

H. Cost Sharing

Please check the cost sharing rules for all applicable eligibility categories in the chart below:

Eligibility Category	Nominal Amounts Per Regulation	Up to 5 Percent of Family Income	State Defined
Mandatory			
Optional – Existing (Children)			
Optional – Existing (Adults)			
Optional – Expansion (Children)			
Optional – Expansion (Adults)			
Title XXI – Medicaid Expansion			
Title XXI – Separate SCHIP			
Existing section 1115 Expansion			
New HIFA Expansion		✓ (See Attachment E)	

Cost-sharing for children

Only those cost-sharing amounts that can be attributed directly to the child (i.e. co-payments for the child's physician visits or prescription drugs) must be counted against the cap of up to five percent of family income. Cost-sharing amounts that are assessed to a family group that includes adults, such as family premiums, do not need to be counted as 'child cost-sharing' for the purposes of the up to five percent cost-sharing limit. A premium covering only the children in a family must be counted against the cap.

Below, please provide a brief description of the methodology that will be used to monitor child-only cost-sharing expenses when the child is covered as part of the entire family and how those expenses will be limited to up to five percent of the family's income.

Any State defined cost sharing must be described in Attachment E. In addition, if cost sharing limits will differ for participants in a premium assistance program or other private health insurance coverage option, the limits must be specified in detail in Attachment E to your proposal.

V. Accountability and Monitoring

Please provide information on the following areas:

1. Insurance Coverage

The rate of uninsurance in your State using the 1998 through 2000 Current Population Survey for individuals below 200 percent of poverty and any other groups that will be covered under the demonstration project.

See table on next page

The coverage rates in your State for the insurance categories for individuals below 200 percent of poverty and any other groups that will be covered under the demonstration project:

Private Health Insurance Coverage Under a Group Health Plan _____

Other Private Health Insurance Coverage _____

Medicaid (please separately identify enrollment in any section 1906 or section 1115 premium assistance)

SCHIP (please separately identify any premium assistance)

Medicare _____

Other Insurance _____

CPS Data Merge 1998 – 2000 (CYs 1997 – 1999)

	Total Population ¹		Total Adults ²		Adult Population ³			
	Percent	Estimated Number	Percent	Est. Number	With Kids		Without Kids	
					Percent	Est. Number	Percent	Est. Number
Those Less Than 100% FPL ⁴	23.6%	1,152,041	18.8%	631,864	23.3%	290,893	16.1%	340,902
Of Those Less Than 100% FPL ⁵ :								
The Percent of Uninsured	51.8%	596,988	46.3%	292,743	50.7%	147,599	42.6%	145,122
The Percent with <Medicaid	22.7%	261,283	14.3%	90,293	15.6%	45,467	13.1%	44,794
The Percent with Medicare	8.2%	94,237	14.9%	94,148	2.4%	6,836	25.6%	87,305
The Percent with Private Insurance	20.1%	231,560	31.2%	197,205	32.8%	95,384	29.9%	101,827
The Percent with Other Insurance	3.6%	41,934	4.2%	26,728	4.0%	11,723	4.4%	15,034
Those Between 100% and 200% FPL ⁶	21.2%	1,035,713	20.2%	677,598	22.9%	286,641	18.5%	390,960
Of Those Between 100% and 200% FPL ⁷ :								
The Percent of Uninsured	41.3%	427,542	28.7%	194,742	30.5%	87,425	27.5%	107,318
The Percent with Medicaid	10.3%	106,161	6.4%	43,298	6.6%	18,890	6.2%	24,396
The Percent with Medicare	16.9%	175,346	25.1%	170,145	4.2%	12,039	40.4%	158,104
The Percent with Private Insurance	36.6%	378,553	51.6%	349,708	58.2%	166,825	46.8%	182,891
The Percent with Other Insurance	9.3%	96,632	7.7%	52,243	11.8%	33,881	4.7%	18,375

Total Population (estimated): **4,887,745**
 Total Adults (estimated): **3,362,768**
 Total Adults with Kids (estimated): **1,250,615**
 Total Adults without Kids (estimated): **2,112,155**

- ¹ Total Population includes both children and adults
- ² Total Adults is a subset of the Total Population
- ³ Adult Population is a subset of Total Adults, broken out by Adults with Kids and Adults without Kids; The percentages are calculated based on two new population bases:

- Adults with Kids
- Adults without Kids

⁴ Those Less Than 100% FPL Represents the Following:

- Total Population Less Than 100% FPL
- Total Adults Less Than 100% FPL
- Adult Population subsets Total Adults by Adults with Kids and Adults without Kids

⁵ Of Those Less Than 100% FPL: Takes the population that is less than 100% FPL and categorizes it into the following:

- Uninsured
- Medicaid
- Medicare
- Private Insurance
- Other Insurance

Please note: The CPS numbers may not equal the CPS numbers on the Those Less Than 100% FPL line because an individual may have more than one type of insurance

⁶ Those Between 100% and 200% FPL Represents the Following:

- Total Population Between 100% and 200% FPL
- Total Adults Between 100% and 200% FPL
- Adult Population subsets Total Adults by Adults with Kids and Adults without Kids

⁷ Of Those Between 100% and 200% FPL: Takes the population that is Between 100% and 200% FPL and categorizes it into the following:

- Uninsured
- Medicaid
- Medicare
- Private Insurance
- Other Insurance

Please note: The CPS numbers may not equal the CPS numbers on the Those Between 100% and 200% FPL line because an individual may have more than one type of insurance

Indicate the data source used to collect the insurance information presented above (the State may use different data sources for different categories of coverage, as appropriate):

 Current Population Survey

 Other National Survey (please specify)

 State Survey (please specify)

 Administrative records (please specify)

 Other (please specify)

Adjustments were made to the Current Population Survey or another national survey.

Yes No

If yes, a description of the adjustments must be included in Attachment F.

A State survey was used.

Yes No

If yes, provide further details regarding the sample size of the survey and other important design features in Attachment F.

If a State survey is used, it must continue to be administered through the life of the demonstration so that the State will be able to evaluate the impact of the demonstration on coverage using comparable data.

2. State Coverage Goals and State Progress Reports

The goal of the HIFA demonstration is to reduce the uninsured rate. For example, if a State was providing Medicaid coverage to families, a coverage goal could be that the State expects the uninsured rate for families to decrease by 5 percent. Please specify the State's goal for reducing the uninsured rate:

Arizona's goal is to reduce the uninsured rate by 1%

Attachment F must include the State's Plan to track changes in the uninsured rate and trends in sources of insurance as listed above. States should monitor whether there are unintended consequences of the demonstration such as high levels of substitution of private coverage and major decreases in employer contribution levels. (See the attached Special Terms and Conditions.)

Annual progress reports will be submitted to CMS six months after the end of each demonstration year which provide the information described in this plan for monitoring the uninsured rate and trends in sources of insurance coverage.

States are encouraged to develop performance measures related to issues such as access to care, quality of services provided, preventative care, and enrollee satisfaction. The performance plan must be provided in Attachment F.

VI. PROGRAM COSTS

A requirement of HIFA demonstrations is that they not result in an increase in federal costs compared to costs in the absence of the demonstration. Please submit expenditure data as Attachment G to your proposal. For your convenience, a sample worksheet for submission of base year data is included as part of the application packet.

The base year will be trended forward according to one of the growth rates specified below. Please designate the preferred option:

_____ Medical Care Consumer Price Index, published by the Bureau of Labor Statistics. (Available at <http://istats.bls.gov>.) The Medical Care Consumer Price Index will only be offered to States proposing statewide demonstrations under the HIFA initiative. If the State chooses this option, it will not need to submit detailed historical data.

_____ Medicaid-specific growth rate. States choosing this option should submit five years of historical data for the eligibility groups included in the demonstration proposal for assessment by CMS staff, with quantified explanations of trend anomalies. A sample worksheet for submission of this information is included with this application package. The policy for trend rates in HIFA demonstrations is that trend rates are the lower of State specific history or the President's Budget Medicaid baseline for the eligibility groups covered by a State's proposal. This option will lengthen the review time for a State's HIFA proposal because of the data generation and assessment required to establish a State specific trend factor.

The State estimates the cost of this program will be \$144 million in Title XXI funds over its five year approval period.

VII. WAIVERS AND EXPENDITURE AUTHORITY REQUESTED

A. Waivers

The following waivers are requested pursuant to the authority of section **1115(a)(1)** of the Social Security Act (Please check all applicable):

Title XIX:

_____ **Statewide 1902(a)(1)**

To enable the State to phase in the operation of the demonstration.

_____ **Amount, Duration, and Scope ~~1902(a)(1)(B)~~**

To permit the provision of different benefit packages to different populations in the demonstration. Benefits (i.e., amount, duration and scope) may vary by individual based on eligibility category.

_____ **Freedom of Choice ~~1902(a)(23)~~**

To enable the State to restrict the choice of provider.

Title XXI:

_____ **Benefit Package Requirements 2103**

To permit the State to offer a benefit package that does not meet the requirements of section 2103.

_____ **Cost Sharing Requirements 2103(e)**

To permit the State to impose cost sharing in excess of statutory limits.

B. Expenditure Authority

Expenditure authority is requested under Section 1115(a)(2) of the Social Security Act to allow the following expenditures (which are not otherwise included as expenditures under Section 1903 or Section 2105) to be regarded as expenditures under the State's Title XIX or Title XXI plan.

Note: Checking the appropriate **box(es)** will allow the State to claim Federal Financial Participation for expenditures that otherwise would not be eligible for Federal match.

_____ Expenditures to provide services to populations not otherwise eligible to be covered under the Medicaid State Plan.

Expenditures related to providing _____ months of guaranteed eligibility to demonstration participants.

_____ Expenditures related to coverage of individuals for whom cost-sharing rules not otherwise allowable in the Medicaid program apply.

Title XXI:

_____ Expenditures to provide services to populations not otherwise eligible under a State child health plan.

_____ Expenditures related to providing an initial twelve months of guaranteed eligibility to demonstration participants.

_____ Expenditures that would not be payable because of the operation of the limitations at 2105(c)(2) because they are not for targeted low-income children.

If additional waivers or expenditure authority are desired, please include a detailed request and justification as Attachment H to the proposal.

VIII. ATTACHMENTS

Place check marks beside the attachments you are including with your application.

_____ Attachment A: Discussion of how the State will ensure that covering individuals above 200 percent of poverty under the waiver will not induce individuals with private health insurance coverage to drop their current coverage.

_____ Attachment B: Detailed description of expansion populations included in the demonstration.

Attachment C: **Benefit** package description.

Attachment D: Detailed description of private health insurance coverage options, including premium assistance if applicable.

Attachment E: Detailed discussion of cost sharing limits.

Attachment F: Additional detail regarding measuring progress toward reducing the rate of uninsurance.

Attachment G: Budget worksheets.

Attachment H: Additional waivers or expenditure authority request and justification.

IX. SIGNATURE

Date

Name of Authorizing State Official (Typed)

Signature of Authorizing State Official

Attachment C
Benefit Package

- ❑ Inpatient General Hospital Services
- ❑ Physician and Primary Care Physician and Practitioner Services
- ❑ Organ and Tissue Transplantation Services
- ci Dental Services
- ❑ Laboratory, Radiology, and Medical Imaging Services
- ❑ Pharmaceutical Services
- ❑ Emergency Medical Services
- o Transportation Services (Emergency and non-emergency)
- o Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices
- ❑ Health Risk Assessment and Screening Services
- o Other Medical Professional Services (dialysis, family planning services, certified nurse midwife services, podiatry services, respiratory therapy, ambulatory and outpatient surgery facilities services, home health services, private duty nursing services, rehabilitation services, total parenteral nutritional services, chemotherapy, and hospice)
- o Nursing Facility Services (90 days per contract year as alternative to hospitalization)
- ❑ Behavioral Health Services (inpatient services, partial care, outpatient services, emergency services, and case management)

ATTACHMENT D
PRIVATE HEALTH INSURANCE COVERAGE OPTIONS

EMPLOYER SPONSORED INSURANCE

AHCCCS will evaluate the feasibility of a pilot program for employer sponsored insurance (ESI) coverage. In the next several months, Arizona will evaluate the cost, benefit, and feasibility of conducting a pilot program that will allow Arizona to help **KidsCare** families with income up to 200% of the federal poverty level purchase employer sponsored insurance coverage. The state will develop a model based on the CMS' assurances that Arizona will have flexibility to design a program that is tailored for Arizona and is not hampered by many of the previous barriers in the SCHIP requirements for ESI.

The state envisions a model that allows AHCCCS to pay all or part the employee's share of the employer's health insurance coverage. Costs for the pilot will not be significantly higher in the aggregate than the costs would have been without the **ESI** pilot. AHCCCS will evaluate the aggregate costs based on the amount the state would have paid in a ~~capitation~~ payment. In no event will the total program cost for the entire HIFA Waiver exceed the allotment plus the state match available given the Waiver's funding priority system. As currently envisioned, there will be no wrap-around coverage provided to supplement **ESI** coverage and the state does not intend to supplement out-of-pocket costs for **ESI** enrollees.

As part of the cost benefit analysis and for administrative simplicity, AHCCCS will explore the feasibility of contracting with insurers in the pilot area that would participate in an electronic transfer of the subsidized premium from AHCCCS to the insurer.

AHCCCS will need more time to develop a model that can be evaluated based on cost effectiveness and the benefit to the employee and employer. Among the questions that must be explored are:

- ⚡ Who will participate in the pilot (e.g. Title XXI parent under the HIFA waiver, Title XXI children applying for **KidsCare**).
- ⚡ Will there be minimum or maximum coverage that the pilot will subsidize?
- ⚡ Can the pilot be designed to increase the number of insured rather than substituting an alternative funding source for coverage that already exists?
- ⦿ How should the pilot be structured? Some thoughts are by a geographic area or by employer.
- ⚡ Will a parent select **ESI** coverage if Title XXI coverage is available with lower out-of-pocket expenses? AHCCCS will need to evaluate whether offering choice would frustrate the purpose of the pilot, which is to test the viability of using **ESI** as a vehicle to increase the insurance coverage percentage within the state.

We expect that by March 1, 2002, AHCCCS will complete our evaluation and advise CMS about our findings and the feasibility of implementing an **ESI** pilot on or after October 1, 2002.

Attachment E
Cost Sharing Limits

All members will be responsible for a \$5.00 copayment for non emergency use of the emergency room. There will also be a small monthly premium for families with income greater than 150% of FPL. See chart below. A family's premium will not exceed \$25 per month.

Families will be advised that total cost sharing (copayments and premiums) cannot exceed 5% of the family's income. Families will be advised to contact AHCCCS if total cost sharing will exceed 5%. Upon notification, AHCCCS will make changes to the system to stop the imposition of monthly premiums and advise the family that they do not have to pay the \$5.00 copayment if they use the emergency room for a non-emergency condition. Although AHCCCS will have safeguards in place to ensure that families do not pay more than the 5% limit, given the low copayments and premiums, the agency believes that this will not be an issue.

Percent of FPL	Premium		
	1 Eligible Child	More than 1 Eligible Child	Entire Family
150% to 175%	\$10	\$15	\$20
175% to 200%	\$15	\$20	\$25

Attachment F
Additional Detail Regarding Measuring Progress Toward Reducing the Rate of Uninsurance

AHCCCS used CPS data to determine the coverage rates provided in Section V. Adjustments made to the data include:

1. The redefinition of “family” to meet AHCCCS eligibility requirements as opposed to the CPS which uses the Census definition. Census defines a family as a group of two or more people related by birth, marriage, or adoption as one family. For example, for Medicaid and this waiver, in a situation where a married couple are living with their parents, AHCCCS defines the son and the wife as one family separate from the parents.
2. The HHS poverty guidelines were used to determine poverty level rather than the Census Bureau poverty thresholds used in the CPS
3. Three years of CPS data were pooled, excluding re-interviews, rather than taking the average of three years of CPS estimates.
4. AHCCCS defines children as those 18 years of age and/or 19 and still in school. Census defines everyone less than or equal to 17 as a child.
5. AHCCCS provides for a \$90 earned income credit, Census does not.
6. Census excludes secondary individuals who are less than or equal to 15 (foster children). AHCCCS includes this population.

AHCCCS will track changes in the uninsured rate and trends in the source of coverage using unadjusted CPS data. As part of the first report to CMS AHCCCS will establish a baseline using unadjusted CPS data.

In addition, AHCCCS will measure performance related to access to care, quality of services, preventive care, and enrollment satisfaction. With the support of CMS, AHCCCS began a major Quality Improvement Initiative in 1995. The health plans and members participating in this demonstration will be included in this initiative, but there will not be separate reports for this group. The major components of the initiative are quality indicators, financial indicators, member satisfaction surveys, and provider satisfaction surveys. The quality indicators were defined using HEDIS 3.0 as a guide and include acute care utilization reports and behavioral health indicators. The member and provider satisfaction surveys provide valuable information on access to care, communication between members and providers, and member and provider perception regarding quality of care.

Reducing the Number of Uninsured Children and Adults

The state plans to reduce the uninsured rate by 5% by year 2003 for childless adults. As of the merged CPS sample for 1998 to 2000, the uninsured rate for childless adults under 100% of the FPL was 42.6%.

The state plans to reduce the uninsured rate by 5% by year 2005 for parents of Medicaid and SCHIP children. As of the merged CPS sample for 1998 to 2000, the uninsured rate for parents ~~100-200%~~ FPL was 30.5%.

The state plans to reduce the uninsured rate for children eligible for SCHIP by approximately ~~35-40%~~ by July 1, 2003. The merged CPS sample for 1998 to 2000 for

uninsured children between 100% to 200% of the FPL was 19% of the total population. The HIFA Amendment that enables the state to begin covering adults as of October 1, 2002 should enable the state to reduce the number of uninsured children by another 1-2%.

As a result of the HIFA amendment, the State overall uninsured rate, which is 22.3% as of the merged CPS sample for 1998 to 2000, will decrease by 1% by year 2005.