Arizona Demonstration Renewal Proposal

(2021-2026)

Contents

I. SUMMARY

The Arizona Health Care Cost Containment System (AHCCCS) is requesting a five-year renewal of Arizona's Demonstration project under Section 1115 of the Social Security Act. Arizona's existing Demonstration project is currently approved through September 30, 2021, and the application is seeking a renewal period from October 1, 2021 through September 30, 2026.

Arizona's Medicaid agency, AHCCCS, has long been a leader in health care innovation, serving its members through the creative and effective use of managed care delivery systems. Since its inception, AHCCCS has operated its program under a Section 1115 Demonstration project, which must be renewed every five years. The State's current Demonstration exempts Arizona from particular provisions of the Social Security Act and also includes expenditure authority permitting federal financial participation (FFP) for State expenditures that would not otherwise qualify for federal participation. Moreover, Demonstration projects, including Arizona's, must establish budget neutrality where Medicaid costs to the federal government are not expected to exceed costs to the federal government in the absence of the Demonstration.

The Centers for Medicare and Medicaid Services' (CMS) approval of Arizona's Demonstration renewal application will continue the success of Arizona's unique Medicaid program and statewide managed care model, extending authority for Arizona to implement programs including, but not limited to:

- Mandatory managed care
- Home and community-based services for individuals in the Arizona Long Term Care System (ALTCS)
- Administrative simplifications that reduce inefficiencies in eligibility determination
- Integrated health plans for AHCCCS members
- Payments to providers participating in the Targeted Investments Program
- AHCCCS Works
- Waiver of Prior Quarter Coverage for specific populations

In addition to renewing current waiver and expenditure authorities, AHCCCS is seeking to implement the following:

- Authority to allow for verbal consent in lieu of written signature for up to 30 days for all care and treatment documentation for ALTCS members when included in the member's record and when identity can be reliably established.
- Authority to reimburse traditional healing services provided in, at, or as part of services offered by facilities and clinics operated by the Indian Health Service (IHS), a tribe or tribal organization, or an Urban Indian health program.
- Authority to reimburse Indian Health Services and Tribal 638 facilities to cover the cost of adult dental services that are eligible for 100 percent FFP, that are in excess of the $1,000 emergency dental limit for adult members in Arizona's State Plan and the $1,000 dental limit for individuals age 21 or older enrolled in the ALTCS program.

II. AHCCCS DEMONSTRATION HISTORICAL BACKGROUND

Arizona has operated a Section 1115 Demonstration project for the last 38 years. Throughout that time, AHCCCS has learned that, just as populations change, a Medicaid managed care program is most effective when it continually evolves and innovates. Arizona routinely seeks opportunities to refine, modernize, and streamline its Demonstration. The result is a Medicaid managed care operation that strives to build upon past successes to improve health outcomes for its members and ensures its long-term sustainability.

THE INCEPTION OF ARIZONA'S DEMONSTRATION: MANAGED CARE & LONG TERM CARE DEMONSTRATIONS

Since 1982, AHCCCS has been delivering high-quality, cost-effective health care services to Arizonans. The State of Arizona has the unique distinction of being the first state to operate under a statewide managed care Demonstration, and the only state to have done so from the start of its Medicaid program. This public-private,

managed care partnership ensures that members receive high-quality care while at the same time maximizing efficiency and containing costs.

Arizona's initial Demonstration allowed it to operate a statewide managed care system that covered only acute care services and 90 days of post-hospital skilled nursing facility coverage. This program continues to operate under Arizona's Demonstration today, referred to as the AHCCCS Acute Care program (AACP).

AHCCCS established two special programs within AACP to serve children with special needs: the Comprehensive Medical and Dental Program (CMDP), which provides health care services to Arizona's children in foster care under a capitation arrangement with the Arizona Department of Child Safety (DCS); and the Children's Rehabilitative Services (CRS) program which provides health care services for children with qualifying CRS conditions pursuant to ARS 36-261 et seq.

In 1988, six years after implementation, the original Demonstration was substantially amended to allow Arizona to implement ALTCS, a long term care program for individuals who are elderly and/or have physical disabilities and individuals with intellectual disabilities. The ALTCS program provides acute care, behavioral health, and long term care services and supports, including home and community based services (HCBS), to Medicaid members who are at risk of institutionalization.

ALTCS is a managed care program administered separately from AACP that provides program services through prepaid, capitated arrangements with managed care organizations (MCOs). ALTCS members with intellectual disabilities are served through a statewide MCO operated by the Arizona Department of Economic Security (DES), Division of Developmental Disabilities (DDD). The ALTCS program strives to ensure that members are living in the least restrictive and most integrated settings possible, and are actively engaged and participating in community life. Over the past 32 years, the ALTCS Demonstration has achieved remarkable success in increasing member placement in HCBS, resulting in significant program savings while also meeting the needs of members.

A 1987 federal evaluation concluded that the AHCCCS managed care program provided health care services with equal or superior access, quality, and member satisfaction, as well as lower costs, as compared to the more common fee-for-service model. Importantly, this evaluation supported innovative development in other states modeled on Arizona's success.[1]

Evaluations have also shown that AHCCCS managed care program costs (excluding ALTCS) were seven percent less per year, and costs to cover members enrolled in ALTCS were 16 percent less per year, as compared to a traditional fee-for-service Medicaid program.[2]

Arizona continues to lead the nation in operating a cost effective managed care model. In fact, Arizona's Medicaid program has one of the lowest per-enrollee costs among states at only $6,411 per-enrollee compared with the national average of $7,794 per-enrollee.[3]

EXPANSION OF BEHAVIORAL HEALTH SERVICES & MEDICAID POPULATION COVERAGE

In 1990, AHCCCS began phasing in comprehensive behavioral health services, starting with children determined to have a serious emotional disturbance (SED) under the age of 18 who required residential care. Over the next five years, other populations were added, including children who are non-SED in 1991, individuals with a serious mental illness (SMI) designation in 1992, and adults needing general mental health and/or substance use services in 1995. The State contracted with an MCO that operated a separate system of care for the treatment of behavioral health conditions instead of "carving-in" those services in the benefit plan administered by the acute

[1] McCall, N. (1997). Lessons From Arizona's Medicaid Managed Care Program. Health Affairs, 16(4), 194–199. https://doi.org/10.1377/hlthaff.16.4.194; United States General Accounting Office (GAO). (1995). Arizona Medicaid Competition Among Managed Care Plans Lowers Program Costs. https://www.govinfo.gov/content/pkg/GAOREPORTS-HEHS-96-2/pdf/GAOREPORTS-HEHS-96-2.pdf

[2] McCall, N., Wrightson, C. W., Korb, J., Crane, M., & Weissert, W. (1996). Evaluation of Arizona's Health Care Cost Containment System Demonstration—Final Report. Laguna Research Associates.

[3] AHCCCS Presentation for the Arizona State Legislature Appropriations Committee. (2020). [Slides]. Arizona State Legislature. https://www.azleg.gov/jlbc/21axsagypres.pdf

health plans. At the time, the behavioral health advocacy community preferred this separate, non-integrated approach.

The Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (DBHS), a separate state agency, contracted with AHCCCS to act as an MCO to manage behavioral health services. ADHS/DBHS established subcapitated managed care contracts with behavioral health organizations, known as Regional Behavioral Health Authorities (RBHAs), that were responsible for delivering behavioral health services for the majority of AHCCCS members. DBHS merged with AHCCCS effective July 1, 2016 and today AHCCCS administers both physical and behavioral health services.

Subsequent to the behavioral health service expansions, AHCCCS added two major population groups to the program. In 1998, Arizona implemented a separate Children's Health Insurance Program (CHIP) authorized under Title XXI of the Social Security Act, known in Arizona as "KidsCare." This program covers children under age 19 whose family's employment income is below 200 percent of the Federal Poverty Level (FPL) and who do not qualify for other AHCCCS programs. Arizona voter-approved Proposition 204 populations were added to Arizona's Demonstration in 2001. These populations included the following Medicaid-eligible individuals whose income is below 100 percent of the FPL: adults without dependent children ("childless adults"); parents and caretaker relatives; and Supplemental Security Income populations.

THE EFFECTS OF THE GREAT RECESSION ON ARIZONA'S DEMONSTRATION

In 2008, the nation experienced a significant economic recession that had a far-reaching and lasting effect on Arizona's economy. The rapid growth of the Medicaid program, coupled with revenue declines, placed a tremendous strain on the State's General Fund. Consequently, the Arizona legislature made cuts of 21.7 percent to the AHCCCS budget for State Fiscal Year (SFY) 2012. This was the largest Medicaid budget reduction nationally and was more than twice that of the next highest state cut. In response to the reductions in funding, AHCCCS implemented the following programmatic changes:

- **Elimination of HIFA:** AHCCCS eliminated the Health Insurance For Parents (HIFA) program on October 1, 2009. This program typically covered parents of KidsCare children who had income between 100 percent and 200 percent of the FPL.

- **KidsCare Enrollment Freeze:** Due to insufficient state funds available for the state match, new enrollment in the KidsCare program was frozen. Existing members could continue on the program. Spanning from January 1, 2010, to August 31, 2016, enrollment totals dropped from 45,820 children to 528 children due to this freeze. In 2016, Governor Doug Ducey signed SB 1457, restoring KidsCare coverage effective September 1, 2016. As of January 1, 2020, there were 35,764 children enrolled in the KidsCare Program.

- **Proposition 204 AHCCCS Enrollment Freeze:** In 2011, the Arizona Legislature passed, and the Governor signed, a budget that froze AHCCCS enrollment for the Proposition 204 population. On March 31, 2011, AHCCCS requested to implement an enrollment freeze for the childless adult population. On July 1, 2011, CMS approved the state's phase-out plans for that population. Spanning from July 1, 2011, to December 31, 2013, enrollment totals dropped from 230,123 members to 67,770 members due to this freeze. In 2013, the Arizona legislature voted to adopt Governor Brewer's Medicaid Restoration and Expansion Plan, which restored coverage for the Proposition 204 population and expanded coverage to the new adult group under the Affordable Care Act (ACA) effective January 1, 2014. The State's restoration and expansion of Medicaid has extended coverage to approximately 400,000 Arizonans (enrollment as of January 1, 2020); 330,330 in the Proposition 204 population and 74,980 in the Expansion Adult population).

- **Copay Implementation:** AHCCCS received waiver authority to implement mandatory copay requirements for childless adult members in 2011. This Demonstration authority expired in 2013. Furthermore, through

a State Plan Amendment (SPA), AHCCCS implemented cost sharing for certain populations as authorized under the Deficit Reduction Act (DRA) (§§ 1916 and 1916A of the Social Security Act) as of July 1, 2010.

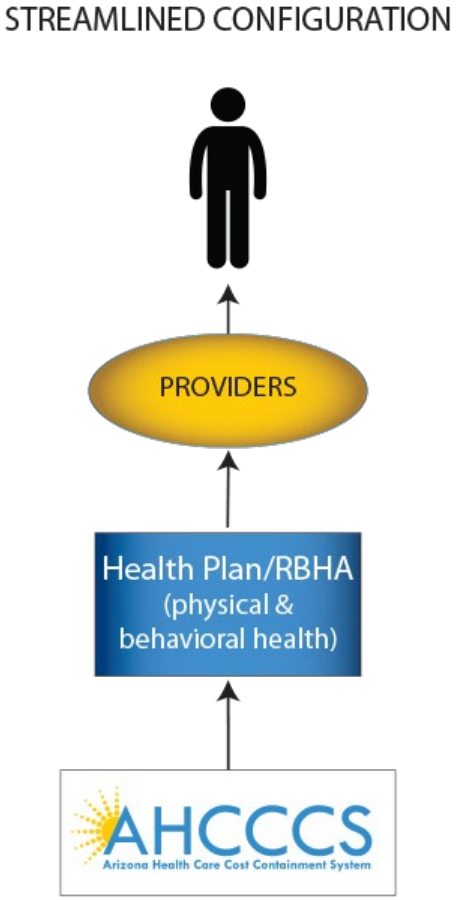
- **Safety Net Care Pool (SNCP):** In April 2012, CMS approved the Safety Net Care Pool (SNCP) designed to help hospitals manage the burden of uncompensated care costs. Many hospitals across the state participated in SNCP, and the program proved to be incredibly valuable during the economic recession. The SNCP program ended for most hospitals on December 31, 2013, as result of the State's restoration and expansion of childless adult coverage. However, SNCP was extended to address issues unique to freestanding children's hospitals that did not benefit from adult coverage restoration and expansion. This waiver authority expired on January 1, 2018.

- **Indian Health Service and Tribal-638 Facilities Uncompensated Care Payment**: On April 6, 2012, CMS granted AHCCCS the authority to make supplemental payment to IHS and 638 facilities to address the fiscal burden of uncompensated care for services provided by such facilities to Medicaid-eligible adults.

ARIZONA'S INITIATIVES TO INTEGRATE PHYSICAL AND BEHAVIORAL HEALTH SERVICES

Perhaps the most transformational initiative AHCCCS has undertaken in its history is integrating physical and behavioral health services under the same MCO in order to enhance care management and quality of care across the entire continuum of care. Supported by evidence of integration's benefits (including whole-person care, increased care coordination, simplifying a complex health care system for members and providers, and ultimately, improved health outcomes), AHCCCS has engaged in a multi-year effort to reduce delivery system fragmentation at all levels.

Figure 1



Historically, most AHCCCS members received behavioral health services through the RBHAs. Physical health and medical care were delivered by separate MCOs (known as acute plans). Through a strategic, incremental process, AHCCCS integrated care for its members under the same MCO, beginning with children with qualifying CRS conditions. In 2013, CMS approved Arizona's waiver amendment request to create a single, statewide integrated health plan contract to oversee all physical health, behavioral health, and specialty services for children with special health care needs enrolled in the CRS program.

Subsequently, CMS approved Arizona's waiver amendment request to establish an integrated RBHA, the first model nationwide to bring physical health, behavioral health, and social support services together in one plan for individuals with a SMI designation. The model was first launched in Maricopa County in 2014, and expanded to the balance of the State in 2015. Early studies illustrate how this integration has led to improvements in health outcomes for members with SMI. For example, an independent study conducted by Mercer determined that over 75 percent of the program indicators demonstrated improvement during the post-integration period when compared to the pre-integration period for members in Maricopa County. The study showed that all measures of ambulatory care, preventive care, and chronic disease management improved, with two measures related to medication maintenance compliance for asthma both increasing by more than 30 percent.[4] Another study conducted by NORC at the University of Chicago demonstrated that members with SMI enrolled in Mercy Maricopa Integrated Care (MMIC), who were also receiving supportive housing services,

[4] Mercer. (2018). Independent Evaluation of Arizona's Integration Efforts. https://www.azahcccs.gov/shared/Downloads/News/CRS_SMI_IndependentEvaluationReport_11_27_18.pdf

experienced a 20 percent reduction in psychiatric hospitalizations, with a 24 percent decrease in total cost of care, with savings driven by reductions in behavioral health costs.[5]

At the provider level, AHCCCS has supported integration through a number of initiatives. Most notably, AHCCCS launched the Targeted Investments (TI) Program to advance integration, investing $300 million over five years to support provider-level efforts to develop the systems required to deliver integrated care. CMS approved the TI Program under Arizona's Demonstration in 2017. The goals of TI Program are to reduce fragmentation that occurs between acute care and behavioral health care, increase efficiencies in service delivery for members with behavioral health needs, and improve health outcomes for adults and children with behavioral health needs and individuals transitioning from incarceration. Participating TI Program providers receive payments for completing core components and milestones through year three, and then become eligible to receive performance-based payments through year five based on quality measures for specific populations.

Overall, the TI Program has been an important catalyst for breaking down silos between a broad range of provider types. Through the TI Program, AHCCCS incentivized the establishment of co-located, integrated clinics where behavioral and physical health providers and county probation offices deliver services to justice-involved individuals. This is a critical foundational step to ensure that individuals transitioning into the community from incarceration have immediate access to health care including substance use and behavioral health services. Furthermore, the TI Program requirement prompting behavioral health providers to identify physical health concerns and to effectively connect the member to appropriate physical health care has forged new relationships and workflows between behavioral health and physical health providers.

The changes in Arizona's Medicaid delivery system over the past decade paved the way for AHCCCS Complete Care (ACC), the program's largest integration accomplishment to date. On October 1, 2018, AHCCCS transitioned 1.5 million members into seven ACC plans that provide integrated physical and behavioral health care services. By joining physical and behavioral health services under single plans with their own networks of providers who treat all aspects of health care needs, providers are more able to facilitate care coordination and achieve better health outcomes.

AHCCCS continued the journey towards managed care integration when physical and behavioral health services were integrated under one health plan for members with intellectual disabilities. DES/DDD awarded new subcontracts to MCOs, called "DDD Health Plans," effective October 1, 2019. These DDD Health Plans offer eligible members physical and behavioral health services, specialty services for children with CRS conditions, and limited long term services and supports including nursing facility care, and emergency alert system services, and habilitative physical therapy. All other long term services and supports will continue to be provided directly by DES/DDD.

The next step in Arizona's move towards integration will focus on foster children enrolled in CMDP. AHCCCS will integrate behavioral health coverage into the CMDP health plan to further simplify health care coverage and encourage better care coordination for foster children. CMDP awarded a subcontract to an MCO effective April 1, 2021. The single subcontracted health plan will work in coordination with CMDP to provide integrated physical and behavioral health services, including specialty services for children with CRS conditions, to members enrolled with CMDP.

Information regarding Arizona's future Demonstration evaluation goals are discussed in more detail in Section VI.

[5] NORC at the University of Chicago. (2017). *Case Study: Supportive Service Expansion for Individuals with Serious Mental Illness: A Case Study of Mercy Maricopa Integrated Care*. https://www.mercycareaz.org/assets/pdf/news/NORC-MercyMaricopa-CaseStudy.pdf

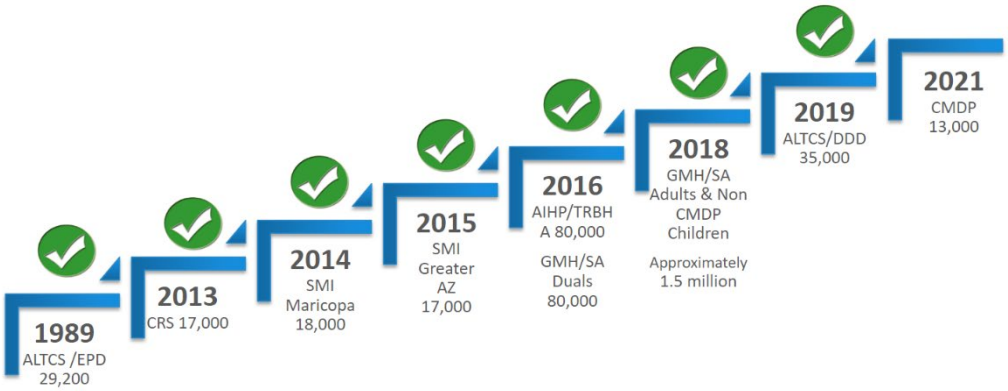


Figure 2: Integration Process to Date

AHCCCS WORKS: ARIZONA'S COMMUNITY ENGAGEMENT PROGRAM

In 2019, CMS approved Arizona's waiver amendment request to implement community engagement requirements for able-bodied adult members who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (henceforth referred to as the "Group VIII" population, individuals with income at or below 133% of the FPL who do not qualify for Medicaid in any other category). The AHCCCS Works program's objective is to increase employment, employment opportunities, and activities that enhance employability, increase financial independence, and improve health outcomes of AHCCCS members.

The AHCCCS Works program requires able-bodied members between the ages of 19 and 49 who do not qualify for an exemption to meet the following activities or combination of activities for at least 80 hours per month: be employed, actively seeking employment, attending school (less than full time), participating in other employment readiness activities (i.e. job skills training, life skills training, and health education), and/or engaging in community service. To ease the burden on members to report qualifying income, AHCCCS will use available systems and data sources to determine whether a member receives earned income that is consistent with being employed or self-employed for at least 80 hours per month at the state minimum wage. Members who have earned income consistent with being employed or self-employed for at least 80 hours a month at the state minimum wage will not be required to report compliance on a monthly basis. In cases where the State is unable to locate earned income data through available systems and data sources, members will be able to attest to compliance through an AHCCCS online portal, by phone, by mail, and in person.

On October 17, 2019, AHCCCS informed CMS of Arizona's decision to postpone implementation of AHCCCS Works until further notice. This decision was informed by the evolving national landscape concerning Medicaid community engagement programs and ongoing related litigation.

OTHER PERSONAL RESPONSIBILITY INITIATIVES IN ARIZONA'S DEMONSTRATION

In 2016, CMS approved Arizona's request to implement AHCCCS CARE (Choice, Accountability, Responsivity, Engagement), a program designed to engage adult members with incomes over 100 percent FPL to improve health literacy and prepare for a transition into private health coverage. Under this initiative, members would be required to pay monthly premiums and strategic coinsurances applied retrospectively for services already received. AHCCCS CARE would also provide certain incentives for timely payment of these monthly contributions and completion of healthy targets. AHCCCS did not implement the AHCCCS CARE program during the current waiver period, and is requesting this program to be discontinued from Arizona's Demonstration.

On January 18, 2019, CMS approved Arizona's waiver amendment request to limit retroactive coverage to the month of application for all Medicaid members, except for pregnant women, women who are 60 days or less postpartum, and children under 19 years of age. Under this amendment, Arizona is evaluating whether waiving

retroactive coverage for certain groups of Medicaid members encourages them to obtain and maintain health coverage, even when healthy. The State will also evaluate whether this policy encourages individuals to apply for Medicaid expeditiously when they believe they meet the criteria for eligibility for programs such as ALTCS. The State is also evaluating whether the new policy increases continuity of care by reducing gaps in coverage that can occur when members move on and off Medicaid or enroll in Medicaid only when sick, and facilitates receipt of preventive services when members are healthy. Furthermore, the State is evaluating the financial impacts of the waiver of retroactive eligibility. The effective date for the implementation of retroactive coverage changes was July 1, 2019.

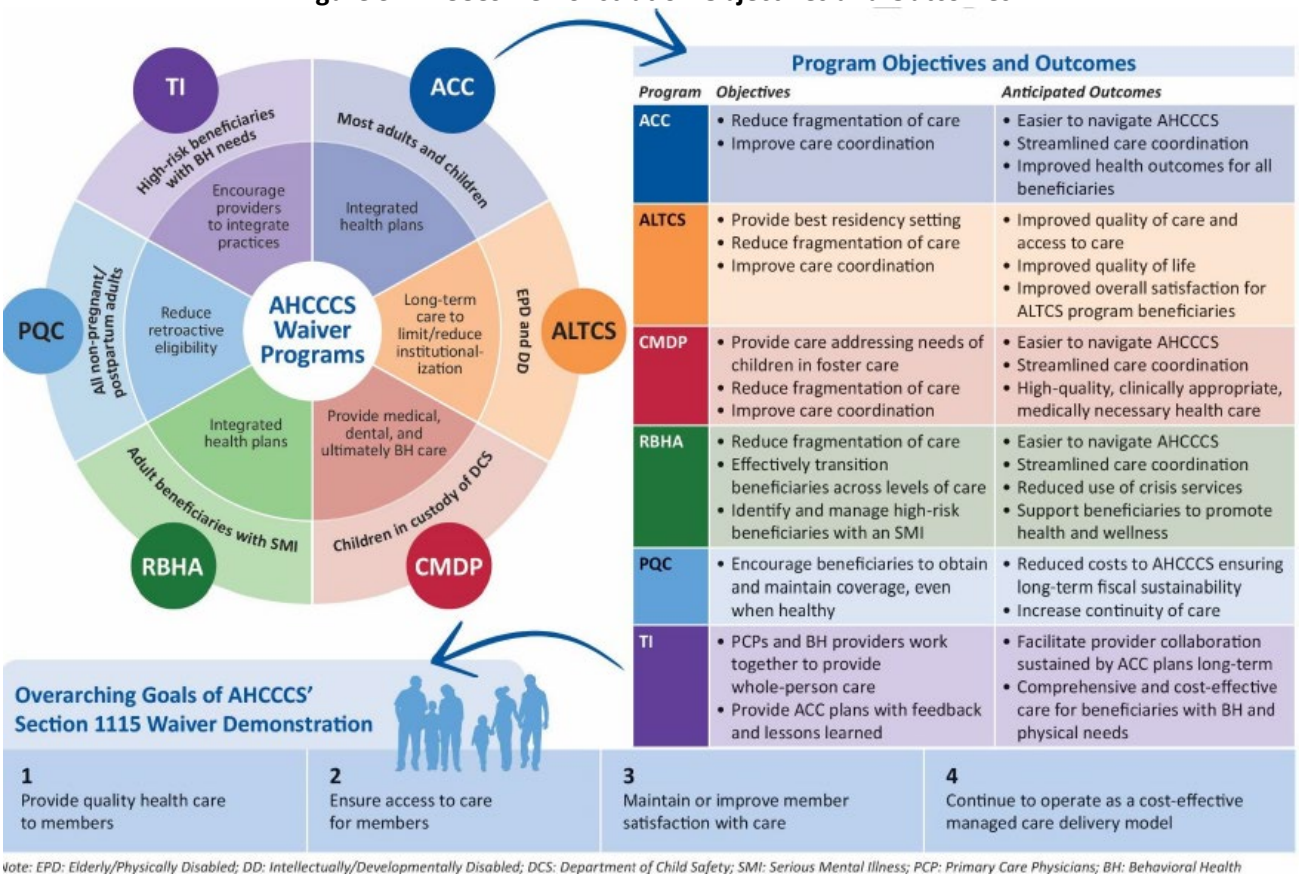
III. CURRENT DEMONSTRATION GOALS, OBJECTIVES & EVALUATION

Arizona's Demonstration strives to provide, through the employment of a managed care model, quality health care services to members while at the same time achieving cost efficiencies. Specific goals for Arizona's Demonstration are:

- Providing quality healthcare to members
- Ensuring access to care for members
- Maintaining or improving member satisfaction with care
- Continuing to operate as a cost-effective managed care delivery model within the predicted budgetary expectations

In order to evaluate the effectiveness and success of Arizona's Demonstration and to identify future opportunities for improvement, AHCCCS contracted with Health Services Advisory Group (HSAG) to conduct an independent evaluation. This evaluation was designed to meet the Special Terms and Conditions (STCs) of Arizona's current 1115 Demonstration, including testing specific hypotheses and performance measures that evaluate the following Demonstration programs: ACC, ALTCS, CMDP, RBHA, TI Program, and Waiver of Prior Quarter Coverage. The key objectives and anticipated outcomes for each Demonstration program are described in Figure 3 below.

Figure 3: AHCCCS Demonstration Objectives and Outcomes



Note: EPD: Elderly/Physically Disabled; DD: Intellectually/Developmentally Disabled; DCS: Department of Child Safety; SMI: Serious Mental Illness; PCP: Primary Care Physicians; BH: Behavioral Health

Demonstration Evaluation Deliverables & Activities

Arizona's Demonstration evaluation consists of the three components: evaluation design, interim evaluation, and summative evaluation.

EVALUATION DESIGN

Arizona's evaluation design plans discuss the goals, objectives, and specific testable hypotheses, including those that focus on target populations for the Demonstration; methodology that will be used for testing the hypotheses; and how the effects of the Demonstration will be isolated from other changes occurring in the State.
On November 13, 2019, HSAG submitted an evaluation design plan to CMS for Arizona's Demonstration components (ACC, ALTCS, CMDP, RBHA, TI Program, and Waiver of Prior Quarter Coverage). Additionally, HSAG developed and submitted a separate evaluation design plan to CMS for the AHCCCS Works program. Arizona intends to use this design plan to guide the evaluation of the AHCCCS Works program upon the implementation of the community engagement requirements. Arizona's evaluation design plans were approved by CMS on November 19, 2020

Since Arizona has not implemented the AHCCCS CARE program during the current waiver period, and does not intend to include this program in this Demonstration renewal request, no evaluation design plan has been drafted or submitted to CMS for this program.

INTERIM EVALUATION

As required by the STCs of Arizona's approved Demonstration, an interim evaluation report must be submitted that discusses the evaluation progress and findings to date. This interim report must be submitted in conjunction with Arizona's Demonstration renewal application.

Due to limitations in the availability of data and operational constraints imposed by the 2019 novel coronavirus (COVID-19) pandemic, Arizona's interim evaluation report does not include data from all sources described in Arizona's evaluation design plan. Qualitative data based on key informant interviews and focus groups, as well as beneficiary survey data, was not collected as the timing of the COVID-19 pandemic presented significant challenges in safely collecting qualitative data.

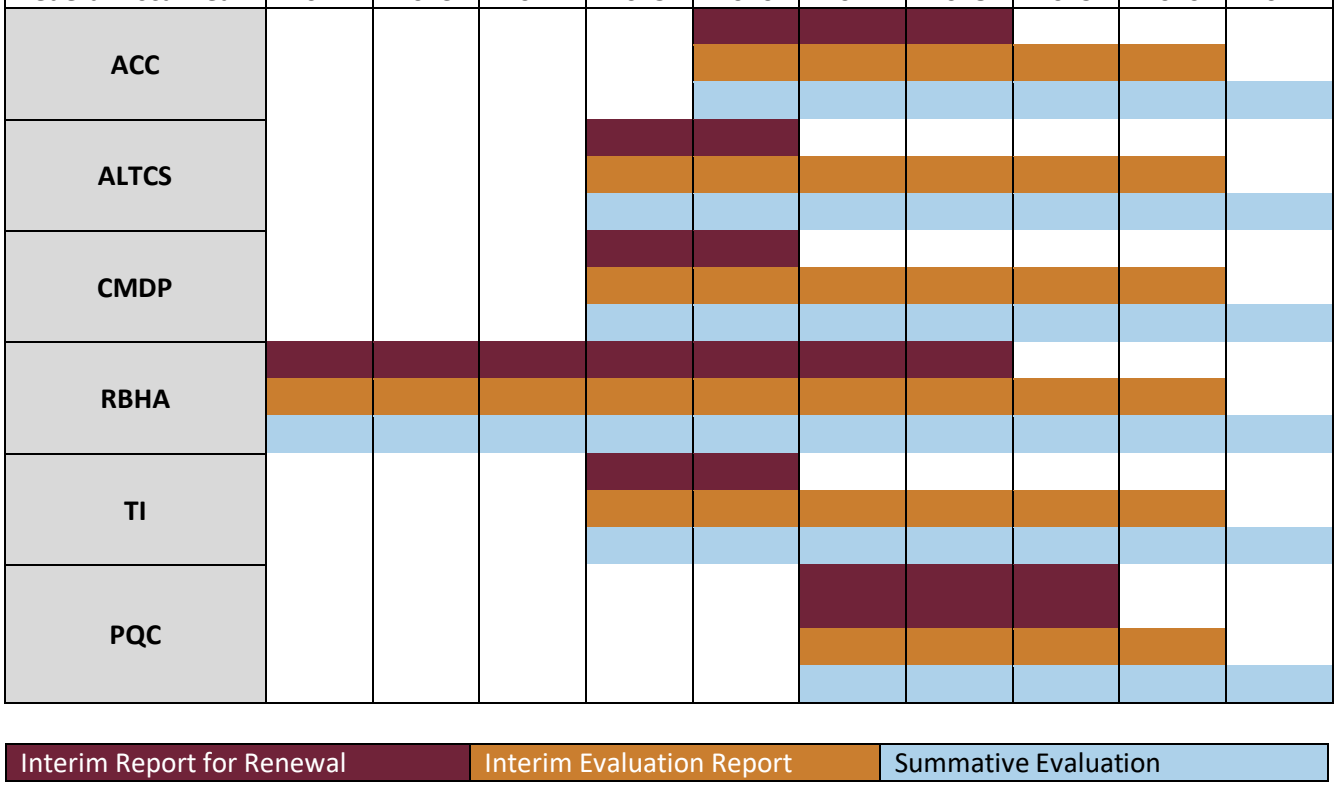
Accordingly, Arizona's interim evaluation report only includes results for a limited set of baseline performance measures across all six Demonstration components. The rates presented in this interim evaluation report primarily cover the baseline years prior to the implementation of ACC, ALTCS-DD, and CMDP integrated health plans. Furthermore, this report only includes the baseline performance rates for the Waiver of Prior Quarter Coverage and TI Program. Therefore, the results presented in the interim evaluation report should be interpreted as descriptions of baseline performance only, and not as an evaluation of program performance. Even for the RBHA integration evaluation, robust statistical methods such as interrupted time series have not been applied, which prevents causal conclusions.

For this reason, an updated interim evaluation report will be completed by HSAG in the summer of 2021. This report will contain results for additional years and include findings to date from focus groups and qualitative interviews. In addition, the updated interim evaluation report will use statistical techniques, where possible, in order to control for confounding factors and identify the impact of Arizona's Demonstration initiatives on access to care, quality of care, and member experience with care. AHCCCS intends to post the updated interim evaluation report to its website for public comment

SUMMATIVE EVALUATION

Arizona will develop and submit to CMS a summative evaluation report within 18 months of the end of the current Demonstration period (no later than February 12, 2023), with the full results of all measures described in the evaluation design plan. Figure 4 illustrates the years covered by the interim and summative evaluation reports.

Figure 4: Time Periods Covered By Interim & Summative Evaluations Reports



Summary of Interim Evaluation Findings

This section summarizes the main interim evaluation findings (see Appendix A) for the ACC, ALTCS, CMDP, RBHA, TI Program, and Waiver of Prior Quarter Coverage Demonstrations. As described previously, the performance rates presented in the interim evaluation report have not been analyzed using the statistical methods described in the evaluation design plan. Therefore, no conclusions can be drawn at this point from these results. An updated interim evaluation report will be completed by HSAG in 2021 which will include results for additional years and will use robust statistical methods to assess the impact of the six Demonstration programs on member outcomes, quality, and access to care.

ACC Evaluation Findings

The interim report assesses member health care outcomes prior to the implementation of ACC.

Rates for adults who accessed a primary care provider (PCP) remained mostly unchanged throughout the baseline period, at around 77 percent. The rate of child and adolescent PCP visits remained steady during the baseline period with little change between 2017 and 2018, declining by only an average of 0.8 percent per year. The rate of child dental visits remained largely unchanged during the baseline period, increasing by 0.9 percent (Fig. 5).

Figure 5: Utilization Of Primary Care Services Prior To ACC Implementation

	Weighted Rate[1]			Average Relative Rate Change[2]
	2016	2017	2018	
Percentage of adults who accessed preventive/ambulatory health services	77.3%	76.2%	76.9%	-0.2%
Percentage of children and adolescents who accessed PCPs	88.4%	86.8%	86.9%	-0.8%
Percentage of beneficiaries under 21 with an annual dental visit	59.8%	60.6%	61.0%	0.9%

[1]Rates are weighted by duration of enrollment in ACC

[2]Average relative change reports the averaged relative percentage changes between years 1 and 2 and between years 2 and 3.

Rates for well-child visits in the first 15 months of life improved during the baseline period. The percentage of members with no visits declined from 5.1 percent in 2017 to 2.9 percent in 2018. Meanwhile, the percentage of members with six or more visits steadily increased by an average relative change of 5.6 percent from 56.0 percent in 2016 to 62.4 percent in 2018 (Fig. 6).

Figure 6: Utilization Preventive & Well Child Visits Prior To ACC Implementation

	Weighted Rate[1]			Average Relative Rate Change[2]
	2016	2017	2018	
Percentage of beneficiaries with a well-child visit in the first 15 months of life				
0 Visits	4.6%	5.1%	2.9%	-16.7%
1 Visits	3.8%	3.9%	3.0%	-11.1%
2 Visits	4.6%	4.3%	3.9%	-8.6%
3 Visits	6.6%	5.9%	5.5%	-8.4%
4 Visits	9.7%	8.9%	8.7%	-5.5%
5 Visits	14.7%	13.8%	13.7%	-3.3%
6+ Visits	**56.0%**	**58.1%**	**62.4%**	5.6%
Percentage of beneficiaries with well-child visits in the third, fourth, fifth, and sixth years of life	60.9%	60.8%	61.3%	0.4%
Percentage of beneficiaries with an adolescent well-care visit	38.8%	39.0%	40.3%	2.0%

[1]Rates are weighted by duration of enrollment in ACC.

[2]Average relative change reports the averaged relative percentage changes between years 1 and 2 and between years 2 and years 3.

The percentage of members who had engagement of treatment of alcohol and other drug abuse treatment increased from 12.6 percent in 2016 to 14.3 percent in 2018. Rates for initiation of treatment also increased from 41.7 percent to 44.2 percent between 2016 and 2018 (Fig. 7).

Figure 7: Utilization Of Substance Use Treatment Prior To ACC Implementation

	Weighted Rate[1]			Average Relative Rate Change[2]
	2016	2017	2018	
Percentage of beneficiaries who had initiation of alcohol and other drug abuse or dependence treatment	41.7%	42.4%	44.2%	2.9%
Percentage of beneficiaries who had engagement of alcohol and other drug abuse or dependence treatment	12.6%	12.8%	14.3%	6.6%

[1]Rates are weighted by duration of enrollment in ACC.

[2]Average relative change reports the averaged relative percentage changes between years 1 and 2 and between years 2 and years 3

The rate of emergency department visits declined by 3 percent from 2016 through 2018. Inpatient utilization remained steady through the baseline period. Similarly, 30-day, all-cause hospital readmissions remained relatively steady particularly during the latter two years of the baseline period at 16.6 percent in 2017 and 16.8 percent in 2018 (Fig. 8).

Figure 8: ED & Hospital Utilization Prior To ACC Implementation

	Weighted Rate[1]			Average Relative Rate Change[2]
	2016	2017	2018	
Number of ED visits per 1,000 member months	58.0	55.6	54.6	**-3.0%**
Number of inpatient stays per 1,000 member months	7.9	7.7	7.9	**-0.1%**
Percentage of adult inpatient discharges with an unplanned readmission within 30 days	15.7%	16.6%	16.8%	**3.3%**

[1]Rates are weighted by duration of enrollment in ACC.
[2]Average relative change reports the averaged relative percentage changes between years 1 and 2 and between years 2 and years 3

ALTCS Evaluation Findings

Results collected through the National Core Indicator (NCI) interview survey for DD adults and DD children indicate that nearly all (97 percent) of Arizona DD members who responded to the question reported having a primary care doctor, 81 percent of respondents reported having a physical exam, 80 percent reported having a flu shot, 75 percent reported having a dental exam, and 61 percent of respondents reporting having an eye exam in the past year (Fig. 9).

Figure 9: Access to PCP Care for ALTCS DD Members

	Number of Responses	Rate
Has a primary care doctor or practitioner	463	**97%**
Had a complete physical exam in the past year	365	**81%**
Had a dental exam in the past year	313	**75%**
Had an eye exam in the past year	226	**61%**
Had a flu vaccine in the past year	166	**80%**

Source: National Core Indicators Adult Consumer Survey Arizona Report 2015-2016. Total sample size = 476

The percentage of members receiving a follow-up visit with a mental health provider after hospitalization for mental illness increased by almost 40 percent for the ALTCS-EPD population during the baseline period (Fig. 10). In the ALTCS-DD population, rates of adherence to antidepressant treatment decreased between 2015 and 2016 during the baseline period. The rate of mental health utilization (for any mental health service) remained relatively unchanged during the baseline period for both the ALTCS-DD and EPD populations. While there were large relative rate changes for the percentage of members with a screening for depression, the relative change is skewed by the low rates in 2015 and 2016.

Figure 10: Management of Behavioral Health Conditions for ALTCS Members

	ALTCS-DD			ALTCS-EPD		
	Weighted Rate[1]		Relative Change	Weighted Rate[1]		Relative Change
	2015	2016		2015	2016	
Percentage of beneficiaries with a follow-up visit after hospitalization for mental illness	68.3%	69.2%	**1.3%**	21.4%	29.9%	**39.7%**
Percentage of adult beneficiaries who remained on an antidepressant medication treatment (84 days)	52.3%	45.9%	**-12.2%**	61.3%	63.2%	**3.1%**
Percentage of adult beneficiaries who remained on an antidepressant medication treatment (180 days)	38.8%	33.1%	**-14.7%**	44.2%	45.7%	**3.3%**
Percentage of beneficiaries with a screening for depression and follow-up plan	0.6%	0.4%	**-38.1%**	0.3%	0.4%	**15.4%**
Percentage of beneficiaries receiving mental health services						
Any	**31.2%**	**31.5%**	**0.8%**	**19.8%**	**19.7%**	**-0.8%**
ED	0.2%	0.3%	**95.2%**	0.1%	0.1%	**-0.3%**
Intensive outpatient or partial hospitalization	0.9%	0.9%	**3.9%**	0.2%	0.3%	**52.5%**
Inpatient	1.2%	1.2%	**-2.2%**	7.4%	6.9%	**-7.1%**
Outpatient	31.1%	31.4%	**0.8%**	13.7%	14.2%	**3.8%**
Telehealth	0.4%	0.7%	**73.7%**	0.1%	0.1%	**-35.8%**

[1]Rates are weighted by duration of enrollment in ALTCS

DD members expressed high levels of satisfaction with their living arrangements and the services and supports they receive (Fig. 11). Only 13 percent of members who responded to the NCI survey expressed that they would prefer to live somewhere else, and 97 percent indicate that services and supports help them live a good life. In addition, members reported being satisfied with their ability to engage with the community. Two-thirds have friends outside their families and service providers. Most members (89 percent) also report a high or moderate degree of autonomy, at least with respect to planning or having a voice in planning their daily schedules.

Figure 11: ALTCS DD Member Experience With Living Arrangement & Engagement

	Denominator	Rate
Wants to live somewhere else	418	**13%**
Services and supports help the person live a good life	416	**97%**
Able to go out and do the things s/he like to do in the community	412	**93%**
Has friends who are not staff or family members	422	**67%**
Decides or has input in deciding daily schedule	468	**89%**

Source: National Core Indicators Adult Consumer Survey Arizona Report 2015-2016. Total sample size = 476

CMDP Evaluation Findings

In both 2015 and 2016, over 95 percent of children and adolescents enrolled in CMDP had a visit with a PCP (Fig. 12). Approximately two out of three CMDP members had an annual dental visit in both 2015 and 2016, dropping by less than 2 percent between the two years.

Figure 12: Utilization Of PCP & Specialist Services For CMDP Members

	Weighted Rate[1]		Relative Change
	2015	2016	
Percentage of children and adolescents who accessed PCPs	95.4%	95.3%	-0.1%
Percentage of beneficiaries under 21 with an annual dental visit	67.6%	66.3%	-1.9%

[1]Rates are weighted by duration of enrollment in CMDP

Emergency Department (ED) utilization and inpatient stays decreased for CMDP members during the baseline period. These rates decreased by more than 5 percent in 2016 to 41.8 ED visits and 3.1 inpatient stays per 1,000 member months (Fig. 13).

Figure 13: ED & Inpatient Hospital Utilization By CMDP Members

	Weighted Rate[1]		Relative Change
	2015	2016	
Number of ED visits per 1,000 member months	44.3	41.8	-5.6%
Number of inpatient stays per 1,000 member months	3.3	3.1	-5.9%

[1]Rates are weighted by duration of enrollment in CMDP

RBHA Evaluation Findings

Rates of preventive or ambulatory health services for SMI members in RBHAs increased during the Demonstration period from 84.1 percent in 2012 to 91.8 percent in 2018 (Fig. 14).

Figure 14: Utilization Of Primary Care Services By SMI Members In RBHAs

	Weighted Rate[1]							Relative Change[2]
	Baseline		Evaluation					
	2012	2013	2014	2015	2016	2017	2018	
Percentage of adults who accessed preventive/ambulatory health services	84.1%	92.8%	93.5%	92.0%	93.0%	92.4%	91.8%	4.6%

[1]Rates are weighted by duration of enrollment in RBHA
[2]Relative Change reports the relative change between the average rate during the evaluation period compared to the average rate during the baseline period

The percentage of members initiating treatment for alcohol, opioid, or other drug abuse remained steady from an average rate of 46.8 percent in the baseline period to an average rate of 45.0 percent in the evaluation period (Fig. 15). In contrast, rates of engagement of treatment increased by more than 200 percent from an average rate of 2.4 percent in the baseline to an average rate of 7.7 percent in the evaluation period.

Figure 15: Utilization Of Substance Use Treatment By SMI Members In RBHAs

	Weighted Rate[1]							Relative Change[2]
	Baseline		Evaluation					
	2012	2013	2014	2015	2016	2017	2018	
Percentage of beneficiaries who had initiation of alcohol and other drug abuse or dependence treatment	46.6%	47.0%	50.1%	42.6%	42.9%	44.5%	44.9%	-3.9%
Percentage of beneficiaries who had engagement of alcohol and other drug abuse or dependence treatment	3.1%	1.6%	1.9%	6.9%	8.7%	9.8%	11.0%	229.5%

[1]Rates are weighted by duration of enrollment in RBHA
[2]Relative Change reports the relative change between the average rate during the evaluation period compared to the average rate during the baseline period

Figure 16 indicates that all performance measures improved related to the management of behavioral health conditions for SMI members enrolled in a RBHA. Most notably, the percentage of members with a follow-up visit with a mental health practitioner after hospitalization for a mental illness increased substantially from a baseline rate of 40.1 percent in 2013 to 70 percent in 2018. Rates of intensive outpatient or partial hospitalization, and outpatient service utilization increased by 7.9 percent and 8.8 percent, respectively. In addition, utilization of inpatient mental health services increased from an average rate of 12.7 percent in the baseline to an average rate of 14.9 percent in the evaluation period.

Figure 16: Management of Behavioral Health Conditions For SMI Members Enrolled In RBHAs

	Weighted Rate[1]								
	Baseline		Evaluation						Relative Change[2]
	2012	2013	2014	2015	2016	2017	2018		
Percentage of adult beneficiaries who remained on an antidepressant medication treatment (84 days)	39.3%	46.3%	44.2%	42.5%	45.7%	46.2%	43.5%		3.7%
Percentage of adult beneficiaries who remained on an antidepressant medication treatment (180 days)	23.3%	27.5%	26.9%	26.4%	28.9%	27.7%	24.8%		6.1%
Percentage of beneficiaries with a follow-up visit after hospitalization for mental illness	N/A	40.1%	47.2%	65.1%	70.7%	70.6%	70.0%		61.5%
Percentage of beneficiaries with a follow-up visit after emergency department (ED) visit for mental illness	56.1%	59.3%	61.0%	62.0%	62.7%	62.8%	61.5%		7.8%
Percentage of beneficiaries with a follow-up visit after ED visit for alcohol and other drug abuse or dependence	18.8%	18.4%	17.5%	21.6%	21.1%	19.7%	21.0%		8.4%
Percentage of beneficiaries with a screening for depression and follow-up plan	0.0%	0.0%	0.1%	0.2%	0.1%	0.2%	0.1%		--
Percentage of beneficiaries receiving mental health services									
Any[4]	73.6%	83.4%	85.5%	82.5%	85.9%	86.4%	85.9%		8.6%
ED	0.0%	0.0%	0.4%	0.9%	1.5%	1.5%	1.2%		--
Intensive outpatient or partial hospitalization	12.3%	13.2%	12.8%	12.1%	14.3%	14.8%	14.9%		7.9%
Inpatient	12.2%	13.1%	13.2%	14.2%	14.9%	16.0%	16.3%		18.1%
Outpatient	72.8%	82.9%	85.0%	81.9%	85.4%	85.9%	85.3%		8.8%
Telehealth	0.1%	0.8%	1.6%	2.1%	2.8%	4.2%	6.7%		--

[1] Rates are weighted by duration of enrollment in RBHA

[2] Relative Change reports the relative change between the average rate during the evaluation period compared to the average rate during the baseline period.

[3] The rate was not presented due to large rate variation attributable to changes in specifications.

[4] The Any Services category is not a sum of the inpatient, Intensive Outpatient or Partial Hospitalization, Outpatient, ED and Telehealth categories.

Prior Quarter Coverage (PQC) Findings

Figure 17 illustrates the average number of months with Medicaid coverage for AHCCCS members prior to the implementation of the Waiver of Prior Quarter Coverage. The average number of months with Medicaid coverage for both baseline years was approximately 10 months.

Figure 17: Enrollment continuity for AHCCCS members

	Baseline		Relative Change
	Y1[1]	Y2[1]	
Average number of months with Medicaid Coverage	10.0	10.2	1.2%

[1]Baseline Y1 extends from 7/1/2017 through 6/30/2018 and Baseline Y2 extends from 7/1/2018 through 6/30/2019

TI Findings

Figure 18 shows the percent of TI-affiliated children with a hospitalization for mental illness had a follow-up visit with a mental health practitioner within seven days. About two-thirds of TI-affiliated children had a follow-up visit in 2015 and this number increased to about 71 percent in 2016.

Figure 18: Follow up after hospitalization or ED visits for mental illness for TI affiliated children

	Rate		Relative Change
	2015	2016	
Percentage of beneficiaries with a follow-up visit after hospitalization for mental illness	66.4%	71.1%	7.0%

Figure 19 assesses the rates of alcohol and other drug abuse or dependence treatment and medication assisted treatment (MAT) among TI-affiliated adults. The rate remained steady between both baseline years, with the highest rate of treatment for opioids over both baseline years. The rate of treatment engagement was 9% overall in 2015 and increased to 11% overall. Similar to initiation of treatment, the rate of treatment engagement was highest for opioids at 13.5 percent for both baseline years.

Figure 19: Rates of alcohol and drug abuse treatment and adherence for TI vs non TI affiliated adults

	Rate		Relative Change
	2015	2016	
Percentage of beneficiaries who had initiation of alcohol and other drug abuse or dependence treatment			
Total	**40.6%**	**42.5%**	**4.9%**
Alcohol	42.9%	44.2%	3.0%
Opioid	43.7%	48.2%	10.4%
Other Drug	40.0%	40.1%	0.4%
Percentage of beneficiaries who had engagement of alcohol and other drug abuse or dependence treatment			
Total	**9.3%**	**11.1%**	**19.1%**
Alcohol	8.9%	9.7%	8.9%
Opioid	13.5%	13.5%	-0.4%
Other Drug	7.0%	9.8%	39.3%
Percentage of beneficiaries with OUD receiving any medication assisted treatment	N/A[1]	30.5%	N/A

[1]The rate was not presented due to large rate variation attributable to changes in specifications

External Quality Review

Part of the overall quality strategy mandated by Section 1932(c)(2) of the Social Security Act and 42 CFR §438.350-370 requires states to include annual independent external quality reviews (EQRs) in each managed care contract. This approach requires an independent External Quality Review Organization (EQRO) to validate performance measures, conduct compliance reviews and otherwise evaluate the performance of Medicaid managed care plans. AHCCCS contracts with HSAG as its EQRO vendor. A summary of activities performed by the Arizona EQRO along

with their key findings are contained in **Appendix B.** Arizona's EQR reports are posted on State's website: https://www.azahcccs.gov/Resources/HPRC/

IV. CURRENT PROGRAM FEATURES TO CONTINUE UNDER DEMONSTRATION RENEWAL

The following section summarizes the programs under Arizona's existing Demonstration and how the State will approach each of these features under the waiver renewal request. The full list of waivers and expenditure authorities that Arizona is requesting in this renewal period is detailed in Chapter VII.

Eligibility

Under this renewal proposal, all current AHCCCS eligibility groups will continue to be covered. Arizona's Demonstration also authorizes several expenditure authorities that streamline the eligibility processes detailed in Chapter VII. With the exception of those eligibility waivers, the eligibility requirements for most members enrolled in the managed care delivery system are set forth in Arizona's State Plan. Eligibility requirements for long term care services and supports (including HCBS) will remain unchanged from Arizona's current Demonstration: individuals must be at immediate risk of institutionalization at either a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) and must have income at or below 300 percent of the Federal Benefit Rate.

WAIVER OF PRIOR QUARTER COVERAGE

Arizona's Demonstration authorizes AHCCCS to limit retroactive coverage to the first day of the month of application for all Medicaid members, except for pregnant women, women who are 60 days or less postpartum, and children under 19 years of age. Pregnant women, women who are 60 days or less postpartum, and children under the age of 19 are eligible for Medicaid coverage for up to three months prior to the month in which their application was submitted. AHCCCS is requesting the authority to continue to limit retroactive coverage in order to fully evaluate the Demonstration's progress toward achieving the goals of continuity of care and personal responsibility, and to assess the impact to individuals and providers.

AHCCCS WORKS

Arizona's Demonstration also authorizes the AHCCCS Works program. The AHCCCS Works program requires able-bodied AHCCCS members between the ages of 19 and 49 who do not qualify for an exemption to participate in the following activities or combination of activities for at least 80 hours per month: be employed, actively seeking employment, attending school (less than full time), participating in other employment readiness activities (i.e. job skills training, life skills training, and health education), and/or engaging in community service. Under this waiver renewal, AHCCCS is seeking to maintain its current authority to implement the AHCCCS Works program.

AHCCCS has exempted members who are particularly vulnerable or whose circumstances make community engagement participation challenging. Arizona's Demonstration exempts individuals who meet any of the following conditions from the AHCCCS Works program:

- Individuals under age 19 and above age 49
- Pregnant women and women up to the end of the month in which the 60th day of post-pregnancy occurs
- Former foster care youth up to age 26
- Individuals who are members of a federally recognized tribe
- Individuals with a SMI designation
- Individuals currently receiving temporary or permanent long-term disability benefits from a private insurer or from the state or federal government, including workers compensation benefits
- Individuals who are medically frail
- Individuals who are in active treatment with respect to a substance use disorder (SUD)
- Full time high school, trade school, college or graduate students
- Survivors of domestic violence
- Individuals who are homeless
- Designated caretakers of a child under 18 years of age

- Caregivers who are responsible for the care of an individual with a disability
- Individuals who have an acute medical condition
- Individuals who are receiving Supplemental Nutrition Assistance Program (SNAP), Cash Assistance, or Unemployment Insurance income benefits
- Individuals participating in other AHCCCS approved work programs
- Individuals not mentioned above who have a disability as defined by federal disabilities rights laws (ADA, Section 504, and Section 1557) who are unable to participate in AHCCCS Works Requirements for disability-related reasons

As of July 2020, AHCCCS estimates that approximately 119,532 members will be subject to the AHCCCS Works requirements, an estimate derived by excluding the number of persons in categories exempted from the list above. However, due to limitations in available data, some exempted categories cannot yet be quantified. Therefore, the total number of members required to participate in AHCCCS Works is anticipated to be lower.

Figure 20: AHCCCS Works Exemptions

AHCCCS Works Exemptions	Members (Ages 19-49) Who Are Subject To AHCCCS Works Requirement Who Qualify For This Exemption
American Indians	26,338
Individuals designated as having a Serious Mental Illness	9,279
Individuals receiving disability benefits	1,324
Individuals who are homeless	3,164
Full time student	17,572
Designated caretakers of a child under 18 years of age	40,738
Members receiving SNAP, Cash Assistance, or Unemployment Insurance	50,185

Individuals may fall into multiple exemption groups (e.g., an individual designated as having a Serious Mental Illness who is also a full time student is counted in both groups above). AHCCCS currently does not collect information on some of the exemptions that will be allowed under the AHCCCS Works program.

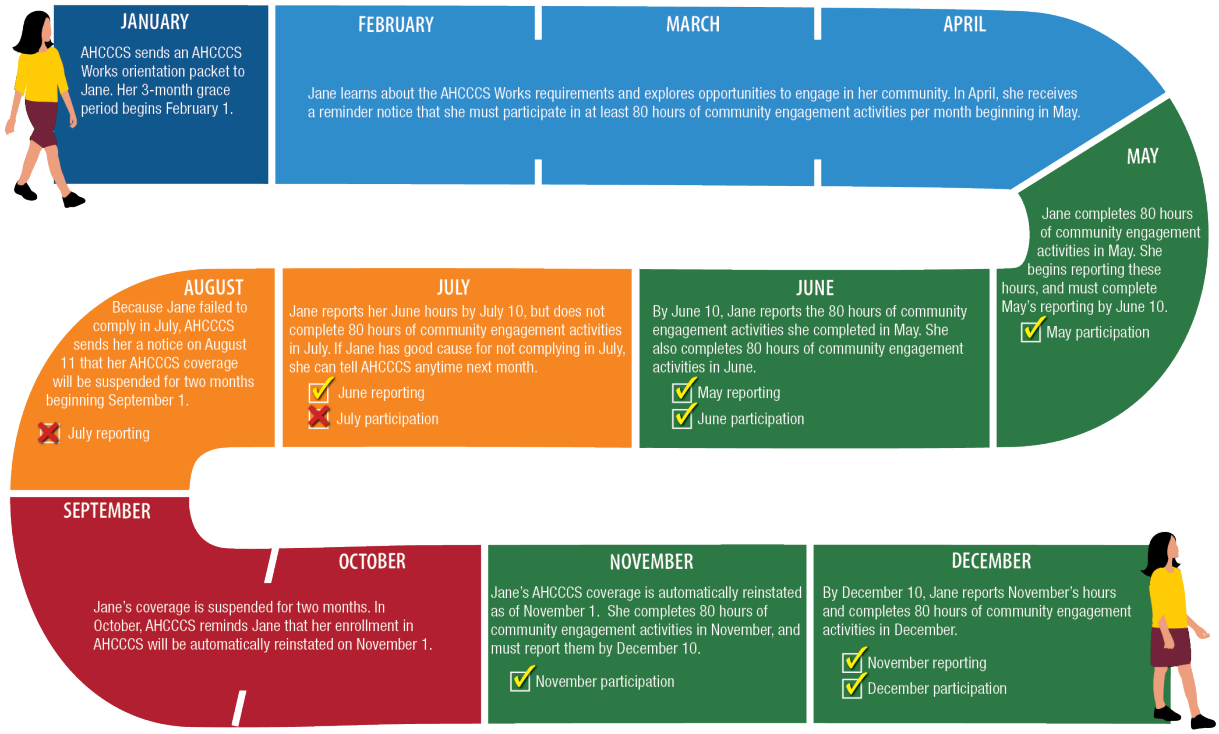
Prior to program implementation, AHCCCS will notify members in writing as to whether or not they are required to comply with the community engagement requirements. Members will also receive written notice in annual renewal letters and whenever there is a change in their community engagement status.

Members who are required to comply with AHCCCS Works requirements will begin the program with a three-month orientation period in which to become familiar with the program compliance requirements. During this three month orientation period, members will not be subject to the community engagement requirements. During this timeframe members will receive detailed material about AHCCCS Works, including, but not limited to, information explaining the qualifying community engagement activities, how to comply and report community engagement hours, and how to access available community engagement resources. Members will be required to comply with the community engagement requirements once the initial three-month orientation period expires.

Failure to report at least 80 hours of qualifying community engagement activity for any month after the orientation period will result in suspension of the member's AHCCCS coverage for two months unless the member requests: (1) a good cause exemption for failing to comply with the requirements; or (2) an appeal of the suspension. A member whose eligibility is suspended for failing to comply with the community engagement requirements will be reinstated at the expiration of the two-month suspension period, as long as he or she meets all other AHCCCS eligibility criteria. Figure 21 illustrates the AHCCCS Works member compliance obligation.

Figure 21

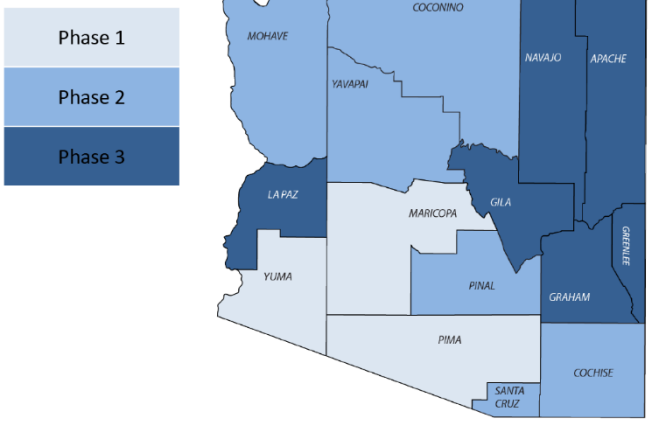
In this example, January represents the first month any new AHCCCS member is required to comply.



The AHCCCS Works program will be implemented geographically, in three phases, starting with the counties that have the largest percentage of urban populations (Fig. 22).

- **Phase I** will be implemented in the most urbanized counties (counties with less than 20 percent rural population): Maricopa, Pima and Yuma.
- **Phase II** will be implemented in semi-urbanized counties (counties with 40-50 percent moderate rural population): Cochise, Coconino, Mohave, Pinal, Santa Cruz and Yavapai.
- **Phase III** will be implemented in the least urbanized counties (counties with greater than 50 percent rural population): Gila, Graham, Greenlee, Navajo, La Paz and Apache.

Figure 22



This phased-in approach will give the State time to assess the availability of community engagement resources in rural areas and address gaps. Counties with a higher percentage of urban populations are likely to have sufficient community engagement resources compared to counties with a higher percentage of rural populations.

Furthermore, the State will assess areas that have high rates of unemployment, areas with limited economies and/or educational opportunities, and areas that lack public transportation to determine whether further exemptions from the AHCCCS Works requirements and/or additional mitigation strategies are needed to alleviate unreasonable burden on members.

Delivery System

Arizona's foundational Demonstration program grants the authority to operate a mandatory managed care program as a means for coordinating high-quality, cost-effective member care. AHCCCS partners with the private health insurance market to leverage efficiencies, flexibilities, and resources in order to create a program that delivers quality, comprehensive health care while maximizing taxpayer dollars. In Arizona, Medicaid managed care was adopted across most populations and all service areas, including long-term care services and supports, behavioral health services, and dual eligible members. Today, 85 percent of AHCCCS members are enrolled in managed care.

In general, populations participating in the managed care program have a choice of managed care entities within each geographic service area designated by the State. Some individuals with a designated serious mental illness are restricted to a single managed care entity in each geographic service area. ALTCS members with developmental disabilities are restricted to one state-wide managed care entity for long term care services and supports, but are offered the choice of two subcontracted managed care plans for physical and behavioral health services. Members in the ALTCS program serving individuals who are elderly or have physical disabilities are offered a choice of managed care entity in Maricopa, Pinal, Gila and Pima counties but are limited to one managed care entity in the remaining eleven counties of the state. Foster children are restricted to a single managed care entity.

Consistent with federal law, American Indians and Alaska Natives (AI/AN) members have the choice of receiving health care coverage from a contracted managed care plan or from the American Indian Health Program (AIHP), a fee-for-service program managed by AHCCCS. In addition, non-qualified aliens whose benefits are limited to treatment of emergency conditions under section 1903(v) of the Social Security Act are not enrolled in the managed care delivery system but receive care on a fee-for-service basis.

Under this waiver renewal, AHCCCS is seeking waiver authority to continue the current managed care model, one of the nation's leading managed care programs recognized for delivering quality health care services to members while simultaneously achieving cost efficiencies.

In addition, AHCCCS proposes renewing the Targeted Investments Program from 2021 through 2026. Building on the successes and lessons learned from the current waiver, Arizona's Targeted Investments Program will continue to drive the transformation of Arizona's delivery system toward an integrated, whole person health delivery system. The details of this proposal are discussed in Chapter V.

Arizona's Demonstration also authorizes supplemental payments to IHS and 638 facilities to address the fiscal burden of uncompensated care for services provided by such facilities to Medicaid-eligible adults. Reports submitted to the State by IHS and 638 facilities show that these payments warded off staffing reductions and elimination of services, which would have severely impacted an already fragile delivery system that provides critical care for a population struggling to overcome healthcare disparities during the recession. AHCCCS is seeking to maintain this authority under this renewal proposal.

Benefits

Under this proposal, all current benefits will continue to be covered. All acute care members have access to the same benefit package regardless of their managed care plan enrollment. Similarly, all ALTCS members have access to the same benefit package across all managed care plans.

Through this renewal application, AHCCCS seeks to continue its existing expenditure authorities regarding certain services not covered (or not coverable) under the State Plan. This includes $1,000 in dental services for ALTCS members and certain home and community based services: respite care, habilitation services, home delivered meals, home modifications, and personal care services and similar services provided under the Spouse as Paid Caregiver program.

To enhance service delivery for ALTCS members, AHCCCS is requesting authority to allow for verbal consent in lieu of written signature for up to 30 days for all care and treatment documentation for ALTCS members when identity can be reliably established and documented in the member's record. This proposal is discussed in more detail in Chapter V.

Also, in an effort to reduce health care disparities in the AI/AN population, AHCCCS is seeking new authority to provide dental benefits in excess of the currently established emergency dental benefit which is limited to $1,000 per year under the Arizona State Plan for AHCCCS AI/AN members receiving services provided in, at, or as part of services offered by facilities and clinics operated by the IHS, a tribe or tribal organization. AHCCCS is also requesting expenditure authority to reimburse for traditional healing services in, at, or as part of services provided by IHS, a tribe or tribal organization, or an Urban Indian health program. The details for both proposals are discussed in Chapter V.

AHCCCS CARE and Cost Sharing

AHCCCS did not implement the AHCCCS CARE program during the current waiver period, and is requesting this program to be discontinued from Arizona's Demonstration. Cost sharing requirements for persons impacted by Arizona's Demonstration are defined in the Arizona State Plan.

V. PROPOSED CHANGES TO THE CURRENT DEMONSTRATION

Verbal Consent In Lieu Of Written Signature For Person Centered Service Plans For ALTCS Members

On March 13, 2020, the President of the United States declared the 2019 novel coronavirus (COVID-19) a nationwide emergency pursuant to Section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5207 (the "Stafford Act"). The President's declaration provides authority for the Secretary of the U.S. Department of Health and Human Services to enhance states' ability to respond to the COVID-19 outbreak, including authority to temporarily waive or modify Medicaid and CHIP requirements under Section 1135 of the Social Security Act. Also referred to as "1135 Waivers," these authorities expire no later than the termination of the COVID-19 public health emergency (PHE) period. Currently, the PHE is scheduled to expire on January 21, 2020, unless renewed by the Secretary.

Arizona was one of the first states to submit a request to waive certain Medicaid program requirements in order to address the COVID-19 outbreak. CMS approved components of Arizona's request under the 1135 Waiver, including the authority to temporarily waive written consent requirements for person-centered service plans through home and community based service programs. Federal regulations specify that members provide written consent for person-centered service plans and that the service plans be signed by members and all providers responsible for their implementation. In light of the circumstances unique to Arizona's members, geography, and culture, Arizona sought the authority to obtain documented verbal consent as an alternative. The purpose of this authority was to establish a reliable and timely process for ALTCS members to obtain prompt authorization of critically needed health services while reducing risk of COVID-19 transmission or infection through the document signature process.

As a result of considerable conversation with community stakeholders, AHCCCS has decided to pursue the continuation of this waiver authority beyond the termination of the COVID-19 public health emergency. Therefore, AHCCCS is seeking 1115 Waiver authority to allow for verbal consent in lieu of a written signature for all care and treatment documentation for ALTCS members.

Verbal consent will be obtained telephonically where the identity of the member can be reliably established. The member's consent will be documented in the member's record. Utilization of telephonic methods for members to

verify required documents is critical to ensure continued and timely access to health care for vulnerable individuals who are elderly and/or have disabilities. Examples of the populations most affected by this authority include: members who are living on reservations and members residing in rural settings or in other locations where written consent/confirmation cannot be obtained due to unreliable internet access, extended distances, transportation challenges, restrictions due to COVID-19 infection, or lack of other reasonable means to comply with the written requirement.

After verbal consent is received, members will have 30 days to submit their signature to the case manager electronically or by mail. The process for using electronic signatures will satisfy privacy and security requirements, and it will be added as a method for the participant or legal guardian who signs the individual service plan (ISP) to indicate approval of the plan. Services for the member will commence during this 30-day time period. Signatures will include a date reflecting the ISP meeting date.

As of July 2020, 66,613 members are enrolled in ALTCS and approximately 89 percent are receiving HCBS.

WAIVER AND EXPENDITURE AUTHORITIES NECESSARY TO AUTHORIZE THIS DEMONSTRATION

Waiver Authority Requested	Brief Description
Section 1915(c) of the Social Security Act and 42 CFR 441.301(c)(2)(ix)	To the extent necessary to enable the State to waive requirements under home and community based service programs that require person-centered service plans to receive written consent from members and be signed by members and all providers responsible for its implementation and allow for verbal consent in lieu of written signature for up to 30 days for all care and treatment documentation when identity can be reliably established and documented in member's record.

Targeted Investments Program Renewal Request (TI Program 2.0)

OVERVIEW OF THE CURRENT TI PROGRAM (2016-2021)

Arizona's health care system has historically been siloed, due to a fragmented system of care prior to the state's participation in Medicaid and the establishment of a delivery system model within the Medicaid program in which members accessed physical health services through an acute care health plan and behavioral health services through a RBHA. As a result of this delivery system fragmentation, AHCCCS members often found themselves interacting with multiple managed care entities and receiving care from a myriad providers who were funded from different sources. This fragmentation has historically hindered effective care coordination, impacted members' health status, and resulted in increased costs for members with complex behavioral and physical health needs.

Over the past decade, Arizona has taken significant steps to reduce these silos and integrate care for AHCCCS members, integrating the provision of physical health and behavioral health services under a single managed care plan. In large part, AHCCCS' effort to integrate care and improve health outcomes for members relies on the unique partnership between the MCOs and AHCCCS providers. The ability for the managed care plans to effectively coordinate care and provide integrated care is directly linked with the providers' ability to participate in that process. The providers who deliver care are in a better position to coordinate care in real time, but to do so effectively, many need infrastructure support to build data sharing and analysis capabilities, to integrate team-based care, and to create workflows that connect members to social services.

Through its Targeted Investments Program, AHCCCS supports providers in moving toward integrated and coordinated care and aims to reduce fragmentation between acute care and behavioral health care, increase efficiencies in service delivery for members with behavioral health needs, and improve health outcomes for the affected populations. The TI Program has successfully funded time-limited, outcome-based projects aimed at

building the necessary infrastructure to create and sustain integrated, high-performing health care delivery systems that improve care coordination and drive better health and financial outcomes for: adults with behavioral health needs; children with behavioral health needs, including children with or at risk for Autism Spectrum Disorder (ASD); children engaged in the child welfare system; and individuals transitioning from incarceration.

In the first three years of the five-year, $300 million program, participating providers (including primary care providers, behavioral health providers, and hospitals) received payments for completing core components and milestones supporting behavioral health and physical health integration. In years four and five, providers are eligible to receive performance-based payments on quality measures for specific populations. Figure 23 illustrates the number of participating providers, by area of concentration, at the end of year three of the Demonstration.

Figure 23: TI Program Providers

Participating Area of Concentration	Number of Sites
Adult Behavioral Health	154
Adult Primary Care	182
Pediatric Behavioral Health	117
Pediatric Primary Care	91
Hospital	21
Justice	13

The TI Program has achieved noteworthy accomplishments in several of these areas of concentration, as discussed below.

INTEGRATED CLINICS FOR INDIVIDUALS RELEASED FROM INCARCERATION

Numerous studies have shown that individuals who are incarcerated have a high prevalence of behavioral health conditions, usually undiagnosed or underdiagnosed. In addition, research on recidivism indicates that three out of four incarcerated individuals are re-incarcerated over the course of five years.[6] The inability to access behavioral health services, including treatment to address substance use disorder, is a contributing factor to recidivism.

Recognizing the unique circumstances and needs of this population, in addition to incentivizing integrated care within traditional clinic settings, the TI Program supported the establishment of thirteen co-located, integrated clinics where primary care and behavioral health providers deliver services to justice-involved individuals. The co-located clinics are located with or adjacent to probation and/or parole offices that collaborate with providers to meet the members' health and social needs. The co-located justice clinics prioritize access to appointments for individuals with complex health conditions, with a specialized focus on ensuring that this population has same-day access to appointments on the day of release and during visits to a probation or parole office. In FFY 2019, 4,272 formerly incarcerated members received services through the integrated justice clinics.

In addition, AHCCCS has established Medicaid suspension agreements with the majority of counties such that individuals who become incarcerated (for less than one year) while enrolled in AHCCCS are suspended from Medicaid eligibility and then reinstated upon release from incarceration, rather than having to complete a new eligibility application. AHCCCS also requires the MCOs to have reach-in policies, mandating that they engage individuals with complex health conditions and high criminogenic needs prior to release, ensuring that they are able to access care immediately upon transition back into the community. Many of the members identified

[6] Durose, Matthew R., Alexia D. Cooper, and Howard N. Snyder, Recidivism of Prisoners Released in 30 States in 2005: Patterns from 2005 to 2010 (pdf, 31 pages), Bureau of Justice Statistics Special Report, April 2014, NCJ 244205.

through these processes are referred to TI justice clinics. This is a critical foundational step to ensure that individuals transitioning into the community from incarceration have immediate access to health care including substance use and behavioral health services.

IMPROVEMENTS IN PHYSICAL AND BEHAVIORAL HEALTH INTEGRATION FOR TI PARTICIPATING PROVIDERS

To address the challenges associated with fragmentation at the point of service, the TI Program incentivizes and supports a comprehensive approach to integrated care in any care setting in which an AHCCCS member may receive either physical or behavioral health services. For that reason, TI Program participants are financially incentivized to establish numerous protocols, policies, and systems of care that support the provision of person centered integrated care, such as:

- Integrated care plans for members with behavioral health needs
- Primary care screening for behavioral health using standardized tools for depression, SUD, anxiety, and suicide risk
- Primary care screening, intervention and treatment for children with developmental delays, including early childhood cognitive and emotional problems
- Protocols for behavioral health providers to identify physical health concerns and to effectively connect the member to appropriate physical health care
- Health risk assessment tools, predictive analytic systems, and other data mining structures to identify individuals at high risk of a decline in acute and/or behavioral health status
- Trauma-Informed care protocols including screening for adverse childhood events (ACEs), referral processes for children that screen positive, and use of evidence-based practices and trauma-informed services
- Protocols to send and receive core Electronic Health Record (EHR) data with the state's Health Information Exchange (Health Current) and receipt of Admission, Discharge, and Transfer (ADT) alerts to notify providers when their patients are in the hospital

Additionally, TI Program participants (except hospitals) are required to complete the Integrated Practice Assessment Tool (IPAT) to assess their level of integration on the Substance Abuse and Mental Health Services Administration (SAMHSA) Levels of Integrated Healthcare continuum at the end of each program year. SAMHSA defines six levels of coordinated/integrated care grouped into three broad categories, ranging from minimal collaboration to co-located care to fully integrated care (Fig. 24).

Figure 24: SAMHSA Six Levels of Collaboration/Integration

Coordinated Care Key Element: Communication		Co-Located Care Key Element: Physical Proximity		Integrated Care Key Element: Practice Change	
LEVEL 1 Minimal Collaboration	**LEVEL 2** Basic Collaboration at a Distance	**LEVEL 3** Basic Collaboration On site	**LEVEL 4** Close Collaboration On site with Some Systems Integration	**LEVEL 5** Close Collaboration Approaching an Integrated Practice	**LEVEL 6** Full Collaboration in Transformed/ Merged Integrated Practice

Early results indicate the TI Program funding was important in increasing the levels of integrated care for participating providers. The majority of TI Program participants reported having a higher level of integration after implementing the protocols associated with the TI Program between Demonstration Years (DYs) 2 and 3. Sixty percent of unique provider sites reported an increase in integration by at least one IPAT level, and 38 percent of provider sites reported an increase by at least two IPAT levels. Most notably, nearly 25 percent (46 clinics) of PCP

participants attested to increasing their IPAT scores by four or more levels—transitioning from levels 1 or 2 (minimal coordination) to levels 5 or 6 (fully integrated care), within one demonstration year. This higher level of integration among participating PCPs means members are able to immediately access behavioral health services when the PCP's screening identifies a need within the integrated practice setting.

In addition, many participating behavioral health providers successfully transitioned to a higher level of integration. The number of providers that reported successfully transitioning to co-located care (levels 3 or 4) or fully integrated care (levels 5 or 6) increased by threefold in DY 3.

These results illustrate the important role the TI Program has played in incentivizing and supporting providers to transform their practices. AHCCCS anticipates that additional providers will achieve greater levels of integration by DYs 4 and 5.

Figure 25: Change in IPAT Level for DY2 and DY3 Attesting Sites by TI Participation Category

Category:	All Sites	Program		Project		Area of Concentration			
		PCP	BH	Adult	Peds	Adult PCP	Adult BH	Peds PCP	Peds BH
Increased:	221 (60%)	128 (68%)	97 (51%)	159 (57%)	111 (59%)	95 (68%)	70 (46%)	54 (64%)	60 (55%)
Increased 5 Levels:	*12 (3%)*	*8 (4%)*	*4 (2%)*	*8 (3%)*	*4 (2%)*	*4 (3%)*	*4 (3%)*	*4 (5%)*	*0 (0%)*
Increased 4 Levels:	*46 (13%)*	*38 (20%)*	*7 (4%)*	*41 (15%)*	*11 (6%)*	*36 (26%)*	*6 (4%)*	*8 (10%)*	*3 (3%)*
Increased 3 Levels:	*56 (15%)*	*32 (17%)*	*26 (14%)*	*39 (14%)*	*36 (19%)*	*28 (20%)*	*12 (8%)*	*15 (18%)*	*22 (20%)*
Increased 2 Levels:	*27 (7%)*	*10 (5%)*	*19 (10%)*	*23 (8%)*	*13 (7%)*	*10 (7%)*	*15 (10%)*	*2 (2%)*	*11 (10%)*
Increased 1 Level:	*80 (22%)*	*40 (21%)*	*41 (22%)*	*48 (17%)*	*47 (25%)*	*17 (12%)*	*33 (22%)*	*25 (30%)*	*24 (22%)*
No Increase:	147 (40%)	61 (32%)	92 (49%)	121 (43%)	76 (41%)	44 (32%)	83 (54%)	30 (36%)	50 (45%)
Total Sites:	**368**	**189**	**189**	**280**	**187**	**139**	**153**	**84**	**110**
Median Increase:	**1**	**1**	**1**	**1**	**1**	**2**	**0**	**1**	**1**

IMPROVEMENTS IN KEY PERFORMANCE MEASURES

The Arizona State University Center for Health Information and Research (ASU CHiR) analyzed the impact of the TI Program on specific performance measures using administrative data from September 2017 and September 2019. The team implemented a difference-in-difference approach, using National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) certified software to compare member outcomes for TI beneficiaries (AHCCCS members with at least one encounter during the report period with a TI-participating provider) and non-TI beneficiaries (AHCCCS members that did not receive services or only received services from non-TI-participating providers in the report period).[7]

Figure 27 shows that, across a number of performance measures, TI beneficiaries experienced greater improvement in outcomes than non-TI beneficiaries, including most measures related to timely follow up after hospitalization. Participants largely attribute this to their policies and procedures for using ADT and other HIE alerts, a foundational requirement of TI. Many participants further developed processes to engage patients at time of admission, thus increasing successful contact and better coordination with hospital discharge planners. AHCCCS expects increased improvement for the TI Program participating providers in the remaining measures as all are aligned with DY 4 and DY 5 performance measures that drive participants' target-based incentives.

[7] Difference in Difference (DiD) is a statistical technique that compares the difference in average outcome in the treatment group (i.e. TI-beneficiaries) before and after the implementation of the TI Program minus the difference in average outcome in the control group (i.e. non-TI beneficiaries) before and after the implementation of TI Program.

Figure 27: Performance Outcomes For TI vs. Non-TI Beneficiaries

	Non-TI beneficiaries			TI beneficiaries			TI vs. Non-TI beneficiaries
Measure Description	**2017**	**2019**	**% Change**	**2017**	**2019**	**% Change**	**Difference- in-Difference**
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)	55.72%	57.51%	1.78%	58.73%	62.03%	3.30%	**1.52%**
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	39.82%	36.67%	-3.15%	41.26%	41.30%	0.03%	**3.18%**
Follow-Up after Hospitalization for Mental Illness: 6-17 Years (7-day)	57.22%	55.92%	-1.30%	72.13%	70.79%	-1.34%	**-0.04%**
Follow-Up after Hospitalization for Mental Illness: 6-17 Years (30-day)	70.00%	70.14%	0.14%	87.82%	88.43%	0.61%	**0.47%**
Follow-Up after Hospitalization for Mental Illness: 18 and Older (7-day)	30.97%	24.76%	-6.21%	43.72%	45.12%	1.40%	**7.61%**
Follow-Up after Hospitalization for Mental Illness: 18 and Older (30-day)	45.35%	36.96%	-8.39%	66.82%	67.00%	0.17%	**8.57%**
Follow-Up after Emergency Department Visit for Mental Illness: 6-17 Years (7-day)	29.05%	30.66%	1.60%	76.48%	75.76%	-0.71%	**-2.32%**
Follow-Up after Emergency Department Visit for Mental Illness: 6-17 Years (30-day)	41.22%	41.61%	0.39%	84.43%	87.17%	2.74%	**2.35%**
Follow-Up after Emergency Department Visit for Mental Illness: 18 and Older (7-day)	17.84%	15.45%	-2.39%	46.30%	45.09%	-1.21%	**1.17%**
Follow-Up after Emergency Department Visit for Mental Illness: 18 and Older (30-day)	24.50%	24.28%	-0.22%	56.18%	54.29%	-1.88%	**-1.66%**
Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: 18 and Older (7-day)	7.44%	5.43%	-2.01%	27.44%	24.84%	-2.60%	**-0.58%**
Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: 18 and Older (30-day)	9.37%	8.08%	-1.30%	35.44%	33.61%	-1.83%	**-0.53%**
Well-Child Visits (Ages 3-6 Years): 1 or More Well-Child	57.40%	57.71%	0.31%	75.57%	77.64%	2.06%	**1.76%**
Adolescent Well-Care Visits: At Least 1 Comprehensive	36.36%	36.95%	0.59%	52.68%	56.47%	3.79%	**3.21%**

OVERVIEW OF TI PROGRAM 2.0

While the TI Program has helped AHCCCS providers achieve impressive results, much work remains in order to fully transform Arizona's delivery system into an integrated whole-person health care system.

In order to continue progress toward delivery system and payment reform and to bring the current TI Program initiatives to scale, AHCCCS seeks waiver authority to extend the TI Program from 2021 through 2026. This proposal, known as the TI Program 2.0, will include two distinct participant cohorts – "extension" and "expansion" cohorts.

The "extension" cohort will include current TI Program providers. As the movement to integrate behavioral health and primary care continues for this cohort, their next step will be to incorporate non-clinical or social needs into the delivery system to provide a truly holistic, person-centered approach to care. Therefore, TI Program projects for this cohort will be designed to foster collaboration between medical providers and Community Based Organizations (CBOs), particularly those crucial to addressing social risk factors such as housing, food, employment, social isolation, and non-medical transportation for AHCCCS members. The incentive payments for this group of participants will be based on the achievement of outcome measures, continuation of high priority promising practices, and establishment of additional systems and infrastructure that supports advancing whole person care.

The "expansion" cohort will include primary care practices, behavioral health providers, and integrated clinics that volunteer to participate in the TI Program 2.0 with no prior TI participation. Eligibility requirements will include a certified EHR that is capable of bi-directional data exchange, minimum volume thresholds, and a commitment to participate in the Learning/Quality Improvement Collaborative established to support TI program participants. The structure of the Program for this cohort will be modeled on the 2016 waiver TI Program with updates and revisions to the original core components and milestones, and incentives in the later years based on performance measures.

AHCCCS will develop a concept paper in 2021 that outlines the details for the TI Program 2.0, and publish this document on its website.

Traditional Healing Services

AHCCCS is seeking waiver authority to reimburse traditional healing services provided in, at, or as part of services offered by facilities and clinics operated by the Indian Health Service, a tribe or tribal organization, or an Urban Indian health program (I/T/U). AHCCCS is seeking to claim FFP for these services when provided by I/T/U facilities at the 100 percent Federal Medical Assistance Percentage (FMAP) pursuant to Sections 1903(a)(1) and 1905(b) of the Act. The purpose of this Demonstration is to provide culturally appropriate options for AHCCCS members to maintain and sustain health and wellness through traditional healing services made available at, in, or as part of services offered by facilities and clinics that provide or arrange traditional healing services.

Tribes in Arizona have incorporated traditional healing practices into their existing health care delivery system. These services, while beneficial to members, have not been approved as covered Medicaid services, despite the fact that they are promoted in the Indian Health Care Improvement Act and by IHS. Over the years, the provision of traditional healing services has been supported primarily through tribal funds, various pilot programs, grants, and individual personal resources. The tribes have long recognized the

DEFINITIONS

This section defines the terms used for the proposed traditional healing Demonstration.

Facility: Indian Health Service, Tribal Title I. or Title V. P.L.93- 638 Facility, and Urban Indian Health Organizations (I/T/U) located on and off Tribal lands.

Medical Provider: Licensed and/or credentialed healthcare professional responsible for the medical care of the member.

Traditional Healing: A system of culturally appropriate healing methods developed and practiced by generations of Tribal healers who apply methods for physical, mental and emotional healing. The array of practices provided by traditional healers shall be in accordance with an individual tribe's established and accepted traditional healing practices as identified by the Qualifying Entity.

contribution of healers and practitioners who are valued for their role in aiding the healing of the spirit, mind, and body. The goal of this Demonstration is to improve the health outcomes of AHCCCS members by making traditional healing services available in, at, or as part of services offered by I/T/U facilities and clinics in a complementary fashion with allopathic medicine (i.e. Western medical approaches).

IHS was established in 1954 and initiated the efforts to increase access to conventional Western medical services in tribal communities. Yet long before this system of medical practice was made available, and up to the present time, traditional American Indian healing practices have been a part of the lifeways of the twenty-two tribal nations that reside in the state of Arizona. Several tribes, IHS, and Urban Indian health facilities continue to make traditional healing services available as a component of what is now called integrated service delivery. From an American Indian perspective, traditional healing practices are a fundamental element of Indian health care that helps patients achieve wellness and healing for a specific physical or mental ailment or affliction and to restore emotional balance and one's relationship to the environment. AHCCCS recognizes that reimbursement for these services in a manner that retains the sanctity of these ancient practices is important. The tribes have advised AHCCCS that traditional healing services will aid care coordination and help AHCCCS members achieve improved health outcomes.

Traditional Healing Provider: Individual recognized by the Qualifying Entity to provide traditional healing services that is a contractor or employee of the Facility.

Qualifying Entity: Facility governing body or its tribal governing body responsible to define and endorse traditional healers and the services they perform.

Covered Traditional Healing Services: The coverage of traditional healing services will be limited to the practices approved by the facility governing body to be performed and billed by the facility. As with many Medicaid covered services, traditional healing services should be part of a comprehensive plan of health care that includes specific individualized goals.

Qualified Traditional Healing Providers: For the purpose of this waiver, a qualified traditional healing provider is an individual endorsed by the Qualifying Entity to provide traditional healing services as reflected in an official signed and dated endorsement letter by the Qualifying Entity stating that the traditional healing provider meets all qualifications to provide traditional healing services.

Upon approval by CMS, the AHCCCS Medical Policy Manual (AMPM) will require the IHS or 638 tribal governing bodies to adopt policies and procedures and determine the array of covered traditional healing services that may be offered. The covered traditional services, limitations, and exclusions shall be described by each facility (working with each tribe they primarily serve) seeking to participate in this program.

It is recognized that the training and qualifications of traditional healing providers may vary widely depending on the tribe. For this reason, the array of practices provided by traditional healers shall be in accordance with an individual tribe's established and accepted traditional healing practices as identified by the Qualifying Entity. A facility or clinic governing body may serve as the Qualifying Entity or the tribe(s) served by the facility may choose to designate another governing body as its Qualifying Entity to define what constitutes as a traditional healing service. In addition, the Qualifying Entity will be responsible for identifying the type of practitioner, including educational or cultural requirements traditional healing providers must possess. Upon approval of this expenditure authority AHCCCS will claim traditional healing services at 100 percent FMAP when the service is provided in either an outpatient or inpatient setting by the IHS, a tribal organization with a Section 638 agreement, or an Urban Indian Health Center. Traditional healing services must be included in the member's care plan in order to be deemed medically necessary.

In 1978, with the passage of the American Indian Religious Freedom Act, IHS policy required the Service Units to comply with patients' requests for the services of native practitioners, to provide a private space to accommodate the services, and required the staff to be respectful of individual religious and native beliefs. In 1994, IHS updated the policy, indicating that IHS would facilitate access to traditional medicine practices recognizing that traditional health care practices for many patients contribute to the healing process and help patients maintain their health and wellness. The Indian Health Care Improvement Act (U.S. Code Title 25 Chapter 18) contains several sections noting the acceptance of and respect for these practices, specifically incorporating them into various preventative

service categories including behavioral health services and treatment. Title 25 U.S.C. § 1680u clarifies that, "Although the Secretary may promote traditional health care practices, consistent with the Service standards for the provision of health care, health promotion, and disease prevention under this chapter, the United States is not liable for any provision of traditional health care practices pursuant to this chapter that results in damage, injury, or death to a patient. Nothing in this subsection shall be construed to alter any liability or other obligation that the United States may otherwise have under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) or this chapter." With nearly half of all services offered to AI/AN members provided by I/T/Us, incorporating traditional health services benefits into Medicaid services will further enhance Indian health care in accordance with these long standing IHS policies.

REIMBURSEMENT METHODOLOGY FOR TRADITIONAL HEALING SERVICES

Traditional healing services must be part of a comprehensive plan of health care that includes specific individualized goals. AHCCCS requests expenditure authority to claim FFP for these services when provided by the I/T/U facilities at 100 percent FMAP.

AHCCCS would reimburse the I/T/U facilities and clinics for covered traditional healing services provided in an outpatient setting at the outpatient All-Inclusive Rate (AIR) published in the Federal Register that is in effect on the date of service for Medicaid outpatient services, whether the traditional healing service is provided on or off reservation.

A traditional healing service provided in an inpatient setting, when provided in conjunction with a separate qualifying Medicaid inpatient stay, would be reimbursed as a professional fee. Reimbursable professional fees for traditional healing services would be identified based upon a Healthcare Common Procedure Coding System (HCPCS) code for traditional services. Payment as a professional fee is established based on that code whether the traditional healing service is provided inpatient, at an outpatient clinic, or whether the traditional healing service is provided on or off reservation.

In order to reimburse for services, the following arrangements between the Traditional Health Provider and the Facility must be in place:

- The array of traditional healing services to be available to Medicaid eligible members would need to be authorized and provided by the Facility.
- Traditional healing policies and procedures would be developed by the Facility governing body.
- The Facility would be responsible for establishing the traditional healing services to be utilized or arranged with a qualified traditional healer (as either an employee or contractor) to provide the services.
- The Facility would be responsible for having policies in place by which traditional healing and the clinical and preventive allopathic health care providers consult each other and share treatment information for members.
- The Facility system of performance evaluation or a customer service satisfaction survey that provides information on the effectiveness of the traditional healing program would be required.

WAIVER AND EXPENDITURE AUTHORITIES NECESSARY TO AUTHORIZE THIS DEMONSTRATION

Waiver Authority Requested	Brief Description
Section 1902(a)(B) of the Social Security Act and 42 CFR 440.240 (comparability)	To the extent necessary to enable the State to reimburse for traditional healing services for American Indian and Native Alaska members provided in, at, or as a part of services offered by facilities and clinics operated by the Indian Health Service, a tribe or tribal organization, or an Urban Indian health program.
Expenditure authority for services not covered under Section 1905 of the Social Security Act	To the extent necessary to enable the State to claim FFP for the cost of traditional healing services provided in, at, or as a part of services offered by facilities and clinics operated by the Indian Health Service, a tribe or tribal organization, or an Urban Indian health program and receive 100 percent FMAP.

Tribal Dental Benefit (House Bill 2244; ARS 36-2907 and 36-2939)

Oral health care is essential to a person's overall health and quality of life. A growing body of evidence has linked oral health, particularly periodontal (gum) disease, to several chronic diseases, including diabetes, heart disease, and stroke.[8] Recognizing the importance of oral health care, Governor Ducey, in partnership with the Arizona legislature, restored limited AHCCCS coverage for dental benefits that were eliminated during the Great Recession. As part of the 2016 legislative session, the Arizona Legislature, through HB 2704, authorized AHCCCS to provide a limited dental benefit of $1,000 per member per contract year for individuals enrolled in ALTCS. In 2017, Governor Ducey approved the 2018 fiscal year budget which restored the emergency dental benefit for adult AHCCCS members. The adult emergency dental benefit was capped at $1,000 per member per contract year. In 2020, Governor Ducey and the Arizona Legislature, through HB 2244 (ARS 36-2907 and 36-2939), authorized AHCCCS to seek approval from CMS to reimburse Indian Health Services and Tribal 638 facilities to cover the cost of adult dental services that are eligible for 100 percent FMAP, that are in excess of the $1,000 emergency dental limit for adult members in Arizona's State Plan and the $1,000 dental limit for individuals age 21 or older enrolled in the ALTCS program.

According to the Centers for Disease Control and Prevention, non-Hispanic blacks, Hispanics, and American Indians and Alaska Natives generally have the poorest oral health of any racial and ethnic groups in the United States.[9] AI/AN adults suffer from untreated dental caries at twice the prevalence of untreated caries in the general U.S. population.[10] Among 35-49 year olds, 27 percent of the general U.S. population has untreated caries compared to 64 percent of AI/AN dental patients. The relative geographic isolation of tribal populations and the inability to attract dentists to practice in IHS or tribal health facilities in rural and frontier areas are significant contributors to these oral health disparities. A study by the U.S. Government Accountability Office (GAO) reported 27 percent of the total positions for dentists were vacant in the eight areas in which IHS provides substantial direct care to the AI/AN population, ranging from 14 percent in the Phoenix IHS Area to 34 percent in the Navajo IHS Area.[11]

The purpose of this waiver request is to improve oral health among tribal members and to reduce the disproportionate number of AI/AN population affected by oral disease. Furthermore, this waiver authority will provide the IHS and Tribal 638 facilities with needed financial resources to attract dentists to practice on tribal reservations and rural areas.

The Arizona AI/AN population is approximately 385,000.[12] Almost half of that population is enrolled in AHCCCS, with approximately 75 percent of the AHCCCS eligible AI/AN population enrolled in the AIHP. In FFY 2019, 9,310 adult AI/AN AHCCCS members over the age of 21 received AHCCCS covered dental services in IHS or Tribal 638 facilities. AHCCCS estimates that 11,000 adult AI/AN members will utilize dental services under this Demonstration in FFY 2021. Furthermore, AHCCCS estimates that approximately 150 to 200 members will exceed the $1,000 limit for emergency and ALTCS dental in FFY 2021.

This proposed tribal dental benefit Demonstration would be effective on October 1, 2021 or when approved by CMS whichever is later.

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[8] Kim, J., & Amar, S. (2006). Periodontal disease and systemic conditions: a bidirectional relationship. Odontology, 94(1), 10–21. https://doi.org/10.1007/s10266-006-0060-6; Arigbede, A., Babatope, B. o., & Bamidele, M. k. (2012). Periodontitis and systemic diseases: A literature review. Journal of Indian Society of Periodontology, 16(4), 487. https://doi.org/10.4103/0972-124x.106878

[9] Disparities in Oral Health | Division of Oral Health | CDC. (2020). Centers for Disease Control and Prevention. www.cdc.gov/oralhealth/oral_health_disparities/index.htm

[10] Phipps, K. P., & Ricks, T. R. (2016). The Oral Health Of American Indian And Alaska Native Adult Dental Patients: Results Of The 2015 IHS Oral Health Survey. Indian Health Service Data Brief, 1–10. https://www.ihs.gov/DOH/documents/IHS_Data_Brief_March_2016_Oral_Health%20Survey_35_plus.pdf

[11] United States Government Accountability Office (GAO). (2018). Indian Health Service Agency Faces Ongoing Challenges Filling Provider Vacancies. https://www.gao.gov/assets/700/693940.pdf

[12] U.S. Census Bureau QuickFacts: Arizona. (2020). Census Bureau QuickFacts. https://www.census.gov/quickfacts/AZ

WAIVER AND EXPENDITURE AUTHORITIES NECESSARY TO AUTHORIZE THIS DEMONSTRATION

Waiver Authority Requested	Brief Description
Section 1902(a)(B) of the Social Security Act and 42 CFR 440.240 (comparability)	To the extent necessary to enable the State to reimburse for dental services for American Indian and Alaska Native members provided in, at, or as a part of services offered by facilities and clinics operated by the Indian Health Service or a tribe or tribal organization.
Expenditure authority for services not covered under Section 1905 of the Social Security Act	To the extent necessary to enable the State to claim FFP to cover the cost of adult dental services that are eligible for 100 percent FMAP, that are in excess of the $1,000 emergency dental limit for adult members in Arizona's State Plan and $1,000 dental limit for individuals age 21 or older enrolled in the ALTCS program.

VI. GOALS AND OBJECTIVES OF THE PROPOSED DEMONSTRATION RENEWAL

AHCCCS proposes the following research hypotheses and initial design approach for Arizona's Demonstration renewal.

<table>
<tr><th>Objectives</th><th>Proposed Hypotheses</th><th>Potential Approaches</th></tr>
<tr><td colspan="3">AHCCCS Complete Care (ACC)</td></tr>
<tr><td rowspan="6">The ACC Demonstration will provide quality healthcare to members, ensuring access to care for members, maintaining or improving member satisfaction with care, and continuing to operate as a cost-effective managed care delivery model.</td><td>Health plans will encourage and/or facilitate care coordination among PCPs and behavioral health practitioners.</td><td rowspan="6">Data will be drawn from a variety of sources including, but not limited to:
Member survey
State eligibility and enrollment data
Claims/encounter data
Administrative program data(PMMIS)
T-MSIS
National/regional benchmarks
Key informant interviews & focus groups</td></tr>
<tr><td>Access to care will be maintained and enhanced as a result of the integration of behavioral and physical care.</td></tr>
<tr><td>Quality of care will be maintained or enhanced as a result of the integration of behavioral and physical care.</td></tr>
<tr><td>Member self-assessed health outcomes will be maintained or improved as a result of the integration of behavioral and physical care.</td></tr>
<tr><td>Member satisfaction with the health care received will be maintained or will increase as a result of the integration of behavioral and physical care.</td></tr>
<tr><td>The ACC program will provide cost-effective care.</td></tr>
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<tr><th colspan="3">Arizona Long Term Care System (ALTCS)</th></tr>
<tr><td rowspan="6">The ALTCS Demonstration will provide quality healthcare to members with needs for LTSS, ensuring access to care for members, maintaining or improving member satisfaction with care, and will continue to operate as a cost-effective managed care delivery model.</td><td>ALTCS health plans will encourage and/or facilitate care coordination among PCPs and behavioral health practitioners.</td><td rowspan="6">Data will be drawn from a variety of sources including, but not limited to:
Member survey
State eligibility and enrollment data
Claims/encounter data
Administrative program data (PMMIS)
T-MSIS
National/regional benchmarks
Key informant interviews & focus groups</td></tr>
<tr><td>Access to care will be maintained or expanded over the waiver Demonstration.</td></tr>
<tr><td>Quality of care will be maintained or enhanced over the waiver Demonstration.</td></tr>
<tr><td>Health outcomes for members enrolled in ALTCS will be maintained or improved during the Demonstration.</td></tr>
<tr><td>Quality of life for members will be maintained or enhanced over the waiver Demonstration.</td></tr>
<tr><td>ALTCS will provide cost-effective care.</td></tr>
<tr><th colspan="3">Verbal Consent In Lieu Of Written Signature For Person Centered Service Plans For ALTCS Members</th></tr>
<tr><td rowspan="2">Obtaining verbal consent in lieu of written signature when identity can be reliably established for all LTSS care planning and treatment documentation will ensure continued access to care for ALTCS members and maintain or improve member satisfaction with care.</td><td>Access to care will be maintained or increased during the Demonstration.</td><td rowspan="2">Data will be drawn from a variety of sources including,but not limited to:
Member survey
State eligibility and enrollment data
Claims/encounter data
Administrative program data(PMMIS)
T-MSIS
National/regional benchmarks
Key informant interviews & focus groups</td></tr>
<tr><td>Implementation of verbal consent in lieu of written signature will yield improved member satisfaction.</td></tr>
</table>

Comprehensive Medical and Dental Program (CMDP)		
The CMDP Demonstration will provide quality healthcare to eligible foster children, ensuring access to care for members, maintaining or improving member satisfaction with care, and will continue to operate as a cost-effective managed care delivery model.	CMDP will encourage and/or facilitate care coordination among PCPs and behavioral health practitioners.	Data will be drawn from a variety of sources including, but not limited to: ● Member survey ● State eligibility and enrollment data ● Claims/encounter data ● Administrative program data(PMMIS) ● T-MSIS ● National/regional benchmarks ● Key informant interviews & focus groups
	Access to care will be maintained or increased during the Demonstration.	
	Quality of care for members enrolled in CMDP will be maintained or enhanced during the Demonstration.	
	Health outcomes for members enrolled in CMDP will be maintained or improved during the Demonstration.	
	Member satisfaction with the health care received will be maintained or will increase during the Demonstration.	
	CMDP will provide cost-effective care.	
Regional Behavioral Health Authorities (RBHA)		
The RBHA demonstration will provide quality healthcare to members with behavioral health needs, ensuring access to care for members, maintaining or improving member satisfaction with care, and will continue to operate as a cost-effective managed care delivery model.	RBHAs will encourage and/or facilitate care coordination among PCPs and behavioral health practitioners.	Data will be drawn from a variety of sources including, but not limited to: ● Member survey ● State eligibility and enrollment data ● Claims/encounter data ● Administrative program data(PMMIS) ● T-MSIS ● National/regional benchmarks ● Key informant interviews & focus groups
	Access to care for members with an SMI enrolled in a RBHA will be maintained or increased during the Demonstration.	
	Quality of care for members with an SMI enrolled in a RBHA will be maintained or enhanced during the Demonstration.	
	Health outcomes for members with an SMI enrolled in a RBHA will be maintained or improved during the Demonstration.	
	Member satisfaction in RBHA health plans will be maintained or improved over the waiver Demonstration.	

	RBHAs will provide cost-effective care for members with an SMI.	
Targeted Investments Program		
The Targeted Investments Demonstration will continue to reduce fragmentation that occurs between acute care and behavioral health care, increase efficiencies in service delivery for members with behavioral health needs, and improve health outcomes for the affected populations.	The TI Program will improve physical and behavioral health care integration for children.	Data will be drawn from a variety of sources including, but not limited to: ● Member survey ● State eligibility and enrollment data ● Claims/encounter data ● Administrative program data (PMMIS) ● T-MSIS ● National/regional benchmarks ● Key informant interviews & focus groups
	The TI Program will improve physical and behavioral health care integration for adults.	
	The TI Program will improve care coordination for AHCCCS-enrolled adults released from criminal justice facilities.	
	The TI Program will provide cost-effective care.	
	Providers will increase the level of care integration over the course of the Demonstration.	
	Providers will conduct care coordination activities.	
	Providers will identify members' social service needs and successfully connect them to community based organizations that can address those needs.	
Supplemental Payments to IHS and 638 Providers		
Ensure the viability of the IHS and 638 systems for the provision of care and maintain or improve access	Implementing uncompensated care payments to IHS and 638 facilities will allow staffing levels to be maintained or increased.	Data will be drawn from a variety of sources including, but not limited to: ● Member survey

to care to AI/AN members enrolled with AHCCCS.	Uncompensated care payments to IHS and 638 facilities will increase capacity to provide care and services resulting in AI/AN members enrolled with AHCCCS receiving health care services.	• State eligibility and enrollment data • Claims/encounter data • Administrative program data(PMMIS) • T-MSIS • National/regional benchmarks • Key informant interviews & focus groups
Tribal Dental Benefit (HB 2244; ARS 36-2907 and ARS 36-2939)		
AI/AN members enrolled with AHCCCS receiving services in IHS and 638 facilities will have improved access to dental services while maintaining or improving member outcomes/experience.	The rate of dental visits will be maintained or improved in IHS and 638 facilities for AI/AN members enrolled with AHCCCS.	Data will be drawn from a variety of sources including, but not limited to: • Member survey • State eligibility and enrollment data • Claims/encounter data • Administrative program data(PMMIS) • T-MSIS • National/regional benchmarks • Key informant interviews & focus groups
	Health outcomes of AI/AN members enrolled with AHCCCS will be maintained or improved.	
	Oral health disparities will be reduced for AI/AN members enrolled with AHCCCS.	
Traditional Healing Services		
Traditional healing will enhance access to care for AI/AN members enrolled with AHCCCS, while maintaining or improving member health and satisfaction with care.	Implementation of traditional healing services will yield improved member satisfaction.	Data will be drawn from a variety of sources including, but not limited to: • Member survey • State eligibility and enrollment data • Claims/encounter data • Administrative program data(PMMIS) • T-MSIS • National/regional benchmarks • Key informant interviews & focus groups
	Traditional healing services will improve the health outcomes of AI/AN members enrolled with AHCCCS.	
	Availability of traditional healing services in allopathic primary care settings will increase the utilization of primary care services.	

AHCCCS Works		
The AHCCCS Works program will increase employment, employment opportunities, and activities to enhance employability, increase financial independence, and improve health outcomes of AHCCCS members.	The AHCCCS Works program will increase the rate of "able bodied adults" that are employed.	Data will be drawn from a variety of sources including, but not limited to: ● Member survey ● State eligibility and enrollment data ● Claims/encounter data ● Administrative program data(PMMIS) ● T-MSIS ● National/regional benchmarks ● Key informant interviews & focus groups
	The AHCCCS Works program will increase the rate of "able bodied adults" that are actively seeking employment.	
	The AHCCCS Works program will increase the rate of "able bodied adults" that are engaged in training or educational activities.	
	Current and former AHCCCS members subject to the community engagement requirement will have better health outcomes than members not subject to the requirement.	
	The AHCCCS Works program will increase the average household income of "able bodied adults" that are employed.	
Waiver of Prior Quarter Coverage		
The waiver of Prior Quarter Coverage will encourage members to obtain and continuously maintain/retain health coverage.	The implementation of the proposal will not adversely affect access to care.	Data will be drawn from a variety of sources including, but not limited to: ● Member survey ● State eligibility and enrollment data ● Claims/encounter data ● Administrative program data(PMMIS) ● T-MSIS ● National/regional benchmarks ● Key informant interviews & focus groups
	The implementation of the proposal will not reduce member satisfaction.	
	The implementation of the proposal will not adversely affect health outcomes	

VII. REQUESTED WAIVER AND EXPENDITURE AUTHORITIES

The following table summarizes the current Demonstration waiver and expenditure authorities and whether AHCCCS is requesting to continue these authorities in this renewal request.

Waiver/ CNOM	Title	Summarized Description	Status Under Extension
Waiver Authorities			
1.	**Proper and Efficient Administration** **Section 1902(a)(4) (42 CFR 438.52, 438.56)**	Permits AHCCCS to limit choice of managed care plans to a single managed care organization for individuals enrolled in the ALTCS, CMDP and RBHA programs (as detailed above). This authority also allows AHCCCS to restrict member disenrollment based on 42 CFR 438.56(d)(2)(v), 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.	**Continue**
2.	**Eligibility Based on Institutional Status** **Section 1902(a)(10)(A) (ii)(V) (42 CFR 435.217 and 435.236)**	Allows AHCCCS to exclude hospitalized individuals and others in medical institutions for more than 30 days from automatically becoming eligible for long term care services if they do not meet the level of care standard for long term care. AHCCCS would otherwise be required to provide long term care services to acute care individuals with income up to 300% of the FPL who may not be at risk of institutionalization but are in the hospital for more than 30 days.	**Continue**
3.	**Amount, Duration, Scope of Services** **Section 1902(a)(10)(B) (42 CFR 440.240 and 440.230)**	Permits the State to offer different/additional services based on different care arrangements for members receiving Spousal Caregiver Services. This authority also permits the State to offer coverage through MCOs that provide additional or different benefits to enrollees, than those otherwise available for other eligible individuals.	**Continue**

4.	**Disproportionate Share Hospital (DSH) Payments** **Section 1902(a)(13) insofar as it incorporates Section 1923**	Allowed AHCCCS to operate Disproportionate Share Hospital (DSH) program under the waiver instead of the State Plan. On October 1, 2017, AHCCCS transferred the DSH program to the Medicaid State Plan. Therefore, this authority is no longer needed.	**Discontinue**
5.	**Estate Recovery** **Section 1902(a)(18) (42 CFR 433.36)**	Relieves AHCCCS from creating an estate recovery program for acute care enrollees age 55 and older who receive long term care services.	**Continue**
6.	**Freedom of Choice** **Section 1902(a)(23)(A) (42 CFR 431.51)**	Permits AHCCCS to operate a statewide mandatory managed care system. AHCCCS members are able to choose from at least two primary care physicians within their health care plan. Other protections are in place to assure quality and continuity of care through policy, contract and standards. Additionally, this authority enables AHCCCS to impose a limitation on providers on charges associated with non-covered activities.	**Continue**
7.	**Drug Utilization Review** **Section 1902(a) (54) insofar as it incorporates Section 1927(g) (42 CFR 456.700 through 456.725 and 438.3(s) (4) and (5))**	Relieves the State from the requirements of Section 1927(g) of the Act pertaining to drug use review.	**Continue**
8.	**Premiums** **Section 1902(a) (14) insofar as it incorporates Sections 1916 and 1916A**	Allows AHCCCS to impose monthly premiums for adult members enrolled in AHCCCS CARE. The State has not implemented AHCCCS CARE and does not intend to include the AHCCCS CARE program under this waiver renewal request; therefore this authority is no longer required.	**Discontinue**

9.	**Comparability** **Section 1902(a)(17)**	Enables AHCCCS to vary the premiums and cost-sharing for members enrolled in the AHCCCS CARE program. The State has not implemented AHCCCS CARE and does not intend to include the AHCCCS CARE program under this waiver renewal request; therefore this authority is no longer required.	**Discontinue**
10.	**Provision of Medical Assistance** **1902(a)(8) and (a)(10)**	Allows AHCCCS to suspend eligibility for, and not make medical assistance available to, members subject to the AHCCCS Works community engagement requirements who fail to comply with those requirements.	**Continue**
11.	**Eligibility** **Section 1902(a)(10)**	Allows the AHCCCS to impose the AHCCCS Works community engagement and associated reporting requirements as a condition of eligibility.	**Continue**
12.	**Retroactive Eligibility** **Section 1902(a)(10) and (a)(34)**	Permits the State to limit retroactive coverage to the month of application for AHCCCS members, except for a pregnant woman (including during the 60-day period beginning on the last day of the pregnancy), an infant under age 1, or a child under age 19.	**Continue**
Expenditure Authorities			
Expenditures Related to Administrative Simplification and Delivery Systems			
1.	**MCO Requirements (Companion to Waiver #1)**	Allows the State to claim as medical assistance payments to MCOs who do not meet requirements of 1932(a)(3) (freedom of choice of MCOs) to operate one MCO for individuals enrolled in ALTCS, CMDP, and RBHA.	**Continue**
2.	**MCO Requirements (Companion to Waiver #1)**	Allows AHCCCS to automatically re-enroll a member into the same health plan as was previously enrolled if the member lost eligibility within 90 days. AHCCCS would otherwise only have two months to re-enroll a member into the same health plan pursuant to 42 CFR 438.56(g).	**Continue**

3.	**MCO Requirements**	Permits AHCCCS to contract 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 such services are not included within the scope of the managed care contract. In addition, this authority permits AHCCCS to make direct payments to IHS or Tribal 638 providers, which are offset from the managed care capitation rate.	**Continue**
4.	**Outpatient Drugs (Companion to Waiver #7)**	Permits AHCCCS to claim federal financial participation for outpatient drugs which are not otherwise allowable under Section 1903(i)(10) of the Act that have not undergone a drug utilization review.	**Continue**
5.	**Direct Payments to Critical Access Hospitals**	Permits 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.	**Continue**
6.	**Fee-For-Service Upper Payment Limit**	Permits AHCCCS to claim federal financial participation for items and services provided to AHCCCS fee-for-service member that exceed the amounts allowable under Section 1902(a)(30)(A) of the Act and the upper payment limitation and actual cost requirements of 42 CFR 447.250 through 447.280 (regarding payments for inpatient hospital and long-term care facility services), 447.300 through 447.321 (regarding payment methods for other institutional and non-institutional services) and 447.512 through 447.518(b) regarding payment for drugs) so long as those expenditures are in accordance with Special Term and Condition (STC) 91 entitled "Applicability of Fee-for-Service Upper Payment Limit."	**Continue**
7.	**Disproportionate Share Hospital** **(Companion to Waiver #4)**	Permits 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. On October 1, 2017, AHCCCS transferred the DSH program to the Medicaid State Plan. Therefore, this authority is no longer needed.	**Discontinue**

8.	**HCBS Alternative Residential Settings**	Permits the State to claim as medical assistance expenditures for HCBS through ALTCS for those over 18 who reside in Alternative Residential Settings classified as residential Behavioral Health facilities. The primary focus of a licensed Behavioral Health Residential Facility (BHRF) is to provide clinical interventions with minimal personal care support, to treat a behavioral health issue(s) while promoting resident independence to transition into their own housing. Arizona's HCBS Rules Assessment concluded that BHRFs are clinical, treatment-based settings and transitional in nature, and therefore cannot be considered a HCBS. Therefore, BHRFs will be re-classified as an acute care behavioral health setting. However, BHRFs will continue to be available in the array of covered behavioral health benefits for ALTCS members.	**Modification**
Expenditures Related to Expansion of Existing Eligibility Groups based on Eligibility Simplification			
9a.	**ALTCS Income Disregard**	Permits AHCCCS to claim federal financial participation for 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.	**Continue**
9b.	**300% of Federal Benefit Rate**	Permits AHCCCS to claim federal financial participation for 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.	**Continue**
9c.	**Children/ Spouses in Separation**	Permits AHCCCS to claim federal financial participation for 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.	**Continue**

9d.	**QMB, SLMB, QI-1, SSI MAO, ISM income disregard**	Permits AHCCCS to claim federal financial participation for 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).	**Continue**
9e.	**SSI-MAO**	Permits AHCCCS to claim federal financial participation for 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.	**Continue**
9f.	**Disregard of Interest**	Permits AHCCCS to claim federal financial participation for 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.	**Continue**
9g.	**Disregard of Interest**	Permits AHCCCS to claim federal financial participation for 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.	**Continue**
9h.	**Disregard of Excess Resources**	Permits AHCCCS to claim federal financial participation for 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).	**Continue**

9i.	**Disregard of Quarterly Income Totaling Less than $20**	Permits AHCCCS to claim federal financial participation for medical assistance that would not be allowable but for the disregard of quarterly income totaling less than $20 from the post-eligibility determination.	**Continue**
10.	**SSI Eligibility**	Allows AHCCCS 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.	**Continue**
11.	**Medicare Part B Premiums**	Permits AHCCCS to pay for 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.	**Continue**
12.	**ALTCS PAS**	Allows AHCCCS 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 intellectual disability on the preadmission screening instrument.	**Continue**
13.	**Home and Community Based Services**	Permits AHCCCS to claim federal financial participation for expenditures associated with the provision of HCBS to individuals enrolled in ALTCS with income levels up to 300 percent of the SSI income level, as well as individuals enrolled in the ALTCS Transitional program.	**Continue**

Other Expenditure Authorities Related to Arizona's Demonstration			
14.	**HCBS Spouses as Paid Caregivers**	Permits AHCCCS to claim federal financial participation for expenditures associated with the provision of paid caregiver services provided by spouses for eligible ALTCS members.	**Continue**
15.	**ALTCS Adult Dental Benefit**	Allows expenditures to provide certain dental services up to a cost of $1,000 per person annually to individuals age 21 or older enrolled in the Arizona Long Term Care System.	**Continue**
16.	**Safety Net Care Pool (SNCP)**	Permits Safety Net Care Pool (SNCP) payments to Phoenix Children's Hospital reflecting uncompensated care costs incurred by Phoenix Children's Hospital, on or before December 31, 2017, for 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 hospital pursuant to section 1923 of the Act. This authority to make SNCP payments to Phoenix Children's Hospital expired on December 31, 2017.	**Discontinue**
17.	**Hospital Presumptive Eligibility for Pregnant Women**	Allows expenditures for all state plan and Demonstration covered services for pregnant women during their hospital presumptive eligibility (HPE) period.	**Continue**
18.	**I.H.S./638 Uncompensated Care**	Permits payments to participating IHS and tribal 638 facilities for categories of care that were previously covered under the State Medicaid plan, furnished in or by such facilities.	**Continue**
19.	**Targeted Investments Program**	Allows expenditures to pay incentive payments to providers participating in the Targeted Investments Program as described in Arizona's Demonstration.	**Continue**
20.	**Targeted Investments Program**	Grants expenditure authority to AHCCCS to claim federal financial participation for expenditures made for certain designated state health programs (DSHP), not to exceed amounts specified in Arizona's Demonstration, for the Targeted Investments Program.	**Continue**

The table below summarizes the new authorities that AHCCCS is seeking under this waiver renewal proposal.

Proposed Demonstration	Waiver Authority Requested	Brief Description
Verbal Consent In Lieu Of Written Signature For Person Centered Service Plans For ALTCS Members	**Section 1915(c) of the Social Security Act and 42 CFR 441.301(c)(2)(ix)**	To the extent necessary to enable the State to waive requirements under home and community based service programs that require person-centered service plans to receive written consent from members and be signed by members and all providers responsible for its implementation and allow for verbal consent in lieu of written signature for up to 30 days for all care and treatment documentation when identity can be reliably established and documented in member's record.
Traditional Healing Services	**Section 1902(a)(B) of the Social Security Act and 42 CFR 440.240 (comparability)**	To the extent necessary to enable the State to reimburse for traditional healing services for American Indian and Native Alaska members provided in, at, or as a part of services offered by facilities and clinics operated by the Indian Health Service, a tribe or tribal organization, or an Urban Indian health program.
Traditional Healing Services	**Expenditure authority for services not covered under Section 1905 of the Social Security Act**	To the extent necessary to enable the State to claim Federal Financial Participation (FFP) at 100 percent FMAP for the cost of traditional healing services provided in, at, or as a part of services offered by facilities and clinics operated by the Indian Health Service, a tribe or tribal organization, or an Urban Indian health program.
Tribal Dental Benefit (HB 2244)	**Section 1902(a)(B) of the Social Security Act and 42 CFR 440.240 (comparability)**	To the extent necessary to enable the State to reimburse for dental services for American Indian and Native Alaska members provided in, at, or as a part of services offered by facilities and clinics operated by the Indian Health Service or a tribe or tribal organization.
Tribal Dental Benefit (HB 2244)	**Expenditure authority for services not covered under Section 1905 of the Social Security Act**	To the extent necessary to enable the State to claim FFP to cover the cost of adult dental services that are eligible for 100 percent FMAP, that are in excess of the $1,000 emergency dental limit for adult members in Arizona's State Plan and $1,000 dental limit for individuals age 21 or older enrolled in the ALTCS program.

VIII. BUDGET NEUTRALITY

Arizona's Demonstration is required to be budget-neutral, meaning that federal spending under the Demonstration cannot exceed what it would have been in absence of the waivers and expenditure authorities. Information regarding Arizona's Demonstration budget neutrality assessments for the projected renewal period can be found in **Appendix C.**

IX. PUBLIC NOTICE PROCESS

Pursuant to the terms and conditions that govern Arizona's Demonstration, Arizona must provide documentation of its compliance with Demonstration of Public Notice process (42 CFR 431.408), the tribal consultation requirements pursuant to Section 1902(a)(73) of the Act as amended by Section 5006(e) of the American Recovery and Reinvestment Act of 2009, and the tribal consultation requirements outlined in STC 13.

Public Website:
The Demonstration renewal request was posted on the AHCCCS website for public comment on October 2, 2020 at: www.azahcccs.gov/WaiverRenewal. The web page includes a summary of Arizona's Demonstration renewal request, the schedule (dates and times) of public forums across the state, this draft Demonstration renewal proposal, and budget neutrality worksheets. In addition to the website posting, AHCCCS used social media accounts and electronic mail to notify interested parties about Arizona's Demonstration renewal proposal.

Publication of Public Notice in the Arizona Administrative Register:
On October 2, 2020, public notice of Arizona's Demonstration renewal request was published in the Arizona Administrative Register. The notice included a summary description of the Demonstration request, the locations, dates and times of the public hearings, instructions on how to submit comments and a link to where copies of the Demonstration application are available for public review and comments.

Stakeholder Meetings:
AHCCCS presented the details about Arizona's Demonstration renewal proposal to the public. Feedback was solicited at several agency meetings: three Demonstration renewal public forum meetings held online and attended by a variety of community stakeholders, as well as through other public meetings such as the State Medicaid Advisory Committee (SMAC), and several tribal consultations.

All public forum meetings were held via webinar to promote social distancing and to mitigate the spread of COVID-19. The meetings included video streaming and telephonic conference capabilities to ensure statewide accessibility. The public was provided the opportunity to review and submit comments on the proposal at the public meetings and in writing via e-mail to waiverpublicinput@azahcccs.gov or by mail to AHCCCS, c/o Division of Community Advocacy and Intergovernmental Relations, 801 E. Jefferson Street, MD 4200, Phoenix, AZ 85034. Details regarding the public forum meetings can be found in **Appendix E.**

X. PUBLIC COMMENT SUMMARY

As part of Arizona's Demonstration renewal, AHCCCS acknowledged, reviewed, and considered all comments received through the public input process. Overall, AHCCCS directly engaged more than 450 stakeholders across the state and received 39 comment letters from stakeholders, including but not limited to, current members, providers, public health organizations, legal advocates, hospital associations, and consumer advocacy groups. Copies of the written comments are included in **Appendix F**. Below is a summary of the key themes that emerged from the public comment process.

AHCCCS Works

Stakeholders expressed concerns regarding the implementation of the AHCCCS Works program. The majority of stakeholders requested that the community engagement requirements be discontinued in Arizona's

Demonstration. Stakeholder concerns centered upon the potential loss of coverage resulting from non-compliance with AHCCCS Works requirements, the increase in programmatic administrative costs due to reporting requirements, and the undue burden associated with reporting requirements that may be placed on members who have limited resources. Specifically, AHCCCS received comments expressing concerns about members' abilities to comply with the reporting requirement if they do not have access to a reliable internet connection.

Arizona's Response: Arizona's community engagement requirement is designed to encourage members to obtain employment and/or undertake other community engagement activities that are associated with improved health and wellness. To minimize the adverse impact of community engagement requirements on particularly vulnerable members and members whose circumstances may make participation in qualifying activities challenging, Arizona has adopted a broad array of exemptions from participation in the community engagement program. AHCCCS has also incorporated multiple communication options, so that members are provided the opportunity to request an exemption or attest to program compliance in a manner that most easily suits their circumstances. These include using an AHCCCS web-based portal, by telephone, by mail, and in person. For these reasons, Arizona will not make changes to the AHCCCS Works program design at this time.

AHCCCS recognizes that clear, consistent, and continuing communication about the AHCCCS Works program and its requirements is critical to successful member compliance. We are committed to developing a comprehensive communication strategy, using a variety of approaches, to educate members about how to succeed in the AHCCCS Works program and, when operational, we intend to continually reinforce this objective. The agency's communication strategy includes, but is not limited to: multiple written letters mailed to members; content and documents posted on the AHCCCS website and distributed at in-person meetings; video content for members and providers to be posted in the AHCCCS Works portal; and social media awareness campaigns. Additionally, contracted health plans will support agency efforts to educate members with their own direct member communication resources.

Waiver of Prior Quarter Coverage

AHCCCS received numerous comments regarding Arizona's Waiver of Prior Quarter Coverage. The majority of comments requested AHCCCS to reinstate Prior Quarter Coverage for all populations. AHCCCS received comments expressing concerns that the Waiver of Prior Quarter Coverage will shift health care costs to members and providers, resulting in increased out-of-pocket spending, medical bankruptcies, and uncompensated care costs, especially during the COVID-19 pandemic. Many comments noted that the Medicaid application process is lengthy, complicated, and burdensome to individuals trying to apply for or maintain coverage. Some stakeholders requested AHCCCS to exclude specific populations from the Waiver of Prior Quarter Coverage including American Indian members, individuals who apply for the ALTCS program, and individuals who have been diagnosed with serious illnesses such as cancer. AHCCCS also received comments requesting that the agency suspend the Waiver of Prior Coverage until HSAG completes the interim evaluation for this component of Arizona's Demonstration.

Arizona's Response: Arizona's Waiver of Prior Quarter Coverage promotes the objectives of the Medicaid program by encouraging members to obtain and continuously maintain health coverage without gaps in eligibility, regardless of health status or needs. The Waiver of Prior Quarter Coverage was designed to promote improved continuity of coverage by discouraging gaps in coverage that can occur when individuals wait until they are sick to apply for Medicaid or delay completing renewals of eligibility. Furthermore, a waiver from this requirement encourages members to obtain preventive health services and promotes efficiency that will enable the state to better contain Medicaid costs, thereby promoting the sustainability of the Medicaid program.

Arizona's Waiver of Prior Quarter Coverage was authorized by CMS through September 30, 2021. As described in Arizona's Demonstration renewal narrative, an updated interim evaluation report will be completed by HSAG in summer 2021, before the end of the current demonstration period. This report will contain results for additional years and include findings to date from focus groups and qualitative interviews. In addition, the updated interim evaluation report will use statistical techniques, where possible, in order to control for confounding factors and

identify the impact of the Waiver of Prior Quarter Coverage on access to care, quality of care, and member experience with care.

Arizona is committed to ensuring ongoing access to care for AHCCCS members during the COVID-19 pandemic and continues to monitor the stability of provider networks during the public health emergency. To help Arizona's providers weather the impact of COVID-19, AHCCCS advanced payments, increased payments, and offered retention payments to providers, with a particular focus on hospitals, nursing facilities and assisted living facilities, HCBS providers, behavioral health providers, and other community based providers. For example, at the onset of the COVID-19 public health emergency period, AHCCCS made available more than $50 million in accelerated hospital payments and advances and extended an additional $5 million in new COVID-19 related funding to Critical Access Hospitals throughout the state. In addition, AHCCCS received federal approval from CMS to increase Arizona hospital reimbursement rates by more than 30 percent. This change in reimbursement alone will result in a net increase in payments to eligible Arizona hospitals of approximately $800 million in the first year of implementation. AHCCCS also educated providers about the provider relief funding available at the federal level including federal reimbursement for COVID-19 testing and treatment for uninsured individuals.

At this time, no changes related to the design of the Waiver of Prior Quarter Coverage are proposed in Arizona's Demonstration renewal request as a result of public comment.

Traditional Healing Services

Stakeholders support the inclusion of traditional healing services in Arizona's Demonstration renewal application. Many stakeholders applauded AHCCCS for working closely with tribal stakeholders to develop the traditional healing proposal. Tribal stakeholders commended the language included in the proposal that allows each Arizona tribe to select its own Qualifying Entity to define and endorse traditional healers and the services they perform. Many tribal stakeholders commented that this flexibility respects tribal sovereignty and recognizes that the training and qualifications of traditional healing providers may vary widely depending on the tribe. Stakeholders also expressed the importance of traditional healing services in helping American Indian members achieve wellness.

AHCCCCS Response: AHCCCS appreciates the commentary provided supporting the traditional healing services proposal. The agency will continue to work closely with tribes and CMS to incorporate this benefit in Arizona's Demonstration project.

Tribal Dental Benefit (House Bill 2244; ARS 36-2907 and 36-2939)

AHCCCS received several comments supporting the tribal dental benefit request (HB 2244; ARS §§36-2907 and 36-2939). AHCCCS is seeking authority to reimburse IHS and tribal 638 facilities to cover the cost of adult dental services that are eligible for 100 percent FFP, that are in excess of the $1,000 emergency dental limit for adult members in Arizona's State Plan and the $1,000 dental limit for individuals age 21 or older enrolled in the ALTCS program. Many stakeholders expressed concerns that the geographic isolation of tribal populations and the inability to attract dentists to practice in IHS or tribal health facilities in rural and frontier areas are significant contributors to oral health disparities in the American Indian population. Stakeholders noted that this dental proposal will serve to increase access to oral health care for American Indian members, especially in geographic regions where dental services are needed the most. Several stakeholders thanked State Representative T.J. Shope for bringing forward HB 2244, the Arizona Legislature for passing the bill with nearly unanimous support, and Governor Ducey for signing the bill into law.

AHCCCS Response: AHCCCS appreciates the broad support received from stakeholders with regard to Arizona's tribal dental benefit request. The agency will continue to work closely with tribes, legislators, and IHS and 638 providers to receive CMS authorization for this important legislative mandate.

ALTCS Verbal Consent

Stakeholders unanimously support giving Arizona waiver authority, beyond the termination of the COVID-19 public health emergency, to allow for verbal consent in lieu of written signature for up to 30 days for all care and treatment documentation for ALTCS members when included in the member's record and when identity can be reliably established. Stakeholders noted that this flexibility has proven to be valuable during the COVID-19 pandemic in caring for vulnerable members living on reservations as well as for members residing in rural settings and in other locations where written consent/confirmation cannot reasonably be obtained.

AHCCCCS Response: AHCCCS appreciates the commentary provided for the ALTCS Verbal Consent proposal. The agency looks forward to working with CMS to incorporate this flexibility into Arizona's Demonstration project.

Targeted Investments Program 2.0

Stakeholders expressed full support for Arizona's TI Program renewal request. Stakeholders praised the TI Program for breaking down silos between acute and behavioral health providers. Many commenters acknowledged the crucial role that social determinants of health play in providing care for Arizona's Medicaid population, and expressed support for leveraging the TI Program to incentivize collaboration between medical providers and CBOs, particularly those crucial to addressing social risk factors such as housing, food, employment, social isolation, and non-medical transportation for AHCCCS members. Many stakeholders underscored the importance of using TI Program funding to support the participating CBOs in building infrastructure and capacity to serve AHCCCS members. AHCCCS received several requests to add provider types which were not included in the current TI Program.

AHCCCCS Response: AHCCCS appreciates stakeholders' broad support and positive feedback for the TI Program 2.0 proposal, an exciting opportunity to continue progress toward achieving a truly holistic, person-centered approach to health care for AHCCCS members. The agency acknowledges and appreciates the comments received on providing funding to assist the CBOs in building infrastructure and capacity to participate in the program. AHCCCS also appreciates the recommendation from stakeholders to include additional provider types in the program. The TI Program 2.0 section of Arizona's Demonstration application is purposefully high level and outlines only the primary objectives for the renewal request. AHCCCS will develop a concept paper in 2021 that outlines the details for the TI Program 2.0, and will seek extensive stakeholder input to develop this proposal.

Whole Person Care Services

Stakeholders provided feedback urging AHCCCS to request waiver expenditure authority to reimburse for whole person care services, such as housing, food, and non-medical transportation. Commenters stressed that non-medical services and supports are critical in addressing social determinants of health, reducing health disparities and improving health outcomes for AHCCCS members. Many stakeholders noted the spike in unsheltered homelessness in Maricopa County and other regions of the state, expressed concern about the looming housing evictions during the COVID-19 pandemic, and voiced the need for additional housing funding to support AHCCCS members who are homeless and who also have behavioral health needs. Specific housing services recommended by stakeholders include permanent supportive housing, rapid rehousing, and utility support. Other services recommended by stakeholders include food boxes, employment and training services, transportation to legal and social services, such as mental health and drug courts, probation and parole offices, city and county housing departments, and domestic violence services.

AHCCCS Response: AHCCCS acknowledges and appreciates the extensive feedback from stakeholders, requesting expenditure authority to reimburse for housing and other whole person care services. The agency shares the stakeholder perspective that non-medical services and supports are critical in addressing social determinants of health and improving health equity and health outcomes for Medicaid members. AHCCCS will research and explore the opportunity to incorporate whole person care services in Arizona's Demonstration project in the near future.

AHCCCS Demonstration Renewal: Community Forum Summary

The Arizona Healthcare Cost Containment System (AHCCCS) held public forums regarding Arizona's Demonstration renewal request. Feedback was solicited at several agency meetings: three Demonstration renewal public forum meetings held online and attended by a variety of community stakeholders, as well as through other public meetings such as the State Medicaid Advisory Committee (SMAC), and several tribal consultations. The following is a summary of questions and comments from the public and Agency's responses during the forums. The summary is divided into seven major sections: (1) AHCCCS Works; (2) Waiver of Prior Quarter Coverage; (3) tribal dental benefit; (4) traditional healing services; (4) verbal consent in lieu of written signature for ALTCS members; (5) COVID-19 pandemic response; (6) waiver evaluation; and (7) other topics.

Name/Organization	Stakeholder Questions and Comments	AHCCCS Response
AHCCCS Works		
Eddie Sissons, Community Member	In light of Georgia's recent community engagement waiver approval, when will Arizona implement AHCCCS Works? Yuma has a high rate of seasonal unemployment compared to other counties in Arizona. What will AHCCCS do to address this challenge for members in Yuma required to participate in AHCCCS Works?	At this time, AHCCCS does not have a timetable for implementing the AHCCCS Works program and continues to monitor litigation filed in other states. The agency will inform the public when a timetable for implementing this program has been established. AHCCCS recognizes the challenges specific to Yuma with respect to seasonal unemployment. It is important to note, however, that community engagement activities are broad and include other activities such as conducting job searches, volunteering, education/training, etc. Given the concern, AHCCCS will explore adding Yuma to Phase II of the AHCCCS Works implementation.
Alida Montiel, Inter Tribal Council of Arizona	If the unemployment rates are high or at some predetermined level in some geographic regions, will AHCCCS Works be delayed?	The phased roll out of the program is framed around the level of urbanization of a county and the corresponding level of resources available to support members' success in the AHCCCS Works program. Furthermore, AHCCCS will assess areas that have high rates of unemployment, areas with limited economies and/or educational opportunities, and areas that lack public transportation to determine whether further exemptions from the AHCCCS Works requirements and/or additional mitigation strategies are needed to alleviate unreasonable burden on members.

Community Member	I appreciate that exemption for American Indian members of federally recognized tribes. However, in many tribal communities, children and grandchildren of tribal members have not yet enrolled in the tribe, or they are eligible for IHS but may not have the blood quantum to officially enroll. Does the American Indian exemption include children and grandchildren of members enrolled in a federally recognized tribe? We would like to ensure that these children and grandchildren who are not enrolled in a tribe are still exempt from the AHCCCS Works program.	Children and grandchildren of members enrolled in a federally recognized tribe will be exempted from the AHCCCS Works program, including those who are not enrolled in tribes or do not have the blood quantum to officially enroll.
Community Member	How many American Indian members will be exempted from AHCCCS Works?	At this time, AHCCCS estimates approximately 26,338 American Indian members will be exempted from the AHCCCS Works program. This figure may change in the future.
Community Member	Children and grandchildren move away from the tribal land. This is going to put a burden on facilities to verify tribal enrollment. Once a member turns 18, they could be charged for services if they are an AHCCCS member. Situations can get complicated, but the overall exemption is worthwhile and the tribes appreciate it. Just want to remind everyone how complicated this can get.	Noted.
Kim Russell, Arizona Advisory Council on Indian Health Care	I am grateful that there is an American Indian exemption for the AHCCCS Works program. I am aware that AHCCCS intends to set up a process where members can self-identify through Health-e Arizona Plus (HEA Plus). However, this assumes that all tribal members have access to the internet. Can patient business offices or other community resources assist with member attestation for the American Indian exemption?	Yes, a phone line will be available for members to call and attest to exemptions. Community navigators will also be available to assist members.
Vince Torres, First Things First	Do you anticipate administrative challenges in processing the AHCCCS Works exemptions? Do members have to seek exemptions on a monthly basis?	AHCCCS will develop an implementation protocol to mitigate administrative challenges in processing the AHCCCS Works program exemptions.

		Most AHCCCS Works exemptions will be granted for at least 6 months. AHCCCS is committed to minimizing the administrative burden placed on members seeking to document exemptions or establish compliance. In part, this will be accomplished by maximizing the use of available systems and data sources such as SMI determination indicators, wage data from federal and state hubs, interfaces with the SNAP and TANF eligibility system, and disability data obtained through State Online Query Internet (SOLQI) from the Social Security Administration. Using the extensive information available from these resources will lessen the reporting requirements on members. Moreover, to simplify member reporting requirements and minimize hardship, AHCCCS will accept member attestation to demonstrate compliance in cases where the state is unable to locate data through available systems and data sources (i.e. volunteer and community service hours performed). To maximize members' ability to successfully attest and report compliance, AHCCCS will accept attestations through an online member portal, by phone, by mail, and in person.
Siman Qaasim, Children's Action Alliance	What is the anticipated go live date for AHCCCS Works?	AHCCCS does not have an anticipated implementation date at this time, and is continuing to monitor litigation challenging community engagement programs across the nation.
PRIOR QUARTER COVERAGE		
Wendy Armendariz, Neighborhood Outreach Access to Health	What are the benefits to limiting Prior Quarter Coverage?	The Waiver of Prior Quarter Coverage was designed to promote improved continuity of coverage by discouraging gaps in coverage that can occur when individuals sign up for Medicaid only when sick.
Rick Poulin, Gila River Health Care	We share concerns with other TRBHAs (Tribal Regional Behavioral Health Authorities) that although this PQC waiver does encourage accountability for the members, some of our	Noted.

	AHCCCS members may not have stable housing and in addition to that they don't have transportation and live many miles away from a P.O. Box. We often hear that they do not get the notices or are not aware of the notices regarding renewal; we think this has an adverse impact on our members. Gila River would like the consideration to include an exemption for American Indian members on reservations.	
Alida Montiel, Inter Tribal Council	The TRBHAs urge AHCCCS to reinstate PQC for American Indian and Alaska Native AIHP members. Please consider reinstating PQC for adult members receiving services through Indian Health Services, a tribe or tribal organization, or an Urban Indian health program (I/T/Us).	Noted.
White Mountain Apache TRBHA	We urge AHCCCS to reinstate PQC for members receiving services through I/T/Us.	Noted.
Dr. Corey Pascua Yaqui tribe	American Indian members should be exempted from the Waiver of Prior Quarter Coverage.	Noted.
Carol Chicharello, Indian Health Services	We request AHCCCS to reinstate Prior Quarter coverage to members served in IHS/638 facilities	Noted.
TRIBAL DENTAL BENEFIT (HB 2244)		
Kim Russell, Arizona Advisory Council on Indian Health Care	I noticed the waiver includes an emergency dental benefit. It was relayed in a past tribal consultation that the emergency dental benefit was going to be pursued through a State Plan Amendment (SPA). Why is this now in the waiver?	After conversations with CMS, AHCCCS determined the waiver is the most appropriate vehicle for the emergency dental request.
Bahney Dedolph, Arizona Council of Human Service Providers	What percentage of AHCCCS members will have dental coverage under the tribal dental benefit? We also recommend AHCCCS to provide preventive dental services to pregnant women.	AHCCCS estimates that 11,000 adult AI/AN members will utilize dental services under this demonstration in FFY 2021. Furthermore, AHCCCS estimates that approximately 150 to 200 members will exceed the $1,000 limit for emergency and ALTCS dental in FFY 2021. Legislative authority is needed to implement a preventive dental benefit for pregnant women.
Suzanne Legander, AHCCCS Provider	We urge AHCCCS to establish preventive dental care benefits for adult members.	Legislative authority is needed to expand the adult dental benefit.

TRADITIONAL HEALING SERVICES		
Rick Poulin, Gila River Healthcare	We are supportive of traditional healing waiver proposals. Empirical evidence shows medical treatment is more effective when it matches a person's cultural beliefs.	Noted.
Ginny Rountree, Deputy Director, Arizona Department of Economic Security (DES)	The addition of traditional healing services is excellent and is such an important service to add to the waiver.	Noted.
Alida Montiel, Inter Tribal Council	Are Urban Indian Organizations eligible to participate in the traditional healing demonstration?	Yes, AHCCCS is seeking waiver authority to reimburse traditional healing services provided in, at, or as part of services offered by facilities and clinics operated by I/T/U providers.
Dianna Yazzie Devine, Native American Connections	Are Urban Indian health providers eligible for 100% FMAP and can they become a Qualifying Entity under this proposal?	No, the Urban Indian health program currently does not qualify for 100% FMAP. However, AHCCCS is seeking an expenditure authority to reimburse the Urban Indian health program at 100% FMAP for traditional healing services. Urban Indian health providers can serve as a Qualifying Entity.
Kim Russell, Arizona Advisory Council on Indian Health Care	I recommend that AHCCCS consider including TRBHAs in the traditional healing demonstration in the future.	Noted.
Melinda Vasquez, Inter-Growth Health Care	If a qualified entity does identify a traditional healer, can that healer provide services at a non - IHS or 638 facility?	Traditional healing services must be provided in, at, or as part of, services offered by facilities and clinics operated by I/T/Us.
VERBAL CONSENT IN LIEU OF WRITTEN SIGNATURE FOR ALTCS MEMBERS		
HCBS Provider	I think that this is great, and very appropriate in regard to COVID-19. Please consider expanding this type of flexibility to other populations throughout the Medicaid program.	Noted.
TARGETED INVESTMENTS 2.0		
Peggy Chase, Terros Health	What is the Arizona State University (ASU) Learning Collaborative?	The purpose of the ASU TI Program Quality Improvement Collaborative (QIC) is to help

		TI providers meet and exceed Years Four and Five TI Program performance measure targets. The QIC is a peer learning forum to share best practices, and disseminate the practical content needed to achieve the TI Program performance measure targets.
Toni Panetta, Nurse-Family Partnership	Are the metrics listed in the waiver application document the same metrics that are explored in the TI Program Learning Collaborative facilitated through ASU?	Yes, the metrics are the same as the measures monitored in the TI Program Learning Collaborative.
Wendy Armendariz, Neighborhood Outreach Access to Health	What are the provider types currently participating in the TI Program?	The following provider types are participating in the TI Program: hospitals, primary care providers, behavioral health providers, and integrated clinics.
Alida Montiel, Inter Tribal Council	Can TRBHAs participate in the current TI program?	TRBHAs are not participating providers in the current TI Program.
TI Program provider	The TI program should be expanded to new providers and there should be a funding enhancement as well.	Noted.
Vicky Staples, Valley Wise	Will AHCCCS include peer-run organizations in the TI Program 2.0 proposal?	AHCCCS will explore allowing new provider types in the TI Program 2.0, including peer-run organizations.
COVID-19 PANDEMIC RESPONSE		
Brandy Petrone, Dignity Health	Are there any Appendix K flexibilities that AHCCCS is looking at to be made permanent and do those flexibilities need to be part of the Waiver renewal?	Yes, AHCCCS is seeking to implement authority to allow for verbal consent in lieu of written signature for up to 30 days for all care and treatment documentation for ALTCS members (when included in the member's record and when identity can be reliably established).
Alida Montiel, Inter Tribal Council	What about the increased enrollment? Has there been any access to care problems during the COVID-19 pandemic?	Arizona is committed to ensuring ongoing access to care for AHCCCS members and continues to monitor the stability of provider networks during the COVID-19 pandemic. At this time, AHCCCS is not aware of any concerns related to member access to care.
Terrylin Nez Chee, Indian Health Services	Has AHCCCS published any information regarding the COVID-19 vaccine reimbursement?	Yes, AHCCCS has published FAQs regarding vaccine reimbursement on its website.

WAIVER EVALUATION		
AHCCCS Provider	Will AHCCCS evaluate the ALTCS integration effort?	Yes, AHCCCS is evaluating the ALTCS integration effort. Details regarding Arizona Demonstration's evaluation are included in the renewal application.
Community Member	The recruitment and retention of dental providers should be an evaluation metric for the tribal dental program.	Noted.
OTHERS		
Meera Norris, AHCCCS provider	How is AHCCCS engaging providers to serve members from the LGBTQ community and specifically youth transitioning to adult care?	AHCCCS recently launched a health equity committee to identify and address health disparities impacting various populations served by the program and identify interventions aimed at eliminating those disparities.
Vernon Smith, Former Michigan Medicaid director	I can confirm that the Medicaid community regarded Arizona as a leader, especially in Medicaid managed care. We sent a team from Michigan Medicaid in the early 1990s to Phoenix to learn from AHCCCS. We were just one of many states who came to Arizona to benefit from your experience. It was very helpful to us in Michigan Medicaid.	Noted.
Mary Jo Whitfield, Jewish Family and Children's Services	I think expanding bus passes for folks would be an excellent idea. The closed loop referral system would also help support addressing social determinants of health.	Noted.
Marcus Johnson, Vitalyst Health Foundation	What is the deadline for submitting public comments for Arizona's Demonstration?	Public comments were due by November 30, 2020.
Community Member	What are anticipated future changes to the foster care program?	CMDP awarded a subcontract to an MCO, effective on April 1, 2021. The single subcontracted health plan will work in coordination with CMDP to provide integrated physical and behavioral health services, including specialty services for children with CRS conditions, to members enrolled with CMDP.

Debbie Johnson, Arizona Hospital and Health Care Association	Will AHCCCs move the managed care program out of the waiver, and under the authorities allowable under the managed care regulations?	AHCCCS is seeking waiver authority to continue to operate its managed care and HCBS programs under Arizona's Demonstration project.
Kim Russell, Arizona Advisory Council on Indian Health Care	I understand that the Whole Person Care Initiative (WPCI) was not included in the waiver due to possible recession impacts to the state budget, but could there still be an opportunity to work with tribes on this while drawing down the 100% FMAP. This is a great initiative. The long-term goal should be to sustain Community Health Representatives (CHRs) and to get them more integrated into primary care teams.	Noted.
Marcus Johnson, Vitalyst	Congrats on putting together a pretty phenomenal proposal. The latest Joint Legislative Budget Committee (JLBC) projections indicate we will not be in as bad of a position as we previously thought. Does this change AHCCCS' thinking of including things that you decided to not include in the waiver such as the WPCI?	While recent budget forecasts are more favorable, AHCCCS has elected to exercise caution at this time. The agency has shifted course and is focusing on a series of smaller-scale initiatives within the parameters of the existing Medicaid program. At this time, we will refrain from the pursuit of a broader WPCI in conjunction with the five-year Demonstration renewal. For example, AHCCCS and Health Current, Arizona's Health Information Exchange, are sourcing a new technical tool for providers— a closed-loop referral system, allowing providers to more easily identify social risk factors and make referrals to community based agencies who can address members' specific needs.