminations due in the next 60 days. This file can be sorted by zip code and eligibility category.
  - The 270/271 eligibility and enrollment verification will include redetermination due dates for each member effective June 19, 2011. The 270/271 is available on line (AHCCCS On Line), through IVR and through batch processing. Batch processing will be updated effective October 1, 2011.

- Stakeholders/Community Partners

  - AHCCCS will send mass emails to stakeholders and community partners to notify them when the AHCCCS website has been updated with new information.
  - AHCCCS will distribute information about program changes to its Health-e-Arizona subscribers. Health-e-Arizona subscribers have 220 located across the state and are very dedicated to assisting people in applying for or renewing coverage. They will receive complete information about this phase out plan and how they can assist.
  - Although AHCCCS has already held tribal consultation on this matter, AHCCCS will ensure specific communication to the tribes, I.H.S. and 638 facilities and host any consultation or information session as needed. As a result AHCCCS has modified its monthly renewal file which provides the names of members whose renewal dates are due in the next 60 days. As of May 4, 2011 IHS and 638 contractors can sort this file by zip code and eligibility category.

- AHCCCS will work with the Health-e-Arizona Steering Committee to develop an outreach plan for AHCCCS Care households. The plan will include notification to community partners of the change to the AHCCCS Care program and ideas for assisting AHCCCS Care members. See Attachment #9
- In addition, AHCCCS will host two one-hour training sessions for community partners and stakeholders that assist the AHCCCS Care population. The training will focus on walking through the steps of the Childless Adult Phase out Plan.

- News Entities

  - AHCCCS may also provide information through news entities.

## 9. Consideration of Public Comment:

AHCCCS has received numerous comments from the public, including individual members, family members, organizations and providers. Many of these comments were part of the Community Forum held on June 1, 2011. A summary of this forum can be found on the AHCCCS website at: http://www.azahcccs.gov/publicnotices/Downloads/ChildlessAdultsForumFromJune1_2011_SummaryFINAL.pdf

Other comments have been submitted electronically via the AHCCCS website or email. Some of these comments were submitted through the comment portal on the 1115 Waiver section of the AHCCCS website and will be addressed individually. Some comments were received as part of the formal administrative rules process.

In addition, AHCCCS staff have attended meetings with community groups where there has been discussion of the childless adult phase out plan. In addition, the phase out plan has been discussed with Health-e-Arizona Steering Committee partners who have assisted in developing fact sheets and alternative resources materials for community health centers and other organizations who regularly assist consumers that may fall into the childless adult category.

AHCCCS has considered all public comments and incorporated the public comments in the following ways:

- Transitioning all members who are designated SMI to the SSI MAO category;
- Transitioning members with HIV/AIDS in the childless adult category who fall off for failure to comply with their annual renewal to the SSI MAO category;
- Transitioning children who age out of SOBRA, 1931, YATI and KidsCare to the childless adult category;
- Updating the provider portal and the myahcccs.com site by providing specific redetermination dates by June 17 to assist providers in reaching out to members;
- Providing specific outreach to I.H.S. and 638 facilities with a review file so that these facilities can obtain redetermination dates;

- Developing a fact sheet for organizations who assist consumers;
- Developing a list of alternative resources for individuals;
- Including a notice specifically for those individuals whose redetermination is June 30 and may not be aware of the potential enrollment freeze in childless adults eligibility category;
- Facilitating the process for public input via the AHCCCS website and community forums.

## 10. Health-e-Arizona:

Health-e-Arizona (HEA) is our online system for public assistance applications. A consortium of Federally Qualified Health Centers (FQHCs) brought the original model to Arizona in June 2002. We call the original model (still in place) the subscription model and it is used by community partners, such as FQHCs and hospitals, who pay a subscription fee to use it. Today we have 70 Subscribers at 220 locations statewide.

When patients come into a subscriber's facility, facility staff assists them with the completion of the application online, get an electronic signature and use fax or scanning to associate necessary documentation with the application. When the application is complete, the system screens it and identifies potential eligibility for Medicaid, CHIP, SNAP and TANF. An application can be submitted even if the applicant does not screen potentially eligible. The application is sent to the correct location electronically and is automatically entered into the eligibility systems of AHCCCS and DES. The facility can track workloads, communicate with the eligibility agency and get a final determination from the eligibility agency. Facilities who build a consistent process around this product are much more successful in getting their patients enrolled in Medicaid or CHIP and getting reimbursement for services to uninsured patients.

When an application is initiated, HEA interfaces with the AHCCCS PMMIS system to see if the applicant is already Medicaid eligible. If the applicant is known to PMMIS two things will happen:

1. HEA will pull name, date of birth (DOB) and SSN from PMMIS and will compare it to the name, DOB and SSN entered by the applicant. If there are discrepancies between PMMIS and the data that the applicant entered, HEA will require the applicant to resolve the discrepancy. This will significantly reduce problems pushing the data into the AHCCCS and DES eligibility systems.

2. Once HEA knows that the applicant is an active Medicaid recipient, it will treat their application as a renewal and ask questions appropriate for renewals.

   If the applicant has entered data into HEA on a previous occasion, HEA will pre-populate that data into the application or renewal.

In December 2008, AHCCCS implemented a public access version of Health-e-Arizona. Because this was a new feature, AHCCCS set a modest first-year goal of 17,000 Medicaid and CHIP applicants. Instead AHCCCS received 170,000 applicants using the public access version of Health-e-Arizona. In the last 12 months, AHCCCS has received 500,000 applications through the public and subscription models. Health-e-Arizona now represents nearly 40% of all Medicaid, Medicare Savings Programs and CHIP applications received each month in Arizona.

**11. Reports:**

AHCCCS will produce the following reports every month regarding the Childless Adult Freeze:

- Report #1: The number of members enrolled in the Childless Adult program as of the 1st of each month and the percentage of change from the previous month.

- Report #2: The number of SMI members transferred from Childless adults to SSI MAO effective the first of each month and the total number of SMI members transferred to date.

- Report #3: The number of members age 65 and older transferred from Childless Adults to SSI MAO effective the first of each month and the total number transferred to date.

- Report #4: The number of members under age 65, with Medicare transferred from Childless Adults to SSI MAO effective the first of each month and the total number transferred to date.

- Report #5: The number of members identified with HIV/AIDS transferred from Childless Adults to SSI MAO effective the first of each month and the total number transferred to date.

- Report #6: The number of SMI members who did not meet SSI MAO requirements and were transferred back into the Childless Adults program.

- Report #7: The number of members with HIV/AIDS who did not meet SSI MAO requirements and were discontinued because they did not qualify for any Medicaid category.

- Report #8: The number of individuals aged 65 and older or under age 65 with Medicare who do not meet the eligibility requirements for SSI MAO and are transferred back to Childless Adults.

**Attachment #1: Notice #1**

AHCCCS is Arizona's Medical Assistance NO

# ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

You get AHCCCS Health Insurance through the AHCCCS Care program. Due to the current budget crisis in Arizona, the State will "freeze" new enrollment in the AHCCCS Care program beginning July 8, 2011. This means that no new applications for the AHCCCS Care program will be accepted after July 7, 2011.

**People who are already on the AHCCCS Care program will still receive medical services from AHCCCS, but only as long as they stay eligible for AHCCCS.**

**If you lose coverage for the AHCCCS Care program because you no longer meet eligibility requirements, you will not be able to get back on the AHCCCS Care Program.**

**To keep your AHCCCS Care benefits, you must:**

- **Continue to meet the eligibility requirements of the AHCCCS Care program;**
- **Cooperate with all requests you receive from the Department of Economic Security (DES) or AHCCCS staff; and**
- **Complete your renewal when notified.**

This change only applies to the AHCCCS Care program. Please quickly answer any requests that you may receive from DES or AHCCCS about your AHCCCS Care benefits. If you have family members on other AHCCCS programs, their benefits are not affected at this time.

If you do lose coverage for AHCCCS Care, you may be eligible under another AHCCCS program if you are:

- Pregnant,
- The parent of a deprived child under 18,
- Age 65 and older or
- Have a disability.

If you do lose coverage for AHCCCS Care, DES and AHCCCS will let you know how to apply for other programs. If you have specific questions, please contact your AHCCCS office or call DES at 602-542-9935 or 1-800-352-8401

If you do lose coverage for AHCCCS and you are employed and your employer offers health insurance, under new federal law you may be able to enroll in your employer's insurance plan within 60 days of losing coverage under AHCCCS. You should contact your employer immediately if you lose your AHCCCS Care benefits. Listed below are some other health care programs that may also be able to help you afford health care services if your AHCCCS Care benefits end.

**SEE IMPORTANT INFORMATION ON THE OTHER SIDE OF THIS NOTICE**

**Here are some other health care programs that may also be able to help you afford health**

**care services if your AHCCCS Care benefits end:**

Community Health Centers
Phone: 602-253-0090
On the Web: www.aachc.org/associatemembersl.php

Health Care Connect
Maricopa County
Phone: 602-288-7564
On the Web: www.healthcareconnect.org/contactus.php

Pima Community Access Program (PCAP)
Pima and Santa Cruz County
Phone: 520-694-0418
On the Web: www.pcap.cc

Community Access Programs of Arizona and Mexico (CAPAZ-MEX)
Yuma County
Phone: 928-627-9222
On the Web: www.rcfbh.org/programCAPAZMEX

Pre-existing Condition Insurance Plan
Phone: 1-866-717-5826
On the Web: http://www.healthcare.gov/law/provisions/preexisting/states/az.html

**If you need free legal advice, call the following numbers:** Phoenix at 602-258-3434 (800-852-9075); Tucson at 520-623-9461 (800-248-6789); and Flagstaff at 928-774-0653 (800-789-5781). For persons in other parts of the state, call 1-866-637-5341 to find the nearest legal services office in your area.

Additional sources of free legal service can be found at these web sites:

http://apps.americanbar.org/legalservices/probono/directory/arizona.html

http://www.acdl.com/gettinghelp.html

If you have specific questions, please contact your Eligibility Specialist in your local DES or AHCCCS office.

**Attachment #2: Notice #2**

AHCCCS is Arizona's Medical Assistance

AHCCCS

# ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

## VI.

## VII. IMPORTANT NOTICE ABOUT CHANGES TO THE MEDICAL EXPENSE DEDUCTION (MED) PROGRAM AND THE AHCCCS CARE PROGRAM

You may have heard that enrollment in some AHCCCS programs is being frozen or may end due to the current budget crisis in Arizona.

At this time, only the Medical Expense Deduction (MED) program and the AHCCCS Care Program have been affected.

### What is MED and AHCCCS Care?

MED is an AHCCCS program administered by the Department of Economic Security (DES). MED provides AHCCCS benefits to people who have income too high to qualify for other programs, but who have high medical expenses. Enrollment in the MED program was frozen on May 1, 2011 and the program will end on October 1, 2011.

AHCCCS Care provides AHCCCS benefits to people whose income is not too high, but they do not meet some other requirements for the rest of the AHCCCS programs. Enrollment in the AHCCCS Care Program was frozen on July 8, 2011. Effective July 8, 2011 no one can be added to this program.

### Does This Change Affect Me?

**If you are not on MED or the AHCCCS Care Program, these changes do not affect you.** These changes do not affect AHCCCS coverage under any other programs at this time. However, if you or other family members receive AHCCCS coverage under the MED or AHCCCS Care programs, you or other family members have already received a separate letter describing the changes in more detail.

**This letter is sent only for your information so that you will know that if you are not on the MED or AHCCCS Care programs, you are not affected by the changes for the MED and AHCCCS Care programs. If you have specific questions, please contact your AHCCCS office or call DES at 602-542-9935 or 1-800-352-8401.**

**Attachment #3: Notice #3**

AHCCCS is Arizona's Medical Assistance

AHCCCS

# ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

## IMPORTANT NOTICE ABOUT YOUR AHCCCS ELIGIBILITY

You get AHCCCS Health Insurance through the AHCCCS Care program.

Due to the current budget crisis in Arizona, the State will "freeze" new enrollment in the AHCCCS Care program beginning July 8, 2011. This means that no new applications for the AHCCCS Care program will be accepted after July 7, 2011.

**Because you are over age 65 or are under age 65 and have Medicare, your case has been sent to the AHCCCS SSI MAO office, which provides AHCCCS health insurance to people who are aged, blind or disabled. There is not a freeze on enrollment for this program. The SSI MAO office will contact you when your redetermination is due to determine your eligibility for the SSI MAO program.**

The SSI MAO office is located at:

801 E. Jefferson Street, MD 3800
Phoenix, AZ 85034

To stay eligible for SSI MAO benefits, you must:

- Meet the eligibility requirements of the SSI MAO program;
- Let AHCCCS know if you move;
- Cooperate with all requests you receive from AHCCCS staff; and
- Complete your renewal when requested.

If you have any questions or need to report a change, call the SSI MAO office at a phone number listed below:

602-417-5010 (Area Codes 602, 480 and 623)
Toll Free: 1-800-528-0142FAX: 602-258-4619

For information about SSI MAO eligibility go to:

http://www.azahcccs.gov/community/Downloads/resources/Description_of_AHCCCS_Programs.pdf

**Attachment #4: Notice #4**

AHCCCS is Arizona's Medical Assistance

# ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

## ELIGIBILITY

You were getting AHCCCS Health Insurance through the AHCCCS Care program with the Department of Economic Security (DES) or through AHCCCS, but your benefits ended when you failed to complete your annual renewal.

Due to the current budget crisis in Arizona, the State will "freeze" new enrollment in the AHCCCS Care program beginning July 8, 2011. This means that you will not be able to get back on the AHCCCS Care program.

**However, your case has been sent to the AHCCCS SSI MAO office, which provides AHCCCS health insurance to people who are aged, blind or disabled. There is no freeze on enrollment for this program.**

**The SSI MAO office will contact you soon to determine your eligibility under the SSI MAO program.**

**In order to be eligible, you must:**

- Meet the eligibility requirements of the SSI MAO program; and
- Cooperate with all requests you receive from AHCCCS staff.
- Complete your renewal when requested.

The SSI MAO office is located at:

801 E. Jefferson Street, MD 3800
Phoenix, AZ 85034

If you have any questions or need to report a change, call the SSI MAO office at a phone number listed below:

Ph: 602-417-5010 (Area Codes 602, 480 and 623)
Toll Free: 1-800-528-0142

FAX: 602-258-4619

For information about SSI MAO eligibility go to:

http://www.azahcccs.gov/community/Downloads/resources/Description_of_AHCCCS_Programs.pdf

**Attachment #5: Notice #5**

AHCCCS is Arizona's Medical Assistance

AHCCCS

# ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

## ELIGIBILITY

You get AHCCCS Health Insurance through the AHCCCS Care program.

Due to the current budget crisis in Arizona, the State will "freeze" new enrollment in the AHCCCS Care program beginning July 8, 2011. This means that no new applications for the AHCCCS Care program will be accepted after July 7, 2011.

**Your case has been sent to the AHCCCS SSI MAO office. The AHCCCS SSI MAO program provides AHCCCS health insurance to people who are aged, blind or disabled. There is no freeze on enrollment for this program.**

**The SSI MAO office will contact you at your redetermination time to do a determination of your eligibility under the SSI MAO program.**

**In order to be eligible, you must:**

- Complete an SSI MAO eligibility redetermination;
- Meet the eligibility requirements of the SSI MAO program; and
- Cooperate with all requests you receive from AHCCCS staff.

The SSI MAO office is located at:

801 E. Jefferson Street, MD 3800
Phoenix, AZ 85034

If you have any questions or need to report a change, call the SSI MAO office at a phone number listed below:

Ph: 602-417-5010 (Area Codes 602, 480 and 623)
Toll Free: 1-800-528-0142

FAX: 602-258-4619

For information about SSI MAO eligibility go to:

**http://www.azahcccs.gov/community/Downloads/resources/Description_of_AHCCCS_Programs.pdf**

**Attachment #6: Notice #6**

AHCCCS is Arizona's Medical Assistance

AHCCCS

# ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

## XII. IMPORTANT NOTICE ABOUT YOUR AHCCCS ELIGIBILITY

You are on AHCCCS Care and you recently received a letter from DES or AHCCCS telling you that your AHCCCS Health Insurance will stop June 30, 2011 because you did not complete the renewal process.

Due to the current budget crisis in Arizona, the State will "freeze" new enrollment in the AHCCCS Care program beginning July 8, 2011. This means that you will not be able to get back on the AHCCCS Care program after your eligibility ends.

If you contact your eligibility worker before your AHCCCS Health Insurance stops and provide needed information, you may still be eligible.

If you do lose coverage for AHCCCS Care, you may be eligible under another AHCCCS program if you are:

- Pregnant,
- The parent of a deprived child under 18,
- Age 65 and older or
- Have a disability including serious mental illness or HIV/AIDS.

If you do lose coverage for AHCCCS Care, DES and AHCCCS will let you know how to apply for other programs.

If you do lose coverage for AHCCCS and you are employed and your employer offers health insurance, under new federal law you may be able to enroll in your employer's insurance plan within 60 days of losing coverage under AHCCCS. You should contact your employer immediately if you lose your AHCCCS Care benefits.

If you have specific questions, please contact your AHCCCS office or call DES at 602-542-9935 or 1-800-352-8401. They can answer questions and help you complete your renewal for AHCCCS Care.

**SEE IMPORTANT INFORMATION ON THE OTHER SIDE OF THIS NOTICE**

**Here are some other health care programs that may also be able to help you afford health care services if your AHCCCS benefits end:**

Community Health Centers
Phone: 602-253-0090
On the Web: www.aachc.org/associatemembersl.php

Health Care Connect
Maricopa County
Phone: 602-288-7564
On the Web: www.healthcareconnect.org/contactus.php

Pima Community Access Program (PCAP)
Pima and Santa Cruz County
Phone: 520-694-0418
On the Web: www.pcap.cc

Community Access Programs of Arizona and Mexico (CAPAZ-MEX)
Yuma County
Phone: 928-627-9222
On the Web: www.rcfbh.org/programCAPAZMEX

Pre-existing Condition Insurance Plan
Phone: 1-866-717-5826
On the Web: http://www.healthcare.gov/law/provisions/preexisting/states/az.html

**If you need free legal advice, call the following numbers:** Phoenix at 602-258-3434 (800-852-9075); Tucson at 520-623-9461 (800-248-6789); and Flagstaff at 928-774-0653 (800-789-5781). For persons in other parts of the state, call 1-866-637-5341 to find the nearest legal services office in your area.

Additional sources of free legal service can be found at these web sites:

http://apps.americanbar.org/legalservices/probono/directory/arizona.html

http://www.acdl.com/gettinghelp.html

If you have specific questions, please contact your Eligibility Specialist in your local DES or AHCCCS office.

Attachment #7 Notice #7
NOTICE: X051
TITLE: MISSED REVIEW NOTICE

Si necesita esta noticia traducida en espanol, llame a la oficina
local al numero que aparece arriba, o al numero de Servicio al Cliente
al (602) 542-9935 o 1-800-352-8401.@@
>>
**********@@
* IMPORTANT INFORMATION ABOUT YOUR CASH ASSISTANCE *@@
* AND AHCCCS HEALTH INSURANCE *@@
**********@@
>>
Your Cash Assistance and/or AHCCCS Health Insurance will be stopped
without further notice beginning %%%%%%%%%%%%%%%%%%%%. The item listed
below applies to you.@@
//@@
|##|A. You failed to report to your local office for an interview to@@
renew your Cash Assistance and/or AHCCCS Health Insurance@@
eligibility.@@
||@@
|##|B. You failed to turn in an application for an interview to@@
renew your Cash Assistance and/or AHCCCS Health Insurance@@
eligibility.||@@
\\@@
If you want your benefits to continue you need to fill out an
application and complete an interview by %%%%%%%%%%%%%%%%%%%.@@
>>
If you need a special appointment time, day or location (for example:
home visit, phone interview, before 8:00 AM or after 5:00 PM) due to
work, school, distance to a DES local office, or other reasons, please
let us know when you turn in your application.@@
>>
Even if you are employed, you may continue to be eligible for AHCCCS
Health Insurance. Please call us for details.@@

If you do lose coverage for AHCCCS Care, you may be eligible under another AHCCCS program if you are:

- Pregnant,
- The parent of a deprived child under 18,
- Age 65 and older or
- Have a disability including serious mental illness or HIV/AIDS.

If you do lose coverage for AHCCCS Care, DES and AHCCCS will let you know how to apply for other programs.

>>
If you have a child who was born in the past 12 months while you were
receiving AHCCCS Health Insurance, the child(ren) may continue to be

eligible. If you have not called us, please do so immediately.@@
>>
This action is based on 42 Code of Federal Regulations (CFR) 435.916
and 45 CFR 206.10 and Arizona Administrative Code R9-22-1414. The CFR
references are available through public libraries.@@
>>
If you think your benefits should not be stopped, ask for a hearing by
filling out the form on the back now.@@
>>
NOTE: If you are interested in registering to VOTE or making changes
to your voter registration, contact your local DES office.@@
>>
If you have questions or need help, please call us at %%%%%%%%%%%%%%.
You can also get information from our 24 hour Interactive Voice
Response (IVR) System at (602) 542-9935 (If calling from area code
602, 480 or 623) or 1-800-352-8401 (for all other area codes). To
apply for free legal help, call %%%%%%%%%%%%%%. Fair Hearing rights
are explained on the back of this notice.@@

Attachment #8

## XIII. IMPORTANT NOTICE: YOU MUST COMPLETE YOUR RENEWAL FOR AHCCCS BY JUNE 30, 2011

You get AHCCCS Health Insurance through the AHCCCS Care program. Your current coverage period will end on June 30, 2011 unless you renew your coverage on time. Your deadline to renew your coverage is June 30, 2011.

Due to the current budget crisis in Arizona, the State is planning to "freeze" new enrollment in the AHCCCS Care program beginning July 1, 2011. This means that no new applications for the AHCCCS Care program will be accepted after June 30, 2011.

**If you do not return your completed renewal application by the June 30, 2011 deadline, your coverage will end on July 1, 2011. You will be discontinued from the AHCCCS Care program, and if the program is "frozen" on July 1st, you will not be able to get back on the program.**

**To keep your AHCCCS Care benefits, you must**:

- **Turn in a renewal application by June 30, 2011;**
- **Meet the eligibility requirements of the AHCCCS Care program; and**
- **Cooperate with all requests you receive from the Department of Economic Security (DES) or AHCCCS staff.**

If you have already turned in a renewal application, please be sure to reply to any mail you get from DES or AHCCCS, and provide any proof requested.

This change only applies to the AHCCCS Care program. If you have family members on other AHCCCS programs, they still need to complete their renewal applications. However, if they lose their AHCCCS coverage because they do not complete a renewal application, they may still be able to get back on other AHCCCS programs.

If you do lose coverage for AHCCCS Care, you may be eligible under another AHCCCS program if you are:

- Pregnant;
- The parent of a deprived child under 18;
- Age 65 and older; or
- Have a disability.

If you lose eligibility for AHCCCS Care, DES and AHCCCS will let you know how to apply for other AHCCCS programs. If you have specific questions, please contact your AHCCCS office or call DES at 602-542-9935 or 1-800-352-8401.

If you do lose coverage for AHCCCS and you are employed and your employer offers health insurance, under new federal law you may be able to enroll in your employer's insurance plan within 60 days of losing coverage under AHCCCS. You should contact your employer immediately if you lose your AHCCCS Care benefits.

### SEE IMPORTANT INFORMATION ON THE OTHER SIDE OF THIS NOTICE

**Note:** This notice was already sent to AHCCCS Care members in this group and so reflects the original proposed July 1, 2011, effective date. This notice will be sent to AHCCCS Care members with a July 31, 2011, redetermination date, and will reflect the revised July 8, 2011, AHCCCS Care enrollment freeze effective date.

**Here are some other health care programs that may also be able to help you afford health care services if your AHCCCS Care benefits end:**

Community Health Centers
Phone: 602-253-0090
On the Web: www.aachc.org/associatemembersl.php

Health Care Connect
Maricopa County
Phone: 602-288-7564
On the Web: www.healthcareconnect.org/contactus.php

Pima Community Access Program (PCAP)
Pima and Santa Cruz County
Phone: 520-694-0418
On the Web: www.pcap.cc

Community Access Programs of Arizona and Mexico (CAPAZ-MEX)
Yuma County
Phone: 928-627-9222
On the Web: www.rcfbh.org/programCAPAZMEX

Pre-existing Condition Insurance Plan
Phone: 1-866-717-5826
On the Web: http://www.healthcare.gov/law/provisions/preexisting/states/az.html

**If you need free legal advice, call the following numbers:** Phoenix at 602-258-3434 (800-852-9075); Tucson at 520-623-9461 (800-248-6789); and Flagstaff at 928-774-0653 (800-789-5781). For persons in other parts of the state, call 1-866-637-5341 to find the nearest legal services office in your area.

Additional sources of free legal service can be found at these web sites:

http://apps.americanbar.org/legalservices/probono/directory/arizona.html

http://www.acdl.com/gettinghelp.html

If you have specific questions, please contact your Eligibility Specialist in your local DES or AHCCCS

office.

**Attachment #9**

**AHCCCS Care (Childless Adults) Phase out Plan**
**Fact Sheet**
**June 1, 2011**

**Eligibility for the AHCCCS Care program will be frozen July 8, 2011 until additional funds become available to reopen enrollment into the program. No one will be approved for AHCCCS Care for the month of July 2011 and ongoing, except children aging out of their eligibility group because they turned 19 or 21. The phase out plan is waiting for approval from the Centers for Medicare and Medicaid Services (CMS), and the enrollment freeze will not be implemented until federal approval is granted.**

**What is the AHCCCS Care program?**
AHCCCS Care or Childless Adults, as it is sometimes known, is a waiver program for adults who have not been determined eligible under one of the regular Medicaid groups (aged, blind, disabled, pregnant, under 18 or parent of a deprived child). An asset test is not required and they must have income under 100% of the Federal Poverty Level (FPL). Eligibility must be renewed every 12 months.

**How many people are on AHCCCS Care?**
As of June 1, 2011 there are nearly 225,000 AHCCCS Care members.

**What will happen to those already on AHCCCS Care?**
All AHCCCS Care members with eligibility that began before July 8, 2011 will remain eligible for the program, unless they lose eligibility because they no longer meet the requirements. This includes the requirement to comply with the renewal process.

AHCCCS will make an administrative change from AHCCCS Care to SSI MAO – a program for people who are aged, blind or disabled (SSI MAO enrollment will not be frozen) – if the member is over age 65, under age 65 and has Medicare or is diagnosed as seriously mentally ill (SMI) by the Department of Health Services. AHCCCS Care members who are diagnosed with HIV/AIDS will be administratively changed to SSI MAO, if they lose eligibility for AHCCCS Care for failure to complete the renewal process. Most SMI and HIV/AIDS members under the age of 65 will have to later be determined disabled under federal requirements by the Disability Determination Service Administration (DDSA), Department of Economic Security. If an SMI member does not meet the federally defined criteria of disabled for Medicaid under the SSI MAO category, AHCCCS will continue their coverage under the AHCCCS Care category, as long as they meet all other required eligibility criteria, such as income.

Although AHCCCS will make every effort, using information already available to the state, to identify people who are age 65 or older, disabled, pregnant, or the parent of a deprived child to ensure that their coverage continues under other categories, we may not identify all of these individuals. If an individual's coverage in the Childless Adult program is being terminated and the individual believes that they may be covered under one of these other groups, they can notify their eligibility worker, who can help them apply for coverage under these categories. AHCCCS is also working with DDSA to streamline the process of collecting and submitting documentation for the disability determination. RBHA providers can also assist individuals in submitting documentation to DDSA.

**What can AHCCCS Care members do?**

AHCCCS Care members should do everything in their power to complete their renewal on time. They can complete a paper renewal form or complete an electronic renewal on line at www.healthearizona.org. They should also report any changes in address to their eligibility worker to insure no loss of contact.

**How will AHCCCS Care members know their renewal date?**
**1st Notice:** All AHCCCS Care members will be notified 60 days before the due date of their renewal and given information about how to comply.
**2nd Notice:** If they have not complied they will receive a notice telling them their benefits will stop, the date they will stop and giving them appeal rights.
**3rd Notice:** AHCCCS will send another notice on the 25th of each month as a 3rd warning that AHCCCS Care members have until the end of that month to comply with the renewal process.

AHCCCS members can find their renewal dates on www.myahcccs.com. AHCCCS registered providers can obtain an AHCCCS Care members' renewal date through the provider portal on the AHCCCS website.

**What appeal rights will AHCCCS Care members have?**
If AHCCCS Care members lose their eligibility and they believe their eligibility was not determined correctly, they can ask for a hearing. If they request a hearing within 10 days their eligibility can be continued until the final decision is made.

**Alternative resources**
See: http://www.azahcccs.gov/community for ideas about helping people who are not eligible for AHCCCS Care or other AHCCCS programs.

**Attachment 10**

Comparison of SSI MAO Budgeting Methodology to AHCCCS Care

| | **AHCCCS Care** | **SSI-MAO** |
|---|---|---|
| Cash Program methodology | Title IV-A | Title XVI |
| Categorical link | No categorical link requirement. | Must be aged, blind or disabled. |
| Monthly income calculation | Income received more often than monthly is averaged and converted to a monthly amount.<br>Weekly income is multiplied by 4.3<br>Bi-weekly income is multiplied by 2.15 | Monthly income is based on actual income received and not converted. |
| Deductions | • $90 earned income deduction (per wage earner)<br>• Up to $200 per dependent for dependent care expenses. "Dependent" includes a minor child or incapacitated spouse. | <u>FBR Test (100% FBR)</u><br>• $20 General deduction<br>• $65 standard earned income deduction<br>• **1/2 earned income deduction**<br>• Child allocation*<br>• Student earned income deduction**<br><br><u>FPL Test (100% FPL)</u><br>• $20 General deduction<br>• $65 standard earned income deduction<br>• Child allocation*<br>• Student earned income deduction**<br><br>* Deduction per child of *up to* $337. If the child has countable income of his/her own, the deduction is reduced by the child's countable income.<br>** Deduction per student under age 22 of $1640 per month, up to a maximum of $6600 per year. |
| Due to different Cash Program methodologies, a few income types count differently | Examples:<br>• In-kind income – Counted<br>• Interest/dividends (if withdrawn) – Counted<br>• TANF payments - Excluded | Examples:<br>• In-kind income – Excluded<br>• Interest/dividends (if withdrawn) – Excluded<br>• TANF payments - Counted |
| Budgeting Methodology | <u>Sneede v. Kizer methodology</u><br>Net income after deductions is divided equally and allocated based on financial responsibility (spouse to spouse; parent to child).<br>Allocated income is compared to the income limit for a single person, or if married, to ½ the 2-person income limit. | Net income after deductions is compared to the income limit for a single person or couple as appropriate. |

**Attachment 11 Notice #9**

AHCCCS is Arizona's Medical Assistance

AHCCCS

# ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

## XIV. IMPORTANT NOTICE: YOU MUST COMPLETE YOUR RENEWAL FOR AHCCCS BY JUNE 30, 2011

You get AHCCCS Health Insurance through an AHCCCS program with an age limit of 19 or 21. You have reached the program's age limit. Your eligibility must be redetermined to see if you qualify for any other AHCCCS programs. One of these programs is AHCCCS Care. Due to the current budget crisis in Arizona, the State is planning to "freeze" new enrollment in the AHCCCS Care program beginning July 1, 2011. This means no new applications for the AHCCCS Care program will be accepted after July 1, 2011.

**To make sure that the AHCCCS Care program is available to you, you must complete your renewal application by June 30, 2011. If you do not complete your renewal application by June 30, 2011, and the program is "frozen" on July 1st, you will not be able to get on the AHCCCS Care program, even if you do not qualify for any other AHCCCS program.**

**To be able to get on AHCCCS Care, if you do not qualify for any other AHCCCS program, you must**:

- **Turn in a renewal application by June 30, 2011;**
- **Meet the eligibility requirements of the AHCCCS Care program; and**
- **Cooperate with all requests you receive from Department of Economic Security (DES) or AHCCCS staff.**

If you have already turned in a renewal application, please be sure to reply to any mail you get from DES or AHCCCS, and provide any proof requested.

This change only applies to the AHCCCS Care program. If you have family members on other AHCCCS programs, they still need to complete their renewal application. However, if they lose their AHCCCS coverage because they do not complete a renewal application, they may still be able to get back on other AHCCCS programs.

If you do not qualify for AHCCCS Care, you may be eligible under another AHCCCS program if you are:

- pregnant
- the parent of a deprived child under 18
- age 65 and older or
- have a disability.

If you lose coverage for AHCCCS Care, DES and AHCCCS will let you know how to apply for other AHCCCS programs. If you have specific questions, please contact your AHCCCS office or call DES at 602-542-9935 or 1-800-352-8401.

If you do lose coverage for AHCCCS and you are employed and your employer offers health insurance, under new federal law you may be able to enroll in your employer's insurance plan within 60 days of losing coverage under AHCCCS. You should contact your employer immediately if you lose your AHCCCS Care benefits.

**SEE IMPORTANT INFORMATION ON THE OTHER SIDE OF THIS NOTICE**

**Note:** This notice was already sent and reflects the original proposed enrollment freeze effective date of July 1, 2011. This notice will be sent every month to children whose redetermination date and birth date fall in the same month.

**Here are some other health care programs that may also be able to help you afford health care services if your AHCCCS Care benefits end:**

Community Health Centers
Phone: 602-253-0090
On the Web: www.aachc.org/associatemembersl.php

Health Care Connect
Maricopa County
Phone: 602-288-7564
On the Web: www.healthcareconnect.org/contactus.php

Pima Community Access Program (PCAP)
Pima and Santa Cruz County
Phone: 520-694-0418
On the Web: www.pcap.cc

Community Access Programs of Arizona and Mexico (CAPAZ-MEX)
Yuma County
Phone: 928-627-9222
On the Web: www.rcfbh.org/programCAPAZMEX

Pre-existing Condition Insurance Plan
Phone: 1-866-717-5826
On the Web: http://www.healthcare.gov/law/provisions/preexisting/states/az.html

**If you need free legal advice, call the following numbers:** Phoenix at 602-258-3434 (800-852-9075); Tucson at 520-623-9461 (800-248-6789); and Flagstaff at 928-774-0653 (800-789-5781). For persons in other parts of the state, call 1-866-637-5341 to find the nearest legal services office in your area.

Additional sources of free legal service can be found at these web sites:

http://apps.americanbar.org/legalservices/probono/directory/arizona.html

http://www.acdl.com/gettinghelp.html

If you have specific questions, please contact your Eligibility Specialist in your local DES or AHCCCS

office.

**Attachment #12 Notice #10**

AHCCCS is Arizona's Medical Assistance

AHCCCS

# ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

## XV. IMPORTANT NOTICE ABOUT YOUR AHCCCS ELIGIBILITY

You were getting AHCCCS Health Insurance through an AHCCCS program with an age limit of 19 or 21. When you reached that program's age limit, you were made eligible for the AHCCCS Care program.

Due to the current budget crisis in Arizona, the State has "frozen" new enrollment in the AHCCCS Care program beginning July 8, 2011. This means no new applications for the AHCCCS Care program will be accepted after July 8, 2011.

**People who are already on the AHCCCS Care program will still receive medical services from AHCCCS, but only as long as they stay eligible for the program.**

**If you lose coverage for the AHCCCS Care program because you no longer meet eligibility requirements, you will not be able to get back on the AHCCCS Care Program.**

**To keep your AHCCCS Care benefits, you must:**

- **Continue to meet the eligibility requirements of the AHCCCS Care program;**
- **Cooperate with all requests you receive from the Department of Economic Security (DES)or AHCCCS staff; and**
- **Complete your renewal when notified.**

If you do not qualify for AHCCCS Care, you still may be eligible for coverage under another AHCCCS program if you are:

- Pregnant;
- The parent of a deprived child under 18; or
- Have a disability.

If you lose coverage for AHCCCS Care, DES and AHCCCS will let you know how to apply for other AHCCCS programs. If you have specific questions, please contact your AHCCCS office or call DES at 602-542-9935 or 1-800-352-8401.

If you do lose coverage for AHCCCS and you are employed, and your employer offers health insurance, under new federal law you may be able to enroll in your employer's insurance plan within 60 days of losing coverage under AHCCCS. You should contact your employer immediately if you lose your AHCCCS Care benefits.

**SEE IMPORTANT INFORMATION ON THE OTHER SIDE OF THIS NOTICE**

**Here are some other health care programs that may also be able to help you afford health care services if your AHCCCS Care benefits end:**

Community Health Centers
Phone: 602-253-0090
On the Web: www.aachc.org/associatemembersl.php

Health Care Connect
Maricopa County
Phone: 602-288-7564
On the Web: www.healthcareconnect.org/contactus.php

Pima Community Access Program (PCAP)
Pima and Santa Cruz County
Phone: 520-694-0418
On the Web: www.pcap.cc

Community Access Programs of Arizona and Mexico (CAPAZ-MEX)
Yuma County
Phone: 928-627-9222
On the Web: www.rcfbh.org/programCAPAZMEX

Pre-existing Condition Insurance Plan
Phone: 1-866-717-5826
On the Web: http://www.healthcare.gov/law/provisions/preexisting/states/az.html

**If you need free legal advice, call the following numbers:** Phoenix at 602-258-3434 (800-852-9075); Tucson at 520-623-9461 (800-248-6789); and Flagstaff at 928-774-0653 (800-789-5781). For persons in other parts of the state, call 1-866-637-5341 to find the nearest legal services office in your area.

Additional sources of free legal service can be found at these web sites:

http://apps.americanbar.org/legalservices/probono/directory/arizona.html

http://www.acdl.com/gettinghelp.html

If you have specific questions, please contact your Eligibility Specialist in your local DES or AHCCCS office.

## Attachment B - Quarterly Report Guidelines

As written in STC paragraph 34, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 30 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include the budget neutrality monitoring workbook. An electronic copy of the report narrative and the Microsoft Excel budget neutrality monitoring workbook is provided.

**NARRATIVE REPORT FORMAT:**

**TITLE**

**Title Line One** – Arizona Health Care Cost Containment System -- AHCCCS, A Statewide Approach of Cost Effective Health Care Financing

**Title Line Two - Section 1115 Quarterly Report**

**Demonstration/Quarter Reporting Period:**

Example:
Demonstration Year: 5 (5/01/04 - 4/30/05)
Federal Fiscal Quarter: 4/2004 (7/04 - 9/04)

**INTRODUCTION:**

Information describing the goal of the Demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

**ENROLLMENT INFORMATION:**

Please complete the following table that outlines all enrollment activity under the Demonstration. The State should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by "0".

**Note:** Enrollment counts should be person counts, not participant months.

| **Population Groups (as hard coded in the CMS 64)** | **Current Enrollees** (to date) | **No. Voluntary Disenrolled in current Quarter** | **No. Involuntary Disenrolled in current Quarter** |
|---|---|---|---|
| **Population 1 – AFDC / SOBRA** | | | |
| **Population 2 - SSI** | | | |
| **Population 3 – ALTCS DD** | | | |
| **Etcetera** | | | |

Voluntary Disenrollments:
Cumulative Number of Voluntary Disenrollments Within Current Demonstration Year:
Reasons for Voluntary Disenrollments:

Involuntary Disenrollments:
Cumulative Number of Involuntary Disenrollments Within Current Demonstration Year:
Reasons for Involuntary Disenrollments:

**Outreach/Innovative Activities:**

Summarize outreach activities and/or promising practices for the current quarter.

**Operational/Policy Developments/Issues:**

Identify all significant program developments/issues/problems that have occurred in the current quarter.

**Financial/Budget Neutrality Developments/Issues:**

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the State's actions to address these issues.

**Consumer Issues:**

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken, or to be taken, to prevent other occurrences.

**Quality Assurance/Monitoring Activity:**

Identify any quality assurance/monitoring activity in current quarter.

**ESI Issues:**
Identify all significant program developments/issues/problems that have occurred in the current quarter.

**Family Planning Extension Program:**
Identify all significant program developments/issues/problems that have occurred in the current quarter, including the required data and information included in STC 34(d) and (e), including enrollment data requested that is not represented in the formatted tables.

**Enclosures/Attachments:**

Identify by title any attachments along with a brief description of what information the document contains.

**State Contact(s):**

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

***The State may also add additional program headings as applicable.***

**Date Submitted to CMS:**

## Attachment C – Evaluation Guidelines

Section 1115 demonstrations are valued for information on health services, health services delivery, health care delivery for uninsured populations, and other innovations that would not otherwise be part of Medicaid programs. CMS encourages States with demonstration programs to conduct or arrange for evaluations of the design, implementation, and/or outcomes of their demonstrations. The CMS also conducts evaluation activities.

The CMS believes that all parties to demonstrations; States, Federal Government, and individuals benefit from State conducted self-evaluations that include process and case-study evaluations—these would include, but are not limited to: 1) studies that document the design, development, implementation, and operational features of the demonstration, and 2) studies that document participant and applicant experiences that are gathered through surveys, quality assurance activities, grievances and appeals, and in-depth investigations of groups of participants and applicants and/or providers (focus groups, interviews, other). These are generally studies of short-term experiences and they provide value for quality assurance and quality improvements programs (QA/QI) that are part of quality assurance activities and/or demonstration refinements and enhancements.

Benefit also derives from studies of intermediate and longer-term investigations of the impact of the demonstration on health outcomes, self-assessments of health status, and/or quality of life. Studies such as these contribute to State and Federal formation and refinements of policies, statutes, and regulations.

States are encouraged to conduct short-term studies that are useful for QA/QI that contribute to operating quality demonstration programs. Should States have resources available after conducting these studies, they are encouraged to conduct outcome studies.

The following are criteria and content areas to be considered for inclusion in Evaluation Design Reports.

- Evaluation Plan Development - Describe how plan was or will be developed and maintained:
    - Use of experts through technical contracts or advisory bodies;
    - Use of techniques for determining interest and concerns of stakeholders (funding entities, administrators, providers, clients);
    - Selection of existing indicators or development of innovative indicators;
    - Types of studies to be included, such as Process Evaluations, Case-Studies and Outcome investigations;
    - Types of data collection and tools that will be used – for instance, participant and provider surveys and focus groups; collection of health service utilization; employment data; or, participant purchases of other sources of health care coverage; and, whether the data collection instruments will be existing or newly developed tools;
    - Incorporation of results through QA/QI activities into improving health service delivery; and

- Plans for implementation and consideration of ongoing refinement to the evaluation plan.

- Study Questions – Discuss:
  - Hypothesis or research questions to be investigated;
  - Goals, such as:
    - Increase Access
    - Cost Effectiveness
    - Improve Care Coordination
    - Increase Family Satisfaction and Stability
  - Outcome Measures, Indicators, and Data Sources

- Control Group and/or Sample Selection Discussion:
  - The type of research design(s) to be included -
    - Pre/Post Methodology
    - Quasi-Experimental
    - Experimental
  - Plans for Base-line Measures and Documentation – time period, outcome measures, indicators, and data sources that were used or will be used

- Data Collection Methods – Discuss the use of data sources such as:
  - Enrollment and outreach records;
  - Medicaid claims data;
  - Vital statistics data;
  - Provide record reviews;
  - School record reviews; and
  - Existing or custom surveys

- Relationship of Evaluation to Quality Assessment and Quality Improvement Activities– Discuss:
  - How evaluation activities and findings are shared with program designers, administrators, providers, outreach workers, etc., in order to refine or redesign operations;
  - How findings will be incorporated into outreach, enrollment and education activities;
  - How findings will be incorporated into provider relations such as provider standards, retention, recruitment, and education; and
  - How findings will be incorporated into grievance and appeal proceedings.

- Discuss additional points as merited by interest of the State and/or relevance to nuances of the demonstration intervention.

**ATTACHMENT D**
**AHCCCS DISPROPORTIONATE SHARE HOSPITAL PROGRAM**
**DSH 102**

Congress established the Medicaid Disproportionate Share Hospital (DSH) program in 1981 to provide financial support to hospitals that serve a significant number of low-income patients with special needs.

This document sets forth the criteria by which Arizona defines DSH hospitals and the methodology through which DSH payments are calculated and distributed. The document is divided into the following major topics:

- Hospital eligibility requirements
- Data on a State Plan Year Basis
- Timing of eligibility determination
- Medicaid Inpatient Utilization Rate (MIUR) calculation (Overall and Group 1 eligibility)
- Low Income Utilization Rate (LIUR) calculation (Group 2 eligibility)
- Governmentally-operated hospitals (Group 4 eligibility)
- Obstetrician Requirements
- Payment
- Aggregate Limits
- Reconciliations
- Certified Public Expenditures (CPEs)
- Grievances and appeals
- Other provisions

## Eligibility Requirements

In order to be considered a DSH hospital in Arizona, a hospital must be located in the state of Arizona, must submit the information required by AHCCCS by the specified due date, must satisfy one (1) of the conditions in Column A, AND must satisfy one (1) of the conditions in Column B, AND must satisfy the condition in Column C.

| COLUMN A | COLUMN B | COLUMN C |
|---|---|---|
| 1. The hospital has a Medicaid Inpatient Utilization Rate (MIUR) which is at least one standard deviation above the mean MIUR for all hospitals receiving a Medicaid payment in the state (“Group 1”) | 1. The hospital has at least two (2) obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid patients<br>2. The hospital is outside a Metropolitan Statistical | The hospital has an MIUR of at least 1 percent |

| | | |
|---|---|---|
| 1.A. The hospital meets all of the requirements of 1 above (Group 1) and is a privately owned or privately operated hospital licensed by the State of Arizona ("Group 1A")<br>2. The hospital has a Low Income Utilization Rate (LIUR) that exceeds 25% ("Group 2")<br>2.A. The hospital meets all of the requirements of 2 above (Group 2) and is a privately owned or privately operated hospital licensed by the State of Arizona ("Group 2A")<br>3. The hospital is a governmentally-operated hospital ("Group 4") | Area and has at least two (2) physicians with staff privileges to perform non-emergency obstetric procedures<br>3. The patients of the hospital are predominantly under 18 years of age<br>4. The hospital was in existence on December 22, 1987 but did not offer non-emergency obstetric services as of that date | |

Notice that within Column A, there are six group numbers assigned. Group 1 and Group 2 contain those hospitals that are "deemed" to be DSH hospitals under federal Medicaid law. Group 1A, Group 2A, and Group 4 contain additional hospitals that the state has designated to be DSH hospitals within its federal authority to do so. The criteria listed in Columns B and C are federal eligibility requirements which apply regardless of whether or not the hospital is deemed or designated as a DSH hospital.

- In Group 4, the term "governmentally-operated hospital" refers to a hospital provider which under federal law is able to participate in the financing of the non-federal portion of medical assistance expenditures. A governmentally-operated hospital is differentiated herein from "non-governmental", "non-public", "private", "privately operated" or "privately owned" hospitals as well as IHS or tribal or 638 hospitals and facilities as well as other federally owned or operated facilities.

Medicare Certification

In addition to the eligibility requirements outlined above, in order to receive payment under Medicaid, hospitals must meet the requirements for participation as a hospital in Medicare (except in the case of medical supervision of nurse-midwife services). Therefore, for purposes of DSH, the facility must be Medicare-certified during the state plan rate year for which the initial

DSH payment is made.

If a facility is Medicare-certified for the full state plan rate year for which the initial DSH payment is made, but subsequently loses that certification, the facility remains eligible to receive the payment (together with any payment adjustments). If a hospital is only Medicare-certified for part of the state plan rate year for which the initial DSH payment is made, the eligibility and the payment will be calculated based on the period for which the hospital was Medicare-certified.

**Data on a State Plan Year Basis**

DSH payments are made based on the State Plan Rate Year. The State Plan Rate Year (or State Plan Year or SPY) is equivalent to the Federal Fiscal Year and runs from October 1 to September 30 of each year. The calculations to determine eligibility for, and the amount of, DSH payments, will be made on the basis of the State Plan Year. This requirement will impact the information collected and submitted by all hospitals that do not have a fiscal year and/or CMS 2552 Report year that runs from 10/1 to 9/30.

In order to make the necessary calculations to determine eligibility and payments on a State Plan Year basis, hospitals that do not have a fiscal/CMS Report year that runs from 10/1 to 9/30 will have to submit cost reports and other data elements for each of the fiscal/CMS Report years that encompass the State Plan Year. For example, for SPY 2008 (10/1/07 to 9/30/08), for a hospital that has a CMS 2552 Report year that runs from 7/1 to 6/30, the hospital will have to submit the CMS 2552 Report and other data elements for the fiscal/CMS Report year that ends on 6/30/08 and the same information for the fiscal/CMS Report year that ends 6/30/09.[2]

As discussed later in this Attachment, AHCCCS will extract all Title XIX (Medicaid) claims and encounters from the PMMIS system on the basis of each hospital's CMS 2552 Report year and these data will serve as the basis for all Medicaid days, charges and payments. Similarly, AHCCCS will collect and distribute to hospitals all Medicaid supplemental payments (e.g. GME, Critical Access Hospitals (CAH), Rural Inpatient Payments) and Non-Title XIX payments (for Children Rehabilitative Services, the Comprehensive Medical and Dental Program, Behavioral Health Services and Payments for Trauma and Emergency Departments) on the basis of each hospital's CMS 2552 Report year.

All data compiled by the hospitals (e.g. total, uninsured and charity days; charges and payments; and state and local subsidy payment information not provided by AHCCCS) will be compiled on a CMS 2552 Report year basis.

---

[2] Note however that the use of the 2008 and 2009 reports and information referred to in this paragraph is for the determination of *final* DSH payments. For the initial 2008 DSH payments, reports and information for 2006 and 2007 will be submitted. For a discussion of initial payments, final payments and data sources, see the discussions that follow.

Except in the case where a hospital's fiscal year is identical to the State Plan Year – the calculations to determine eligibility for, and the amount of, DSH payments, will be performed separately for each hospital's fiscal year and these results will be prorated based on the distribution of months from each of the two years that encompass the SPY. For example, for SPY 2008 (10/1/07 to 9/30/08), for a hospital that has a CMS 2552 Report year that runs from 7/1 to 6/30, the proration of the results of the calculations will be derived by summing:

1. 9/12th of the result of the calculations performed for the fiscal/CMS Report year ending 6/30/08, and
2. 3/12th of the result of the calculations performed for the fiscal/CMS Report year ending 6/30/09.

**Timing of Eligibility Determination**

The eligibility determination calculations will be performed annually for all hospitals located in the State of Arizona that are registered as providers with AHCCCS. Eligibility calculations will be performed only with and for hospitals that have submitted the information required by this document and/or as otherwise requested by AHCCCS. In order to be considered "submitted", the information must be received by AHCCCS by the due date specified in a request for information communicated to the Chief Financial Officer of the hospital. The calculations will be performed with the information submitted by, or available to AHCCCS on the due date specified as the deadline for the submission of information.

The eligibility determination will be made in at least two steps:

1. The first step of the eligibility process will occur in the state plan rate year of the initial DSH payment. To determine initial eligibility, AHCCCS will:
    a. Extract from the PMMIS system all inpatient and outpatient hospital claims and encounters by date of service for each registered hospital for that hospital's fiscal years that encompass the state plan rate year two years prior to the state plan year of the initial DSH payment.
    b. Based on the extracted claims and encounters data and data provided by the hospitals, determine for each hospital whether or not that hospital has a Medicaid Inpatient Utilization Rate (MIUR) of at least 1%. For hospitals that qualify under this criteria, determine if the hospital:
        i. Meets the criteria for Group 1
        ii. Meets the criteria for Group 1A
        iii. Meets the criteria for Group 2
        iv. Meets the criteria for Group 2A
        v. Meets the criteria for Group 4
    c. Based on certifications filed by each hospital, determine if the hospital satisfies the criteria in Column B above.

2. The second step of the eligibility process will occur in the state plan rate year two years after the state plan rate year of the initial DSH payment. To determine final eligibility, AHCCCS will:
    a. Extract from the PMMIS system all inpatient and outpatient hospital claims and encounters by date of service for each registered hospital for that hospital's fiscal years that encompass the state plan rate year of the initial DSH payment.
    b. Based on the extracted claims and encounters data and data provided by the hospitals determine for each hospital whether or not that hospital has a MIUR of at least 1%. For hospitals that qualify under this criteria, determine if the hospital:
        i. Meets the criteria for Group 1
        ii. Meets the criteria for Group 1A
        iii. Meets the criteria for Group 2
        iv. Meets the criteria for Group 2A
        v. Meets the criteria for Group 4
    c. Based on certifications filed by each hospital, determine if the hospital satisfies the criteria in Column B above.

3. AHCCCS may redetermine any hospital's eligibility for any DSH payment should the agency become aware of any information that may prove that the hospital was not eligible for a DSH payment.

**MIUR Calculation (Overall Eligibility Criteria and Group 1 and Group 1A Eligibility)**

A hospital's Medicaid Inpatient Utilization Rate (MIUR) will determine the hospital's overall eligibility for DSH (Column C above) as well as the hospital's eligibility for Group 1 and Group 1A. A hospital's MIUR is calculated using the following equation:

$$\boxed{MIUR = \frac{Total\ Medicaid\ Inpatient\ Days}{Total\ Number\ of\ Inpatient\ Days}}$$

The calculation will be performed based on the state plan rate year. In order to find each hospital's MIUR for the state plan year, AHCCCS will calculate a MIUR separately for each hospital fiscal/CMS Report year that encompasses the relevant State Plan Year and then prorate the results from the two hospital fiscal/CMS Report years as described in the discussion above entitled "Data on a State Plan Year Basis".

If a hospital has a MIUR of at least 1%, and the obstetrical criteria of Column B above are satisfied, it will meet the overall eligibility criteria. If a hospital has a MIUR which is at least one standard deviation above the mean MIUR for all Arizona hospitals receiving a Medicaid payment in that State Plan Year, it will meet the eligibility for Group 1. If a hospital meets the eligibility criteria for Group 1 and is a privately owned or privately operated hospital licensed by the State of Arizona, it will meet the eligibility for Group 1A. NOTE that meeting overall eligibility criteria does not ensure that a hospital will meet the eligibility criteria for any Group.

In performing the calculations:

1. "Inpatient Days" includes:
    a. Fee-for-service and managed care days, and
    b. Each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward, and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

2. "Medicaid Inpatient Days" includes:
    a. All adjudicated inpatient days for categorically eligible Title XIX clients including days paid by Medicare except as noted below
    b. All adjudicated inpatient days for Demonstration eligible Title XIX clients – that is clients that are eligible for Title XIX including days paid by Medicare and days funded by Title XXI except as noted below

3. "Medicaid Inpatient Days" does not include:
    a. Inpatient days in which a categorically or Demonstration eligible Title XIX client was in an Institution for Mental Disease (IMD) and the client was between 21 and 65 years of age

*Data Sources for MIUR Calculations*

1. For "Medicaid Inpatient Days" the PMMIS claims and encounters
    a. For the initial determination of a hospital's MIUR, extracted based on date of service for the hospital's fiscal/CMS Report years that encompass the state plan rate year that ends two years prior to the state plan rate year of the initial DSH payment.
    b. For the second determination of a hospital's MIUR, extracted based on date of service for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.

2. For "Total Number of Inpatient Days" the CMS 2552-96
    a. For the initial determination of a hospital's MIUR, the cost report (or reports) for the hospital that encompass the state plan rate year two years prior to the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet S-3, Lines 1 and 6 through 11, Column 6 plus Line 14, Column 6 for hospital subprovider days. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.
    b. For the second determination of a hospital's MIUR, the cost report(s) for the hospital that encompass the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet S-3, Lines 1 and 6 through 11, Column 6 plus Line 14, Column 6 for hospital subprovider days. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-

96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.

*Calculation of the mean MIUR and the Standard Deviation*

In calculating the mean MIUR, the MIUR calculated for the state plan year for all Arizona hospitals that have received a Medicaid payment will be used. The mean MIUR – the average of the individual MIURs – will be calculated based on all the individual state plan year MIURs greater than zero (i.e. including the MIURs that are less than 1%). The standard deviation will be calculated based on the same list of individual hospital MIURs.

**LIUR Calculation (Group 2 Eligibility)**

A hospital's Low Income Utilization Rate (LIUR) will determine the hospital's eligibility for Group 2. A hospital's LIUR is calculated by summing the following two equations:

$$LIUR = \frac{Total\ Medicaid\ Patient\ Services\ Charges + Total\ State\ and\ Local\ Cash\ Subsidies\ for\ Patient\ Services}{Total\ Charges\ for\ Patient\ Services}$$

$$+$$

$$\frac{Total\ Inpatient\ Charges\ Attributable\ to\ Charity\ Care - Cash\ Subsidies\ Portion\ Attributable\ to\ Inpatient}{Total\ Inpatient\ Charges}$$

The calculation will be performed based on the state plan rate year. In order to find each hospital's LIUR for the state plan year, AHCCCS will calculate a LIUR separately for each hospital fiscal/CMS Report year that encompasses the relevant State Plan Year and then prorate the results from the two hospital fiscal/CMS Report years as described in the discussion above entitled "Data on a State Plan Year Basis".

If a hospital has a LIUR that exceeds 25% it will meet the eligibility for Group 2. If a hospital meets the eligibility criteria for Group 2 and is a privately owned or privately operated hospital licensed by the State of Arizona, it will meet the eligibility for Group 2A.

In performing the calculations:

1. "Total Medicaid Patient Services Charges" includes Title XIX charges for inpatient and outpatient services (both fee-for-service and managed care)

2. "Total Medicaid Patient Services Charges" does not include DSH payments or payments made for GME, Critical Access Hospitals, Rural Inpatient Payments or any other TXIX supplemental payments authorized by the Legislature as these amounts are effectively included in charges

3. "Total State and Local Cash Subsidies for Patient Services" includes payments made with state-only or local-only funds and includes, but is not limited to
    a. Payments made for:
        i. Non-Title XIX and Non-Title XXI enrollees in the DES Comprehensive Medical and Dental Program
        ii. Non-Title XIX and Non-Title XXI enrollees in the DHS Children's Rehabilitative Services program
        iii. Non-Title XIX and Non-Title XXI enrollees in the DHS Behavioral Health Services Program (note that these payments are typically made through Regional Behavioral Health Authorities)
        iv. The support of trauma centers and emergency departments
    b. Payments made by:
        i. An appropriation of state-only funds
        ii. The Arizona State Hospital
        iii. Local governments including (but not limited to):
            (1) Tax levies dedicated to support a governmentally-operated hospital
            (2) Tax levies from a hospital district organized pursuant to A.R.S. § 48-1901 et seq.
            (3) Subsidies for the general support of a hospital

4. "Total State and Local Cash Subsidies for Patient Services" does not include payments for or by:
    a. Inpatient or outpatient services for employees of state or local governments
    b. Governmentally-operated AHCCCS health plans or program contractors
    c. Tax reductions or abatements

5. "Total Charges for Patient Services" includes total gross patient revenue for hospital services (including hospital subprovider charges).

6. "Total Inpatient Charges Attributable to Charity Care" includes the amount of inpatient services – stated as charges – that is provided free to individuals who cannot afford health care due to inadequate resources as determined by the hospital's charity care policy and do not otherwise qualify for government subsidized insurance. In order to qualify as charity care, payment may neither be received nor expected.

7. "Total Inpatient Charges Attributable to Charity Care" does not include bad debt expense or contract allowances and discounts offered to third party payors or self pay patients that do not qualify for charity care pursuant to the hospital's charity care policy.

8. "Cash Subsidies Portion Attributable to Inpatient" means that portion of "Total State and Local Cash Subsidies for Patient Services" that is attributable to inpatient services.

9. "Total Inpatient Charges" includes total inpatient and hospital subprovider charges without any deductions for contract allowances or discounts offered to third party payors or self pay patients.

*Data Sources for LIUR Calculations*

1. For "Total Medicaid Patient Services Charges":
    a. For the initial determination of a hospital's LIUR:
        i. The PMMIS claims and encounters extracted based on date of service for each registered hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the year of the initial DSH payment.
    b. For the second determination of a hospital's LIUR:
        i. The PMMIS claims and encounters extracted based on date of service for each registered hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.

2. For the portion of "Total State and Local Cash Subsidies for Patient Services" and "Cash Subsidies Portion Attributable to Inpatient" attributed to Non-Title XIX and Non-Title XXI payments for the CMDP, CRS or Behavioral Health programs and for the payments in support of trauma centers and emergency departments:
    a. For the initial determination of a hospital's LIUR:
        i. AHCCCS will provide to hospitals the amounts of such payments made during the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the year of the initial DSH payment based on data from its financial records or from the financial records of the state agencies making the payments.
    b. For the second determination of a hospital's LIUR:
        i. AHCCCS will provide to hospitals the amounts of such payments made during the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment based on data from its financial records or from the financial records of the state agencies making the payments.
    c. In the case of CRS payments, if AHCCCS does not provide a breakdown of inpatient and outpatient payments, the hospital shall allocate the CRS payments between outpatient and inpatient based on the percentage of total inpatient charges to total charges for patient services

3. For all other "Total State and Local Cash Subsidies for Patient Services" and "Cash Subsidies Portion Attributable to Inpatient":
    a. For the initial determination of a hospital's LIUR:
        i. The hospital financial records for the payments received during the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the year of the initial DSH payment.
    b. For the second determination of a hospital's LIUR:
        i. The hospital financial records for the payments received during the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.

c. In the case of "Cash Subsidies Portion Attributable to Inpatient", if the hospital receives subsidies for the general operation of the hospital, allocation between outpatient and inpatient should be based on the percentage of total inpatient charges to total charges from patient services.

4. For "Total Inpatient Charges Attributable to Charity Care":
    a. For the initial determination of a hospital's LIUR:
        i. The hospital claims and financial records for the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the year of the initial DSH payment.
    b. For the second determination of a hospital's LIUR:
        i. The hospital claims and financial records for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.

5. For "Total Inpatient Charges":
    a. For the initial determination of a hospital's LIUR, the cost report (or reports) for the hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet C Part 1, Column 6 Line 101 less Lines 34 to 36, less Lines 63.5 to 63.99, and less Lines 64 to 68. If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted from Line 101. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.
    b. For the second determination of a hospital's LIUR, the cost report(s) for the hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet C Part 1, Column 6 Line 101 less Lines 34 to 36, less Lines 63.5 to 63.99, and less Lines 64 to 68. If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted from Line 101. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.

6. For "Total Charges for Patient Services":
    a. For the initial determination of a hospital's LIUR, the cost report (or reports) for the hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet C Part 1, Column 8 Line 101 less Lines 34 to 36, less Lines 63.5 to 63.99, and less Lines 64 to 68.

If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted from Line 101. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.

b. For the second determination of a hospital's LIUR, the cost report(s) for the hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet C Part 1, Column 8 Line 101 less Lines 34 to 36, less Lines 63.5 to 63.99, and less Lines 64 to 68. If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted from Line 101. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.

**Group 4 Eligibility Determination – Governmentally-operated Hospitals**

Because the state has designated all governmentally-operated hospitals (represented in Group 4) as DSH hospitals, no eligibility calculations are required.

**Obstetrician Requirements**

In order to ensure that hospitals receiving DSH payments meet requirements related to obstetricians, all hospitals that are determined to have a MIUR of at least 1% must file a completed certification statement indicating their compliance with the requirements. Any hospital that fails to return the certification statement by the date specified by AHCCCS will not be eligible to receive DSH payments for the state plan rate year of the initial DSH payment.

For the determination of a hospital's compliance with the obstetrician requirement, the certification will be based on the state plan rate year of the initial DSH payment from the start of the state plan rate year to the date of certification.

The certification statement shall incorporate the following language:

> I certify that the hospital indicated below currently has and has had since the beginning of the current state plan year at least two (2) obstetricians with staff privileges who have agreed to provide obstetric services to individuals eligible for Medicaid, OR
>
> I certify that the hospital indicated below is located in a rural area and currently has and

has had since the beginning of the current state plan year at least two (2) qualified physicians with staff privileges who have agreed to provide non-emergency obstetric services to individuals eligible for Medicaid, OR

I certify that the hospital indicated below did not offer non-emergency obstetric services to the general population as of December 22, 1987, or that the inpatients of the hospital are predominantly individuals under 18 years of age.

**Payment**

Pools and Changing Payment Levels

The DSH program in Arizona is funded through a six pool system. Each of the pools correlates to one of the hospital eligibility Groups. Therefore, there are five non-governmental hospital pools and one governmental hospital pool. The non-governmental hospital pool amounts are set by AHCCCS as authorized by the Arizona Legislature; the governmental pool amount is established by the Arizona Legislature. The amounts of funding for the pools for the current state plan year are contained in Exhibit 3.

If a non-governmental hospital qualifies for pool 1A it will be removed from pool 1. Similarly, if a non-governmental hospital qualifies for pool 2A it will be removed from pool 2. The non-governmental hospitals in pool 1 and pool 2 will be considered as a group and if a non-governmental hospital qualifies for more than one pool, the hospital will be categorized into the pool that maximizes its DSH payment. The non-governmental hospitals in pool 1A and 2A will be considered as a group, and if a non-governmental hospital qualifies for more than one pool, the hospital will be categorized into the pool that maximizes its DSH payment. The payment amount to each non-governmental hospital will be determined based on the maximization process performed during the state plan rate year of the initial DSH payment. The maximization process will be performed separately for 1) the non-governmental hospitals that qualify for pools 1 and 2, and; 2) the non-governmental hospitals that qualify for pools 1A and 2A.

There are five instances where the initial DSH payment to one or more non-governmental hospitals may change:

1. A hospital is found on the second eligibility determination (or any subsequent eligibility check) to not be eligible for a DSH payment in the state plan rate year of the initial DSH payment. In this instance, the amount of payment to the hospital will be recouped and the recouped amount will be distributed proportionately based on the initial DSH payments to the eligible hospitals remaining in the pool in which the ineligible hospital was placed in the state plan rate year of the initial DSH payment, up to each hospital's OBRA limit (see discussion below).

2. A hospital is found to have exceeded its finalized OBRA limit (see discussions below). In this instance, the amount of payment to the hospital in excess of its finalized OBRA limit will be recouped, and the recouped amount will be distributed proportionately based

on the initial DSH payments to the eligible hospitals remaining in the pool in which the hospital was placed in the state plan rate year of the initial DSH payment, up to each hospital's finalized OBRA limit.

3. In the event of a recoupment of an initial DSH payment and as a result of the process of distributing the recoupment to the pool to which the recouped payment was originally made, the distribution would result in all the hospitals in the pool receiving a total DSH payment in excess of their finalized OBRA limit, the amount of recoupment will be proportionately allocated among the remaining non-governmental hospital pools based on the initial DSH payments and distributed proportionately based on the initial DSH payments to the hospitals in the remaining pools up to each hospital's finalized OBRA limit.

4. In the event that litigation (either by court order or settlement), or a CMS audit, financial review, or proposed disallowance requires AHCCCS to issue DSH payment amounts to one or more hospitals in a pool in excess of the initial DSH payment amount, AHCCCS will proportionately recoup funds based on the initial DSH payments from the remaining hospitals in the pool or pools effected to satisfy the requirement. This process will be followed to ensure that the annual federal DSH allotment is not exceeded.

5. In the event that a hospital qualifies for a DSH payment in the second (or any subsequent) eligibility determination that did not qualify in the initial eligibility determination, that hospital will receive the minimum payment under the DSH program which is $5,000.

The payment amount to each governmentally-operated hospital will be determined during the state plan rate year of the initial DSH payment. The payment amount will only change if the total DSH payment to a hospital in the pool would be in excess of its finalized OBRA limit (see discussion below). To the extent that the excess amount recouped from a governmentally-operated hospital can be distributed to other hospitals in the pool without exceeding the interim or finalized OBRA limits of the remaining governmentally-operated hospitals, the excess amount will be distributed to the other governmentally-operated hospitals.

<u>Determination of Payment Amounts</u>

The amount that each non-governmental hospital receives as an initial DSH payment from the pool for which it qualifies is determined by a weighting method that considers both the amounts/points over the Group threshold and the volume of services. The volume of services is either measured by Title XIX days or net inpatient revenue, depending upon the group being considered.

*Hospitals that only qualify for Group 1 or Group 2*

There are ten steps to determining the DSH payment amount for non-governmental hospitals that only qualify for Group 1 or Group 2 (and not Group 1A or 2A). After determining the initial DSH payment amount through the ten step process, there is a final adjustment that may be made depending on the result of the hospital's OBRA limit.

1. Determine Points Exceeding Threshold.
   Each of the Groups 1 and 2 has thresholds established for qualification of the hospital. For Group 1 it is one standard deviation above the mean MIUR; for Group 2 it is greater than 25% LIUR. Step 1 merely determines the difference between each hospital's "score" for the Group measure and that Group's threshold.

2. Convert Points Exceeding Threshold into a Value.
   Each of the Groups 1 and 2 are measuring a value: for Group 1 the value is Medicaid days; for Group 2 it is revenue. Step 2 multiplies the Points Exceeding Threshold by the value of the associated Group.

3. Determine Relative Weight of Each Hospital in Each Group.
   The relative weight of each hospital in each Group is determined by dividing each hospital's value for a Group determined in Step 2 by the total of all hospital values for that Group.

4. Initial Allocation of Dollars to Each Hospital in Each Group.
   The amount of funds available to each of the Groups 1 and 2 is determined by AHCCCS as authorized by the Legislature. The funding amount for the current state plan year is contained in Exhibit 3. The initial allocation to each hospital in each group is determined by multiplying each hospital's relative weight in a Group (determined in Step 3) by the amount of funds available for that Group.

5. Maximize Allocation of Dollars Between Group 1 and Group 2.
   This step selects the greater of the allocation to each hospital between Group 1 and Group 2.

6. Recalculating the Relative Weights of Each Hospital in Group 1 and Group 2.
   Since Step 5 eliminated hospitals from both Group 1 and Group 2, it is necessary to redetermine the weight for each remaining hospital. This is accomplished by dividing the value of each hospital remaining in Group 1 and Group 2 after Step 5 by the total of the remaining hospitals.

7. Second Allocation of Dollars Within Group 1 and Group 2.
   The second allocation to each hospital remaining in Group 1 and Group 2 is determined by multiplying each hospital's recalculated relative weight pursuant to Step 6 by the amount of funds available for that Group.

8. Identifying Minimum Payment.
   It is policy that the minimum payment made to any hospital qualifying for DSH is $5,000. This step identifies any amount thus far determined for any hospital that is less than $5,000.

9. Ensuring Minimum Payment.
   This step replaces any amount thus far determined for any hospital that is less than

$5,000 with a $5,000 amount.

10. Determining Penultimate Payment Amount.
    With the replacement of values with the $5,000 minimum amounts, it is necessary to recalculate and redistribute the values within any Group where the minimum payment amount was imposed in order to ensure that the total funding for a Group is not exceeded. Step 10 accomplishes this.

After determining the penultimate initial DSH payment amount for each non-governmental hospital that only qualifies for Group 1 or Group 2 (and not Group 1A or 2A) a check of the determined amount is made against the hospital's initial OBRA limit. The description of that limit follows in a subsequent section. If the initial DSH payment amount exceeds the initial OBRA limit, the initial DSH amount is set to the OBRA limit and the excess amount is distributed to the remaining hospitals in the group, with a recheck of the initial DSH amounts against the OBRA limit. This process is repeated until all amounts are distributed or all hospitals in the group are at their OBRA limit.

*Hospitals that qualify for Group 1A or Group 2A*

There are thirteen steps to determining the DSH payment amount for non-governmental hospitals that qualify for Group 1A or 2A . After determining the initial DSH payment amount through the thirteen step process, there is a final adjustment that may be made depending on the result of the hospital's OBRA limit.

1. Determine Points Exceeding Threshold.
   Each of the Groups 1A or 2A has thresholds established for qualification of the hospital. For Group 1A it is one standard deviation above the mean MIUR; for Group 2A it is greater than 25% LIUR. Step 1 merely determines the difference between each hospital's "score" for the Group measure and that Group's threshold.

2. Convert Points Exceeding Threshold into a Value.
   Each of the Groups 1A and 2A are measuring a value: for Group 1A the value is Medicaid days; for Group 2A it is revenue.; Step 2 multiplies the Points Exceeding Threshold by the value of the associated Group.

3. Determine Relative Weight of Each Hospital in Each Group.
   The relative weight of each hospital in each Group is determined by dividing each hospital's value for a Group determined in Step 2 by the total of all hospital values for that Group.

4. Initial Allocation of Dollars to Each Hospital in Each Group.
   The amount of funds available to each of the Groups 1A and 2A is determined by AHCCCS as authorized by the Legislature. The funding amount for the current state plan year is contained in Exhibit 3. The initial allocation to each hospital in each group is determined by multiplying each hospital's relative weight in a Group (determined in Step 3) by the amount of funds available for that Group.

5. Maximize Allocation of Dollars Between Group 1A and Group 2A.
   This step selects the greater of the allocation to each hospital between Group 1A and Group 2A.

6. Recalculating the Relative Weights of Each Hospital in Group 1A and Group 2A.
   Since Step 5 eliminated hospitals from both Group 1A and Group 2A, it is necessary to redetermine the weight for each remaining hospital. This is accomplished by dividing the value of each hospital remaining in Group 1A and Group 2A after Step 5 by the total of the remaining hospitals.

7. Second Allocation of Dollars Within Group 1A and Group 2A.
   The second allocation to each hospital remaining in Group 1A and Group 2A is determined by multiplying each hospital's recalculated relative weight pursuant to Step 6 by the amount of funds available for that Group.

8. Identifying Minimum Payment.
   It is policy that the minimum payment made to any hospital qualifying for DSH is $5,000. This step identifies any amount thus far determined for any hospital that is less than $5,000.

9. Ensuring Minimum Payment.
   This step replaces any amount thus far determined for any hospital that is less than $5,000 with a $5,000 amount.

10. Determining Penultimate Payment Amount.
    With the replacement of values with the $5,000 minimum amounts, it is necessary to recalculate and redistribute the values within any Group where the minimum payment amount was imposed in order to ensure that the total funding for a Group is not exceeded.

After determining the penultimate initial DSH payment amount for each non-governmental hospital that qualifies for Group 1A or 2A a check of the determined amount is made against the hospital's initial OBRA limit. The description of that limit follows in the next section. If the initial DSH payment amount exceeds the initial OBRA limit, the initial DSH amount is set to the OBRA limit and the excess amount is distributed to the remaining hospitals in the group, with a recheck of the initial DSH amounts against the OBRA limit. This process is repeated until all amounts are distributed or all hospitals in the group are at their OBRA limit.

*Hospitals that qualify for Group 4*

To determine the initial DSH payment amount for each governmentally-operated hospital, the relative allocation percentage for each hospital is computed based on the lesser of the hospital's CPE and the amount of funding specified by the Legislature. The funding amount for the current state plan year is contained in Exhibit 3.

OBRA Limits

The DSH payment ultimately received by qualifying non-governmental hospitals is the *lesser* of the amount calculated pursuant to the above-described methodologies or the hospital's OBRA limit. The DSH payment ultimately received by governmentally-operated hospitals is the *lesser* of the amount funded and specified by the Legislature or the hospital's finalized OBRA limit. All DSH payments are subject to the federal DSH allotment.

The OBRA limit is calculated using the following equation:

$$\boxed{\begin{array}{l}\textit{Uncompensated Care Costs Incurred Serving Medicaid Recipients} + \\ \textit{Uncompensated Care Costs Incurred Serving the Uninsured}\end{array}}$$

Pursuant to the above equation, the OBRA limit is comprised of two components:

1. The amount of uncompensated care costs associated with providing inpatient and outpatient hospital services to Medicaid individuals (the Medicaid shortfall), and
2. The amount of uncompensated care costs associated with providing inpatient and outpatient hospital services to individuals with no source of third party coverage for the inpatient and outpatient hospital services they received (uninsured costs).

The OBRA limit for the state plan rate year of the initial DSH payment will be computed for each hospital up to three times:

1. The OBRA limit will be calculated in the state plan rate year of the initial DSH payment for all eligible hospitals based on the cost report(s) and days and charges and other program data for the state plan rate year two years prior to the state plan rate year of the initial DSH payment
2. For governmentally-operated hospitals, the OBRA limit will be recalculated when the cost report for the state plan rate year of the initial DSH payment is filed
3. The final calculation of each hospital's OBRA limit will be performed when the cost report for the state plan rate year of the initial DSH payment is finalized

The steps to computing the OBRA limit are[3]:

1. The hospital shall prepare its CMS 2552 Report (cost report(s)). Each hospital must complete the cost report to determine per diems (for inpatient routine services) and ratios of cost to charges (RCC) (for ancillary services). The cost reports must be completed

[3] Note: The following discussion applies to hospitals that do not have a per diem ancillary allocation methodology approved by Medicare. For the steps to calculate the OBRA limit for governmental hospitals that do have such approval, see Exhibit 2 to this Attachment D. Non-governmental hospitals that have such approval should contact AHCCCS for further information.

based on Medicare cost principles and Medicare cost allocation process as specified in the CMS 2552 instructions and the CMS Provider Reimbursement Manual, volumes 15-1 and 15-2, including updates.
2. Medicaid shortfall will be calculated based on information available from PMMIS, other AHCCCS financial systems, and the cost report.
3. Uninsured costs will be calculated based on uninsured days and charges and other program data collected by each hospital from its claims and financial records, other systems, and the cost report.

The sum of each hospital's Medicaid shortfall (whether positive or negative) and uninsured costs (whether positive or negative) is that hospital's OBRA limit.

The Medicaid Shortfall

The data used to calculate the Medicaid shortfall is extracted from the cost report(s) as well as from the AHCCCS PMMIS system and other AHCCCS financial reporting systems. The Medicaid shortfall will be calculated for each hospital for each fiscal/CMS Report year that encompasses the state plan year. The resulting Medicaid shortfall for each fiscal/CMS Report year will be prorated to derive the state plan year Medicaid shortfall according to the above discussion entitled "Data on a State Plan Year Basis".

The information from AHCCCS will include, but not be limited to:

1. The number of Medicaid fee for service (FFS) inpatient hospital days (for governmentally-operated hospitals this will be accumulated for each inpatient routine service cost center on the cost report)
2. The number of Medicaid managed care inpatient hospital days (for governmentally-operated hospitals this will be accumulated for each inpatient routine service cost center on the cost report)
3. The Medicaid inpatient and outpatient hospital FFS charges for ancillary cost centers (for governmentally-operated hospitals this will be accumulated separately for each ancillary cost center on the cost report)
4. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital FFS services
5. The amounts of Medicaid payments made by AHCCCS for inpatient and outpatient hospital FFS services
6. The Medicaid inpatient and outpatient hospital managed care charges for ancillary cost centers (for governmentally-operated hospitals this will be accumulated separately for each ancillary cost center on the cost report)
7. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services for health plans and program contractors
8. The amounts of Medicaid payments made by health plans and program contractors for inpatient and outpatient hospital services for health plans and program contractors
9. Other amounts of Medicaid payments for Medicaid inpatient and outpatient services furnished during the Medicaid state plan rate year under review (e.g. GME, CAH, etc.)

For each hospital, the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report will be applied to the data extracted from PMMIS (days and charges) to determine the cost of providing inpatient and outpatient Medicaid services. Inpatient and outpatient Medicaid services will not include services reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services. The per diem amounts will be calculated by dividing:

- The individual amounts on Worksheet B Part 1 Column 25 Lines (and where applicable Subscript Lines) 25 to 33
- By
- The corresponding day totals on Lines (and where applicable Subscript Lines) 5 through 11 and Line 14 (for inpatient hospital subproviders) from Worksheet S-3 Part I Column 6.

Note: when calculating the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 25, Line 25 should have deducted the amounts appearing on Worksheet D-1, Part I, Lines 26 and 36 and the amount on Worksheet S-3, Part I, Column 6, Line 5 should have added the amount appearing on Line 26 (observation bed days).

The ancillary RCCs will be calculated by dividing:

1. The individual Line and Subscript amounts for each of the Lines 37 to 63 taken from Worksheet B Part 1 Column 25
2. By
3. The individual Line and Subscript amounts for each of the Lines 37 to 63 taken from Worksheet C Part 1 Column 8

Costs will be offset by the payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services as well as payments made by AHCCCS including FFS payments, payments by health plans and program contractors, and supplemental payments (such as GME, Rural Hospital Payments and CAH) made during the hospital's fiscal/CMS Report years that encompass the state plan rate year.

Uninsured Costs

Each hospital will collect uninsured days and charges and program data for the hospital's fiscal/CMS Report years that encompass the state plan year from the hospital's claims and auditable financial records. Only hospital inpatient and outpatient days and charges and program data for medical services that would otherwise be eligible for Medicaid should be included in the DSH calculation. Inpatient and outpatient uninsured services will not include services that would be reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services if the patient were eligible for Medicaid. The uninsured days, charges and program information provided to the state is subject to the same audit standards and procedures as the data included in the cost report.

When providing uninsured days, charges and program information hospitals should be guided by the following:

The Uninsured are defined as:

- Self pay and self insured patients
- Individuals with no source of third party coverage for inpatient and outpatient hospital services
- Third party coverage does not include state and local government subsidized care (i.e. individuals covered by indigent programs without other forms of third party coverage are uninsured)
- Payments made by state or local government are not considered a source of third party payment
- It is permissible to include in the Uninsured individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.
- Individuals with AHCCCS coverage (either Medicaid or KidsCare) are not considered uninsured
- Individuals participating in a Ryan White HIV/AIDS Program that have no source of third party coverage for the services provided other than the Ryan White program are considered uninsured. However, the funding provided under the program must be considered payments received from or on behalf of patients or payments received from third parties.

When submitting uninsured days, charges and program information hospitals should accompany the submission with:

- A listing of all payor types that are included in the uninsured data compilation, and
- A CD or DVD that contains sufficient claims or other information (e.g. ICNs) to enable an auditor to tie the amounts submitted to the financial records of the hospital

The uninsured costs will be calculated for each hospital for each fiscal/CMS Report year that encompasses the state plan year. The resulting uninsured costs for each fiscal/CMS Report year will be prorated to derive the state plan year uninsured costs according to the above discussion entitled "Data on a State Plan Year Basis".

The information to be collected will include, but not be limited to:

1. The number of uninsured inpatient hospital days (for governmentally-operated hospitals this will be accumulated for each inpatient routine service cost center on the cost report)
2. The uninsured inpatient and outpatient hospital ancillary charges (for governmentally-operated hospitals this will be accumulated for each ancillary cost center on the cost report)
3. The amounts of payments received during the hospital's fiscal/CMS Report years that encompass the state plan year made by or on behalf of patients and payments made by third parties related to uninsured inpatient and outpatient hospital services. The information collected shall:

a. Include payments received during the hospital's fiscal/CMS Report years that encompass the state plan year under Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, of the MMA,
b. Not include payments, funding and subsidies made by the state or a unit of local governments (e.g., state-only, local-only or state-local health program)

For each hospital the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report (as determined for Medicaid) will be applied to the data collected by the hospital to determine the uninsured costs.

Costs will be offset by the payments received during the state plan year from or on behalf of patients and payments received during the hospital's fiscal/CMS Report years that encompass the state plan year from third parties related to all uninsured inpatient and outpatient hospital services. Payments made by state or local government are not considered a source of third party payment.

The OBRA Limit

The summation of the Medicaid shortfall (whether positive or negative) and the uninsured costs (whether positive or negative) is the hospital's OBRA limit.

**Group 5 Eligibility Determination**

Any Arizona hospital that qualifies for funding in Groups 1 and 2 (Group 1, 1A, 2, or 2A) is eligible for funding through Group 5. Group 5 is created to enable DSH-eligible hospitals to get qualifying DSH payments matched via voluntary intergovernmental agreements (IGAs). Per State Medicaid Director Letter #10-010, the State will require the appropriate documentation that the funding has been voluntarily provided. Group 5 DSH payments are on top of the Groups 1 and 2 DSH payments, but no individual hospital will receive aggregate DSH payments that exceed its OBRA limit.

Funding for any hospital in Group 5 must be arranged via a voluntary intergovernmental agreement with a political subdivision, tribal government or public university, using public funds not derived from impermissible sources, such as impermissible provider-related donations or impermissible health care-related taxes, as a match to draw down DSH payments. Political subdivisions, tribal governments and public universities will notify AHCCCS of the hospitals designated to receive funds and of the amount of matching funds that are available through their IGAs.
For hospitals that qualify for Group 5, a "LOM" score will be calculated by multiplying the hospital's LIUR times the hospital's full OBRA limit, times the hospital's MIUR.

Example:
Hospital A
OBRA = $54,734,467, MIUR = 0.3542, LIUR = 0.2946
Group 5 LOM score for Hospital A = $54,734,467 x 0.3542 x 0.2946 = $5,711,394

For the first round of distributions, each hospital's percentage of the total group LOM score will be calculated using the hospital's LOM score as the numerator and the total of all eligible hospitals' LOM

scores as the denominator. The total amount of DSH available as a result of the IGAs (Group 5 DSH funds) will be multiplied by each hospital's LOM percentage of this first round. If any allocation from this round is higher than a hospital's OBRA limit (remaining after Group 1 and 2 DSH distributions) or higher than the matching funds (in total computable) for that hospital, the lower of those two limits will be recorded as the allocation for round one.

For subsequent rounds, only the hospitals that have not hit their OBRA limit or matching fund limit will be considered in that round. The LOM score for only those hospitals will be totaled. Each hospital's percentage of the total LOM score for that round will be calculated. The total amount of Group 5 DSH funds remaining for that round will be multiplied by each hospital's LOM percentage for that round. If any allocation from any round is higher than a hospital's remaining OBRA limit or higher than the remaining total computable matching funds for that hospital, the lower of those two limits will be recorded as the allocation for that round.

Distribution rounds will continue until all Group 5 DSH funds are distributed, or all Group 5 qualifying hospitals have received the maximum distribution identified in the IGAs or reached their individual OBRA limits, whichever comes first. All excess IGA funds not used for Group 5 DSH distributions, due to application of the above limits, will be returned to the originating political subdivisions, tribal governments or public universities and will not be retained by AHCCCS for other uses.

The Group 5 DSH distribution for any hospital will consist of that hospital's total of allocations from all rounds.

## Aggregate Limits

*IMD Limit*

Federal law provides that aggregate DSH payments to Institutions for Mental Diseases (IMDs) in Arizona is confined to the *lesser* of $28,474,900 or the amount equal to the product of Arizona's current year total computable DSH allotment and 23.27%. Therefore, DSH payment to IMDs will be reduced proportionately to the extent necessary to ensure that the aggregate IMD limit is not exceeded.

"Institutions for Mental Diseases" includes hospitals that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

*Overall Total Limit*

The federal government shares in the cost of Medicaid DSH expenditures based on the Federal Medical Assistance Percentage (FMAP) for each state. However, for each fiscal year, the amount of federal funds available to states for DSH payment is fixed. As such, the total amount of DSH payments for a state plan rate year will not exceed the federal allotment divided by the FMAP.

## Reconciliation

The initial DSH payment issued to a hospital by AHCCCS is considered "interim" and is subject to different reconciliation methodologies depending upon whether the hospital is non-governmental or governmentally-operated. The payments to hospitals are generally made as a single lump sum payment that is made once the calculations of the payment amounts are completed. The purpose of the interim DSH payment is to provide reimbursement that approximates the Medicaid and uninsured inpatient hospital and outpatient hospital uncompensated care costs eligible for Federal Financial Participation (FFP).

The reasons for a change in the initial (or interim) DSH payment for both non-governmental and governmentally-operated hospitals are outlined above under "Pools and Changing Payment Levels".

If it is determined that the total amount of payments made to non-governmental hospitals under the methodology outlined in the "Pools and Changing Payment Levels" exceeds the amount of all finalized non-governmental hospital OBRA limits, the amount in excess will be recouped by AHCCCS and any associated federal funding claimed will be properly credited to the federal government.

If it is determined that the total amount of payments made to governmentally-operated hospitals under the methodology outlined in the "Pools and Changing Payment Levels" exceeds the amount of either:

1. All governmentally-operated hospital OBRA limits calculated based on the "finalized" cost report, or
2. The total amount of certified public expenditures of governmentally-operated hospitals, then
3. The amount in excess will be recouped by AHCCCS and any associated federal funding claimed will be properly credited to the federal government.

## Certified Public Expenditures

Expenditures by governmentally-operated hospitals shall be used by AHCCCS in claiming FFP for DSH payments to the extent that the amount of funds expended are certified by the appropriate officials at the governmentally-operated hospital.

The method for determining a governmentally-operated hospital's allowable uncompensated care costs eligible for DSH reimbursement when such costs are funded through the certified public expenditure (CPE) process will be the same as the method for calculating and reconciling the OBRA limit for governmentally-operated hospitals set forth above.

However, because governmentally-operated hospitals are certifying expenditures for the state plan year of the initial DSH payment and final expenditures may not be known at the time of initial certification of public expenditures, governmentally owned hospitals may certify an amount of expenditures for the initial DSH payment based on an estimate of the OBRA limit for

the state plan year of the initial DSH payment.

In certifying estimates of public expenditure for the initial DSH payment, the governmentally operated hospital will first calculate its expenditures based on the methodology for calculating the OBRA limit for the state plan year two years before the state plan year of the initial payment (as specified in the protocols in Exhibit 1 or Exhibit 2) and then provide for adjustments to such OBRA limit. The adjustments may increase or decrease the days, costs, charges or payments reflected on the cost reports, Medicaid and/or uninsured information used to calculate the OBRA limit. The adjustments will reflect increases and decreases resulting from changes in operations or circumstances that are not reflected in the information from the state plan year two years prior to the state plan year of the initial payment, but will be reflected in the final information for the state plan year of the initial payment. All adjustments must be supported by adequate explanation/justification and is subject to review by AHCCCS and CMS.

In order to use CPE, the certifying governmentally-operated hospital must follow the protocol in Exhibit 1 or Exhibit 2 and provide a certification as to the amount of allowable uncompensated care costs eligible for DSH reimbursement. If CPE is used, the amount of expenditures used to determine the FFP will not exceed the amount of the CPE.

The payment of FFP to governmentally-operated hospitals is subject to legislative appropriation.

## Grievances and Appeals

The state considers a hospital's DSH eligibility and DSH payment amount to be appealable issues. A DSH eligibility list along with the initial DSH payment amounts that eligible hospitals have been calculated to receive will be distributed. Hospitals will be permitted thirty (30) days from distribution to appeal their DSH eligibility and payment amounts. Because the total amount of DSH funds is fixed, the successful appeal of one DSH hospital will reduce DSH payment amounts to all other providers. Once the final reconciliation process is completed, no additional DSH payment will be issued.

## Other Provisions

Ownership

DSH payment will only be issued to the entity which is currently registered with AHCCCS as a participating hospital provider. Therefore, it is expected that facilities will consider this information when negotiating ownership changes.

**Attachment D - AHCCCS Disproportionate Share Hospital (DSH) Payments Exceptions (Revised May 29, 2009)**

**An exception to the use of the Medicare Cost Report (Form CMS 2552-96) as a data source shall apply to:**

I. **Hospitals that:**

- Serve patients that are predominantly under 18 years of age, and
- Are licensed for fewer than 50 beds, and
- Do not file a comprehensive Form CMS 2552-96 (Medicare Cost Report), and
- Receive an acceptance letter from the CMS fiscal intermediary for the portion of the CMS 2552-96 (Medicare Cost Report) that the hospital does file with the fiscal intermediary, and
- Receive written permission from AHCCCS to invoke the provisions of this exception.

Such hospitals may extract data from their financial records in lieu of extracting data from the Form CMS 2552-96 (Medicare Cost Report) as provided in this Attachment D.

The method of extracting and compiling the data from the hospital's financial records shall conform to the instructions for the Form CMS 2552-96. All other non-Medicare Cost Report data and documentation as described in this Attachment D shall be required from such hospitals.

**II. Indian Health Service (IHS) Hospitals** and tribally-operated 638 hospitals who do not file a full Form CMS 2552-96 Medicare Cost Report but rather file an abbreviated Medicare cost report in accordance with Medicare Provider Reimbursement Manual, Part I, Section 2208.1.E (Method E cost report).

Such IHS Hospitals and tribally-operated 638 hospitals can submit a Private Facility Information Sheet (PFIS) to AHCCCS using data from the IHS Method E report that is filed with CMS as well as supporting hospital financial reports, as necessary.

The method of extracting and compiling the data from the hospital's financial records shall conform to the instructions for the Form CMS 2552-96. All other non-Medicare Cost Report data and documentation as described on the PFIS cover sheet will be required by such hospitals.

**EXHIBIT 1 to ATTACHMENT D**

**AHCCCS**
**Disproportionate Share Hospital Payment Methodology**
**Calculation of OBRA Limits for**
**Governmentally-Operated Hospitals for the Purpose of**
**Certified Public Expenditures**

Each governmentally-operated hospital certifying its expenditures for Disproportionate Share Hospital (DSH) payments shall compute and report its OBRA limit as prescribed by this Exhibit. The governmentally-operated hospital's OBRA limit is comprised of two components:

1. The amount of uncompensated care costs associated with providing inpatient and outpatient hospital services to Medicaid individuals (the Medicaid shortfall), and
2. The amount of uncompensated care costs associated with providing inpatient and outpatient hospital services to individuals with no source of third party coverage for the inpatient and outpatient hospital services they received (uninsured costs).

The steps to computing the governmentally-operated hospital's OBRA limit are[4]:

1. The hospital shall prepare its CMS 2552 Report (cost report(s)). Each hospital must complete the cost report to determine per diems (for inpatient routine services) and ratios of cost to charges (RCC) (for ancillary services). The cost reports must be completed based on Medicare cost principles and Medicare cost allocation process as specified in the CMS 2552 instructions and the CMS Provider Reimbursement Manual, volumes 15-1 and 15-2, including updates.
2. Medicaid shortfall will be calculated based on information available from PMMIS, other AHCCCS financial systems, and the cost report.
3. Uninsured costs will be calculated based on uninsured days and charges and other program data collected by the hospital from its claims and financial records, other systems, and the cost report.
4. Finally, the governmentally-operated hospital will compile and summarize the calculations on The OBRA Limit and CPE Schedule. In compiling and summarizing the OBRA calculations, the governmentally-operated hospital may make adjustments to the calculated OBRA limit to estimate the OBRA limit for a future state plan year. The adjustments may increase or decrease the days, costs, charges or payments reflected on the cost reports, Medicaid and/or uninsured information used to calculate the OBRA limit. The adjustments will reflect increases and decreases resulting from changes in operations or circumstances that are not reflected in the information from the state plan

[4] Note: The following discussion applies to hospitals that do not have a per diem ancillary allocation methodology approved by Medicare. For the steps to calculate the OBRA limit for governmental hospitals that do have such approval, see Exhibit 2 to this Attachment D.

year two years prior to the state plan year of the initial payment, but will be reflected in the final information for the state plan year of the initial payment. All adjustments must be supported by adequate explanation/justification and is subject to review by AHCCCS and CMS. The Schedule will be submitted to AHCCCS, with backup documentation, for the cost reporting period(s) covered by the Medicaid state plan rate year(s) under review.

The Medicaid Shortfall

AHCCCS will provide each governmentally-operated hospital with a report from the PMMIS system and other agency financial reporting systems to assist each governmentally-operated hospital in completing required schedules. The information to be provided by AHCCCS will include, but not be limited to:

1. The number of Medicaid fee for service (FFS) inpatient hospital days (for each inpatient routine service cost center on the cost report)
2. The number of Medicaid managed care inpatient hospital days (for each inpatient routine service cost center on the cost report)
3. The Medicaid inpatient and outpatient hospital FFS charges (separately for each ancillary cost center on the cost report). Inpatient and outpatient Medicaid charges will not include charges reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services.
4. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital FFS services
5. The amounts of Medicaid payments made by AHCCCS for inpatient and outpatient hospital FFS services
6. The Medicaid inpatient and outpatient hospital managed care charges (for each ancillary cost center on the cost report). Inpatient and outpatient Medicaid charges will not include charges reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services.
7. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services for health plans and program contractors
8. The amounts of Medicaid payments made by health plans and program contractors for inpatient and outpatient hospital services for health plans and program contractors
9. Other amounts of Medicaid payments for Medicaid inpatient and outpatient services furnished during the Medicaid state plan rate year under review (e.g. GME, CAH, etc.)

Each governmentally-operated hospital will use the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report and the data extracted from PMMIS (days and charges) to determine the cost of providing inpatient and outpatient Medicaid services. Inpatient and outpatient Medicaid services will not include services reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services. The Medicaid shortfall will be calculated for each hospital for each fiscal/CMS Report year that encompasses the state plan year. The resulting Medicaid shortfall for each fiscal/CMS Report year will be prorated to derive the state plan year Medicaid shortfall according to the discussion entitled “Data on a State Plan Year Basis”.

The per diem amounts will be calculated by dividing:

- The individual amounts on Worksheet B Part 1 Column 25 Lines (and where applicable Subscript Lines) 25 to 33
- By
- The corresponding day totals on Lines (and where applicable Subscript Lines) 5 through 11 and Line 14 (for inpatient hospital subproviders) from Worksheet S-3 Column 6.

Note: when calculating the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 25, Line 25 should have deducted the amounts appearing on Worksheet D-1, Part I, Lines 26 and 36 and the amount on Worksheet S-3, Part I, Column 6, Line 5 should have added the amount appearing on Line 26 (observation bed days).

The ancillary RCCs will be calculated by dividing:

1. The individual Line and Subscript amounts for each of the Lines 37 to 63 taken from Worksheet B Part 1 Column 25
2. By
3. The individual Line and Subscript amounts for each of the Lines 37 to 63 taken from Worksheet C Part 1 Column 8

Each governmentally-operated hospital will use the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report and the data supplied by AHCCCS to compile the Medicaid Schedule of Costs on the OBRA Limit and CPE Schedule. The Medicaid Schedule of Costs depicts:

1. The governmentally-operated hospital specific Medicaid inpatient and outpatient cost data,
2. The payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services,
3. The Medicaid inpatient and outpatient net cost data,
4. Payments made by AHCCCS including FFS and payments by health plans and program contractors
5. The amount of supplemental Medicaid payments related to inpatient and outpatient hospital services (e.g., GME and CAH)
6. The Medicaid shortfall
7. Adjustments to the calculated Medicaid shortfall to estimate a Medicaid shortfall for a future state plan year.

Uninsured Costs

Each governmentally-operated hospital will collect uninsured days and charges and program data for the hospital's fiscal/CMS Report years that encompass the state plan year from the hospital's claims and auditable financial records. Only hospital inpatient and outpatient days and charges and program data for medical services that would otherwise be eligible for Medicaid should be included in the calculation. Inpatient and outpatient uninsured services will not include services that would be reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services if the patient were eligible for Medicaid. The uninsured days, charges and program information

provided to the state is subject to the same audit standards and procedures as the data included in the cost report.

When providing uninsured days, charges and program information hospitals should be guided by the following:

The Uninsured are defined as:

- Self pay and self insured patients
- Individuals with no source of third party coverage for inpatient and outpatient hospital services
- Third party coverage does not include state and local government subsidized care (i.e. individuals covered by indigent programs without other forms of third party coverage are uninsured)
- Payments made by state or local government are not considered a source of third party payment
- It is permissible to include in the Uninsured individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.
- Individuals with AHCCCS coverage (either Medicaid or KidsCare) are not considered uninsured
- Individuals participating in a Ryan White HIV/AIDS Program that have no source of third party coverage for the services provided other than the Ryan White program are considered uninsured. However, the funding provided under the program must be considered payments received from or on behalf of patients or payments received from third parties.

When submitting uninsured days, charges and program information hospitals should accompany the submission with:

- A listing of all payor types that are included in the uninsured data compilation, and
- A CD or DVD that contains sufficient claims or other information (e.g. ICNs) to enable an auditor to tie the amounts submitted to the financial records of the hospital

The information to be collected will include, but not be limited to:

1. The number of uninsured inpatient hospital days (for each inpatient routine service cost center on the cost report)
2. The uninsured inpatient and outpatient hospital ancillary charges (for each ancillary cost center on the cost report)
3. The amounts of payments received during the hospital's fiscal/CMS Report years that encompass the state plan year made by or on behalf of patients and payments made by third parties related to uninsured inpatient and outpatient hospital services. The information collected shall:
    a. Include payments received during the hospital's fiscal/CMS Report years that encompass the state plan year under Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, of the MMA,

b. Not include payments, funding and subsidies made by the state or a unit of local governments (e.g., state-only, local-only or state-local health program)

Each governmentally-operated hospital will use the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report (as determined for Medicaid), the uninsured days and charges, and other program data collected by the governmentally-operated hospital to compile the Uninsured Schedule of Costs on the OBRA Limit and CPE Schedule. The Uninsured Schedule of Costs depicts:

1. The governmentally-operated hospital specific uninsured inpatient and outpatient cost data,
2. The payments made by or on behalf of patients and payments made by third parties related to uninsured inpatient and outpatient hospital services, and
3. The uninsured inpatient and outpatient cost.
4. Adjustments to the calculated uninsured inpatient and out patient cost to estimate the uninsured inpatient and outpatient cost for a future state plan year.

The Governmentally-Operated Hospital OBRA Limit

The summation of the Medicaid shortfall (whether positive or negative) and the uninsured costs (whether positive or negative) is the hospital's OBRA limit and is depicted on the Calculation of OBRA Limit and CPE on the OBRA Limit and CPE Schedule.

The summation of the estimated Medicaid shortfall (whether positive or negative) and the estimated uninsured costs (whether positive or negative) is the hospital's OBRA limit for a future state plan year and is depicted on the Calculation of OBRA Limit and CPE on the OBRA Limit and CPE Schedule.

Certification

The appropriate official of the governmentally-operated hospital will sign the certification statement on the Governmentally-Operated Hospital OBRA Limit and CPE Schedule. A certification will be signed for each of the three times the OBRA limit for the state plan rate year of the initial DSH payment is calculated as described below under "Reconciliation".

Reconciliation

The OBRA limit for the state plan rate year of the initial DSH payment will be computed for each governmentally-operated hospital three times:

1. The OBRA limit will be calculated in the state plan rate year of the initial DSH payment based on the cost report(s) and days and charges and other program data for the state plan rate year two years prior to the state plan rate year of the initial DSH payment. This calculation may include an adjustment to the calculated OBRA limit of the state plan rate year two years prior to the state plan rate year of the initial DSH payment in order to estimate the OBRA limit of the state plan rate year of the initial DSH payment.

2. The OBRA limit will be recalculated when the cost report(s) for the state plan rate year of the initial DSH payment are filed. In recalculating the OBRA limit the cost data from the as-filed cost report(s) and program data (days, charges, and payments) from the actual cost reporting period(s) will be used in the calculation. This calculation may not include any adjustment to the calculated OBRA limit of the state plan rate year of the initial DSH.
3. The final calculation of each governmentally-operated hospital's OBRA limit will be performed when the cost report(s) for the state plan rate year of the initial DSH payment are finalized. In finalizing the OBRA limit the cost data from the finalized cost report(s) and program data (days, charges, and payments) from the actual cost reporting period(s) will be used in the calculation.

**EXHIBIT 2 to ATTACHMENT D**

**AHCCCS**
**Disproportionate Share Hospital Payment Methodology**
**Calculation of OBRA Limits for**
**Arizona State Hospital**
**A Hospital with a Per Diem Ancillary Cost Allocation Method**
**Approved by Medicare**

Arizona State Hospital (ASH), a governmentally-operated hospital that is an all-inclusive rate provider under Medicare, shall compute, report and certify its OBRA limit as prescribed by this Exhibit. Because ASH only provides inpatient services, the OBRA limit will by calculated based only on inpatient information. ASH's OBRA limit is comprised of two components:

1. The amount of uncompensated care costs associated with providing inpatient hospital services to Medicaid individuals (the Medicaid shortfall), and
2. The amount of uncompensated care costs associated with providing inpatient hospital services to individuals with no source of third party coverage for the inpatient hospital services they received (uninsured costs).

The steps to computing ASH's OBRA limit are:

1. The hospital shall prepare its CMS 2552 Report (cost report(s)). The hospital must complete the cost report to determine per diems (for inpatient routine services and for ancillary services). The cost reports must be completed based on Medicare cost principles and Medicare cost allocation process as specified in the CMS 2552 instructions and the CMS Provider Reimbursement Manual, volumes 15-1 and 15-2, including updates.
2. Medicaid shortfall will be calculated based on information available from PMMIS, other AHCCCS financial systems, and the cost report.
3. Uninsured costs will be calculated based on uninsured days and other program data collected by the hospital from its claims and financial records, other systems, and the cost report.
4. Finally, ASH will compile and summarize the calculations on The OBRA Limit and CPE Schedule. In compiling and summarizing the OBRA calculations, ASH may make adjustments to the calculated OBRA limit to estimate the OBRA limit for a future state plan year. The adjustments may increase or decrease the days, costs, charges or payments reflected on the cost reports, Medicaid and/or uninsured information used to calculate the OBRA limit. The adjustments will reflect increases and decreases resulting from changes in operations or circumstances that are not reflected in the information from the state plan year two years prior to the state plan year of the initial payment, but will be reflected in the final information for the state plan year of the initial payment. All adjustments must be supported by adequate explanation/justification and is subject to review by AHCCCS and CMS. The Schedule will be submitted to AHCCCS, with backup documentation, for the cost reporting period(s) covered by the Medicaid state plan rate year(s) under review.

The Medicaid Shortfall

AHCCCS will provide ASH with a report from the PMMIS system and other agency financial reporting systems to assist ASH in completing required schedules. The information to be provided by AHCCCS will include, but not be limited to:

1. The number of Medicaid fee for service (FFS) inpatient hospital days (for the single inpatient routine service cost center on the cost report)
2. The number of Medicaid managed care inpatient hospital days (for the single inpatient routine service cost center on the cost report)
3. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient hospital FFS services
4. The amounts of Medicaid payments made by AHCCCS for inpatient hospital FFS services
5. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient hospital services for health plans and program contractors
6. The amounts of Medicaid payments made by health plans and program contractors for inpatient hospital services for health plans and program contractors
7. Other amounts of Medicaid payments for Medicaid inpatient services furnished during the Medicaid state plan rate year under review (e.g. GME, CAH, etc.)

ASH will use a single total per diem calculated from the cost report and the inpatient days extracted from PMMIS to determine the cost of providing inpatient Medicaid services. The Medicaid shortfall will be calculated for ASH for each fiscal/CMS Report year that encompasses the state plan year. The resulting Medicaid shortfall for each fiscal/CMS Report year will be prorated to derive the state plan year Medicaid shortfall according to the discussion entitled "Data on a State Plan Year Basis".

The single total per diem amount will be calculated by summing the inpatient per diem amount and the ancillary per diem amount.

The inpatient per diem amount will be found by dividing the amounts on Worksheet B Part 1 Column 25 Line 25 by the day total on Line 5 from Worksheet S-3 Column 6. Note: when calculating the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 25, Line 25 should have deducted the amounts appearing on Worksheet D-1, Part I, Lines 26 and 36 and the amount on Worksheet S-3, Part I, Column 6, Line 5 should have added the amount appearing on Line 26 (observation bed days).

The ancillary per diem amount will be calculated by:

1. Summing the Line and Subscript amounts for each of the Lines 37 to 63 (but excluding Subscript Lines 63.5 to 63.99) taken from Worksheet B Part 1 Column 25
2. Dividing the amount determined in step 1 above by the amount determined in step 3 below

3. Summing the Lines 5 and 17 from Worksheet S-3 Column 6

ASH will use the single total per diem calculated from the cost report and the data supplied by AHCCCS to compile the Medicaid Schedule of Costs on the OBRA Limit and CPE Schedule. The Medicaid Schedule of Costs depicts:

1. The governmentally-operated hospital specific Medicaid inpatient cost data (determined by multiplying the single total per diem by the number of inpatient Medicaid days),
2. The payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient hospital services,
3. The Medicaid inpatient net cost data,
4. Payments made by AHCCCS including FFS and payments by health plans and program contractors
5. The amount of supplemental Medicaid payments (e.g., GME and CAH)
6. The Medicaid shortfall
7. Adjustments to the calculated Medicaid shortfall to estimate a Medicaid shortfall for a future state plan year.

Uninsured Costs

ASH will collect uninsured days and program data for the hospital's fiscal/CMS Report years that encompass the state plan year from the hospital's claims and auditable financial records. Only hospital inpatient days and program data for medical services that would otherwise be eligible for Medicaid should be included in the calculation. Inpatient uninsured services will not include services that would be reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services if the patient were eligible for Medicaid. The uninsured days and program information provided to the state is subject to the same audit standards and procedures as the data included in the cost report.

When collecting uninsured days and program information ASH should be guided by the following:

The Uninsured are defined as:

- Self pay and self insured patients
- Individuals with no source of third party coverage for inpatient hospital services
- Third party coverage does not include state and local government subsidized care (i.e. individuals covered by indigent programs without other forms of third party coverage are uninsured)
- Payments made by state or local government are not considered a source of third party payment
- It is permissible to include in the Uninsured individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.
- Individuals with AHCCCS coverage (either Medicaid or KidsCare) are not considered uninsured
- Individuals participating in a Ryan White HIV/AIDS Program that have no source of third party coverage for the services provided other than the Ryan White program are

considered uninsured. However, the funding provided under the program must be considered payments received from or on behalf of patients or payments received from third parties.

The uninsured costs will be calculated for ASH for each fiscal/CMS Report year that encompasses the state plan year. The resulting uninsured costs for each fiscal/CMS Report year will be prorated to derive the state plan year uninsured costs according to the discussion entitled "Data on a State Plan Year Basis".

The information to be collected will include, but not be limited to:

1. The number of uninsured inpatient hospital days (for the single inpatient routine service cost center on the cost report)
2. The amounts of payments received during the hospital's fiscal/CMS Report years that encompass the state plan year made by or on behalf of patients and payments made by third parties related to uninsured inpatient hospital services. The information collected shall:
    a. Include payments received during the hospital's fiscal/CMS Report years that encompass the state plan year under Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, of the MMA,
    b. Not include payments, funding and subsidies made by the state or a unit of local governments (e.g., state-only, local-only or state-local health program)

ASH will use the total inpatient per diem calculated from the cost report (as determined for Medicaid), the uninsured days, and other program data collected by ASH to compile the Uninsured Schedule of Costs on the OBRA Limit and CPE Schedule. The Uninsured Schedule of Costs depicts:

1. The ASH specific uninsured inpatient cost data (determined by multiplying the single total per diem by the number of uninsured inpatient days),
2. The payments made by or on behalf of patients and payments made by third parties related to uninsured inpatient hospital services, and
3. The uninsured inpatient cost.
4. Adjustments to the calculated uninsured inpatient and out patient cost to estimate the uninsured inpatient and outpatient cost for a future state plan year.

The Governmentally-Operated Hospital OBRA Limit

The summation of the Medicaid shortfall (whether positive or negative) and the uninsured costs (whether positive or negative) is the hospital's OBRA limit and is depicted on the OBRA Limit and CPE Schedule.

The summation of the estimated Medicaid shortfall (whether positive or negative) and the estimated uninsured costs (whether positive or negative) is the hospital's OBRA limit for a future state plan year and is depicted on the Calculation of OBRA Limit and CPE on the OBRA Limit and CPE Schedule.

Certification

The appropriate official of ASH will sign the certification statement on the OBRA Limit and CPE Schedule. A certification statement will be signed for each of the three times the OBRA limit for the state plan year of the initial DSH payment is calculated as described below under "Reconciliation".

Reconciliation

The OBRA limit for the state plan rate year of the initial DSH payment will be computed for ASH three times:

1. The OBRA limit will be calculated in the state plan rate year of the initial DSH payment based on the cost report(s) and days and other program data for the state plan rate year two years prior to the state plan rate year of the initial DSH payment. This calculation may include an adjustment to the calculated OBRA limit of the state plan rate year two years prior to the state plan rate year of the initial DSH payment in order to estimate the OBRA limit of the state plan rate year of the initial DSH payment.
2. The OBRA limit will be recalculated when the cost report(s) for the state plan rate year of the initial DSH payment are filed. In recalculating the OBRA limit the cost data from the as-filed cost report(s) and program data (days and payments) from the actual cost reporting period(s) will be used in the calculation. This calculation may not include any adjustment to the calculated OBRA limit of the state plan rate year of the initial DSH.
3. The final calculation of ASH's OBRA limit will be performed when the cost report(s) for the state plan rate year of the initial DSH payment are finalized. In finalizing the OBRA limit the cost data from the finalized cost report(s) and program data (days and payments) from the actual cost reporting period(s) will be used in the calculation.

**EXHIBIT 3 to ATTACHMENT D**

**AHCCCS**
**Disproportionate Share Hospital Payment Methodology**
**Pool Funding Amount for SPY 2013**

This Exhibit contains the amount of funding for six pools in the Arizona DSH pool methodology.

For State Plan Year (SPY) 2008 and 2009, funding will be allocated among six pools (pools 1, 1A, 2, 2A, 3, and 4). For SPY 2010, funding will be allocated among seven pools (pools 1, 1A, 2, 2A, 3, 4, and 5). For SPY 2011, SPY 2012, and 2013 the funding will be allocated among six pools (pools 1, 1A, 2, 2A, 4, and 5).

Pools 1, 1A, 2, 2A, and 3 - Non-governmentally-operated hospitals
The funding for pools 1 and 2 will be sufficient to provide an average payment amount of $6,000 for all hospitals qualifying for both of the two pools. No hospital in pools 1 or 2 will receive less than $5,000. Therefore, the amount of funding for pools 1 and 2 will be determined by multiplying the number of hospitals qualifying for pools 1 and 2 by $6,000.

The funding for pools 1A, 2A and 3 (if applicable) will be derived by subtracting the total amount allocated for pools 1 and 2 from the amount of DSH authorized by the Legislature for non-governmentally operated hospitals. Beginning SPY 2011, these remaining funds will be split with 15% for Pool 1A and 85% for Pool 2A.

For SPY 2008, the funding for pools 1, 2, 1A, and 2A and 3 will be $26,147,700.
For SPY 2009, the funding for pools 1, 2, 1A, and 2A and 3 will be $26,147,700.
For SPY 2010, the funding for pools 1, 2, 1A, and 2A and 3 will be $500,000.
For SPY 2011, the funding for pools 1, 2, 1A, and 2A will be $9,284,800.
For SPY 2012, the funding for pools 1, 2, 1A, and 2A will be $9,284,800.
For SPY 2013, the funding for pools 1, 2, 1A, and 2A will be $9,284,800.

Pool 4 – Governmentally-operated hospitals
The funding for pool 4 is the amount authorized by the Legislature for governmentally operated hospitals.

For SPY 2008, the funding for pool 4 is $117,914,800.
For SPY 2009, the funding for pool 4 is $128,427,000.
For SPY 2010, the funding for pool 4 is $132,596,900.
For SPY 2011, the funding for pool 4 is $128,637,400.
For SPY 2012, the funding for pool 4 is $119,784,246
For SPY 2013, the funding for pool 4 is $118,352,300

For SPY 2009, any excess DSH funding in pool 4 not allocated due to OBRA limits may be reallocated and distributed to DSH-qualifying hospitals in pools 1, 1A, 2, 2A or 3 until September 30, 2011. AHCCCS shall notify CMS prior to the distribution of any pool 4

reallocated DSH funds.

For SPY 2010, funding will be reallocated first to pools 1, 1A, 2, 2A, and 3, should the State make available matching funds. This reallocation to the pools will be based proportionately on the SPY 2009 pool allocations. For each pool, the distribution of the reallocated DSH funding to the hospitals within the pool will be based on each hospital's 2010 relative weights as described in the "Determination of Payment Amounts" section of this Attachment D. SPY 2010 payments made from reallocated funds will be added to the hospital's original SPY 2010 payments with the total SPY payments subject to each hospital's OBRA limit. For SPY 2010, any excess DSH funding in pool 4 not allocated due to OBRA limits may be reallocated to DSH pools 1, 1A, 2, 2A, 3, and 5 until September 30, 2012. A determination will be made by June 30, 2012, by the Administration if any reallocation will occur. AHCCCS shall notify CMS prior to the distribution of any pool 4 reallocated DSH funds.

For SPY 2011, funding will be reallocated first to pools 1, 1A, 2, and 2A should the State make available matching funds. This reallocation to the pools will be based proportionately on the SPY 2011 pool allocation For each pool, the distribution of the reallocated DSH funding to the hospitals within the pool will be based on each hospital's 2011 relative weights as described in the "Determination of Payment Amounts" section of this Attachment D. SPY 2011 payments made from reallocated funds will be added to the hospital's original SPY 2011 payments with the total SPY payments subject to each hospital's OBRA limit. For SPY 2011, any excess DSH funding in pool 4 not allocated due to OBRA limits may be reallocated to DSH pools 1, 1A, 2, 2A, and 5 until September 30, 2013. A determination will be made by June 30, 2013, by the Administration if any reallocation will occur. AHCCCS shall notify CMS prior to the distribution of any pool 4 reallocated DSH funds.

For SPY 2012, funding will be reallocated first to pools 1, 1A, 2, and 2A should the State make available matching funds. This reallocation to the pools will be based proportionately on the SPY 2012 pool allocation For each pool, the distribution of the reallocated DSH funding to the hospitals within the pool will be based on each hospital's 2012 relative weights as described in the "Determination of Payment Amounts" section of this Attachment D. SPY 2012 payments made from reallocated funds will be added to the hospital's original SPY 2012 payments with the total SPY payments subject to each hospital's OBRA limit. For SPY 2012, any excess DSH funding in pool 4 not allocated due to OBRA limits may be reallocated to DSH pools 1, 1A, 2, 2A, and 5 until September 30, 2014. A determination will be made by June 30, 2014, by the Administration if any reallocation will occur. AHCCCS shall notify CMS prior to the distribution of any pool 4 reallocated DSH funds.

For SPY 2013, funding will be reallocated first to pools 1, 1A, 2, and 2A should the State make available matching funds. This reallocation to the pools will be based proportionately on the SPY 2013 pool allocation For each pool, the distribution of the reallocated DSH funding to the hospitals within the pool will be based on each hospital's 2013 relative weights as described in the "Determination of Payment Amounts" section of this Attachment D. SPY 2013 payments made from reallocated funds will be added to the hospital's original SPY 2013 payments with the total SPY payments subject to each hospital's OBRA limit. For SPY 2013, any excess DSH funding in pool 4 not allocated due to OBRA limits may be reallocated to DSH pools 1, 1A, 2,

2A, and 5 until September 30, 2015. A determination will be made by June 30, 2015, by the Administration if any reallocation will occur. AHCCCS shall notify CMS prior to the distribution of any pool 4 reallocated DSH funds.

Additionally, for SPY 2010 forward, any remaining excess funding may be reallocated to pool 5. Additional DSH payments from Pool 5 are funded by transfers per IGAs. If more than one hospital has available voluntary match, the reallocation will be allocated based proportionately according to the hospital's LOM scores, subject to the lower of each hospital's remaining OBRA limit or the total computable matching fund amount designated for each hospital per the applicable IGA. AHCCCS shall notify CMS prior to the distribution of any pool 4 reallocated DSH funds. Any additional payments will be limited to a hospital's overall OBRA limit.

Pool 5 – Voluntary Intergovernmental Agreements
The funding for pool 5 will be provided through voluntary intergovernmental transfers to hospitals designated by political subdivisions, universities, and tribal governments. Political subdivisions, public universities, and tribal governments will notify AHCCCS of the hospitals that will be designated to receive funds and of the amount of matching funds that will be available through their intergovernmental agreements (IGAs). AHCCCS will provide CMS with a list of designated pool 5 hospitals as soon as it becomes available.

For SPY 2010, the funding for pool 5 is $26,000,000
For SPY 2011, the funding for Pool 5 is $16,000,000.
For SPY 2012, the funding for Pool 5 is $25,000,000.
For SPY 2013, the funding for Pool 5 is $ is $34,178,795.

Upon reconciliation, the non-federal portion of any Pool 5 funds that has to be recouped due to changes in hospital qualification or payment limits will be returned to the local match entity. The resulting federal funds will be returned to CMS.

**[To Be Placed on Public Hospital Letter Head]**

**State Plan Year _____**

☐ Initial

☐ Final

**CERTIFICATION STATEMENT**
**DISPROPORTIONATE SHARE HOSPITAL PAYMENT**

As the of Maricopa Medical Center, I certify that:

- Maricopa Medical Center has expended local funds in an amount equal to the OBRA Limit(s) indicated below.

- The local funds were not obligated to match other federal funds for any federal program and these funds are not federal funds.

- The attached Maricopa Medical Center OBRA Limit and CPE Schedule is true, accurate and complete to the best of my knowledge and belief and the information presented thereon is either identified and supported in the Hospital's accounting system, has been supplied to me by AHCCCS, or is supported by the attached documentation. I understand that the information presented on the Schedule is subject to audit.

- Maricopa Medical Center and I understand that the Disproportionate Share Hospital Payment received by the hospital will be from Federal funds, that any overpayment of those funds to the hospital will be recovered by AHCCCS, and that any falsification or concealment of a material fact made to receive payment of those funds may be prosecuted under Federal and/or State laws.

The estimated OBRA Limit Calculation for State Plan Year _____ is $ _____.

(Another line to certify a finalized amount will be added in the future)

_____ _____
Signature of CEO or CFO Printed Name

_____ _____
Title Date

**[To Be Placed on Public Hospital Letter Head]**

**State Plan Year 2008**

☐ Initial
☐ Final

**CERTIFICATION STATEMENT**
**DISPROPORTIONATE SHARE HOSPITAL PAYMENT**

As the of Arizona State Hospital, I certify that:

- Arizona State Hospital has expended State funds in an amount equal to the OBRA Limit(s) indicated below.

- The State funds were not obligated to match other federal funds for any federal program and these funds are not federal funds.

- The attached Arizona State Hospital OBRA Limit and CPE Schedule is true, accurate and complete to the best of my knowledge and belief and the information presented thereon is either identified and supported in the Hospital's accounting system, has been supplied to me by AHCCCS, or is supported by the attached documentation. I understand that the information presented on the Schedule is subject to audit.

- Arizona State Hospital and I understand that the Disproportionate Share Hospital Payment received by the hospital will be from Federal funds, that any overpayment of those funds to the hospital will be recovered by AHCCCS, and that any falsification or concealment of a material fact made to receive payment of those funds may be prosecuted under Federal and/or State laws.

The estimated OBRA Limit Calculation for State Plan Year _____ is $ _____.

(Another line to certify a finalized amount will be added in the future)

_____ _____
Signature of CEO or CFO Printed Name

_____ _____
Title Date

Spreadsheets – Excel Files

**Attachment E**

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

## Center for Medicaid and State Operations

### Letter Summary

*This letter clarifies some methods by which HCBS waivers under section 1915(c) may aid in the transitioning of individuals from institutional settings to their own home in the community through coverage of one-time transitional expenses. This clarification was promised in the HHS New Freedom Report to the President.*

---

SMDL #02-008

May 9, 2002

Dear State Medicaid Director:

Medicaid home and community-based services (HCBS) waivers are the statutory alternative to institutional care. Many states have found in HCBS waivers a cost-effective means to implement a comprehensive plan to provide services in the most integrated setting appropriate to the needs of individuals with disabilities.

However, individuals seeking a return to the community from institutions are faced with many one-time expenses, and many states are unclear about the extent to which waivers cover transition costs. Examples of those expenses include the cost of furnishing an apartment, the expense of security deposits, utility set-up fees, etc. Other states have expressed interest in having the waivers pay for apartment/housing rent. This letter is designed to answer such questions.

Federal funding under Medicaid HCBS waivers is not available to cover the cost of rent. States may offset rental expenses from state-only funds that augment federal HCBS resources, but federal financial participation (FFP) for such a purpose is not available for any apartment/housing rental expenses.

As the HHS Report for the President's *New Freedom Initiative* stated, however, states may secure federal matching funds under HCBS waivers for one-time, set-up expenses for individuals who make the transition from an institution to their own home or apartment in the community, such as security deposits, that do not constitute payment for housing rent.

States may pay the reasonable costs of *community transition services*, including some or all of the following components:

- Security deposits that are required to obtain a lease on an apartment or home;
- Essential furnishings and moving expenses required to occupy and use a community domicile;
- Set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating);
- Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy.

By reasonable costs, we mean necessary expenses in the judgment of the state for an individual to establish his or her basic living arrangement. For example, essential furnishings in the above context would refer to necessary items for an individual to establish his or her basic living arrangement, such a bed, a table, chairs, window blinds, eating utensils, and food preparation items. We would not consider essential furnishings to include diversional or recreational items such as televisions, cable TV access or VCRs.

States that choose to include community transition services in their HCBS waivers must demonstrate that this service, in combination with other services furnished under the waiver, would be cost-neutral to the Medicaid program. (In the streamlined HCBS waiver format, this cost neutrality is demonstrated in appendix G.) To be eligible for FFP, the service must be included in the individual's written plan of care (service plan) and fit within the service definitions established by the state.

For more than three years CMS has awarded "Nursing Facility Transition Grants" to states in which transition costs have been paid from grant funds. Those states found that coverage of transition expenses has been manageable, cost-effective and has greatly facilitated the expeditious integration of individuals into their communities from prior institutional living arrangements. Contacts and other relevant information about those states may be found on the CMS website.

Any questions concerning this letter may be referred to Mary Jean Duckett at (410) 786-3294.

Sincerely,

/s/

Dennis G. Smith
Director

cc:

CMS Regional Administrators
CMS Associate Regional Administrators
for Medicaid and State Operations

Lee Partridge
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Brent Ewig
Senior Director, Access Policy
Association of State and Territorial Health Officials

Jim Frogue
Acting Director, Health and Human Services Task Force
American Legislative Exchange Council

Trudi Matthews
Senior Health Policy Analyst
Council of State Governments

## Attachment F
## REIMBURSEMENT FOR CRITICAL ACCESS HOSPITALS

**Subject to the availability of state funds**, beginning May 1, 2002, supplemental payments will be made to non-I.H.S., non-638 facility in-state hospitals, certified by Medicare as Critical Access Hospitals (CAHs) under 42 CFR 485, Subpart F and 42CFR 440.170(g). These supplemental CAH payments shall be made in addition to the other payments described in Attachments 4.19-A (inpatient hospital) and 4.19-B (outpatient hospital). Supplemental payments shall be made based on each CAH designated hospital's percentage of total inpatient and outpatient Title XIX reimbursement paid relative to other CAH designated hospitals for the time period from July 1 through June 30 of the previous year.

AHCCCS will allocate the amount available through legislative appropriation in the following manner:

(1) Gather all adjudicated claims/encounters with dates of service from July 1 through June 30 of the prior year for each CAH-designated hospital.

(2) Sum the AHCCCS payments for inpatient and outpatient services for the year to establish a hospital-specific hospital paid amount.

(3) Total all AHCCCS payments for inpatient and outpatient services for the year to establish a total paid amount.

(4) Divide the hospital paid amount by the total paid amount to establish the hospital's utilization percentage.

(5) Divide the annual CAH appropriation by twelve to get the monthly CAH allocation.

(6) Multiply each hospital's monthly relative utilization by the monthly CAH allocation to establish each hospital's monthly payment.

Funding will be distributed based on the number of CAH-designated hospitals in each month and their Medicaid utilization. Because there may be a different number of CAH-designated hospitals each month, the hospital-specific weightings and payments may fluctuate from month to month. The calculations will be computed monthly and the distribution of the CAH dollars to the CAH-designated hospitals will be made twice a year.

**Attachment G**

**AACP** Acute Care and Behavioral Health Services

The following chart summarizes the services available to expansion populations covered under the Demonstration. It is not intended to be a detailed or comprehensive statement of benefit coverage. Except as specifically noted in the chart or elsewhere in the List of Waivers, CNOM's, and/or the Special Terms and Conditions, the scope of services for the expansion populations are as set forth in the Arizona State Plan.

| **Benefit** | **Title XIX** | | **Title XXI** |
|---|---|---|---|
| Age | < 21 yrs | ≥ 21 yrs | < 19 yrs |
| Inpatient Hospital Services | X | X | X |
| Outpatient Hospital Services and Rural Health Clinic Services | X | X | X |
| Other Lab and X-ray Services | X | X | X |
| Nursing Facility Services for Individuals 21 age or older other than services in an institution for mental disease | X | X | X |
| EPSDT- medical services and other services covered by Title XXI | X | | X |
| Family Planning Services and Supplies | X | X | |
| Physician Services | X | X | X |
| Medical and surgical services of a dentist | X | X | X |
| Medical or other remedial care provided by licensed practitioners | X | X | X |
| Home Health Services | X | X | X |
| Private Duty Nursing Services | X | X | X |
| Clinic Services | X | X | X |
| Dental Services | X | X | X |
| Physical Therapy and Related Services | X | X | X |
| Occupational Therapy | X | X | X |
| Services for individuals with speech hearing and language disorders | X | X | X |
| Prescribed Drugs | X | X | X |
| Prosthetic Devices | X | X | X |
| Eyeglasses | X | X | X |
| Diagnostic Services | X | X | X |
| Screening Services | X | X | X |
| Preventive Services | X | X | X |
| Rehabilitative services | | | |
| Inpatient hospital services, nursing facility services and intermediate care facility services for individuals age 65 or older in institutions for mental disease | X | X | X |
| Inpatient psychiatric facility services for individuals under 21 years of age | X | | X |
| Nurse mid-wife services | X | X | X |
| Hospice Care | | X | |
| Case Management and Tuberculosis related services | X | X | X |
| Respiratory care services | X | X | X |
| Certified Pediatric or family nurse practitioners' services | X | X | X |
| Transportation | X | X | X |
| Services of nurses in Religious Non-Medical Health Care Institutions | X | X | X |
| Nursing facility services for patients under 21 years of age | X | | X |
| Emergency hospital services | X | X | X |
| Personal Care Services | X | X | X |
| Behavioral Health | See Table 2 in STC #17 | | |
| | | | |

**Attachment H**
KidsCare II Operational Protocol

The following protocol provides operational specifics with respect to the opening of the KidsCare II program.

**Eligibility**
Children who were on the KidsCare waiting list and have income at or below 175 percent of the FPL, are not otherwise eligible for Medicaid, and meet all other requirements for the KidsCare II program are eligible for the KidsCare II program, based on available funding. Children who are on the KidsCare waiting list must pay outstanding KidsCare premiums before they can enroll into the KidsCare II program. In addition, children age 6 with income at or below 175 percent of the FPL who were Medicaid beneficiaries but who no longer qualify for Medicaid, will automatically be transferred to the KidsCare II program, if eligible.

**Enrollment Process**

Notices will be sent to households on the waiting list in the order in which they joined the waiting list, starting with the children who have been on the waiting list the longest. Households will have 30 days to respond and apply for KidsCare II. If a household does not respond within that 30 day period, it will be removed from the waiting list. However, households who respond after the 30 day response period has ended will be reviewed on a case-by-case basis if enrollment slots are still available. Notices will direct people to apply through Health-e-Arizona, the online application. The notices will provide locations and contact information for community assistors, including Health-e-Arizona subscriber sites and other community groups engaged in the statewide outreach effort. The notices will also include the telephone numbers for the Pima County Access Program (PCAP) hotline. Technical assistance will be available to households who request it.

AHCCCS will mail notices to 20,000 households in two initial phases of 10,000 mailings each, one week apart. In addition to the notices, AHCCCS will also use email addresses it has on file as another mechanism to contact households on the waiting list notifying them that they can apply for KidsCare II. The timing of these emails will correspond to the date when the notices described above are mailed.

In the event that less than 5,000 applications have been received for KidsCare II after the first two mailings, AHCCCS will have the next batch of notices to 20,000 households ready to go within two weeks after the date of the first mailing as an “on-deck” approach. AHCCCS will also ensure that the corresponding group of emails is also ready to be sent in tandem with the regular mail notices. AHCCCS will, on a weekly basis, monitor the caseload size/take-up rate, and adjust the size and timing of future mailings accordingly. The size and frequency of future mailings (e.g., lower to 5,000 or maintain at 20,000) will be based on actual application return rate, approval rate, and attrition. Should enrollment in KidsCare II drop below 15,000 children, AHCCCS will prepare additional mailings and utilize the same approach as described above.

Once a household has applied for the KidsCare II program through the Health-e-Arizona system, applications will be routed to the Department of Economic Security (DES) for Medicaid and KidsCare II determination. These applications will, in turn, be routed directly to a centralized office for Health-e-Arizona for processing. DES also has its own customer support line where KidsCare II applicants can call to determine the status of their application, but DES will refer applicants to the AHCCCS call center in order to receive information with respect to whether they are on the KidsCare waiting list, and if they are included in one of the "active" notice batches, i.e., the caller will be able to inquire if AHCCCS had sent them a notice informing them that they are eligible to apply for the KidsCare II program.

AHCCCS/DES will conduct specialized training for Health-e-Arizona staff, the State-operated customer service staff, and AHCCCS Office of the Client Advocate to ensure appropriate understanding of the KidsCare II program so that staff can more effectively assist beneficiary and applicant inquiries.

**Community Outreach**

Letters will be sent to Health-e-Arizona subscribers (representing about 220 community groups and facilities statewide) to educate about the new KidsCare II program. Once CMS approval is obtained, special training will be conducted for Health-e-Arizona subscribers, and additional training will be provided to the public through an AHCCCS Community Forum. Information regarding eligibility and process of the KidsCare II program will be posted to the AHCCCS website.

A third-party hotline will be established by PCAP that will operate during extended business hours during the week for a limited period. The hotline will work in coordination with AHCCCS to provide information about the KidsCare II waitlist to families. AHCCCS will provide PCAP access to the KidsCare waiting list as well as information on the children that have been sent notices to apply for the KidsCare II program in a manner that ensures the protection of hotline callers' and waitlist families' personal information.

**Attachment I**

Safety Net Care Pool Claiming Protocol

In accordance with the Special Terms and Conditions (STC) Section VI, this Attachment I serves as the claiming protocol for Arizona's Safety Net Care Pool (SNCP) uncompensated care payments. The protocol provides for the computation of the uncompensated care cost limit for each provider type that is authorized to receive uncompensated care payments in accordance with Section VI and identified in Attachment J. For each Demonstration Year (DY), aggregate uncompensated care payments will be a distribution of the SNCP pool established in Section VI for each DY, and payments to each individual provider cannot exceed the uncompensated care cost limit as determined by this cost claiming protocol for each DY.

Generally, the uncompensated care cost limit is determined based on each provider's uncompensated costs pertaining to Section 1905(a) medical services furnished to Medicaid eligible and uninsured individuals. Allowable patient care costs, consistent with Medicare and Medicaid cost principles and OMB Circular A-87, are identified using a CMS-approved cost report. Such costs are apportioned to the eligible Medicaid and uninsured services and then offset by all applicable revenues. SNCP payments made based on interim computation of the uncompensated care cost limit (using prior period cost data) must be subsequently reconciled to a recomputation of the uncompensated care costs using the provider's as-filed and audited cost reports for the actual service period covered by the DY.

Additionally, this Attachment also provides for the claiming protocol for Arizona Designated State Health Program (DSHP) approved for federal matching in accordance with STC Section VI.

**Hospital Inpatient and Outpatient Uncompensated Care Costs**

To be eligible for Federal financial participation (FFP), SNCP uncompensated care payments to each individual hospital cannot exceed the uncompensated care costs as computed by the following steps:

*Interim Computation of Uncompensated Care Costs*

SNCP uncompensated care payments will be made to eligible providers and claimed for FFP in quarterly installments per DY. Each DY's SNCP will be distributed based on the provider's proportionate share of projected uncompensated care, to the extent that sufficient local matching funds are available. This interim computation of uncompensated care costs will be used as the basis for SNCP distribution and will also serve as the uncompensated care cost limit for SNCP payments made to the provider in each demonstration year.

1. The process of determining the hospital's interim uncompensated care cost limit begins with the use of each hospital's most recent CMS 2552 filed with its Medicare contractor.

2. Per diem amount for each hospital routine cost center is computed by dividing:
   - The individual amounts on Worksheet B, Part I, Column 25, Lines (and where applicable subscripted lines) 25 to 33
   - by
   - The corresponding day totals on Lines (and where applicable subscripted lines) 5 through 11 and Line 14 (for inpatient hospital subproviders) from Worksheet S-3, Part I, Column 6

   Note when computing the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 25, Line 25 should have deducted the amounts appearing on Worksheet D-1, Part I, Lines 26 and 36 (for swing bed and private room differential adjustments, respectively), and the amount on Worksheet S-3, Part I, Column 6, Line 5 should have added the amount appearing on Line 26 (observation bed days).

   Ancillary ratio of cost-to-charges (RCC) for each hospital ancillary cost center is computed by dividing:
   - The individual line and subscript amounts for each of the Lines 37 to 63, taken from Worksheet B, Part I, Column 25
   - by
   - The individual line and subscript amounts for each of the Lines 37 to 63, taken from Worksheet C, Part I, Column 8

   (Note that the above cost report references are based on the CMS-2552-96. For later versions of the CMS-2552, the equivalent worksheets, columns and lines should be identified.)

3. For each hospital routine cost center, the per diem amount computed in Step #2 is applied to the number of Medicaid and uninsured hospital inpatient days for the service period

covered by the cost report used. Only *hospital* inpatient days are to be included; all days pertaining to long term care units or any other non-hospital units must be excluded. The number of Medicaid and uninsured hospital inpatient days must be derived from auditable sources, including the State's PMMIS, managed care encounter data, and provider patient accounting records. Hospital Medicaid and uninsured days are identified for each hospital routine cost center. The result is the facility's Medicaid and uninsured hospital routine cost.

For each hospital ancillary cost center, the RCC computed in Step #2 is applied to the Medicaid and uninsured hospital inpatient and hospital outpatient ancillary charges for the service period covered by the cost report used. Only *hospital* ancillary charges are to be included; all charges pertaining to non-hospital units, including Rural Health Clinics, Federally Qualified Health Centers, and clinics that are not recognized as hospital outpatient departments, must be excluded. The Medicaid and uninsured hospital ancillary charges must be derived from auditable sources, including the State's PMMIS, managed care encounter data, and provider patient accounting records. Hospital Medicaid and uninsured ancillary charges are identified for each hospital ancillary cost center. The result is the facility's Medicaid and uninsured hospital inpatient and hospital outpatient ancillary cost.

4. The Medicaid and uninsured costs computed in Step #3 will be offset by all revenues received by the hospital for the Medicaid and uninsured hospital inpatient and hospital outpatient services, including but not limited to Medicaid FFS and supplemental payments made by AHCCCS; Medicaid payments made by health plans and program contractors; payments made by or on behalf of patients; payments made by third parties; and any other payments received by for uninsured services that are not excluded from offset under Section 1923(g)(1)(A) of the Social Security Act as State-only or local-only indigent care program payments.

5. The computed Medicaid and uninsured uncompensated care costs based on a prior period may be inflated to the current period using CMS market basket. Furthermore, the State apply trending factors to account for changes in utilization (e.g., due to changes in Medicaid eligibility criteria) and Medicaid payment rates to ensure that interim uncompensated care costs approximate final uncompensated care costs for the current service period as closely as possible. Such trending factors must account for both increases and decreases affecting a provider's uncompensated care costs.

6. The hospital's Medicaid and uninsured costs must be further adjusted to remove costs related to non-emergency services furnished to unqualified aliens. For this purpose, the hospital's uncompensated care costs will be reduced by 12.88% to the extent that such unqualified alien non-emergency service costs are not fully reimbursed by DSH dollars.

7. For SNCP uncompensated care payments, the State must ensure that the payments made to hospitals are accounted for in the facility's disproportionate share hospital (DSH) OBRA 93 hospital-specific limit. There cannot be any duplication of payments for the same hospital uncompensated care costs under the SNCP and under DSH.

8. The interim computation of hospital uncompensated care cost limit as described above uses the same prior period cost report and other relevant data as that used by the State in its initial OBRA 93 hospital-specific limit computation for DSH payments for the current DSH State Plan Rate Year.

*Interim Reconciliation*

Each hospital's uncompensated care costs must be recomputed based on the hospital's as-filed cost report for the actual service period. The cost report is filed with the Medicare contractor five months after the close of the cost reporting period. SNCP uncompensated care payments made to the hospital for a DY cannot exceed the recomputed uncompensated care cost limit. If, at the end of the interim reconciliation process, it is determined that expenditures claimed exceeded the individual hospital's uncompensated care cost limit, the overpayment will be recouped from the hospital, and the federal share will be properly credited to the federal government.

The interim reconciliation follows the same computation as outlined above in the *Interim Computation of Uncompensated Care Costs* steps, except that the per diems and RCCs, Medicaid and uninsured days and charges, and payment offset amounts used will pertain to the actual service period (rather than the prior period). Per diems and RCCS will be derived from the as-filed cost report; and Medicaid and uninsured days, charges and payments will be derived from the latest available auditable data for the service period. No trending factor will be applied. The uncompensated care costs must again be adjusted to remove costs related to non-emergency services furnished to unqualified aliens. The State must ensure that there is no duplication of payments for the same hospital uncompensated care costs under the SNCP and under DSH; SNCP payments must be accounted for in the hospital's OBRA 93 hospital-specific limit.

A hospital's uncompensated care cost limit is determined for the twelve month period in each DY, except for DY 3 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2013. Where a hospital's cost reporting period does not coincide with the DY (or partial DY in DY3), the uncompensated care costs computed for a cost reporting period can be allocated to the DY (or partial DY) based on the number of cost reporting months that overlap with the DY (or partial DY). This is consistent with the methodology for the computation of the OBRA 93 hospital-specific limit for a given DSH State plan rate year.

The interim reconciliation described above will be performed and completed within six months after the filing of the hospital Medicare cost report(s).

*Final Reconciliation*

Each hospital's uncompensated care costs must be recomputed based on the hospital's audited cost report for the actual service period. The cost report is audited and settled by the Medicare contractor to determine final allowable costs and reimbursement amounts as recognized by Medicare. SNCP uncompensated care payments made to the hospital for a DY cannot exceed

the recomputed uncompensated care cost limit. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual hospital's uncompensated care cost limit, the overpayment will be recouped from the hospital, and the federal share will be properly credited to the federal government.

The final reconciliation follows the same computation as outlined above in the *Interim Computation of Uncompensated Care Costs* steps, except that the per diems and RCCs, Medicaid and uninsured days and charges, and payment offset amounts used will pertain to the actual service period (rather than the prior period). Per diems and RCCS will be derived from the audited cost report, and Medicaid and uninsured days, charges and payments will be updated with the latest available auditable data for the service period. No trending factor will be applied. The uncompensated care costs must again be adjusted to remove costs related to non-emergency services furnished to unqualified aliens. The State must ensure that there is no duplication of payments for the same hospital uncompensated care costs under the SNCP and under DSH; SNCP payments must be accounted for in the hospital's OBRA 93 hospital-specific limit.

A hospital's uncompensated care cost limit is determined for the twelve month period in each DY, except for DY 3 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2013. Where a hospital's cost reporting period does not coincide with the DY (or partial DY in DY3), the uncompensated care costs computed for a cost reporting period can be allocated to the DY (or partial DY) based on the number of cost reporting months that overlap with the DY (or partial DY). This is consistent with the methodology for the computation of the OBRA 93 hospital-specific limit for a given DSH State plan rate year.

The final reconciliation described above will be performed and completed within six months after the audited hospital Medicare cost report(s) are made available.

The final computation of hospital uncompensated care cost limit as described above uses the same final cost report and other relevant data as that used by the State in its final OBRA 93 hospital-specific limit computation for DSH payments for the given DSH State Plan Rate Year.

**Federally Qualified Health Center Lookalike (FQHC-LA) Uncompensated Care Costs**

To be eligible for Federal financial participation (FFP), SNCP uncompensated care payments to each individual FQHC-LA cannot exceed the uncompensated care cost limit as computed by the following steps:

*Interim Computation of Uncompensated Care Costs*

SNCP uncompensated care payments will be made to eligible providers and claimed for FFP in quarterly installments per DY. Each DY's SNCP will be distributed based on the provider's proportionate share of projected uncompensated care, to the extent that sufficient local matching funds are available. This interim computation of uncompensated care costs will be used as the basis for SNCP distribution and will also serve as the uncompensated care cost limit for SNCP payments made to the provider in each demonstration year.

1. The process of determining the FQHC-LA's interim uncompensated care cost limit begins with the use of each clinic's most recently available average cost per visit used for Medicaid reimbursement, as computed under the FQHC Alternative Payment Methodology in the Arizona State plan Attachment 4.19-B.

   The average cost per visit is derived from FQHC-LA cost reports filed with AHCCCS. (The State plan provides that this average cost per visit is computed based on costs and visits for two consecutive cost reporting periods.) The State must ensure that the FQHC-LA cost report accounts for only allowable costs related to FQHC health care services, including staff and other healthcare costs and allocable overhead; removes any costs related to non-FQHC services and any overhead allocable to non-reimbursable activities; allows only for costs that are consistent with Medicare and Medicaid cost principles and OMB Circular A-87; and defines a visit consistent with the State plan definition of an FQHC visit.

2. The average cost per visit is multiplied by the number of uninsured visits pertaining to the most recently available cost reporting period. The number of uninsured FQHC-LA visits must be derived from auditable sources. The result is the facility's uninsured cost.

   Note that for interim computation of uncompensated care costs, Medicaid visits are not included, as these Medicaid visits are reimbursed at the average cost per visit being used to estimate current period actual cost per visit.

3. The uninsured costs computed in Step #2 will be offset by all revenues received by the FQHC-LA for the uninsured services, including but not limited to payments made by or on behalf of patients and any other payments received for uninsured services including applicable grants.

5. The average cost per visit has already been trended to the current period. However, the State can apply trending factors to account for known changes in uninsured utilization to ensure that interim uncompensated care costs approximate final uncompensated care

costs for the current service period as closely as possible. Such trending factors must account for both increases and decreases affecting a provider's uncompensated care costs.

6. The FQHC-LA's uninsured costs must be further adjusted to remove costs related to non-emergency services furnished to unqualified aliens. For this purpose, the clinic's uncompensated care costs will be reduced by 12.88.

*Interim Reconciliation*

Each FQHC-LA's uncompensated care costs must be recomputed based on the actual as-filed cost report for the actual service period. The cost report is filed with AHCCCS covering the federal fiscal year (ending September 30) by April of the following year. SNCP uncompensated care payments made to the FQHC-LA for a DY cannot exceed the recomputed uncompensated care cost limit. If, at the end of the interim reconciliation process, it is determined that expenditures claimed exceeded the individual clinic's uncompensated care cost limit, the overpayment will be recouped from the clinic, and the federal share will be properly credited to the federal government.

The interim reconciliation follows the same computation as outlined above in the *Interim Computation of Uncompensated Care Costs* steps, except that:

- The cost per visit is computed based on allowable FQHC-LA cost and total visits pertaining to the actual service period cost report.
- Both Medicaid visits and uninsured visits furnished during the service period are applied to the actual cost per visit to determine the clinic's Medicaid and uninsured costs. Medicaid and uninsured visits must be derived from auditable sources, including the State's PMMIS, managed care encounter data, and provider patient accounting records.
- Both Medicaid and uninsured revenues, applicable to actual service period and derived from auditable sources, are offset against Medicaid and uninsured costs to arrive at the clinic's uncompensated care costs.
- No trending factor will be applied.

The uncompensated care costs must again be adjusted to remove costs related to non-emergency services furnished to unqualified aliens.

An FQHC-LA's uncompensated care cost limit is determined for the twelve month period in each DY, except for DY 3 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2013. Where a clinic's cost reporting period does not coincide with the DY (or partial DY in DY3), the uncompensated care costs computed for a cost reporting period can be allocated to the DY (or partial DY) based on the number of cost reporting months that overlap with the DY (or partial DY).

The interim reconciliation described above will be performed and completed within six months after the filing of the FQHC-LA cost report(s).

*Final Reconciliation*

Each FQHC-LA's uncompensated care costs must be recomputed based on the actual audited cost report for the actual service period. The cost report is audited to ensure costs are allowable consistent with Medicare and Medicaid cost principles and OMB Circular A-87; and that FQHC services and visits are recognized consistent with the Medicaid State plan. SNCP uncompensated care payments made to the FQHC-LA for a DY cannot exceed the recomputed uncompensated care cost limit. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual clinic's uncompensated care cost limit, the overpayment will be recouped from the clinic, and the federal share will be properly credited to the federal government.

The final reconciliation follows the same computation as outlined above in the *Interim Computation of Uncompensated Care Costs* steps, except that:

- The cost per visit is computed based on audited allowable FQHC-LA cost and total visits pertaining to the actual service period cost report.
- Both Medicaid visits and uninsured visits furnished during the service period are applied to the audited cost per visit to determine the clinic's Medicaid and uninsured costs. Medicaid and uninsured visits must be derived from the latest available auditable sources, including the State's PMMIS, managed care encounter data, and provider patient accounting records.
- Both Medicaid and uninsured revenues, applicable to actual service period and derived from the latest available auditable sources, are offset against Medicaid and uninsured costs to arrive at the clinic's uncompensated care costs.
- No trending factor will be applied.

The uncompensated care costs must again be adjusted to remove costs related to non-emergency services furnished to unqualified aliens.

An FQHC-LA's uncompensated care cost limit is determined for the twelve month period in each DY, except for DY 3 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2013. Where a clinic's cost reporting period does not coincide with the DY (or partial DY in DY3), the uncompensated care costs computed for a cost reporting period can be allocated to the DY (or partial DY) based on the number of cost reporting months that overlap with the DY (or partial DY).
The final reconciliation described above will be performed and completed within eighteen months after the filing of FQHC-LA cost report(s).

**Physician Professional Service Uncompensated Care Costs**

To be eligible for Federal financial participation (FFP), SNCP uncompensated care payments to each provider cannot exceed the uncompensated care costs as computed by the following steps. The eligible providers include hospitals that employ and contract for physician services and incur physician professional service costs (whether the professional services are billed by the hospital or by the physicians). (Physician professional service uncompensated care costs incurred by physician practice groups will be addressed in a future revision to this protocol.)

*Interim Computation of Uncompensated Care Costs*

SNCP uncompensated care payments will be made to eligible providers and claimed for FFP in quarterly installments per DY. Each DY's SNCP will be distributed based on the provider's proportionate share of projected uncompensated care, to the extent that sufficient local matching funds are available. This interim computation of uncompensated care costs will be used as the basis for SNCP distribution and will also serve as the uncompensated care cost limit for SNCP payments made to the provider in each demonstration year.

1. Steps for hospitals incurring physician professional service costs

a. The professional component of physician costs are identified from each hospital's most recently filed Medi-Cal 2552 cost report Worksheet A-8-2, Column 4. These professional costs are:

    1. Limited to allowable and auditable physician compensations that have been incurred by the hospital;
    2. For the professional, direct patient care furnished by the hospital's physicians;
    3. Identified as professional costs on Worksheet A-8-2, Column 4 of the cost report of the hospital claiming payment (or, for registry physicians only, Worksheet A-8, if the physician professional compensation cost is not reported by the hospital on Worksheet A-8-2 because the registry physicians are contracted solely for direct patient care activities (i.e., no administrative, teaching, research, or any other provider component or non-patient care activities));
    4. Supported by a time study, accepted by Medicare for Worksheet A-8-2 reporting purposes, that identified the professional, direct patient care activities of the physicians (not applicable to registry physicians discussed above); and
    5. Removed from hospital costs on Worksheet A-8.

b. The professional costs on Worksheet A-8-2, Column 4 (or Worksheet A-8 for registry physicians) are subject to further adjustments and offsets, including any necessary adjustment to bring the costs in line with Medicare and Medicaid cost principles and OMB Circular A-87. However, Medicare physician reasonable compensation equivalents are not applied for physician professional cost determination purposes. The professional costs are further subject to offsets to account for any applicable non-patient care revenues that were not previously offset or accounted for by the application of time study. The resulting costs represent the net allowable professional service costs incurred by the

hospitals.

c. Reimbursement for other professional practitioner service costs that have also been identified and removed from hospital costs on the Medicare cost report. The practitioner types to be included are:

1. Certified Registered Nurse Anesthetists
2. Nurse Practitioners
3. Physician Assistants
4. Dentists
5. Certified Nurse Midwives
6. Clinical Social Workers
7. Clinical Psychologists
8. Optometrists

d. To the extent these practitioners' professional compensation costs are not included in Worksheet A-8-2, Column 4, but are removed from hospital costs through an A-8 adjustment on the Medi-Cal cost report, these costs may be recognized if they meet the following criteria:

1. the practitioners must engage in the direct provision of care in addition to being Medicaid-qualified practitioners for whom the services are billable under Medicaid separate from hospital services;
2. for all non physician practitioners there must be an identifiable and auditable data source by practitioner type;
3. a CMS-approved time study must be employed to allocate practitioner compensation between clinical and non-clinical costs; and
4. the clinical costs resulting from the CMS-approved time study are subject to further adjustments and offsets, including adjustments to bring the costs in line with Medicare cost principles and offset of applicable non-patient care revenues that were not previously offset or accounted for by the application of CMS-approved time study.

The resulting net clinical non-physician practitioner compensation costs are allowable costs. The compensation costs for each non-physician practitioner type are identified separately.

e. Professional costs incurred for freestanding clinics (clinics that are not recognized as hospital outpatient departments on the 2552) are not included in this protocol.

f. Hospitals may additionally include physician support staff compensation, data

processing, and patient accounting costs as physician-related costs to the extent that:

1. These costs are removed from hospital inpatient and outpatient costs because they have been specifically identified as costs related to physician professional services;
2. They are directly identified on ws A-8 as adjustments to hospital costs;
3. They are otherwise allowable and auditable provider costs; and
4. They are further adjusted for any non-patient-care activities such as research based on physician time studies.

If these are removed as A-8 adjustments to the hospital's general service cost centers, these costs should be stepped down to the physician cost centers based on the accumulated physician professional compensation costs. Other than the physician and non-physician practitioner compensation costs and the A-8 physician-related adjustments discussed above, no other costs are allowed.

g. Total billed professional charges by cost center related to physician services are identified from auditable provider records. Similarly, for each non-physician practitioner type, the total billed professional charges are identified from provider records. Charges must be identified for all professional services for which the hospital incurred its cost (whether salaried or contracted). Where the professional services are not billed by the hospital directly, the hospital must obtain those professional charges from the billing party.

h. A physician cost to charge ratio for each cost center is calculated by dividing the total costs for each cost center as established in paragraphs a-f of subsection 1 by the total billed professional charges for each cost center as established in paragraph g of subsection 1. For each non-physician practitioner type, a cost to charge ratio is calculated by dividing the total costs for each practitioner type as established in paragraphs a-f of subsection 1 by the total billed professional charges for each practitioner type as established in paragraph g of subsection 1.

i. The total professional charges for each cost center related to eligible Medicaid and uninsured physician services are identified using auditable records. Hospitals must map the charges to their cost centers. Each charge may only be mapped to one cost center to prevent duplicate mapping and claiming. These charges must be associated with services furnished during the period covered by the latest as-filed cost report.

For each non-physician practitioner type, the eligible Medicaid and uninsured professional charges are identified using auditable records. Hospitals must map the charges to non-physician practitioner type. Each charge may only be mapped to one practitioner type to prevent duplicate mapping and claiming. These charges must be associated with services furnished during the period covered by the latest as-filed cost report.

Auditable records include the State's PMMIS, managed care encounter data, and hospital records.

j. The total Medicaid and uninsured costs related to physician practitioner professional services are determined for each cost center by multiplying total Medicaid and uninsured charges as established in paragraph i of subsection 1 by the respective cost to charge ratio for the cost center as established in paragraph h of subsection 1.

For each non-physician practitioner type, the total Medicaid and uninsured costs related to non-physician practitioner professional services are determined by multiplying total Medicaid and uninsured charges as established in paragraph i of subsection 1 by the respective cost to charge ratios as established in paragraph h of subsection 1.

k. The total Medicaid and uninsured uncompensated care costs are determined by subtracting all revenues received for the Medicaid and uninsured physician/practitioner services from the Medicaid and uninsured costs as established in paragraph j of subsection 1. The revenues are derived from auditable records. All revenues received for the Medicaid and uninsured professional services will be offset against the computed cost; these revenues include but are not limited to all Medicaid payments from the State or its program contractors, payments from or on behalf of patients, and payments from any other third party payer. The total professional service uncompensated care costs as computed above should be reduced by 12.88% to account for non-emergency care furnished to unqualified aliens.

l. The Medicaid and uninsured physician/practitioner amount computed in paragraph k of subsection 1 above can be trended to current period to account for cost inflation based on CMS market basket update factor. Furthermore, the State apply trending factors to account for changes in utilization (e.g., due to changes in Medicaid eligibility criteria) and Medicaid payment rates to ensure that interim uncompensated care costs approximate final uncompensated care costs for the current service period as closely as possible. Such trending factors must account for both increases and decreases affecting a provider's uncompensated care costs.

*Interim Reconciliation*

Each hospital's uncompensated care costs must be recomputed based on the as-filed cost report for the actual service period. The hospital cost report is filed with the Medicare contractor five months after the close of the cost reporting period. SNCP uncompensated care payments made to the hospital for a DY cannot exceed the recomputed uncompensated care cost limit. If, at the end of the interim reconciliation process, it is determined that expenditures claimed exceeded the individual hospital's uncompensated care cost limit, the overpayment will be recouped, and the federal share will be properly credited to the federal government.

The interim reconciliation follows the same computation as outlined above in the *Interim Computation of Uncompensated Care Costs* steps, except that the RCCs, Medicaid and uninsured charges, and payment offset amounts used will pertain to the actual service period

(rather than the prior period). RCCS will be derived from the as-filed cost report; and Medicaid and uninsured charges and payments will be derived from the latest available auditable data for the service period. No trending factor will be applied. The uncompensated care costs must again be adjusted to remove costs related to non-emergency services furnished to unqualified aliens.

A hospital's uncompensated care cost limit is determined for the twelve month period in each DY, except for DY 3 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2013. Where a hospital's cost reporting period does not coincide with the DY (or partial DY in DY3), the uncompensated care costs computed for a cost reporting period can be allocated to the DY (or partial DY) based on the number of cost reporting months that overlap with the DY (or partial DY).

The interim reconciliation described above will be performed and completed within six months after the filing of the cost report(s).

*Final Reconciliation*

Each hospital's uncompensated care costs must be recomputed based on the audited cost report for the actual service period. The hospital cost report is audited and settled by the Medicare contractor to determine final allowable costs and reimbursement amounts as recognized by Medicare. SNCP uncompensated care payments made to the hospital for a DY cannot exceed the recomputed uncompensated care cost limit. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual hospital's uncompensated care cost limit, the overpayment will be recouped, and the federal share will be properly credited to the federal government.

The final reconciliation follows the same computation as outlined above in the *Interim Computation of Uncompensated Care Costs* steps, except that the RCCs, Medicaid and uninsured charges, and payment offset amounts used will pertain to the actual service period (rather than the prior period). RCCS will be derived from the audited cost report, and Medicaid and uninsured charges and payments will be updated with the latest available auditable data for the service period. No trending factor will be applied. The uncompensated care costs must again be adjusted to remove costs related to non-emergency services furnished to unqualified aliens.

A hospital's uncompensated care cost limit is determined for the twelve month period in each DY, except for DY 3 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2013. Where a hospital's cost reporting period does not coincide with the DY (or partial DY in DY3), the uncompensated care costs computed for a cost reporting period can be allocated to the DY (or partial DY) based on the number of cost reporting months that overlap with the DY (or partial DY).

For hospital-incurred professional service uncompensated care costs, the final reconciliation described above will be performed and completed within six months after the audited hospital Medicare cost report(s) are made available.

**Designated State Health Program (DSHP) - Trauma and Emergency Services Fund**

Arizona State Proposition 202 authorizes the use of State tribal gaming revenues for the Trauma and Emergency Services Fund. The fund, administered by AHCCCS, provides payments to Arizona hospitals to offset trauma center readiness costs and emergency services costs.

The fund, as it is currently operated, distributes 90% of available funds to Arizona hospitals that qualify as Level 1 Trauma Centers and 10% of available funds to Arizona hospitals that operate an emergency department. The 90% Level I Trauma Center amount is distributed proportionally to qualifying hospitals based upon each hospital's total of Injury Severity Score times the number of cases at that level. Hospitals report trauma scores and case volume on an Acuity-Adjusted Volume worksheet that uses hospital utilization from a twelve-month period that ends on June 30 of the previous Federal Fiscal Year. The 10% Emergency Department amount is distributed proportionately to qualifying hospitals based on each hospital's emergency department costs, as reported on its Medicare cost report, Worksheet B, Part I, Column 0, Line 61. In DY1, cost report data for the period July 2010 through June 2011 will be used. In DY2, cost report data for the period July 2011 through June 2012 will be used. When a hospital has two cost reports that span this reporting period, data from the two hospital cost reports that span that period will be allocated based upon each cost report's proportion of the reporting period.

Section VI of these STCs allows the Trauma and Emergency Services Fund to be recognized as a DSHP eligible for SNCP claiming in DY 1 and DY 2. The maximum amount per each Demonstration year that would qualify for SNCP claiming is $20 million total computable.

For each demonstration year, the State should document its computation and distribution of its Trauma and Emergency Services Fund payments to each qualifying hospital. Upon distribution of payments to the hospitals, the State would be allowed to claim FFP of the actual paid amounts as part of the SNCP claims, subject to the $20 million total computable limit. The State should include a schedule of the payment amounts made to each qualifying hospital in its annual DY SNCP reporting to CMS.

**Attachment J**

Participating Providers in the SNCP

Hospital Uncompensated Care Cost Payments

- Phoenix Children's Hospital
- University Medical Center
- University Physicians Healthcare Hospital at Kino Campus
- Maricopa Medical Center
- Little Colorado Medical Center (Winslow Memorial Hospital) - effective DYs 2 and 3 only
- Southeast Arizona Medical Center - effective DYs 2 and 3 only
- White Mountain Regional Medical Center - effective DYs 2 and 3 only

Federally Qualified Health Center Lookalike (FQHC-LA) Uncompensated Care Cost Payments

**Avondale Family Health Center**
950 E. Van Buren, Avondale 85323
623.344.6800

**El Mirage Family Health Center**
12428 W. Thunderbird, El Mirage 85335
623.344.6500

**Glendale Family Health Center**
5141 W. Lamar St., Glendale 85301
623.344.6700

**Maryvale Family Health Center**
4011 N. 51st Ave., Phoenix 85031
623.344.6900

**Chandler Family Health Center**
811 S. Hamilton, Chandler 85225
480.344.6100

**Guadalupe Family Health Center**
5825 E. Calle Guadalupe, Guadalupe 85283
480.344.6000

**Mesa Family Health Center**
59 S. Hibbert, Mesa 85210
480.344.6200

**Comprehensive Healthcare Center**
2525 E. Roosevelt St., Phoenix 85008
602.344.1015

**McDowell Healthcare Center**
1144 E. McDowell Rd., Phoenix 85006
602.344.6550

**7th Avenue Family Health Center**
1205 S. 7th Ave., Phoenix 85007
602.344.6600

**South Central Family Health Center**
33 W. Tamarisk St., Phoenix 85041
602.344.6400

**Sunnyslope Family Health Center**
934 W. Hatcher, Phoenix 85021
602.344.6300

**7th Avenue Walk In Clinic**
1201 S. 7th Ave.
Phoenix 85007
**Phone:** (602) 344-6655

Physician Professional Service Uncompensated Care Cost Payments
- Phoenix Children's Hospital
- Maricopa Medical Center
- University Physician's Healthcare

Non-Physician Practitioner Professional Service Uncompensated Care Cost Payments - effective DYs 2 and 3
- Maricopa Medical Center

**Attachment K**

IHS and 638 Facilities Uncompensated Care Payment Methodologies

The two methodologies outlined below have been approved for structuring a payment that will be made to IHS and 638 facilities that take in to account their uncompensated costs in furnishing specified types of care furnished by IHS and tribal 638 facilities, to Medicaid-eligible individuals, and other individuals with net family income at or below 100 percent of the Federal poverty level (FPL).

Participating facilities must select one of the two possible options as described below in determining these payments to the facilities:

**Option 1 – Encounter Based Approach**

1. On a monthly basis, facilities will track services provided to individuals with net family income up to 100 percent of the FPL using the appropriate family size and income level limit as specified in the annual Federal Poverty Level tables issued by the U.S. Department of Health & Human Services. These services would include those that are no longer covered for Medicaid eligible individuals under the Arizona Medicaid State plan as well as services provided to individuals who are no longer Medicaid eligible, but under the 100 percent income threshold.
2. The facilities will utilize the attached tracking documents in Exhibits 1 – 3 to record the service provided, the unit of service, the all-inclusive rate, and if the service was provided to an American Indian/Alaskan Native (AI/AN) or to a non-native.
3. The facility will conduct a high-level income determination, which can include, but is not limited to self-attestation or the use of a recent pay stub.
4. The tracking document, along with the cover letter signed by the facility CEO or CFO facility director certifying that the information contained in the tracking document is accurate, will be sent to AHCCCS which will pay the facility the rate AHCCCS would have otherwise paid for the recorded services and draw down the correct FMAP based on the facility's breakdown of AI/AN versus non-native services.

**Option 2 – Historical Data Approach**

This approach is comprised of the following two steps that will be used to calculate the total dollar amount of uncompensated care that will be paid to IHS and 638 facilities on a prospective basis. The steps are as follows:

1) The State will calculate a per member per month (PMPM) rate for AI/AN childless adults enrolled in AHCCCS Acute Care Plan (AACP) using historical utilization data (July 1, 2010 through June 30, 2011) for the services that were furnished in or by IHS/tribal 638 facilities to the childless adult population (who are no longer covered under AHCCCS). This rate is multiplied by the total number of AI/AN childless adults that have been disenrolled from the program in that month since July 2011. This PMPM will be adjusted on an annual basis to mirror the medical inflation adjustment applied to the all-inclusive rate.

2) The State will calculate a second PMPM, using historical data, to reflect the services that it removed from the Medicaid State plan effective October 1, 2010, that were furnished in or by IHS/tribal 638 facilities to AHCCCS-enrolled individuals, and would multiply this rate by the total number of adult AI/ANs currently enrolled in the AHCCCS program. This PMPM will be adjusted on an annual basis to mirror the medical inflation adjustment applied to the all-inclusive rate.

Once this aggregate dollar amount has been computed using the steps 1 and 2 as outlined above, the State will disburse payments to the IHS and 638 facilities based on payments made to each facility for care provided to AI/AN childless adults from July 1, 2010 through June 30, 2011.

In addition, the State will annually review whether the PMPMs calculated in steps 1 and 2 above were accurate within a reasonable margin of error by comparing them to actual claims submitted under approach 1 by one or more facilities or, if no facilities elect approach 1, by reviewing actual records of services furnished by one or more facilities. If the PMPM is not validated, the State will apply an adjustment factor for the following year.

As part of this option, the non-Federal share for services provided to non-natives would be calculated based on the following.

1. After analyzing claims data from 2009-10, the State calculated a ratio of claims paid for currently covered Arizona Medicaid State plan services that were provided at IHS and 638 facilities to non-natives to the total number of paid claims to IHS and 638 facilities. Using this ratio, the State calculated that approximately $2 million out of total claims paid to IHS facilities was for services provided to non-natives. As such, the State will pay the non-Federal share of the $2 million. The State will review the claims data on an annual basis and will adjust the non-Federal share amount accordingly.
2. The State will apply the ratio that was calculated of non-native costs to total IHS costs as described above to calculate the non-Federal portion of the eligibility and service PMPM payments as described above.

**Calculation for Cost of Services to Persons Ineligible for AHCCCS**

| | |
|---|---|
| FY 2011 Total Paid | 90,000,000 |
| Average monthly membership | 22,996 |
| per member per month (pmpm) | $326 |

**Monthly Payment Calculation – Ineligible Individuals**

| | |
|---|---|
| March - Decrease in Native American Childless Adult coverage since Freeze | 9,391 |
| March Eligibility Payment (PMPM * 9,391) | $3,061,466 |

**Monthly Payment Calculation – Services**

| | |
|---|---|
| Adult Per Member Per Month Service Funding | $15.11 |
| Total Number of AI/AN Adults Enrolled with AHCCCS | 56,851 |
| May Services Payment | $859,018.61 |
| Total May Payment to I.H.S and 638 Facilities (Eligibility + Services) | $3,920,484.61 |
| Facility A - Allocation - 1% | $39,204.85 |
| Facility B - Allocation - 5% | $196,024.23 |

**Exhibit 1 to Attachment K**
**Option 1 Encounter Based Approach Cover Letter**

# Summary of the Monthly Report to AHCCCS for the Option 1 Supplemental Payment

Reporting Month: _____

Facility Name:_____

# of Adults under 100% FPL who are not Medicaid eligible to whom covered services was provided:

_____

# of visits that were provided to the above individuals for AHCCCS covered services:

_____

# of Medicaid individuals to whom services were provided that were eliminated from the Medicaid program in the 2010 & 2011 benefit reductions:

_____

# of visits that were provided to the Medicaid individuals for services that were eliminated from the Medicaid program in the 2010 & 2011 benefit reductions:

_____

I hereby attest that the information submitted is prepared in compliance with the Option 1 payment methodology Desk Level Procedures and is current, complete, and accurate to the best of my knowledge and belief. The expenditures included in this report are based on the accounting records of actual recorded expenditures, and are not based on estimates. I understand that payment of these claims will be from federal funds and whoever knowingly and willfully makes or causes to be made a false statement or representation on the reports may be prosecuted under the applicable federal and state laws.

CEO or CFO Signature:_____

**Exhibit 2 to Attachment K**
**Option 1 Encounter Based Approach Tracking Sheet**

The spreadsheet below will be used in tracking uncompensated care costs associated with services provided to individuals who have net family income up to 100 percent of the FPL, but are not enrolled in the AHCCCS program.

**Facility Name:** _____

| Name of Individual Receiving Services | Income verified | American Indian Y/N | Service Date | Service Provided | Inpatient or Outpatient | Service Rate | Patient Account Number |
|---|---|---|---|---|---|---|---|

DRAFT

**Exhibit 3 to Attachment K**
**Option 1 Encounter Based Approach Tracking Sheet**

The spreadsheet below will be used in tracking uncompensated care costs associated with services provided to AHCCCS beneficiaries that are no longer covered under the Arizona Medicaid State plan.

**Facility Name:** _____

| AHCCCS ID | American Indian Y/N | Service Date | Service Provided | Inpatient or Outpatient | Service Rate | Patient Account Number |
|---|---|---|---|---|---|---|

DRAFT

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

Center for Medicaid and CHIP Services

APR 0 6 2012

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

Dear Mr. Betlach:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is granting your request to amend Arizona's Medicaid section 1115 Demonstration, the Arizona Health Care Cost Containment (AHCCCS) Demonstration (11-W-00275/09 and 21-W-00064/9). Approval of the amendment to this Demonstration is under the authority of section 1115(a) of the Social Security Act and is effective from the date of this letter through the end of the Demonstration.

This award approves outstanding requests that Arizona had included in its request for its new section 1115 demonstration last year along with the additional measure that permits Arizona to resume some coverage of CHIP eligible children. Specifically, CMS is approving the State's request to establish a new coverage program for children up to age 19 with family income above Medicaid income levels and below 175 percent of the Federal poverty level (FPL), the KidsCare II Program. Expanding coverage to children is an important feature of the Demonstration as it furthers the coverage objectives of the Medicaid and CHIP programs.

CMS is also approving the creation of the Safety Net Care Pool (SNCP), which will allow the State to make payments to certain hospitals and other providers to reflect the burden of uncompensated care costs, as well as for costs associated with Arizona's Proposition 202 Trauma/Emergency Room Designated State Health Program. The SNCP will help to fund the KidsCare II program by allocating a percentage of the total pool amount to KidsCare II.

As indicated in our February 17, 2012, letter, CMS shares the State's goal of maintaining the financial viability of IHS facilities, including tribal facilities funded under compacts or contracts pursuant to Public Law 93-638 ("tribal 638 facilities"), to ensure the continuing availability of their robust health care service delivery network for current and future Medicaid beneficiaries. As such, this award also provides the State authority to make payments to such facilities to reflect uncompensated care that is in categories that, prior to October 1, 2010, would have been covered under the Medicaid State plan and that is furnished in or by the facility to individuals with family income up to 100 percent of the FPL. The State's assumption of responsibility for the non-Federal share with respect to services that are provided at IHS and 638 facilities to beneficiaries who are not identified as American Indian/Alaskan Native (Al/AN) is central to

CMS' ability to approve this request. With this authority, the State will be able to test the effects of the payments on the financial viability of IHS and 638 providers

The CMS approval of the AHCCCS Demonstration amendment is conditioned upon continued compliance with the enclosed set of Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated Federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

A copy of the revised STCs and expenditure authorities is enclosed. The waivers for the Demonstration are unchanged by this amendment, and remain in force.

I appreciate the work that you and your staff have done on these amendments, as well as the partnership of the Arizona tribes and the hospital community. Your project officer for this demonstration is Ms. Jessica Schubel. She is available to answer any questions concerning your section 1115 demonstration and this amendment. Ms. Schubel's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-3032
Facsimile: (410) 786-5882
E-mail: Jessica.Schubel@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Schubel and to Ms. Gloria Nagle, Associate Regional Administrator for the Division of Medicaid and Children's Health in our San Francisco Regional Office. Ms. Nagle's contact information is as follows:

Ms. Gloria Nagle
Associate Regional Administrator
Division of Medicaid and Children Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103 -6706

If you have questions regarding this approval, please contact Ms. Victoria Wachino, Director, Children and Adults Health Programs Group, Center for Medicaid and CHIP and Services, at (410) 786-5647:

Sincerely,

/s/

Cindy Mann
Director

Enclosures

cc: Victoria Wachino, Director, Children and Adults Health Programs Group, CMCS
Gloria Nagle, ARA, San Francisco Regional Office

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**EXPENDITURE AUTHORITY**

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

**TITLE:** **Arizona Medicaid Section 1115 Demonstration**

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

**Medicaid Costs Not Otherwise Matchable**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below (which would not otherwise be included as matchable expenditures under section 1903 of the Act) shall, for the period beginning October 22, 2011, through September 30, 2016, unless otherwise specified, be regarded as matchable expenditures under the State's Medicaid State plan:

## I. Expenditures Related to Administrative Simplification and Delivery Systems

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

    a Section 1903(m)(2)(A)(vi) of the Act insofar as it requires compliance with requirements in section 1932(a)(4) of the Act and 42 CFR 438.56(c)(2)(i) that enrollees be permitted an initial period after enrollment that would be longer than 30 days to disenroll without cause.

    b Section 1903(m)(2)(A)(xii) of the Act, but only insofar as it requires the State to comply with section 1932(a)(3) of the Act and 42 CFR 438.52 to offer a choice of at least two managed care organizations (MCOs) in the Arizona Long Term Care Service (ALTCS) and Comprehensive Medical and Dental Program (CMDP) programs, and only as long as enrollees in such plans have a choice of at least two primary care providers, and may request change of primary care provider at least at the times described in 42 CFR 438.56(c). Notwithstanding this authority, the State must offer a choice of at least two MCOs to elderly and physically disabled individuals in Maricopa County.

    c Section 1903(m)(2)(H) of the Act and 42 CFR 438.56(g), but only insofar as to allow the State to automatically reenroll an individual who loses Medicaid eligibility for a period of 90 days or less in the same managed care plan from which the individual was previously enrolled.

2. Expenditures under contracts with managed care entities that do not provide for payment for Indian health care providers as specified in section 1932(h) of the Act, when the State pays Indian health providers for covered services furnished to AHCCCS managed care plan enrollees at the State plan rate.

3. Expenditures for State payments for services furnished to managed care enrollees by Indian health providers, when those payments are offset from the managed care capitation payment.

4. Expenditures that would have been disallowed under section 1903(u) of the Act and 42 CFR 431.865 based on Medicaid Eligibility Quality Control (MEQC) findings.

5. Expenditures for outpatient drugs which are not otherwise allowable under section 1903(i)(10) of the Act.

6. Expenditures for outpatient drugs which are not otherwise allowable under section 1903(i)(23) of the Act. This expenditure authority will expire on November 1, 2012.

7. Expenditures for direct payments to Critical Access Hospitals (CAH) for services provided to AHCCCS enrollees in the Acute Care and ALTCS managed care programs that are not consistent with the requirements of 42 CFR 438.60.

8. Expenditures for inpatient hospital and long-term care facility services, other institutional and non-institutional services (including drugs) provided to AHCCCS fee-for-service beneficiaries, that exceed the amounts allowable under section 1902(a)(30)(A) of the Act (42 CFR 447.250 through 447.280, 447.300 through 447.334) but are in accordance with Special Term and Condition (STC) #52 entitled "Applicability of Fee-for-Service Upper Payment Limit."

9. Expenditures for inpatient hospital services that take into account the situation of hospitals with a disproportionate share of low-income patients but are not allowable under sections 1902(a)(13)(A) and 1923 of the Act, but are in accordance with the provisions for disproportionate share hospital (DSH) payments that are described in the STCs.

10. Expenditures for medical assistance including Home and Community Based Services furnished through ALTCS for individuals over age 18 who reside in Alternative Residential Settings classified as residential Behavioral Health Facilities.

**II. Expenditures Related to Expansion of Existing Eligibility Groups based on Eligibility Simplification**

11. Expenditures related to:

    a. Medical assistance furnished to ALTCS enrollees who are eligible only as a result of the disregard from eligibility of income currently excluded under section

1612(b) of the Act, and medical assistance that would not be allowable for some of those enrollees but for the disregard of such income from post-eligibility calculations.

b. Medical assistance furnished to ALTCS enrollees who are financially eligible with income equal to or less than 300 percent of the Federal Benefit Rate and who are eligible for ALTCS based on the functional, medical, nursing, and social needs of the individual.
c. Medical assistance furnished to some dependent children or spouses who qualify for ALTCS based on a disregard of income and resources of legally responsible relatives or spouses during the month of separation from those relatives or spouses.
d. Medical assistance furnished to individuals who are eligible as Qualified Medicare Beneficiary (QMB), Special Low Income Beneficiary (SLMB), Qualified Individuals-1(QI-1), or Supplemental Security Income Medical Assistance Only (SSI MAO) beneficiaries based only on a disregard of in-kind support and maintenance (ISM).
e. Medical assistance furnished to individuals who are eligible based only on an alternate budget calculation for ALTCS and SSI-MAO income eligibility determinations when spousal impoverishment requirements of section 1924 of the Act do not apply or when the applicant/recipient is living with a minor dependent child.
f. Medical assistance furnished to individuals who are eligible only based on the disregard of interest and dividend from resources, and are in the following eligibility groups:

    i. The Pickle Amendment Group under 42 CFR 435.135;
    ii. The Disabled Adult Child under section 1634(c) of the Act;
    iii. Disabled Children under section 1902(a)(10)(A)(i)(II) of the Act; and
    iv. The Disabled Widow/Widower group under section 1634(d) of the Act.

g. Medical assistance furnished to ALTCS enrollees under the eligibility group described in section 1902(a)(10)(A)(ii)(V) of the Act that exceeds the amount that would be allowable except for a disregard of interest and dividend from the post-eligibility calculations.
h. Medical assistance provided to individuals who would be eligible but for excess resources under the "Pickle Amendment," section 503 of Public Law 94-566; section 1634(c) of the Act (disabled adult children); or section 1634(b) of the Act (disabled widows and widowers).
i. Medical assistance that would not be allowable but for the disregard of quarterly income totaling less than $20 from the post-eligibility determination.

12. Expenditures to extend eligibility past the timeframes specific in 42 CFR §435.1003 for demonstration participants who lose SSI eligibility for a period of up to 2-months from the SSI termination effective date.

13. Expenditures to provide Medicare Part B premiums on behalf of individuals enrolled in ALTCS with income up to 300 percent of the FBR who are also eligible for Medicare, but do not qualify as a QMB, SLMB or QI; are eligible for Medicaid under a mandatory or optional Title XIX coverage group for the aged, blind, or disabled (SSI-MAO); are eligible for continued coverage under 42 CFR 435.1003; or are in the guaranteed enrollment period described in 42 CFR 435.212 and the State was paying their Part B premium before eligibility terminated.

14. Expenditures to extend ALTCS eligibility to individuals under the age of 65 who meet the applicable financial criteria but are not disabled, but who are found to be at risk of needing nursing facility services based on medical illness or mental retardation on the preadmission screening instrument.

15. Expenditures associated with the provision of Home & Community-Based Services (HCBS) to individuals enrolled in the Arizona Long Term Care system with income levels up to 300 percent of the SSI income level, as well as individuals enrolled in the ALTCS Transitional program.

16. Expenditures for demonstration caregiver services provided by spouses of the demonstration participants.

**The following expenditures (which would not otherwise be included as matchable expenditures under section 1903 of the Act) shall be regarded as matchable expenditures under the State's Medicaid State plan through December 31, 2013:**

17. Expenditures to provide coverage through employer-sponsored insurance for eligible employees of small businesses and with family income below 200 percent of the FPL that would not otherwise be allowable because it is not cost effective.

18. Expenditures to provide medical assistance for adults without children who were enrolled in the AHCCCS under Demonstration project #11-W-00032/9 and #21-W-00009/9 as of July 8, 2011, as long as they continue to meet the State’s eligibility criteria and redetermination requirements.

19. Expenditures to provide medical assistance to adults without children with adjusted net countable family income at or below 100 percent of the FPL who are not otherwise eligible for Medicaid.

20. Expenditures to provide medical assistance for individuals who applied for the Medical Expense Deduction (MED) program (under Expenditure Authority 16 of Demonstration project #11-W-00032/9 and #21-W-00009/9) prior to May 1, 2011, and were determined eligible for that population for a 6-month guaranteed eligibility period after that date, until the end of that 6-month period.

21. Expenditures for family planning and family planning-related services for up to 24 months for women losing Medicaid pregnancy coverage at the conclusion of their 60-day postpartum period, and who are not otherwise eligible for Medicare, Medicaid (including other components of this section 1115 demonstration), Children's Health Insurance Program (CHIP), or health insurance coverage that provides family planning services, and who have a family income at or below 150 percent of the Federal poverty level (FPL) at the time of annual redetermination. (Family Planning Extension Program).

22. Expenditures for payments to participating IHS and tribal facilities reflecting uncompensated care, limited to categories of care that were previously covered under the State Medicaid plan, furnished in or by such facilities to Medicaid-eligible individuals, and other individuals, with family income at or below 100 percent of the FPL.

23. Subject to the overall cap on the Safety Net Care Pool (SNCP), expenditures for payments to certain hospitals and other providers reflecting uncompensated costs of medical services that are within the scope of the definition of "medical assistance" under 1905(a) of the Act, that are provided to Medicaid eligible or uninsured individuals, and that exceed the amounts paid to the hospitals pursuant to section 1923 of the Act.

24. Expenditures for uncompensated care payments made under the Proposition 202 Trauma/Emergency Room Designated State Health Program, which is otherwise a State-funded program, as specified in the reimbursement protocol for the SNCP.

**Medicaid Requirements Not Applicable**

Medicaid populations made eligible by virtue of the expenditure authorities expressly granted in this Demonstration are not subject to Medicaid laws or regulations except as specified in the STCs and waiver and expenditure authorities for this Demonstration. The following Medicaid requirements will not apply to such demonstration populations, and will expire on December 31, 2013 (sections refer to the Social Security Act):

| | | |
|---|---|---|
| **1.** | **Cost Sharing** | **Section 1902(a)(14) insofar as it incorporates section 1916 (42 CFR 447.50 through 447.56)** |

To enable the State to impose cost sharing, to the extent necessary, for those in the employer-sponsored insurance program, and individuals without dependent children with family income up to 100 percent of the FPL

**2. Amount, Duration, Scope of Services** **Section 1902(a)(10)(B) (42 CFR 440.210)**

To enable the State to modify the Medicaid benefits package for those in the employer-sponsored insurance program in order to offer a different benefit package than would otherwise be required under the State plan. This authority is granted only to the extent necessary to allow those in the employer-sponsored insurance plan to receive coverage through a private or employer-sponsored insurance plan, which may offer a different benefit package than that available through the State plan.

**3. Retroactive Coverage** **Section 1902(a)(34) (42 CFR 435.914)**

Individuals who enroll in the employer-sponsored insurance program and individuals without dependent children with family income up to 100 percent of the FPL.

**4. Early and Periodic Screening, Diagnostic, Treatment (EPSDT)** **Section 1902(a)(43)(A)and (42 CFR 440.40 and 441.50 through 441.62**

To enable the State to not provide or arrange for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to adults without dependent children with family income up to 100 percent of FPL ages 19 and 20 years old.

**Medicaid Requirements Not Applicable to the Family Planning Extension Program**

All Medicaid requirements apply to the Family Planning Extension Program, with the exception of the following:

**1. Amount, Duration, and Scope (Comparability)** **Section 1902(a)(10)(B) (42 CFR 440.240)**

To the extent necessary to allow the State to offer the family planning demonstration population a benefit package consisting only of family planning and family planning-related services.

**2. Eligibility Redetermination** **Section 1902(a)(19) (42 CFR 435.916)**

To enable the State to exempt women, who are eligible for the family planning program by virtue of losing Medicaid eligibility at the conclusion of their 60-day postpartum period (SOBRA women), from reporting changes in income during their 12-month eligibility period.

**3. Retroactive Eligibility** — **Section 1902(a)(34) (42 CFR 435.914)**

To the extent necessary to enable the State to not provide medical assistance to the Demonstration population for any time prior to when an application for the Demonstration is made.

**4. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)** — **Section 1902(a)(43)(A) (42 CFR 440.40 and 441.50 through 441.62)**

To the extent necessary to enable the State to not furnish or arrange for EPSDT services to the demonstration population.

## CHIP Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act as incorporated into title XXI by section 2107(e)(2)(A) of the Act, State expenditures described below, shall, for the period through December 31, 2013, and to the extent of the State's available allotment under section 2104 of the Act; be regarded as matchable expenditures under the State's title XXI plan. All requirements of title XXI will be applicable to such expenditures for the demonstration population described below, except those specified below as not applicable to these expenditure authorities.

1. **Employer-Sponsored Insurance**. Expenditures to provide coverage to CHIP-eligible children up to age 19 with incomes above 100 percent of the FPL up to and including 200 percent of the FPL, who meet the definition of a targeted low-income child and who elect to receive coverage through the State's Employer-Sponsored Insurance (ESI) program rather than coverage under the CHIP State plan. Such children are no longer subject to the title XXI requirements listed below.
2. **KidsCare II Program**. Expenditures to provide coverage to children up to age 19 with family income up to 175 percent of the FPL not otherwise eligible for Medicaid.

## CHIP Requirements Not Applicable to CHIP Expenditure Authorities

(Sections refer to the Social Security Act.)

**1. General Requirements, Eligibility, and Outreach** — **Section 2102 (42 CFR 457.90)**

Only to the extent that the State child health plan would be required to reflect the demonstration population.

**2. Annual Reporting Requirements** **Section 2108 (42 CFR 457.700 through 457.750)**

To the extent that the State would have to meet the annual reporting requirements with respect to the demonstration populations (the submission of an annual report into the CHIP Annual Report Template System/CARTS).The State will report on issues related to the demonstration populations in quarterly and annual reports and enrollment data through the Statistical Enrollment Data System (SEDS).

**3. Cost Sharing** **Section 2103(e) (42 CFR 457.530 through 457.560)**

Rules governing cost sharing under section 2103(e) of the Act shall not apply to the demonstration populations.

**4. Benefit Package Requirements** **Section 2103**

To the extent necessary to permit the State to offer a benefit package for the ESI program that does not meet the requirements of section 2103 of the Act, outlined at 42 CFR 457.410(b)(1).

**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.

**SPECIAL TERMS AND CONDITIONS**
**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)**

**MEDICAID SECTION 1115 DEMONSTRATION**

**NUMBER:** 11-W00275/9
21-W-00064/9

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

**AWARDEE:** Arizona Health Care Cost Containment System

## I. PREFACE

The following are the Special Terms and Conditions (STCs) for Arizona's section 1115(a) Medicaid demonstration extension (hereinafter "Demonstration"). The parties to this agreement are the State of Arizona and the Centers for Medicare & Medicaid Services (CMS). This Demonstration is approved for a 5-year period, from October 22, 2011, through September 30, 2016. The STCs set forth below and the lists of waivers and expenditure authorities are incorporated in their entirety into the letter approving the Demonstration. The STCs are effective as of October 22, 2011, unless otherwise specified.

The STCs have been arranged into the following subject areas:

I. Preface;
II. Program Overview and Historical Context;
III. General Program Requirements;
IV. Eligibility;
V. Demonstration Programs;
VI. Funding Pools Under the Demonstration;
VII. Delivery Systems;
VIII. Evaluation;
IX. General Reporting Requirements;
X. General Financial Requirements under Title XIX;
XI. General Financial Requirements under Title XXI;
XII. Monitoring Budget Neutrality; and
XIII. Schedule of State Deliverables During the Demonstration.

## II. PROGRAM OVERVIEW AND HISTORICAL CONTEXT

Until 1982, Arizona was the only State that did not have a Medicaid program under title XIX of the Social Security Act. In October 1982, Arizona implemented the AHCCCS in the State's first section 1115 demonstration project. AHCCCS initially covered only acute care services, however, by 1989, the program was expanded to include the Arizona Long Term Care System (ALTCS), the State's capitated long term care (LTC) program for the elderly and physically disabled (EPD) and the developmentally disabled (DD) populations. In 2000, the State also expanded coverage to adults without dependent children with family income up to and including 100 percent of the Federal poverty level (FPL) as well as established the Medical Expense Deduction (MED) program for adults with income in excess of 100 percent of the FPL who have qualifying healthcare costs that reduce their income at or below 40 percent of the FPL. On March 31, 2011, Arizona requested to terminate its initial section 1115 demonstration in order to eliminate the MED program and implement an enrollment freeze on the adults without dependent children population. On April 30, 2011, and July 1, 2011, CMS approved the State's required phase-out plans for the MED program and the adults without dependent children population, respectively.

The new Demonstration provides health care services through a prepaid, capitated managed care delivery model that operates statewide for both Medicaid State plan groups as well as Demonstration expansion groups. The goal of the Demonstration is to test health care delivery systems to provide organized and coordinated health care for both acute and long term care that include pre-established provider networks and payment arrangements, administrative and clinical systems for utilization review, quality improvement, patient and provider services, and management of health services. The Demonstration will also test the extent to which health outcomes in the overall population are improved by expanding coverage to additional needy groups.

The Demonstration affects coverage for certain specified mandatory State plan eligibles by requiring enrollment in coordinated, cost effective, health care delivery systems. In this way, the Demonstration will test the use of managed care entities to provide cost effective care coordination. The Demonstration also provides coverage to limited groups the State does not currently cover under its Medicaid State plan, including adults without dependent children, and a limited number of children with incomes above the levels under the Medicaid State plan and at or below 175 percent of the FPL, which will show the benefits of such coverage using these approaches to a wider population. In addition, the Demonstration will provide for payments to IHS and tribal 638 facilities to address the fiscal burden of uncompensated care for services provided in or by such facilities to individuals with income up to 100 percent of the FPL. This authority will enable the State to evaluate how this approach impacts the financial viability of IHS and 638 facilities and ensures the continued availability of a robust health care delivery network for current and future Medicaid beneficiaries.

Finally, the Demonstration will allow the State to also test the effects of increasing personal financial responsibility on utilization and health outcomes on some populations by permitting cost sharing. Specifically, the Demonstration will test the effects of the imposition of mandatory co-payments on adults without dependent children in the following areas:

1. Utilization of needed preventive, primary care, and treatment services;
2. Appropriate utilization of emergency room care, and appropriate, cost and clinically effective use of generic and brand name drugs;
3. State and Federal expenditures (per enrollee) in the short and long term; and
4. Physician participation, including physician willingness to accept appointments from the adults without dependent children population.

In order to evaluate these hypotheses, the Demonstration will review utilization and cost data and quality measures related to the adults without dependent children enrolled under the Demonstration as specified in paragraph 28(c).

## III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program, or the Children's Health Insurance Program (CHIP) for the separate CHIP population, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the Demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid program that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

   a) To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

   b) If mandated changes in the Federal law require State legislation, the changes must take effect on the earlier of the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State will not be required to submit title XIX and XXI State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid State plan is affected by a change to the Demonstration, a conforming amendment to the State Plan is required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must include, but are not limited to, the following:

    a) An explanation of the public process used by the State, consistent with the requirements of paragraph 14 to reach a decision regarding the requested amendment;

    b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

    c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

    d) If applicable, a description of how the evaluation designs will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the Demonstration, the chief executive officer of the State must submit to CMS either a Demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

As part of the Demonstration extension request, the state must provide documentation of compliance with the public notice requirements outlined in paragraph 14 as well as include the following supporting documentation:

a) Demonstration Summary and Objectives: The State must provide a summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met.

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

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

d) Compliance with the Budget Neutrality Cap: The State must provide financial data (as set forth in the current STCs) demonstrating that the State has maintained and will maintain budget neutrality for the requested period of extension. CMS will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension.

e) Interim Evaluation Report: The State must provide an evaluation report reflecting the hypotheses being tested and any results available.

9. **Demonstration Phase-Out.** The State may only suspend or terminate this Demonstration in whole, or in part, consistent with the following requirements.

a) Notification of Suspension or Termination: The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The State must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the Demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the State must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the State must provide a summary of each public comment received, the State's response to the comment and how the State incorporated the received comment into the revised

phase-out plan.

The State must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

b) Phase-out Plan Requirements: The State must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c) Phase-out Procedures: The State must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2010, State Health Official Letter #10-008.

d) Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge CMS' finding that the State materially failed to comply.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** The State will ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The State must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the State's approved State plan, when any program changes to the Demonstration, including (but not limited to) those referenced in STC 6, are proposed by the State.

    In States with Federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the State's approved Medicaid State plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

    In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any Demonstration proposal and/or renewal of this Demonstration (42 C.F.R. §431.408(b)(3)).

    The State must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

15. **FFP.** Federal funds are not available for expenditures for this Demonstration until the effective date identified in the Demonstration approval letter.

## IV. ELIGIBILITY

16. **Eligibility.** The Demonstration affects all of the mandatory Medicaid eligibility groups set forth in Arizona's approved State plan, 14 optional groups set forth in the State plan, and 5 expansion groups made eligible under this Demonstration. Mandatory and optional State plan groups described below are subject to all applicable Medicaid laws and regulations except as expressly waived. Expansion populations are defined as those groups made eligible by virtue of the expenditure authorities expressly granted in this Demonstration and are subject to Medicaid and CHIP laws or regulations except as specified in the STCs and waiver and expenditure authorities for this Demonstration. These cited documents generally provide that all requirements of Medicaid and CHIP

laws and regulations do apply, except to the extent waived or specified as not applicable. The criteria for Arizona eligibility groups are as follows (Table 1):

**Table 1 –** State Plan and Expansion Populations Affected by the Demonstration

| Description | Program | Social Security Act Cite | 42CFR Cite |
|---|---|---|---|
| **STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS**<br>**Families and Children** | | | |
| 1931 (Title IV A program that was in place in July 1996) including:<br>• pregnant women with no other eligible children (coverage for third trimester)<br>• persons 18 years of age, if a full-time student<br>• family with unemployed parent | AACP | 1902(a)(10)(A)(i)(I) | 435.110 |
| Twelve months continued coverage (transitional medical assistance) 1931 ineligible due to increase in income from employment or work hours or loss of "income disregard." | AACP | 1902(a)(52)<br>1902(e)(l)<br>1925(a)(b)(c) | 435.112 |
| 1931 Extension-Extension of MA when child or spousal support collection results in 1931 ineligibility. (4 months continued coverage) | AACP | 408(a)(11)(B)<br>1902 (a) (10) (A) (i) (I)<br>1931 (c) | 435.115 |
| **STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS**<br>**Pregnant Women, Children, and Newborns** | | | |
| Qualified pregnant women who:<br>• would be AFDC eligible if child were born and<br>• meet AFDC income & resource criteria | AACP | 1902(a)(10)(A)(i)III<br>1905(n) | 435.116 |
| "S.O.B.R.A. WOMEN & INFANTS"<br>Pregnant women & infants under age 1 with incomes less than or equal to 133% FPL. (optional group extends coverage up to 140% FPL for infants under age 1) | AACP<br>ALTCS | 1902(a)(10)(A)(i)(IV)<br>1902(l)(1)(A) | |
| "S.O.B.R.A. CHILDREN"<br>Children age 1+ but not yet 6 with incomes at or below 133% FPL. | AACP<br>ALTCS | 1902(a)(10)(A)(i)(VI)<br>1902(l)(1)(C) | |
| "S.O.B.R.A. CHILDREN"<br>Children age 6+ but not yet 19, born after 9-30-83, with income less than or equal to 100% FPL. | AACP<br>ALTCS | 1902(a)(10)(A)(i)(VII)<br>1902(l)(1)(D) | |
| "DEEMED CATEGORICAL NEWBORNS"<br>Children born to a woman who was eligible and received Medicaid on the date of the child's birth. Children living with their mothers are eligible for 1 year as long as mothers are eligible or would be eligible if pregnant.* | AACP | 1902(e)(4) | 435.117 |
| **STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS**<br>**Qualified Family Members** | | | |
| Qualified members of family with unemployed principal wage earner (persons who would be eligible if state did not limit number of months AFDC-UP cash was available). | AACP | 1902(a)(10)(A)(i)<br>1905(m)(l) | 435.119 |
| **STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS**<br>**Aged, Blind, and Disabled** | | | |

| Description | Program | Social Security Act Cite | 42CFR Cite |
|---|---|---|---|
| All SSI cash recipients: aged, blind or disabled persons | AACP<br>ALTCS | 1902(a)(10)(A)(i)(II) | 435.120 |
| Qualified severely impaired working blind or disabled persons < 65 who were: a) receiving Title XIX, SSI or State supplement under 1619(a); or b) eligible for Medicaid under 1619(b) in 6/87 | AACP | 1902(a)(10)(A)(i)(II)<br>1905(q) | 435.120 |
| "DAC" Disabled adult child (age 18+) who lost SSI by becoming OASDI eligible (i.e., due to blindness or disability that began before age 22) or due to increase in amount of child's benefits. | AACP | 1634(c) | |
| SSI cash or state supplement ineligible for reasons prohibited by Title XIX. | AACP<br>ALTCS | | 435.122 |
| SSA Beneficiaries who lost SSI or state supplement cash benefits due to cost of living adjustment (COLA) increase in Title II benefits | AACP | | 435.135 |
| Disabled widow/widower who lost SSI or State supplement due to 1984 increase in OASDI caused by elimination of reduction factor in PL 98-21. (person must apply for this by 7/88) | AACP | 1634(b) | 435.137 |
| Disabled widow/widower (age 60-64 and ineligible for Medicare Part A) who lost SSI or State supplement due to early receipt of Social Security benefits. | AACP | 1634(d) | 435.138 |
| "DC Children" Children under the age of 18 who were receiving SSI Cash on 8/26/96 and would continue to be eligible for SSI Cash if their disability met the childhood definition of disability that was in effect prior to 8/26/96. | AACP | 1902(a)(10)(A)(i)(II) | |
| **STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS**<br>**Adoption Assistance and Foster Care Children** | | | |
| Children in adoption subsidy/foster care Title IV-E programs | AACP<br>ALTCS | 473(b)(l)<br>1902(a)(10)(A)(i)(I) | 435.145 |
| **STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS**<br>**Special Groups** | | | |
| "POSTPARTUM"<br>Title XIX eligible women who apply on or before pregnancy ends, (continuous coverage through the month in which the 60th day postpartum period ends) | AACP | 1902(e)(5)<br>1902(e)(6) | 435.170 |
| **STATE PLAN OPTIONAL TITLE XIX COVERAGE GROUPS** | | | |
| **Description** | **Program** | **Social Security Act Cite** | **42CFR Cite** |
| "210 GROUP" Persons who meet AFDC, SSI or State supplement income & resource criteria. | AACP<br>ALTCS Case Management | 1902(a)(10)(A)(ii)(I) | 435.210 |
| “211 GROUP" Persons who would be eligible for cash assistance except for their institutional status. | ALTCS | 1902(a)(10)(A)(ii)(IV) | 435.211 |
| "GUARANTEED ENROLLMENT" Continuous coverage for persons enrolled in AHCCCS Health Plans who lose categorical eligibility prior to 6 months from enrollment. (5 full months plus month of enrollment) | AACP | 1902(e)(2) | 435.212 |
| "S.O.B.R.A. Infants” infants with incomes between the 133% FPL mandatory group maximum and a 140% FPL optional State maximum. | AACP<br>ALTCS | 1902(a)(10)(A)(ii)(IX) | |
| Pregnant women, including postpartum, who maintain eligibility without regard to changes in income. | AACP | 1902(e)(6) | |

| Description | Program | Social Security Act Cite | 42CFR Cite |
|---|---|---|---|
| "HCBS GROUP" Persons receiving HCBS under a waiver with incomes < or equal to 300% of the Federal benefit rate (FBR). | ALTCS | 1902(a)(10)(A)(ii)(VI) | 435.217 |
| "State Adoption Subsidy" Children who receive a state adoption subsidy payment. | AACP | 1902(a)(10)(ii)(VIII) | 435.227 |
| "236 GROUP" Persons in medical institutions for 30 consecutive days who meet state-set income level of < or equal to 300% of FBR. | ALTCS | 1902(a)(10)(A)(ii)(V) | 435.236 |
| "Freedom to Work" Basic Coverage Group – individuals aged 16-64 with a disability who would be eligible, except for earnings, for SSI up to and including 250% of FPL. | AACP<br>ALTCS | 1902(a)(10)(A)(ii)(XV) | |
| "Freedom to Work" Medical Improvement Group – employed individuals aged 16-64 with a medically improved disability up to and including 250% of FPL. | AACP<br>ALTCS | 1902(a)(10)(A)(ii)(XVI) | |
| Women under 65 who need treatment for breast or cervical cancer, and not otherwise eligible for Medicaid. | AACP | 1902(a)(10)(A)(ii)(XVIII) | |
| Children who have aged out of foster care at 18 up to age 21 | AACP | 1902(a)(10)(A)(ii)(XVII) | |
| 1931 Expansion-Income Greater than 36% FPL and less than or equal to 100% FPL. | AACP | | |
| SSI-MAO Expansion (Optional 210 Group)- aged, blind, or disabled individuals with income greater than 100% FBR and less than or equal to 100% FPL. | AACP | Arizona State Plan | |
| **TITLE XIX AND XXI EXPANSION GROUPS UNDER THE DEMONSTRATION** | | | |
| Adults without dependent children who were enrolled in the AHCCCS under Demonstration project #11-W-00032/9 and #21-W-00009/9 as of July 8, 2011 as long as they continue to meet the State's eligibility criteria and redetermination requirements. | AACP | ARS 36-2901.01 | |
| To the extent the State gives notice to CMS described in 17.b below, adults without dependent children with adjusted net countable income at or below 100% FPL who are not otherwise eligible for Medicaid. | AACP | ARS 36-2901.01 | |
| Individuals who applied for the Medical Expense Deduction (MED) program (under Expenditure Authority 16 of Demonstration project #11-W-00032/9 and #21-W-00009/9) prior to May 1, 2011 and were determined eligible for that population for a 6-month guaranteed eligibility period after that date, until the end of that 6-month period. | AACP | ARS 36-2901.04 | |
| Women who lose Medicaid pregnancy coverage at the conclusion of 60 days postpartum, and who are not otherwise eligible for Medicare, Medicaid, Children's Health Insurance Program (CHIP) or health insurance coverage that provides family planning services, and who have a family income at or below 150 percent of the FPL at the time of annual redetermination (up to 24 months following the postpartum period). | Family Planning Extension Program | ARS 36-2907.04 | |
| Children up to age 19 with incomes above 100 percent of the FPL up to and including 200 percent of the FPL who meet the definition of a targeted low-income child and who have access to ESI coverage | ESI | | |
| Children with family income at or below 175 percent of the FPL who are not otherwise eligible for Medicaid, subject to available funding. | KidsCare II | | |

*Arizona's 1115 Demonstration provides the authority to waive some of the provisions.

## V. DEMONSTRATION PROGRAMS

17. **Arizona Acute Care Program (AACP)**. The AACP is a statewide, managed care system which delivers acute care services through prepaid, capitated MCOs that AHCCCS calls "Health Plans." Most Health Plan contracts are awarded by Geographic Service Area (GSA), which is a specific county or defined grouping of counties designated by AHCCCS within which a Contractor provides, directly or through subcontract, covered health care to members enrolled with that Contractor. AACP enrollees receive most Medicaid-covered services through the Health Plans, but receive, on a "carve out" basis, behavioral health services through a separate PIHP contract and certain specialty care services for children eligible under the CRS Program through a separate MCO contract.

a) **AACP Eligibility –** Those Groups identified in Table 1.

b) **Enrollment** - The Arizona DES processes applications and determines acute care Medicaid eligibility for children, pregnant women, families and non-disabled adults under the age of 65 years. The Social Security Administration (SSA) determines eligibility for the Supplemental Security Income (SSI) cash-related groups, and AHCCCS determines eligibility for the SSI- related aged and disabled groups, Medicare Savings Programs, women diagnosed with breast or cervical cancer, and Freedom to Work recipients. Individuals determined eligible must then select and enroll in a Health Plan, or they will be auto-assigned by the AHCCCS administration.

   i. The State will not make individuals eligible based on applications received on and/or after July 8, 2011, for AHCCCS benefits from adults without dependent children with family income up to 100 percent of the FPL. Adults without dependent children who were enrolled in the AHCCCS under Demonstration project #11-W-00032/9 and #21-W-00009/9 as of July 8, 2011, will continue to receive AHCCCS benefits under this Demonstration as long as such individuals continue to meet the State's eligibility criteria and redetermination requirements.

   ii. The State may open new enrollment for the adults without dependent children population. The State must notify CMS prior to re-opening enrollment, and must include a process by which it will notify the public, such as the use of public forums, tribal consultations, and community stakeholder meetings.

   iii. The State must maintain eligibility for individuals who were enrolled in AHCCCS under Demonstration #11-W-00032/9 and #21-W-00009/9 as of July 8, 2011 in the adults without dependent children population unless the individuals no longer meet the eligibility criteria.

c) **Benefits** – Benefits for AACP and the expansion population authorized by the 1115 Demonstration will consist of all acute care benefits covered under the Medicaid State plan (see Attachment G), unless otherwise noted within these STCs.

i. **Notice -** The State must include the CMS Central Office when submitting a State plan amendment (SPA) to the CMS Regional Office that would impact the expansion population authorized by the 1115 Demonstration inclusive of:
   a. The proposed date of implementation;
   b. The date the State plans to submit the SPA; and
   c. Revised budget neutrality projections.

ii. **Demonstration Amendment.** CMS reserves the right to require the State to submit an amendment if it is determined that it is warranted.

iii. Behavioral health services are outlined in Table 2 and subject to limitations set forth in the existing State plan.

Table 2 – AACP Behavioral Management

| **Benefit** | **Title XIX** | | **Title XXI** |
|---|---|---|---|
| Age | < 21 yrs | ≥ 21 yrs | < 19 yrs |
| | | | |
| Behavioral Management | X | X | X |
| Case Management | X | X | X |
| Emergency Behavioral Health Care | X | X | X |
| Evaluation | X | X | X |
| Therapeutic Residential Support (in home, excluding room and board ) | X | X | X |
| Inpatient Services | | | |
| Inpatient Hospital | X | X | X |
| Inpatient Psychiatric Facilities | X | X | X |
| Lab & X – Ray | X | X | X |
| Medications (Psychotropic) | X | X | X |
| Medication Adjustment & Monitoring | X | X | X |
| Methadone / IAAM | X | X | X |
| Partial Care | X | X | X |
| Professional Services | | | |
| Individual | X | X | X |
| Group & Family | X | X | X |
| Psychosocial Rehabilitation | X | X | X |
| Respite (with limits) | X | X | X |
| Screening | X | X | X |
| Transportation – Emergency | X | X | X |
| Transportation – Non Emergency | X | X | X |

d) **AACP Cost Sharing** – Cost sharing shall be imposed as specified in the Medicaid State plan for all populations, except for the adults without dependent children with income up to 100 percent of the FPL which are as follows:

Table 3 – Adults without Dependent Children Copayments

| Service | Copayment Amount | Geographic Applicability |
|---|---|---|
| Generic prescription, or brand name prescription if generic is not available | $4 | Statewide |
| Brand name prescription when generic is available | $10 | Statewide |
| Non-emergency use of the emergency room | $30 | Statewide |
| Physician office visit | $5 | Statewide |
| Non-emergency medical transportation (NEMT) (taxi rides only) | $2 per trip ($4 roundtrip maximum) | Only in Maricopa and Pima counties |

i. The NEMT copayment shall be imposed only on taxi rides for adults without dependent children who reside in Maricopa and Pima counties. Adults without dependent children residing in all other counties within the State are exempt from the NEMT copayment. The American Indian/Alaskan Native (AI/AN) population is also exempt.

ii. The copayments referenced in the Table 3 above are subject to the evaluation requirements in STC# 26(c).

e) **AACP Permissible Provider Fee for Missed Appointments.**

i. The State may permit a provider to impose a $3 fee on the TANF parent and adults without dependent children population for the non-covered activity of reserving an appointment that an individual misses provided that:

1) Beneficiaries are notified in easily understood, plain language at the time of scheduling their appointment of the consequences of missing appointments without cancelling 24 hours prior to the appointment. This includes, but is not limited to notification of the $3 fee, and the possibility of the provider refusing future service until the $3 fee has been paid. In addition, the provider must present its missed appointment policy to a beneficiary on an annual basis and obtain a signed acknowledgment of such policy from the beneficiary;
2) Participating providers have a mechanism in place that notifies beneficiaries 48 hours in advance of their scheduled appointment time. The provider shall make available to the beneficiary a choice from among two or more different notice mechanisms (such as a telephone call, a text message to a mobile device, and/or an email) and permit the beneficiary to utilize whichever method of communication is preferable to the beneficiary. The provider shall keep a record of such notifications;
3) Beneficiaries receive written confirmation of his/her scheduled appointment. This could include, but is not limited to, a postcard given to the beneficiary at the time the appointment is scheduled, a mailed letter, an email, or a text message to a mobile device. The times and dates of individual appointments, and a record of the date and time that

confirmation was delivered, should be recorded and maintained by the provider.

4) Providers develop a mechanism by which they can track, and subsequently report to the State on a quarterly basis, the following information through claims data:
    a. The number of missed appointment fees in the reporting period;
    b. The number of individuals assessed the missed appointment fee;
    c. The number of individuals who have been assessed the fee more than once during the reporting period, including the average number of times the fee has been assessed for this subpopulation; and
    d. The reason for missing the scheduled appointment (if provided by the beneficiary).
5) The State, after reviewing the quarterly reports submitted by the providers as specified in subparagraph 4, monitors providers that it has identified as having an above average rate of beneficiaries assessed the missed appointment fee and identifies the reasons for this higher rate. This may include conducting outreach to the providers to ensure that they are in compliance with the requirements specified in subparagraphs 1 – 4, as well as providing any necessary corrective action.
6) The State includes in its quarterly report to CMS, as specified in STC #34, the information required in subparagraphs 4 and 5. In addition, the State must report to the CMS the number of providers with a high volume of missed appointment copayments, clearly identifying those that have been reported on a previous quarterly report. The State should also supply its assessment of the reasons for these missed appointments.

ii. A missed appointment occurs when a beneficiary is more than 20 minutes late to his/her scheduled appointment time.

iii. Missed appointments cannot not be considered in any utilization limits as specified in the Medicaid State plan as the service has not been rendered.

iv. Providers who elect to impose the $3 missed appointment fee on beneficiaries must submit to the State a plan assuring that they can comply with the requirements in paragraphs 1 – 4 as well as a process by which a beneficiary would be exempt from the fee, such as lack of adequate transportation, an appointment scheduled by a third party, or a disability or mental illness.

v. The authority to impose the $3 missed appointment fee on the TANF parent and adults without dependent children populations is time-limited, and will expire on January 1, 2013. On November 1, 2012, as specified in STC# 26(d), the State must submit an independent evaluation for CMS review and approval documenting the effectiveness of the missed appointment copayment in reducing the number of missed appointments. Upon concluding the review

of the evaluation and at the request of the State, CMS may extend this authority to December 31, 2013.

18. **Children in Foster Care** – Services for Arizona's children in foster care are provided through an MCO contract between AHCCCS and the Arizona DES/CMDP. CMDP operates in the same manner as other AACP Health Plans, but children in foster care who receive acute care services will be enrolled in CMDP instead of other Health Plans. Children in foster care who are eligible for or receive ALTCS will be enrolled or remain with the Program Contractor. Case Management services provided and reimbursed through this contractual relationship must be provided consistent with Federal policy, regulations and law.

a) **FFP**. FFP will not be available for:

i. Duplicate payments made to public agencies or private entities under other program authorities for case management services or other Medicaid services for the same purpose; or

ii. Activities integral to the administration of the foster care program excluding any health care related activities.

19. **Children Rehabilitative Services (CRS)**. AHCCCS contracts on a sole-source, capitated basis for the CRS program. Children enrolled in the Acute Care and ALTCS plans with qualifying conditions receive their specialty care for these conditions through the CRS contractor while they remain enrolled in their acute care or ALTCS plan.

20. **Arizona Long Term Care System (ALTCS).** The ALTCS program is for individuals who are age 65 and over, blind, disabled, or who need ongoing services at a nursing facility or ICF/MR level of care. ALTCS enrollees do not have to reside in a nursing home and may live in their own homes or an alternative residential setting and receive needed in-home services. The ALTCS package also includes all medical care covered under AACP inclusive of doctor's office visits, hospitalization, prescriptions, lab work, behavioral health services, and rehabilitative services. Rehabilitative services may only be eligible for FFP if these services reduce disability or restore the program enrollee to the best possible level of functionality.

The ALTCS is administered through a statewide, managed care system which delivers acute, long-term care, home-and-community based, and behavioral health care services through capitated MCOs that AHCCCS calls "Program Contractors." The one exception is ALTCS enrollees eligible under the CRS program receive specialty care on a "carve-out" basis through a separate MCO contract.

With one exception, ALTCS contracts are awarded in the same geographic service areas as AACP are awarded. The exception is for the ALTCS contract with the Arizona

DES/DDD to provide coverage on a statewide basis of the full ALTCS benefit package to all eligible individuals with developmental disabilities. Under State law, A.R.S. 36-2940, AHCCCS is required to enter into an intergovernmental agreement (IGA) with DES/DDD to serve as the managed care organization for individuals with developmental disabilities. The DES/DDD ALTCS contract is an at-risk MCO contract that complies with 42 C.F.R. Part 438 and as such is reviewed and approved by CMS. Payments to DES/DDD under the ALTCS contract shall not include any payments other than payments that meet the requirements of 42 C.F.R. 438.6(c) including the requirement that all payments and risk-sharing mechanisms in the contract are actuarially sound. State law, A.R.S. 36-2953, requires DES/DDD to maintain a separate fund to account for all revenues and expenditures under the ALTCS contract and limits use of the fund for the administration of the ALTCS contract. ALTCS enrollees in Maricopa and Pima Counties have a choice of Program Contractors, but ALTCS enrollees in the rest of the State enroll in the Program Contractor for their GSA.

a) **ALTCS Eligibility Groups -** Individuals as defined in Table 1 requiring health care services at a nursing facility or ICF/MR level of care.

b) **ALTCS Financial Eligibility -** Individuals must be financially eligible for ALTCS with income equal to or less than 300 percent of the Federal Benefit Rate (FBR), as used by SSA to determine eligibility for SSI.

    i. The State may disregard income in excess of the FBR for persons with AHCCCS approved income-only trusts.

    ii. The resource (cash, bank accounts, stocks, bonds, etc.) limit is $2,000 for a single individual. Resources, such as a person's home, vehicle, and irrevocable burial plan are not counted toward the resource limit.

    iii. When the applicant has a spouse who resides in the community, the spouse can retain one-half of the couple's resources, up to the Federal maximum as specified in section 1924(f)(2) of the Act. Resources, such as a person's home, vehicle, and irrevocable burial plan are not counted toward the resource limit.

    iv. The total gross income for a married couple is combined and divided by 2. The resulting income may not exceed 300 percent of the single FBR. If the resulting income exceeds 300 percent of the single FBR, the income of the applicant only (name on check) is compared to 300 percent of the single FBR.

c) **Pre-Admission Screening (PAS) -** Once financial eligibility has been established, a PAS will be conducted by a registered nurse or social worker to determine if the individual is at immediate risk of institutionalization in either a nursing facility or an ICF/MR. The PAS must be used to determine if the applicant is eligible for ALTCS based on functional, medical, nursing, and social needs of the individual.

d) **Written Plan of Care -** An individual written plan of care will be developed by qualified providers for ALTCS enrollees under this demonstration. This plan of care will describe the medical and other services to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the review of AHCCCS.

   i. **FFP -** will not be claimed for Demonstration services furnished prior to the development of the plan of care. FFP will not be claimed for Demonstration services which are not included in the individual written plan of care.

e) **ALTCS Safeguards** – AHCCCS will take the following necessary safeguards to protect the health and welfare of persons receiving HCBS services under the ALTCS program. Those safeguards include:

   i. Adequate standards for all types of providers that furnish services under the ALTCS program;

   ii. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the ALTCS program. The State assures that these requirements will be met on the date that the services are furnished; and

   iii. Assurance that all facilities covered by section 1616 (e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirement of 45 CFR Part 1397 for board and care facilities.

   iv. A formal quality control system which monitors the health and welfare of members served in the ALTCS program.

      1) Monitoring will ensure that all provider standards and health and welfare assurances are continually met, and that plans of care are periodically reviewed to ensure that the services furnished are reasonably consistent with the identified needs of the individuals.

      2) The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

f) **ALTCS Benefits and Services**

   i. **ALTCS Acute Care -** Enrollees receive the same acute services as defined in paragraph 17(c).

   ii. **ALTCS Behavioral Health Care -** Enrollees receive behavioral health care services as defined in paragraph 17(c)(iii).

iii. **Home and Community-Based Services (HCBS) -** ALTCS will provide a comprehensive HCBS package to eligible enrollees in the enrollee's home or in an ALTCS approved Alternative Residential Setting.

1) **Alternative Residential Settings** include:

a. Adult foster care.
Assisted living homes, assisted living centers, adult developmental homes, child developmental homes and group homes, hospices, group homes for traumatic brain injured members, and rural substance abuse transitional agencies.

b. Behavioral Health Facilities that are licensed to provide behavioral health services in a structured setting with 24-hour supervision. ALTCS covers services, except room and board, that are provided to ALTCS members who have a behavioral health disorder and are residing in one of the following behavioral health facilities:

i. Level II behavioral health facility – Licensed by ADHS. An HCBS alternative residential behavioral health treatment setting for individuals who do not require the intensity of services or onsite medical services found in a Level I facility.

ii. Level III behavioral health facility - Licensed by ADHS. An HCBS alternative residential behavioral health treatment setting with 24-hour supervision and supportive, protective oversight. These services are excluded for individuals involuntarily living in the secure custody of law enforcement, judicial, or penal systems.

2) **HCBS Services** – Services provided to ALTCS enrollees receiving HCBS are enumerated in Table 4.

Table 4 – ALTCS HCBS

| Service | Title XIX | |
|---|---|---|
| | EPD | DD |
| Acute Hospital Admission | X | X |
| Adult Day Health Services | X | N/A |
| Attendant Care | X | X |
| Behavioral Health Services | X | X |
| Community Transition Services* | X | X |
| DME / Medical Supplies | X | X |
| Emergency Alert | X | X |

| Service | Title XIX | |
|---|---|---|
| Habilitation | X | X |
| Home Delivered Meals | X | n/a |
| Home Health Agency Services | X | X |
| Home Modifications | X | X |
| Home Maker Services | X | X |
| Hospice Services (HCBS & Institutional) | X | X |
| ICF / MR | n/a | X |
| Medical Care Acute Services | X | X |
| Nursing Facility Services | X | X |
| Personal Care | X | X |
| Respite Care (in home) | X | X |
| Respite Care (Institutional) | X | X |
| Therapies | X | X |
| Transportation | X | X |

*As Defined in State Medicaid Director Letter #02-008 (Attachment D)

3) **HCBS Expenditures**- Expenditures for individual members are limited to an amount that does not exceed the cost of providing care to the eligible individual in an institutional setting. Exceptions are permitted including when the need for additional services is due to a change in condition that is not expected to last more than 6 months.

iv. **Spouses As Paid Care Givers**. AHCCCS may implement a voluntary program for spouses as paid caregivers. The program will provide reimbursement to spouses who elect to provide needed in-home care for eligible ALTCS enrollees. Spouses providing care to eligible enrollees will be employed by an ALTCS network contractor, or registered with AHCCCS as an ALTCS independent provider when providing services to an ALTCS FFS Native American or developmentally disabled member. In order for the State to receive FFP from CMS for Paid Caregiver Spouses of Medicaid beneficiaries, the personal care service or support must meet the following criteria and monitoring provisions.

1) Services provided by the Spouse as Paid Caregiver must meet the definition of a "service/support" for personal care or similar services that are rendered by a Paid Caregiver when such services are deemed extraordinary care.
    a. Personal care or similar services – Is defined as assistance with the Activities of Daily Living (ADLs), or Instrumental Activities of Daily Living (IADLs), whether furnished in the home or the community, including personal assistance, attendant care, and closely related services such as home health aide, homemaker, chore, and companion services which may include improving and maintaining mobility and physical functioning, promoting health and personal safety, preparation with meals and snacks, accessing and using transportation, and participating in community experiences and activities.

b. Extraordinary care - Is defined as care that exceeds the range of activities that a spouse would ordinarily perform in the household on behalf of the recipient spouse, if he/she did not have a disability or chronic illness, and which are necessary to assure the health and welfare of the beneficiary, and avoid institutionalization.

2) The Spouse as Paid Caregiver must be a service/support that is specified in a plan of care prepared on behalf of the enrollee.

3) The enrollee who selects the Spouse as Paid Caregiver is not eligible to receive like services from another attendant caregiver.

4) The enrollee will remain eligible to receive other HCBS such as skilled/professional type services, home modifications, respite care, and other services that are not within the scope of the personal/attendant care services prescribed in the provider's plan of care.

5) The Services must be provided by a Spouse as Paid Caregiver who meets specified provider qualifications and training standards prepared by the State for a Paid Caregiver.

6) The Spouse as Paid Caregiver must be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the State Medicaid Agency (SMA) for the payment of personal care/attendant services; and

7) The Spouse as Paid Caregiver will comply with the following conditions.
   a. A Spouse as Paid Caregiver may not be paid for more than 40 hours of services in a 7-day period;
   b. The Spouse as Paid Caregiver must maintain and submit time sheets and other required documentation for hours worked/paid;
   c. The Spouse as Paid Caregiver may only submit claims for services that have been authorized by the Program Contractor or ALTCS FFS case manager;
   d. The ALTCS enrollee must be offered a choice of providers, other than his/her spouse. The enrollee's choice of a Paid Caregiver Spouse as provider must be recorded in his/her plan of care, at least annually.

8) AHCCCS and its Program Contractors must comply with the following monitoring requirements:
    a. Require Program Contractors and FFS case managers to make an on-site case management visit at least every 90 days to reassess a beneficiary's need for services, including the health, safety, and welfare status of the beneficiary serviced by the Spouse as Paid Caregiver;
    b. Require Program Contractors to provide quarterly financial statements that include separate authorized hours and expenditure information for Paid Caregiver Spouses; and
    c. Require AHCCCS to perform quarterly financial analysis that includes authorized hours and expenditure information for ALTCS FFS Spouses as Paid Caregivers.

v. **Institutional Care** ALTCS will provide institutional care in facilities appropriate to their needs that hold State licenses and Medicaid provider agreements indicating compliance with Medicaid requirements.

g) **Cost Sharing.**

i. Monthly Premiums for ALTCS. The AHCCCS may implement a monthly premium on ALTCS eligible households with an adjusted gross income at or above 400 percent of the FPL that have children under the age of 18 years with developmental disabilities enrolled in ALTCS.

ii. The total of all monthly premiums will be 2 percent of the annual adjusted gross income for households with income between 400 percent and 500 percent of the FPL, and 4 percent for households with income at and above 500 percent the FPL. There will be no distinction between institutional or non-institutional placements.

iii. AHCCCS will compute the premium amount using annual adjusted gross income from the parent's most recent Federal income tax return.
    1) Premiums will be billed monthly on the 1st and due on the 15th.
    2) AHCCCS will establish a grievance and appeal process allowing families to dispute the initial amount of the premium based on annual income or family size, increases in premiums and discontinuances for failure to pay the monthly premiums or deductibles.
        a. Premiums will continue to be billed and incurred during an eligibility appeal period and failure to pay the premium during the appeal period could mean a loss of eligibility.
        b. If the appeal is based on an increase in the premium amount, the premium increase will not be imposed until after an appeal decision.

h) **Other ALTCS Requirements**

i. The State of Arizona will continue to provide access to ALTCS services to American Indians on the reservation as it does to other citizens of the State.

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

iii. In the absence of a limit, AHCCCS will report annually on current placements and ongoing activities for expanding HCB services and settings. The report will be due by March 31 of each year.

iv. The DES/DDD will comply with all contractual and reporting requirements as specified in the contract between AHCCCS and DES/DDD and in any subsequent amendments. DES/DDD will be sanctioned as specified in the contract if DES/DDD fails to comply with the stated contractual and reporting requirements.

21. **ALTCS Transitional Program**. AHCCCS will complete a second scoring of the PAS for members who are enrolled in ALTCS, but fail to be at "immediate risk of institutionalization" based on the PAS conducted at the time of the re-determination.

    If determined eligible for the ALTCS Transitional Program, AHCCCS will transfer the member to the ALTCS Transitional Program which limits institutional services to 90-days per admission and provides the member with medically necessary acute care services, HCBS, behavioral health services and case management services as prescribed in paragraph #20.

22. **Medicare Part B Premiums.** The State of Arizona will continue to pay the Medicare Part B premiums on behalf of individuals enrolled in ALTCS with income up to 300 percent of the FBR who are also eligible for Medicare, but do not qualify as a QMB, SLMB or QI; eligible for Medicaid under a mandatory or optional Title XIX coverage group for the aged, blind, or disabled (SSI-MAO); eligible for continued coverage under 42 CFR 435.1003; or are in the guaranteed enrollment period described in 42 CFR 435.212 and the State was paying their Part B premium before eligibility terminated. Once the State has received the Medicare Part B premium invoice, it will automatically make an electronic payment on behalf of the beneficiary.

23. **Title XXI Programs under the Demonstration.**

    a) **Employer-Sponsored Insurance (ESI)**

i. **Eligibility.** Children who are eligible for KidsCare or KidsCare II whose family income is between 100 percent up to and including 200 percent of FPL, and who have access to a qualifying employer sponsored insurance (ESI) plan, as described in (iv) and (v) below.

ii. **Enrollment Process.** Prior to enrollment in the ESI, children (either directly or through their parents or guardians) must specify that they are declining enrollment into KidsCare or KidsCare II and instead requesting enrollment in the ESI. Before such a request is accepted, the individual must receive information/counseling in order to ensure that enrollment is an informed choice. ESI enrollees will have the choice to opt back into direct coverage, if available, at any time.

iii. **Premium Assistance Benefits**: The State will subsidize premium assistance through a monthly per child subsidy that will not exceed the per capita cost of direct CHIP coverage for the child. This monthly subsidy does not need to be allocated between eligible and ineligible family members.

iv. **Minimum Employer Contribution.** Qualifying ESI must include employer contributions of at least 30 percent of the total premium or cost under the employer plan.

v. **Minimum Benefit package.** Qualifying ESI will include coverage that provides a basic primary care package of inpatient hospital services, outpatient services, laboratory and x-ray services, pharmacy services, and behavioral health services. Coverage may be provided through any commercial group package or self-insurance program offered by the employer to all employees in a class. Within these parameters, benefits may vary between employers. Wrap-around services are not provided.

vi. **Choice of ESI Plans.** To the extent that premium assistance is extended to individuals, the individuals must agree not to exercise choice among available ESI plans without obtaining State concurrence. The State will not, however, deny coverage based on a prior exercise of such choice.

vii. **Cost Sharing.** Enrollees in the ESI program will have cost sharing set by their employer-based coverage.

viii. **Enrollment Data.** Each quarter, the State will provide CMS with end of quarter actual and unduplicated ever-enrolled figures. These enrollment data will be entered into the Statistical Enrollment Data System within 30 days after the end of each quarter. The data will also be referenced in the quarterly reports described in paragraph 37. In addition, the State will provide monthly enrollment data as specified by CMS in the monthly Eligibility and Enrollment Reports.

b) **Kids Care II Program.** This program is authorized, subject to the available funding as specified in paragraph 25(i), from May 1, 2012 through December 31, 2013.

i. **Eligibility.** Targeted low-income children defined in 42 CFR 457.310 with family income from 100 percent of the FPL up to and including 175 percent of the FPL who are not otherwise eligible for Medicaid but are otherwise eligible for the Arizona CHIP State Plan, except for the enrollment cap and/ or waiting period.

ii. **Enrollment Process.** Eligible children will enroll into the KidsCare II program as outlined in sub-paragraphs (1) and (2). Attachment H provides further operational details with respect to the enrollment process.

1) **Children "Aging Out" of Medicaid.** Beginning April 6, 2012, the State will conduct an administrative renewal for a child turning age 6 to determine if the child is eligible for Medicaid under a different eligibility category, or if the child is eligible for the KidsCare II program. If the child is no longer eligible for Medicaid, the State will automatically transfer the child from the AACP program into the KidsCare II program if they meet KidsCare II eligibility requirements. These children will remain enrolled if otherwise eligible, until the KidsCare II program ends on December 31, 2013, at which time they will seamlessly transition to other forms of coverage.

2) **KidsCare Waiting List**. Families with children on the KidsCare waiting list who are notified by the State will have the opportunity to apply for the KidsCare II program. In order to be determined eligible for KidsCare II coverage, children must have income at or below 175 percent of the FPL, and have no outstanding KidsCare premiums and must meet all other eligibility requirements. KidsCare premiums must be paid before a child can enroll in the KidsCare II program. Once determined eligible, a child will remain in the KidsCare II program if otherwise eligible until the program ends on December 31, 2013.

3) **Open Enrollment**. Subject to available program funding and notification to all the families with children on the KidsCare waiting list as described above in subparagraph (2) and in Attachment H, the State will open enrollment to the KidsCare II program to all eligible children up to 19 years old with family income at or below 175 percent of the FPL. The State must notify CMS prior to opening enrollment, and must include a process by which it will notify the public, such as the use of public forums, tribal consultations, and community stakeholder meetings.

iii. **Enrollment Threshold.** Enrollment for the KidsCare II program is subject to the available funding as specified in paragraph 25(i), in order to enroll a target number of 21,700 children. The State will seek to maintain full enrollment in the program. If the enrollment drops below 15,000 children, the State shall conduct additional outreach activities as outlined in Attachment H in order to increase enrollment.

iv. **Benefits.** Children enrolled in the KidsCare II program will be offered the same benefit package provided under Arizona's CHIP State plan.

v. **Cost Sharing.** Children in the KidsCare II program will be subject to cost sharing requirements, including monthly premiums, specified in Arizona's CHIP State Plan. Cost sharing for children in KidsCare II must meet the same requirements as those for children receiving coverage under the CHIP State plan, consistent with the requirements at section 2103(e). Cost sharing for families at or below 150 percent of the Federal poverty level (FPL), must be "nominal" in accordance with 42 CFR 457.540 - 457.555and total charges may not exceed 5 percent of the family's income for children of all income levels, in accordance with 42 CFR 457.560.

c) **Funding for Title XXI Programs.** The State will establish a monitoring process to ensure that expenditures do not exceed available title XXI funding (i.e., the title XXI allotment or reallocated funds) and the appropriated State match. The State will use title XXI funds to cover services for the CHIP, ESI and KidsCare II populations in the following priority order:

i. Title XXI State plan eligibles, as well as children that opt for ESI, who are children up to age 19 years with family incomes up to and including 200 percent of the FPL.
ii. KidsCare II program participants who are children up to age 19 years with family incomes above 100 percent of the FPL up to and including 175 percent of the FPL.
iii. If the State determines that title XXI funding will be exhausted, available title XXI funding will first be used to cover costs associated with the title XXI State plan population.

24. **Family Planning Extension Program.** Family planning and family planning related services are provided, for a period of up to 24 months, to eligible recipients who lose Medicaid pregnancy coverage at the conclusion of 60 days postpartum, and who are not otherwise eligible for Medicare, Medicaid, CHIP, or health insurance coverage that provides family planning services, and who have a family income at or below 150 percent of the FPL at the time of annual redetermination.

a) **Benefits.**

i. Family planning services and supplies described in section 1905(a)(4)(c) and are limited to those services and supplies whose primary purpose is family planning and which are provided in a family planning setting. Family planning services and supplies are reimbursable at the 90 percent matching rate, including:
   1) Approved methods of contraception;
   2) Sexually transmitted infection (STI)/sexually transmitted disease (STD) testing, Pap smears and pelvic exams;
      i. Note: The laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs/STDs, blood count and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.
   3) Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the State's provider enrollment requirements (subject to the national drug rebate program requirements); and
   4) Contraceptive management, patient education, and counseling.

ii. Family planning-related services and supplies are defined as those services provided as part of or as follow-up to a family planning visit and are reimbursable at the State's regular Federal Medical Assistance Percentage (FMAP) rate. Such services are provided because a "family planning-related" problem was identified and/or diagnosed during a routine or periodic family planning visit. Examples of family planning-related services and supplies include[1]:
   1) Colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit.
   2) Drugs for the treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is identified/ diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered.
   3) Drugs/treatment for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, where

[1] For more information on which of these family planning-related services is covered, see the AHCCCS Medical Policy Manual at: http://ahcccsnew/shared/MedicalPolicyManual/MedicalPolicyManual.aspx?ID=policymanuals

these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/ drugs may also be covered.

4) Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.
5) Treatment of major complications arising from a family planning procedure such as:
    i. Treatment of a perforated uterus due to an intrauterine device insertion;
    ii. Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or
    iii. Treatment of surgical or anesthesia-related complications during a sterilization procedure.

b) **Primary Care Referral.** Primary care referrals to other social service and health care providers as medically indicated are provided; however, the costs of those primary care services are not covered for enrollees of this program. The State must facilitate access to primary care services for participants in the Family Planning Extension Program and must assure CMS that written materials concerning access to primary care are distributed to participants. The written materials must explain to the participants how they can access primary care services.

c) **Eligibility Re-determinations.** The State must ensure that redeterminations of eligibility for the Demonstration are conducted at least every 12 months. At the State's option, redeterminations may be administrative in nature. The State must notify CMS within the previous quarterly or annual report, described in STCs 34 and 35, if it chooses to utilize administrative redeterminations.

d) **Disenrollment.** If a woman becomes pregnant while enrolled in the Demonstration, she may be determined eligible for Medicaid under the State plan. The State must not submit claims under the Demonstration for any woman who is found to be eligible under the Medicaid State plan. In addition, women who receive a sterilization procedure and complete all necessary follow-up procedures will be disenrolled from the Demonstration.

## VI. Funding Pools and Payments under the Demonstration.

25. **Safety Net Care Pool (SNCP).** Payments from this pool will assist hospitals and other eligible providers that have high levels of uncompensated care related to medical assistance provided to Medicaid eligibles or to individuals who have no source of third party coverage. In each Demonstration Year (DY), the annual SNCP will be distributed to each provider based on its proportionate share of projected uncompensated care (based on prior period data). Furthermore, payments to each provider in each DY will be subject to a limit computed based on the provider's uncompensated care costs incurred for a 12-month period covered by the DY, except in DY 3 where the limit will be computed based

on uncompensated care costs incurred up to December 31, 2013. The total computable amount for the SNCP is $332 million per DY. Any unspent cap amount cannot be transferred to the following DY in order to increase the annual cap amount.

a) **SNCP Payments.** Funds may be used to assist providers with high levels of uncompensated care related to medical services that meet the definition of "medical assistance" contained in section 1905(a) of the Act, that are provided to Medicaid eligible or uninsured individuals incurred by hospitals, clinics, or by other provider types, as agreed upon by CMS and the State and identified in Attachment J. Expenditures must be claimed in accordance with CMS-approved claiming protocols in Attachment I for each provider type. FFP claiming for payments made from the SNCP will begin upon CMS approval of the claiming protocol as identified in sub-paragraph (c). For any provider receiving SNCP payments, the total Medicaid payments, Disproportionate Share Hospital (DSH) payments, SNCP payments, and any other payments for medical services furnished to Medicaid eligible and uninsured individuals cannot exceed the actual cost of providing services to Medicaid eligibles and the uninsured as defined in the claiming protocol. SNCP payments will be made directly from the State to the eligible providers as defined in subparagraph (d), who incurred uncompensated care costs.

b) **Prohibited Use of SNCP Funds.** SNCP funds cannot be used to pay for costs associated with non-emergency services provided to non-qualified aliens. The State must develop a methodology as part of the claiming protocol to exclude such costs from eligible uncompensated care costs.

c) **Uncompensated Care Cost Limit** The aggregate amount of SNCP payments to the providers identified in Attachment J will not exceed the SNCP amount of $332 million per DY. The annual SNCP payment distributed to each individual provider will not exceed its uncompensated care costs for providing section 1905(a) medical services to Medicaid eligible and uninsured individuals for the period.

The State must submit to CMS for approval and incorporation into Attachment I a claiming protocol for each provider type to provide for the computation of a provider's uncompensated care costs. No FFP is available for SNCP payments until the associated claiming protocol is approved by CMS. Such protocols must take into consideration:

i. The cost reporting tool (i.e., the CMS-2552 cost report for hospital providers, and other cost reports for non-hospital providers as approved by CMS) to be used to determine a provider's allowable patient care costs, consistent with Medicare cost principles and OMB Circular A-87, for a specific service period.

ii. A methodology to apportion allowable patient care costs to Section 1905(a) services furnished to Medicaid eligible and uninsured individuals.

iii. An offset of all payments received for the services furnished to Medicaid eligible and uninsured individuals, including all Medicaid payments, third party payments, and payments by or on behalf of the patients, to arrive at the provider's uncompensated care cost.

iv. A carve-out of costs associated with non-emergency services provided to non-qualified aliens, which is a prohibited use of SNCP funds.

v. A payment methodology to allow the State to distribute SNCP payments to providers based on projected uncompensated care costs.

vi. Reconciliations of payments to the provider's uncompensated care cost limits as computed based on the provider's as-filed and finalized cost reports for the actual service period.

The uncompensated care cost limit is computed and SNCP payments are made on a DY basis. To the extent that a provider's cost reporting period does not coincide with the DY, the cost protocol will provide for an allocation of uncompensated care costs to the DY.

Any SNCP payments made in excess of the individual provider's uncompensated care cost limit for a demonstration period will be recouped from the provider, and the Federal share of the overpayment will be returned to CMS.

d) **Eligible Providers.** The eligible providers for SNCP payments are those identified in Attachment J. The State must seek prior approval from CMS to amend the list of eligible providers. The State must also submit to CMS for review and approval any additional claiming protocol needed due to the expansion of the eligible provider list.

The State will consider providers which meet the following criteria for SNCP participation:

i. Safety Net Hospital Systems which are defined as the health systems in each of the State's two largest metropolitan statistical areas that (a) are providing the highest percentage of care (measured in terms of discharges) within their MSA for adult AHCCCS and low-income uninsured patients and (b) sponsor multiple adult residency programs.

ii. Rural Hospitals which are defined as (a) Arizona hospitals that are not in Pima or Maricopa Counties; or (b) Arizona hospitals that are in counties of 500,000 or fewer persons.

iii. Critical Access Hospitals, which are defined as rural community hospitals that meet defined criteria outlined in the Conditions of Participation at 42 C.F.R.

485, Subpart F and 42 C.F.R. 440.170(g).

iv. Hospitals that qualify for a disproportionate share hospitals (DSH) payment as outlined in Attachment D.

v. Any provider affiliated with the hospitals outlined in the above subparagraphs (i-iv).

e) **DSH and SNCP.** All applicable inpatient hospital and outpatient hospital SNCP payments received by a hospital provider must be included as offsetting revenue in the State's annual DSH audit reports. Hospitals cannot receive total payments, including DSH and SNCP payments, related to inpatient and outpatient hospital services furnished to Medicaid eligible and uninsured individuals that exceed the hospital's total eligible inpatient hospital and outpatient hospital uncompensated care costs.

**f) Intergovernmental Transfers (IGTs).** The non-Federal share of the SNCP payments will be funded by IGTs by eligible governmental entities. The State will submit to CMS for review and approval all IGT agreements to ensure compliance with Section 1903(w)(6)(A) of the Act and Part X of these STCs. Such agreements should specify the amount and source of the IGT money, including funds to provide the non-federal share of KidsCare II referenced in subparagraph (i). The agreements shall ensure that the IGT is not derived from an impermissible source, including recycled Medicaid payments, Federal money precluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. The agreements shall also ensure that providers will retain the SNCP payments.

**g) Annual Reporting Requirements for SNCP Payments**. The State will submit to CMS an annual report specifically related to the amount of payments made from the SNCP per DY. The reporting requirements are as follows:

Within ninety (90) days after the end of each DY, the State shall provide the following information to CMS:

1) Actual SNCP payments to each provider for each DY, including the interim payments and any reconciliation payments;

2) The uncompensated care cost limit computed for each provider for each DY, including the projected uncompensated care costs used for interim payment purposes, the uncompensated care costs based on the as-filed cost reports, and the uncompensated care costs based on the finalized cost reports.

h) **SNCP Designated State Health Program (DSHP**). In addition to the $332 million uncompensated care cost payments outlined above, the State may claim FFP for the Trauma and Emergency Services Fund Payments as authorized by Arizona State Proposition 202 for DY 1 and DY 2. The total program amount eligible for FFP

cannot exceed $20 million total computable per DY, and expenditures must be claimed in accordance with a CMS-approved claiming protocol. Claiming of FFP cannot begin until the protocol is approved by CMS and incorporated into Attachment I. Any unspent funds cannot be transferred to the following DY in order to increase the annual amount.

i) **Contribution to the KidsCare II Program.** The eligible governmental entities in subparagraph (f) will provide IGTs to fund the non-federal share of KidsCare II Program expenditures. The funding amount is estimated at up to $76,991,169 total computable.

26. **Payments to IHS and 638 Facilities.** The State is authorized under the expenditure authorities of this Demonstration to make payments to IHS and tribal 638 facilities that take in to account their uncompensated costs in furnishing specified types of care furnished by IHS and tribal 638 facilities to Medicaid-eligible individuals and other individuals with family income at or below 100 percent of the FPL.

    Facilities will have the option to elect one of two approved methodologies, as further outlined in Attachment K, to calculate and receive payment for their uncompensated care costs. The facilities will notify AHCCCS of their selection by April 30, 2012, and will have the option to switch their methodology election only once. If a facility elects to switch the methodology by which their uncompensated care payment is calculated, the facility must notify the State by December 15, 2012. The new methodology will be utilized to calculate the facility's uncompensated care payment effective January 1, 2013.

## VII. DELIVERY SYSTEMS

27. **Contracts.** All contracts and modifications of existing contracts between the State and MCOs must be prior approved by CMS. The State will provide CMS with a minimum of 30 days to review and approve changes.

## VIII. EVALUATION

28. **State Must Separately Evaluate Components of the Demonstration.** As outlined in subparagraphs (a) - (e) the outcomes from each evaluation component must be integrated into one programmatic summary that describes whether the State met the Demonstration goal, with recommendations for future efforts regarding all components. The evaluation must outline and address evaluation questions for all of the following components:

    a) **Evaluation Design Plan.** The State must submit to CMS for approval a draft evaluation design no later April 1, 2012. At a minimum, the draft design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those outlined in subparagraphs (c) and (d), as well as

those that focus specifically on the target populations within the Acute Care, ALTCS, ESI program and the Family Planning Extension Program within the demonstration. The draft design plan must also include a separate section discussing the AACP cost sharing and missed appointment fee evaluation requirements as described further in subparagraphs (c) and (d). The draft design shall discuss the outcome measures that must be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes (Attachment C – Evaluation Design Guidelines). The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration are isolated from other initiatives occurring in the State.

The State must submit a revised draft evaluation design plan by June 1, 2012, in order to include the specific hypotheses outlined in subparagraph (e).

b) **ESI Evaluation**. Arizona must conduct an evaluation of the ESI demonstration as described in paragraph 23(a). The State shall report on its progress in the quarterly and annual reports. AHCCCS will monitor the private insurance market as it relates to the ESI program (e.g., changes in employer contribution levels, trends in sources of insurance, etc.). AHCCCS will also continue to monitor substitution of coverage (i.e., participants dropping private coverage to enroll in the Demonstration).

c) **AACP Cost Sharing Evaluation.** Arizona must conduct an independent evaluation of the AACP cost sharing requirements as described in paragraph 17(d). The evaluation must test the following specific hypotheses related to the mandatory copayments assessed on the adults without dependent children population:

   i. How will utilization of needed preventive, primary care, and treatment services be affected;
   ii. To what extent will the imposition of the pharmacy co-payments and copayments related to non-emergent use of emergency rooms ensure appropriate utilization of emergency room care and appropriate utilization of cost and clinically effective generic and brand name drugs; and
   iii. Will the mandatory co-payments affect State and federal expenditures (per enrollee) in the short and long term; and
   iv. Will there be an impact on physician participation, or physician willingness to accept appointments from the adults without dependent children population.

Methods by which the State can evaluate these hypotheses include evaluating the

relative utilization of, and access to, services provided to the adults without dependent children population compared to a similar population of parents (who are not subject to the copayment requirements), as well as, comparing selected access, utilization and quality indicators, across the pre-copayment adults without dependent children population with those of the post-co-payment adults without dependent children population, as well as across the adults without dependent children populations Measures could include examining the impact of the copayments on rates of emergency department utilization, rates of inpatient readmission, and selected evidence-based measures indicating management of chronic conditions (such as diabetes and asthma).

In addition, the State will evaluate how the NEMT copayment on adults without dependent children residing in Maricopa and Pima counties has affected access compared to the same population residing in all other counties.

Finally, the State shall report on the evaluation's progress in the State's quarterly and annual reports.

d) **Permissible Provider Fee for Missed Appointments Evaluation.** The State must submit an independent evaluation of the missed appointment fee on the TANF parents and adults without dependent children residing in all counties except for Maricopa and Pima counties. This evaluation must be submitted to CMS by November 1, 2012. In addition to the other hypotheses that the State has developed to test this fee, the State must evaluate the following to determine the fee's impact on:

i. Reducing the number of missed appointments;
ii. Beneficiaries seeking more care from walk-in clinics, urgent care centers, and/or emergency rooms, and any resulting impact on costs;
iii. Denial of service as a result of the fee;
iv. Subgroups within the adults without dependent children population, i.e., were there variations by income level, age, gender, etc.;
v. Program integrity;
vi. Compliance with the provisions for missed appointment fees in STC 17(e);
vii. Administrative feasibility and cost to the provider; and
viii. The rate of missed appointment fees assessed by provider type and region of the State.

As specified in paragraph 17(e), the authority to impose this copayment is time limited, and will expire on January 1, 2013. CMS may, upon reviewing the State's evaluation, and at the State's request, extend the authority until December 31, 2013.

e) **Uncompensated Care Payments to IHS and 638 Facilities.** Arizona must conduct

an independent evaluation of the uncompensated care payments provided to IHS and 638 facilities as described in paragraph 26 and Attachment K. The evaluation must test the following specific hypotheses related to the uncompensated care payments:

i. What is the affect on service utilization as a result of the uncompensated care payments broken down by type of service as well as the population served?
ii. Are the affected facilities able to maintain and/or increase their current staffing levels?

Methods by which the State can evaluate these hypotheses include evaluating staffing levels as well as the relative utilization of, and access to, services provided to adults pre-uncompensated care payment period to services with those of the post-uncompensated care payment period. Measures could include examining selected evidence-based measures indicating management of chronic conditions (such as diabetes and asthma).

29. **Final Evaluation Design and Implementation.** CMS must provide comments on the draft design, within 60 days of receipt, and the State must submit a final design within 60-days of receipt of CMS comments. The State must implement the evaluation design, and submit to CMS a draft of the evaluation 120 days after the expiration of the demonstration. CMS shall provide comments within 60 days of receipt of the draft evaluation. Within 60 days of receipt of comments from CMS, a revised final report must be submitted.

30. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the Demonstration, the State must fully cooperate with Federal evaluators' and their contractors' efforts to conduct an independent, federally funded evaluation of the Demonstration program.

## IX. GENERAL REPORTING REQUIREMENTS

31. **General Financial Requirements.** The State shall comply with all general financial requirements under title XIX and title XXI.

32. **Reporting Requirements Relating to Budget and Allotment Neutrality.** The State shall comply with all reporting requirements for monitoring budget and allotment neutrality set forth in this Agreement.

33. **Budget Neutrality Information.** For each quarter, the State will correctly report expenditures and member months that are subject to budget neutrality. Where data are incorrect and upon the request of CMS, the State must submit corrected budget neutrality data.

34. **Monthly Calls.** CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the

Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost sharing, employer-sponsored insurance progress, family planning issues, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, health plan financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers, or State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

35. **Monthly Childless Adult Enrollment Reports.** As required in the July 1, 2011, childless adult phase-out plan (Attachment A), the State must submit a monthly enrollment report for the childless adult populations by the 15th of each month until December 31, 2013. The enrollment report must contain the following:

    a) Population, including the percent change from the previous month;

    b) Beneficiaries transferred from the childless adult eligibility category to the SSI-MAO eligibility category;

    c) Beneficiaries who did not meet the SSI-MAO eligibility requirements and were transferred back to the childless adult eligibility category; and

    d) Beneficiaries who were transferred to the SSI-MAO eligibility and were discontinued because they did not comply with the State's redetermination requirements.

36. **KidsCare II Monthly Reports.** The State must submit a monthly report for the KidsCare II population by the 15th of each month until December 31, 2013. The monthly report must contain the following the information:

    a) **Enrollment.** The monthly report must contain the following enrollment information broken down by the number of children enrolled through the application process and the number of title XIX children transferred from the AACP:

        i. Number of children newly enrolled in KidsCare II;
        ii. Number of children enrolled to date; and
        iii. Current enrollment at end of each quarter with an annual total.

    b) **Applications.** Of the total number of families who received notices, the number of children applying with a breakdown of the number who are eligible for Medicaid, eligible for KidsCare II and those that are ineligible for KidsCare II.

    For those determined to be ineligible for KidsCare II, the reason for ineligibility, including, but not limited to following reasons:

i. Over income limit;
ii. Did not pay outstanding KidsCare premiums; and
iii. Did not provide required documentation during application process.

c) **KidsCare II PCAP Dedicated Hotline.** This section of the monthly report must contain the following information:

i. Number of calls;
ii. Where did callers hear about the helpline? (letter, TV/radio/newspaper, family/friend, community organization);
iii. Number of callers who said they received a notice;
iv. Number of callers for whom address must be updated;
v. Number of callers referred to subscriber for application assistance;
vi. Number of calls in other categories; and
vii. Time of day helpline most busy.

37. **Quarterly Reports.** The State shall submit progress reports in a format agreed upon by CMS and the State no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports shall include, but not be limited to (Attachment B – Quarterly Report Guidelines):

a) A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, enrollment, quality of care, access, health plan financial performance that is relevant to the Demonstration, the benefit package, and other operational issues;

b) Action plans for addressing any policy and administrative issues identified;

c) The quarterly reports must also include at least enrollment data, member month data, and budget neutrality monitoring tables;

d) The number of IHS and 638 facilities receiving uncompensated care payments, broken down by the methodology selected in which the uncompensated care payment is calculated as well as a discussion on how the payments are affecting the financial viability of the facilities, using metrics that the State will develop in consultation with IHS and tribal programs, and the impact on service utilization broken down by type of service and by populations served.

e) The number of individuals enrolled in the Family Planning Extension Program at the end of the quarter, as well as the number of participants served during the prior quarter (participants include all individuals who obtain one or more covered family planning or family planning-related services through the Demonstration);

f) Notification of any changes in enrollment and/or participation to the Family

Planning Extension Program that fluctuate 10 percent or more in relation to the previous quarter within the same Demonstration Year (DY) and the same quarter in the previous DY; and

g) Any issues which arise in conjunction with the Employer Sponsored Insurance (ESI) portion of the program, including but not limited to enrollment, quality of care, grievances, and other operational issues; and evaluation activities.

38. **Annual Report.** The State shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, the status of the collection and verification of encounter data and policy and administrative difficulties in the operation of the Acute Care, ALTCS, ESI, KidsCare II, SNCP/DSHP, IHS and 638 facilities uncompensated care payments, and Family Planning components of the Demonstration. The State shall submit the draft annual report no later than 120-days after the end of each operational year. Within 30-days of receipt of comments from CMS, a final annual report shall be submitted.

For the Family Planning Extension Program, the annual report must include the following:

a) The number of actual births that occur to Family Planning Extension Program participants (participants include all individuals who obtain one or more covered medical family planning services through the Family Planning Extension Program each year);

b) Total number of individuals enrolled at the end of the demonstration year;

c) Total number of participants enrolled at the end of the demonstration year; and

d) The average total Medicaid expenditures for a Medicaid-funded birth each year. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth up to age 1 (the services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants.)

39. **Transition Plan**. On or before July 1, 2012, the State is required to submit a draft, and incrementally revise, a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the Demonstration. This plan will address how the State plans to coordinate the transition of these individuals, including children enrolled in the KidsCare II program, to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The plan must contain the required elements and milestones described in paragraphs 39(a)-(f) outlined below. In addition, the Plan will include a schedule of implementation activities that the State will use to operationalize the Transition Plan.

a) Seamless Transitions: Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the State plans to obtain and

review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the Demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. Specifically, the State must:

i. Determine eligibility under all January 1, 2014, eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL.

ii. Identify Demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014.

iii. Implement a process for considering, reviewing, and making preliminarily determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility.

iv. Conduct an analysis that identifies populations in the Demonstration that may not be eligible for or affected by the Affordable Care Act and the authorities the State identifies that may be necessary to continue coverage for these individuals.

v. Develop a modified adjusted gross income (MAGI) conversion for program eligibility.

b) KidsCare II Transition: The Plan must include the State's process to seamlessly transition children enrolled in the KidsCare II program to other forms of coverage once the program expires December 31, 2013. The State must include the information outlined in subparagraph (a) as applied to the KidsCare II program.

c) Cost-sharing Transition: The Plan must include the State's process to come into compliance with all applicable Federal cost-sharing requirements, including the section 1916(f) requirements that apply to the adults without dependent children population when it becomes a mandatory State plan population on January 1, 2014.

d) Access to Care and Provider Payments and System Development or Remediation: The State should assure adequate provider supply for the State plan and Demonstration populations affected by the Demonstration on December 31, 2013. Additionally, the Transition Plan for the Demonstration is expected to expedite the State's readiness for compliance with the requirements of the Affordable Care Act and other Federal legislation.

e) Pilot Programs: Progress towards developing and testing, when feasible, pilot programs that support Affordable Care Act activities, such as the State's Medicare-Medicaid integration project to allow for more efficient and effective management of dually eligible ALTCS EPD beneficiaries.

f) Progress Updates: After submitting the initial Transition Plan for CMS approval, the State must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed.

g) Implementation:

i. By October 1, 2013, the State must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the Demonstration to Medicaid, the Exchange or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the State plan, the State will not require these individuals to submit a new application.

ii. On or before December 31, 2013, the State must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

40. **Final Report.** The State shall submit a final report pursuant to the requirements of section 1115 of the Act.

41. **Contractor Reviews**. The State will forward summaries of the financial and operational reviews that:

a) The Arizona Department of Health Services/ Behavioral Health Services (ADHS/BHS) completes on the Regional Behavioral Health Authorities (RBHAs).

b) The Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD) performs on its subcontracting MCOs.

c) The State will also forward summaries of the financial and operational reviews that AHCCCS completes on the Children's Rehabilitative Services Program (CRS) contractor; and the Comprehensive Medical and Dental Program (CMDP) at the Arizona DES.

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

43. **Contractor Disclosure of Ownership**. Before contracting with any provider of service, the State will obtain from the provider full disclosure of ownership and control and related party transactions, as specified in sections 1124 and 1902(a)(38) of the Act. No FFP will be available for providers that fail to provide this information.

## X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

44. **Quarterly Expenditure Reports.** Effective with the quarter beginning October 1, 2011, the State shall provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in this Agreement.

45. **Reporting Expenditures in the Demonstration**. The following describes the reporting of expenditures subject to the budget neutrality cap:

    a) **Tracking Expenditures.** In order to track expenditures under this Demonstration, Arizona shall report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap shall be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this Demonstration), the adjustments should be reported on lines 9 or 10.C through 10.F, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below.

    b) **Use of Forms**. For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the Demonstration, subject to the budget neutrality cap. The State must complete separate forms for the following categories:

        i. AFDC/SOBRA
        ii. SSI
        iii. AC
        iv. MED
        v. ALTCS-DD
        vi. ALTCS-EPD
        vii. Family Planning Extension
        viii. Uncompensated Care Payments to IHS and 638 Facilities
        ix. SNCP/DSHP

x. DSH and Critical Access Hospital Payments (CAHP)**
**Critical Access Hospital Payments as defined in Attachment F

c) **Expenditures Subject to the Budget Neutrality Cap**. For purposes of section X, the term "expenditures subject to the budget neutrality cap" shall include all Medicaid expenditures except those as described below, on behalf of the individuals who are enrolled in this Demonstration. Expenditures excluded from this Demonstration and the budget neutrality cap are Direct Services Claiming program expenditures for Medicaid in the public schools, Breast and Cervical Cancer Treatment program expenditures, Freedom to Work program expenditures, and all administrative expenditures.

d) **Premium and Cost Sharing Adjustment**. Premiums and other applicable cost sharing contributions from enrollees that are collected by the State from enrollees under the Demonstration shall be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that the Demonstration is properly credited with premium collections, premium collections (both total computable and Federal share) should also be reported on the CMS-64 Narrative. The State should include these section 1115 premium collections as a manual adjustment (decrease) to the Demonstration's actual expenditures on a quarterly basis.

e) **Administrative Costs.** Administrative costs shall not be included in the budget neutrality limit. All administrative costs shall be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

f) **Claiming Period**. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

g) **Pharmacy Rebates.** The State may propose a methodology for assigning a portion of pharmacy rebates to the Demonstration. The proposed methodology must determine, in a way that reasonably reflects actual rebate-eligible pharmacy utilization, the amounts of rebate that are attributable to pharmacy utilization under the Demonstration *vs.* outside the Demonstration, and appropriate subtotals by EG and DY. The methodology (and any subsequent changes to the methodology) must be approved in advance by the CMS Regional Office prior to use. Rebate amounts assigned to the Demonstration must be reported on the appropriate Forms CMS-64.9 or 64.9P Waiver, and not on any other CMS-64.9 form (to avoid double-counting). In

the absence of an approved methodology, all pharmacy rebates must be reported on Forms CMS-64.9 or 64.9P Base.

46. **Reporting of Member Months.** The following describes the reporting of member months in the Demonstration.

a) Member months subject to the budget neutrality cap include:

i. For the purpose of calculating the budget neutrality expenditure cap described in this Agreement, the State shall provide to CMS on a quarterly basis the actual number of eligible member months for:

1) Eligibility Group 1:AFDC / SOBRA
2) Eligibility Group 2: SSI
3) Eligibility Group 3: AC
4) Eligibility Group 4 ALTCS-DD
5) Eligibility Group 5: ALTCS–EPD
6) Eligibility Group 6: Family Planning Extension Program

ii. This information shall be provided to CMS 30 days after the end of each quarter as part of the CMS-64 submission, either under the narrative section of the MBES/CBES or as a stand-alone report.

iii. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member months.

iv. For the purposes of this Demonstration, the term “Demonstration eligibles” refers to all individuals covered by Arizona Medicaid with the exception of individuals in the Freedom to Work and Breast and Cervical Cancer Treatment programs

b) Demonstration Member Months subject to reporting on the CMS 64-Narrative includes the MED Group – described in paragraph 16 as:

i. MED - Individuals who applied for the MED program (under Expenditure Authority 20 of Demonstration project #11-W-00032/9 and #21-W-00009/9) prior to May 1, 2011 and were determined eligible for that population for a 6-month guaranteed eligibility period after that date, until the end of that 6-month period.

47. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality

expenditure cap and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

48. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the following, subject to the limits described in this Agreement.

a) Administrative costs, including those associated with the administration of the Demonstration;

b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan; and

c) Net expenditures and prior period adjustments made with dates of service during the operation of the Demonstration.

d) CMS shall provide FFP for family planning and family planning-related services and supplies at the applicable Federal matching rates described in STC 24(a)(i) and (ii), subject to the limits and processes described below:

i. For family planning services, reimbursable codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service;
ii. Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate, described in STC 24(a)(i), should be entered in Column (D) of the Forms CMS-64.9 Waiver.
iii. Allowable family planning-related expenditures eligible for reimbursement at the FMAP rate, as described in STC 24(a)(ii), should be entered in Column (B) on the Forms CMS-64.9 Waiver.
iv. FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. For example, in the instance of testing for STIs as part of a family planning visit, FFP will be available at the 90 percent Federal matching rate. The match rate for the subsequent treatment would be paid at the applicable Federal matching rate for the State. For testing or treatment not associated with a family planning visit, no FFP will be available.
v. Pursuant to 42 CFR 433.15(b)(2), FFP is available at the 90 percent administrative match rate for administrative activities associated with administering the family planning services provided under the Demonstration

including the offering, arranging, and furnishing of family planning services. These costs must be allocated in accordance with OMB Circular A-87 cost allocation requirements. The processing of claims is reimbursable at the 50 percent administrative match rate.

49. **Medicare Part D Drugs.** No FFP is available for this Demonstration for Medicare Part D drugs.

50. **Sources of Non-Federal Share**. The State certifies that the source of the non-Federal share of funds for the Demonstration is State/local monies. The State further certifies that such funds shall not be used as the non-Federal share for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with Title XIX of the Social Security Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

    a) CMS shall review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

    b) The State shall provide information to CMS regarding all sources of the non-Federal share of funding for any amendments that impact the financial status of the program.

    c) Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as Demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State and/or local government to return and/or redirect any portion of the Medicaid or Demonstration payments. This confirmation of Medicaid and Demonstration payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid or the Demonstration and in which there is no connection to Medicaid or Demonstration payments) are not considered returning and/or redirecting a Medicaid or Demonstration payment.

51. **Certification of Public Expenditures.** The State must certify that the following conditions for non-Federal share of Demonstration expenditures are met:

    a) Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-Federal share of funds under the Demonstration.

    b) To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a

detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

i. To the extent that Arizona institutes the use of CPEs, the requirements of this term and condition fully apply. The State is subject to any policy guidance or regulation released by CMS regarding the use of CPEs.

ii. The disproportionate share hospital (DSH) payment methodology for Arizona State Hospital (ASH) and the Maricopa Medical Center will be cost reimbursement and will utilize CPEs as the funding system. The methodology and the cost identification/reconciliation process, as approved by CMS, is included as an amendment to the DSH methodology in Attachment D.

c) To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration to non-governmental providers, the governmental entity appropriating funds to the provider must certify to the State the amount of such tax revenue (State or local) appropriated to the non-governmental provider used to satisfy demonstration expenditures. The non-governmental provider that incurred the cost must also provide cost documentation to support the State's claim for Federal match.

d) The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

52. **Applicability of Fee for Service Upper Payment Limits.** If expenditures (excluding expenditures for members enrolled with the Indian Health Service for inpatient hospital and long-term-care facility services, other institutional and non-institutional services (including drugs) provided to AHCCCS fee-for-service beneficiaries equal or exceed 5 percent of the State's total Medical Assistance expenditures, the expenditure authority will be terminated and the State shall submit a demonstration amendment that includes a plan to comply with the administrative requirements of section 1902(a)(30)(A). The State shall submit documentation to CMS on an annual basis that shows the percentage AHCCCS fee-for-service beneficiary expenditures as compared to total Medical Assistance expenditures.

53. **Fraud and Abuse Recoveries**: The State must improve fraud and abuse recoveries by:

a) Submitting for CMS review an action plan by April 1, 2012, to enhance Medicaid fraud and abuse recoveries by the end of the Demonstration period ending September 30, 2016.

b) Submitting to CMS an annual report of the State's implementation of its action plan as required in paragraph 38.

c) Demonstrating by September 30, 2016, that its level of recoveries is equal to, or greater than, the level anticipated in the action report approved by CMS.

## XI. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

54. **Quarterly CHIP Expenditure Reports.** The State shall provide quarterly expenditure reports using the Form CMS-21 to report total expenditures for services provided to all Demonstration populations receiving title XXI funds under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS will provide FFP only for allowable Demonstration title XXI expenditures that do not exceed the State's available title XXI funding.

55. **Tracking CHIP Expenditures.** In order to track title XXI expenditures under this Demonstration, the State will report Demonstration expenditures, excluding KidsCare II, through the MBES/CBES, following routine CMS-21 reporting instructions. Title XXI Demonstration expenditures will be reported on separate Forms CMS-21 Waiver and/or CMS-21P Waiver identified by the Demonstration project number assigned by CMS (including project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). Expenditures for the KidsCare II program will be reported on the CMS-21 with the state plan population in the MBES/CBES. Separate KidsCare II reporting will be provided in the CMS-21 Narrative using a proportion of KidsCare II to the total KidsCare population based on date of payments.

a) **CHIP Claiming.** All claims for expenditures related to the Demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the Form CMS-21.

b) **Standard CHIP Funding Process.** The standard CHIP funding process will be used during the Demonstration. Arizona must estimate matchable CHIP expenditures on the quarterly Form CMS-21B. On a separate CMS-21B, the State shall provide updated

estimates of expenditures for the Demonstration population. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

c) **Sources of CHIP Non-Federal Share.** The State will certify State/local monies used as matching funds for the Demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law. All sources of non-Federal share of funding and distribution of monies involving Federal match are subject to CMS approval. Upon review of the sources of the non-Federal share of funding and distribution methodologies of funds under the Demonstration, all funding sources and distribution methodologies deemed unacceptable by CMS shall be addressed within the timeframes set by CMS. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding

56. **Limit on Title XXI Funding**. Arizona will be subject to a limit on the amount of Federal title XXI funding that the State may receive for Demonstration expenditures during the Demonstration period. Federal title XXI funding available for Demonstration expenditures is limited to the State's available allotment, including currently available reallocated funds. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the Demonstration until the next allotment becomes available.

57. **Compliance with Federal Rules.** All Federal rules shall continue to apply during the period of the Demonstration if title XXI Federal funds are not available and the State decides to continue the program.

## XII. MONITORING BUDGET NEUTRALITY

58. **Monitoring Demonstration Funding Flows.** The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

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

from which AHCCCS has sole disbursement authority.

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

59. **Limit on Title XIX Funding.** The State shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. The data supplied by the State to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

60. **Risk.** The State shall be at risk for the per capita cost (as determined by the method described below) for Demonstration eligibles under this budget neutrality agreement, but not for the number of Demonstration eligibles in each of the groups. By providing FFP for all Demonstration eligibles, the State shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing the State at risk for the per capita costs for Demonstration eligibles under this agreement, CMS assures that Federal Demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration.

61. **Demonstration Populations and Programs Subject to the Budget Neutrality Cap.** The following Demonstration populations are subject to the budget neutrality cap and are incorporated into the following eligibility groups:

a) Eligibility Group 1: AFDC / SOBRA

b) Eligibility Group 2: SSI

c) Eligibility Group 3: AC

d) Eligibility Group 4: ALTCS-DD

e) Eligibility Group 5: ALTCS–EPD

f) Eligibility Group 6: Family Planning Extension Program

g) Program Group 1: DSH

h) Program Group 2: Uncompensated Care Payments to IHS and Tribal Facilities

i) Program Group 3: SNCP/DSHP

j) Program Group 4: KidsCare II

62. **Budget Neutrality Expenditure Cap:** The following describes the method for calculating the budget neutrality expenditure cap for the Demonstration:

a) For each year of the budget neutrality agreement an annual budget neutrality expenditure cap is calculated for each eligibility group described in paragraph 61 as follows:

i. An annual eligibility group expenditure cap must be calculated as a product of the number of eligible member months reported by the State under paragraph 46 for each eligibility group, times the appropriate estimated per member per month (PM/PM) costs from the table in subparagraph (iii) below.

ii. The PM/PM costs in subparagraph (iii) below are net of premiums paid by Demonstration eligibles.

iii. The PM/PM costs for the calculation of the annual budget neutrality expenditure cap for the eligibility groups subject to the budget neutrality agreement under this Demonstration are specified below. In addition, the PM/PM cost for each eligibility group in DY 1 has been increased by the appropriate growth rate included in the President's Federal fiscal year 2012 budget for DYs 2, 3, 4 and 5, as outlined below. The AC and Family Planning Extension Program populations are structured as a "pass-through" or a "hypothetical State plan population" beginning in DY 1. Therefore, the State may not derive savings from these populations.

| Eligibility Group | Trend Rate | DY 1<br>FFY 2012 | DY 2<br>FFY 2013 | DY 3<br>FFY 2014 | DY 4<br>FFY 2015 | DY 5<br>FFY 2016 |
|---|---|---|---|---|---|---|
| **AFDC / SOBRA** | 5.2% | $585.28 | $615.71 | $647.73 | $681.41 | $716.85 |
| **SSI** | 6.0% | $885.41 | $938.53 | $994.84 | $1054.53 | $1117.81 |
| **AC** | 0.0% | $707.33 | $707.58 | $707.58 | $0 | $0 |
| **ALTCS - EPD** | 5.2% | $4737.37 | $4983.71 | $5242.86 | $5515.49 | $5802.30 |
| **ALTCS - DD** | 6.0% | $4922.38 | $5217.72 | $5530.78 | $5862.63 | $6214.39 |
| **Family Planning Extension Program** | 5.8% | $30.06 | $31.80 | $33.65 | $35.60 | $37.66 |

iv. The annual budget neutrality expenditure cap for the Demonstration as a whole is the sum of DSH allotment, the uncompensated care payments to IHS and tribal facilities, expenditures for the SNCP/DSHP and KidsCare II program plus the annual expenditure caps for each eligibility group calculated in subparagraph 62(a)(i) above.

b) The overall budget neutrality expenditure cap for the 5-year demonstration period is the sum of the annual budget neutrality expenditure caps calculated in subparagraph 62(a)(iv) above for each of the 5 years. The Federal share of the overall budget neutrality expenditure cap represents the maximum amount of FFP that the State may receive for

expenditures on behalf of Demonstration populations and expenditures described in paragraph 48 during the Demonstration period.

c) Apply the effective FMAP, or enhanced 90 percent match for family planning services, that is determined from the MBES/CBES Schedule C report.

63. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State exceeds the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the DYs, the State must submit a corrective action plan to CMS for approval.

| Cumulative Demonstration Years | Cumulative Expenditure Cap Definition | Percentage |
|---|---|---|
| Year 1 | Budget neutrality expenditure cap plus Year 1 Budget Cap | 1.0 % |
| Year 2 | Combined budget neutrality expenditure caps plus Year 1 through 2 Budget Cap | 0.75 % |
| Year 3 | Combined budget neutrality expenditure caps plus Year 1 through 3 Budget Cap | 0.5 % |
| Year 4 | Combined budget neutrality expenditure caps plus Year 1 through 4 Budget Cap | 0.25 % |
| Year 5 | Combined budget neutrality expenditure caps plus Year 1 through 5 Budget Cap | 0.0 % |

64. **Exceeding Budget Neutrality.** If, at the end of this Demonstration period the overall budget neutrality expenditure cap has been exceeded, the excess Federal funds must be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

## XIII. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

| **Date** | **Deliverable** |
|---|---|
| April 1, 2012 | Submission of draft Evaluation Design STC # 28(a) |
| July 1, 2012 | Submission of revised Evaluation Design STC # 28(a) |
| July 1, 2012 | Transition Plan. |
| September 30, 2015 | Written Notice of State's Intent to Extend the Demonstration Under 1115 |
| March 31, 2016 | Complete Demonstration Extension Application (1115) |
| January 1, 2017 | Submit Draft Evaluation Report - STC # 29 |
| March 1, 2017 | Final Evaluation Report - STC #29. Final Report - STC# 40. End of Demonstration Period. |
| **Monthly Deliverables** | Monthly call - STC# 34 |

| Date | Deliverable |
|---|---|
| | Monthly Childless Adult Enrollment Report – STC # 35 |
| **Quarterly Deliverables** | Requirements for Quarterly Reports – STC # 37 |
| | Quarterly Budget Neutrality Reports – STC # 33 |
| | Expenditure Reports CMS 64 and CMS21 - STC# 44 and STC# 53 |
| | Member Months Report - STC# 46 |
| | SEDS Enrollment Data - STC# 23(h) |
| **Annual Deliverables** | Requirement for Annual Report - STC# 38 |
| | Requirement for annual HCBS Report on March 31st - STC# 20 (f)(iv) |
| | Comparison of Costs for the DES Interagency Agreement, including how any excess revenues are spent, and for ADHS/BHS. Both reports will be due by January 15 – STC # 58 (b) |

**Attachment A – Approved Childless Adult Phase-out Plan under Demonstration #11-W-0003/09 and 21-W-0009/9**

# Childless Adults Freeze Implementation Milestones
# Phase Out Plan and Corresponding Enrollment Freeze

## Effective July 8, 2011

### 1. Summary of Childless Adults

Childless adults is a waiver program for adults who have not been determined Medicaid eligible under a categorical link (aged, blind, disabled, pregnant, under 18 or parent of a deprived child). Childless adults have open ended eligibility with redeterminations every 12 months. An asset test is not required and they have income under 100% of the Federal Poverty Level (FPL).

Eligibility for the Childless Adult program is determined primarily by DES. DES also determines eligibility for Medicaid programs for children, pregnant women, families and the MED program.

AHCCCS determines eligibility for CHIP, long term care, aged, blind, disabled populations, the Breast and Cervical Cancer Treatment Program and Medicare Savings Programs. AHCCCS also determines eligibility under Medicaid programs for children, pregnant women, families and the Childless Adult program for family members of KidsCare (CHIP) eligible members.

As of March 1, 2011 AHCCCS had about 2,800 Childless Adults in KidsCare households. Although the KidsCare program has been frozen since January 1, 2010, AHCCCS still processes renewals and changes for the active KidsCare population and their families, sometimes resulting in applications for Childless Adults. When KidsCare was open to new enrollment, AHCCCS processed KidsCare and Medicaid applications for everyone in the household. Even though enrollment in KidsCare is now frozen, AHCCCS still manages the entire household, including any category of Medicaid under which a household member qualifies. AHCCCS processes the renewals for the entire household. KidsCare children who age out of KidsCare will be processed by AHCCCS for Childless Adult coverage.

Below is an example of a KidsCare household with AHCCCS Care parents:

| | | |
|---|---|---|
| Mother | no income | eligible for AC |
| Father | 3050.00 earnings | eligible for AC |
| Child 15 yrs old | no income | eligible for KidsCare |
| Child 6 yrs old | no income | eligible for KidsCare |
| Child 10 yrs old | no income | eligible for KidsCare |

- Total household income: $3050.00
- KidsCare income limit for family of 5: $4362.00
- The children are ineligible for SOBRA because of their share of their father's income but they are eligible for KidsCare.
- The mother and father are eligible for AHCCCS Care because when the father's income is allocated between the members, their share of the income is $610.00 which is under the $613.00 income limit.

**2. Applications submitted prior to 7/8/11**

Applications that are received prior to July 8, 2011 will be processed, even if DES or AHCCCS cannot complete the eligibility determination until after July 8, 2011. If household members meet all eligibility requirements, before July 8, 2011, they will be approved for Childless Adults, even if the determination cannot be made until after July 8, 2011. If household members do not meet eligibility requirements until July 8, 2011 or later, the household member will not be approved for Childless Adults.

**3. Potential Consumer Notices:**

- Notice #1: In the first week of July 2011, AHCCCS will notify all Childless Adult members that on July 8, 2011 enrollment into the Childless Adult program will be frozen. If they want to retain Medicaid coverage under the Childless Adult program they will need to comply with redetermination requirements and continue to meet the eligibility requirements for that program.

  The first group of Childless Adult members who are SMI, aged 65 and older, under age 65 and have Medicare, and AHCCCS Care members who have HIV/AIDS and have lost coverage for AHCCCS Care because they failed to comply with the redetermination will have been already transferred to SSI MAO before this notice is generated.

  See Attachment #1

- Notice #2: In the month of July 2011, AHCCCS will send a notice to all AHCCCS eligible members, who are not on MED or the Childless Adult program, explaining to all remaining populations that they are not impacted by the elimination of the MED program or the freeze of the Childless Adult Program.

  See Attachment #2

- Notice #3 Beginning June 28 2011, and every month thereafter, AHCCCS will notify all Childless Adults who are age 65 and older, and all Childless Adults, who are under age 65 and who have Medicare, that they are being transferred to the SSI MAO program. The SSI MAO program will not be frozen and SSI MAO staff will contact these individuals for a redetermination of their eligibility under SSI MAO rules.

  Every month AHCCCS will identify Childless Adults who are age 65 or older, or under age 65 and have Medicare, and transfer them to SSI MAO. AHCCCS will notify these individuals that they are being transferred shortly after their eligibility category has changed from AHCCCS Care to SSI MAO. This transfer will occur when the member turns 65, or when the member obtains Medicare if under age 65, and is not based on their redetermination date. AHCCCS will give these individuals the same redetermination date that they had in AHCCCS Care.

  See Attachment #3

- Notice #4: Beginning June 28, 2011, and every month thereafter, Childless Adults who lose coverage for the Childless Adult program, because they failed to comply with the redetermination process AND they have a diagnosis of HIV/AIDS and/or take antiretroviral drugs, will receive a notice that they are being transferred to the SSI MAO program. The SSI MAO program will not be frozen and SSI MAO staff will contact these individuals for a redetermination of their eligibility under SSI MAO rules. These individuals will be indentified every month and will be transferred to the SSI MAO program. They will be notified that they are being transferred to SSI MAO shortly after their eligibility category has changed from AHCCCS Care to SSI MAO. They will have a redetermination shortly after they are transferred since they failed to comply with their Childless Adult redetermination requirements.

  See Attachment #4

- Notice #5: Beginning June 28, 2011, and every month thereafter, AHCCCS will notify all Childless Adults, who are identified in the AHCCCS PMMIS system as Seriously Mentally Ill (SMI) by the Arizona Department of Health Services (ADHS), that they will be transferred to the SSI MAO program. The SSI MAO program will not be frozen and SSI MAO staff will contact these individuals for a redetermination of their eligibility under SSI MAO rules. Every month AHCCCS will identify Childless Adults who are seriously mentally ill and transfer them to the SSI MAO program. The timing of the transfer occurs upon a member's designation as being SMI. They will be notified that they are being transferred to SSI MAO shortly after their eligibility category has changed from AHCCCS Care to SSI MAO. We will give these individuals the same redetermination date that they had in AHCCCS Care.

See Attachment #5

- Notice #6: Childless Adults who lose coverage for the Childless Adult program (and they are not SMI, HIV/AIDS, over 65 or under 65 with Medicare), because they failed to comply with the redetermination process will receive a third and final notice from AHCCCS beginning June 25, 2011, and each month thereafter. The notice will tell them that they cannot get back into the Childless Adult program, but if they comply with redetermination requirements before the effective date of their discontinuance they can remain on AHCCCS Care.

See Attachment #6

- Notice #7: Childless Adults who lose coverage for the Childless Adult program (and they are not SMI, HIV/AIDS, over 65 or under 65 with Medicare), because they failed to comply with the redetermination process will receive a discontinuance notice from the eligibility agency. The notice will tell them that they cannot get back into the Childless Adult program, they can file an appeal if they believe the discontinuance was made in error, if they appeal timely they can request continued benefits and that they can reapply for AHCCCS (but not Childless Adults). If they reapply they will need to demonstrate that they have a categorical link, including: pregnancy, parent of a deprived child, disability, or being age 65 or older.

See Attachment #7

- Notice #8: Childless Adults whose redetermination is due by June 30, 2011 will receive a notice from AHCCCS in June letting them know that AHCCCS is planning to freeze Childless Adults effective July 1, 2011, pending approval from CMS. The notice will also let them know that if they do not comply with the redetermination process by June 30, 2011 they will lose AHCCCS coverage under the Childless Adult category and may not be able to get back onto AHCCCS, unless they are eligible under a categorical link such as: age 65 or older, blind, disabled, pregnant or the parent of a deprived child.

  This notice will also be sent in July to Childless Adults whose redetermination is due July 31, 2011, letting them know that AHCCCS will freeze enrollment for Childless Adults effective July 8, 2011, pending approval from CMS. The notice will also let them know that if they do not comply with the redetermination process by July 31, 2011, they will lose AHCCCS coverage under the Childless Adult category and may not be able to get back onto AHCCCS, unless they are eligible under a categorical link such as: age 65 or older, blind, disabled, pregnant

or the parent of a deprived child.

See Attachment #8

- Notice #9: Children who are aging out of the 1931, SOBRA Child, YATI (Young Adult Transitional Insurance for children 18-21 years old who aged out of foster care) and KidsCare programs will receive Notice #9 if they are aging out in the month in which their redetermination is due. The notice will advise them that if they comply with the redetermination requirements, they may be redetermined under the Childless Adults program. If they do not comply with the redetermination requirements, and their eligibility ends, they cannot apply for coverage under the Childless Adult program while enrollment is frozen.

  This notice will be sent June 22, 2011, and then every subsequent month. Additionally, the notice will be sent early in the month that the renewal is due. Note that Notice #9 is only triggered when an individual both ages out AND has a redetermination in the same month. This will occur each month for a small sub-set of children who are aging out of the 1931, SOBRA Child, YATI and KidsCare programs.

- Notice #10: Children who aged out of the 1931, SOBRA Child, YATI and KidsCare programs will receive Notice #10 to notify them that they have been determined eligible for Childless Adults, and that they will need to comply with the redetermination process in order to remain eligible. Children who age out will be transferred to Childless Adults at the time of their birth date, and will be notified shortly after their eligibility category has changed. They will keep their same redetermination date.

**4. Ex Parte Determinations and other Processes:**
**After 7-1-11 for Childless Adult Members Who Are No Longer Eligible as Childless Adults and for Children Aging Out of 1931, SOBRA Child, YATI and KidsCare**

- On June 28, 2011, and every month thereafter, any Childless Adult who is age 65 and older, or who is under age 65 and has Medicare, who is eligible as a Childless Adult for the following month will be transferred to the SSI MAO program and will be redetermined under that category. These members will be identified in our PMMIS system and their eligibility key codes will be changed from Childless Adult to SSI MAO-Aged or SSI MAO-Disabled. We have an automated process from PMMIS to post this change back into DES' AZTECS system and AHCCCS' ACE system to close the Childless Adult case. There will be no break in coverage

for these members. If they lose coverage for Childless Adults for any other eligibility reason, i.e., excess income, loss of residency, etc, they will not be moved to SSI MAO. AHCCCS and DES may become aware of these other reasons for losing eligibility for the Childless Adults program through a variety of means, such as, redetermination, self reporting (all Medicaid members are required to report changes in their circumstances), or PARIS updates (which is a data system that allows state Medicaid agencies across the country to share data regarding state residency and other issues).
AHCCCS will look for individuals who are age 65 and older, and for individuals under age 65 with Medicare every month subsequent to June 28, 2011. This process will ensure that individuals turning 65 or individuals under age 65 receiving Medicare are moved to SSI MAO. The same process described for June 28, 2011 will be followed each month. By transferring these individuals prior to our month end processing, we will get them into the correct capitation rate category prior to paying monthly capitation to our contractors for the following month.

These individuals will be scheduled for a redetermination based on their next redetermination due date for AHCCCS Care.

AHCCCS makes a file available monthly to all of its contracted health plans, Indian Health Services and 638 tribal contractors that identifies AHCCCS members with redeterminations due in the next 60 days. This file can be sorted by zip code and eligibility category.
The 270/271 eligibility and enrollment verification will include redetermination due dates for each member effective June 19, 2011. The 270/271 file is available on line (AHCCCS On Line), through Interactive Voice Response (a phone bank) and through batch processing. Batch processing allows the registered provider to access information on multiple members at one time. Batch processing will be updated effective October 1, 2011.

Members age 65 and older or under age 65 with Medicare, who are moved to SSI MAO and subsequently determined to be ineligible under the requirements for that program, will be returned to the Childless Adult program without a break in coverage.

- On June 28, 2011, and every month thereafter, any Seriously Mentally Ill (SMI) adult, who is eligible under the Childless Adult program for the following month will be moved into the SSI MAO program and will be redetermined under that category. If they lose coverage for Childless Adults for any other eligibility reason, e.g., excess income, loss of residency, etc, they will not be moved to SSI MAO. AHCCCS and DES may become aware of these other reasons for losing eligibility (e.g., excess income, loss of residency) for the Childless Adults program through a variety of means, such as, redetermination, self reporting (all

Medicaid members are required to report changes in their circumstances), or PARIS updates.

SMI members are identified by the Arizona Department of Health Services (ADHS) through their Regional Behavioral Health Authorities (RBHAs) and their behavioral health provider network. This information is posted in the AHCCCS PMMIS system.

AHCCCS will look for individuals who are SMI every month subsequent to June 28, 2011. This process will ensure that individuals diagnosed as SMI are moved to SSI MAO. The same process described for June 28, 2011 will be followed each month. By transferring these individuals prior to our month end processing, we will get them into the correct capitation rate category prior to paying monthly capitation to our contractors for the following month.

These individuals will be scheduled for a redetermination based on their next redetermination due date for AHCCCS Care. AHCCCS will share a listing of transferred SMI members who are due for renewal within 60 days with each Regional Behavioral Health Authority (RHBA) on a monthly basis. The RBHAs work with their providers; application assistor staff use Health-e-Arizona to complete the renewal application, including submission of any necessary documentation. Application assistors are individuals employed by a Health-e-Arizona facility who are trained in using the Health-e-Arizona product and helping individuals complete the application process. Using Health-e-Arizona will allow the RBHA providers to track and follow up with the renewal process, and ensure members have support in completing the process.

In addition, AHCCCS has reached agreement with the Disability Determination Service Administration (DDSA) to significantly streamline the process of collecting and submitting documentation for the disability determination, if one is required. Typically, the disability determination through DDSA requires a lot of documentation. AHCCCS is working with DDSA to allow RHBA providers to submit data that is essential to the disability determination directly to DDSA. This way, DDSA can coordinate with providers to obtain the required documentation rather than rely solely on the individual.

AHCCCS makes a file available monthly to all of its contracted health plans, Indian Health Services and 638 tribal contractors that identifies AHCCCS members with redeterminations due in the next 60 days. This file can be sorted by zip code and eligibility category.
The 270/271 eligibility and enrollment verification will include redetermination due dates for each member effective June 19, 2011. The 270/271 file is available on line (AHCCCS On Line), through IVR and through batch processing. Batch processing will be updated effective October 1, 2011.

SMI members who are moved to SSI MAO and subsequently determined to be

ineligible under the requirements for that program will be returned to the Childless Adult program without a break in coverage.

- Effective June 28, 2011, and every month thereafter, Childless Adults who have a diagnosis of HIV/AIDs and/or take antiretrovirals, and lose coverage under the Childless Adults program, because they did not comply with the redetermination process, will be moved into the SSI MAO program and will be redetermined under the rules of that category. If the adult with HIV/AIDS does not meet the requirements for SSI MAO, that individual's eligibility ends.

  Adults with HIV/AIDS, who are moved to SSI MAO, because they did not comply with the Childless Adult redetermination process, will not have a break in coverage when they are transferred from the Childless Adults program to SSI MAO.

  Adults with HIV/AIDS, who are moved to SSI MAO, will be scheduled for a redetermination as soon as possible, since they lost AHCCCS Care for failure to comply with the redetermination process.

  If the adult with HIV/AIDS loses coverage for Childless Adults for any other eligibility reason, i.e., excess income or loss of residency, they will not be moved to SSI MAO.

  AHCCCS will identify these individuals based on the diagnosis code of 042 and/or antiretrovirals for which there are encounters and claims in the PMMIS system. AHCCCS will look for these individuals every month before our month end processing, starting June 28, 2011.

  AHCCCS makes a file available monthly to health plans, Indian Health Services and 638 tribal contractors that identifies AHCCCS members with redeterminations due in the next 60 days. This file can be sorted by zip code and eligibility category.
  The 270/271 eligibility and enrollment verification will include redetermination due dates for each member effective June 19, 2011. The 270/271 file is available on line (AHCCCS On Line), through IVR and through batch processing. Batch processing will be updated effective October 1, 2011.

- Other Childless Adults who lose coverage because they did not comply with the redetermination process, will be advised by the eligibility agency using Notice #7 that they are no longer eligible for AHCCCS Care, that they can file an appeal if they believe their eligibility was discontinued in error and that they can apply for Medicaid, if they believe they are aged, blind, disabled, pregnant, or the parent of a deprived child. They will receive a final notification from AHCCCS using Notice #6 that their eligibility is ending and advising them to complete their renewal prior to the effective date of their discontinuance.

AHCCCS makes a file available monthly to health plans, Indian Health Services and 638 tribal contractors that identifies AHCCCS members with redeterminations due in the next 60 days. This file can be sorted by zip code and eligibility category.
The 270/271 eligibility and enrollment verification will include redetermination due dates for each member effective June 19, 2011. The 270/271 file is available on line (AHCCCS On Line), through IVR and through batch processing. Batch processing will be updated effective October 1, 2011.

- Children who are aging out of the 1931, SOBRA Child, YATI and KidsCare programs, and meet the qualifications for Childless Adults, can continue to be determined eligible for Childless Adults after the enrollment freeze is in effect. Children who have a redetermination due the month they are aging out of the 1931, SOBRA Child, YATI and KidsCare programs must comply with the redetermination process. If they do not comply with the redetermination, and as a result, lose coverage, and then reapply after the effective date of the discontinuance of their coverage, they cannot be determined eligible for Childless Adults.

  AHCCCS makes a file available monthly to health plans, Indian Health Services and 638 tribal contractors that identifies AHCCCS members with redeterminations due in the next 60 days. This file can be sorted by zip code and eligibility category.
  The 270/271 eligibility and enrollment verification will include redetermination due dates for each member effective June 19, 2011. The 270/271 file is available on line (AHCCCS On Line), through IVR and through batch processing. Batch processing will be updated effective October 1, 2011.

  DES and AHCCCS staff will automatically determine eligibility for children aging out of the 1931, SOBRA Child, YATI and KidsCare programs, who do not have a redetermination due. If DES and AHCCCS staff are unable to complete the eligibility determination for the child before the child ages out, the child will be transferred to Childless Adults and will remain eligible for Childless Adults if they meet all other eligibility criteria. The child's redetermination date will remain the same as it was under his or her previous eligibility category.

- Households are advised that they can submit a paper application or can use the Health-e-Arizona on line application at www.healthearizona.org.

- All households that have not submitted a renewal application by the second week of the renewal month receive an automated reminder call, if they have a phone number.

**5. Examples of Childless Adult Members:**

- **CASE SCENARIO 1** – Childless Adult member is SMI and is transferred from the Childless Adult program to SSI MAO effective July 1, 2011. AHCCCS has a unique identifier for SMI members in our PMMIS system. This information is supplied by the Arizona Department of Health Services (ADHS), who is responsible for diagnosing and serving this population.

  Household consists of John Smith, age 55, who has been identified by the Department of Health Services as SMI.

  John earns $400 monthly. A notice is sent to John in June 2011 informing him that his eligibility has been transferred from the Childless Adult program to SSI MAO. John will be contacted by SSI MAO staff to complete a redetermination for that program, based on the redetermination date he would have had in Childless Adults.

  On November 1, 2011 an SSI MAO eligibility specialist tries to contact John to start the redetermination process. The Eligibility Specialist phones John and his phone has been disconnected. John is sent a redetermination notice to complete the redetermination process, and is informed that he has until January 31, 2012 to respond. The redetermination notice is returned by the U.S. Post Office as undeliverable. His SSI MAO eligibility is discontinued effective February 1, 2012. John is ineligible for SSI MAO.

- **CASE SCENARIO 2** – Childless Adult member fails to comply with the redetermination process after the freeze is in effect and is diagnosed with HIV/AIDs. (We will identify and track these individuals before they lose coverage)

  John earns $400 monthly. A notice requiring John to send a renewal application was sent to John on November 1, 2011. John was required to respond by December 31, 2011. No renewal application was received from John. His Childless Adult eligibility is discontinued effective January 1, 2012. But John is transferred to SSI MAO effective January 1, 2012 and will be contacted by SSI MAO staff to complete a redetermination for that program.

  John is sent a notice that he has been transferred to SSI MAO and that he will need to complete the redetermination process and meet the requirements for SSI MAO in order to remain eligible for that program.

  On February 1, 2012 an SSI MAO eligibility specialist telephones John to start

the redetermination process. The eligibility specialist then sends John a disability packet to complete and answers questions for John after he reviews it. John returns the requested information and the disability packet is sent to the DES Disability Determination Service Administration (DDSA).

On June 15, 2012 DDSA determines that John meets the requirements for disability and returns that information to the eligibility specialist. The eligibility specialist updates the eligibility system, ACE, with the DDSA information and completes the redetermination. John is eligible for SSI MAO.

- **Case Scenario #3 -** Childless adult member is age 66 on July 8, 2011 when the Childless Adult program is frozen. These members will be identified in our PMMIS system and their eligibility key codes will be changed from Childless Adult to SSI MAO-Aged.

  Household consists of John Smith, aged 66, who has been identified in our MMIS system as being over age 65.

  We change his eligibility category to SSI MAO aged in our PMMIS system and the system sends a message to the DES AZTECS system to discontinue his Childless Adult eligibility. We notify the SSI MAO Office to add him to the ACE eligibility system and conduct a redetermination based on the redetermination date he would have had in Childless Adults.

  On September 1, 2011 an SSI MAO eligibility specialist contacts John by telephone to start the redetermination process. John provides requested information by September 15, 2011 and the eligibility specialist updates the eligibility system, ACE with John's information and completes the redetermination. John is eligible for SSI MAO.

- **Case Scenario #4 –** Childless adult member fails to comply with the redetermination process after the freeze is in effect and is pregnant.

  Household consists of Jane Smith, age 35. Jane earns $400 monthly. A notice requiring Jane to send a renewal application was sent to Jane on November 1, 2011. Jane was required to respond by December 31, 2011. No renewal application was received from Jane.

  A discontinuance notice is sent to Jane on December 19, 2011 advising her that her Childless Adult eligibility will be discontinued effective January 1, 2012.

  The discontinuance notice advises Jane that she no longer qualifies for the Childless Adult program, but she can file an appeal if she feels this

discontinuance was made in error and advises her that she can reapply for AHCCCS. Her Childless Adult eligibility is discontinued effective January 1, 2012.

Jane reapplied for AHCCCS on January 5, 2012 and indicates that she is pregnant. An eligibility determination is made under SOBRA Pregnant Woman and on January 18, 2012 she is approved for AHCCCS effective January 1, 2012. Jane is eligible as a SOBRA Pregnant Woman.

- **Case Scenario #5: -** Childless adult member fails to comply with the redetermination process after the freeze is in effect and is disabled.

  Household consists of Jane Smith, age 35. Jane earns $400 monthly. A notice requiring Jane to send a renewal application was sent to Jane on November 1, 2011. Jane was required to respond by December 31, 2011. No renewal application was received from Jane.

  A discontinuance notice is sent to Jane on December 19, 2011 advising her that her Childless Adult eligibility will be discontinued effective January 1, 2012. No renewal application was received from Jane. The discontinuance notice advises Jane that she no longer qualifies for the Childless Adult program, but she can file an appeal if she feels this discontinuance was made in error and advises her that she can reapply for AHCCCS. The notice tells her that she will need a categorical link to AHCCCS such as pregnancy, disability, being the parent of a deprived child or being over age 65. Her Childless Adult eligibility is discontinued effective January 1, 2012.

  Jane reapplied for AHCCCS on January 5, 2012 and indicates that she is disabled. An application for SSI MAO is entered into the ACE eligibility system and Jane is asked to complete a disability determination packet. A disability determination is made by the DES Disability Determination Service Administration (DDSA) and Jane is determined to have a disability on April 1, 2012. Jane is approved for SSI MAO on April 10, 2012, effective January 1, 2012. Jane is eligible for SSI MAO.

- **Case Scenario #6:** Child ages out of SOBRA Child after the freeze is in effect.

  Household consists of Jane Smith, age 35 and Jimmy Smith, who turns age nineteen in August. Jane earns $775 monthly. Jimmy earns $500. Jimmy's scheduled redetermination under SOBRA Child is in March. An alert is generated in July notifying eligibility staff that Jimmy is turning 19. On July 25th, eligibility is redetermined for Jimmy using the most current information in the file.

Jimmy does not have a deprived, dependent child and is not disabled. He is determined eligible for the Childless Adult program effective September 1st without a break in coverage. Jimmy will receive Notice #10 informing him of his transfer to Childless Adults. Jimmy will then complete his redetermination under Childless Adults in March as scheduled. Jane remains eligible for the Childless Adult program.

**6. System Changes:**

- Changes to the Department of Economic Security AZTECS eligibility system: AZTECS will not approve Childless Adults for applications dated July 8, 2011 or later. It will approve Childless Adults for applications dated prior to July 8, 2011, if all eligibility criteria were met prior to July 8, 2011. AZTECS will generate Notice #7. It will allow children aging out of the 1931, SOBRA Child, and YATI programs to move into Childless Adults if they meet the eligibility requirements.

- Changes to the AHCCCS ACE eligibility system: ACE will not approve Childless Adults for applications dated July 8, 2011 or later. It will approve Childless Adults for applications dated prior to July 8, 2011, if all eligibility criteria were met prior to July 8, 2011. ACE will generate Notice #7. It will allow children aging out of the 1931, SOBRA Child, and KidsCare programs to move into Childless Adults if they meet the eligibility requirements.

- Changes to the AHCCCS PMMIS system: On July 8, 2011 PMMIS will stop accepting Childless Adults for eligibility effective July 8, 2011 or later. It will accept Childless Adults eligibility from children aging out of the 1931, SOBRA Child, YATI, and KidsCare programs. It will permit manual update of Childless Adults for cases closed in error. It will produce notices #1, #2, #3, #4, #5, #6, #8, #9 and #10.

  PMMIS will move members age 65 and older, and members under age 65 with Medicare to SSI MAO. PMMIS will post a file of those members in the DES AZTECS system and the AHCCCS ACE system to close their Childless Adult cases. PMMIS will produce a file of these members so they can be added into the ACE system as SSI MAO eligibles. AHCCCS will run this process every month effective June 28, 2011.

  AHCCCS will identify individuals from the PMMIS Claims and Encounters systems, who have a diagnosis code of 042 (HIV/AIDS) and/or who have a pharmacy claim or encounter for an antiretroviral. We will create an electronic file of these individuals monthly and run it against our PMMIS Recipient system monthly to ensure their Childless Adult cases remains active. If a future termination date is sent for these members, PMMIS can identify through the

coding if the case is being closed because they did not comply with the redetermination process. If it is, the member will be transferred to SSI MAO and scheduled for a redetermination, without a break in their coverage. AHCCCS will run this process every month, effective June 28, 2011.

AHCCCS will identify individuals from the PMMIS Recipient System, who have been identified as SMI. We will transfer all of these individuals to SSI MAO on July 1, 2011 and schedule them for a redetermination, without a break in their coverage. AHCCCS will run this process every month.

The 270/271 process for eligibility and enrollment verification will be updated to include redetermination dates for each member effective June 19, 2011. This process includes web based and IVR tools. Batch 270/271 will be updated effective October 1, 2011.

- Changes to the AHCCCS/DES Health-e-Arizona on line application and renewal system: Effective July 8, 2011 Health-e-Arizona will stop screening for Childless Adults.

**7. Eligibility Appeals:**

The Department of Economic Security has an Office of Appeals, which hears eligibility appeals for eligibility determinations made by DES employees. Eligibility appeals for eligibility determinations made by AHCCCS employees are heard by a separate agency, the Office of Administrative Hearings (OAH). Other than the two different offices the eligibility appeals process are essentially the same. Any differences are noted below.

If a Childless Adult loses eligibility for any reason, they have 30 calendar days from the date the decision notice is mailed to request an appeal of the decision. A request for appeal can be submitted either verbally or in writing. The member may request to withdraw the hearing request at any time.

Benefits will continue if the request for appeal is received within 10 calendar days from the date the decision notice is mailed. Benefits will not be continued if the action appealed is due solely to a change required by a change in federal or state law.

Within 7 days from receipt of the appeal request at DES and within 10 days at AHCCCS, the DES or AHCCCS eligibility office schedules a pre-hearing conference and sends copies of the budget calculations, income screens, notices, and case notes to the member. The conference may be conducted by telephone at the request of the member.

Within 10 calendar days of receipt of the appeal request, a DES or AHCCCS

supervisor reviews the results of the pre-hearing conference and documents in the appeal packet the accuracy of the eligibility decision.

When the pre-hearing conference may result in an informal resolution of the dispute at DES, a request to withdraw from the appeal is sent to the member. An informal resolution may happen when the decision is discussed with the member directly and the member agrees that the agency made the correct decision. A request to withdraw from the appeal is not sent to the member when the decision requires correction. When the review of the circumstances indicates that the case needs correction, DES sends the Request to Vacate and Remand (FAA-1389A) form to the Office of Appeals. The case is not corrected until a response is received from the Office of Appeals or the Office of Administrative Hearings that indicates that the matter was vacated and remanded to the local office for correction.

At AHCCCS, when the pre-hearing conference may result in an informal resolution of the dispute, a request to withdraw from the appeal is sent to the member. If a correction is needed, AHCCCS takes the action necessary to correct the adverse action being appealed. When the completed Voluntary Withdrawal from Appeal form is received, it is sent electronically to OAH with a request to vacate the appeal.

When a resolution is not reached during the pre-hearing conference, DES or AHCCCS continues processing the request for appeal.

Appeals are scheduled to allow for a decision to be rendered within 90 days from the request for appeal. Appeals are scheduled not fewer than 20, nor more than 45, calendar days from the date the request is filed. The member may request less than 20 calendar days notice in order to expedite the appeal.

Appeals may be conducted by phone when mutually agreed on by the member and the Office of Appeals for DES or the Office of Administrative Hearings for AHCCCS. The member is afforded the same rights as members who attend face-to-face hearings.

The member presents the facts and knowledge of the case, and has an opportunity to address witnesses, present evidence, advance arguments, refute testimony or evidence, and examine evidence introduced by any party at the hearing.

The Office of Appeals for DES or the AHCCCS Director, for AHCCCS appeals, notifies the member of the appeal decision. If the appeal decision is unfavorable to the member, he/she may request an appeals board review of the decision. If the Appeals Board decision is unfavorable to the member, he/she may request a Judicial Review of the Appeals Board decision.

For AHCCCS, OAH makes a written recommended decision within 20 days from the day of the hearing. The AHCCCS Director reviews the recommendation and issues a written decision to the member within 30 days. If the decision is unfavorable to the

member, the member may request a re-hearing.

Local eligibility offices are required to take action to implement all appeal decisions and remands within 10 days. Based on historical appeals data relating to changes in eligibility, copayments, etc., the State has seen a minimal increase in the number of appeals. Given the other elements in the phase out plan, such as specific community outreach, the ex parte process and exceptions made to target particular groups, DES does not expect a heavy influx of appeal requests. There is a significant amount of variation regarding total number of appeals received in any one month. Thus, DES is staffed in such a way as to deal with peak highs and lows.

Eligibility appeals are given priority and appeals from providers and others are secondary. Also, DES provides a quarterly report on number of hearing requests, number of decisions and timeliness that AHCCCS monitors. The State does not shift staff to address high/low peaks. The Arizona Office of Administrative Hearings conducts hearings on a number of different subjects, in addition to eligibility appeals. The State has a longstanding agreement that eligibility appeals are given priority. This agreement – that eligibility cases are a priority for the State to remain in compliance with federal law – is included in AHCCCS' Intergovernmental Agreement with the Office of Administrative Hearings. In the event that the State receives a significant increase of appeals in a given month, the State is aware of its responsibilities to process eligibility appeals timely and would appropriately allocate resources to that end.

**8. Other Communication:**

- Web
  - The AHCCCS website, www.azahcccs.gov will be updated continually to reflect program changes as decisions are made.
  - The Childless Adults phase out plan will be posted on the AHCCCS website, www.azahcccs.gov.
  - The AHCCCS website will provide opportunity for the public to electronically submit comment. Those comments will be posted on the website.
  - Information for members will be posted on the AHCCCS website member portal, www.azahcccs.gov/members, the Health-e-Arizona website, www.healthearizona.org and the DES website, https://egov.azdes.gov/dbme/faa/myFamilyBenefits.
  - Members can access information about the status of their eligibility at www.azahcccs.gov/members/myahcccs.
  - Providers can verify the status of member eligibility at https://azweb.statemedicaid.us/Home.asp.

- Legislative and Rule Making Process

- Should this plan require legislative action, it will go through the normal public process at the Legislature where there is public notice, a hearing and opportunity to be heard.
- Notice will also be published statewide through the Secretary of State and/or newspaper publication and a 30-day public comment period will be provided. Public comment can be submitted electronically via the AHCCCS website or by mail. Comments received electronically will be posted on the AHCCCS website.

- Providers/Health Plans

  - AHCCCS will distribute information regarding program changes to all of its contracted health plans.
  - Providers will receive information regarding program changes through the monthly AHCCCS electronic newsletter for providers, "Claims Clues."
  - The health plans will disseminate information as a component of their normal member outreach tools. AHCCCS health plans have community and provider relations staff that will be able to assist AHCCCS in its efforts to inform members and the public.
  - AHCCCS makes a file available monthly to health plans, Indian Health Services and 638 tribal contractors that identifies AHCCCS members with redeterminations due in the next 60 days. This file can be sorted by zip code and eligibility category.
  - The 270/271 eligibility and enrollment verification will include redetermination due dates for each member effective June 19, 2011. The 270/271 is available on line (AHCCCS On Line), through IVR and through batch processing. Batch processing will be updated effective October 1, 2011.

- Stakeholders/Community Partners

  - AHCCCS will send mass emails to stakeholders and community partners to notify them when the AHCCCS website has been updated with new information.
  - AHCCCS will distribute information about program changes to its Health-e-Arizona subscribers. Health-e-Arizona subscribers have 220 located across the state and are very dedicated to assisting people in applying for or renewing coverage. They will receive complete information about this phase out plan and how they can assist.
  - Although AHCCCS has already held tribal consultation on this matter, AHCCCS will ensure specific communication to the tribes, I.H.S. and 638 facilities and host any consultation or information session as needed. As a result AHCCCS has modified its monthly renewal file which provides the names of members whose renewal dates are due in the next 60 days. As of May 4, 2011 IHS and 638 contractors can sort this file by zip code and eligibility category.

- AHCCCS will work with the Health-e-Arizona Steering Committee to develop an outreach plan for AHCCCS Care households. The plan will include notification to community partners of the change to the AHCCCS Care program and ideas for assisting AHCCCS Care members. See Attachment #9
- In addition, AHCCCS will host two one-hour training sessions for community partners and stakeholders that assist the AHCCCS Care population. The training will focus on walking through the steps of the Childless Adult Phase out Plan.

- News Entities

  - AHCCCS may also provide information through news entities.

**9. Consideration of Public Comment:**

AHCCCS has received numerous comments from the public, including individual members, family members, organizations and providers. Many of these comments were part of the Community Forum held on June 1, 2011. A summary of this forum can be found on the AHCCCS website at: http://www.azahcccs.gov/publicnotices/Downloads/ChildlessAdultsForumFromJune1_2011_SummaryFINAL.pdf

Other comments have been submitted electronically via the AHCCCS website or email. Some of these comments were submitted through the comment portal on the 1115 Waiver section of the AHCCCS website and will be addressed individually. Some comments were received as part of the formal administrative rules process.

In addition, AHCCCS staff have attended meetings with community groups where there has been discussion of the childless adult phase out plan. In addition, the phase out plan has been discussed with Health-e-Arizona Steering Committee partners who have assisted in developing fact sheets and alternative resources materials for community health centers and other organizations who regularly assist consumers that may fall into the childless adult category.

AHCCCS has considered all public comments and incorporated the public comments in the following ways:

- Transitioning all members who are designated SMI to the SSI MAO category;
- Transitioning members with HIV/AIDS in the childless adult category who fall off for failure to comply with their annual renewal to the SSI MAO category;
- Transitioning children who age out of SOBRA, 1931, YATI and KidsCare to the childless adult category;
- Updating the provider portal and the myahcccs.com site by providing specific redetermination dates by June 17 to assist providers in reaching out to members;
- Providing specific outreach to I.H.S. and 638 facilities with a review file so that these facilities can obtain redetermination dates;

- Developing a fact sheet for organizations who assist consumers;
- Developing a list of alternative resources for individuals;
- Including a notice specifically for those individuals whose redetermination is June 30 and may not be aware of the potential enrollment freeze in childless adults eligibility category;
- Facilitating the process for public input via the AHCCCS website and community forums.

## 10. Health-e-Arizona:

Health-e-Arizona (HEA) is our online system for public assistance applications. A consortium of Federally Qualified Health Centers (FQHCs) brought the original model to Arizona in June 2002. We call the original model (still in place) the subscription model and it is used by community partners, such as FQHCs and hospitals, who pay a subscription fee to use it. Today we have 70 Subscribers at 220 locations statewide.

When patients come into a subscriber's facility, facility staff assists them with the completion of the application online, get an electronic signature and use fax or scanning to associate necessary documentation with the application. When the application is complete, the system screens it and identifies potential eligibility for Medicaid, CHIP, SNAP and TANF. An application can be submitted even if the applicant does not screen potentially eligible. The application is sent to the correct location electronically and is automatically entered into the eligibility systems of AHCCCS and DES. The facility can track workloads, communicate with the eligibility agency and get a final determination from the eligibility agency. Facilities who build a consistent process around this product are much more successful in getting their patients enrolled in Medicaid or CHIP and getting reimbursement for services to uninsured patients.

When an application is initiated, HEA interfaces with the AHCCCS PMMIS system to see if the applicant is already Medicaid eligible. If the applicant is known to PMMIS two things will happen:

1. HEA will pull name, date of birth (DOB) and SSN from PMMIS and will compare it to the name, DOB and SSN entered by the applicant. If there are discrepancies between PMMIS and the data that the applicant entered, HEA will require the applicant to resolve the discrepancy. This will significantly reduce problems pushing the data into the AHCCCS and DES eligibility systems.

2. Once HEA knows that the applicant is an active Medicaid recipient, it will treat their application as a renewal and ask questions appropriate for renewals.

   If the applicant has entered data into HEA on a previous occasion, HEA will pre-populate that data into the application or renewal.

In December 2008, AHCCCS implemented a public access version of Health-e-Arizona. Because this was a new feature, AHCCCS set a modest first-year goal of 17,000 Medicaid and CHIP applicants. Instead AHCCCS received 170,000 applicants using the public access version of Health-e-Arizona. In the last 12 months, AHCCCS has received 500,000 applications through the public and subscription models. Health-e-Arizona now represents nearly 40% of all Medicaid, Medicare Savings Programs and CHIP applications received each month in Arizona.

**11. Reports:**

AHCCCS will produce the following reports every month regarding the Childless Adult Freeze:

- Report #1: The number of members enrolled in the Childless Adult program as of the 1st of each month and the percentage of change from the previous month.

- Report #2: The number of SMI members transferred from Childless adults to SSI MAO effective the first of each month and the total number of SMI members transferred to date.

- Report #3: The number of members age 65 and older transferred from Childless Adults to SSI MAO effective the first of each month and the total number transferred to date.

- Report #4: The number of members under age 65, with Medicare transferred from Childless Adults to SSI MAO effective the first of each month and the total number transferred to date.

- Report #5: The number of members identified with HIV/AIDS transferred from Childless Adults to SSI MAO effective the first of each month and the total number transferred to date.

- Report #6: The number of SMI members who did not meet SSI MAO requirements and were transferred back into the Childless Adults program.

- Report #7: The number of members with HIV/AIDS who did not meet SSI MAO requirements and were discontinued because they did not qualify for any Medicaid category.

- Report #8: The number of individuals aged 65 and older or under age 65 with Medicare who do not meet the eligibility requirements for SSI MAO and are transferred back to Childless Adults.

**Attachment #1: Notice #1**

AHCCCS is Arizona's Medical Assistance

# ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

**IMPORTANT NOTICE**

You get AHCCCS Health Insurance through the AHCCCS Care program. Due to the current budget crisis in Arizona, the State will "freeze" new enrollment in the AHCCCS Care program beginning July 8, 2011. This means that no new applications for the AHCCCS Care program will be accepted after July 7, 2011.

**People who are already on the AHCCCS Care program will still receive medical services from AHCCCS, but only as long as they stay eligible for AHCCCS.**

**If you lose coverage for the AHCCCS Care program because you no longer meet eligibility requirements, you will not be able to get back on the AHCCCS Care Program.**

**To keep your AHCCCS Care benefits, you must:**

- **Continue to meet the eligibility requirements of the AHCCCS Care program;**
- **Cooperate with all requests you receive from the Department of Economic Security (DES) or AHCCCS staff; and**
- **Complete your renewal when notified.**

This change only applies to the AHCCCS Care program. Please quickly answer any requests that you may receive from DES or AHCCCS about your AHCCCS Care benefits. If you have family members on other AHCCCS programs, their benefits are not affected at this time.

If you do lose coverage for AHCCCS Care, you may be eligible under another AHCCCS program if you are:

- Pregnant,
- The parent of a deprived child under 18,
- Age 65 and older or
- Have a disability.

If you do lose coverage for AHCCCS Care, DES and AHCCCS will let you know how to apply for other programs. If you have specific questions, please contact your AHCCCS office or call DES at 602-542-9935 or 1-800-352-8401

If you do lose coverage for AHCCCS and you are employed and your employer offers health insurance, under new federal law you may be able to enroll in your employer's insurance plan within 60 days of losing coverage under AHCCCS. You should contact your employer immediately if you lose your AHCCCS Care benefits. Listed below are some other health care programs that may also be able to help you afford health care services if your AHCCCS Care benefits end.

**SEE IMPORTANT INFORMATION ON THE OTHER SIDE OF THIS NOTICE**

**Here are some other health care programs that may also be able to help you afford health**

**care services if your AHCCCS Care benefits end:**

Community Health Centers
Phone: 602-253-0090
On the Web: www.aachc.org/associatemembersl.php

Health Care Connect
Maricopa County
Phone: 602-288-7564
On the Web: www.healthcareconnect.org/contactus.php

Pima Community Access Program (PCAP)
Pima and Santa Cruz County
Phone: 520-694-0418
On the Web: www.pcap.cc

Community Access Programs of Arizona and Mexico (CAPAZ-MEX)
Yuma County
Phone: 928-627-9222
On the Web: www.rcfbh.org/programCAPAZMEX

Pre-existing Condition Insurance Plan
Phone: 1-866-717-5826
On the Web: http://www.healthcare.gov/law/provisions/preexisting/states/az.html

**If you need free legal advice, call the following numbers:** Phoenix at 602-258-3434 (800-852-9075); Tucson at 520-623-9461 (800-248-6789); and Flagstaff at 928-774-0653 (800-789-5781). For persons in other parts of the state, call 1-866-637-5341 to find the nearest legal services office in your area.

Additional sources of free legal service can be found at these web sites:

http://apps.americanbar.org/legalservices/probono/directory/arizona.html

http://www.acdl.com/gettinghelp.html

If you have specific questions, please contact your Eligibility Specialist in your local DES or AHCCCS office.

**Attachment #2: Notice #2**

AHCCCS is Arizona's Medical Assistance

AHCCCS

# ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

## VI.

## VII. IMPORTANT NOTICE ABOUT CHANGES TO THE MEDICAL EXPENSE DEDUCTION (MED) PROGRAM AND THE AHCCCS CARE PROGRAM

You may have heard that enrollment in some AHCCCS programs is being frozen or may end due to the current budget crisis in Arizona.

At this time, only the Medical Expense Deduction (MED) program and the AHCCCS Care Program have been affected.

### What is MED and AHCCCS Care?

MED is an AHCCCS program administered by the Department of Economic Security (DES). MED provides AHCCCS benefits to people who have income too high to qualify for other programs, but who have high medical expenses. Enrollment in the MED program was frozen on May 1, 2011 and the program will end on October 1, 2011.

AHCCCS Care provides AHCCCS benefits to people whose income is not too high, but they do not meet some other requirements for the rest of the AHCCCS programs. Enrollment in the AHCCCS Care Program was frozen on July 8, 2011. Effective July 8, 2011 no one can be added to this program.

### Does This Change Affect Me?

**If you are not on MED or the AHCCCS Care Program, these changes do not affect you.** These changes do not affect AHCCCS coverage under any other programs at this time. However, if you or other family members receive AHCCCS coverage under the MED or AHCCCS Care programs, you or other family members have already received a separate letter describing the changes in more detail.

**This letter is sent only for your information so that you will know that if you are not on the MED or AHCCCS Care programs, you are not affected by the changes for the MED and AHCCCS Care programs. If you have specific questions, please contact your AHCCCS office or call DES at 602-542-9935 or 1-800-352-8401.**

**Attachment #3: Notice #3**

AHCCCS is Arizona's Medical Assistance

AHCCCS

# ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

## IMPORTANT NOTICE ABOUT YOUR AHCCCS ELIGIBILITY

You get AHCCCS Health Insurance through the AHCCCS Care program.

Due to the current budget crisis in Arizona, the State will "freeze" new enrollment in the AHCCCS Care program beginning July 8, 2011. This means that no new applications for the AHCCCS Care program will be accepted after July 7, 2011.

**Because you are over age 65 or are under age 65 and have Medicare, your case has been sent to the AHCCCS SSI MAO office, which provides AHCCCS health insurance to people who are aged, blind or disabled. There is not a freeze on enrollment for this program. The SSI MAO office will contact you when your redetermination is due to determine your eligibility for the SSI MAO program.**

The SSI MAO office is located at:

801 E. Jefferson Street, MD 3800
Phoenix, AZ 85034

To stay eligible for SSI MAO benefits, you must:

- Meet the eligibility requirements of the SSI MAO program;
- Let AHCCCS know if you move;
- Cooperate with all requests you receive from AHCCCS staff; and
- Complete your renewal when requested.

If you have any questions or need to report a change, call the SSI MAO office at a phone number listed below:

602-417-5010 (Area Codes 602, 480 and 623)
Toll Free: 1-800-528-0142FAX: 602-258-4619

For information about SSI MAO eligibility go to:

http://www.azahcccs.gov/community/Downloads/resources/Description_of_AHCCCS_Programs.pdf

**Attachment #4: Notice #4**

AHCCCS is Arizona's Medical Assistance

AHCCCS

# ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

## ELIGIBILITY

You were getting AHCCCS Health Insurance through the AHCCCS Care program with the Department of Economic Security (DES) or through AHCCCS, but your benefits ended when you failed to complete your annual renewal.

Due to the current budget crisis in Arizona, the State will "freeze" new enrollment in the AHCCCS Care program beginning July 8, 2011. This means that you will not be able to get back on the AHCCCS Care program.

**However, your case has been sent to the AHCCCS SSI MAO office, which provides AHCCCS health insurance to people who are aged, blind or disabled. There is no freeze on enrollment for this program.**

**The SSI MAO office will contact you soon to determine your eligibility under the SSI MAO program.**

**In order to be eligible, you must:**

- Meet the eligibility requirements of the SSI MAO program; and
- Cooperate with all requests you receive from AHCCCS staff.
- Complete your renewal when requested.

The SSI MAO office is located at:

801 E. Jefferson Street, MD 3800
Phoenix, AZ 85034

If you have any questions or need to report a change, call the SSI MAO office at a phone number listed below:

Ph: 602-417-5010 (Area Codes 602, 480 and 623)
Toll Free: 1-800-528-0142

FAX: 602-258-4619

For information about SSI MAO eligibility go to:

http://www.azahcccs.gov/community/Downloads/resources/Description_of_AHCCCS_Programs.pdf

**Attachment #5: Notice #5**

AHCCCS is Arizona's Medical Assistance

AHCCCS

# ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

## ELIGIBILITY

You get AHCCCS Health Insurance through the AHCCCS Care program.

Due to the current budget crisis in Arizona, the State will "freeze" new enrollment in the AHCCCS Care program beginning July 8, 2011. This means that no new applications for the AHCCCS Care program will be accepted after July 7, 2011.

**Your case has been sent to the AHCCCS SSI MAO office. The AHCCCS SSI MAO program provides AHCCCS health insurance to people who are aged, blind or disabled. There is no freeze on enrollment for this program.**

**The SSI MAO office will contact you at your redetermination time to do a determination of your eligibility under the SSI MAO program.**

**In order to be eligible, you must:**

- Complete an SSI MAO eligibility redetermination;
- Meet the eligibility requirements of the SSI MAO program; and
- Cooperate with all requests you receive from AHCCCS staff.

The SSI MAO office is located at:

801 E. Jefferson Street, MD 3800
Phoenix, AZ 85034

If you have any questions or need to report a change, call the SSI MAO office at a phone number listed below:

Ph: 602-417-5010 (Area Codes 602, 480 and 623)
Toll Free: 1-800-528-0142

FAX: 602-258-4619

For information about SSI MAO eligibility go to:

**http://www.azahcccs.gov/community/Downloads/resources/Description_of_AHCCCS_Programs.pdf**

**Attachment #6: Notice #6**

AHCCCS is Arizona's Medical Assistance

AHCCCS

# ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

## XII. IMPORTANT NOTICE ABOUT YOUR AHCCCS ELIGIBILITY

You are on AHCCCS Care and you recently received a letter from DES or AHCCCS telling you that your AHCCCS Health Insurance will stop June 30, 2011 because you did not complete the renewal process.

Due to the current budget crisis in Arizona, the State will "freeze" new enrollment in the AHCCCS Care program beginning July 8, 2011. This means that you will not be able to get back on the AHCCCS Care program after your eligibility ends.

If you contact your eligibility worker before your AHCCCS Health Insurance stops and provide needed information, you may still be eligible.

If you do lose coverage for AHCCCS Care, you may be eligible under another AHCCCS program if you are:

- Pregnant,
- The parent of a deprived child under 18,
- Age 65 and older or
- Have a disability including serious mental illness or HIV/AIDS.

If you do lose coverage for AHCCCS Care, DES and AHCCCS will let you know how to apply for other programs.

If you do lose coverage for AHCCCS and you are employed and your employer offers health insurance, under new federal law you may be able to enroll in your employer's insurance plan within 60 days of losing coverage under AHCCCS. You should contact your employer immediately if you lose your AHCCCS Care benefits.

If you have specific questions, please contact your AHCCCS office or call DES at 602-542-9935 or 1-800-352-8401. They can answer questions and help you complete your renewal for AHCCCS Care.

**SEE IMPORTANT INFORMATION ON THE OTHER SIDE OF THIS NOTICE**

**Here are some other health care programs that may also be able to help you afford health care services if your AHCCCS benefits end:**

Community Health Centers
Phone: 602-253-0090
On the Web: www.aachc.org/associatemembersl.php

Health Care Connect
Maricopa County
Phone: 602-288-7564
On the Web: www.healthcareconnect.org/contactus.php

Pima Community Access Program (PCAP)
Pima and Santa Cruz County
Phone: 520-694-0418
On the Web: www.pcap.cc

Community Access Programs of Arizona and Mexico (CAPAZ-MEX)
Yuma County
Phone: 928-627-9222
On the Web: www.rcfbh.org/programCAPAZMEX

Pre-existing Condition Insurance Plan
Phone: 1-866-717-5826
On the Web: http://www.healthcare.gov/law/provisions/preexisting/states/az.html

**If you need free legal advice, call the following numbers:** Phoenix at 602-258-3434 (800-852-9075); Tucson at 520-623-9461 (800-248-6789); and Flagstaff at 928-774-0653 (800-789-5781). For persons in other parts of the state, call 1-866-637-5341 to find the nearest legal services office in your area.

Additional sources of free legal service can be found at these web sites:

http://apps.americanbar.org/legalservices/probono/directory/arizona.html

http://www.acdl.com/gettinghelp.html

If you have specific questions, please contact your Eligibility Specialist in your local DES or AHCCCS office.

Attachment #7 Notice #7
NOTICE: X051
TITLE: MISSED REVIEW NOTICE

Si necesita esta noticia traducida en espanol, llame a la oficina
local al numero que aparece arriba, o al numero de Servicio al Cliente
al (602) 542-9935 o 1-800-352-8401.@@
>>
**********@@
* IMPORTANT INFORMATION ABOUT YOUR CASH ASSISTANCE *@@
* AND AHCCCS HEALTH INSURANCE *@@
**********@@
>>
Your Cash Assistance and/or AHCCCS Health Insurance will be stopped
without further notice beginning %%%%%%%%%%%%%%%%%%%%. The item listed
below applies to you.@@
//@@
|##|A. You failed to report to your local office for an interview to@@
renew your Cash Assistance and/or AHCCCS Health Insurance@@
eligibility.@@
||@@
|##|B. You failed to turn in an application for an interview to@@
renew your Cash Assistance and/or AHCCCS Health Insurance@@
eligibility.||@@
\\@@
If you want your benefits to continue you need to fill out an
application and complete an interview by %%%%%%%%%%%%%%%%%%.@@
>>
If you need a special appointment time, day or location (for example:
home visit, phone interview, before 8:00 AM or after 5:00 PM) due to
work, school, distance to a DES local office, or other reasons, please
let us know when you turn in your application.@@
>>
Even if you are employed, you may continue to be eligible for AHCCCS
Health Insurance. Please call us for details.@@

If you do lose coverage for AHCCCS Care, you may be eligible under another AHCCCS program if you are:

- Pregnant,
- The parent of a deprived child under 18,
- Age 65 and older or
- Have a disability including serious mental illness or HIV/AIDS.

If you do lose coverage for AHCCCS Care, DES and AHCCCS will let you know how to apply for other programs.

>>
If you have a child who was born in the past 12 months while you were
receiving AHCCCS Health Insurance, the child(ren) may continue to be

eligible. If you have not called us, please do so immediately.@@
>>
This action is based on 42 Code of Federal Regulations (CFR) 435.916
and 45 CFR 206.10 and Arizona Administrative Code R9-22-1414. The CFR
references are available through public libraries.@@
>>
If you think your benefits should not be stopped, ask for a hearing by
filling out the form on the back now.@@
>>
NOTE: If you are interested in registering to VOTE or making changes
to your voter registration, contact your local DES office.@@
>>
If you have questions or need help, please call us at %%%%%%%%%%%%%%.
You can also get information from our 24 hour Interactive Voice
Response (IVR) System at (602) 542-9935 (If calling from area code
602, 480 or 623) or 1-800-352-8401 (for all other area codes). To
apply for free legal help, call %%%%%%%%%%%%%%. Fair Hearing rights
are explained on the back of this notice.@@

Attachment #8

## XIII. IMPORTANT NOTICE: YOU MUST COMPLETE YOUR RENEWAL FOR AHCCCS BY JUNE 30, 2011

You get AHCCCS Health Insurance through the AHCCCS Care program. Your current coverage period will end on June 30, 2011 unless you renew your coverage on time. Your deadline to renew your coverage is June 30, 2011.

Due to the current budget crisis in Arizona, the State is planning to "freeze" new enrollment in the AHCCCS Care program beginning July 1, 2011. This means that no new applications for the AHCCCS Care program will be accepted after June 30, 2011.

**If you do not return your completed renewal application by the June 30, 2011 deadline, your coverage will end on July 1, 2011. You will be discontinued from the AHCCCS Care program, and if the program is "frozen" on July 1st, you will not be able to get back on the program.**

**To keep your AHCCCS Care benefits, you must**:

- **Turn in a renewal application by June 30, 2011;**
- **Meet the eligibility requirements of the AHCCCS Care program; and**
- **Cooperate with all requests you receive from the Department of Economic Security (DES) or AHCCCS staff.**

If you have already turned in a renewal application, please be sure to reply to any mail you get from DES or AHCCCS, and provide any proof requested.

This change only applies to the AHCCCS Care program. If you have family members on other AHCCCS programs, they still need to complete their renewal applications. However, if they lose their AHCCCS coverage because they do not complete a renewal application, they may still be able to get back on other AHCCCS programs.

If you do lose coverage for AHCCCS Care, you may be eligible under another AHCCCS program if you are:

- Pregnant;
- The parent of a deprived child under 18;
- Age 65 and older; or
- Have a disability.

If you lose eligibility for AHCCCS Care, DES and AHCCCS will let you know how to apply for other AHCCCS programs. If you have specific questions, please contact your AHCCCS office or call DES at 602-542-9935 or 1-800-352-8401.

If you do lose coverage for AHCCCS and you are employed and your employer offers health insurance, under new federal law you may be able to enroll in your employer's insurance plan within 60 days of losing coverage under AHCCCS. You should contact your employer immediately if you lose your AHCCCS Care benefits.

### SEE IMPORTANT INFORMATION ON THE OTHER SIDE OF THIS NOTICE

**Note:** This notice was already sent to AHCCCS Care members in this group and so reflects the original proposed July 1, 2011, effective date. This notice will be sent to AHCCCS Care members with a July 31, 2011, redetermination date, and will reflect the revised July 8, 2011, AHCCCS Care enrollment freeze effective date.

**Here are some other health care programs that may also be able to help you afford health care services if your AHCCCS Care benefits end:**

Community Health Centers
Phone: 602-253-0090
On the Web: www.aachc.org/associatemembersl.php

Health Care Connect
Maricopa County
Phone: 602-288-7564
On the Web: www.healthcareconnect.org/contactus.php

Pima Community Access Program (PCAP)
Pima and Santa Cruz County
Phone: 520-694-0418
On the Web: www.pcap.cc

Community Access Programs of Arizona and Mexico (CAPAZ-MEX)
Yuma County
Phone: 928-627-9222
On the Web: www.rcfbh.org/programCAPAZMEX

Pre-existing Condition Insurance Plan
Phone: 1-866-717-5826
On the Web: http://www.healthcare.gov/law/provisions/preexisting/states/az.html

**If you need free legal advice, call the following numbers:** Phoenix at 602-258-3434 (800-852-9075); Tucson at 520-623-9461 (800-248-6789); and Flagstaff at 928-774-0653 (800-789-5781). For persons in other parts of the state, call 1-866-637-5341 to find the nearest legal services office in your area.

Additional sources of free legal service can be found at these web sites:

http://apps.americanbar.org/legalservices/probono/directory/arizona.html

http://www.acdl.com/gettinghelp.html

If you have specific questions, please contact your Eligibility Specialist in your local DES or AHCCCS

office.

**Attachment #9**

**AHCCCS Care (Childless Adults) Phase out Plan**
**Fact Sheet**
**June 1, 2011**

**Eligibility for the AHCCCS Care program will be frozen July 8, 2011 until additional funds become available to reopen enrollment into the program. No one will be approved for AHCCCS Care for the month of July 2011 and ongoing, except children aging out of their eligibility group because they turned 19 or 21. The phase out plan is waiting for approval from the Centers for Medicare and Medicaid Services (CMS), and the enrollment freeze will not be implemented until federal approval is granted.**

**What is the AHCCCS Care program?**
AHCCCS Care or Childless Adults, as it is sometimes known, is a waiver program for adults who have not been determined eligible under one of the regular Medicaid groups (aged, blind, disabled, pregnant, under 18 or parent of a deprived child). An asset test is not required and they must have income under 100% of the Federal Poverty Level (FPL). Eligibility must be renewed every 12 months.

**How many people are on AHCCCS Care?**
As of June 1, 2011 there are nearly 225,000 AHCCCS Care members.

**What will happen to those already on AHCCCS Care?**
All AHCCCS Care members with eligibility that began before July 8, 2011 will remain eligible for the program, unless they lose eligibility because they no longer meet the requirements. This includes the requirement to comply with the renewal process.

AHCCCS will make an administrative change from AHCCCS Care to SSI MAO – a program for people who are aged, blind or disabled (SSI MAO enrollment will not be frozen) – if the member is over age 65, under age 65 and has Medicare or is diagnosed as seriously mentally ill (SMI) by the Department of Health Services. AHCCCS Care members who are diagnosed with HIV/AIDS will be administratively changed to SSI MAO, if they lose eligibility for AHCCCS Care for failure to complete the renewal process. Most SMI and HIV/AIDS members under the age of 65 will have to later be determined disabled under federal requirements by the Disability Determination Service Administration (DDSA), Department of Economic Security. If an SMI member does not meet the federally defined criteria of disabled for Medicaid under the SSI MAO category, AHCCCS will continue their coverage under the AHCCCS Care category, as long as they meet all other required eligibility criteria, such as income.

Although AHCCCS will make every effort, using information already available to the state, to identify people who are age 65 or older, disabled, pregnant, or the parent of a deprived child to ensure that their coverage continues under other categories, we may not identify all of these individuals. If an individual's coverage in the Childless Adult program is being terminated and the individual believes that they may be covered under one of these other groups, they can notify their eligibility worker, who can help them apply for coverage under these categories. AHCCCS is also working with DDSA to streamline the process of collecting and submitting documentation for the disability determination. RBHA providers can also assist individuals in submitting documentation to DDSA.

**What can AHCCCS Care members do?**

AHCCCS Care members should do everything in their power to complete their renewal on time. They can complete a paper renewal form or complete an electronic renewal on line at www.healthearizona.org. They should also report any changes in address to their eligibility worker to insure no loss of contact.

**How will AHCCCS Care members know their renewal date?**
**1st Notice:** All AHCCCS Care members will be notified 60 days before the due date of their renewal and given information about how to comply.
**2nd Notice:** If they have not complied they will receive a notice telling them their benefits will stop, the date they will stop and giving them appeal rights.
**3rd Notice:** AHCCCS will send another notice on the 25th of each month as a 3rd warning that AHCCCS Care members have until the end of that month to comply with the renewal process.

AHCCCS members can find their renewal dates on www.myahcccs.com. AHCCCS registered providers can obtain an AHCCCS Care members' renewal date through the provider portal on the AHCCCS website.

**What appeal rights will AHCCCS Care members have?**
If AHCCCS Care members lose their eligibility and they believe their eligibility was not determined correctly, they can ask for a hearing. If they request a hearing within 10 days their eligibility can be continued until the final decision is made.

**Alternative resources**
See: http://www.azahcccs.gov/community for ideas about helping people who are not eligible for AHCCCS Care or other AHCCCS programs.

**Attachment 10**

Comparison of SSI MAO Budgeting Methodology to AHCCCS Care

| | **AHCCCS Care** | **SSI-MAO** |
|---|---|---|
| Cash Program methodology | Title IV-A | Title XVI |
| Categorical link | No categorical link requirement. | Must be aged, blind or disabled. |
| Monthly income calculation | Income received more often than monthly is averaged and converted to a monthly amount.<br>Weekly income is multiplied by 4.3<br>Bi-weekly income is multiplied by 2.15 | Monthly income is based on actual income received and not converted. |
| Deductions | • $90 earned income deduction (per wage earner)<br>• Up to $200 per dependent for dependent care expenses. "Dependent" includes a minor child or incapacitated spouse. | <u>FBR Test (100% FBR)</u><br>• $20 General deduction<br>• $65 standard earned income deduction<br>• **1/2 earned income deduction**<br>• Child allocation*<br>• Student earned income deduction**<br><br><u>FPL Test (100% FPL)</u><br>• $20 General deduction<br>• $65 standard earned income deduction<br>• Child allocation*<br>• Student earned income deduction**<br><br>* Deduction per child of *up to* $337. If the child has countable income of his/her own, the deduction is reduced by the child's countable income.<br>** Deduction per student under age 22 of $1640 per month, up to a maximum of $6600 per year. |
| Due to different Cash Program methodologies, a few income types count differently | Examples:<br>• In-kind income – Counted<br>• Interest/dividends (if withdrawn) – Counted<br>• TANF payments - Excluded | Examples:<br>• In-kind income – Excluded<br>• Interest/dividends (if withdrawn) – Excluded<br>• TANF payments - Counted |
| Budgeting Methodology | <u>Sneede v. Kizer methodology</u><br>Net income after deductions is divided equally and allocated based on financial responsibility (spouse to spouse; parent to child).<br>Allocated income is compared to the income limit for a single person, or if married, to ½ the 2-person income limit. | Net income after deductions is compared to the income limit for a single person or couple as appropriate. |

**Attachment 11 Notice #9**

AHCCCS is Arizona's Medical Assistance

AHCCCS

# ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

## XIV. IMPORTANT NOTICE: YOU MUST COMPLETE YOUR RENEWAL FOR AHCCCS BY JUNE 30, 2011

You get AHCCCS Health Insurance through an AHCCCS program with an age limit of 19 or 21. You have reached the program's age limit. Your eligibility must be redetermined to see if you qualify for any other AHCCCS programs. One of these programs is AHCCCS Care. Due to the current budget crisis in Arizona, the State is planning to "freeze" new enrollment in the AHCCCS Care program beginning July 1, 2011. This means no new applications for the AHCCCS Care program will be accepted after July 1, 2011.

**To make sure that the AHCCCS Care program is available to you, you must complete your renewal application by June 30, 2011. If you do not complete your renewal application by June 30, 2011, and the program is "frozen" on July 1st, you will not be able to get on the AHCCCS Care program, even if you do not qualify for any other AHCCCS program.**

**To be able to get on AHCCCS Care, if you do not qualify for any other AHCCCS program, you must**:

- **Turn in a renewal application by June 30, 2011;**
- **Meet the eligibility requirements of the AHCCCS Care program; and**
- **Cooperate with all requests you receive from Department of Economic Security (DES) or AHCCCS staff.**

If you have already turned in a renewal application, please be sure to reply to any mail you get from DES or AHCCCS, and provide any proof requested.

This change only applies to the AHCCCS Care program. If you have family members on other AHCCCS programs, they still need to complete their renewal application. However, if they lose their AHCCCS coverage because they do not complete a renewal application, they may still be able to get back on other AHCCCS programs.

If you do not qualify for AHCCCS Care, you may be eligible under another AHCCCS program if you are:

- pregnant
- the parent of a deprived child under 18
- age 65 and older or
- have a disability.

If you lose coverage for AHCCCS Care, DES and AHCCCS will let you know how to apply for other AHCCCS programs. If you have specific questions, please contact your AHCCCS office or call DES at 602-542-9935 or 1-800-352-8401.

If you do lose coverage for AHCCCS and you are employed and your employer offers health insurance, under new federal law you may be able to enroll in your employer's insurance plan within 60 days of losing coverage under AHCCCS. You should contact your employer immediately if you lose your AHCCCS Care benefits.

**SEE IMPORTANT INFORMATION ON THE OTHER SIDE OF THIS NOTICE**

**Note:** This notice was already sent and reflects the original proposed enrollment freeze effective date of July 1, 2011. This notice will be sent every month to children whose redetermination date and birth date fall in the same month.

**Here are some other health care programs that may also be able to help you afford health care services if your AHCCCS Care benefits end:**

Community Health Centers
Phone: 602-253-0090
On the Web: www.aachc.org/associatemembersl.php

Health Care Connect
Maricopa County
Phone: 602-288-7564
On the Web: www.healthcareconnect.org/contactus.php

Pima Community Access Program (PCAP)
Pima and Santa Cruz County
Phone: 520-694-0418
On the Web: www.pcap.cc

Community Access Programs of Arizona and Mexico (CAPAZ-MEX)
Yuma County
Phone: 928-627-9222
On the Web: www.rcfbh.org/programCAPAZMEX

Pre-existing Condition Insurance Plan
Phone: 1-866-717-5826
On the Web: http://www.healthcare.gov/law/provisions/preexisting/states/az.html

**If you need free legal advice, call the following numbers:** Phoenix at 602-258-3434 (800-852-9075); Tucson at 520-623-9461 (800-248-6789); and Flagstaff at 928-774-0653 (800-789-5781). For persons in other parts of the state, call 1-866-637-5341 to find the nearest legal services office in your area.

Additional sources of free legal service can be found at these web sites:

http://apps.americanbar.org/legalservices/probono/directory/arizona.html

http://www.acdl.com/gettinghelp.html

If you have specific questions, please contact your Eligibility Specialist in your local DES or AHCCCS

office.

**Attachment #12 Notice #10**

AHCCCS is Arizona's Medical Assistance

AHCCCS

# ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

## XV. IMPORTANT NOTICE ABOUT YOUR AHCCCS ELIGIBILITY

You were getting AHCCCS Health Insurance through an AHCCCS program with an age limit of 19 or 21. When you reached that program's age limit, you were made eligible for the AHCCCS Care program.

Due to the current budget crisis in Arizona, the State has "frozen" new enrollment in the AHCCCS Care program beginning July 8, 2011. This means no new applications for the AHCCCS Care program will be accepted after July 8, 2011.

**People who are already on the AHCCCS Care program will still receive medical services from AHCCCS, but only as long as they stay eligible for the program.**

**If you lose coverage for the AHCCCS Care program because you no longer meet eligibility requirements, you will not be able to get back on the AHCCCS Care Program.**

**To keep your AHCCCS Care benefits, you must:**

- **Continue to meet the eligibility requirements of the AHCCCS Care program;**
- **Cooperate with all requests you receive from the Department of Economic Security (DES)or AHCCCS staff; and**
- **Complete your renewal when notified.**

If you do not qualify for AHCCCS Care, you still may be eligible for coverage under another AHCCCS program if you are:

- Pregnant;
- The parent of a deprived child under 18; or
- Have a disability.

If you lose coverage for AHCCCS Care, DES and AHCCCS will let you know how to apply for other AHCCCS programs. If you have specific questions, please contact your AHCCCS office or call DES at 602-542-9935 or 1-800-352-8401.

If you do lose coverage for AHCCCS and you are employed, and your employer offers health insurance, under new federal law you may be able to enroll in your employer's insurance plan within 60 days of losing coverage under AHCCCS. You should contact your employer immediately if you lose your AHCCCS Care benefits.

**SEE IMPORTANT INFORMATION ON THE OTHER SIDE OF THIS NOTICE**

**Here are some other health care programs that may also be able to help you afford health care services if your AHCCCS Care benefits end:**

Community Health Centers
Phone: 602-253-0090
On the Web: www.aachc.org/associatemembersl.php

Health Care Connect
Maricopa County
Phone: 602-288-7564
On the Web: www.healthcareconnect.org/contactus.php

Pima Community Access Program (PCAP)
Pima and Santa Cruz County
Phone: 520-694-0418
On the Web: www.pcap.cc

Community Access Programs of Arizona and Mexico (CAPAZ-MEX)
Yuma County
Phone: 928-627-9222
On the Web: www.rcfbh.org/programCAPAZMEX

Pre-existing Condition Insurance Plan
Phone: 1-866-717-5826
On the Web: http://www.healthcare.gov/law/provisions/preexisting/states/az.html

**If you need free legal advice, call the following numbers:** Phoenix at 602-258-3434 (800-852-9075); Tucson at 520-623-9461 (800-248-6789); and Flagstaff at 928-774-0653 (800-789-5781). For persons in other parts of the state, call 1-866-637-5341 to find the nearest legal services office in your area.

Additional sources of free legal service can be found at these web sites:

http://apps.americanbar.org/legalservices/probono/directory/arizona.html

http://www.acdl.com/gettinghelp.html

If you have specific questions, please contact your Eligibility Specialist in your local DES or AHCCCS office.

## Attachment B - Quarterly Report Guidelines

As written in STC paragraph 34, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 30 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include the budget neutrality monitoring workbook. An electronic copy of the report narrative and the Microsoft Excel budget neutrality monitoring workbook is provided.

**NARRATIVE REPORT FORMAT:**

**TITLE**

**Title Line One** – Arizona Health Care Cost Containment System -- AHCCCS, A Statewide Approach of Cost Effective Health Care Financing

**Title Line Two - Section 1115 Quarterly Report**

**Demonstration/Quarter Reporting Period:**

Example:
Demonstration Year: 5 (5/01/04 - 4/30/05)
Federal Fiscal Quarter: 4/2004 (7/04 - 9/04)

**INTRODUCTION:**

Information describing the goal of the Demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

**ENROLLMENT INFORMATION:**

Please complete the following table that outlines all enrollment activity under the Demonstration. The State should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by "0".

**Note:** Enrollment counts should be person counts, not participant months.

| **Population Groups (as hard coded in the CMS 64)** | **Current Enrollees** (to date) | **No. Voluntary Disenrolled in current Quarter** | **No. Involuntary Disenrolled in current Quarter** |
|---|---|---|---|
| **Population 1 – AFDC / SOBRA** | | | |
| **Population 2 - SSI** | | | |
| **Population 3 – ALTCS DD** | | | |
| **Etcetera** | | | |

Voluntary Disenrollments:
Cumulative Number of Voluntary Disenrollments Within Current Demonstration Year:
Reasons for Voluntary Disenrollments:

Involuntary Disenrollments:
Cumulative Number of Involuntary Disenrollments Within Current Demonstration Year:
Reasons for Involuntary Disenrollments:

**Outreach/Innovative Activities:**

Summarize outreach activities and/or promising practices for the current quarter.

**Operational/Policy Developments/Issues:**

Identify all significant program developments/issues/problems that have occurred in the current quarter.

**Financial/Budget Neutrality Developments/Issues:**

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the State's actions to address these issues.

**Consumer Issues:**

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken, or to be taken, to prevent other occurrences.

**Quality Assurance/Monitoring Activity:**

Identify any quality assurance/monitoring activity in current quarter.

**ESI Issues:**
Identify all significant program developments/issues/problems that have occurred in the current quarter.

**Family Planning Extension Program:**
Identify all significant program developments/issues/problems that have occurred in the current quarter, including the required data and information included in STC 34(d) and (e), including enrollment data requested that is not represented in the formatted tables.

**Enclosures/Attachments:**

Identify by title any attachments along with a brief description of what information the document contains.

**State Contact(s):**

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

***The State may also add additional program headings as applicable.***

**Date Submitted to CMS:**

## Attachment C – Evaluation Guidelines

Section 1115 demonstrations are valued for information on health services, health services delivery, health care delivery for uninsured populations, and other innovations that would not otherwise be part of Medicaid programs. CMS encourages States with demonstration programs to conduct or arrange for evaluations of the design, implementation, and/or outcomes of their demonstrations. The CMS also conducts evaluation activities.

The CMS believes that all parties to demonstrations; States, Federal Government, and individuals benefit from State conducted self-evaluations that include process and case-study evaluations—these would include, but are not limited to: 1) studies that document the design, development, implementation, and operational features of the demonstration, and 2) studies that document participant and applicant experiences that are gathered through surveys, quality assurance activities, grievances and appeals, and in-depth investigations of groups of participants and applicants and/or providers (focus groups, interviews, other). These are generally studies of short-term experiences and they provide value for quality assurance and quality improvements programs (QA/QI) that are part of quality assurance activities and/or demonstration refinements and enhancements.

Benefit also derives from studies of intermediate and longer-term investigations of the impact of the demonstration on health outcomes, self-assessments of health status, and/or quality of life. Studies such as these contribute to State and Federal formation and refinements of policies, statutes, and regulations.

States are encouraged to conduct short-term studies that are useful for QA/QI that contribute to operating quality demonstration programs. Should States have resources available after conducting these studies, they are encouraged to conduct outcome studies.

The following are criteria and content areas to be considered for inclusion in Evaluation Design Reports.

- Evaluation Plan Development - Describe how plan was or will be developed and maintained:
    - Use of experts through technical contracts or advisory bodies;
    - Use of techniques for determining interest and concerns of stakeholders (funding entities, administrators, providers, clients);
    - Selection of existing indicators or development of innovative indicators;
    - Types of studies to be included, such as Process Evaluations, Case-Studies and Outcome investigations;
    - Types of data collection and tools that will be used – for instance, participant and provider surveys and focus groups; collection of health service utilization; employment data; or, participant purchases of other sources of health care coverage; and, whether the data collection instruments will be existing or newly developed tools;
    - Incorporation of results through QA/QI activities into improving health service delivery; and

- Plans for implementation and consideration of ongoing refinement to the evaluation plan.

- Study Questions – Discuss:
  - Hypothesis or research questions to be investigated;
  - Goals, such as:
    - Increase Access
    - Cost Effectiveness
    - Improve Care Coordination
    - Increase Family Satisfaction and Stability
  - Outcome Measures, Indicators, and Data Sources

- Control Group and/or Sample Selection Discussion:
  - The type of research design(s) to be included -
    - Pre/Post Methodology
    - Quasi-Experimental
    - Experimental
  - Plans for Base-line Measures and Documentation – time period, outcome measures, indicators, and data sources that were used or will be used

- Data Collection Methods – Discuss the use of data sources such as:
  - Enrollment and outreach records;
  - Medicaid claims data;
  - Vital statistics data;
  - Provide record reviews;
  - School record reviews; and
  - Existing or custom surveys

- Relationship of Evaluation to Quality Assessment and Quality Improvement Activities– Discuss:
  - How evaluation activities and findings are shared with program designers, administrators, providers, outreach workers, etc., in order to refine or redesign operations;
  - How findings will be incorporated into outreach, enrollment and education activities;
  - How findings will be incorporated into provider relations such as provider standards, retention, recruitment, and education; and
  - How findings will be incorporated into grievance and appeal proceedings.

- Discuss additional points as merited by interest of the State and/or relevance to nuances of the demonstration intervention.

**ATTACHMENT D**
**AHCCCS DISPROPORTIONATE SHARE HOSPITAL PROGRAM**
**DSH 102**

Congress established the Medicaid Disproportionate Share Hospital (DSH) program in 1981 to provide financial support to hospitals that serve a significant number of low-income patients with special needs.

This document sets forth the criteria by which Arizona defines DSH hospitals and the methodology through which DSH payments are calculated and distributed. The document is divided into the following major topics:

- Hospital eligibility requirements
- Data on a State Plan Year Basis
- Timing of eligibility determination
- Medicaid Inpatient Utilization Rate (MIUR) calculation (Overall and Group 1 eligibility)
- Low Income Utilization Rate (LIUR) calculation (Group 2 eligibility)
- Governmentally-operated hospitals (Group 4 eligibility)
- Obstetrician Requirements
- Payment
- Aggregate Limits
- Reconciliations
- Certified Public Expenditures (CPEs)
- Grievances and appeals
- Other provisions

**Eligibility Requirements**

In order to be considered a DSH hospital in Arizona, a hospital must be located in the state of Arizona, must submit the information required by AHCCCS by the specified due date, must satisfy one (1) of the conditions in Column A, AND must satisfy one (1) of the conditions in Column B, AND must satisfy the condition in Column C.

| COLUMN A | COLUMN B | COLUMN C |
|---|---|---|
| 1. The hospital has a Medicaid Inpatient Utilization Rate (MIUR) which is at least one standard deviation above the mean MIUR for all hospitals receiving a Medicaid payment in the state (“Group 1”) | 1. The hospital has at least two (2) obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid patients<br>2. The hospital is outside a Metropolitan Statistical | The hospital has an MIUR of at least 1 percent |

| | | |
|---|---|---|
| 1.A. The hospital meets all of the requirements of 1 above (Group 1) and is a privately owned or privately operated hospital licensed by the State of Arizona ("Group 1A")<br>2. The hospital has a Low Income Utilization Rate (LIUR) that exceeds 25% ("Group 2")<br>2.A. The hospital meets all of the requirements of 2 above (Group 2) and is a privately owned or privately operated hospital licensed by the State of Arizona ("Group 2A")<br>3. The hospital is a governmentally-operated hospital ("Group 4") | Area and has at least two (2) physicians with staff privileges to perform non-emergency obstetric procedures<br>3. The patients of the hospital are predominantly under 18 years of age<br>4. The hospital was in existence on December 22, 1987 but did not offer non-emergency obstetric services as of that date | |

Notice that within Column A, there are six group numbers assigned. Group 1 and Group 2 contain those hospitals that are "deemed" to be DSH hospitals under federal Medicaid law. Group 1A, Group 2A, and Group 4 contain additional hospitals that the state has designated to be DSH hospitals within its federal authority to do so. The criteria listed in Columns B and C are federal eligibility requirements which apply regardless of whether or not the hospital is deemed or designated as a DSH hospital.

- In Group 4, the term "governmentally-operated hospital" refers to a hospital provider which under federal law is able to participate in the financing of the non-federal portion of medical assistance expenditures. A governmentally-operated hospital is differentiated herein from "non-governmental", "non-public", "private", "privately operated" or "privately owned" hospitals as well as IHS or tribal or 638 hospitals and facilities as well as other federally owned or operated facilities.

Medicare Certification

In addition to the eligibility requirements outlined above, in order to receive payment under Medicaid, hospitals must meet the requirements for participation as a hospital in Medicare (except in the case of medical supervision of nurse-midwife services). Therefore, for purposes of DSH, the facility must be Medicare-certified during the state plan rate year for which the initial

DSH payment is made.

If a facility is Medicare-certified for the full state plan rate year for which the initial DSH payment is made, but subsequently loses that certification, the facility remains eligible to receive the payment (together with any payment adjustments). If a hospital is only Medicare-certified for part of the state plan rate year for which the initial DSH payment is made, the eligibility and the payment will be calculated based on the period for which the hospital was Medicare-certified.

**Data on a State Plan Year Basis**

DSH payments are made based on the State Plan Rate Year. The State Plan Rate Year (or State Plan Year or SPY) is equivalent to the Federal Fiscal Year and runs from October 1 to September 30 of each year. The calculations to determine eligibility for, and the amount of, DSH payments, will be made on the basis of the State Plan Year. This requirement will impact the information collected and submitted by all hospitals that do not have a fiscal year and/or CMS 2552 Report year that runs from 10/1 to 9/30.

In order to make the necessary calculations to determine eligibility and payments on a State Plan Year basis, hospitals that do not have a fiscal/CMS Report year that runs from 10/1 to 9/30 will have to submit cost reports and other data elements for each of the fiscal/CMS Report years that encompass the State Plan Year. For example, for SPY 2008 (10/1/07 to 9/30/08), for a hospital that has a CMS 2552 Report year that runs from 7/1 to 6/30, the hospital will have to submit the CMS 2552 Report and other data elements for the fiscal/CMS Report year that ends on 6/30/08 and the same information for the fiscal/CMS Report year that ends 6/30/09.[2]

As discussed later in this Attachment, AHCCCS will extract all Title XIX (Medicaid) claims and encounters from the PMMIS system on the basis of each hospital's CMS 2552 Report year and these data will serve as the basis for all Medicaid days, charges and payments. Similarly, AHCCCS will collect and distribute to hospitals all Medicaid supplemental payments (e.g. GME, Critical Access Hospitals (CAH), Rural Inpatient Payments) and Non-Title XIX payments (for Children Rehabilitative Services, the Comprehensive Medical and Dental Program, Behavioral Health Services and Payments for Trauma and Emergency Departments) on the basis of each hospital's CMS 2552 Report year.

All data compiled by the hospitals (e.g. total, uninsured and charity days; charges and payments; and state and local subsidy payment information not provided by AHCCCS) will be compiled on a CMS 2552 Report year basis.

---

[2] Note however that the use of the 2008 and 2009 reports and information referred to in this paragraph is for the determination of *final* DSH payments. For the initial 2008 DSH payments, reports and information for 2006 and 2007 will be submitted. For a discussion of initial payments, final payments and data sources, see the discussions that follow.

Except in the case where a hospital's fiscal year is identical to the State Plan Year – the calculations to determine eligibility for, and the amount of, DSH payments, will be performed separately for each hospital's fiscal year and these results will be prorated based on the distribution of months from each of the two years that encompass the SPY. For example, for SPY 2008 (10/1/07 to 9/30/08), for a hospital that has a CMS 2552 Report year that runs from 7/1 to 6/30, the proration of the results of the calculations will be derived by summing:

1. 9/12th of the result of the calculations performed for the fiscal/CMS Report year ending 6/30/08, and
2. 3/12th of the result of the calculations performed for the fiscal/CMS Report year ending 6/30/09.

**Timing of Eligibility Determination**

The eligibility determination calculations will be performed annually for all hospitals located in the State of Arizona that are registered as providers with AHCCCS. Eligibility calculations will be performed only with and for hospitals that have submitted the information required by this document and/or as otherwise requested by AHCCCS. In order to be considered "submitted", the information must be received by AHCCCS by the due date specified in a request for information communicated to the Chief Financial Officer of the hospital. The calculations will be performed with the information submitted by, or available to AHCCCS on the due date specified as the deadline for the submission of information.

The eligibility determination will be made in at least two steps:

1. The first step of the eligibility process will occur in the state plan rate year of the initial DSH payment. To determine initial eligibility, AHCCCS will:
    a. Extract from the PMMIS system all inpatient and outpatient hospital claims and encounters by date of service for each registered hospital for that hospital's fiscal years that encompass the state plan rate year two years prior to the state plan year of the initial DSH payment.
    b. Based on the extracted claims and encounters data and data provided by the hospitals, determine for each hospital whether or not that hospital has a Medicaid Inpatient Utilization Rate (MIUR) of at least 1%. For hospitals that qualify under this criteria, determine if the hospital:
        i. Meets the criteria for Group 1
        ii. Meets the criteria for Group 1A
        iii. Meets the criteria for Group 2
        iv. Meets the criteria for Group 2A
        v. Meets the criteria for Group 4
    c. Based on certifications filed by each hospital, determine if the hospital satisfies the criteria in Column B above.

2. The second step of the eligibility process will occur in the state plan rate year two years after the state plan rate year of the initial DSH payment. To determine final eligibility, AHCCCS will:
    a. Extract from the PMMIS system all inpatient and outpatient hospital claims and encounters by date of service for each registered hospital for that hospital's fiscal years that encompass the state plan rate year of the initial DSH payment.
    b. Based on the extracted claims and encounters data and data provided by the hospitals determine for each hospital whether or not that hospital has a MIUR of at least 1%. For hospitals that qualify under this criteria, determine if the hospital:
        i. Meets the criteria for Group 1
        ii. Meets the criteria for Group 1A
        iii. Meets the criteria for Group 2
        iv. Meets the criteria for Group 2A
        v. Meets the criteria for Group 4
    c. Based on certifications filed by each hospital, determine if the hospital satisfies the criteria in Column B above.

3. AHCCCS may redetermine any hospital's eligibility for any DSH payment should the agency become aware of any information that may prove that the hospital was not eligible for a DSH payment.

**MIUR Calculation (Overall Eligibility Criteria and Group 1 and Group 1A Eligibility)**

A hospital's Medicaid Inpatient Utilization Rate (MIUR) will determine the hospital's overall eligibility for DSH (Column C above) as well as the hospital's eligibility for Group 1 and Group 1A. A hospital's MIUR is calculated using the following equation:

$$\boxed{MIUR = \frac{Total\ Medicaid\ Inpatient Days}{Total\ Number\ of\ Inpatient Days}}$$

The calculation will be performed based on the state plan rate year. In order to find each hospital's MIUR for the state plan year, AHCCCS will calculate a MIUR separately for each hospital fiscal/CMS Report year that encompasses the relevant State Plan Year and then prorate the results from the two hospital fiscal/CMS Report years as described in the discussion above entitled "Data on a State Plan Year Basis".

If a hospital has a MIUR of at least 1%, and the obstetrical criteria of Column B above are satisfied, it will meet the overall eligibility criteria. If a hospital has a MIUR which is at least one standard deviation above the mean MIUR for all Arizona hospitals receiving a Medicaid payment in that State Plan Year, it will meet the eligibility for Group 1. If a hospital meets the eligibility criteria for Group 1 and is a privately owned or privately operated hospital licensed by the State of Arizona, it will meet the eligibility for Group 1A. NOTE that meeting overall eligibility criteria does not ensure that a hospital will meet the eligibility criteria for any Group.

In performing the calculations:

1. "Inpatient Days" includes:
    a. Fee-for-service and managed care days, and
    b. Each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward, and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

2. "Medicaid Inpatient Days" includes:
    a. All adjudicated inpatient days for categorically eligible Title XIX clients including days paid by Medicare except as noted below
    b. All adjudicated inpatient days for Demonstration eligible Title XIX clients – that is clients that are eligible for Title XIX including days paid by Medicare and days funded by Title XXI except as noted below

3. "Medicaid Inpatient Days" does not include:
    a. Inpatient days in which a categorically or Demonstration eligible Title XIX client was in an Institution for Mental Disease (IMD) and the client was between 21 and 65 years of age

*Data Sources for MIUR Calculations*

1. For "Medicaid Inpatient Days" the PMMIS claims and encounters
    a. For the initial determination of a hospital's MIUR, extracted based on date of service for the hospital's fiscal/CMS Report years that encompass the state plan rate year that ends two years prior to the state plan rate year of the initial DSH payment.
    b. For the second determination of a hospital's MIUR, extracted based on date of service for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.

2. For "Total Number of Inpatient Days" the CMS 2552-96
    a. For the initial determination of a hospital's MIUR, the cost report (or reports) for the hospital that encompass the state plan rate year two years prior to the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet S-3, Lines 1 and 6 through 11, Column 6 plus Line 14, Column 6 for hospital subprovider days. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.
    b. For the second determination of a hospital's MIUR, the cost report(s) for the hospital that encompass the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet S-3, Lines 1 and 6 through 11, Column 6 plus Line 14, Column 6 for hospital subprovider days. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-

96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.

*Calculation of the mean MIUR and the Standard Deviation*

In calculating the mean MIUR, the MIUR calculated for the state plan year for all Arizona hospitals that have received a Medicaid payment will be used. The mean MIUR – the average of the individual MIURs – will be calculated based on all the individual state plan year MIURs greater than zero (i.e. including the MIURs that are less than 1%). The standard deviation will be calculated based on the same list of individual hospital MIURs.

**LIUR Calculation (Group 2 Eligibility)**

A hospital's Low Income Utilization Rate (LIUR) will determine the hospital's eligibility for Group 2. A hospital's LIUR is calculated by summing the following two equations:

$$LIUR = \frac{Total\ Medicaid\ Patient\ Services\ Charges + Total\ State\ and\ Local\ Cash\ Subsidies\ for\ Patient\ Services}{Total\ Charges\ for\ Patient\ Services}$$

$$+$$

$$\frac{Total\ Inpatient\ Charges\ Attributable\ to\ Charity\ Care - Cash\ Subsidies\ Portion\ Attributable\ to\ Inpatient}{Total\ Inpatient\ Charges}$$

The calculation will be performed based on the state plan rate year. In order to find each hospital's LIUR for the state plan year, AHCCCS will calculate a LIUR separately for each hospital fiscal/CMS Report year that encompasses the relevant State Plan Year and then prorate the results from the two hospital fiscal/CMS Report years as described in the discussion above entitled "Data on a State Plan Year Basis".

If a hospital has a LIUR that exceeds 25% it will meet the eligibility for Group 2. If a hospital meets the eligibility criteria for Group 2 and is a privately owned or privately operated hospital licensed by the State of Arizona, it will meet the eligibility for Group 2A.

In performing the calculations:

1. "Total Medicaid Patient Services Charges" includes Title XIX charges for inpatient and outpatient services (both fee-for-service and managed care)

2. "Total Medicaid Patient Services Charges" does not include DSH payments or payments made for GME, Critical Access Hospitals, Rural Inpatient Payments or any other TXIX supplemental payments authorized by the Legislature as these amounts are effectively included in charges

3. "Total State and Local Cash Subsidies for Patient Services" includes payments made with state-only or local-only funds and includes, but is not limited to
    a. Payments made for:
        i. Non-Title XIX and Non-Title XXI enrollees in the DES Comprehensive Medical and Dental Program
        ii. Non-Title XIX and Non-Title XXI enrollees in the DHS Children's Rehabilitative Services program
        iii. Non-Title XIX and Non-Title XXI enrollees in the DHS Behavioral Health Services Program (note that these payments are typically made through Regional Behavioral Health Authorities)
        iv. The support of trauma centers and emergency departments
    b. Payments made by:
        i. An appropriation of state-only funds
        ii. The Arizona State Hospital
        iii. Local governments including (but not limited to):
            (1) Tax levies dedicated to support a governmentally-operated hospital
            (2) Tax levies from a hospital district organized pursuant to A.R.S. § 48-1901 et seq.
            (3) Subsidies for the general support of a hospital

4. "Total State and Local Cash Subsidies for Patient Services" does not include payments for or by:
    a. Inpatient or outpatient services for employees of state or local governments
    b. Governmentally-operated AHCCCS health plans or program contractors
    c. Tax reductions or abatements

5. "Total Charges for Patient Services" includes total gross patient revenue for hospital services (including hospital subprovider charges).

6. "Total Inpatient Charges Attributable to Charity Care" includes the amount of inpatient services – stated as charges – that is provided free to individuals who cannot afford health care due to inadequate resources as determined by the hospital's charity care policy and do not otherwise qualify for government subsidized insurance. In order to qualify as charity care, payment may neither be received nor expected.

7. "Total Inpatient Charges Attributable to Charity Care" does not include bad debt expense or contract allowances and discounts offered to third party payors or self pay patients that do not qualify for charity care pursuant to the hospital's charity care policy.

8. "Cash Subsidies Portion Attributable to Inpatient" means that portion of "Total State and Local Cash Subsidies for Patient Services" that is attributable to inpatient services.

9. "Total Inpatient Charges" includes total inpatient and hospital subprovider charges without any deductions for contract allowances or discounts offered to third party payors or self pay patients.

*Data Sources for LIUR Calculations*

1. For "Total Medicaid Patient Services Charges":
    a. For the initial determination of a hospital's LIUR:
        i. The PMMIS claims and encounters extracted based on date of service for each registered hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the year of the initial DSH payment.
    b. For the second determination of a hospital's LIUR:
        i. The PMMIS claims and encounters extracted based on date of service for each registered hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.

2. For the portion of "Total State and Local Cash Subsidies for Patient Services" and "Cash Subsidies Portion Attributable to Inpatient" attributed to Non-Title XIX and Non-Title XXI payments for the CMDP, CRS or Behavioral Health programs and for the payments in support of trauma centers and emergency departments:
    a. For the initial determination of a hospital's LIUR:
        i. AHCCCS will provide to hospitals the amounts of such payments made during the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the year of the initial DSH payment based on data from its financial records or from the financial records of the state agencies making the payments.
    b. For the second determination of a hospital's LIUR:
        i. AHCCCS will provide to hospitals the amounts of such payments made during the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment based on data from its financial records or from the financial records of the state agencies making the payments.
    c. In the case of CRS payments, if AHCCCS does not provide a breakdown of inpatient and outpatient payments, the hospital shall allocate the CRS payments between outpatient and inpatient based on the percentage of total inpatient charges to total charges for patient services

3. For all other "Total State and Local Cash Subsidies for Patient Services" and "Cash Subsidies Portion Attributable to Inpatient":
    a. For the initial determination of a hospital's LIUR:
        i. The hospital financial records for the payments received during the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the year of the initial DSH payment.
    b. For the second determination of a hospital's LIUR:
        i. The hospital financial records for the payments received during the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.

c. In the case of "Cash Subsidies Portion Attributable to Inpatient", if the hospital receives subsidies for the general operation of the hospital, allocation between outpatient and inpatient should be based on the percentage of total inpatient charges to total charges from patient services.

4. For "Total Inpatient Charges Attributable to Charity Care":
    a. For the initial determination of a hospital's LIUR:
        i. The hospital claims and financial records for the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the year of the initial DSH payment.
    b. For the second determination of a hospital's LIUR:
        i. The hospital claims and financial records for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.

5. For "Total Inpatient Charges":
    a. For the initial determination of a hospital's LIUR, the cost report (or reports) for the hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet C Part 1, Column 6 Line 101 less Lines 34 to 36, less Lines 63.5 to 63.99, and less Lines 64 to 68. If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted from Line 101. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.
    b. For the second determination of a hospital's LIUR, the cost report(s) for the hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet C Part 1, Column 6 Line 101 less Lines 34 to 36, less Lines 63.5 to 63.99, and less Lines 64 to 68. If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted from Line 101. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.

6. For "Total Charges for Patient Services":
    a. For the initial determination of a hospital's LIUR, the cost report (or reports) for the hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet C Part 1, Column 8 Line 101 less Lines 34 to 36, less Lines 63.5 to 63.99, and less Lines 64 to 68.

If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted from Line 101. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.

b. For the second determination of a hospital's LIUR, the cost report(s) for the hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet C Part 1, Column 8 Line 101 less Lines 34 to 36, less Lines 63.5 to 63.99, and less Lines 64 to 68. If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted from Line 101. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.

**Group 4 Eligibility Determination – Governmentally-operated Hospitals**

Because the state has designated all governmentally-operated hospitals (represented in Group 4) as DSH hospitals, no eligibility calculations are required.

**Obstetrician Requirements**

In order to ensure that hospitals receiving DSH payments meet requirements related to obstetricians, all hospitals that are determined to have a MIUR of at least 1% must file a completed certification statement indicating their compliance with the requirements. Any hospital that fails to return the certification statement by the date specified by AHCCCS will not be eligible to receive DSH payments for the state plan rate year of the initial DSH payment.

For the determination of a hospital's compliance with the obstetrician requirement, the certification will be based on the state plan rate year of the initial DSH payment from the start of the state plan rate year to the date of certification.

The certification statement shall incorporate the following language:

> I certify that the hospital indicated below currently has and has had since the beginning of the current state plan year at least two (2) obstetricians with staff privileges who have agreed to provide obstetric services to individuals eligible for Medicaid, OR
>
> I certify that the hospital indicated below is located in a rural area and currently has and

has had since the beginning of the current state plan year at least two (2) qualified physicians with staff privileges who have agreed to provide non-emergency obstetric services to individuals eligible for Medicaid, OR

I certify that the hospital indicated below did not offer non-emergency obstetric services to the general population as of December 22, 1987, or that the inpatients of the hospital are predominantly individuals under 18 years of age.

**Payment**

Pools and Changing Payment Levels

The DSH program in Arizona is funded through a six pool system. Each of the pools correlates to one of the hospital eligibility Groups. Therefore, there are five non-governmental hospital pools and one governmental hospital pool. The non-governmental hospital pool amounts are set by AHCCCS as authorized by the Arizona Legislature; the governmental pool amount is established by the Arizona Legislature. The amounts of funding for the pools for the current state plan year are contained in Exhibit 3.

If a non-governmental hospital qualifies for pool 1A it will be removed from pool 1. Similarly, if a non-governmental hospital qualifies for pool 2A it will be removed from pool 2. The non-governmental hospitals in pool 1 and pool 2 will be considered as a group and if a non-governmental hospital qualifies for more than one pool, the hospital will be categorized into the pool that maximizes its DSH payment. The non-governmental hospitals in pool 1A and 2A will be considered as a group, and if a non-governmental hospital qualifies for more than one pool, the hospital will be categorized into the pool that maximizes its DSH payment. The payment amount to each non-governmental hospital will be determined based on the maximization process performed during the state plan rate year of the initial DSH payment. The maximization process will be performed separately for 1) the non-governmental hospitals that qualify for pools 1 and 2, and; 2) the non-governmental hospitals that qualify for pools 1A and 2A.

There are five instances where the initial DSH payment to one or more non-governmental hospitals may change:

1. A hospital is found on the second eligibility determination (or any subsequent eligibility check) to not be eligible for a DSH payment in the state plan rate year of the initial DSH payment. In this instance, the amount of payment to the hospital will be recouped and the recouped amount will be distributed proportionately based on the initial DSH payments to the eligible hospitals remaining in the pool in which the ineligible hospital was placed in the state plan rate year of the initial DSH payment, up to each hospital's OBRA limit (see discussion below).

2. A hospital is found to have exceeded its finalized OBRA limit (see discussions below). In this instance, the amount of payment to the hospital in excess of its finalized OBRA limit will be recouped, and the recouped amount will be distributed proportionately based

on the initial DSH payments to the eligible hospitals remaining in the pool in which the hospital was placed in the state plan rate year of the initial DSH payment, up to each hospital's finalized OBRA limit.

3. In the event of a recoupment of an initial DSH payment and as a result of the process of distributing the recoupment to the pool to which the recouped payment was originally made, the distribution would result in all the hospitals in the pool receiving a total DSH payment in excess of their finalized OBRA limit, the amount of recoupment will be proportionately allocated among the remaining non-governmental hospital pools based on the initial DSH payments and distributed proportionately based on the initial DSH payments to the hospitals in the remaining pools up to each hospital's finalized OBRA limit.

4. In the event that litigation (either by court order or settlement), or a CMS audit, financial review, or proposed disallowance requires AHCCCS to issue DSH payment amounts to one or more hospitals in a pool in excess of the initial DSH payment amount, AHCCCS will proportionately recoup funds based on the initial DSH payments from the remaining hospitals in the pool or pools effected to satisfy the requirement. This process will be followed to ensure that the annual federal DSH allotment is not exceeded.

5. In the event that a hospital qualifies for a DSH payment in the second (or any subsequent) eligibility determination that did not qualify in the initial eligibility determination, that hospital will receive the minimum payment under the DSH program which is $5,000.

The payment amount to each governmentally-operated hospital will be determined during the state plan rate year of the initial DSH payment. The payment amount will only change if the total DSH payment to a hospital in the pool would be in excess of its finalized OBRA limit (see discussion below). To the extent that the excess amount recouped from a governmentally-operated hospital can be distributed to other hospitals in the pool without exceeding the interim or finalized OBRA limits of the remaining governmentally-operated hospitals, the excess amount will be distributed to the other governmentally-operated hospitals.

<u>Determination of Payment Amounts</u>

The amount that each non-governmental hospital receives as an initial DSH payment from the pool for which it qualifies is determined by a weighting method that considers both the amounts/points over the Group threshold and the volume of services. The volume of services is either measured by Title XIX days or net inpatient revenue, depending upon the group being considered.

*Hospitals that only qualify for Group 1 or Group 2*

There are ten steps to determining the DSH payment amount for non-governmental hospitals that only qualify for Group 1 or Group 2 (and not Group 1A or 2A). After determining the initial DSH payment amount through the ten step process, there is a final adjustment that may be made depending on the result of the hospital's OBRA limit.

1. Determine Points Exceeding Threshold.
   Each of the Groups 1 and 2 has thresholds established for qualification of the hospital. For Group 1 it is one standard deviation above the mean MIUR; for Group 2 it is greater than 25% LIUR. Step 1 merely determines the difference between each hospital's "score" for the Group measure and that Group's threshold.

2. Convert Points Exceeding Threshold into a Value.
   Each of the Groups 1 and 2 are measuring a value: for Group 1 the value is Medicaid days; for Group 2 it is revenue. Step 2 multiplies the Points Exceeding Threshold by the value of the associated Group.

3. Determine Relative Weight of Each Hospital in Each Group.
   The relative weight of each hospital in each Group is determined by dividing each hospital's value for a Group determined in Step 2 by the total of all hospital values for that Group.

4. Initial Allocation of Dollars to Each Hospital in Each Group.
   The amount of funds available to each of the Groups 1 and 2 is determined by AHCCCS as authorized by the Legislature. The funding amount for the current state plan year is contained in Exhibit 3. The initial allocation to each hospital in each group is determined by multiplying each hospital's relative weight in a Group (determined in Step 3) by the amount of funds available for that Group.

5. Maximize Allocation of Dollars Between Group 1 and Group 2.
   This step selects the greater of the allocation to each hospital between Group 1 and Group 2.

6. Recalculating the Relative Weights of Each Hospital in Group 1 and Group 2.
   Since Step 5 eliminated hospitals from both Group 1 and Group 2, it is necessary to redetermine the weight for each remaining hospital. This is accomplished by dividing the value of each hospital remaining in Group 1 and Group 2 after Step 5 by the total of the remaining hospitals.

7. Second Allocation of Dollars Within Group 1 and Group 2.
   The second allocation to each hospital remaining in Group 1 and Group 2 is determined by multiplying each hospital's recalculated relative weight pursuant to Step 6 by the amount of funds available for that Group.

8. Identifying Minimum Payment.
   It is policy that the minimum payment made to any hospital qualifying for DSH is $5,000. This step identifies any amount thus far determined for any hospital that is less than $5,000.

9. Ensuring Minimum Payment.
   This step replaces any amount thus far determined for any hospital that is less than

$5,000 with a $5,000 amount.

10. Determining Penultimate Payment Amount.
    With the replacement of values with the $5,000 minimum amounts, it is necessary to recalculate and redistribute the values within any Group where the minimum payment amount was imposed in order to ensure that the total funding for a Group is not exceeded. Step 10 accomplishes this.

After determining the penultimate initial DSH payment amount for each non-governmental hospital that only qualifies for Group 1 or Group 2 (and not Group 1A or 2A) a check of the determined amount is made against the hospital's initial OBRA limit. The description of that limit follows in a subsequent section. If the initial DSH payment amount exceeds the initial OBRA limit, the initial DSH amount is set to the OBRA limit and the excess amount is distributed to the remaining hospitals in the group, with a recheck of the initial DSH amounts against the OBRA limit. This process is repeated until all amounts are distributed or all hospitals in the group are at their OBRA limit.

*Hospitals that qualify for Group 1A or Group 2A*

There are thirteen steps to determining the DSH payment amount for non-governmental hospitals that qualify for Group 1A or 2A . After determining the initial DSH payment amount through the thirteen step process, there is a final adjustment that may be made depending on the result of the hospital's OBRA limit.

1. Determine Points Exceeding Threshold.
   Each of the Groups 1A or 2A has thresholds established for qualification of the hospital. For Group 1A it is one standard deviation above the mean MIUR; for Group 2A it is greater than 25% LIUR. Step 1 merely determines the difference between each hospital's "score" for the Group measure and that Group's threshold.

2. Convert Points Exceeding Threshold into a Value.
   Each of the Groups 1A and 2A are measuring a value: for Group 1A the value is Medicaid days; for Group 2A it is revenue.; Step 2 multiplies the Points Exceeding Threshold by the value of the associated Group.

3. Determine Relative Weight of Each Hospital in Each Group.
   The relative weight of each hospital in each Group is determined by dividing each hospital's value for a Group determined in Step 2 by the total of all hospital values for that Group.

4. Initial Allocation of Dollars to Each Hospital in Each Group.
   The amount of funds available to each of the Groups 1A and 2A is determined by AHCCCS as authorized by the Legislature. The funding amount for the current state plan year is contained in Exhibit 3. The initial allocation to each hospital in each group is determined by multiplying each hospital's relative weight in a Group (determined in Step 3) by the amount of funds available for that Group.

5. Maximize Allocation of Dollars Between Group 1A and Group 2A.
   This step selects the greater of the allocation to each hospital between Group 1A and Group 2A.

6. Recalculating the Relative Weights of Each Hospital in Group 1A and Group 2A.
   Since Step 5 eliminated hospitals from both Group 1A and Group 2A, it is necessary to redetermine the weight for each remaining hospital. This is accomplished by dividing the value of each hospital remaining in Group 1A and Group 2A after Step 5 by the total of the remaining hospitals.

7. Second Allocation of Dollars Within Group 1A and Group 2A.
   The second allocation to each hospital remaining in Group 1A and Group 2A is determined by multiplying each hospital's recalculated relative weight pursuant to Step 6 by the amount of funds available for that Group.

8. Identifying Minimum Payment.
   It is policy that the minimum payment made to any hospital qualifying for DSH is $5,000. This step identifies any amount thus far determined for any hospital that is less than $5,000.

9. Ensuring Minimum Payment.
   This step replaces any amount thus far determined for any hospital that is less than $5,000 with a $5,000 amount.

10. Determining Penultimate Payment Amount.
    With the replacement of values with the $5,000 minimum amounts, it is necessary to recalculate and redistribute the values within any Group where the minimum payment amount was imposed in order to ensure that the total funding for a Group is not exceeded.

After determining the penultimate initial DSH payment amount for each non-governmental hospital that qualifies for Group 1A or 2A a check of the determined amount is made against the hospital's initial OBRA limit. The description of that limit follows in the next section. If the initial DSH payment amount exceeds the initial OBRA limit, the initial DSH amount is set to the OBRA limit and the excess amount is distributed to the remaining hospitals in the group, with a recheck of the initial DSH amounts against the OBRA limit. This process is repeated until all amounts are distributed or all hospitals in the group are at their OBRA limit.

*Hospitals that qualify for Group 4*

To determine the initial DSH payment amount for each governmentally-operated hospital, the relative allocation percentage for each hospital is computed based on the lesser of the hospital's CPE and the amount of funding specified by the Legislature. The funding amount for the current state plan year is contained in Exhibit 3.

OBRA Limits

The DSH payment ultimately received by qualifying non-governmental hospitals is the *lesser* of the amount calculated pursuant to the above-described methodologies or the hospital's OBRA limit. The DSH payment ultimately received by governmentally-operated hospitals is the *lesser* of the amount funded and specified by the Legislature or the hospital's finalized OBRA limit. All DSH payments are subject to the federal DSH allotment.

The OBRA limit is calculated using the following equation:

$$\boxed{\begin{array}{l} \textit{Uncompensated Care Costs Incurred Serving Medicaid Recipients} + \\ \textit{Uncompensated Care Costs Incurred Serving the Uninsured} \end{array}}$$

Pursuant to the above equation, the OBRA limit is comprised of two components:

1. The amount of uncompensated care costs associated with providing inpatient and outpatient hospital services to Medicaid individuals (the Medicaid shortfall), and
2. The amount of uncompensated care costs associated with providing inpatient and outpatient hospital services to individuals with no source of third party coverage for the inpatient and outpatient hospital services they received (uninsured costs).

The OBRA limit for the state plan rate year of the initial DSH payment will be computed for each hospital up to three times:

1. The OBRA limit will be calculated in the state plan rate year of the initial DSH payment for all eligible hospitals based on the cost report(s) and days and charges and other program data for the state plan rate year two years prior to the state plan rate year of the initial DSH payment
2. For governmentally-operated hospitals, the OBRA limit will be recalculated when the cost report for the state plan rate year of the initial DSH payment is filed
3. The final calculation of each hospital's OBRA limit will be performed when the cost report for the state plan rate year of the initial DSH payment is finalized

The steps to computing the OBRA limit are[3]:

1. The hospital shall prepare its CMS 2552 Report (cost report(s)). Each hospital must complete the cost report to determine per diems (for inpatient routine services) and ratios of cost to charges (RCC) (for ancillary services). The cost reports must be completed

[3] Note: The following discussion applies to hospitals that do not have a per diem ancillary allocation methodology approved by Medicare. For the steps to calculate the OBRA limit for governmental hospitals that do have such approval, see Exhibit 2 to this Attachment D. Non-governmental hospitals that have such approval should contact AHCCCS for further information.

based on Medicare cost principles and Medicare cost allocation process as specified in the CMS 2552 instructions and the CMS Provider Reimbursement Manual, volumes 15-1 and 15-2, including updates.

2. Medicaid shortfall will be calculated based on information available from PMMIS, other AHCCCS financial systems, and the cost report.
3. Uninsured costs will be calculated based on uninsured days and charges and other program data collected by each hospital from its claims and financial records, other systems, and the cost report.

The sum of each hospital's Medicaid shortfall (whether positive or negative) and uninsured costs (whether positive or negative) is that hospital's OBRA limit.

The Medicaid Shortfall

The data used to calculate the Medicaid shortfall is extracted from the cost report(s) as well as from the AHCCCS PMMIS system and other AHCCCS financial reporting systems. The Medicaid shortfall will be calculated for each hospital for each fiscal/CMS Report year that encompasses the state plan year. The resulting Medicaid shortfall for each fiscal/CMS Report year will be prorated to derive the state plan year Medicaid shortfall according to the above discussion entitled "Data on a State Plan Year Basis".

The information from AHCCCS will include, but not be limited to:

1. The number of Medicaid fee for service (FFS) inpatient hospital days (for governmentally-operated hospitals this will be accumulated for each inpatient routine service cost center on the cost report)
2. The number of Medicaid managed care inpatient hospital days (for governmentally-operated hospitals this will be accumulated for each inpatient routine service cost center on the cost report)
3. The Medicaid inpatient and outpatient hospital FFS charges for ancillary cost centers (for governmentally-operated hospitals this will be accumulated separately for each ancillary cost center on the cost report)
4. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital FFS services
5. The amounts of Medicaid payments made by AHCCCS for inpatient and outpatient hospital FFS services
6. The Medicaid inpatient and outpatient hospital managed care charges for ancillary cost centers (for governmentally-operated hospitals this will be accumulated separately for each ancillary cost center on the cost report)
7. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services for health plans and program contractors
8. The amounts of Medicaid payments made by health plans and program contractors for inpatient and outpatient hospital services for health plans and program contractors
9. Other amounts of Medicaid payments for Medicaid inpatient and outpatient services furnished during the Medicaid state plan rate year under review (e.g. GME, CAH, etc.)

For each hospital, the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report will be applied to the data extracted from PMMIS (days and charges) to determine the cost of providing inpatient and outpatient Medicaid services. Inpatient and outpatient Medicaid services will not include services reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services. The per diem amounts will be calculated by dividing:

- The individual amounts on Worksheet B Part 1 Column 25 Lines (and where applicable Subscript Lines) 25 to 33
- By
- The corresponding day totals on Lines (and where applicable Subscript Lines) 5 through 11 and Line 14 (for inpatient hospital subproviders) from Worksheet S-3 Part I Column 6.

Note: when calculating the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 25, Line 25 should have deducted the amounts appearing on Worksheet D-1, Part I, Lines 26 and 36 and the amount on Worksheet S-3, Part I, Column 6, Line 5 should have added the amount appearing on Line 26 (observation bed days).

The ancillary RCCs will be calculated by dividing:

1. The individual Line and Subscript amounts for each of the Lines 37 to 63 taken from Worksheet B Part 1 Column 25
2. By
3. The individual Line and Subscript amounts for each of the Lines 37 to 63 taken from Worksheet C Part 1 Column 8

Costs will be offset by the payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services as well as payments made by AHCCCS including FFS payments, payments by health plans and program contractors, and supplemental payments (such as GME, Rural Hospital Payments and CAH) made during the hospital's fiscal/CMS Report years that encompass the state plan rate year.

Uninsured Costs

Each hospital will collect uninsured days and charges and program data for the hospital's fiscal/CMS Report years that encompass the state plan year from the hospital's claims and auditable financial records. Only hospital inpatient and outpatient days and charges and program data for medical services that would otherwise be eligible for Medicaid should be included in the DSH calculation. Inpatient and outpatient uninsured services will not include services that would be reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services if the patient were eligible for Medicaid. The uninsured days, charges and program information provided to the state is subject to the same audit standards and procedures as the data included in the cost report.

When providing uninsured days, charges and program information hospitals should be guided by the following:

The Uninsured are defined as:

- Self pay and self insured patients
- Individuals with no source of third party coverage for inpatient and outpatient hospital services
- Third party coverage does not include state and local government subsidized care (i.e. individuals covered by indigent programs without other forms of third party coverage are uninsured)
- Payments made by state or local government are not considered a source of third party payment
- It is permissible to include in the Uninsured individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.
- Individuals with AHCCCS coverage (either Medicaid or KidsCare) are not considered uninsured
- Individuals participating in a Ryan White HIV/AIDS Program that have no source of third party coverage for the services provided other than the Ryan White program are considered uninsured. However, the funding provided under the program must be considered payments received from or on behalf of patients or payments received from third parties.

When submitting uninsured days, charges and program information hospitals should accompany the submission with:

- A listing of all payor types that are included in the uninsured data compilation, and
- A CD or DVD that contains sufficient claims or other information (e.g. ICNs) to enable an auditor to tie the amounts submitted to the financial records of the hospital

The uninsured costs will be calculated for each hospital for each fiscal/CMS Report year that encompasses the state plan year. The resulting uninsured costs for each fiscal/CMS Report year will be prorated to derive the state plan year uninsured costs according to the above discussion entitled "Data on a State Plan Year Basis".

The information to be collected will include, but not be limited to:

1. The number of uninsured inpatient hospital days (for governmentally-operated hospitals this will be accumulated for each inpatient routine service cost center on the cost report)
2. The uninsured inpatient and outpatient hospital ancillary charges (for governmentally-operated hospitals this will be accumulated for each ancillary cost center on the cost report)
3. The amounts of payments received during the hospital's fiscal/CMS Report years that encompass the state plan year made by or on behalf of patients and payments made by third parties related to uninsured inpatient and outpatient hospital services. The information collected shall:

a. Include payments received during the hospital's fiscal/CMS Report years that encompass the state plan year under Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, of the MMA,
b. Not include payments, funding and subsidies made by the state or a unit of local governments (e.g., state-only, local-only or state-local health program)

For each hospital the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report (as determined for Medicaid) will be applied to the data collected by the hospital to determine the uninsured costs.

Costs will be offset by the payments received during the state plan year from or on behalf of patients and payments received during the hospital's fiscal/CMS Report years that encompass the state plan year from third parties related to all uninsured inpatient and outpatient hospital services. Payments made by state or local government are not considered a source of third party payment.

The OBRA Limit

The summation of the Medicaid shortfall (whether positive or negative) and the uninsured costs (whether positive or negative) is the hospital's OBRA limit.

**Group 5 Eligibility Determination**

Any Arizona hospital that qualifies for funding in Groups 1 and 2 (Group 1, 1A, 2, or 2A) is eligible for funding through Group 5. Group 5 is created to enable DSH-eligible hospitals to get qualifying DSH payments matched via voluntary intergovernmental agreements (IGAs). Per State Medicaid Director Letter #10-010, the State will require the appropriate documentation that the funding has been voluntarily provided. Group 5 DSH payments are on top of the Groups 1 and 2 DSH payments, but no individual hospital will receive aggregate DSH payments that exceed its OBRA limit.

Funding for any hospital in Group 5 must be arranged via a voluntary intergovernmental agreement with a political subdivision, tribal government or public university, using public funds not derived from impermissible sources, such as impermissible provider-related donations or impermissible health care-related taxes, as a match to draw down DSH payments. Political subdivisions, tribal governments and public universities will notify AHCCCS of the hospitals designated to receive funds and of the amount of matching funds that are available through their IGAs.
For hospitals that qualify for Group 5, a "LOM" score will be calculated by multiplying the hospital's LIUR times the hospital's full OBRA limit, times the hospital's MIUR.

Example:
Hospital A
OBRA = $54,734,467, MIUR = 0.3542, LIUR = 0.2946
Group 5 LOM score for Hospital A = $54,734,467 x 0.3542 x 0.2946 = $5,711,394

For the first round of distributions, each hospital's percentage of the total group LOM score will be calculated using the hospital's LOM score as the numerator and the total of all eligible hospitals' LOM

scores as the denominator. The total amount of DSH available as a result of the IGAs (Group 5 DSH funds) will be multiplied by each hospital's LOM percentage of this first round. If any allocation from this round is higher than a hospital's OBRA limit (remaining after Group 1 and 2 DSH distributions) or higher than the matching funds (in total computable) for that hospital, the lower of those two limits will be recorded as the allocation for round one.

For subsequent rounds, only the hospitals that have not hit their OBRA limit or matching fund limit will be considered in that round. The LOM score for only those hospitals will be totaled. Each hospital's percentage of the total LOM score for that round will be calculated. The total amount of Group 5 DSH funds remaining for that round will be multiplied by each hospital's LOM percentage for that round. If any allocation from any round is higher than a hospital's remaining OBRA limit or higher than the remaining total computable matching funds for that hospital, the lower of those two limits will be recorded as the allocation for that round.

Distribution rounds will continue until all Group 5 DSH funds are distributed, or all Group 5 qualifying hospitals have received the maximum distribution identified in the IGAs or reached their individual OBRA limits, whichever comes first. All excess IGA funds not used for Group 5 DSH distributions, due to application of the above limits, will be returned to the originating political subdivisions, tribal governments or public universities and will not be retained by AHCCCS for other uses.

The Group 5 DSH distribution for any hospital will consist of that hospital's total of allocations from all rounds.

## Aggregate Limits

*IMD Limit*

Federal law provides that aggregate DSH payments to Institutions for Mental Diseases (IMDs) in Arizona is confined to the *lesser* of $28,474,900 or the amount equal to the product of Arizona's current year total computable DSH allotment and 23.27%. Therefore, DSH payment to IMDs will be reduced proportionately to the extent necessary to ensure that the aggregate IMD limit is not exceeded.

"Institutions for Mental Diseases" includes hospitals that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

*Overall Total Limit*

The federal government shares in the cost of Medicaid DSH expenditures based on the Federal Medical Assistance Percentage (FMAP) for each state. However, for each fiscal year, the amount of federal funds available to states for DSH payment is fixed. As such, the total amount of DSH payments for a state plan rate year will not exceed the federal allotment divided by the FMAP.

**Reconciliation**

The initial DSH payment issued to a hospital by AHCCCS is considered "interim" and is subject to different reconciliation methodologies depending upon whether the hospital is non-governmental or governmentally-operated. The payments to hospitals are generally made as a single lump sum payment that is made once the calculations of the payment amounts are completed. The purpose of the interim DSH payment is to provide reimbursement that approximates the Medicaid and uninsured inpatient hospital and outpatient hospital uncompensated care costs eligible for Federal Financial Participation (FFP).

The reasons for a change in the initial (or interim) DSH payment for both non-governmental and governmentally-operated hospitals are outlined above under "Pools and Changing Payment Levels".

If it is determined that the total amount of payments made to non-governmental hospitals under the methodology outlined in the "Pools and Changing Payment Levels" exceeds the amount of all finalized non-governmental hospital OBRA limits, the amount in excess will be recouped by AHCCCS and any associated federal funding claimed will be properly credited to the federal government.

If it is determined that the total amount of payments made to governmentally-operated hospitals under the methodology outlined in the "Pools and Changing Payment Levels" exceeds the amount of either:

1. All governmentally-operated hospital OBRA limits calculated based on the "finalized" cost report, or
2. The total amount of certified public expenditures of governmentally-operated hospitals, then
3. The amount in excess will be recouped by AHCCCS and any associated federal funding claimed will be properly credited to the federal government.

**Certified Public Expenditures**

Expenditures by governmentally-operated hospitals shall be used by AHCCCS in claiming FFP for DSH payments to the extent that the amount of funds expended are certified by the appropriate officials at the governmentally-operated hospital.

The method for determining a governmentally-operated hospital's allowable uncompensated care costs eligible for DSH reimbursement when such costs are funded through the certified public expenditure (CPE) process will be the same as the method for calculating and reconciling the OBRA limit for governmentally-operated hospitals set forth above.

However, because governmentally-operated hospitals are certifying expenditures for the state plan year of the initial DSH payment and final expenditures may not be known at the time of initial certification of public expenditures, governmentally owned hospitals may certify an amount of expenditures for the initial DSH payment based on an estimate of the OBRA limit for

the state plan year of the initial DSH payment.

In certifying estimates of public expenditure for the initial DSH payment, the governmentally operated hospital will first calculate its expenditures based on the methodology for calculating the OBRA limit for the state plan year two years before the state plan year of the initial payment (as specified in the protocols in Exhibit 1 or Exhibit 2) and then provide for adjustments to such OBRA limit. The adjustments may increase or decrease the days, costs, charges or payments reflected on the cost reports, Medicaid and/or uninsured information used to calculate the OBRA limit. The adjustments will reflect increases and decreases resulting from changes in operations or circumstances that are not reflected in the information from the state plan year two years prior to the state plan year of the initial payment, but will be reflected in the final information for the state plan year of the initial payment. All adjustments must be supported by adequate explanation/justification and is subject to review by AHCCCS and CMS.

In order to use CPE, the certifying governmentally-operated hospital must follow the protocol in Exhibit 1 or Exhibit 2 and provide a certification as to the amount of allowable uncompensated care costs eligible for DSH reimbursement. If CPE is used, the amount of expenditures used to determine the FFP will not exceed the amount of the CPE.

The payment of FFP to governmentally-operated hospitals is subject to legislative appropriation.

## Grievances and Appeals

The state considers a hospital's DSH eligibility and DSH payment amount to be appealable issues. A DSH eligibility list along with the initial DSH payment amounts that eligible hospitals have been calculated to receive will be distributed. Hospitals will be permitted thirty (30) days from distribution to appeal their DSH eligibility and payment amounts. Because the total amount of DSH funds is fixed, the successful appeal of one DSH hospital will reduce DSH payment amounts to all other providers. Once the final reconciliation process is completed, no additional DSH payment will be issued.

## Other Provisions

Ownership

DSH payment will only be issued to the entity which is currently registered with AHCCCS as a participating hospital provider. Therefore, it is expected that facilities will consider this information when negotiating ownership changes.

**Attachment D - AHCCCS Disproportionate Share Hospital (DSH) Payments Exceptions (Revised May 29, 2009)**

**An exception to the use of the Medicare Cost Report (Form CMS 2552-96) as a data source shall apply to:**

I. **Hospitals that:**

- Serve patients that are predominantly under 18 years of age, and
- Are licensed for fewer than 50 beds, and
- Do not file a comprehensive Form CMS 2552-96 (Medicare Cost Report), and
- Receive an acceptance letter from the CMS fiscal intermediary for the portion of the CMS 2552-96 (Medicare Cost Report) that the hospital does file with the fiscal intermediary, and
- Receive written permission from AHCCCS to invoke the provisions of this exception.

Such hospitals may extract data from their financial records in lieu of extracting data from the Form CMS 2552-96 (Medicare Cost Report) as provided in this Attachment D.

The method of extracting and compiling the data from the hospital's financial records shall conform to the instructions for the Form CMS 2552-96. All other non-Medicare Cost Report data and documentation as described in this Attachment D shall be required from such hospitals.

**II. Indian Health Service (IHS) Hospitals** and tribally-operated 638 hospitals who do not file a full Form CMS 2552-96 Medicare Cost Report but rather file an abbreviated Medicare cost report in accordance with Medicare Provider Reimbursement Manual, Part I, Section 2208.1.E (Method E cost report).

Such IHS Hospitals and tribally-operated 638 hospitals can submit a Private Facility Information Sheet (PFIS) to AHCCCS using data from the IHS Method E report that is filed with CMS as well as supporting hospital financial reports, as necessary.

The method of extracting and compiling the data from the hospital's financial records shall conform to the instructions for the Form CMS 2552-96. All other non-Medicare Cost Report data and documentation as described on the PFIS cover sheet will be required by such hospitals.

**EXHIBIT 1 to ATTACHMENT D**

**AHCCCS**
**Disproportionate Share Hospital Payment Methodology**
**Calculation of OBRA Limits for**
**Governmentally-Operated Hospitals for the Purpose of**
**Certified Public Expenditures**

Each governmentally-operated hospital certifying its expenditures for Disproportionate Share Hospital (DSH) payments shall compute and report its OBRA limit as prescribed by this Exhibit. The governmentally-operated hospital's OBRA limit is comprised of two components:

1. The amount of uncompensated care costs associated with providing inpatient and outpatient hospital services to Medicaid individuals (the Medicaid shortfall), and
2. The amount of uncompensated care costs associated with providing inpatient and outpatient hospital services to individuals with no source of third party coverage for the inpatient and outpatient hospital services they received (uninsured costs).

The steps to computing the governmentally-operated hospital's OBRA limit are[4]:

1. The hospital shall prepare its CMS 2552 Report (cost report(s)). Each hospital must complete the cost report to determine per diems (for inpatient routine services) and ratios of cost to charges (RCC) (for ancillary services). The cost reports must be completed based on Medicare cost principles and Medicare cost allocation process as specified in the CMS 2552 instructions and the CMS Provider Reimbursement Manual, volumes 15-1 and 15-2, including updates.
2. Medicaid shortfall will be calculated based on information available from PMMIS, other AHCCCS financial systems, and the cost report.
3. Uninsured costs will be calculated based on uninsured days and charges and other program data collected by the hospital from its claims and financial records, other systems, and the cost report.
4. Finally, the governmentally-operated hospital will compile and summarize the calculations on The OBRA Limit and CPE Schedule. In compiling and summarizing the OBRA calculations, the governmentally-operated hospital may make adjustments to the calculated OBRA limit to estimate the OBRA limit for a future state plan year. The adjustments may increase or decrease the days, costs, charges or payments reflected on the cost reports, Medicaid and/or uninsured information used to calculate the OBRA limit. The adjustments will reflect increases and decreases resulting from changes in operations or circumstances that are not reflected in the information from the state plan

[4] Note: The following discussion applies to hospitals that do not have a per diem ancillary allocation methodology approved by Medicare. For the steps to calculate the OBRA limit for governmental hospitals that do have such approval, see Exhibit 2 to this Attachment D.

year two years prior to the state plan year of the initial payment, but will be reflected in the final information for the state plan year of the initial payment. All adjustments must be supported by adequate explanation/justification and is subject to review by AHCCCS and CMS. The Schedule will be submitted to AHCCCS, with backup documentation, for the cost reporting period(s) covered by the Medicaid state plan rate year(s) under review.

The Medicaid Shortfall

AHCCCS will provide each governmentally-operated hospital with a report from the PMMIS system and other agency financial reporting systems to assist each governmentally-operated hospital in completing required schedules. The information to be provided by AHCCCS will include, but not be limited to:

1. The number of Medicaid fee for service (FFS) inpatient hospital days (for each inpatient routine service cost center on the cost report)
2. The number of Medicaid managed care inpatient hospital days (for each inpatient routine service cost center on the cost report)
3. The Medicaid inpatient and outpatient hospital FFS charges (separately for each ancillary cost center on the cost report). Inpatient and outpatient Medicaid charges will not include charges reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services.
4. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital FFS services
5. The amounts of Medicaid payments made by AHCCCS for inpatient and outpatient hospital FFS services
6. The Medicaid inpatient and outpatient hospital managed care charges (for each ancillary cost center on the cost report). Inpatient and outpatient Medicaid charges will not include charges reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services.
7. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services for health plans and program contractors
8. The amounts of Medicaid payments made by health plans and program contractors for inpatient and outpatient hospital services for health plans and program contractors
9. Other amounts of Medicaid payments for Medicaid inpatient and outpatient services furnished during the Medicaid state plan rate year under review (e.g. GME, CAH, etc.)

Each governmentally-operated hospital will use the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report and the data extracted from PMMIS (days and charges) to determine the cost of providing inpatient and outpatient Medicaid services. Inpatient and outpatient Medicaid services will not include services reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services. The Medicaid shortfall will be calculated for each hospital for each fiscal/CMS Report year that encompasses the state plan year. The resulting Medicaid shortfall for each fiscal/CMS Report year will be prorated to derive the state plan year Medicaid shortfall according to the discussion entitled “Data on a State Plan Year Basis”.

The per diem amounts will be calculated by dividing:

- The individual amounts on Worksheet B Part 1 Column 25 Lines (and where applicable Subscript Lines) 25 to 33
- By
- The corresponding day totals on Lines (and where applicable Subscript Lines) 5 through 11 and Line 14 (for inpatient hospital subproviders) from Worksheet S-3 Column 6.

Note: when calculating the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 25, Line 25 should have deducted the amounts appearing on Worksheet D-1, Part I, Lines 26 and 36 and the amount on Worksheet S-3, Part I, Column 6, Line 5 should have added the amount appearing on Line 26 (observation bed days).

The ancillary RCCs will be calculated by dividing:

1. The individual Line and Subscript amounts for each of the Lines 37 to 63 taken from Worksheet B Part 1 Column 25
2. By
3. The individual Line and Subscript amounts for each of the Lines 37 to 63 taken from Worksheet C Part 1 Column 8

Each governmentally-operated hospital will use the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report and the data supplied by AHCCCS to compile the Medicaid Schedule of Costs on the OBRA Limit and CPE Schedule. The Medicaid Schedule of Costs depicts:

1. The governmentally-operated hospital specific Medicaid inpatient and outpatient cost data,
2. The payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services,
3. The Medicaid inpatient and outpatient net cost data,
4. Payments made by AHCCCS including FFS and payments by health plans and program contractors
5. The amount of supplemental Medicaid payments related to inpatient and outpatient hospital services (e.g., GME and CAH)
6. The Medicaid shortfall
7. Adjustments to the calculated Medicaid shortfall to estimate a Medicaid shortfall for a future state plan year.

Uninsured Costs

Each governmentally-operated hospital will collect uninsured days and charges and program data for the hospital's fiscal/CMS Report years that encompass the state plan year from the hospital's claims and auditable financial records. Only hospital inpatient and outpatient days and charges and program data for medical services that would otherwise be eligible for Medicaid should be included in the calculation. Inpatient and outpatient uninsured services will not include services that would be reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services if the patient were eligible for Medicaid. The uninsured days, charges and program information

provided to the state is subject to the same audit standards and procedures as the data included in the cost report.

When providing uninsured days, charges and program information hospitals should be guided by the following:

The Uninsured are defined as:

- Self pay and self insured patients
- Individuals with no source of third party coverage for inpatient and outpatient hospital services
- Third party coverage does not include state and local government subsidized care (i.e. individuals covered by indigent programs without other forms of third party coverage are uninsured)
- Payments made by state or local government are not considered a source of third party payment
- It is permissible to include in the Uninsured individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.
- Individuals with AHCCCS coverage (either Medicaid or KidsCare) are not considered uninsured
- Individuals participating in a Ryan White HIV/AIDS Program that have no source of third party coverage for the services provided other than the Ryan White program are considered uninsured. However, the funding provided under the program must be considered payments received from or on behalf of patients or payments received from third parties.

When submitting uninsured days, charges and program information hospitals should accompany the submission with:

- A listing of all payor types that are included in the uninsured data compilation, and
- A CD or DVD that contains sufficient claims or other information (e.g. ICNs) to enable an auditor to tie the amounts submitted to the financial records of the hospital

The information to be collected will include, but not be limited to:

1. The number of uninsured inpatient hospital days (for each inpatient routine service cost center on the cost report)
2. The uninsured inpatient and outpatient hospital ancillary charges (for each ancillary cost center on the cost report)
3. The amounts of payments received during the hospital's fiscal/CMS Report years that encompass the state plan year made by or on behalf of patients and payments made by third parties related to uninsured inpatient and outpatient hospital services. The information collected shall:
    a. Include payments received during the hospital's fiscal/CMS Report years that encompass the state plan year under Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, of the MMA,

b. Not include payments, funding and subsidies made by the state or a unit of local governments (e.g., state-only, local-only or state-local health program)

Each governmentally-operated hospital will use the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report (as determined for Medicaid), the uninsured days and charges, and other program data collected by the governmentally-operated hospital to compile the Uninsured Schedule of Costs on the OBRA Limit and CPE Schedule. The Uninsured Schedule of Costs depicts:

1. The governmentally-operated hospital specific uninsured inpatient and outpatient cost data,
2. The payments made by or on behalf of patients and payments made by third parties related to uninsured inpatient and outpatient hospital services, and
3. The uninsured inpatient and outpatient cost.
4. Adjustments to the calculated uninsured inpatient and out patient cost to estimate the uninsured inpatient and outpatient cost for a future state plan year.

The Governmentally-Operated Hospital OBRA Limit

The summation of the Medicaid shortfall (whether positive or negative) and the uninsured costs (whether positive or negative) is the hospital's OBRA limit and is depicted on the Calculation of OBRA Limit and CPE on the OBRA Limit and CPE Schedule.

The summation of the estimated Medicaid shortfall (whether positive or negative) and the estimated uninsured costs (whether positive or negative) is the hospital's OBRA limit for a future state plan year and is depicted on the Calculation of OBRA Limit and CPE on the OBRA Limit and CPE Schedule.

Certification

The appropriate official of the governmentally-operated hospital will sign the certification statement on the Governmentally-Operated Hospital OBRA Limit and CPE Schedule. A certification will be signed for each of the three times the OBRA limit for the state plan rate year of the initial DSH payment is calculated as described below under "Reconciliation".

Reconciliation

The OBRA limit for the state plan rate year of the initial DSH payment will be computed for each governmentally-operated hospital three times:

1. The OBRA limit will be calculated in the state plan rate year of the initial DSH payment based on the cost report(s) and days and charges and other program data for the state plan rate year two years prior to the state plan rate year of the initial DSH payment. This calculation may include an adjustment to the calculated OBRA limit of the state plan rate year two years prior to the state plan rate year of the initial DSH payment in order to estimate the OBRA limit of the state plan rate year of the initial DSH payment.

2. The OBRA limit will be recalculated when the cost report(s) for the state plan rate year of the initial DSH payment are filed. In recalculating the OBRA limit the cost data from the as-filed cost report(s) and program data (days, charges, and payments) from the actual cost reporting period(s) will be used in the calculation. This calculation may not include any adjustment to the calculated OBRA limit of the state plan rate year of the initial DSH.
3. The final calculation of each governmentally-operated hospital's OBRA limit will be performed when the cost report(s) for the state plan rate year of the initial DSH payment are finalized. In finalizing the OBRA limit the cost data from the finalized cost report(s) and program data (days, charges, and payments) from the actual cost reporting period(s) will be used in the calculation.

**EXHIBIT 2 to ATTACHMENT D**

**AHCCCS**
**Disproportionate Share Hospital Payment Methodology**
**Calculation of OBRA Limits for**
**Arizona State Hospital**
**A Hospital with a Per Diem Ancillary Cost Allocation Method**
**Approved by Medicare**

Arizona State Hospital (ASH), a governmentally-operated hospital that is an all-inclusive rate provider under Medicare, shall compute, report and certify its OBRA limit as prescribed by this Exhibit. Because ASH only provides inpatient services, the OBRA limit will by calculated based only on inpatient information. ASH's OBRA limit is comprised of two components:

1. The amount of uncompensated care costs associated with providing inpatient hospital services to Medicaid individuals (the Medicaid shortfall), and
2. The amount of uncompensated care costs associated with providing inpatient hospital services to individuals with no source of third party coverage for the inpatient hospital services they received (uninsured costs).

The steps to computing ASH's OBRA limit are:

1. The hospital shall prepare its CMS 2552 Report (cost report(s)). The hospital must complete the cost report to determine per diems (for inpatient routine services and for ancillary services). The cost reports must be completed based on Medicare cost principles and Medicare cost allocation process as specified in the CMS 2552 instructions and the CMS Provider Reimbursement Manual, volumes 15-1 and 15-2, including updates.
2. Medicaid shortfall will be calculated based on information available from PMMIS, other AHCCCS financial systems, and the cost report.
3. Uninsured costs will be calculated based on uninsured days and other program data collected by the hospital from its claims and financial records, other systems, and the cost report.
4. Finally, ASH will compile and summarize the calculations on The OBRA Limit and CPE Schedule. In compiling and summarizing the OBRA calculations, ASH may make adjustments to the calculated OBRA limit to estimate the OBRA limit for a future state plan year. The adjustments may increase or decrease the days, costs, charges or payments reflected on the cost reports, Medicaid and/or uninsured information used to calculate the OBRA limit. The adjustments will reflect increases and decreases resulting from changes in operations or circumstances that are not reflected in the information from the state plan year two years prior to the state plan year of the initial payment, but will be reflected in the final information for the state plan year of the initial payment. All adjustments must be supported by adequate explanation/justification and is subject to review by AHCCCS and CMS. The Schedule will be submitted to AHCCCS, with backup documentation, for the cost reporting period(s) covered by the Medicaid state plan rate year(s) under review.

The Medicaid Shortfall

AHCCCS will provide ASH with a report from the PMMIS system and other agency financial reporting systems to assist ASH in completing required schedules. The information to be provided by AHCCCS will include, but not be limited to:

1. The number of Medicaid fee for service (FFS) inpatient hospital days (for the single inpatient routine service cost center on the cost report)
2. The number of Medicaid managed care inpatient hospital days (for the single inpatient routine service cost center on the cost report)
3. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient hospital FFS services
4. The amounts of Medicaid payments made by AHCCCS for inpatient hospital FFS services
5. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient hospital services for health plans and program contractors
6. The amounts of Medicaid payments made by health plans and program contractors for inpatient hospital services for health plans and program contractors
7. Other amounts of Medicaid payments for Medicaid inpatient services furnished during the Medicaid state plan rate year under review (e.g. GME, CAH, etc.)

ASH will use a single total per diem calculated from the cost report and the inpatient days extracted from PMMIS to determine the cost of providing inpatient Medicaid services. The Medicaid shortfall will be calculated for ASH for each fiscal/CMS Report year that encompasses the state plan year. The resulting Medicaid shortfall for each fiscal/CMS Report year will be prorated to derive the state plan year Medicaid shortfall according to the discussion entitled "Data on a State Plan Year Basis".

The single total per diem amount will be calculated by summing the inpatient per diem amount and the ancillary per diem amount.

The inpatient per diem amount will be found by dividing the amounts on Worksheet B Part 1 Column 25 Line 25 by the day total on Line 5 from Worksheet S-3 Column 6. Note: when calculating the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 25, Line 25 should have deducted the amounts appearing on Worksheet D-1, Part I, Lines 26 and 36 and the amount on Worksheet S-3, Part I, Column 6, Line 5 should have added the amount appearing on Line 26 (observation bed days).

The ancillary per diem amount will be calculated by:

1. Summing the Line and Subscript amounts for each of the Lines 37 to 63 (but excluding Subscript Lines 63.5 to 63.99) taken from Worksheet B Part 1 Column 25
2. Dividing the amount determined in step 1 above by the amount determined in step 3 below

3. Summing the Lines 5 and 17 from Worksheet S-3 Column 6

ASH will use the single total per diem calculated from the cost report and the data supplied by AHCCCS to compile the Medicaid Schedule of Costs on the OBRA Limit and CPE Schedule. The Medicaid Schedule of Costs depicts:

1. The governmentally-operated hospital specific Medicaid inpatient cost data (determined by multiplying the single total per diem by the number of inpatient Medicaid days),
2. The payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient hospital services,
3. The Medicaid inpatient net cost data,
4. Payments made by AHCCCS including FFS and payments by health plans and program contractors
5. The amount of supplemental Medicaid payments (e.g., GME and CAH)
6. The Medicaid shortfall
7. Adjustments to the calculated Medicaid shortfall to estimate a Medicaid shortfall for a future state plan year.

Uninsured Costs

ASH will collect uninsured days and program data for the hospital's fiscal/CMS Report years that encompass the state plan year from the hospital's claims and auditable financial records. Only hospital inpatient days and program data for medical services that would otherwise be eligible for Medicaid should be included in the calculation. Inpatient uninsured services will not include services that would be reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services if the patient were eligible for Medicaid. The uninsured days and program information provided to the state is subject to the same audit standards and procedures as the data included in the cost report.

When collecting uninsured days and program information ASH should be guided by the following:

The Uninsured are defined as:

- Self pay and self insured patients
- Individuals with no source of third party coverage for inpatient hospital services
- Third party coverage does not include state and local government subsidized care (i.e. individuals covered by indigent programs without other forms of third party coverage are uninsured)
- Payments made by state or local government are not considered a source of third party payment
- It is permissible to include in the Uninsured individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.
- Individuals with AHCCCS coverage (either Medicaid or KidsCare) are not considered uninsured
- Individuals participating in a Ryan White HIV/AIDS Program that have no source of third party coverage for the services provided other than the Ryan White program are

considered uninsured. However, the funding provided under the program must be considered payments received from or on behalf of patients or payments received from third parties.

The uninsured costs will be calculated for ASH for each fiscal/CMS Report year that encompasses the state plan year. The resulting uninsured costs for each fiscal/CMS Report year will be prorated to derive the state plan year uninsured costs according to the discussion entitled "Data on a State Plan Year Basis".

The information to be collected will include, but not be limited to:

1. The number of uninsured inpatient hospital days (for the single inpatient routine service cost center on the cost report)
2. The amounts of payments received during the hospital's fiscal/CMS Report years that encompass the state plan year made by or on behalf of patients and payments made by third parties related to uninsured inpatient hospital services. The information collected shall:
    a. Include payments received during the hospital's fiscal/CMS Report years that encompass the state plan year under Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, of the MMA,
    b. Not include payments, funding and subsidies made by the state or a unit of local governments (e.g., state-only, local-only or state-local health program)

ASH will use the total inpatient per diem calculated from the cost report (as determined for Medicaid), the uninsured days, and other program data collected by ASH to compile the Uninsured Schedule of Costs on the OBRA Limit and CPE Schedule. The Uninsured Schedule of Costs depicts:

1. The ASH specific uninsured inpatient cost data (determined by multiplying the single total per diem by the number of uninsured inpatient days),
2. The payments made by or on behalf of patients and payments made by third parties related to uninsured inpatient hospital services, and
3. The uninsured inpatient cost.
4. Adjustments to the calculated uninsured inpatient and out patient cost to estimate the uninsured inpatient and outpatient cost for a future state plan year.

The Governmentally-Operated Hospital OBRA Limit

The summation of the Medicaid shortfall (whether positive or negative) and the uninsured costs (whether positive or negative) is the hospital's OBRA limit and is depicted on the OBRA Limit and CPE Schedule.

The summation of the estimated Medicaid shortfall (whether positive or negative) and the estimated uninsured costs (whether positive or negative) is the hospital's OBRA limit for a future state plan year and is depicted on the Calculation of OBRA Limit and CPE on the OBRA Limit and CPE Schedule.

Certification

The appropriate official of ASH will sign the certification statement on the OBRA Limit and CPE Schedule. A certification statement will be signed for each of the three times the OBRA limit for the state plan year of the initial DSH payment is calculated as described below under "Reconciliation".

Reconciliation

The OBRA limit for the state plan rate year of the initial DSH payment will be computed for ASH three times:

1. The OBRA limit will be calculated in the state plan rate year of the initial DSH payment based on the cost report(s) and days and other program data for the state plan rate year two years prior to the state plan rate year of the initial DSH payment. This calculation may include an adjustment to the calculated OBRA limit of the state plan rate year two years prior to the state plan rate year of the initial DSH payment in order to estimate the OBRA limit of the state plan rate year of the initial DSH payment.
2. The OBRA limit will be recalculated when the cost report(s) for the state plan rate year of the initial DSH payment are filed. In recalculating the OBRA limit the cost data from the as-filed cost report(s) and program data (days and payments) from the actual cost reporting period(s) will be used in the calculation. This calculation may not include any adjustment to the calculated OBRA limit of the state plan rate year of the initial DSH.
3. The final calculation of ASH's OBRA limit will be performed when the cost report(s) for the state plan rate year of the initial DSH payment are finalized. In finalizing the OBRA limit the cost data from the finalized cost report(s) and program data (days and payments) from the actual cost reporting period(s) will be used in the calculation.

## EXHIBIT 3 to ATTACHMENT D

## AHCCCS
## Disproportionate Share Hospital Payment Methodology
## Pool Funding Amounts for SPY 2008, SPY 2009, and SPY 2010

This Exhibit contains the amount of funding for six pools of the Arizona DSH pool methodology for State Plan Year (SPY) 2008 and 2009, and seven pools for SPY 2010. For SPY 2011 the funding will be allocated among six pools

The funding for pools 1 and 2 will be sufficient to provide an average payment amount of $6,000 for all hospitals qualifying for both of the two pools. No hospital in pools 1 or 2 will receive less than $5,000. Therefore, the amount of funding for pools 1 and 2 will be determined by multiplying the number of hospitals qualifying for pools 1 and 2 by $6,000.

The funding for pools 1A, 2A and 3 will be derived by subtracting the total amount allocated for pools 1 and 2 from $26,147,700, the amount of DSH authorized by the Legislature for non-governmentally operated hospitals for SPY 2008 and SPY 2009. For SPY 2010, the funding for pools 1, 2, 1A, 2A, and 3 will be $500,000. For SPY 2011, the funding for pools 1, 2,1A and 2A will be $9,284,800.

The funding for pool 4 is $117,914,800, the amount authorized by the Legislature for governmentally operated hospitals for SPY 2008. For SPY 2009, the funding amount for governmentally operated hospitals in pool 4 is $128,427,000. For SPY 2010, the funding amount for governmentally operated hospitals in pool 4 is $132,596,900. For SPY 2011, the funding amount for governmentally operated hospitals in pool 4 is $128,637,400.

The funding for pool 5 is $26,000,000 and will be provided through voluntary intergovernmental transfers to hospitals designated by political subdivisions, universities, and tribal governments. Political subdivisions, public universities, and tribal governments will notify AHCCCS of the hospitals that will be designated to receive funds and of the amount of matching funds that will be available through their intergovernmental agreements (IGAs). AHCCCS will provide CMS with a list of designated pool 5 hospitals as soon as it becomes available. For SPY 2011, the funding amount for Pool 5 is $16,000,000.

For SPY 2009, any excess DSH funding in pool 4 not allocated due to OBRA limits may be reallocated and distributed to DSH-qualifying hospitals in pools 1, 1A, 2, 2A or 3 until September 30, 2011. AHCCCS shall notify CMS prior to the distribution of any pool 4 reallocated DSH funds. For SPY 2010, any excess DSH funding in pool 4 not allocated due to OBRA limits may be reallocated to DSH pools 1, 1A, 2, 2A, 3, and 5 until September 30, 2012. A determination will be made by June 30, 2012, by the Administration if any reallocation will occur. For SPY 2011, any excess DSH funding in pool 4 not allocated due to OBRA limits may be reallocated to DSH pools 1, 1A, 2, 2A, and 5 until September 30, 2013. A determination will be made by June 30, 2013, by the Administration if any reallocation will occur.

Funding will be reallocated first to pools 1, 1A, 2, 2A, and 3, should the State make available matching funds. This reallocation to the pools will be based proportionately on the SPY 2009 pool allocations. For each pool, the distribution of the reallocated DSH funding to the hospitals within the pool will be based on each hospital's 2010 relative weights as described in the "Determination of Payment Amounts" section of this Attachment D. SPY 2010 payments made from reallocated funds will be added to the hospital's original SPY 2010 payments with the total SPY payments subject to each hospital's OBRA limit.

For SPY 2011, funding will be reallocated first to pools 1, 1A, 2, and 2A should the State make available matching funds. This reallocation to the pools will be based proportionately on the SPY 2011 pool allocation For each pool, the distribution of the reallocated DSH funding to the hospitals within the pool will be based on each hospital's 2011 relative weights as described in the "Determination of Payment Amounts" section of this Attachment D. SPY 2011 payments made from reallocated funds will be added to the hospital's original SPY 2011 payments with the total SPY payments subject to each hospital's OBRA limit.

Any remaining excess funding may be reallocated to pool 5. Additional DSH payments from Pool 5 are funded by transfers per IGAs. If more than one hospital has available voluntary match, the reallocation will be allocated based proportionately according to the hospital's LOM scores, subject to the lower of each hospital's remaining OBRA limit or the total computable matching fund amount designated for each hospital per the applicable IGA.

Upon reconciliation, the non-federal portion of any Pool 5 funds that has to be recouped due to changes in hospital qualification or payment limits will be returned to the local match entity. The resulting federal funds will be returned to CMS.

AHCCCS shall notify CMS prior to the distribution of any pool 4 reallocated DSH funds. Any additional payments will be limited to a hospital's overall OBRA limit.

**[To Be Placed on Public Hospital Letter Head]**

**State Plan Year _____**

☐ Initial

☐ Final

**CERTIFICATION STATEMENT**
**DISPROPORTIONATE SHARE HOSPITAL PAYMENT**

As the of Maricopa Medical Center, I certify that:

- Maricopa Medical Center has expended local funds in an amount equal to the OBRA Limit(s) indicated below.

- The local funds were not obligated to match other federal funds for any federal program and these funds are not federal funds.

- The attached Maricopa Medical Center OBRA Limit and CPE Schedule is true, accurate and complete to the best of my knowledge and belief and the information presented thereon is either identified and supported in the Hospital's accounting system, has been supplied to me by AHCCCS, or is supported by the attached documentation. I understand that the information presented on the Schedule is subject to audit.

- Maricopa Medical Center and I understand that the Disproportionate Share Hospital Payment received by the hospital will be from Federal funds, that any overpayment of those funds to the hospital will be recovered by AHCCCS, and that any falsification or concealment of a material fact made to receive payment of those funds may be prosecuted under Federal and/or State laws.

The estimated OBRA Limit Calculation for State Plan Year _____ is $ _____.

(Another line to certify a finalized amount will be added in the future)

_____ _____
Signature of CEO or CFO Printed Name

_____ _____
Title Date

**[To Be Placed on Public Hospital Letter Head]**

**State Plan Year 2008**

☐ Initial
☐ Final

**CERTIFICATION STATEMENT**
**DISPROPORTIONATE SHARE HOSPITAL PAYMENT**

As the of Arizona State Hospital, I certify that:

- Arizona State Hospital has expended State funds in an amount equal to the OBRA Limit(s) indicated below.

- The State funds were not obligated to match other federal funds for any federal program and these funds are not federal funds.

- The attached Arizona State Hospital OBRA Limit and CPE Schedule is true, accurate and complete to the best of my knowledge and belief and the information presented thereon is either identified and supported in the Hospital's accounting system, has been supplied to me by AHCCCS, or is supported by the attached documentation. I understand that the information presented on the Schedule is subject to audit.

- Arizona State Hospital and I understand that the Disproportionate Share Hospital Payment received by the hospital will be from Federal funds, that any overpayment of those funds to the hospital will be recovered by AHCCCS, and that any falsification or concealment of a material fact made to receive payment of those funds may be prosecuted under Federal and/or State laws.

The estimated OBRA Limit Calculation for State Plan Year _____ is $ _____.

(Another line to certify a finalized amount will be added in the future)

_____ _____
Signature of CEO or CFO Printed Name

_____ _____
Title Date

Spreadsheets – Excel Files

**Attachment E**

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

## Center for Medicaid and State Operations

### Letter Summary

*This letter clarifies some methods by which HCBS waivers under section 1915(c) may aid in the transitioning of individuals from institutional settings to their own home in the community through coverage of one-time transitional expenses. This clarification was promised in the HHS New Freedom Report to the President.*

---

SMDL #02-008

May 9, 2002

Dear State Medicaid Director:

Medicaid home and community-based services (HCBS) waivers are the statutory alternative to institutional care. Many states have found in HCBS waivers a cost-effective means to implement a comprehensive plan to provide services in the most integrated setting appropriate to the needs of individuals with disabilities.

However, individuals seeking a return to the community from institutions are faced with many one-time expenses, and many states are unclear about the extent to which waivers cover transition costs. Examples of those expenses include the cost of furnishing an apartment, the expense of security deposits, utility set-up fees, etc. Other states have expressed interest in having the waivers pay for apartment/housing rent. This letter is designed to answer such questions.

Federal funding under Medicaid HCBS waivers is not available to cover the cost of rent. States may offset rental expenses from state-only funds that augment federal HCBS resources, but federal financial participation (FFP) for such a purpose is not available for any apartment/housing rental expenses.

As the HHS Report for the President's *New Freedom Initiative* stated, however, states may secure federal matching funds under HCBS waivers for one-time, set-up expenses for individuals who make the transition from an institution to their own home or apartment in the community, such as security deposits, that do not constitute payment for housing rent.

States may pay the reasonable costs of *community transition services*, including some or all of the following components:

- Security deposits that are required to obtain a lease on an apartment or home;
- Essential furnishings and moving expenses required to occupy and use a community domicile;
- Set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating);
- Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy.

By reasonable costs, we mean necessary expenses in the judgment of the state for an individual to establish his or her basic living arrangement. For example, essential furnishings in the above context would refer to necessary items for an individual to establish his or her basic living arrangement, such a bed, a table, chairs, window blinds, eating utensils, and food preparation items. We would not consider essential furnishings to include diversional or recreational items such as televisions, cable TV access or VCRs.

States that choose to include community transition services in their HCBS waivers must demonstrate that this service, in combination with other services furnished under the waiver, would be cost-neutral to the Medicaid program. (In the streamlined HCBS waiver format, this cost neutrality is demonstrated in appendix G.) To be eligible for FFP, the service must be included in the individual's written plan of care (service plan) and fit within the service definitions established by the state.

For more than three years CMS has awarded "Nursing Facility Transition Grants" to states in which transition costs have been paid from grant funds. Those states found that coverage of transition expenses has been manageable, cost-effective and has greatly facilitated the expeditious integration of individuals into their communities from prior institutional living arrangements. Contacts and other relevant information about those states may be found on the CMS website.

Any questions concerning this letter may be referred to Mary Jean Duckett at (410) 786-3294.

Sincerely,

/s/

Dennis G. Smith
Director

cc:

CMS Regional Administrators
CMS Associate Regional Administrators
for Medicaid and State Operations

Lee Partridge
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Brent Ewig
Senior Director, Access Policy
Association of State and Territorial Health Officials

Jim Frogue
Acting Director, Health and Human Services Task Force
American Legislative Exchange Council

Trudi Matthews
Senior Health Policy Analyst
Council of State Governments

## Attachment F
## REIMBURSEMENT FOR CRITICAL ACCESS HOSPITALS

**Subject to the availability of state funds**, beginning May 1, 2002, supplemental payments will be made to non-I.H.S., non-638 facility in-state hospitals, certified by Medicare as Critical Access Hospitals (CAHs) under 42 CFR 485, Subpart F and 42CFR 440.170(g). These supplemental CAH payments shall be made in addition to the other payments described in Attachments 4.19-A (inpatient hospital) and 4.19-B (outpatient hospital). Supplemental payments shall be made based on each CAH designated hospital's percentage of total inpatient and outpatient Title XIX reimbursement paid relative to other CAH designated hospitals for the time period from July 1 through June 30 of the previous year.

AHCCCS will allocate the amount available through legislative appropriation in the following manner:

(1) Gather all adjudicated claims/encounters with dates of service from July 1 through June 30 of the prior year for each CAH-designated hospital.

(2) Sum the AHCCCS payments for inpatient and outpatient services for the year to establish a hospital-specific hospital paid amount.

(3) Total all AHCCCS payments for inpatient and outpatient services for the year to establish a total paid amount.

(4) Divide the hospital paid amount by the total paid amount to establish the hospital's utilization percentage.

(5) Divide the annual CAH appropriation by twelve to get the monthly CAH allocation.

(6) Multiply each hospital's monthly relative utilization by the monthly CAH allocation to establish each hospital's monthly payment.

Funding will be distributed based on the number of CAH-designated hospitals in each month and their Medicaid utilization. Because there may be a different number of CAH-designated hospitals each month, the hospital-specific weightings and payments may fluctuate from month to month. The calculations will be computed monthly and the distribution of the CAH dollars to the CAH-designated hospitals will be made twice a year.

**Attachment G**

**AACP** Acute Care and Behavioral Health Services

The following chart summarizes the services available to expansion populations covered under the Demonstration. It is not intended to be a detailed or comprehensive statement of benefit coverage. Except as specifically noted in the chart or elsewhere in the List of Waivers, CNOM's, and/or the Special Terms and Conditions, the scope of services for the expansion populations are as set forth in the Arizona State Plan.

| **Benefit** | **Title XIX** | | **Title XXI** |
|---|---|---|---|
| Age | < 21 yrs | ≥ 21 yrs | < 19 yrs |
| Inpatient Hospital Services | X | X | X |
| Outpatient Hospital Services and Rural Health Clinic Services | X | X | X |
| Other Lab and X-ray Services | X | X | X |
| Nursing Facility Services for Individuals 21 age or older other than services in an institution for mental disease | X | X | X |
| EPSDT- medical services and other services covered by Title XXI | X | | X |
| Family Planning Services and Supplies | X | X | |
| Physician Services | X | X | X |
| Medical and surgical services of a dentist | X | X | X |
| Medical or other remedial care provided by licensed practitioners | X | X | X |
| Home Health Services | X | X | X |
| Private Duty Nursing Services | X | X | X |
| Clinic Services | X | X | X |
| Dental Services | X | X | X |
| Physical Therapy and Related Services | X | X | X |
| Occupational Therapy | X | X | X |
| Services for individuals with speech hearing and language disorders | X | X | X |
| Prescribed Drugs | X | X | X |
| Prosthetic Devices | X | X | X |
| Eyeglasses | X | X | X |
| Diagnostic Services | X | X | X |
| Screening Services | X | X | X |
| Preventive Services | X | X | X |
| Rehabilitative services | | | |
| Inpatient hospital services, nursing facility services and intermediate care facility services for individuals age 65 or older in institutions for mental disease | X | X | X |
| Inpatient psychiatric facility services for individuals under 21 years of age | X | | X |
| Nurse mid-wife services | X | X | X |
| Hospice Care | | X | |
| Case Management and Tuberculosis related services | X | X | X |
| Respiratory care services | X | X | X |
| Certified Pediatric or family nurse practitioners' services | X | X | X |
| Transportation | X | X | X |
| Services of nurses in Religious Non-Medical Health Care Institutions | X | X | X |
| Nursing facility services for patients under 21 years of age | X | | X |
| Emergency hospital services | X | X | X |
| Personal Care Services | X | X | X |
| Behavioral Health | See Table 2 in STC #17 | | |
| | | | |

**Attachment H**
KidsCare II Operational Protocol

The following protocol provides operational specifics with respect to the opening of the KidsCare II program.

**Eligibility**
Children who were on the KidsCare waiting list and have income at or below 175 percent of the FPL, are not otherwise eligible for Medicaid, and meet all other requirements for the KidsCare II program are eligible for the KidsCare II program, based on available funding. Children who are on the KidsCare waiting list must pay outstanding KidsCare premiums before they can enroll into the KidsCare II program. In addition, children age 6 with income at or below 175 percent of the FPL who were Medicaid beneficiaries but who no longer qualify for Medicaid, will automatically be transferred to the KidsCare II program, if eligible.

**Enrollment Process**

Notices will be sent to households on the waiting list in the order in which they joined the waiting list, starting with the children who have been on the waiting list the longest. Households will have 30 days to respond and apply for KidsCare II. If a household does not respond within that 30 day period, it will be removed from the waiting list. However, households who respond after the 30 day response period has ended will be reviewed on a case-by-case basis if enrollment slots are still available. Notices will direct people to apply through Health-e-Arizona, the online application. The notices will provide locations and contact information for community assistors, including Health-e-Arizona subscriber sites and other community groups engaged in the statewide outreach effort. The notices will also include the telephone numbers for the Pima County Access Program (PCAP) hotline. Technical assistance will be available to households who request it.

AHCCCS will mail notices to 20,000 households in two initial phases of 10,000 mailings each, one week apart. In addition to the notices, AHCCCS will also use email addresses it has on file as another mechanism to contact households on the waiting list notifying them that they can apply for KidsCare II. The timing of these emails will correspond to the date when the notices described above are mailed.

In the event that less than 5,000 applications have been received for KidsCare II after the first two mailings, AHCCCS will have the next batch of notices to 20,000 households ready to go within two weeks after the date of the first mailing as an “on-deck” approach. AHCCCS will also ensure that the corresponding group of emails is also ready to be sent in tandem with the regular mail notices. AHCCCS will, on a weekly basis, monitor the caseload size/take-up rate, and adjust the size and timing of future mailings accordingly. The size and frequency of future mailings (e.g., lower to 5,000 or maintain at 20,000) will be based on actual application return rate, approval rate, and attrition. Should enrollment in KidsCare II drop below 15,000 children, AHCCCS will prepare additional mailings and utilize the same approach as described above.

Once a household has applied for the KidsCare II program through the Health-e-Arizona system, applications will be routed to the Department of Economic Security (DES) for Medicaid and KidsCare II determination. These applications will, in turn, be routed directly to a centralized office for Health-e-Arizona for processing. DES also has its own customer support line where KidsCare II applicants can call to determine the status of their application, but DES will refer applicants to the AHCCCS call center in order to receive information with respect to whether they are on the KidsCare waiting list, and if they are included in one of the "active" notice batches, i.e., the caller will be able to inquire if AHCCCS had sent them a notice informing them that they are eligible to apply for the KidsCare II program.

AHCCCS/DES will conduct specialized training for Health-e-Arizona staff, the State-operated customer service staff, and AHCCCS Office of the Client Advocate to ensure appropriate understanding of the KidsCare II program so that staff can more effectively assist beneficiary and applicant inquiries.

**Community Outreach**

Letters will be sent to Health-e-Arizona subscribers (representing about 220 community groups and facilities statewide) to educate about the new KidsCare II program. Once CMS approval is obtained, special training will be conducted for Health-e-Arizona subscribers, and additional training will be provided to the public through an AHCCCS Community Forum. Information regarding eligibility and process of the KidsCare II program will be posted to the AHCCCS website.

A third-party hotline will be established by PCAP that will operate during extended business hours during the week for a limited period. The hotline will work in coordination with AHCCCS to provide information about the KidsCare II waitlist to families. AHCCCS will provide PCAP access to the KidsCare waiting list as well as information on the children that have been sent notices to apply for the KidsCare II program in a manner that ensures the protection of hotline callers' and waitlist families' personal information.

**Attachment I**

Reserved for Safety Net Care Pool Payment Protocol

**Attachment J**
Participating Providers in the SNCP

Hospital Uncompensated Care Cost Payments
- Phoenix Children's Hospital
- University Medical Center
- University Physicians Healthcare Hospital at Kino Campus
- Maricopa Medical Center

Federally Qualified Health Center Lookalike (FQHC-LA) Uncompensated Care Cost Payments
-

**Avondale Family Health Center**
950 E. Van Buren, Avondale 85323
623.344.6800

**El Mirage Family Health Center**
12428 W. Thunderbird, El Mirage 85335
623.344.6500

**Glendale Family Health Center**
5141 W. Lamar St., Glendale 85301
623.344.6700

**Maryvale Family Health Center**
4011 N. 51st Ave., Phoenix 85031
623.344.6900

**Chandler Family Health Center**
811 S. Hamilton, Chandler 85225
480.344.6100

**Guadalupe Family Health Center**
5825 E. Calle Guadalupe, Guadalupe 85283
480.344.6000

**Mesa Family Health Center**
59 S. Hibbert, Mesa 85210
480.344.6200

**Comprehensive Healthcare Center**
2525 E. Roosevelt St., Phoenix 85008
602.344.1015

**McDowell Healthcare Center**
1144 E. McDowell Rd., Phoenix 85006
602.344.6550

**7th Avenue Family Health Center**
1205 S. 7th Ave., Phoenix 85007
602.344.6600

**South Central Family Health Center**
33 W. Tamarisk St., Phoenix 85041
602.344.6400

**Sunnyslope Family Health Center**
934 W. Hatcher, Phoenix 85021
602.344.6300

**7th Avenue Walk In Clinic**
1201 S. 7th Ave.
Phoenix 85007
**Phone:** (602) 344-6655

Physician Professional Service Uncompensated Care Cost Payments

- Phoenix Children's Hospital
- Maricopa Medical Center
- University Physician's Healthcare

**Attachment K**

IHS and 638 Facilities Uncompensated Care Payment Methodologies

The two methodologies outlined below have been approved for structuring a payment that will be made to IHS and 638 facilities that take in to account their uncompensated costs in furnishing specified types of care furnished by IHS and tribal 638 facilities, to Medicaid-eligible individuals, and other individuals with net family income at or below 100 percent of the Federal poverty level (FPL).

Participating facilities must select one of the two possible options as described below in determining these payments to the facilities:

**Option 1 – Encounter Based Approach**

1. On a monthly basis, facilities will track services provided to individuals with net family income up to 100 percent of the FPL using the appropriate family size and income level limit as specified in the annual Federal Poverty Level tables issued by the U.S. Department of Health & Human Services. These services would include those that are no longer covered for Medicaid eligible individuals under the Arizona Medicaid State plan as well as services provided to individuals who are no longer Medicaid eligible, but under the 100 percent income threshold.
2. The facilities will utilize the attached tracking documents in Exhibits 1 – 3 to record the service provided, the unit of service, the all-inclusive rate, and if the service was provided to an American Indian/Alaskan Native (AI/AN) or to a non-native.
3. The facility will conduct a high-level income determination, which can include, but is not limited to self-attestation or the use of a recent pay stub.
4. The tracking document, along with the cover letter signed by the facility CEO or CFO facility director certifying that the information contained in the tracking document is accurate, will be sent to AHCCCS which will pay the facility the rate AHCCCS would have otherwise paid for the recorded services and draw down the correct FMAP based on the facility's breakdown of AI/AN versus non-native services.

**Option 2 – Historical Data Approach**

This approach is comprised of the following two steps that will be used to calculate the total dollar amount of uncompensated care that will be paid to IHS and 638 facilities on a prospective basis. The steps are as follows:

1) The State will calculate a per member per month (PMPM) rate for AI/AN childless adults enrolled in AHCCCS Acute Care Plan (AACP) using historical utilization data (July 1, 2010 through June 30, 2011) for the services that were furnished in or by IHS/tribal 638 facilities to the childless adult population (who are no longer covered under AHCCCS). This rate is multiplied by the total number of AI/AN childless adults that have been disenrolled from the program in that month since July 2011. This PMPM will be adjusted on an annual basis to mirror the medical inflation adjustment applied to the all-inclusive rate.

2) The State will calculate a second PMPM, using historical data, to reflect the services that it removed from the Medicaid State plan effective October 1, 2010, that were furnished in or by IHS/tribal 638 facilities to AHCCCS-enrolled individuals, and would multiply this rate by the total number of adult AI/ANs currently enrolled in the AHCCCS program. This PMPM will be adjusted on an annual basis to mirror the medical inflation adjustment applied to the all-inclusive rate.

Once this aggregate dollar amount has been computed using the steps 1 and 2 as outlined above, the State will disburse payments to the IHS and 638 facilities based on payments made to each facility for care provided to AI/AN childless adults from July 1, 2010 through June 30, 2011.

In addition, the State will annually review whether the PMPMs calculated in steps 1 and 2 above were accurate within a reasonable margin of error by comparing them to actual claims submitted under approach 1 by one or more facilities or, if no facilities elect approach 1, by reviewing actual records of services furnished by one or more facilities. If the PMPM is not validated, the State will apply an adjustment factor for the following year.

As part of this option, the non-Federal share for services provided to non-natives would be calculated based on the following.

1. After analyzing claims data from 2009-10, the State calculated a ratio of claims paid for currently covered Arizona Medicaid State plan services that were provided at IHS and 638 facilities to non-natives to the total number of paid claims to IHS and 638 facilities. Using this ratio, the State calculated that approximately $2 million out of total claims paid to IHS facilities was for services provided to non-natives. As such, the State will pay the non-Federal share of the $2 million. The State will review the claims data on an annual basis and will adjust the non-Federal share amount accordingly.
2. The State will apply the ratio that was calculated of non-native costs to total IHS costs as described above to calculate the non-Federal portion of the eligibility and service PMPM payments as described above.

**Calculation for Cost of Services to Persons Ineligible for AHCCCS**

| | |
|---|---|
| FY 2011 Total Paid | 90,000,000 |
| Average monthly membership | 22,996 |
| per member per month (pmpm) | $326 |

**Monthly Payment Calculation – Ineligible Individuals**

| | |
|---|---|
| March - Decrease in Native American Childless Adult coverage since Freeze | 9,391 |
| March Eligibility Payment (PMPM * 9,391) | $3,061,466 |

**Monthly Payment Calculation – Services**

| | |
|---|---|
| Adult Per Member Per Month Service Funding | $15.11 |
| Total Number of AI/AN Adults Enrolled with AHCCCS | 56,851 |
| May Services Payment | $859,018.61 |
| Total May Payment to I.H.S and 638 Facilities (Eligibility + Services) | $3,920,484.61 |
| Facility A - Allocation - 1% | $39,204.85 |
| Facility B - Allocation - 5% | $196,024.23 |

**Exhibit 1 to Attachment K**
**Option 1 Encounter Based Approach Cover Letter**

# Summary of the Monthly Report to AHCCCS for the Option 1 Supplemental Payment

Reporting Month: _____

Facility Name:_____

# of Adults under 100% FPL who are not Medicaid eligible to whom covered services was provided:

_____

# of visits that were provided to the above individuals for AHCCCS covered services:

_____

# of Medicaid individuals to whom services were provided that were eliminated from the Medicaid program in the 2010 & 2011 benefit reductions:

_____

# of visits that were provided to the Medicaid individuals for services that were eliminated from the Medicaid program in the 2010 & 2011 benefit reductions:

_____

I hereby attest that the information submitted is prepared in compliance with the Option 1 payment methodology Desk Level Procedures and is current, complete, and accurate to the best of my knowledge and belief. The expenditures included in this report are based on the accounting records of actual recorded expenditures, and are not based on estimates. I understand that payment of these claims will be from federal funds and whoever knowingly and willfully makes or causes to be made a false statement or representation on the reports may be prosecuted under the applicable federal and state laws.

CEO or CFO Signature:_____

**Exhibit 2 to Attachment K**
**Option 1 Encounter Based Approach Tracking Sheet**

The spreadsheet below will be used in tracking uncompensated care costs associated with services provided to individuals who have net family income up to 100 percent of the FPL, but are not enrolled in the AHCCCS program.

**Facility Name:** _____

| Name of Individual Receiving Services | Income verified | American Indian Y/N | Service Date | Service Provided | Inpatient or Outpatient | Service Rate | Patient Account Number |
|---|---|---|---|---|---|---|---|

DRAFT

**Exhibit 3 to Attachment K**
**Option 1 Encounter Based Approach Tracking Sheet**

The spreadsheet below will be used in tracking uncompensated care costs associated with services provided to AHCCCS beneficiaries that are no longer covered under the Arizona Medicaid State plan.

**Facility Name:** _____

| AHCCCS ID | American Indian Y/N | Service Date | Service Provided | Inpatient or Outpatient | Service Rate | Patient Account Number |
|---|---|---|---|---|---|---|

DRAFT