ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Arizona Demonstration Renewal Proposal (2027-2032)

July 2026

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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, 2026, and the application is seeking a renewal period from October 1, 2026, through September 30, 2032. Arizona operates the nation's oldest continuously running Section 1115 Demonstration and remains the only state to have delivered its entire Medicaid program through a statewide, mandatory, risk-based managed care model since inception. That model continues to produce among the lowest per-enrollee costs in the country while maintaining access and quality, and it remains the foundation on which this renewal builds.

This renewal is designed to preserve program integrity, reinforce personal responsibility, and sustain fiscal discipline as Arizona implements the significant Medicaid changes enacted in the Working Families Tax Cut legislation. AHCCCS requests continuation of the waiver and expenditure authorities that sustain its managed care and long term care delivery systems, together with the authorities approved during the current period that are now integral to the program. These include the Housing and Health Opportunities (H2O) initiative, the Reentry Demonstration, the KidsCare eligibility expansion, the Former Foster Youth annual automatic renewal, the Parents and Spouses as Paid Caregivers programs, the Traditional Health Care Practices Demonstration, and the Tribal Dental benefit.

AHCCCS also requests a focused set of new authorities that advance accountability and align the Demonstration with current federal law and policy. These include a prohibition on reliance on residency self-attestation absent independent verification, and elimination of the Hospital Presumptive Eligibility program. Both are consistent with recent state program integrity legislation. AHCCCS further requests a time-limited Extraordinary Care Review process for children receiving home and community-based services, and expansion of Traditional Health Care Practices participation to Urban Indian Organizations. Consistent with the discontinuation of designated state health program funding, Arizona will allow the Targeted Investments 2.0 program to sunset in an orderly manner.

Consistent with federal requirements, the Demonstration will remain budget neutral, and AHCCCS will demonstrate budget neutrality under the methodology established by the Working Families Tax Cut legislation and recent CMS guidance. Through this renewal, Arizona seeks to continue a Medicaid program that is accountable to taxpayers, responsive to members, and durable through a period of substantial federal change.

Approval of Arizona's renewal application by the Centers for Medicare & Medicaid Services (CMS) will allow the State to continue operating and building upon its nationally recognized managed care model. Renewal of the Demonstration will extend authority for Arizona to implement programs and initiatives 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
- Housing and Health Opportunities (H2O)
- Reentry Services
- Waiver of Prior Quarter Coverage for specific populations

- Traditional Healing Services delivered through IHS and Tribally operated health facilities
- KidsCare Eligibility Expansion

In addition to renewing existing waiver and expenditure authorities, AHCCCS is seeking approval to implement the following new enhancements and program changes:

- Traditional Healing Expansion for Urban Indian Organizations (UIOs)
- Sunsetting of the Targeted Investments (TI 2.0) Program
- Long Term Services and Supports (LTSS) Extraordinary Care Review Timeliness Waiver
- Modifications to Presumptive Eligibility and Accepting Self-Attestation

AHCCCS also reminds CMS that it remains open to continuing discussions regarding previously submitted proposals that remain under review and negotiation, including:

- Five-Year Lifetime Limit
- Institutions for Mental Disease (IMD)

Arizona's 1115 Waiver has consistently demonstrated its value as an effective and innovative Medicaid delivery model. Through its statewide managed care structure, AHCCCS has maintained access to high-quality, integrated care for members while promoting accountability, improving health outcomes, and ensuring responsible stewardship of state and federal resources. Approval of this renewal will enable Arizona to continue building on this proven framework and advancing its commitment to delivering cost-effective, person-centered care for the populations it serves.

II. AHCCCS Demonstration Historical Background

Arizona has operated its Medicaid program under a Section 1115 Demonstration Waiver since its inception in 1982, making it one of the longest running Demonstrations in the nation. From the onset, Arizona established a statewide mandatory managed care model which has since become the framework for the delivery of Medicaid services nationally. Over the last 44 years, the State has relied on this authority to refine program design and modify eligibility in a way that best serves Arizona's Medicaid members while also being responsive to a changing health care landscape with a focus on maintaining program efficiency, accountability, and improved member outcomes.

Throughout this time, AHCCCS has learned that as key factors such as populations, economic conditions, and delivery systems constantly change, a Medicaid program is most effective when it can continually evolve and innovate to meet the changing needs of its members. AHCCCS frequently seeks new opportunities to refine, modernize, and streamline its Demonstration in a way that builds upon prior successes while also positioning the program in a way to ensure long-term stability.

Inception of Managed Care and Early Program Development

Since 1982, AHCCCS has had the unique distinction of being the first state to operate under a mandatory managed care model and the only state to have done so from the start of its program. This public-private

relationship has continued to mature and evolve over time, enabling the state to ensure that members receive high-quality care while also maximizing efficiency and containing costs.

At the onset of the program, Arizona's Demonstration authorized the operation of a statewide managed care system that covered only acute care services and 90 days of post-hospital skilled nursing facility coverage which is known today as AHCCCS Complete Care (ACC). Additionally, two specialized programs were incorporated early to address the needs of children with complex circumstances. The Comprehensive Medical and Dental Program (CMDP) was created to serve children in foster care through a capitated arrangement with the Arizona Department of Child Safety (DCS) while the Children's Rehabilitative Services (CRS) provided coordinated, multidisciplinary care for children with qualifying chronic or disabling conditions pursuant to ARS 36-261 et seq.

Arizona's first significant 1115 expansion came in 1988 when the Arizona Long Term Care System (ALTCS) was established. ALTCS introduced a capitated managed care structure for long-term services and supports, serving individuals who are elderly, have physical disabilities, or have intellectual and developmental disabilities. The program integrates acute care, behavioral health, and long-term care services, including home and community-based services (HCBS), to Medicaid members who are at risk of institutionalization with the focus of supporting individuals in the least restrictive settings. Administration of the ALTCS program happens separately from ACC, ALTCS members with intellectual disabilities are served through a statewide managed care organization (MCO) operated by the Arizona Department of Economic Security (DES) Division of Developmental Disabilities (DDD), and ALTCS members who are part of the Elderly and Physical Disability program (EPD-ALTCS) are served through public-private partnerships between AHCCCS and contracted MCOs.

Over time, the ALTCS Demonstration has shown continued success in increasing the use of community-based care. This transition has allowed members to stay in the least restrictive and most integrated setting possible, which in turn has produced better member outcomes and a reduced reliance on more costly institutional settings. These improvements were first showcased in a 1987 federal evaluation which found that the AHCCCS managed care program offered comparable or improved access, quality, and satisfaction relative to fee-for-service (FFS) systems, alongside lower per-member costs.[1] Similar results and outcomes have continued to be demonstrated over time and have positioned Arizona as a national example of managed care effectiveness and encouraged the State to continue to take innovate approaches in its delivery of the Medicaid program.

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 $9,213 per-enrollee compared with the national average of $10,426 per-enrollee.[2]

Behavioral Health and Population Expansion

Arizona continued to build upon the Demonstration in 1990 when AHCCCS first began a five-year phased approach to including comprehensive behavioral health services within the Medicaid program. The initial

[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] https://www.macpac.gov/publication/medicaid-benefit-spending-per-full-year-equivalent-enrollee-for-newly-eligible-adult-and-all-enrollees-by-state/

approach started with children determined to have serious emotional disturbance (SED) under the age of 18 who required residential care. This was then followed by additional populations including children without an SED in 1991, adults with a serious mental illness (SMI) designation in 1992, and finally general mental health and/or substance use services for the remaining adult population in 1995. For many years, these services were carved out of the ACC plans and rather delivered through a separate system administered by the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (DBHS) who was contracted with AHCCCS to serve as an MCO and manage care delivery. ADHS/DBHS established sub capitated 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. This structure represented how care was delivered in Arizona until 2016 when DBHS merged with AHCCCS to further supplement the transformative initiative of integrating physical and behavioral health services which are now both administered by AHCCCS.

During this time period and following the behavioral health integration, AHCCCS also began to expand the program to additional populations. The Children's Health Insurance Program (CHIP), otherwise known as "KidsCare" in Arizona, was first implemented in 1998 under Title XXI of the Social Security Act to cover children under age 19 whose family's income was below 200 percent of the Federal Poverty Level (FPL) and who did not otherwise qualify for other AHCCCS programs. This was followed by the 2001 Arizona's voter approved Proposition 204 which added adults without dependent children ("childless adults"), parents and caretaker relative, and Supplemental Security Income populations whose income were below 100 percent of the FPL to the Medicaid program.

The Effects of the Great Recession on Arizona's Demonstration

While Arizona had previously achieved notable progress in expanding access to service and populations, the 2008 Great Recession posed significant challenges for Arizona's Medicaid program, testing the State's ability to balance sustained coverage with preservation of the program amid a time of rapidly shifting fiscal conditions. The rapid growth of the Medicaid program, coupled with revenue declines, placed a tremendous strain on the State's General Fund. As a result, 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. These reductions necessitated difficult but deliberate policy choices to stabilize the program which included:

- **Elimination of the Health Insurance for Parents (HIFA) Program**: In 2009, AHCCCS eliminated the Health Insurance for Parents (HIFA) program which typically covered parents of KidsCare children who had income between 100 percent and 200 percent of the FPL.
- **KidsCare Enrollment Freeze**: Due to the reduction in funds available for state match, new enrollment within the KidsCare program was frozen from 2010 to 2016, resulting in a drop of enrollment from 45,280 children down to just 528 children. This freeze was lifted in 2016, and the KidsCare program's financial eligibility was further expanded through the 1115 Demonstration in 2024 as highlighted within this renewal application.
- **Proposition 204 AHCCCS Enrollment Freeze**: In 2011, the Arizona Legislature and Governor passed a budget that froze AHCCCS enrollment for the Proposition 204 population. This enrollment freeze and

phase-out plan was approved by CMS later that year. This freeze was in effect until 2013 and resulted in an enrollment drop from 230,123 members to 67,770 members. However, enrollment has since been further expanded to the new adult group under the Affordable Care Act (ACA).

- **Copay Implementation**: AHCCCS received Demonstration authority from 2011 to 2013 to implement mandatory copay requirements for childless adult members.
- **Safety Net Care Pool (SNCP)**: To help hospitals manage the burden of rising uncompensated care costs, AHCCCS received approval from CMS in 2012 for the Safety Net Care Pool (SNCP) supplemental payment program. Most hospitals stopped receiving payments in 2013, however, AHCCCS extended SNCP for certain freestanding children's hospitals that did not benefit from the adult coverage restoration and expansion. This waiver authority expired in 2018.
- **Indian Health Service (IHS) and Tribal-638 Facilities Uncompensated Care Payment**: First approved in 2012, the Tribal Uncompensated Care Waiver granted AHCCCS the authority to make 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. Despite AHCCCS not needing to make these payments since these reductions, the authority has remained a key assurance for IHS and Tribal-638 providers and is further being included within this Demonstration renewal as outlined below.

In the years following the recession, AHCCCS has taken deliberate steps to restore, replace, and strengthen many of the policies implemented during that period, with a renewed emphasis on access, system stability, and quality of care. These efforts have allowed the program not only to recover, but to emerge more resilient and better aligned with member needs. However, Arizona anticipates a new set of fiscal pressures driven primarily by federal policy changes associated with the Working Family Tax Cut legislation. As the State prepares for the implementation of significant policy shifts including community engagement requirements and changes to supplemental payment structures and provider financing mechanisms, AHCCCS will draw upon the experience and lessons learned during the 2008 economic downturn. This history provides a foundation for navigating future challenges in a manner that sustains program integrity while continuing to prioritize the health and well-being of Arizona's Medicaid population.

Integration of Physical and Behavioral Health Services

One of the most significant areas of program advancement in AHCCCS's history has been the integration of physical and behavioral health services. Historically, these services were delivered through separate systems for most members, creating fragmentation in care delivery. Over time, AHCCCS pursued a deliberate strategy to align service delivery under unified MCO arrangements to generate the delivery system now seen across Arizona today.

Historically, most AHCCCS members received behavioral health services through the RBHAs while physical health and medical care were delivered by separate MCOs (known as acute plans). Through a strategic, phased process, AHCCCS integrated care for its members under the same MCO, beginning with children with qualifying CRS conditions. This integration was first started in 2013, when 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. Arizona then received additional waiver approval from CMS to establish a first of its kind integrated RBHA which

brought physical health, behavioral health, and social support services together in one plan for individuals with a SMI designation. Implementation of the program began in Maricopa County and subsequently expanded statewide in 2015.

Early independent studies illustrated how this integration has led to improvements in health outcomes for members with SMI. In 2018, Mercer conducted a study that determined over 75 percent of the program indicators demonstrated improvement following integration when compared to the pre-integration period for members in Maricopa County. Specifically, 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.[3] 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, 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.[4]

Throughout integration, AHCCCS implemented a variety of initiatives to support providers in effectively aligning with the system-wide transformation. Most notably, under the 1115 Demonstration Waiver, AHCCCS received approval and launched the Targeted Investments (TI) Program in 2017 which invested $300 million over a five-year period to support providers in developing the necessary systems required to deliver effective integrated care. The TI program aimed 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 adults and children with behavioral health needs and individuals transitioning from incarceration. Participating TI Program providers received payments for completing core components and milestones through year three and then became eligible to receive performance-based payments through year five based on quality measures for specific populations. This program served as an important catalyst for breaking down silos between a broad range of provider types and ensuring effective implementation of behavioral health integration.

The largest phase of integration took place in 2018 when AHCCCS transitioned 1.5 million members into seven ACC plans that provide integrated physical and behavioral health care services. This critical step allows the MCOs to now better facilitate care coordination and improve health outcomes through their own networks of providers who treat all aspects of health care needs.

To finalize the managed care integration, AHCCCS then moved to integrate services for the final two managed care member populations, members with intellectual disabilities and foster care children in the custody of DCS. In 2019, DES/DDD awarded new subcontracts to MCOs offering 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 while all other long-term services and supports continued to be provided directly by DES/DDD. In 2021, AHCCCS integrated coverage for children in DCS custody by replacing the CMDP health plan with the Comprehensive Health Plan (CHP) to further simplify health coverage for this population by providing integrated physical and behavioral

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

health services, including specialty services for children with CRS conditions.

Personal Responsibility Initiatives through Arizona's Demonstration

Arizona has consistently explored ways to incorporate personal responsibility concepts into its Medicaid program, using the 1115 Demonstration as a platform to test approaches that encourage engagement in work, education, and health management. These efforts have focused on promoting greater self-sufficiency, improving health awareness, and supporting more consistent interaction with the health care system, while continuing to preserve access to essential services.

AHCCCS Works - Arizona's Community Engagement Program

In 2015, the Arizona State Legislature passed Senate Bill 1092 (A.R.S. 36-2903.09), requiring AHCCCS to submit to CMS three 1115 Demonstration Waivers that among other things, would institute a work requirement for all "able-bodied adults" receiving Medicaid services.

On December 19, 2017, AHCCCS submitted a formal 1115 Waiver Amendment Request titled "AHCCCS Works." This amendment request would require non-exempt "able-bodied adults" between the ages of 19 and 55 to complete qualifying employment or educational activities for at least 20 hours per week to qualify for AHCCCS coverage. CMS approved Arizona's "AHCCCS Works" request in January 2019 where the Demonstration Special Terms and Conditions specified that the state would implement the AHCCCS Works requirement no sooner than January 1, 2020. Implementation work for the program began and then was later halted in October 2019 due to ongoing litigation of similar Medicaid Work Requirement 1115 Demonstration Waivers. This program was then further delayed by the Public Health Emergency (PHE) in January 2020. The approval and subsequent authority for AHCCCS Works was then rescinded by CMS on February 12, 2021.

As initially approved, AHCCCS Works was designed to apply to certain adults in the "Group VIII" population, who are individuals with incomes between 0 and 138% of the Federal Poverty Level (FPL) who do not qualify for Medicaid in any other category) population. The program framework tied coverage to participation in activities intended to support employment and skill development, requiring eligible individuals between the ages of 19 and 49, unless exempt, to complete at least 80 hours per month of work, job search, education, training, or community service. The state structured the program to minimize reporting burden by using available wage and employment data to verify compliance whenever possible. Members whose participation could not be confirmed through these sources would have been able to report their activity through several accessible channels, including an online portal, telephone, mail, or in person. Despite the detailed design and federal approval, the program was not implemented due to the Public Health Emergency, and subsequent guidance issued by the Biden Administration.

AHCCCS revisited this request by submitting an updated AHCCCS Works proposal to CMS on March 28, 2025, which remains under federal review. Negotiations on the amendment have largely been paused due to federal policy considerations tied to community engagement and cost sharing requirements as reflected in Section 71119 and Section 71120 of the Working Families Tax Cut legislation.

AHCCCS CARE (Choice, Accountability, Responsibility, Engagement)

In 2016, Arizona received approval to implement AHCCCS CARE, an initiative aimed at adults with incomes

above 100 percent of the federal poverty level. The program introduced monthly premium requirements and limited cost-sharing applied after services were received, alongside incentives tied to timely payments and completion of defined health-related activities. The intent was to strengthen understanding of health coverage and prepare members for transitions to commercial insurance. Despite receiving federal approval, the program was ultimately not put into operation and was removed from the demonstration authority during the previous Waiver renewal.

Retroactive Eligibility Waiver

Arizona also secured approval in January 2019 to modify its retroactive eligibility policy, limiting coverage to the month of application for most populations while maintaining protections for pregnant women, postpartum individuals (up to 60 days), and children under age 19. The program seeks to understand whether individuals are more likely to maintain coverage when not experiencing immediate health needs, whether enrollment occurs more promptly when eligibility is anticipated, and how the policy affects preventive service use and program costs.

Arizona's Retroactive Eligibility Waiver is also in close alignment with the passage of the Working Families Tax Cut legislation, at Section 71112 which amends 1902(a)(34) of the SSA to limit the amount of retroactive coverage available to various Medicaid populations. Specifically, effective January 1, 2027, Section 71112 shortens the period of retroactive to two months for most non-expansion groups and one month for beneficiaries enrolled under the adult expansion eligibility categories. As Arizona's Waiver already shortens this retroactive period to the month of the application for most populations, AHCCCS is proposing to continue the existing authority through the next demonstration period while also modifying the retroactive coverage available to pregnant women, postpartum individuals (up to 60 days), and children under age 19 to two months as required by the Working Families Tax Cut legislation.

Collectively, these initiatives demonstrate Arizona's continued effort to test policies that encourage active participation in coverage while supporting long-term stability in both health outcomes and program administration.

Effects of the COVID-19 Public Health Emergency on Arizona's Demonstration

In March of 2020, the Coronavirus disease (also referred to as COVID-19) was declared as a national public health emergency (PHE) by the President of the United States. The President's declaration provided authority for the U.S. Department of Health and Human Services (HHS) to enhance states' ability to respond to the outbreak through the use of Section 1135 Waivers, Section 1115 Appendix K Waivers, and Disaster Relief State Plan Amendments. Arizona's long history with the 1115 Demonstration Waiver allowed the state to quickly leverage and implement these emergency authorities collectively securing approval for 50 distinct flexibilities across these mechanisms. Together, these emergency authorities were designed to strengthen the provider workforce, remove barriers to care for AHCCCS members, enhance services and supports for vulnerable populations, and eliminate cost sharing and administrative requirements that could impede access during a period of widespread disruption.

Several temporary authorities introduced during the emergency period produced meaningful improvements in access, member experience, and care delivery. As a result, AHCCCS pursued continuation of a handful of policies

beyond the end of the public health emergency through subsequent Section 1115 demonstration amendments. Key examples include:

- **Home Delivered Meals for ALTCS Members**: Home delivered meals were initially approved by CMS and implemented for ALTCS members during the PHE to address increasing challenges faced by individuals living in the community. This service provides members with nutritious meals delivered directly to their homes, with each meal meeting at least one-third of the federally recommended daily allowance. Recognizing the value of this support, Arizona subsequently made home delivered meals a permanent component of the 1115 Demonstration for all ALTCS members and expanded the service to also include individuals with intellectual and/or developmental disabilities.
- **Supportive Services to Individuals in an Acute Care Hospital**: Additionally, during this time, AHCCCS temporarily authorized payment for supportive services for waiver participants during acute care hospitalizations or short-term institutional stays when necessary supports, such as communication assistance and intensive personal care, were not otherwise available in those settings. The service was available when individuals required these services for communication and behavioral stabilization that were not otherwise covered. This flexibility helped ensure continuity of care and addressed critical unmet needs during transitions across care environments which has since been retained as an ongoing component of the 1115 Demonstration.
- **Parents as Paid Caregivers**: The PHE required the adoption of flexible and innovative service delivery approaches to ensure members could continue receiving needed support while minimizing potential exposure to COVID-19. In response to significant disruptions to the direct care workforce, as well as concerns raised by families about maintaining consistent and trusted caregivers, AHCCCS sought CMS approval to implement what is now known as the Parents as Paid Caregiver (PPCG) delivery model. On April 6, 2020, CMS approved Arizona's initial Appendix K request, allowing parents to be reimbursed for providing "extraordinary care" to their minor children with complex needs, ensuring continuity of services in a safe and familiar home-based environment during the pandemic. This authority was extended multiple times as the extent of workforce challenges existed further beyond the initial emergency period. Building on the demonstrated success of the model in maintaining service access and supporting family stability, CMS approved Arizona's request on February 16, 2024, to formally incorporate the PPCG service delivery model into the 1115 Demonstration Waiver, solidifying it as an ongoing option for eligible members.

The experience gained during the PHE demonstrated the value of flexibility in program design and service delivery, particularly in maintaining access to care for vulnerable populations during periods of disruption. The authorities described above reflect AHCCCS's commitment to leveraging lessons learned to strengthen the Medicaid program, support workforce stability, and enhance member-centered care. By incorporating these targeted policies into the 1115 Demonstration, Arizona aims to sustain improved outcomes and ensure a more resilient and responsive delivery system moving forward.

III. Current Demonstration Goals, Objectives and Evaluation

Arizona's Demonstration strives to provide, through the employment of a managed care model and robust long term care delivery system, quality health care services to members while at the same time achieving cost

effectiveness to ensure long term stability of the program. Specific goals for Arizona's Demonstration are:

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

To assess the performance of Arizona's Demonstration and identify areas for future refinement, AHCCCS engaged Health Services Advisory Group (HSAG) and Arizona State University (ASU) to conduct an independent evaluation. This evaluation was structured to satisfy the requirements outlined in the Special Terms and Conditions (STCs) of the current 1115 Demonstration and included the testing of defined hypotheses and performance measures across key program areas, including ACC, ALTCS, DCS CHP, RBHA, the Targeted Investments 2.0 Program, the Waiver of Prior Quarter Coverage, KidsCare Eligibility Expansion, Housing and Health Opportunities (H2O), and the Tribal Dental Authority. The key objectives and anticipated outcomes for each Demonstration program are described in Section VI below.

Demonstration Evaluation Deliverables & Activities

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

Evaluation Design

Arizona's evaluation design describes the goals, objectives, and testable hypotheses for the Demonstration, including those focused on target populations. The design outlines the methodologies used to assess the Demonstration's impacts and the approaches used to isolate the effects of the Demonstration from other concurrent changes occurring within the State.

Arizona, in partnership with its independent evaluator, Health Services Advisory Group (HSAG) developed evaluation designs for demonstration components subject to federal evaluation requirements. The evaluation designs establish the framework for assessing the effectiveness of demonstration initiatives and authorities, measuring outcomes, and evaluating progress toward the Demonstration's goals and objectives.

CMS approved Arizona's evaluation designs, and the State has conducted evaluation activities consistent with those approved designs and applicable federal requirements throughout the demonstration period. Arizona will continue to work with CMS to ensure that evaluation activities remain aligned with the goals of the Demonstration and any authorities approved under this renewal request.

In addition to the approved evaluation designs, AHCCCS is developing evaluation designs for recently approved Demonstration authorities. The State is currently finalizing an updated evaluation design for the Traditional Health Care Practices (THCP) Demonstration, which is scheduled for submission to CMS on July 31, 2026. Development of the THCP evaluation design began in late 2025 and has involved extensive collaboration with Tribal stakeholders, Tribal health representatives, and the independent evaluator (HSAG). Through this process,

AHCCCS has worked to ensure that the evaluation design appropriately measures the Demonstration's goals and outcomes while respecting the cultural significance of traditional healing practices, Tribal sovereignty, and Tribal data governance considerations.

Additionally, following receipt of the necessary budgetary authority to implement the Reentry Demonstration, AHCCCS has initiated preliminary planning activities for the development of the Reentry evaluation design. As implementation planning progresses, the State will work with CMS, stakeholders, and its independent evaluator to develop an evaluation framework that assesses the Demonstration's effectiveness in supporting continuity of care and improving health outcomes for eligible justice-impacted individuals transitioning from correctional settings back into the community.

Interim Evaluation

Pursuant to the Demonstration's Special Terms and Conditions (STCs), AHCCCS engaged an independent evaluator, HSAG, to assess the implementation and performance of Demonstration authorities and programs. The evaluation examines the extent to which the Demonstration is achieving its objectives related to access to care, quality of care, care coordination, member experience, health outcomes, and cost-effectiveness. Evaluation activities also support ongoing program improvement and inform state and federal decision-making regarding the effectiveness of Demonstration initiatives.

Interim evaluation findings indicate that the Demonstration has generally supported its overarching goals of maintaining access to comprehensive Medicaid services, improving care coordination for members with complex health and social needs, enhancing quality and member experience, and advancing innovative approaches to service delivery. Evaluation activities have assessed outcomes across key Demonstration initiatives, including managed care delivery systems, long-term services and supports, housing-related interventions, coverage expansions, workforce stabilization efforts, and initiatives designed to improve health outcomes for specific populations.

While findings vary across Demonstration components, interim results provide valuable insights regarding program implementation, utilization patterns, member outcomes, and opportunities for continued improvement. AHCCCS will continue to monitor program performance and evaluate Demonstration outcomes through the remainder of the Demonstration period, with final findings to be presented in the summative evaluation report.

Summative Evaluation

Arizona will submit a summative evaluation report to CMS no later than March 31, 2029, which is within 18 months following the conclusion of the current Demonstration period on September 30, 2027. The summative evaluation report will present the results of the Demonstration and assess the extent to which the Demonstration achieved its goals and objectives. The report will include findings for the measures and hypotheses outlined in the approved evaluation design and will evaluate the effectiveness of the Demonstration authorities implemented during the demonstration period.

Summary of Interim Evaluation Findings

This section summarizes the interim evaluation findings (see Appendix A) for the ACC, ACC-RHBA, ALTCS, DCS CHP, H2O, KidsCare, Tribal Dental Authority, Targeted Investments 2.0, and Waiver of Prior Quarter Coverage Demonstrations.

Evaluation findings indicate that Arizona's 1115 Demonstration has been effective in maintaining and improving access to care, strengthening care coordination, and supporting positive health outcomes across Medicaid populations. Across the demonstration, most performance measures either improved or remained stable, demonstrating sustained program effectiveness.

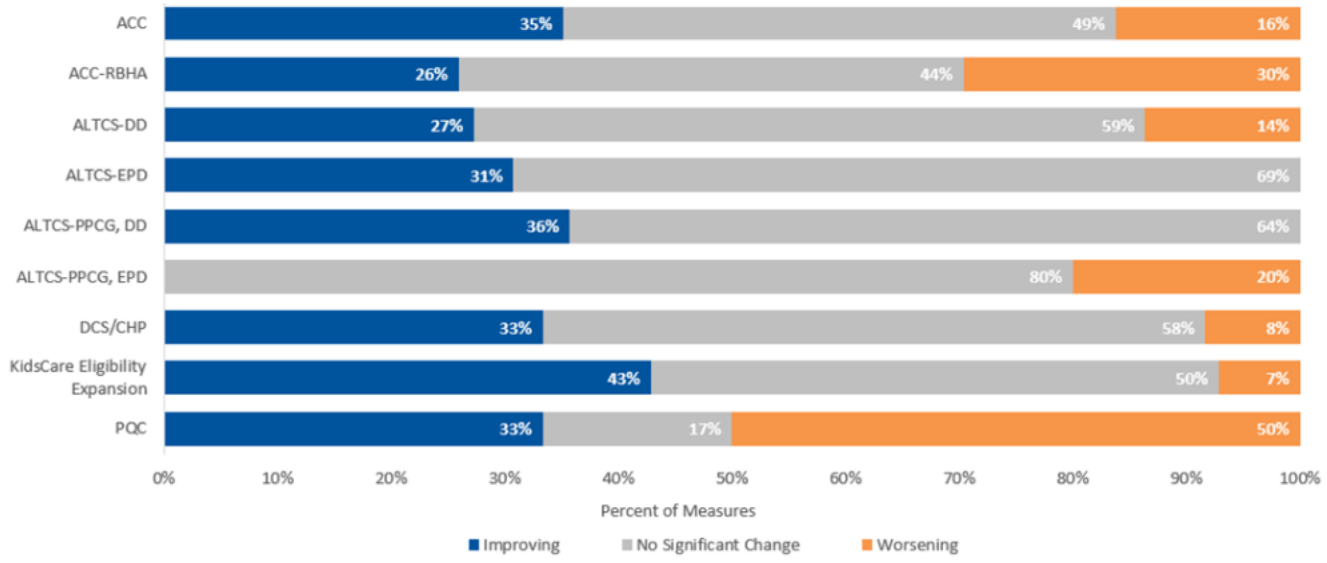
Key improvements were observed in preventive care, substance use disorder treatment engagement, opioid prescribing practices, enrollment continuity, and care coordination for members with complex physical and behavioral health needs. Early baseline findings from the Housing and Health Opportunities (H2O) program demonstrate strong referral and service engagement among high-need members, while the KidsCare eligibility expansion improved continuity of coverage and access to preventive services.

The interim evaluation also identified opportunities to strengthen follow-up care for behavioral health services, expand screening for housing stability and access to food and transportation, improve chronic disease management, and address workforce and data-sharing challenges.

Overall, the evaluation demonstrates that the Demonstration continues to advance Arizona's goals of improving access, promoting integrated and coordinated care, and supporting better health outcomes while informing future program improvements.

Figure 1 below shows that Waiver programs demonstrated substantial variability in the proportion of measures consistent with research hypotheses. Results for the H2O and Tribal Dental Authority programs are not presented at a hypothesis level due to data limitations caused by insufficient time since implementation to conduct formal statistical testing.[5]

Figure 1 - Percentage of Measures Consistent with Research Hypotheses



ACC Evaluation Findings

Follow-up care after an ED visit for members with multiple high-risk chronic conditions increased during the evaluation period, indicating potentially improved care coordination

The *Percentage of members with follow-up after an ED visit for members with multiple high-risk chronic conditions* increased between the baseline and evaluation periods by an average of 3.6 percentage points. Rates in 2023 and 2024 exceeded the baseline projections by 3.4 and 6.9 percentage points, respectively.

Table 2 below utilized Prepaid Medical Management Information System (PMMIS) data to examine changes in the rate of members with multiple high-risk chronic conditions with a follow-up after an ED visit.

Figure 2 - Changes in the rate of members with multiple high-risk chronic conditions with a follow-up after an ED visit

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[3]	Trend Model Difference Between Actual and Projected (*p*-value)	
		Baseline Average[2]	Evaluation Average[2]	(*p*-value)	FFY 2023	FFY 2024
1-3	Percentage of members with a follow-up after an ED visit for members with multiple high-risk chronic conditions	50.7%	54.3%	3.6pp *** (<0.001)	3.4pp *** (<0.001)	6.9pp *** (<0.001)

*p<0.1, **p<0.05, ***p<0.001

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

[3]Change in Rate compares the rate or number in the baseline period (10/01/2018–09/30/2022) to the average rate or number in the evaluation period (10/1/2022–09/30/2024).

The percentage of members who initiated or engaged in substance abuse treatment generally increased during the evaluation period.

The *Percentage of members who had initiation of alcohol and other drug abuse dependence treatment* and the *Percentage of members who had engagement of alcohol and other drug abuse dependence treatment* increased by 1.2 percentage points and 2.1 percentage points, respectively, between the baseline and evaluation periods ($p<0.001$).

The table below utilized PMMIS data to determine the percentage of members initiating and engaging in substance abuse treatment.

Figure 3- Percentage of members initiating and engaging in substance abuse treatment

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[3] (*p*-value)	Trend Model Difference Between Actual and Projected (*p*-value)	
		Baseline Average[2]	Evaluation Average[2]		FFY 2023	FFY 2024
2-9	Percentage of members who had initiation of alcohol and other drug abuse dependence treatment (Total)	49.5%	50.6%	1.2pp *** (<0.001)	-1.0pp ** (0.001)	-5.7pp *** (<0.001)
	Adult	49.6%	50.8%	1.3pp *** (<0.001)	-0.8pp ** (0.013)	-5.5pp *** (<0.001)
	Child	47.9%	46.9%	-1.0pp (0.294)	-5.3pp ** (0.002)	-9.4pp *** (<0.001)
2-10	Percentage of members who had engagement of alcohol and other drug abuse dependence treatment (Total)	16.4%	18.5%	2.1pp *** (<0.001)	0.9pp *** (<0.001)	-2.3pp *** (<0.001)
	Adult	16.7%	18.9%	2.2pp *** (<0.001)	1.0pp *** (<0.001)	-2.1pp *** (<0.001)
	Child	11.6%	11.4%	-0.3pp (0.682)	-0.2pp (0.856)	-3.6pp ** (0.008)

*p <0.1, **p <0.05, ***p <0.001
Note: pp: percentage point.
Data Source: PMMIS data were used in the analysis of RQ 2.2.
[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.
[2]Rates are weighted by enrollment duration in ACC.
[3]Change in Rate compares the rate or number in the baseline period (10/01/2018–09/30/2022) to the average rate or number in the evaluation period (10/1/2022–09/30/2024).

ACC-RBHA Evaluation Findings

Access to substance abuse treatment improved during the evaluation period for ACC-RBHA members, and rates increased faster than projections from baseline.

Both the *Percentage of members who had initiation of SUD treatment* and the *Percentage of members who had engagement of SUD treatment* increased from baseline, rising by 0.5 and 1.1 percentage points, respectively (p=0.276 and p<0.001, respectively). Additionally, rates were significantly higher than the baseline projections for both the initiation and engagement in SUD treatment indicators.

Table 4 below utilized PMMIS data to assess changes in the percentage of members who initiated and engaged in substance use disorder (SUD) treatment.

Figure 4- Percentage of members who initiated and engaged in substance use disorder (SUD) treatment

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[3]	Trend Model Difference Between Actual and Projected (*p*-value)	
		Baseline Average[2]	Evaluation Average[2]	(*p*-value)	FFY 2023	FFY 2024
1-6	Percentage of members who had initiation of SUD treatment	47.0%	47.5%	0.5pp (0.276)	2.4pp ** (0.002)	2.0pp ** (0.020)
1-7	Percentage of members who had engagement of SUD treatment	11.2%	12.3%	1.1pp *** (<0.001)	1.4pp ** (0.003)	1.5pp ** (0.006)

*p <0.1, **p <0.05, ***p <0.001
Note: FFY: federal fiscal year; pp: percentage point.
Data Source: PMMIS data were used in the analysis of RQ 1.2.
[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.
[2]Rates are weighted by enrollment duration in ACC-RBHA.
[3]Change in Rate compares the rate or number in the baseline period (10/01/2016–09/30/2022) to the average rate or number in the evaluation period (10/1/2022–09/30/2024).

The management of opioid prescriptions improved for ACC-RBHA members during the evaluation period.

The *Percentage of members who have prescriptions for opioids at a high dosage* and the *Percentage of members with concurrent use of opioids and benzodiazepines* significantly decreased by 3.5 and 4.7 percentage points between the baseline and evaluation periods, respectively (p<0.001 for both).

The table below utilized PMMIS data to assess the management of opioid prescriptions for ACC-RBHA members.

Figure 5 -Management of opioid prescriptions for ACC-RBHA members

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[3]	Trend Model Difference Between Actual and Projected (*p*-value)	
		Baseline Average[2]	Evaluation Average[2]	(*p*-value)	FFY 2023	FFY 2024
2-11	Percentage of members who have prescriptions for opioids at a high dosage (lower is better)	12.7%	9.3%	-3.5pp *** (<0.001)	-5.3pp *** (<0.001)	-5.2pp *** (<0.001)
2-12	Percentage of members with concurrent use of opioids and benzodiazepines (lower is better)	14.2%	9.5%	-4.7pp *** (<0.001)	1.6pp ** (0.037)	3.5pp *** (<0.001)

*p <0.1, **p <0.05, ***p <0.001
Note: FFY: federal fiscal year; pp: percentage point.
Data Source: PMMIS data were used in the analysis of RQ 2.4.
[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.
[2]Rates are weighted by enrollment duration in ACC-RBHA.
[3]Change in Rate compares the rate or number in the baseline period (10/01/2016–09/30/2022) to the average rate or number in the evaluation period (10/1/2022–09/30/2024).

ALTCS Evaluation Findings

Arizona NCI survey respondents' rates of satisfaction with their living arrangements were generally comparable to those nationwide.

ALTCS-DD

The *Percentage of members who believe services and supports help them live a good life* among Arizona respondents remained high and were generally aligned with national rates; however, there was a slight decrease in the 2023/2024 FGS survey, declining by 3 percentage points relative to the national change (*p*=0.078).

ALTCS-EPD

The *Percentage of members who wanted to live somewhere else*, as reported by their guardian, was 3 percentage points higher in Arizona compared to the national rate in 2023/2024, although this difference was not statistically significant (*p*=0.345).

The *Percentage of members who believed services and supports help them live a good life*, as reported by their guardian, was 4 percentage points lower in Arizona compared to the national rate in 2023/2024, although this difference was not statistically significant (*p*=0.138).

The table below utilized NCI-IDD surveys to assess ALTCS-DD member satisfaction with living arrangements. A DiD analysis compared Arizona rates and national rates.

Figure 6 - ALTCS-DD member satisfaction with living arrangements

				Baseline Period	Evaluation Period		2022/2023	2023/2024
				†	2022/2023	2023/2024	DiD	DiD
ALTCS-DD Population								
3-4	Are services and supports helping your family member to live a good life?	AFS[1]	Arizona	96%	-	96%	-	0pp (0.896)
			National	93%	-	93%		
		FGS	Arizona	96%	94%	93%	0pp (0.773)	-3pp * (0.078)
			National	95%	93%	95%		

*p <0.1, **p <0.05, ***p <0.001

Note: Measure 3-3 was not available for the DD population because the surveys conducted did not contain the relevant item. AFS: Adult Family Survey; ALTCS: Arizona Long Term Care System; DD: developmental disabilities; DiD: difference-in-differences; FGS: Family/Guardian Survey; pp: percentage point.

Data Source: NCI-IDD AFS and NCI-IDD FGS data were used in the analysis of RQ 3.2.

†Baseline periods: 2018/2019, 2020/2021, and 2021/2022.

[1]The AFS was not conducted in 2022/2023.

The table below used NCI-AD surveys responses to examine ALTCS-EPD member satisfaction with living arrangements.

Figure 7- Surveys responses examining ALTCS-EPD member satisfaction with living arrangements.

		Arizona Rate 2023/2024	National Rate 2023/2024	Difference	*p*-value
ALTCS-EPD Population					
3-3	Wants to live somewhere else	33% N=211	30% N=15,997	3pp	0.345
3-4	Services and supports help them live the life they want	84% N=147	88% N=13,011	-4pp	0.138

*p <0.1, **p <0.05, ***p <0.001

Note: No baseline data were available for the the EPD population because the survey was not conducted. N represents the number of responses. ALTCS: Arizona Long Term Care System; EPD: elderly and physically disabled; pp: percentage point.
Data Source: NCI-AD Adult Consumer Survey data were used in the analysis of RQ 3.2.

The percentage of minor ALTCS-DD members receiving services through the PPCG service model increased by over 10 percent between the ramp-up and evaluation periods.

ALTCS-DD

The Percentage of ALTCS-DD members who received habilitation and attendant care services through the PPCG service model increased by nearly 10 percentage points between the ramp-up and evaluation periods ($p<0.001$) for both.

ALTCS-EPD

Among the 448 minor members enrolled in an ALTCS-EPD plan in SFY 2024, 43.3 percent received attendant care services and 7.4 percent received habilitation care services through the PPCG service model. All members who received habilitation care services received attendant care services, and utilization of habilitation care among members with physical disabilities is rare.

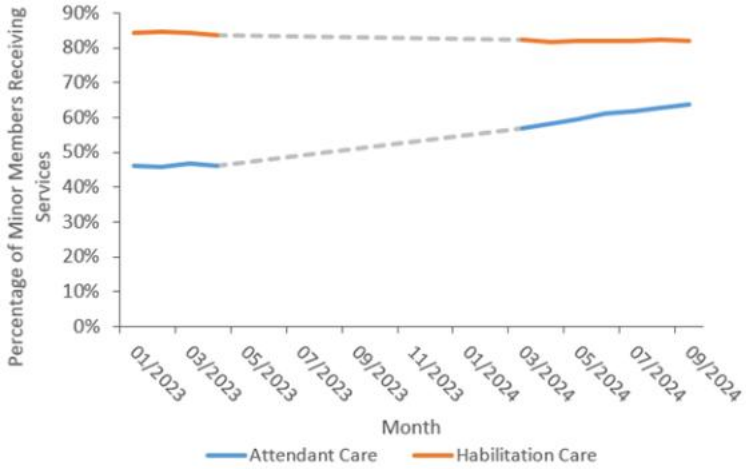
Figure 8 below utilized PMMIS, PPCG utilization, and ALTCS placement data to identify the number and types of services provided to members through the PPCG service model, which provides services to minor children enrolled in ALTCS. Figure 9 illustrates ALTCS-DD members who utilized services under the PPCG service model. Data were unavailable from May 2023 to February 2024, as indicated by gray dashed lines, which may lead to lower average rates during this period

Figure 8 - Number and types of services provided to members through the PPCG service model

Is the percentage of members receiving services at home the same or higher after the implementation of the PPCG service model or EFSS?			Ramp-Up Period 2023	Evaluation Period 2024	Pre/Post Change in Rate[1] (*p* -value)
ALTCS-DD Population					
5-1	Percentage of minor members receiving services through the PPCG service model	Habilitation Care	14.3% N=19,519	24.7% N=21,849	10.4pp *** (<0.001)
		Attendant Care	7.8% N=19,519	18.9% N=21,849	11.1pp *** (<0.001)
5-2	Percentage of members receiving EFSS	—	—	—	—
ALTCS-EPD Population					
5-1	Percentage of minor members receiving services through the PPCG service model	Habilitation Care	N/A	3.1% N=448	N/A
		Attendant Care	N/A	43.3% N=448	N/A
5-2	Percentage of members receiving EFSS	—	—	—	

*p<0.1, **p<0.05, ***p<0.001
Note: N represents the denominator count. ALTCS: Arizona Long Term Care System; DD: developmental disabilities; EFSS: Extended Family Support services; EPD: elderly and physically disabled; PP: percentage points; PPCG: Parents as Paid Caregivers.
— indicates that the program has not been implemented.
N/A indicates that data provided for the ALTCS-EPD ramp-up period were not included in the analysis due to potential bias in reporting, which prevented statistical testing.
Data Source: PMMIS, PPCG-DD utilization data, PPCG-EPD utilization data, and ALTCS Placement files were used in the analysis of RQ 5.1.
[1]Change in Rate compares the rate in the ramp-up period to the evaluation period.
ALTCS-DD: Ramp-up period (01/01/2023–03/31/2023) and evaluation period (04/01/2024–09/30/2024).
ALTCS-EPD: Evaluation period (04/01/2024–09/30/2024).

Figure 9 - ALTCS-DD members who utilized services under the PPCG service model.



Note: Grey dashed lines indicate missing data for that time period.
Data Source: PMMIS, PPCG-DD utilization data, and ALTCS Placement files were used in the analysis of RQ 5.1.

DCS/CHP Evaluation Findings

The percentage of DCS CHP members under 2 years of age with appropriate immunization status was generally maintained or increased during the evaluation period compared to the baseline.

The *Percentage of children 2 years of age with appropriate immunization status* increased for 11 out of 13

indicators. Three indicators—measles, mumps, and rubella (MMR); pneumococcal conjugate; and rotavirus—increased by statistically significant margins of 2.5, 4.4, and 6.5 percentage points, respectively, between the baseline and evaluation periods. (p=0.025, p=0.001, and p<0.001).

The figure below utilized PMMIS data to assess changes in the percentage of children and adolescents with appropriate immunizations.

Figure 10- Changes in the percentage of children and adolescents with appropriate immunizations

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[3]	Trend Model Difference Between Actual and Projected (p-value)		
		Baseline Average[2]	Evaluation Average[2]	(p-value)	FFY 2022	FFY 2023	FFY 2024
2-1	Percentage of children 2 years of age with appropriate immunization status						
	DTaP	42.4%	44.7%	2.2pp * (0.096)	3.7pp (0.451)	-3.6pp (0.543)	-3.3pp (0.642)
	IPV	59.3%	60.3%	1.0pp (0.455)	0.2pp (0.959)	-8.7pp (0.133)	-12.5pp * (0.068)
	MMR	77.8%	80.3%	2.5pp ** (0.025)	-1.5pp (0.692)	-2.6pp (0.565)	0.4pp (0.931)
	HiB	66.5%	67.1%	0.6pp (0.630)	-0.8pp (0.846)	-10.2pp * (0.066)	-7.8pp (0.217)
	Hepatitis B	29.5%	28.1%	-1.4pp (0.247)	0.0pp (1.000)	-3.1pp (0.554)	0.4pp (0.954)
	VZV	77.6%	79.0%	1.5pp (0.191)	-1.1pp (0.777)	-3.3pp (0.488)	-0.5pp (0.925)
	Pneumococcal Conjugate	41.9%	46.3%	4.4pp ** (0.001)	5.2pp (0.296)	2.8pp (0.649)	-2.6pp (0.720)
	Hepatitis A	82.0%	83.7%	1.7pp * (0.100)	-3.7pp (0.265)	-4.7pp (0.229)	-3.6pp (0.399)
	Rotavirus	37.6%	44.1%	6.5pp *** (<0.001)	8.2pp * (0.097)	5.1pp (0.394)	4.6pp (0.521)
	Influenza	37.9%	37.0%	-1.0pp (0.461)	5.9pp (0.225)	-1.7pp (0.770)	-3.0pp (0.650)
	Combination 3	16.5%	16.7%	0.2pp (0.836)	0.4pp (0.923)	-2.2pp (0.624)	-2.4pp (0.662)
	Combination 7	12.2%	13.8%	1.6pp * (0.089)	2.9pp (0.403)	0.4pp (0.924)	0.8pp (0.869)
	Combination 10	7.7%	8.3%	0.6pp (0.409)	1.6pp (0.608)	-2.4pp (0.470)	-3.3pp (0.402)
2-2	Percentage of adolescents 13 years of age with appropriate						
	Meningococcal	73.6%	69.8%	-3.8pp ** (0.026)	-7.9pp (0.191)	-6.0pp (0.402)	-8.3pp (0.333)
	Tdap	73.2%	71.7%	-1.5pp (0.374)	-7.6pp (0.204)	-4.9pp (0.487)	-4.2pp (0.600)
	HPV	35.7%	34.3%	-1.3pp (0.463)	-16.1pp ** (0.016)	-15.0pp * (0.074)	-15.4pp (0.125)
	Combination 1 (Meningococcal, Tdap)	70.2%	67.3%	-3.0pp * (0.094)	-4.9pp (0.438)	-3.2pp (0.670)	-5.7pp (0.531)
	Combination 2 (Meningococcal, Tdap, HPV)	31.0%	30.9%	-0.1pp (0.942)	-17.8pp ** (0.008)	-18.8pp ** (0.027)	-22.5pp ** (0.028)

*p<0.1, **p<0.05, ***p<0.001

Note: DTaP: diphtheria, tetanus, pertussis; FFY: federal fiscal year; HiB: haemophilus influenzae type b; HPV: human papillomavirus; IPV: inactivated poliovirus vaccine; MMR: measles, mumps, and rubella; pp: percentage point; Tdap: tetanus, diptheria, pertussis; VZV: varicella zoster virus.

Data Source: PMMIS data were used in the analysis of RQ 2.1.

[1]Rates are adjusted for the effect of the COVID-19 PHE in 2020.

[2]Rates are weighted by enrollment duration in CHP.

[3]Change in Rate compares the rate or number in the baseline period (10/01/2016–09/30/2020) to the average rate or number in the evaluation period (10/1/2021-09/30/2024). Rates from the ramp-up period (10/01/2020-09/30/2021) are excluded from analysis.

DCS CHP members generally exhibited improved BH condition management during the evaluation period, although not all changes were statistically significant. The percentage of DCS CHP members diagnosed with mental health disorders increased, which may indicate increased access to diagnostic care, but is also consistent

with the growing prevalence of mental health disorders among youth nationwide.

- The *Percentage of children and adolescents on antipsychotics with metabolic monitoring* decreased by 2.3 percentage points between the baseline and evaluation periods (p=0.085); however, the evaluation period observed rates exceeded the baseline trend projection, indicating the rate of decline was not sustained in the evaluation period (p<0.001 for FFY 2022 and FFY 2023, and p=0.006 for FFY 2024).
- The *Percentage of members diagnosed with a mental health disorder* increased between the baseline and evaluation periods by 15.3 percentage points (p<0.001); however, the evaluation period observed rates were lower than the baseline trend projection by 13.9 percentage points or more, indicating that the rate did not increase as fast as expected in the evaluation period (p<0.001 for all years).
- The *Percentage of members with a follow-up visit within 7 days after a hospitalization for mental illness* increased by 5.2 percentage points between the baseline and evaluation periods (p=0.001).

The figure below utilized PMMIS data to assess the changes in members' management of BH conditions between the baseline and evaluation periods.

Figure 11 - Changes in members' management of BH conditions between the baseline and evaluation periods

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[3]	Trend Model Difference Between Actual and Projected (*p*-value)		
		Baseline Average[2]	Evaluation Average[2]	(*p*-value)	FFY 2022	FFY 2023	FFY 2024
2-4	Percentage of children and adolescents on antipsychotics with metabolic monitoring	53.1%	50.8%	-2.3pp * (0.085)	16.3pp *** (<0.001)	20.9pp *** (<0.001)	18.1pp ** (0.006)
2-5	Percentage of members diagnosed with a mental health disorder	58.2%	73.4%	15.3pp *** (<0.001)	-15.5pp *** (<0.001)	-13.9pp *** (<0.001)	-14.2pp *** (<0.001)
2-6	Percentage of members with a follow-up visit within 7 days after an ED visit for mental	81.8%	83.5%	1.7pp (0.563)	6.9pp (0.495)	10.9pp (0.377)	7.4pp (0.651)
2-7	Percentage of members with a follow-up visit within 7 days after a hospitalization for	64.8%	70.0%	5.2pp ** (0.001)	4.0pp (0.491)	4.2pp (0.545)	-3.4pp (0.691)
2-8	Percentage of members with follow-up within 7 days after an ED visit for SUD	60.9%	66.2%	5.3pp (0.285)	-5.3pp (0.743)	-10.3pp (0.594)	-14.7pp (0.515)

*p<0.1, **p<0.05, ***p<0.001

Note: ED: emergency department; FFY: federal fiscal year; pp: percentage point; SUD: substance use disorder.

Data Source: PMMIS data were used in the analysis of RQ 2.3.

[1]Rates are adjusted for the effect of the COVID-19 PHE in 2020.

[2]Rates are weighted by enrollment duration in CHP.

[3]Change in Rate compares the rate or number in the baseline period (10/01/2016–09/30/2020) to the average rate or number in the evaluation period (10/1/2021–09/30/2024). Rates from the ramp-up period (10/01/2020-09/30/2021) are excluded from analysis.

H2O Evaluation Findings

Emergency Department (ED) stays, Inpatient (IP) stays, and the risk-adjusted ratio observed to expected acute IP and observation stay discharges were significantly higher among H2O-enrolled members when compared to those on the waitlist throughout the baseline period. Additionally, unplanned readmissions were significantly higher in FFY 2023 and FFY 2024 for H2O members. These differences may indicate that members who ultimately enroll in H2O had higher demands for hospital care due to their unique health needs, or that members were placed into the H2O program based on high and increasing rates of utilizing high-acuity care settings.

Key Findings:

- The Number of emergent and non-emergent ED visits per 1,000 member months were higher for H2O members compared to waitlist members. For emergent ED visits, differences between the two groups increased from 116.5 visits per 1,000 member months ($p<0.001$) in FFY 2022 to 184.8 visits per 1,000 member months ($p<0.001$) in FFY 2024. Similarly, differences in the number of non-emergent ED visits per 1,000 member months increased from 9.3 ($p<0.001$) in FFY 2022 to 18.7 ($p<0.001$) in FFY 2024.
- The Number of IP stays per 1,000 member months was greater for H2O members compared to waitlist members, and the difference increased throughout the baseline period. The difference increased by 17 stays per 1,000 member months ($p<0.001$) in FFY 2022 to 38 stays per 1,000 member months ($p<0.001$) in FFY 2024.
- The Risk-adjusted ratio of observed to expected acute IP and observation stay discharges was higher among H2O members than waitlist members by between 0.4 and 0.7 ($p<0.001$), representing relative differences of 38 percent ([1.8 / 1.3] -1) and approximately 54 percent ([2.0 / 1.3] -1).
- The table below utilized PMMIS, H2O-PA, and AHP waitlist data to identify H2O members and members on the AHP waitlist in FFY 2025 to determine their hospital and institutional care utilization in the three years prior to H2O implementation. As H2O was not implemented until October 2024, before and after comparisons cannot be made in this Interim Evaluation Report. Instead, H2O and AHP waitlist member utilization of hospital and institutional care rates are compared during the baseline period.

Figure 12 - Institutional Care utilization in the three years prior to H2O implementation

How does the H2O demonstration impact the use of hospital and institutional care?									
			Baseline Period						
			2022	Difference in Rates (*p*-value)		2023	Difference in Rates (*p*-value)		2024	Difference in Rates (*p*-value)	
2-19	Number of emergent ED visits per 1,000 member months	H2O	236.7	116.5	***	294.1	174.3	***	305.4	184.8	***
		H2O Waitlist	120.1	(<0.001)		119.8	(<0.001)		120.6	(<0.001)	
2-20	Number of non-emergent ED visits per 1,000 member months	H2O	17.8	9.3	***	25.9	17.1	***	28.9	18.7	***
		H2O Waitlist	8.4	(<0.001)		8.8	(<0.001)		10.2	(<0.001)	
2-21	Number of IP stays per 1,000 member months	H2O	34.8	17.4	***	47.0	31.7	***	56.4	38.4	***
		H2O Waitlist	17.4	(<0.001)		15.3	(<0.001)		18.0	(<0.001)	
2-22	Risk-adjusted ratio of observed to expected acute IP and observation stay discharges	H2O	1.8	0.4	***	2.0	0.7	***	1.9	0.5	***
		H2O Waitlist	1.3	(<0.001)		1.3	(<0.001)		1.4	(<0.001)	
2-23	Chronic conditions composite (PQI-92)	H2O	4.1	2.4		5.8	4.2		8.2	6.5	
		H2O Waitlist	1.7	(0.525)		1.6	(0.357)		1.7	(0.267)	
2-25	Number of members with admission to an institution from the community, per 1,000 member months										
	Short-term	H2O	110.1	60.5		125.5	77.2		146.9	98.4	
		H2O Waitlist	49.6	(0.573)		48.3	(0.500)		48.5	(0.433)	
	Medium-term	H2O	10.9	5.0		13.0	6.8		21.1	12.7	
		H2O Waitlist	6.0	(0.671)		6.2	(0.602)		8.4	(0.517)	
	Long-term	H2O	S	S		0.9	0.3		0.7	0.1	
		H2O Waitlist	0.4			0.6	(0.807)		0.6	(0.935)	
2-27	Percentage of adult IP discharges with an unplanned readmission within 30 days	H2O	14.4%	-1.2pp		21.7%	4.8pp	**	22.6%	5.8pp	***
		H2O Waitlist	15.5%	(0.483)		16.9%	(0.003)		16.8%	(<0.001)	

*p<0.1, **p<0.05, ***p<0.001

Note: ED: emergency department; H2O: Housing Health Opportunities; IP: inpatient; pp: percentage points; PQI: Prevention Quality Indicator.

Data Source: PMMIS, H2O-PA, and H2O Waitlist data were used in the analysis of RQ 2.3.

Baseline Period: 10/01/2021–09/30/2024.

KidsCare Evaluation Findings

Key Findings:

- KidsCare enrollment declined from a peak of 73,737 members in March 2023 to 56,725 members in April 2025, with the decline coinciding with the unwinding of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) continuous enrollment provision.
- Enrollment in the KidsCare Expansion began in April 2024 and increased steadily to 21,460 members by April 2025.

Although enrollment in the expansion population grew throughout the evaluation period, total KidsCare enrollment remained relatively stable following implementation, averaging 60,813 members per month from June 2023 through April 2025. This suggests that the influx of newly eligible expansion members largely offset enrollment declines associated with the COVID-19 PHE unwinding.

The *Number of uninsured children in Arizona* increased by 0.3 percentage points (p<0.001) more than the increase among comparison states during the same time period. The rate among comparison states increased by approximately 0.4 percentage points, while the rate in Arizona increased by approximately 0.8 percentage points.

The rate of uninsured children increased both in Arizona and among the comparison states between the baseline and evaluation periods, with Arizona experiencing a relatively greater increase in the rate of uninsured children.

The table below utilizes ACS data to identify changes in the uninsured rate among children in Arizona during the baseline and evaluation periods and compared to trends among states with similar Children's Health Insurance Program (CHIP) requirements.[5]

Figure 13- Changes in Arizona's Child Uninsured Rate Compared to Peer States

Did expanding KidsCare eligibility reduce the number of uninsured children?					
			Baseline Average	Evaluation Rate	2023/2024 DiD (p-value)
1-3	Number of uninsured children in Arizona	Arizona	8.5%	9.3%	0.3pp ***
		Comparison[1]	6.0%	6.4%	(<0.001)

*p <0.1, **p <0.05, ***p<0.001

Note: The change in rate displayed may not equal the difference between the baseline (CY 2021–CY 2023) and evaluation (CY 2024) averages due to rounding. pp: percentage point.

Data Source: United States Census, American Community Survey data were used in the analysis of RQ 1.2.

[1]The comparison group is comprised of states with similar federal poverty line (FPL) limits for the Children's Health Insurance Program (CHIP), including, Idaho, Nevada, Utah, Virginia, and Wyoming.

Tribal Dental Authority

Rates of access to routine and preventive dental services remained stable in the evaluation period. Due to the lack of pre-implementation data and viable comparison group, there is insufficient data to attribute any changes directly to the Tribal Dental Authority.

The *Percentage of adult members who received a comprehensive or periodic oral evaluation* averaged approximately 2.25 percent during the evaluation period. The *Number of adult members who received any covered dental service* averaged approximately 12.65 percent during the evaluation period.

The table below utilized PMMIS data to assess whether the Tribal Dental Authority improved member access to dental services.

Figure 14 - Member Access to Dental Services Under the Tribal Dental Authority

Do members have the same or better access to routine, preventative dental services compared to prior to the demonstration?			
		Evaluation Period	
		2023	2024
1-6	Percentage of adult members who received a comprehensive or periodic oral evaluation	2.28%	2.23%
1-7	Number of adult members receiving any covered service in the plan year	12.59%	12.71%

Data Source: PMMIS were used in the analysis of RQ 1.2.

The percentage of members utilizing an emergency dental service remained below one percent throughout the evaluation period following the implementation of the Tribal Dental Authority. Due to the lack of pre-implementation data and viable comparison group, there is insufficient data to attribute any changes directly to the Tribal Dental Authority.

[5] The states selected for comparison included Idaho, Nevada, Utah, Virginia, and Wyoming. These states were selected due to the CHIP federal poverty line (FPL) eligibility being at or below that of Arizona and not fluctuating during the evaluation period. Additionally, these states were primarily located in the Mountain West region, neighboring Arizona

The *Percentage of members that utilized an emergency dental service* decreased by approximately 0.17 percentage points during the evaluation period between SFY 2023 and SFY 2024.

The table below leveraged PMMIS data to determine the percentage of members who utilized an emergency dental service[6] during the evaluation period.

Figure 15- Member utilization of emergency dental services under the Tribal Dental Authority

Has the rate of emergency dental services decreased following implementation of the waiver?		Evaluation Period	
		2023	2024
3-5	Percentage/number of members that utilized an emergency dental service	0.25%	0.08%

Data Source: PMMIS data were used in the analysis of RQ 3.2.

Targeted Investments (T.I 2.0) Evaluation Findings

While the total number of ED visits among TI-attributed child and adolescent patients increased, the percentage of potentially avoidable ED visits decreased.

- A statistically significant reduction in avoidable ED visits among TI patients relative to non-TI patients suggests that the program was associated with more appropriate use of emergency care.
- Among patients aged 3 to 5, those attributed to TI had a greater reduction in potentially avoidable ED visits (22.7%) compared to non-TI patients (19.7%).

The tables below represent two claims-based measures that assessed ED utilization among child and adolescent beneficiaries.

Figure 16 - Claims-based measure assessing ED utilization among child and adolescent beneficiaries

ED Utilization		FFY 2022	FFY 2023
2-15	Number of ED visits among children and adolescents	83,287	92,107
2-16	Number of potentially avoidable ED visits among children and adolescents	52,280 (62.8%)	39,236 (42.6%)

Figure 17- Claims-based measure assessing ED utilization among child and adolescent beneficiaries

Measure 2-15: Number of ED visits among children and adolescents					
Evaluation Year	Group	Baseline	Evaluation	Log DiD Estimate (P-Value)	DiD Rate Ratio [95% CI]
2023	TI	83,287 *N = 53,699*	92,107 *N = 58,922*	-0.0035 (0.36)	0.997 [0.985, 1.01]
	Non-TI	169,078	174,859		

[6] Emergency dental services were identified based on claims containing revenue codes of 045x and 0512.

		N = 111,510	*N = 114,019*		

Note: N represents the count of unique patients.

PQC Evaluation Findings

The COVID-19 PHE had a clear impact on enrollment continuity. Following the start of the COVID-19 PHE, members both completed renewals at a higher rate and had longer coverage periods due to the continuous enrollment provision. Prior to the COVID-19 PHE, positive impacts from the Waiver can be seen, as the monthly trend in completed renewals increased compared to the baseline and members had longer enrollment coverage in 2024 compared to baseline rates.

Upon elimination of PQC, there was an average increase of 50.99 percentage points each month of Medicaid members due for renewal who completed the renewal process compared to the projected baseline trend. Although the COVID-19 PHE continuous eligibility provision initially improved rates of renewals, the monthly trend during the COVID-19 PHE declined by 0.26 percentage points compared to the trend in the implementation period. Immediately after the COVID-19 PHE concluded, renewals decreased to their lowest point before recovering in 2024.

The average number of months with Medicaid coverage within each federal fiscal year (FFY) increased slightly between the baseline period and FFY 2024. Due to the impact of the continuous enrollment provision authorized during the COVID-19 PHE, FFY 2020 through FFY 2023 experienced an increase in enrollment continuity. To better estimate the impact of the PQC waiver, the analysis for Measure 1-6 (Average number of months with Medicaid coverage) does not include COVID-19 PHE-impacted years.

Figures 17 and 18 below display the ITS results comparing trends projected from baseline rates to trends in the evaluation period for the percentage of Medicaid members due for renewal who completed the renewal process.[8] The blue line in Figure 3 represents the model-based average rates for each month. The dashed grey line represents the counterfactual projection of the baseline period trend in the post-policy period before the COVID-19 PHE-affected months. The second table displays the average number of months with Medicaid coverage per year.

Figure 18 - Percentage of Medicaid members due for renewal who complete the renewal process

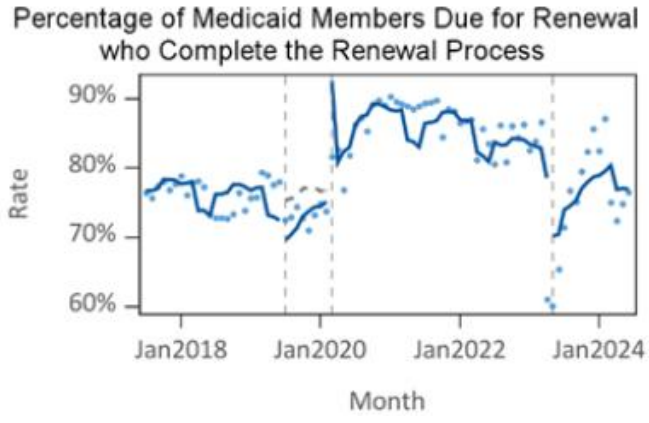


Figure 19 - Projected and observed Medicaid renewal completion rates including PHE affected months

Variable	Estimate	
Intercept	82.77% *(<0.001)*	***
Baseline monthly trend	-0.05pp *(0.447)*	
Level change at implementation	-5.79pp *(0.008)*	**
Change in monthly trend	0.59pp *(0.038)*	**
Level change at beginning COVID-19 PHE	18.18pp *(<0.001)*	***
Change in monthly trend during COVID-PHE	-0.26pp *(0.034)*	**

*p <0.1, **p <0.05, ***p <0.001
p value is presented in parentheses.
Note: Full model results are presented in Appendix A. COVID-19: coronavirus disease 2019; PHE: public health emergency
Baseline period: July 1, 2016–June 30, 2021; Evaluation period: July 1, 2019–September 30, 2024.
The results include rates from the baseline period (FFY 2018–FFY 2019) and the evaluation period (FFY 2020–FFY 2024).
Data Source: PMMIS data were used in the analysis of RQ 1.2.

External Quality Review

In accordance with Section 1932(c)(2) of the Social Security Act and 42 CFR 438.350–438.370, Arizona conducts annual External Quality Reviews (EQRs) for each contracted managed care organization. These reviews are performed by an independent External Quality Review Organization (EQRO) and include validation of performance measures, reviews of performance improvement projects and compliance with federal managed care requirements, and other assessments of health plan performance to evaluate the quality, timeliness, and accessibility of services provided to Medicaid members. AHCCCS contracts with Health Services Advisory Group (HSAG) to serve as its EQRO. A summary of the EQR activities conducted during the current demonstration period and their key findings is provided in Appendix B. Annual EQR Technical Reports are publicly available on the AHCCCS website.

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 Section 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 Section 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

ALTCS (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 Retroactive Coverage (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, postpartum women, 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. Beginning on January 1, 2027, retroactive eligibility for these populations will be limited to two months in alignment with Section 71112 of the Working Families Tax Cut legislation.

AHCCCS is requesting the authority to continue to limit retroactive coverage to the first day of the month of application for the same populations as currently covered within the waiver. This waiver authority is in close alignment with the Working Families Tax Cut legislation and will allow the agency to further 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.

Former Foster Youth Annual Automatic Renewal (YATI Amendment)

Approved by CMS on June 13, 2025, the Former Foster Youth Annual Automatic Renewal Demonstration Waiver authorizes Arizona to waive the condition of eligibility in 42 CFR 435.608 requiring Medicaid beneficiaries to apply for other cash benefits for the Former Foster Youth (FFY) population. AHCCCS currently offers transitional medical care for children leaving foster care that are between the ages of 18 to 26 and typically refers to this group as the Young Adult Transitional Insurance (YATI) population. Although the SUPPORT Act requires Medicaid programs to extend Medicaid eligibility for FFY who aged out of any state on or after 1/1/2023, this Waiver authority allows Arizona to further extend this eligibility to also include individuals who aged out prior to 1/1/2023. Specifically, the Waiver authorizes full Medicaid state plan benefits to FFY who:

- Are under age 26,
- Turned 18 on or before December 31, 2022,
- Were in foster care under the responsibility of another state or tribe on the date of attaining 18 years of age,
- Were enrolled in Medicaid on the date of aging out of foster care, and
- Are now applying for Medicaid in Arizona.

Despite Arizona receiving the federal authority for this program, AHCCCS requires additional state legislative approval to begin implementation, however, is requesting the federal authority be continued to allow for additional time to secure the needed state approvals.

KidsCare Expansion

In November 2023, pursuant to Laws 2023, Chapter 139, AHCCCS submitted a waiver amendment to expand KidsCare (CHIP) eligibility. CMS approved this authority in February 2024, allowing the state to increase the KidsCare eligibility threshold from 200 percent to 225 percent of the federal poverty level, with additional flexibility to extend coverage up to 300 percent FPL subject to legislative approval. The expanded income limit was implemented in March 2024, with an effective date of eligibility for expansion in April 2024.

Following implementation, enrollment under the higher income threshold exceeded initial projections of 9,700 children, reaching 13,233 by September 2024 and continuing to grow to 22,346 by September 2025, representing a 40.8 percent year-over-year increase. Since September 2025, enrollment growth under the expansion has slowed in more recent months, indicating a shift toward stabilization with ongoing changes expected to reflect routine enrollment dynamics such as renewals and coverage transitions rather than significant expansion. Despite this influx of newly eligible members, total enrollment within the KidsCare population has remained relatively stable following the end of the unwinding of the COVID-19 PHE continuous enrollment provision averaging 60,813 total enrolled members from June 2023 through April 2025. Enrollment under the expanded income limit is continually reported monthly within the AHCCCS Population Highlights report found on the population reports web page.

AHCCCS is seeking continued authority to maintain the KidsCare Expansion as currently implemented. Early findings from the Demonstration indicate that the expansion is meeting many of both its short-term and longer-term goals, including improvements in member satisfaction, perceived health outcomes, and access to both medical and dental services, while also maintaining stable performance in areas such as behavioral health management and hospital utilization. At the same time, the Demonstration has played an important role in mitigating coverage losses among children as Arizona has experienced a greater increase in the rate of uninsured children as compared to other states. Specifically, during the demonstration period, the rate of uninsured children in Arizona increased by approximately 0.8 percentage points while comparison states experienced an increase of approximately 0.4 percentage points. Absent the coverage gains achieved through the Demonstration, Arizona would likely face even greater growth in its rates of uninsured children, further compounding existing access challenges. These early findings continue to inform the state's assessment of the program's impact and underscore the importance of maintaining expanded coverage for children into the next demonstration period.

Delivery System

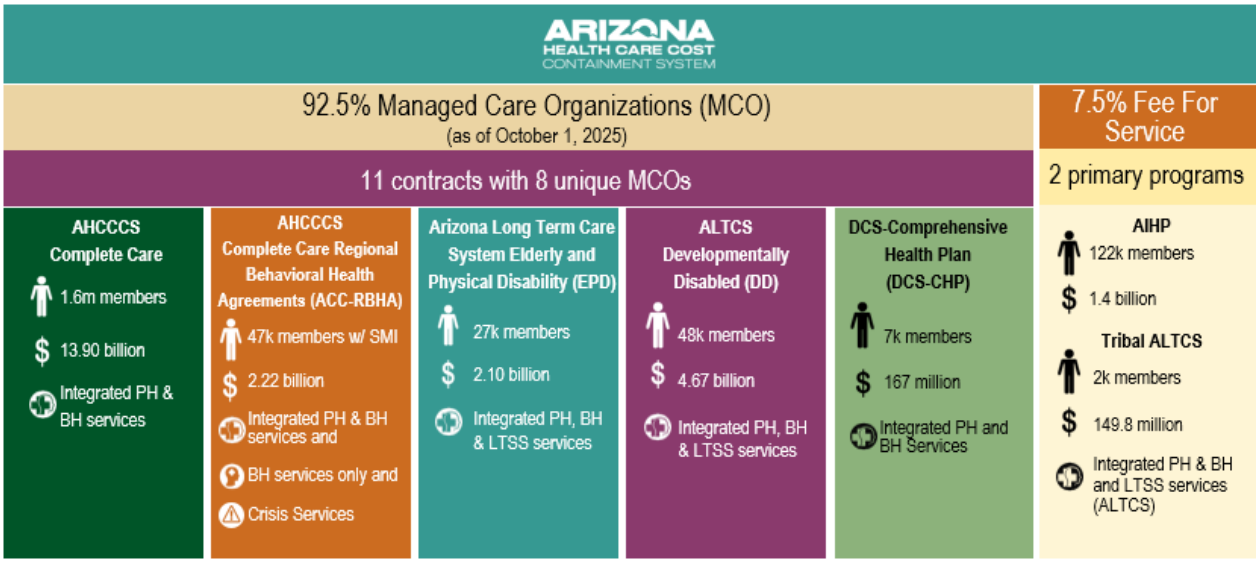
Arizona's Demonstration provides the authority to operate a statewide, mandatory managed care model designed to coordinate high-quality care while also promoting efficient use of resources to ensure long term stability of the program. Through this approach, AHCCCS works in partnership with private health plans to deliver comprehensive services while maintaining fiscal discipline. Although managed care has served as the cornerstone of Arizona's Medicaid program, it has also continued to evolve and expand to meet the needs of Arizona's Medicaid members. Today, managed care is applied broadly across populations and service areas offering an effective solution to coordinate long-term services and supports, behavioral health, and other target services for other specialty populations such as individuals who are dually eligible for Medicare and Medicaid

and children in Arizona's foster care system. Currently, approximately 90 percent of AHCCCS members receive services through managed care arrangements.

Members enrolled within a managed care plan generally have the option to select from multiple contracted health plans within their designated geographic service area, although this varies by population. Individuals with a designated serious mental illness (SMI) are typically enrolled with a single plan within each region. For ALTCS members with developmental disabilities, long-term care services are provided through one statewide contractor, while physical and behavioral health services are delivered through a choice of subcontracted plans. Among ALTCS members who are elderly or have physical disabilities, plan choice is available in more populous counties such as Maricopa, Pinal, Gila, and Pima, while a single plan arrangement exists in the remaining counties. Children in foster care are enrolled with one designated managed care entity to support continuity and coordination of services due to the relatively smaller population size.

American Indians and Alaska Natives may choose to receive services through a managed care plan or through the American Indian Health Program (AIHP), a fee-for-service (FFS) delivery system administered by AHCCCS. In addition, certain non-qualified aliens whose benefits are limited to emergency services under section 1903(v) of the SSA are not permitted to enroll within a managed care plan and are rather served on an FFS basis also administered by AHCCCS.

Figure 20 - AHCCCS Delivery System Overview



Through this waiver renewal, AHCCCS is seeking waiver authority to continue its established managed care delivery system which has continually supported coordinated service delivery and effective cost management across the program.

Supplemental Payments to IHS and Tribal 638 Facilities (Tribal Uncompensated Care Waiver)

In addition to its managed care delivery system, Arizona's current Demonstration authorizes supplemental payments to Indian Health Service (IHS) and tribally operated 638 facilities to offset uncompensated care costs for services provided by such facilities to Medicaid-eligible adults in the case the state reduces or eliminates

services from the Medicaid State Plan. This program is commonly referred to as the Tribal Uncompensated Care Waiver.

Originally approved by CMS in April 2012, this authority was established to help stabilize the tribal health care delivery system during previous program reductions and the childless adult enrollment freeze. Although the State has not needed to operationalize these payments during the current demonstration period due to the absence of comparable program cuts, the authority has remained an important safeguard for tribal health care delivery. Tribal stakeholders have continued to emphasize its value as a protective measure, particularly considering upcoming changes within the Medicaid program as a result of many new Working Families Tax Cut requirements.

The Tribal Uncompensated Care Waiver has also received recent additional support through the state legislative process. On April 13, 2026, Arizona Governor Katie Hobbs enacted HB 2177 which formally codifies the program within state statute and further directs AHCCCS to continually pursue corresponding federal authority authorizing the program. AHCCCS is therefore seeking to preserve this authority under the renewal to ensure continued support for a critical network of providers serving high-need members across rural and Tribal communities.

Benefits

Arizona's Demonstration maintains a comprehensive benefit structure designed to ensure consistency and access across delivery systems. AHCCCS proposes to continue to provide the full range of currently authorized benefits, with standardized coverage available to members regardless of their managed care plan selection. Acute care members receive a uniform benefit package across all contracted plans, and the same approach applies within the ALTCS program, where services are aligned across contractors to ensure consistent access. AHCCCS is seeking the appropriate authorities to continue the following approved waiver services into the next Demonstration period.

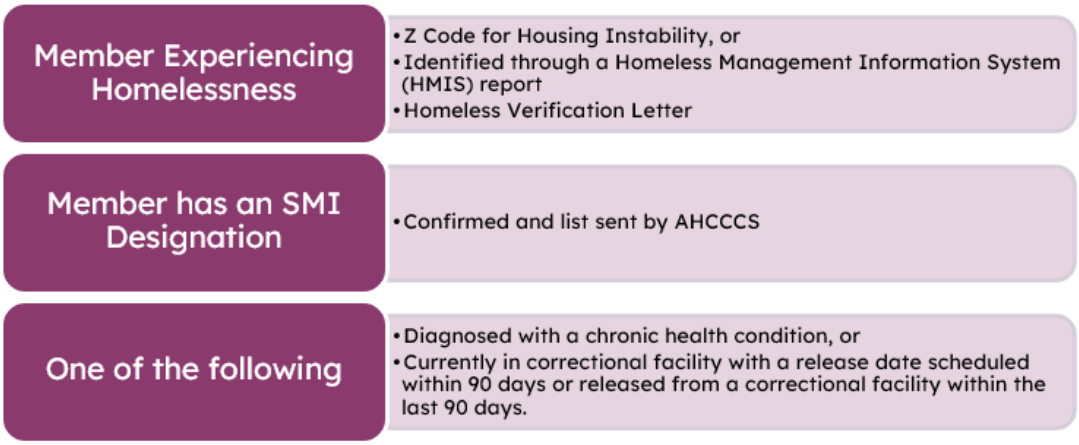
Housing and Health Opportunities (H2O)

The Housing and Health Opportunities (H2O) Program provides short-term housing assistance and wraparound supportive services to some of the state's most vulnerable populations, including individuals with an SMI designation and who are experiencing homelessness and who are either diagnosed with a chronic health condition or have recent justice system involvement as further outlined in figure 20 below. Within this Demonstration renewal, Arizona is seeking to continue the existing authorities which authorize the H2O program based on early results showing measurable progress against the state's objectives and expected outcomes.

Early results support continuation. Comparing the period after H2O eligibility to the twelve months preceding it, emergency department utilization among eligible members fell 11.7 percent and inpatient utilization fell 19 percent, with a corresponding decline in per member per month expenditures. Those findings are preliminary and are detailed later in this section, but they indicate that H2O is reducing avoidable high-cost utilization within a short implementation window. The program pairs time-limited rental assistance with housing

navigation and care coordination, operates as a bridge to long-term housing resources rather than an ongoing subsidy, and is supported by the provider oversight and program integrity controls described below.

Figure 21: H2O Member Eligibility Criteria



H2O was shaped by years of cross-system collaboration in Arizona that revealed a persistent and widespread gap that resulted in many individuals falling in between the housing and healthcare systems despite significant state and federal investments to minimize homelessness. H2O was designed to close that gap by intentionally aligning Medicaid with housing resources like HUD Continuum of Care (CoC) and Public Housing Authorities (PHAs), using Medicaid to fund the time-limited services and supports needed to stabilize people and begin healing, while helping connect them to longer-term housing solutions where possible. The Demonstration targets individuals experiencing homelessness who also have high healthcare needs and costs, with the goal of not only improving outcomes and stability but also demonstrating that better coordination across systems can reduce avoidable healthcare spending. The program was designed to reduce reliance on high-cost crisis services and promote long-term recovery and stabilization by redirecting Medicaid funds from costly emergency and inpatient care to more preventative housing supports.

The Demonstration was approved by CMS in October 2022, and AHCCCS officially launched the program on October 1, 2024, after completing a series of post-approval deliverables and requirements. During this period, the state worked closely with CMS to finalize the following key deliverables which outlined various operational and technical components of the program including the strategic approach to building provider networks, integrating IT systems, and ensuring service quality for the Demonstration.

- Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for H20 Services,
- H2O Protocol for Infrastructure Planning,
- H2O Rate Methodology, and
- H2O Implementation Plan.

AHCCCS proposes to continue the H2O program as currently implemented, maintaining its core services and eligibility criteria. The program has already demonstrated success through member use cases and early outcome data, however, its full potential can only be realized through sustained implementation and evaluation.

H2O Program Features to Continue Under the Demonstration

Rather than limiting the program to a rapid expansion rollout phase, AHCCCS seeks to continue the existing H2O program features as currently implemented and outlined in Figure 22 below to allow additional time for longitudinal data collection, outcome measurement, and continuous quality improvement. This continuation will ensure that the program can demonstrate its effectiveness in improving health outcomes and reducing Medicaid expenditures as the Demonstration continues to mature and solidify itself as a feature within Arizona's Medicaid program.

Figure 22: H2O Program Features to Continue Under the Demonstration

Program Feature	Description
H2O Services	AHCCCS proposes maintaining the existing H2O service continuum and program structure, including Outreach and Education services funded under the H2O Infrastructure benefit. AHCCCS also seeks to continue Transitional Housing services delivered through the two currently approved models: Enhanced Shelter and Short-Term Rental Assistance. Additional core program features AHCCCS seeks to continue include Housing Pre-Tenancy Supports, Tenancy Sustaining Supports, Move-In Assistance, and Home Modifications. These services remain foundational components of the H2O demonstration designed to support housing stabilization, successful community integration, and improved health outcomes for eligible members. All H2O services are further defined within the approved H2O Protocol and Implementation Plan in addition to state policy (AHCCCS Medical Provider Manual (AMPM) Chapter 1700)
H2O Provider Onboarding	AHCCCS designed the H2O Program with a provider structure intended to balance strong accountability with increased accessibility for qualified community-based providers. The model was intentionally developed to ensure that providers can achieve meaningful member outcomes while also reducing unnecessary administrative barriers that have historically limited participation by community-based organizations (CBOs) in the Medicaid delivery system. The H2O provider type structure creates a more flexible pathway for enrollment by removing requirements that are not applicable to the supportive housing services delivered under the demonstration, while maintaining rigorous oversight mechanisms to address fraud, waste, and abuse. This structure has allowed AHCCCS to expand provider capacity by creating viable participation opportunities for trusted CBOs that have longstanding experience serving vulnerable populations, including in rural and underserved communities throughout Arizona. Through this approach, organizations known for delivering high-quality housing and outreach services have been able to enroll as H2O providers and deliver critical Outreach and Education and supportive housing services to Medicaid members experiencing homelessness or housing instability statewide.
H2O Program	To support successful implementation, AHCCCS contracted with a single H2O Program

Administrator	Administrator through the state procurement process and utilized H2O Infrastructure funding to establish significant administrative oversight and technical assistance functions. This administrative structure supports providers through onboarding and operational implementation while ensuring ongoing monitoring of service delivery, compliance, quality, and program integrity. In addition, the administrator provides robust technical assistance and training intended to strengthen provider performance and promote high-quality, high-frequency member engagement.

This combination of flexible provider participation standards and strong administrative oversight has helped increase workforce capacity within Arizona's Medicaid system by expanding the number of individuals trained to deliver housing and supportive services under the H2O model. As a result, AHCCCS has been better positioned to connect members with consistent community-based supports that address housing instability, reduce reliance on avoidable high-cost healthcare utilization, and improve long-term health and community stabilization outcomes.

System Accountability and Integration with Other State and Federal Housing Programs

From the onset, the H2O program was designed with program integrity, transparency, accountability, and the reduction of fraud, waste, and abuse (FWA) as key priorities to ensuring successful implementation and long-term sustainability of the program. AHCCCS also intentionally designed the H2O operational structure to support robust data collection, monitoring, and public reporting. As outlined in the approved H2O Implementation Plan, AHCCCS conducted a statewide procurement process to identify a single Housing and Health Opportunities Program Administrator (H2O-PA) capable of supporting standardized implementation and oversight across Arizona. The H2O-PA plays a critical role in ensuring program consistency and accountability by supporting Community Based Organization (CBO) enrollment, verifying member eligibility under established AHCCCS guidelines, coordinating services with health plans and care coordination teams, streamlining reimbursement processes, monitoring service utilization, providing technical assistance, and serving as a centralized operational point of contact for participating entities.

The selection of a single statewide administrator was intentional to ensure consistency in program implementation and to establish centralized monitoring and tracking processes from the outset of the demonstration. The H2O-PA has the capacity to use AHCCCS eligibility and clinical risk factor data to support H2O eligibility determinations and track services delivered to members across the state, including which services were provided, by whom, and at what frequency. This structure allows AHCCCS and the H2O-PA to collect meaningful and actionable data regarding member engagement, housing outcomes, service utilization, and provider performance. This data is used not only for oversight and monitoring purposes, but also to identify opportunities for improvement and support real-time operational adjustments through targeted technical assistance, workforce development, and provider training.

To further support integration and reduce duplication of services, the H2O program was intentionally designed to operate in coordination with existing federal, state, and local housing systems rather than as a standalone housing resource. As a result, AHCCCS determined that H2O service documentation would occur within Arizona's Homeless Management Information System (HMIS), creating alignment with HUD Continuum of Care (CoC) programs and other community housing resources. This allows H2O supportive housing services to

complement existing housing subsidies and rental assistance programs. For example, in situations where a HUD CoC program funds a member's rental assistance, H2O may provide intensive community-based supportive services focused on housing stabilization, healthcare engagement, independent living skills, income and benefits acquisition, community integration, and connection to employment and vocational rehabilitation resources.

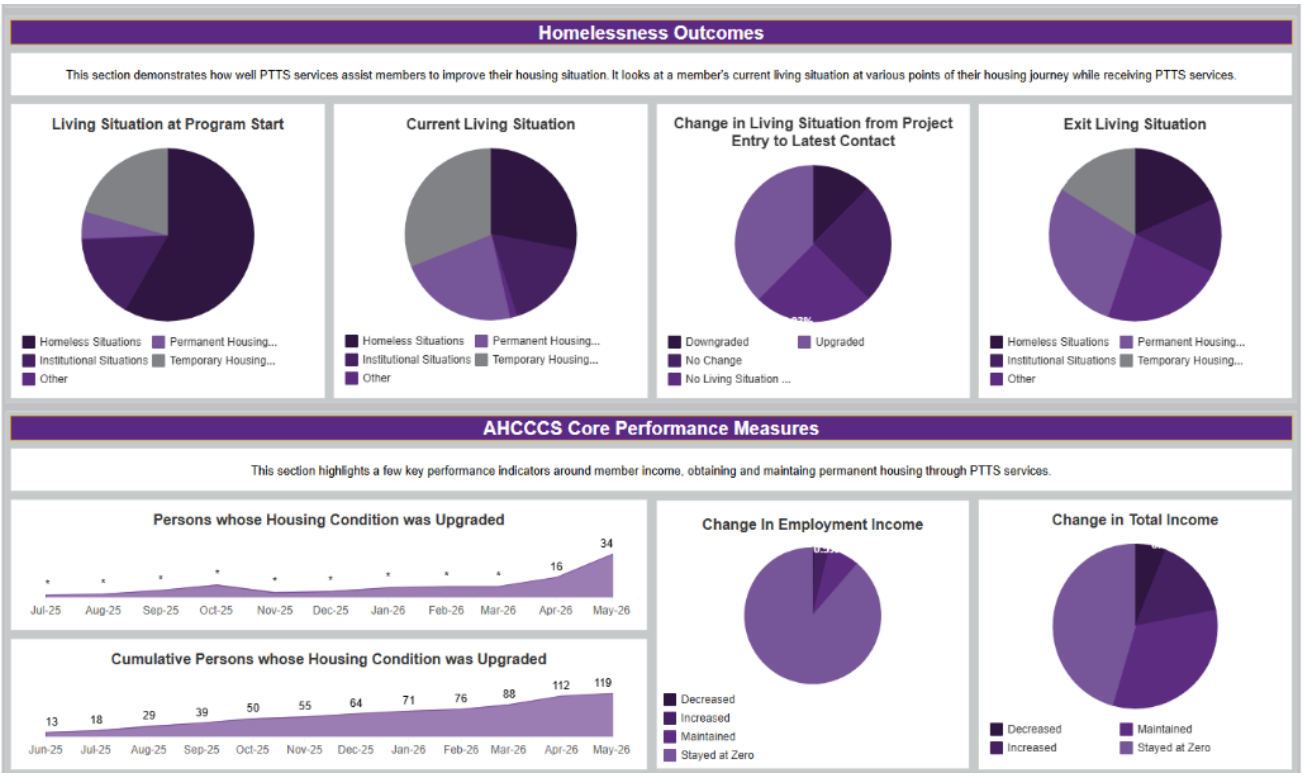
Documenting services within HMIS also creates the ability to integrate housing and supportive service data with additional program and outcome measures to better assess member progress and system performance in real time. Key indicators such as housing stability, changes in living situation, service frequency and type, and income improvements are incorporated into the H2O data structure and reflected within publicly available dashboard reporting. AHCCCS and the H2O-PA continue to collaborate closely to refine and enhance data collection methodologies, strengthen reporting capabilities, and provide actionable information back to providers to improve service delivery and advance program outcomes.

H2O Program Administrator & Program Health Dashboard

The H2O Dashboard is a public-facing data and reporting platform designed to provide transparent, real-time insight into implementation and outcomes of Arizona's H2O program. It tracks key program metrics related to member eligibility, provider participation, outreach activities, service utilization, and housing support interventions across the state. The dashboard integrates data collected through HMIS and H2O provider reporting to monitor outcomes such as housing stability, engagement in supportive services, and changes in member living situations. AHCCCS and the H2O Program Administrator use the dashboard to identify trends, monitor provider performance, and inform technical assistance and quality improvement efforts. This centralized reporting structure supports statewide standardization, strengthens program integrity oversight, and aligns with CMS priorities for transparency, accountability, and data-driven monitoring.[7]

Figure 23: H2O Program Health Dashboard Example

[7] https://community.solari-inc.org/h2o-dash/



H2O Objectives, Goals, and Early Outcomes

The H2O Demonstration is anchored in a clear set of goals focused on improving health and wellbeing outcomes for high-need populations, reducing avoidable healthcare utilization and costs, and decreasing homelessness while increasing long-term housing stability. These goals will be supported by a robust evaluation framework that examines changes in healthcare utilization, housing outcomes, and member experience over time using administrative data, surveys, and comparative analyses.

Due to the program being launched towards the middle of the Demonstration period, and given the scale and complexity of launching a statewide, cross-system initiative of this nature, the program required substantial upfront investment. This included establishing provider networks and contracting, developing eligibility and referral pathways, and delivering intensive technical assistance to ensure fidelity to the H2O Implementation plan, STCs, and policies. Despite this necessary ramp-up period, the program is already demonstrating early signals of success, underscoring both the strength of its design and the longstanding need it was built to address.

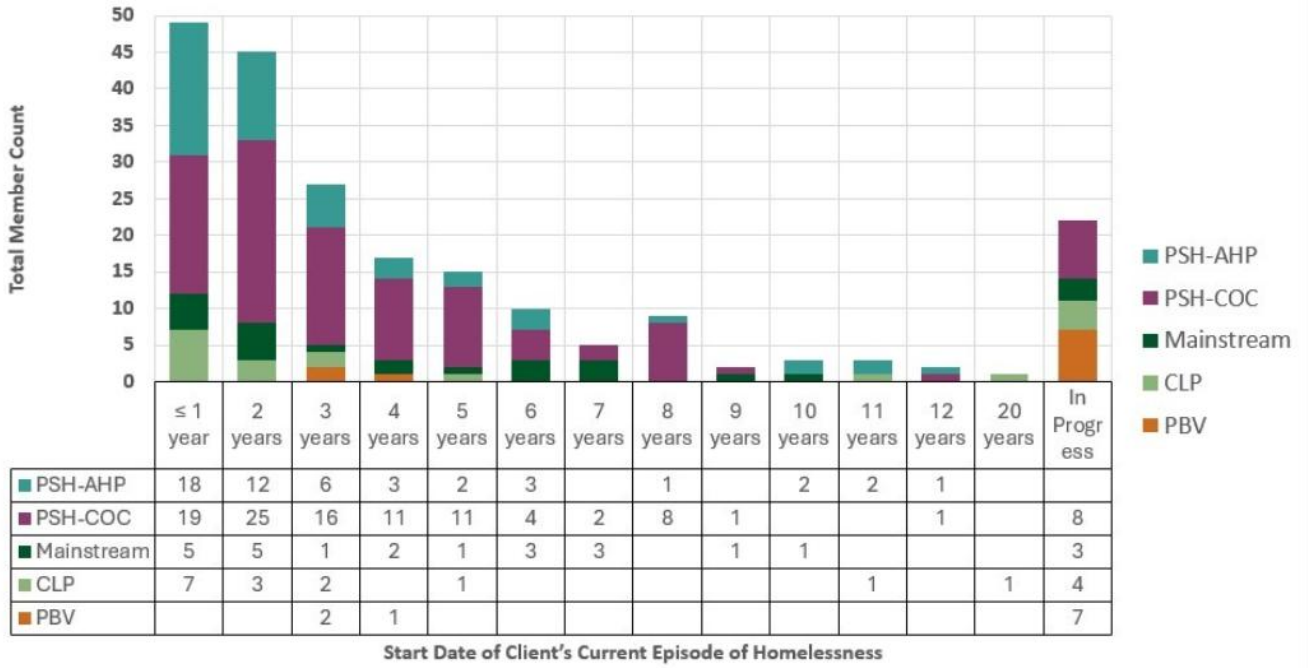
As discussed in Section III above, AHCCCS has finalized development of the Waiver Interim Evaluation Report for all Demonstration programs including H2O. However, given the ramp up period and delayed go-live date when compared to the rest of the Demonstration the H2O claims data currently available for the Interim Evaluation largely reflect Federal Fiscal Year 2024 and therefore represent baseline conditions prior to program implementation rather than post-intervention outcomes. As a result, the interim report primarily describes the characteristics, service utilization, and costs of the population before H2O services were in place. The Summative Evaluation Report, submitted after the conclusion of the Demonstration period, will include a more complete assessment of program effectiveness using post-implementation data that have matured and undergone full validation in accordance with CMS requirements.

However, recognizing these timing constraints, AHCCCS developed and prioritized internal evaluation capacity from the outset by establishing dedicated H2O data resources and partnering closely with actuarial teams to monitor program implementation, service delivery, and early outcome indicators in real time. These analyses, while distinct from the federally required independent evaluation, provide timely insight into program performance and are reflected further below to highlight the early impact of H2O, even within a limited implementation period.

Statewide Housing Administrator – Short Term Rental Subsidy Tracking

AHCCCS has conducted significant analysis to track outcomes for members receiving Short-Term Rental Assistance through the H2O program, including the length of time members experienced homelessness prior to entering housing and the permanent housing resources they transitioned to within six months. The data demonstrates how H2O has successfully implemented a transitional housing model that aligns with Medicaid guardrails by using short-term rental assistance as a bridge to long-term housing stability rather than a permanent subsidy. Figure 24 illustrates how H2O supportive services are paired with intensive housing navigation and care coordination to help highly vulnerable members stabilize while long-term housing solutions are secured. It also reflects successful transitions to permanent housing programs such as HUD Continuum of Care Permanent Supportive Housing, Mainstream Vouchers, and Project-Based Vouchers. These outcomes demonstrate the effectiveness of integrating Medicaid supportive housing services with existing federal and local housing systems to improve housing stability and reduce prolonged homelessness.

Figure 24: H2O Impact – Approximate Date Homeless Started and Housing Intervention



	≤ 1 year	2 years	3 years	4 years	5 years	6 years	7 years	8 years	9 years	10 years	11 years	12 years	20 years	In Progress
PSH-AHP	18	12	6	3	2	3		1		2	2	1		
PSH-COC	19	25	16	11	11	4	2	8	1			1		8
Mainstream	5	5	1	2	1	3	3		1	1				3
CLP	7	3	2		1						1		1	4
PBV			2	1										7

Internal AHCCCS H2O Program Analysis

To supplement the Waiver Interim Evaluation Report and account for the timing of H2O implementation in relation to the Evaluation deliverables, AHCCCS has initiated additional analysis to generate actionable insights on key aspects of the program, including the characteristics of the H2O target population, per member per

month cost trends, and overall utilization patterns, in order to inform ongoing implementation and program refinement.

Figure 25 below reflects AHCCCS' approach to developing clearly defined eligibility criteria for members receiving the H2O benefit by identifying populations with significant health and housing-related vulnerabilities. Specifically, the analyses examine the prevalence of chronic physical health conditions among members who are both SMI and experiencing homelessness, highlighting populations with disproportionately complex healthcare needs and elevated healthcare utilization.

Figure 25: Top 10 Most Recurring Diagnoses in 2024 by SMI Member Count

Recurring CCW Condition	Unhoused Count	Unhoused %	Housed Count	Housed %	Unhoused Per Capita	Housed Per Capita	Per Capita Difference
None	8,520	52%	25,162	56%	$22,024	$13,049	$8,975
Hypertension**	2,453	15%	4,532	10%	$59,505	$33,290	$26,216
Diabetes**	1,245	8%	4,369	10%	$60,141	$39,956	$20,186
Asthma	963	6%	1,228	3%	$56,866	$35,927	$20,939
Hyperlipidemia	948	6%	2,902	6%	$61,206	$33,329	$27,877
Rheumatoid Arthritis/ Osteoarthritis	593	4%	2,632	6%	$42,059	$22,649	$19,410
Anemia	574	4%	806	2%	$60,130	$36,696	$23,434
Chronic Obstructive Pulmonary Disease	418	3%	1,172	3%	$48,950	$34,113	$14,837
Hypothyroidism	383	2%	1,273	3%	$64,457	$42,513	$21,944
Pneumonia	221	1%	258	1%	$53,669	$60,008	-$6,340
Total*	**16,379**	**100%**	**44,707**	**100%**	**$39,700**	**$23,178**	**$16,522**

* Total category includes CCW conditions that are not represented in the table. As such, a sum of the values in the table may not equal the associated Total category.
** Current chronic conditions currently included within H2O eligibility criteria.[8]

The data demonstrates substantial per capita differences across multiple chronic health conditions, reinforcing the connection between housing instability and poor health outcomes for highly vulnerable Medicaid populations. These findings support the underlying H2O program design and indicate that housing stabilization,

[8] https://www.azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/H2OChronicHealthConditions_diagcode.pdf

coupled with supportive services, represents a meaningful intervention strategy to improve health outcomes and reduce avoidable healthcare expenditures. While these analyses are distinct from the federally required independent evaluation, they provide important real-time insight into the populations being served and the early impact of targeted housing interventions under the H2O demonstration.

Figures 26 and 27 below reflect preliminary actuarial analyses conducted to assess early trends in healthcare utilization and Medicaid expenditures for members before and after H2O eligibility determination. These analyses examine whether housing-related interventions authorized under the H2O demonstration are associated with changes in utilization patterns among highly vulnerable members.

Figure 26: H2O Members PMPM by Event Month

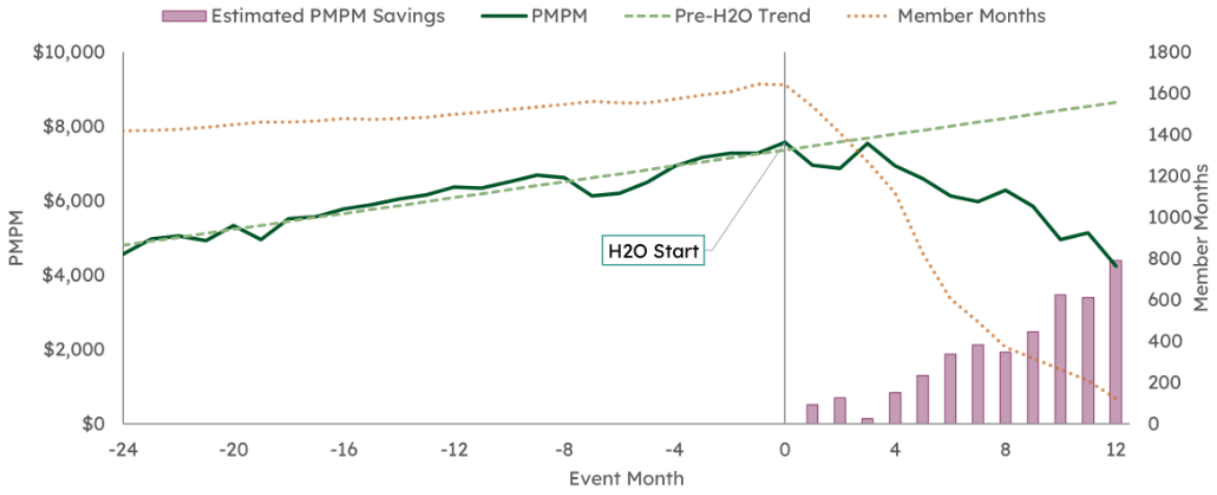
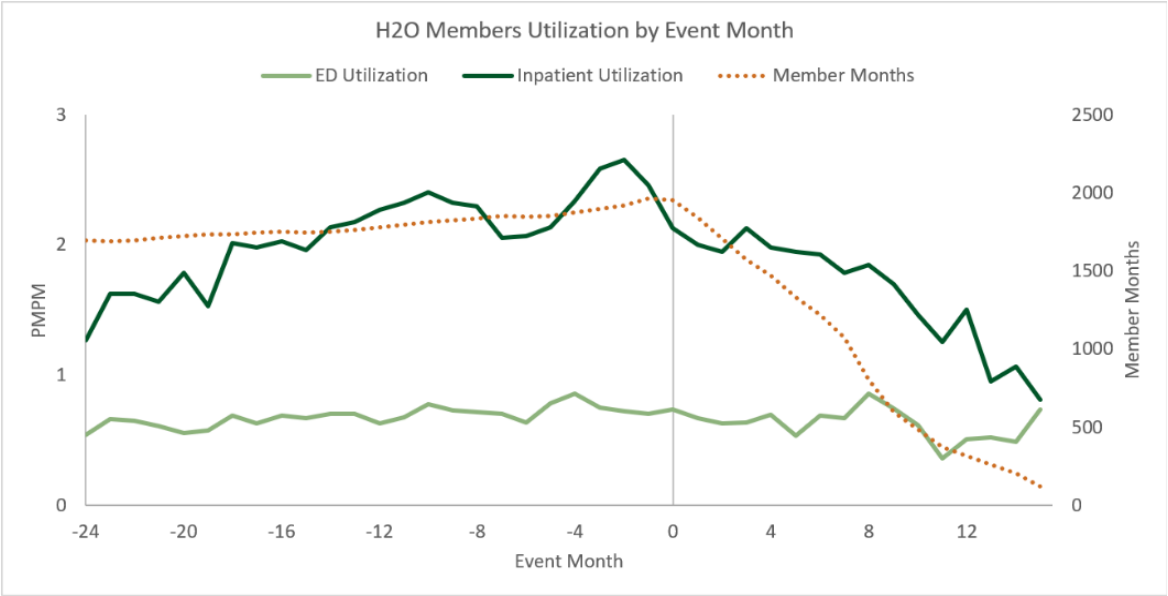


Figure 27: PMPM H2O Eligible Member Utilization



These preliminary results show a visual upward trend in Emergency Department (ED) and Inpatient utilization prior to H2O eligibility determination followed by a downward trend once eligibility triggers services. A similar trend is seen for PMPM Medicaid expenditure. Comparing months after eligibility to the 12-month period prior

to eligibility, ED utilization decreased 11.7% and Inpatient utilization decreased 19%. These results are preliminary and may change as more data become available. Even at this early stage, they indicate that H2O is meeting its goals of reducing expenditures and lowering emergency department and inpatient utilization for eligible members.

Dental Waiver Services

Arizona has taken incremental steps over the past decade to rebuild adult dental coverage following reductions made during the Great Recession. Beginning in 2016, the state authorized a limited dental benefit of $1,000 per contract year for individuals enrolled in the ALTCS program. The following year, emergency dental services for adult AHCCCS members were reinstated through the Medicaid State Plan. Building on these efforts, in 2020 the Governor and the Arizona Legislature authorized ARS 36-2907 and 36-2939 directing AHCCCS to pursue federal authority to expand reimbursement for dental services provided through Indian Health Service (IHS) and tribally operated 638 facilities, particularly designed to extend coverage for services that exceed the existing $1,000 limits in both the Medicaid State Plan and the ALTCS program. Through this renewal, AHCCCS is seeking to continue the authority for both dental programs.

ALTCS Dental Benefit

The Demonstration authorizes AHCCCS to provide a limited dental benefit for ALTCS members beyond what is currently covered within the Medicaid State Plan. First established in 2016, this benefit includes coverage of up to $1,000 per contract year for dental services for individuals enrolled in the ALTCS program. This coverage represents an important component of the overall benefit package for individuals receiving long-term care services and supports. The availability of routine and preventive dental services helps reduce the risk of more serious health complications, supports overall well-being, and contributes to improved quality of life for this population. AHCCCS is seeking to maintain this benefit under the renewal to ensure continued access to essential dental services for ALTCS members.

Tribal Dental Benefit

The Tribal Dental Demonstration was first approved by CMS in October 2022 and allows the reimbursement for medically necessary diagnostic, preventive, and therapeutic dental services provided to American Indian and Alaska Native (AI/AN) members through IHS and tribally operated facilities, even when those services exceed standard adult dental limits. This flexibility applies specifically to services delivered within the IHS and Tribal health system, ensuring that care remains accessible in settings where members already receive services.

This authority reflects an effort to address longstanding gaps in oral health access among AI/AN individuals as this population is among the populations in the United States with the highest rates of untreated dental disease, a gap compounded by the geographic isolation of tribal populations and the limited number of practicing dentists in IHS or tribal health facilities in rural and frontier locations.[9] By expanding reimbursement

[9] US Department of Health and Human Services: National Institutes of Health. Oral Health in America: Advances and Challenges. Available at: https://www.nidcr.nih.gov/sites/default/files/2021-12/Oral-Health-in-America-Advances-and-Challenges.pdf

for services delivered through IHS and Tribal facilities, the Demonstration supports broader access to care while strengthening local delivery systems.

In addition to improving oral health outcomes, reducing rates of untreated disease, the Tribal Dental Demonstration enhances the capacity of IHS and tribally operated clinics. Expanded reimbursement creates additional resources for these facilities, supporting efforts to recruit and retain dental professionals in underserved areas. This, in turn, helps ensure more consistent access to care for Tribal communities and reduces reliance on emergency treatment.

Through this renewal, AHCCCS is seeking to continue its existing federal expenditure authority for the Tribal Dental program which will carry over many of the same goals from the previous Demonstration period of improving oral health outcomes, reducing health disparities, and enhancing the overall care experience for AI/AN members by expanding access to preventive and routine dental services within trusted, community-based care settings.

Traditional Healing

In partnership with Tribal leadership across Arizona, AHCCCS pursued and received approval for a first-in-the-nation initiative to recognize and reimburse traditional healing services within the Medicaid program, commonly referred to as the Traditional Health Care Practices (THCP) Demonstration. The initial Demonstration request was submitted in 2015 and later refined in 2020 to reflect continued collaboration with Tribal partners and evolving program design. CMS approved Arizona's approach in October 2024, and the program went live one year later on October 1, 2025. The development and rollout of this initiative has been guided by the Traditional Healing Workgroup, a community-led advisory body composed of Tribal leaders, representatives from Indian Health Service (IHS), tribally operated 638 facilities, Urban Indian Organizations (UIOs), traditional healers, and other Tribal-serving partners. The Workgroup has and continues to play a central role in shaping how these services are incorporated into the Medicaid program, helping ensure that care remains consistent with the values, practices, and priorities of the communities served.

The Workgroup's role as a lead within this initiative reflects a broader commitment to Tribal sovereignty and self-determination, as well as recognition of the cultural importance of traditional healing practices. AHCCCS continually encourages Tribal Nations, IHS and 638 facilities, and UIOs to designate representatives and identify traditional knowledge holders to contribute to this effort. The strength of the initiative is closely tied to this engagement, with program design and implementation informed by individuals who bring direct knowledge of traditional practices, cultural expertise, and deep connections within their communities.

Since implementation, the program has begun to take shape across the state, with a growing number of participating providers delivering services grounded in longstanding Tribal practices and traditions. Through this renewal, AHCCCS is seeking to maintain the existing federal authorities supporting the THCP program, while also proposing to broaden eligible provider participation to more fully include Urban Indian Organizations (UIOs) as further described below.

Traditional Healing Program Overview

Under this authority, eligible Medicaid members may receive coverage for traditional healing services when they are provided by or through Indian Health Service (IHS) and tribally operated 638 facilities. Additionally, under the current program model, traditional healers affiliated with UIOs may furnish services through a care coordination agreement (CCA) with a partnering IHS or Tribal 638 facility. As of June 2026, a total of 10 providers have successfully begun billing for these services, reflecting early adoption as each facility establishes processes aligned with the Demonstration requirements to best meet the needs of their community.

Traditional healing is a culturally grounded system of care developed and practiced by generations of Tribal healers. These methods support physical, mental, emotional, and spiritual well-being, and reflect the values, beliefs and practices of Arizona's Tribal communities. The initiative is intended to broaden access to culturally appropriate services and support improved health outcomes by aligning care delivery with the practices and preferences of American Indian and Alaska Native (AI/AN) members.

Eligibility for coverage is limited to Medicaid beneficiaries who are able to receive services through IHS or Tribal 638 facilities, as determined by each respective entity. Each participating facility, in coordination with the Tribal communities it serves, defines the specific traditional healing services that will be offered and eligible for reimbursement, along with any applicable limitations or exclusions. This localized approach allows services to remain culturally appropriate to the distinct traditions and priorities of each community.

Oversight of Traditional Healing Practitioners is similarly structured at the facility and Tribal level. A designated qualifying entity, typically the governing body of the facility or a Tribal authority, identifies and recognizes individuals authorized to provide traditional healing services. Practitioners must be employed by or contracted with an IHS or Tribal 638 facility and are required to demonstrate appropriate experience and training as determined by each respective facility. Each participating facility is responsible for establishing its own standards for practitioner qualification, ensuring services are delivered by appropriately recognized individuals, and maintaining documentation to support compliance with program requirements.

AHCCCS is requesting continuation of this authority with additional modification discussed in a subsequent section.

Parents and Spouse as Paid Caregivers

Background

As discussed in the historical background section above, Arizona's PPCG service delivery model emerged from the state's response to unprecedented workforce shortages and service delivery challenges exacerbated during the COVID-19 PHE. To minimize disruption in care for AHCCCS members requiring home and community-based services (HCBS), AHCCCS obtained federal approval in April 2020 to allow parents to receive reimbursement for providing extraordinary care to their minor children when traditional caregiving resources were unavailable, insufficient or presented an exposure risk to members with chronic health conditions or already compromised immune systems. The model proved instrumental in maintaining access to care, reducing service disruptions, and allowing families more flexibility during a period of significant uncertainty. Following several extensions, CMS approved the incorporation of the PPCG service delivery model into Arizona's 1115 Demonstration on

February 16, 2024, establishing it as a permanent component of the state's long-term care service delivery system.

The PPCG model also aligns with other longstanding caregiver delivery models already authorized within Arizona's Medicaid program. Through ALTCS, spouses (other legally responsible individuals) and other non-legally responsible) family members, including parents of adult children, have historically been permitted to provide certain authorized services to eligible members in home and community-based settings. Prior to the PHE, however, parents of minor children were not eligible to receive payment for providing care to their own child due to their legal obligations. The PPCG model filled this gap by recognizing the unique role parents can play in meeting complex care needs while supporting member choice, continuity of care, and family stability.

AHCCCS is seeking authority to continue both the Parents as Paid Caregiver and Spouses as Paid Caregiver service models under their currently approved structures into the next demonstration period.

Post-Approval Implementation

Since CMS approval of the PPCG Demonstration, AHCCCS has undertaken extensive efforts to strengthen program administration, improve oversight, and ensure long-term sustainability of the service model. These activities have focused not only on the PPCG model itself, but also on related assessment and authorization processes used to evaluate care needs and determine when services constitute extraordinary care.

Recognizing the importance of stakeholder engagement throughout implementation, AHCCCS established a PPCG Implementation Work Group in May 2024. The work group included family representatives, advocates, provider organizations, health plans, and DES staff, and served as a collaborative forum for developing policy proposals, reviewing approaches implemented in other states, and identifying opportunities to improve case management practices and stakeholder communication. The group met regularly over the course of the implementation period and provided critical input on policy revisions, operational considerations, and program design. Formal work group activities concluded following publication of draft policy revisions for public comment in May 2025.

Because this program has experienced extraordinary growth, AHCCCS is implementing a series of cost containment and medical necessity reforms that will allow the program to be sustainable moving forward. These reforms include:

- During the 2025 Arizona Legislative Session, the Legislature enacted statutory changes designed to establish additional program safeguards and strengthen oversight of the PPCG model. Among other provisions, the legislation mirrored guardrails required in the 1115 Waiver STCs including directing AHCCCS and DES to implement a standardized assessment methodology for determining when attendant care and habilitation services provided to minor members constitute extraordinary care and a 40-hour weekly limit on paid attendant care and habilitation services furnished by a parent per child. The legislation required further program integrity and cost-control measures including restrictions on reimbursement for services provided while a child is in school or another clinical setting and outside specified service hours, a six-month Arizona residency requirement for participating parents, limitations on provider agency employment arrangements, and additional reporting and electronic verification requirements.

- AHCCCS has since implemented several additional program reforms. The 40-hour weekly limitation on paid caregiver services provided by parents became effective July 1, 2025, and remains an important component of the state's efforts to balance member access with program stewardship responsibilities. The agency also developed and implemented a PPCG attestation process that clearly defines parent responsibilities and expectations within the program and requires participating caregivers to formally acknowledge those requirements. In addition, AHCCCS incorporated parent-specific caregiver indicators into its Electronic Visit Verification (EVV) system, with the associated data module becoming operational on October 1, 2025, improving transparency, monitoring, and compliance oversight.
- Beyond reforms specific to PPCG, AHCCCS has also undertaken broader policy changes affecting the authorization and evaluation of extraordinary care services. The agency worked to better define extraordinary care needs, establish appropriate service parameters while preserving flexibility for medically necessary exceptions, and strengthen assessment methodologies used to evaluate the needs of minor members receiving home and community-based services. As directed by the Legislature, AHCCCS revised policies governing the Home and Community-Based Services Needs Tool (HNT) and developed an Extraordinary Care Review (ECR) process to identify and accommodate children whose care needs exceed standard service thresholds. These efforts were conducted in partnership with DES, clinicians, managed care organizations, and other stakeholders. This HNT and ECR process is further described in the State’s new Waiver request below.

Implementation of these reforms initially required AHCCCS to pursue formal rulemaking under Arizona's Administrative Procedures Act (APA). Emergency rules were issued in October 2025, and public comment on the proposed changes generated substantial stakeholder interest, resulting in more than 4,600 public comments that required extensive review and consideration by the agency. This level of engagement reflects both the significance of the PPCG program to Arizona families and the importance of ensuring that program policies appropriately balance access to care, family support, and program integrity. In June 2026, the Arizona Legislature passed Section 19 of Laws 2026, Chapter 132, which exempts the rules and the policies at issue from rulemaking for Fiscal Year 2026-2027 and provides for adoption through exempt rulemaking. AHCCCS will adopt the HCBS Needs Tool and the Extraordinary Care Review process under the exempt rulemaking authority and implement statewide in 2026.

In order to contain cost, ensure medical necessity, and bring long-term stability to this program moving forward, AHCCCS also seeks permission in this Waiver to implement Long Term Services and Supports (LTSS) Extraordinary Care Review Timeliness Waiver, which is outlined in a later section, below

Closing

The Parents and Spouses as Paid Caregiver programs have become important components of Arizona’s HCBS delivery system, helping eligible members have more flexibility in their choice of caregivers while supporting continuity of services in the least restrictive setting possible. Since receiving federal approval, AHCCCS has implemented substantial operational, policy, and oversight enhancements designed to strengthen program integrity and ensure long-term sustainability while preserving access to needed services. Given the continued value of these caregiver models, the positive impact on members and families, and the significant investments made to establish a comprehensive oversight framework, AHCCCS requests authority to continue both the Parents as Paid Caregiver and Spouses as Paid Caregiver models under their existing approved parameters throughout the next demonstration period, with the approval of the Long Term Services and Supports (LTSS)

Extraordinary Care Review Timeliness Waiver, which will help AHCCCS contain cost and ensure medical necessity moving forward.

Reentry Demonstration

Overview

On December 27, 2024, CMS approved Arizona's 1115 Reentry Demonstration, establishing a framework to improve care coordination and healthcare access for eligible individuals transitioning from incarceration back into their communities. Through this demonstration, Arizona is positioned to address longstanding gaps in care experienced by justice-involved individuals during the critical period immediately preceding and following release from a correctional facility.

To qualify for services under the Reentry Demonstration, an individual must be an inmate of a public institution and be incarcerated in a correctional facility, have been determined eligible for Medicaid or CHIP if not for their incarceration status, and have an expected release date within 90 days. Pre-release services will be provided to eligible individuals in participating jails, prisons, youth correctional facilities, and tribal correctional facilities. By focusing services during the period immediately preceding release, the demonstration is intended to establish connections to healthcare and supportive services before an individual's return to the community, helping to reduce disruptions in care and improve continuity of treatment and care coordination upon reentry.

The Demonstration's pre-release benefit package is further intended to support this transition back into the community by establishing linkages with community providers and proactively identifying both physical and behavioral health needs. Under the approved Demonstration, eligible services include:

- Case management to assess and address physical and behavioral health needs, including housing stability and access to food and transportation,
- Medication-assisted treatment (MAT) for all types of substance use disorders (SUDs), including counseling/behavioral therapies,
- 30-day supply of prescription medications upon release from the correctional facility,
- Practitioner office visit (e.g., physical/wellness exams, SUDs treatment, counseling, etc.), and
- Peer support services.

Arizona's request to continue the Reentry Demonstration builds upon years of state investment in strengthening coordination between the Medicaid program and the justice system. AHCCCS has developed collaborative partnerships with an expanding network of correctional facilities, courts, county governments, behavioral health providers, health plans, and other justice-system stakeholders. The state's efforts in this area predate the approval of the Reentry Demonstration. Arizona has long required its contracted managed care organizations to maintain Justice System Reach-In Care Coordination policies and procedures that facilitate pre-release planning and coordination activities for incarcerated members. Additionally, in 2017, AHCCCS launched the Justice Suspension Initiative, which established processes to suspend rather than terminate Medicaid eligibility for incarcerated members whenever possible, thereby supporting a more seamless return to coverage upon release. These efforts have provided a strong operational foundation for implementation of the Reentry

Demonstration and reflect Arizona's longstanding commitment to addressing the healthcare needs of justice-involved populations.

Implementation Progress

Since receiving CMS approval, AHCCCS has undertaken significant planning and operational activities to prepare for implementation of the Reentry Demonstration. While the demonstration has not yet been launched, implementation efforts have continued in anticipation of the program's operational start. Delayed implementation was primarily due to the need for legislative approval and appropriation to support program operations and service delivery.

To date, implementation activities have focused heavily on stakeholder engagement, education, and program development. These efforts have been closely coordinated with Arizona's ongoing implementation of the Consolidated Appropriations Act (CAA) juvenile justice requirements, which share many of the same objectives and operational considerations as the Reentry Demonstration. While the CAA requirements apply to a more limited population consisting primarily of justice-involved youth and certain former foster youth, provide a narrower service package focused on targeted case management and screening and diagnostic services consistent with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements, and authorize services during a shorter 30-day pre-release period, they have provided valuable implementation experience that has informed the state's broader reentry planning efforts.

In addition to this early implementation planning, AHCCCS has also developed and submitted required CMS implementation deliverables. This has included completion of both the Reentry Demonstration Implementation Plan and Reinvestment Plan, which outlines the state's operational strategy, oversight framework, and reinvestment commitments associated with the Demonstration. These deliverables were most recently updated and resubmitted to CMS on May 29, 2026, and are currently under federal review. Key components of AHCCCS's Reentry Implementation Plan have been highlighted below.

Figure 28: Reentry Implementation Plan Key Features

Program Feature	Description
Facility Readiness and Onboarding	AHCCCS has proposed a phased implementation approach that will initially focus on facilities operated by the Arizona Department of Juvenile Corrections (ADJC), leveraging the agency's experience implementing the CAA juvenile justice requirements. Expansion to additional correctional facilities will occur based on demonstrated readiness and operational capacity. Prior to participation, each facility will undergo a comprehensive readiness assessment designed to evaluate operational alignment, fiscal planning, information-sharing capabilities, staffing resources, and clinical preparedness. These assessments will serve as a critical component of the onboarding process and help ensure successful implementation across participating facilities.
Eligibility and Enrollment	AHCCCS will leverage existing data-sharing agreements to facilitate the exchange of booking and release information between correctional facilities and the Medicaid agency. For facilities that do not currently have data-sharing arrangements in place, AHCCCS will establish the necessary agreements and develop additional data exchange

	capabilities to support timely identification of eligible individuals and seamless activation of pre-release services. In addition, AHCCCS plans to enroll correctional facilities as Community Partner-Assistor Organizations (CP-AOs), enabling facility staff to assist eligible individuals with Medicaid and CHIP applications prior to release. This approach will help ensure that individuals who are not already enrolled in coverage can establish eligibility and access Demonstration services before returning to the community.
Service Delivery	Under the Reentry Demonstration, eligible individuals will have access to certain Medicaid and CHIP services for up to 90 days prior to release from incarceration. AHCCCS intends to primarily operationalize service delivery through partnerships with community-based providers, which will allow individuals to establish relationships with providers before release and create stronger connections to post-release healthcare resources. This approach is intended to support continuity of care and reduce disruptions in treatment as individuals transition back into the community. Service delivery and care coordination activities will be jointly supported by managed care organization (MCO) Justice Liaisons and correctional facility staff to ensure individuals receive timely access to approved demonstration services and appropriate transition planning.

AHCCCS is pleased to report that during the 2026 Arizona legislative session, Governor Hobbs signed into law a budget which contained the funding necessary to support implementation of the Reentry Demonstration. As a result, Arizona is now positioned to operationalize the program and begin delivering services to eligible individuals. AHCCCS currently anticipates launching the initial phase of implementation on October 1, 2026, beginning with a select group of correctional facilities and expanding over time as operational readiness milestones are achieved.

Closing

Arizona has made substantial progress toward implementation of the Reentry Demonstration and has established the partnerships, operational framework, and programmatic infrastructure necessary to support successful statewide expansion. With legislative funding now secured and implementation activities actively underway, AHCCCS is positioned to launch services and evaluate the demonstration's impact on continuity of care, healthcare access, and successful community reintegration for justice-involved individuals. Given that the program remains in the early stages of implementation and has not yet had sufficient opportunity to demonstrate outcomes, AHCCCS is seeking continuation of the Reentry Demonstration under its currently approved structure and authorities for the next demonstration period. Maintaining the demonstration as approved will allow Arizona to continue implementation of the program, assess its effectiveness, and continue advancing the shared state and federal goal of improving health outcomes for individuals transitioning from correctional settings into their communities.

V. Proposed Changes to the Current Demonstration

Arizona's longstanding Section 1115 Demonstration has served as a critical platform for advancing innovative, person-centered approaches to delivering Medicaid services in the state. Through this renewal, AHCCCS seeks to preserve the demonstration's foundational authorities while proposing targeted enhancements informed by stakeholder engagement, legislative action, operational experience, and emerging health priorities. These proposals are designed to improve access to culturally responsive care, strengthen long-term services and supports, modernize behavioral health service delivery, refine existing demonstration programs, and ensure continued stewardship of Medicaid resources.

Specifically, AHCCCS proposes to maintain and expand the Traditional Health Care Practices (THCP) Demonstration by removing administrative barriers to participation for Urban Indian Organizations, sunset the Targeted Investments (T.I. 2.0) Program following the discontinuation of its federal financing mechanism, and make targeted technical refinements to the Housing and Health Opportunities (H2O) demonstration to improve clarity and operational flexibility. AHCCCS also seeks authority to implement an extended review timeline for Extraordinary Care Reviews to support more comprehensive person-centered assessments for children receiving home and community-based service. Finally, AHCCCS reminds CMS that it remains open to continuing negotiations regarding two previously submitted proposals that remain under review and negotiation which include the states Five-Year Lifetime Limit request and the Institutions for Mental Disease (IMD) request.

Together, these proposals are intended to improve access to care, reduce unnecessary administrative burden, strengthen program integrity, and ensure that Arizona's Medicaid demonstration continues to respond to the evolving needs of members, providers, Tribal communities, and other stakeholders while remaining consistent with the objectives of the Medicaid program. The sections below describe each proposed modification and the anticipated benefits for members, providers, and the broader healthcare delivery system.

Traditional Healing

Since the approval and implementation of the Traditional Healing Demonstration, UIOs have raised concerns regarding the current CCA requirement for traditional healing services to be delivered. A central challenge identified by UIOs is surrounding the fact that CCAs must be initiated by an IHS or tribal 638 facility, which can create barriers for UIO participation. UIOs have noted that many individuals they serve do not have established relationships with IHS or Tribal facilities. As a result, requiring the creation of a CCA for individuals who are already engaged in care through a UIO introduces additional administrative steps that can delay or complicate access to services. For many organizations, this process has limited their ability to fully participate in the demonstration despite having existing traditional healing services and established trust within their communities.

This concern has been reinforced through ongoing stakeholder engagement and was further elevated during the Arizona legislative process. The enacted 2026 Arizona Legislative Budget (Laws 2026, Chapter 132) includes authority for AHCCCS to pursue an amendment to the current program design that would remove the CCA requirement for UIO participation and allows for the use of state appropriation to support the non-federal share of expenditures for services delivered through this expanded model. This legislative direction reflects a broader recognition of the role UIOs play in serving AI/AN populations, particularly in urban and non-reservation settings.

UIOs represent a critical component of Arizona's healthcare delivery system and are often key access points for AI/AN individuals who may not otherwise receive services through IHS or tribally operated facilities. Many UIOs already maintain well-established traditional healing programs that are grounded in community practice and cultural knowledge. Expanding their ability to participate directly in the THCP Demonstration would build on this existing infrastructure and strengthen access to culturally appropriate care.

Through this renewal, AHCCCS proposes to remove the CCA requirement for UIOs seeking to participate in the Traditional Healing program. This change would allow UIOs to furnish covered traditional healing services directly, consistent with the overarching goals and framework of the existing demonstration. All other core program elements, including the role of community-defined services, locally determined practitioner qualifications, and tribal-informed oversight, would remain intact.

Eliminating the CCA requirement is expected to reduce administrative burden, improve provider participation, and expand access to traditional healing services for AI/AN members. Importantly, this approach would extend the reach of the demonstration to individuals who may not meet eligibility criteria for IHS services or who reside outside of tribal service areas, while maintaining alignment with the program's emphasis on cultural integrity, community leadership, and self-determination.

Sunset the Targeted Investments 2.0 Program

Arizona currently plans to allow the Targeted Investments (T.I. 2.0) Program to sunset at the conclusion of the existing demonstration period. The primary reason AHCCCS is not seeking to continue the T.I. Program is due to the discontinuation of the DSHP funding mechanism, which was announced through the mentioned April 10, 2025, CMS State Medicaid Director Letter. Because DSHP funding has served as the primary funding mechanism for the T.I. 2.0 program, the State has concluded that it is necessary to initiate an orderly sunsetting of the program. The State remains committed to working collaboratively with CMS throughout this process to ensure transparency, minimize disruption, and support a smooth transition for all affected stakeholders. The state intends to leverage the experience and insights gained from the program to explore additional opportunities to continue advancing whole person care.

H2O Technical Corrections to Service, Provider, and Eligibility Descriptions

Alignment of the H2O Program with Current Federal Priorities

Arizona offers the Housing and Health Opportunities (H2O) program for renewal because it advances three objectives the Administration has identified as central to the Medicaid program and federal homelessness policy. H2O reduces avoidable federal and state Medicaid spending. It moves individuals with serious mental illness off the street and into treatment, recovery, and stable housing. Additionally, it removes a practical obstacle to sustained employment for members who will soon be subject to the community engagement requirement. Arizona does not present H2O as a housing benefit or as a social services program. It is a time-limited clinical intervention that uses housing stability as the mechanism for reducing the most expensive categories of Medicaid utilization.

Fiscal Stewardship and the New Budget Neutrality Standard

H2O already carries utilization data showing the precise result CMS describes in its June 11, 2026, CMS issued State Medicaid Director Letter #26-003 regarding budget neutrality.

Comparing the period following H2O eligibility determination to the twelve months preceding it, emergency department utilization among eligible members declined 11.7 percent and inpatient utilization declined 19 percent, with a corresponding reduction in per member per month expenditures. Those reductions are concentrated in the two most expensive categories of Medicaid service. For a population that cycles repeatedly through emergency departments, inpatient psychiatric admissions, and crisis stabilization, the cost of a short period of housing assistance and care coordination is substantially lower than the cost of the utilization it displaces.

The program is also structured to contain its own exposure. H2O funds time-limited assistance rather than an ongoing subsidy, and the model is built to transition members to permanent housing resources administered by HUD Continuum of Care programs, Public Housing Authorities, and Mainstream and Project-Based Voucher programs. Medicaid pays for the clinical and tenancy support services that stabilize the member, not for permanent rent. That design keeps Medicaid from supplanting other federal and non-federal housing funding, which is a consideration CMS applies directly in evaluating whether demonstration expenditures are appropriate.

Ending Street Homelessness and Restoring Accountability

Executive Order 14321, Ending Crime and Disorder on America's Streets, issued July 24, 2025, directs federal agencies to end support for housing first policies that, in the Order's terms, deprioritize accountability and fail to promote treatment, recovery, and self-sufficiency. The Order redirects federal resources toward moving individuals who are living on the street and suffering from serious mental illness or addiction into treatment settings, and it directs the Department of Health and Human Services to make fuller use of the clinical infrastructure available to serve that population.

H2O is designed consistently with that direction. Eligibility is not open-ended. It reaches members who have a serious mental illness designation and who are experiencing homelessness, and who are either diagnosed with a chronic health condition or have recent justice system involvement. Every participant is enrolled with a managed care organization that carries responsibility for care coordination, and housing assistance is delivered together with behavioral health treatment, tenancy support, and case management rather than as an unconditional benefit. The program is accountable for clinical results and is measured on them.

The population H2O serves is the population Executive Order 14321 identifies as the priority for federal action, and the program's function is to move that population from the street into treatment and toward self-sufficiency.

Supporting Work and Self-Sufficiency

On June 1, 2026, CMS issued an interim final rule with comment period, CMS-2454-IFC, implementing the community engagement requirement at section 1902(xx) of the Social Security Act as enacted by section 71119 of the Working Families Tax Cut legislation. Although the legislation exempts SMI members, the goal of the legislation is that Medicaid members who can work should be working.

Homelessness is a direct obstacle to meeting, finding and maintaining work. A member sleeping outside is substantially less likely to hold steady employment in the first place. H2O addresses that problem directly. Stabilizing a member in housing establishes the address and the daily structure that make employment possible. For members who are able to work, housing stability is frequently the difference between employment and continued crisis utilization.

Technical Changes to Certain Service Descriptions and Provider Requirements

While the overall framework of the H2O program will remain unchanged, AHCCCS is seeking limited authority to make targeted refinements to the H2O Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications Deliverable (Attachment E to the current Demonstration STCs). These adjustments are narrow in scope and are intended to improve clarity, ensure consistency across service definitions and provider requirements, and better align the protocol with more recent federal guidance.

First, AHCCCS proposes to make technical updates to certain service descriptions and provider requirements outlined in Exhibit A of the H2O Protocol. This exhibit currently defines each H2O service in detail, including its amount, duration, and scope, as well as applicable provider qualifications, service delivery settings, and minimum eligibility criteria. AHCCCS is proposing the following three modifications:

1. Community Assistor Provider Requirement: AHCCCS intends to standardize provider requirements across related interventions. Specifically, the state proposes to clarify that providers delivering pre-tenancy and tenancy services must enroll as AHCCCS Community Assistors, consistent with requirements already applicable to Outreach and Education and Transitional Housing providers. This addition reflects the state's original intent and ensures uniform expectations across service categories.
2. Removal of SOAR: AHCCCS proposes to remove references to the SSI/SSDI Outreach, Access, and Recovery (SOAR) model within the Transitional Housing and Tenancy sections. The removal is intended to prevent unnecessary specificity within service descriptions while preserving provider flexibility in selecting appropriate practices and tools to support members.
3. Alignment with Federal Guidance: Finally, AHCCCS proposes updates to the training-related language across all H2O interventions. Specifically, references to the "Housing First Model" and "Harm Reduction" approaches within the detailed setting and provider requirements will be removed. This revision is designed to more closely align the protocol with updated federal guidance and to avoid prescriptive language that could limit provider discretion or create ambiguity in implementation expectations.

Flexibility in Defining Chronic Physical Health Conditions for H2O Eligibility

AHCCCS seeks CMS approval to allow additional flexibility in refining the chronic physical health conditions associated with H2O eligibility criteria, as originally contemplated within the approved H2O Protocol. This request does not represent an expansion of the overall demonstration population, nor does it increase the total number of individuals served. Instead, it reflects a data-driven approach to program refinement that was contemplated in the original protocol design.

Early program experience and data analysis have highlighted certain chronic physical health conditions that appear to disproportionately impact members who are both seriously mentally ill (SMI) and experiencing homelessness, including populations associated with high healthcare utilization and expenditures. By allowing

for adjustments to the qualifying condition criteria based on ongoing evaluation of utilization patterns, outcomes, and actuarial data, AHCCCS would be better positioned to direct H2O services to those members with the greatest combined health and housing needs.

This flexibility would enable the demonstration to remain responsive to evolving trends and emerging evidence without altering its foundational parameters. Enrollment caps, budget neutrality assumptions, and overall program scope would remain unchanged. Rather, the proposed approach would enhance the precision of targeting within the existing framework, supporting improved outcomes for high-need populations while strengthening the overall effectiveness of the demonstration.

Conclusion

Arizona requests continuation of the H2O expenditure authority, with technical changes, on the ground that it satisfies the standards this Administration has set. It produces measurable reductions in high-cost Medicaid utilization and supports the budget neutrality showing that section 1115(g) now requires. It advances the objectives of Executive Order 14321 by moving individuals with serious mental illness from the street into treatment and accountability rather than into an unconditional subsidy. And it supports the Administration's goal of ensuring AHCCCS members who can work are able to do so, by removing a practical barrier that would otherwise cause avoidable coverage churn and administrative expense.

Long Term Services and Supports (LTSS) Extraordinary Care Review Timeliness Waiver

Background

Following CMS approval of the PPCG 1115 Demonstration discussed above, AHCCCS began updates to the HCBS Needs Tool (HNT), which is used to assess the needs of children receiving direct care and habilitation services. To support this effort along with the PPCG programs' overall implementation, AHCCCS convened a PPCG implementation workgroup composed of family members, advocates, providers, DES representatives, and health plans. This group met regularly to develop policy and form revisions, review models from other states, and provide recommendations on case manager competencies and stakeholder engagement strategies. Momentum for updating the assessment tool increased in April 2025, when Arizona enacted legislation requiring AHCCCS to adopt a strengthened standardized assessment tool to determine the need for extraordinary care services for children receiving HCBS through ALTCS. The updated HNT was finalized, and AHCCCS health plans, including DDD, began implementing the revised tool on October 1, 2025. However, implementation was subsequently paused in response to significant feedback from families and providers with concerns surrounding how the extraordinary care criteria were applied within the HNT and whether the updated tool adequately addressed certain complex care needs.

Following this initial implementation, AHCCCS underwent emergency rulemaking to revise the HNT to allow for additional review by clinicians and stakeholders to provide an opportunity for consideration of the unique care needs of the child. This rulemaking introduced an Extraordinary Care Review (ECR) exception process and new assessment categories, like specialty meal preparation, specialty eating, specialty toileting, and specialty supervision.

As part of this rulemaking, AHCCCS conducted extensive stakeholder outreach. AHCCCS held four public forums; two were focused on education and insight into rulemaking and policy efforts, and two were focused on in-depth insight into revised policies and how to engage in the policy public comment process. The public comment process for the revised policies closed on November 24, 2025, with over 4,600 public comments received. One of the major themes/areas of comment was the Extraordinary Care Review process with many stakeholders centering on the need for standardized forms, uniform guidance, policy clarification, and defining extraordinary care when compared to parental responsibility. It was also noted that families needed appropriate time to engage ECR clinician decision makers to ensure that sufficient background information could be considered as part of the decision-making process.

Extraordinary Care Review

AHCCCS is implementing a process to support HCBS service review and authorization of additional direct care and/or habilitation services for children when extraordinary care needs are determined to be present. Arizona's goal is to ensure that all Medicaid-covered services are medically necessary, and in instances of children, that the direct care and habilitation services are extraordinary in nature and not supports that a parent or guardian is routinely obligated to provide for their child regardless of whether or not the child experiences a disability or chronic illness. Arizona has structured this process by developing age-appropriate guidelines and considerations in the needs assessment process, while allowing for a higher-level clinician to review member-specific needs and conditions. The clinical review may result in additional service hours if determined appropriate due to extraordinary care needs of the child.

AHCCCS is now working through the implementation of this review with the goal of creating a streamlined and easily understandable process that supports HCBS needs assessment of children, while also promoting accountability and reinforcing appropriate service utilization. Although the initial needs assessment does contemplate extraordinary care with age-based limitations, the ECR process will provide an additional clinical review should the parent or guardian have concerns the child will experience adverse impacts as a result of the new HNT. AHCCCS intends for this process to support the standard PCSP process between children, health care decisions makers (HCDMs), the member's case manager, and care team participants (to the extent the member/HCDM wants them included). Once initial feedback has been received regarding member-specific care needs, what their day looks like, what their goals are, the assessed hours of HCBS, etc., an extraordinary care review process may be initiated if the HCDM does not feel that the assessment process fully accounts for the member's unique needs and condition(s). From there, an MCO-based clinician will review the assessment and any relevant supporting documentation, engage with the HCDM, conduct a disability index analysis if the HCDM chooses to complete on behalf of the member, and determine if additional hours of HCBS should be authorized for either attendant care and/or habilitation services. The clinician feedback will be incorporated into the HNT as well as the PCSP and members/their HCDM will be offered a Notice of Adverse Benefit Determination/appeal rights if any concerns are noted with the service plan established.

Timeliness Waiver Request

While AHCCCS initially intended to create the ECR process outside of existing prior authorization time limitations, guidance from AHCCCS's EQRO, and subsequent correspondence with CMS has confirmed that the ECR process may not violate the prior authorization timelines without waiver authority. While prior authorization timelines are generally critical to ensuring that members receive timely care, the ECR process is

distinct and was born from member and advocacy requests that the extraordinary review consideration for direct care and habilitation hours include enough time for a thorough review of appropriate clinical records and not be a rushed process. Unlike requests for medical and acute services, direct care and habilitation services are long-term needs, and the members and advocates have emphasized the importance of accuracy of review, over expediency.

Existing managed care regulations do not afford states with sufficient time to conduct this additional clinician-based review. 42 CFR 438.210(d) requires standard authorization decisions to be made within 14 calendar days after receiving the request for service. This timeline will be further reduced to seven days for rating periods starting after January 1, 2026 (or October 1, 2026, for the MCOs in Arizona) because of CMS rulemaking. Although this timeline reduction was likely intended by CMS to add additional protections for the member, AHCCCS anticipates that HCDMs will be supportive of an extended timeline for the ECR as this additional review is optional and is considered to be of benefit to the member. The authority will ultimately support a more comprehensive evaluation of complex member care needs with the goal of promoting access to medically necessary services that are extraordinary in nature.

During this additional authorization period, AHCCCS will safeguard members access to care by immediately authorizing approved hours from the initial assessment for new members who haven't previously received HCBS without delay or waiting for the ECR process to be finalized and by maintaining current service hours for established members without a reduction of services while the additional assessment or ECR process is under way. Both pathways are designed to support members in maintaining access to necessary services while ensuring a clear and timely process for evaluating extraordinary care needs. This approach allows members the opportunity to receive additional HCBS service hours, as appropriate, to prevent unnecessary institutionalization or out-of-home placement. By implementing these safeguards, AHCCCS seeks to avoid any disruption in services that could negatively impact member health and safety and therefore will not reduce authorized service hours pending the completion of a clinically based assessment.

To best support members in receiving a complete and accurate clinical evaluation, AHCCCS is requesting a waiver from the federal requirements under 42 CFR 438.210(d). This waiver will allow AHCCCS to extend ECR timelines beyond standard authorization requirements, providing additional time for clinicians to conduct thorough evaluations and for HCDMs to collect and review necessary documentation to support informed determinations. AHCCCS would not use this authority to allow an unchecked timeframe for MCOs to conduct their review work, rather the authority would ensure that adequate time is dedicated to understanding member-specific considerations, needs, and care preferences in alignment with person-centered practices. AHCCCS is requesting authority to waive the seven-day (14 days with extension that is of benefit to the member) requirements and allow for a process that may take up to 28 days. Additionally, if an extenuating circumstance is identified where additional time may be needed to the benefit of the family (e.g. the member is hospitalized, the HCDM is ill), AHCCCS is requesting authority to allow for additional time in consideration of individual circumstances in limited situations.

For new members or for existing members who seek additional direct care or habilitation services, and who require urgent review due to medical necessity, AHCCCS intends to continue to require expedited determinations, including ECR determinations, within 72-hours.

Closing

The ECR process may be daunting to families who are supporting their child or children with complex needs and conditions. To the extent possible, AHCCCS intends to provide a supportive environment that allows for thoughtful engagement and member-specific consideration of extraordinary care needs. The ECR process was designed using member, family, and advocate feedback. It is currently limited due to CMS prior authorization guidance. By having the authority to allow for additional time, when appropriate for the specific situation, this will create less burden on families, less strain on the legal system (e.g. administrative law judges, MCO attorneys, AHCCCS legal team), and will ultimately serve in the best interest of the member. The ECR process proposed is less costly than legal fees and use of related resources. The authority would also support evaluation of complex member care needs as well as promote access to medically necessary services that are extraordinary in nature, especially when evaluating needs of young children. The ECR process is being established to support appropriate utilization and standardized assessment processes while also allowing for member-specific considerations of individual needs.

Enhanced Residential Treatment

Arizona intends to submit before July 2027 an Amendment to this Waiver Proposal, which will seek authority to establish the AHCCCS SMI Enhanced Residential Treatment Pilot Program pursuant to SB 1630 (A.R.S. 26-2979). The legislation authorizes the state, contingent upon federal approval, to deliver enhanced residential treatment services to a finite number of adults determined to have SMI who meet defined clinical and financial criteria. Because the statutory authority requires significant stakeholder engagement with members, families, providers, contractors, and other critical stakeholders before implementing the legislation, AHCCCS intends to conduct that stakeholder engagement in the second half of 2026, before seeking federal authority to implement the program.

Modifications to Hospital Presumptive Eligibility and Accepting Self-Attestation

Background

Arizona has a history of preserving the integrity of its Medicaid program while ensuring that limited public resources remain available to individuals and families with the greatest need. In recent years, both federal and state policymakers have taken additional steps to strengthen eligibility systems, improve program oversight, and safeguard taxpayer-funded healthcare benefits from fraud, waste, and abuse.

Consistent with these priorities, the Arizona Legislature enacted several Medicaid eligibility and program integrity reforms during the 2026 Arizona legislative session through the budget reconciliation bill aimed at strengthening administrative controls within AHCCCS. Among those reforms, Laws 2026, Chapter 132 directs AHCCCS to seek CMS approval for two 1115 Demonstration programs to implement policy changes designed to enhance eligibility verification processes and improve program administration.

Specifically, HB 4160 requires AHCCCS to seek federal authority to:

1. Prohibit the use of self-attestation of Arizona residency without independent verification prior to Medicaid enrollment, and
2. Eliminates the Hospital Presumptive Eligibility (HPE) program.

These proposals reflect Arizona's ongoing commitment to ensuring that Medicaid eligibility determinations are supported by reliable verification processes while maintaining efficient pathways to coverage for qualified individuals. Both statutory requirements are subject to an automatic repeal provision enacted by the Legislature. Absent further legislative action, the state-law requirement directing AHCCCS to pursue these waiver requests will be repealed after June 30, 2027.

Prohibition of Residency Self-Attestation

Federal regulations at 42 CFR 435.952(c)(3) require state Medicaid programs to establish an exception process which allow individuals to self-attest to eligibility criteria on a case-by-case basis when documentation is unavailable or cannot reasonably be obtained at the time of application or renewal. AHCCCS recognizes the importance of maintaining access to healthcare coverage while also ensuring the accuracy of eligibility determinations. As part of ongoing efforts to strengthen program integrity and align with recent federal initiatives focused on reducing fraud, waste, abuse, and improper enrollment, the Arizona Legislature enacted a requirement directing AHCCCS to discontinue reliance on self-attested residency information absent independent verification prior to enrollment.

Arizona believes that residency is a foundational eligibility requirement that should be verified through objective and reliable sources whenever possible. Requiring independent verification before enrollment will reduce the risk of improper eligibility determinations, strengthen public confidence in the administration of Medicaid benefits, and help mitigate the potential for duplicative enrollment across multiple state Medicaid programs.

As a result of this directive, AHCCCS is seeking waiver authority from 42 CFR 435.952(c)(3), solely with respect to residency verification requirements. Under this proposal, applicants would continue to be subject to all other existing eligibility standards and protections, but Arizona would no longer accept self-attestation of residency in the absence of independent verification. Instead, AHCCCS would align residency verification procedures with existing processes for verifying citizenship and immigration status that require documentary or electronic confirmation before coverage is approved.

This approach will promote greater consistency across eligibility determinations, improve administrative oversight, and ensure that Medicaid benefits are provided only to individuals who can demonstrate residency through verified information prior to enrollment.

Elimination of Hospital Presumptive Eligibility

Under existing federal law and implementing regulations at 42 CFR 435.1110, state Medicaid programs are generally required to provide temporary Medicaid coverage during a presumptive eligibility period for individuals determined by a qualified hospital to be presumptively eligible based on preliminary information. AHCCCS has developed policies, procedures, and operational standards consistent with these requirements governing the Hospital Presumptive Eligibility program and has made those pathways available to Arizona hospitals seeking qualified entity status.

Consistent with broader state and federal efforts to strengthen program integrity and improve eligibility verification processes, the Arizona Legislature directed AHCCCS to seek authority to eliminate the HPE program. The Legislature determined that eliminating this pathway would help ensure that eligibility determinations are

based on complete and verified information while reducing administrative complexity associated with maintaining a program that has seen little to no utilization in Arizona.

This proposal comes at a time where utilization of the Hospital Presumptive Eligibility program in Arizona has been extremely limited. During the previous demonstration period, no hospital enrolled as a qualified entity authorized to make Hospital Presumptive Eligibility determinations. As a result, AHCCCS has not received or approved a Hospital Presumptive Eligibility determination for any applicant for several years. Additionally, this request is also consistent with Arizona's existing demonstration authority related to retroactive coverage limitations and aligns with recent federal legislative changes that have reduced the scope and duration of retroactive Medicaid coverage available to eligible individuals.

Collectively, these policies reflect a broader shift toward ensuring that eligibility determinations and benefit coverage are grounded in timely application and verification processes.

Given the legislative directive, absence of participating hospitals and utilization, and the state's continued focus on verified eligibility determinations, AHCCCS is seeking waiver authority from 42 CFR 435.1110 and any corresponding federal statutory requirements necessary to eliminate the Hospital Presumptive Eligibility program in Arizona.

Closing

Through this renewal request, AHCCCS seeks federal authority to strengthen Medicaid program integrity by requiring independent verification of residency prior to enrollment and eliminating the Hospital Presumptive Eligibility program. Together, these proposals support Arizona's commitment to ensuring accurate eligibility determinations, reducing opportunities for improper enrollment, aligning with evolving federal program integrity goals, and promoting the responsible stewardship of Medicaid resources while preserving access to coverage for eligible Arizonans.

Requests that Remain Pending - Five-Year Lifetime Limit and Institutions for Mental Disease (IMD)

Finally, AHCCCS notes that the agency remains open to continuing discussions with CMS regarding its two pending waiver requests, including the Five-Year Lifetime Limits request submitted in 2025 pursuant to A.R.S. 36-2903.09, and Institutions for Mental Disease (IMD), which the agency first requested in 2017. AHCCCS looks forward to continuing discussions related to both amendment requests for the upcoming 1115 Waiver demonstration period.

VI. Goals and Objectives of the Proposed Demonstration Renewal

Current Demonstration Goals, Objectives & Evaluation

Through the employment of a managed care model, Arizona’s Demonstration strives to provide 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

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: AHCCCS Complete Care (ACC), Arizona Long-Term Care System (ALTCS), Department of Child Safety Comprehensive Health Plan (DCS CHP), AHCCCS Complete Care Regional Behavioral Health Agreements (ACC-RBHA), and Waiver of Prior Quarter Coverage (PQC).

Figure 29 - Goals and Objectives of the Proposed Demonstration Renewal by Program

Objectives	Proposed Hypothesis	Potential Approaches
AHCCCS Complete Care (ACC)		
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.	Health plans will encourage and/or facilitate care coordination among PCPs and behavioral health practitioners.	Data will be drawn from a variety of sources including: • 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 and enhanced as a result of the integration of behavioral and physical care.	
	Quality of care will be maintained or enhanced as a result of the integration of behavioral and physical care.	
	Member self-assessed health outcomes will be maintained or improved as a result of the integration of behavioral and physical care.	
	Member satisfaction with the health care received will be maintained or will increase as a result of the integration of behavioral and physical care.	
	The ACC program will provide cost-effective care.	
Arizona Long Term Care System (ALTCS)		
The ALTCS Demonstration will provide quality healthcare to members with needs for LTSS,	ALTCS health plans will encourage and/or facilitate care coordination among PCPs and behavioral health practitioners.	Data will be drawn from a variety of sources including:

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.	Access to care will be maintained or expanded over the waiver Demonstration.	• Member survey • State eligibility and enrollment data • Claims/encounter data • Administrative program data (PMMIS) • T-MSIS • National/regional benchmarks • Key informant interviews & focus groups
	Quality of care will be maintained or enhanced over the waiver Demonstration.	
	Health outcomes for members enrolled in ALTCS will be maintained or improved during the Demonstration.	
	Quality of life for members will be maintained or enhanced over the waiver Demonstration.	
	ALTCS will provide cost-effective care.	
Comprehensive Health Plan (DCS CHP)		
The DCS CHP 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.	DCS CHP will encourage and/or facilitate care coordination among PCPs and behavioral health practitioners.	Data will be drawn from a variety of sources including: • 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.	
	DCS CHP 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	RBHAs will encourage and/or facilitate care coordination among PCPs and behavioral health practitioners.	Data will be drawn from a variety of sources including: • Member survey • State eligibility and enrollment data • Claims/encounter data • Administrative program data (PMMIS) • T-MSIS
	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.	

managed care delivery model.	Health outcomes for members with an SMI enrolled in a RBHA will be maintained or improved during the Demonstration.	• National/regional benchmarks • Key informant interviews & focus groups
	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.	
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: • Member survey • State eligibility and enrollment data • Claims/encounter data • Administrative program data (PMMIS) • T-MSIS • National/regional benchmarks
	The implementation of the proposal will not reduce member satisfaction.	
	The implementation of the proposal will not adversely affect health outcomes	
Former Foster Youth Annual Automatic Renewal (YATI)		
The AHCCCS Former Foster Youth Eligibility and Enrollment demonstration will promote continuity of care, simplify administrative burden and reduce unnecessary churn of individuals' eligibility to access Medicaid Services.	The AHCCCS Former Foster Youth - Eligibility and Enrollment demonstration will maintain or improve health outcomes for AHCCCS members.	Data will be drawn from a variety of sources including: • 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 Former Foster Youth - Eligibility and Enrollment demonstration will maintain or improve the management of chronic conditions for AHCCCS members.	
	The AHCCCS Former Foster Youth - Eligibility and Enrollment demonstration will maintain or improve the management of chronic conditions for AHCCCS members.	
	The AHCCCS Former Foster Youth - Eligibility and Enrollment demonstration will maintain or increase utilization of primary care and preventative health services.	
	The AHCCCS Former Foster Youth - Eligibility	

	and Enrollment demonstration will maintain or improve member satisfaction with care.	
	The AHCCCS Former Foster Youth - Eligibility and Enrollment demonstration will promote continuity of care for its members.	
	The AHCCCS Former Foster Youth - Eligibility and Enrollment demonstration will yield cost-effective care for AHCCCS members.	
KidsCare Expansion		
The AHCCCS Kidscare Expansion demonstration will reduce the number of uninsured children and maintain or increase the number of annual dental visits, child and adolescent well-care visits, and metabolic monitoring for children and adolescents on antipsychotics.	The AHCCCS Kidscare Expansion Amendment will maintain or improve health outcomes for AHCCCS members.	Data will be drawn from a variety of sources including: • 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 Kidscare Expansion Amendment will maintain or improve the management of chronic conditions for AHCCCS members.	
	The AHCCCS Kidscare Expansion Amendment will maintain or improve access to care for AHCCCS members.	
	The AHCCCS Kidscare Expansion Amendment will maintain or increase the utilization of primary care and preventative health services.	
	The AHCCCS Kidscare Expansion Amendment will maintain or improve member satisfaction with care.	
	The AHCCCS Kidscare Expansion Amendment will promote continuity of care for its members.	
	The AHCCCS Kidscare Expansion Amendment will yield cost-effective care for AHCCCS members.	
Parents and Spouses as Paid Caregivers (PPCG and SPCG)		
The AHCCCS Parents and Spouses as Paid Caregivers delivery model Demonstration will increase member satisfaction, ensure delivery of medically	The AHCCCS PPCG and SPCG Demonstrations will maintain or increase the rate of children in the ALTCS program being served in the home.	Data will be drawn from a variety of sources including: • Member survey • State eligibility and enrollment data • Claims/encounter
	The AHCCCS PPCG and SPCG Demonstrations will yield improved member satisfaction with	

appropriate services in the community, and promote positive health and well-being outcomes for the target population.	care.	data • Administrative program data (PMMIS) • T-MSIS • National/regional benchmarks
	The AHCCCS PPCG and SPCG Demonstrations will mitigate the DCW shortage by increasing timely accessibility to care providers.	
	The AHCCCS PPCG and SPCG Demonstrations will improve ongoing care stability for the target population.	
	The AHCCCS PPCG and SPCG Demonstrations yield cost-effective care for AHCCCS members.	
Supplemental Payments to IHS and Tribal 638 Facilities (Tribal Uncompensated Care)		
Ensure the viability of the IHS and 638 systems for the provision of care and maintain or improve access to care to American Indians.	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: • Member survey • State eligibility and enrollment data • Claims/encounter data • Administrative program data (PMMIS) • T-MSIS • National/regional benchmarks • Key informant interviews & focus groups
	Uncompensated care payments to IHS and 638 facilities will increase capacity to provide care and services resulting in AHCCCS IHS members receiving health care services.	
Housing and Health Opportunities (H2O)		
The AHCCCS Housing and Health Opportunities (H2O) demonstration will increase housing attainment and stabilization, positive health and wellbeing outcomes for target populations, reduce the cost of care for individuals successfully housed, and support state efforts to reduce homelessness and improve ongoing housing stability.	The AHCCCS H2O demonstration will improve health outcomes for AHCCCS members.	Data will be drawn from a variety of sources including, but not limited to: • Member surveys • State eligibility and enrollment data • Claims/encounter data • Administrative program data (PMMIS) • T-MSIS • National/regional benchmarks • Key informant interviews & focus
	The AHCCCS H2O demonstration will improve management of behavioral health conditions for AHCCCS members.	
	The AHCCCS H2O demonstration will improve management of chronic conditions for AHCCCS members.	
	The AHCCCS H2O demonstration will decrease avoidable hospital utilization including emergency department utilization.	
	The AHCCCS H2O demonstration will increase utilization of primary care and preventative	

	health services.	groups • Leasing and housing data from AHCCCS housing programs • Permanent supportive housing fidelity reporting • Data from Homeless Management Information System (HMIS) and other system coordination
	The AHCCCS H2O demonstration will yield improved member satisfaction with care.	
	The AHCCCS H2O demonstration will reduce homelessness and homeless recidivism of AHCCCS members.	
	The AHCCCS H2O demonstration will improve ongoing housing stability for AHCCCS members.	
	The AHCCCS H2O demonstration will increase timely housing placement for AHCCCS members	
	The AHCCCS H2O demonstration will increase engagement and assessment of Medicaid eligible but unenrolled individuals who are experiencing chronic homelessness.	
	The AHCCCS H2O demonstration will improve discharge coordination of identified homeless members and reduce discharges to homelessness.	
	The AHCCCS H2O demonstration will yield cost-effective care for AHCCCS members.	
Tribal Dental		
AHCCCS members 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 AHCCCS members.	Data will be drawn from a variety of sources including: • 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 members will be maintained or improved.	
	Oral health disparities will be reduced for American Indian and Alaska Native members.	
Traditional Healing		

Traditional healing and the states proposed UIO expansion will enhance access to care for American Indian members 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: • 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 members.	
	Availability of traditional healing services in allopathic primary care settings will increase the utilization of primary care services.	
Reentry		
The Reentry Demonstration will facilitate members access to certain healthcare services and case management while incarcerated and allow them to establish relationships with community-based providers from whom they can receive services upon reentry to their communities.	The Reentry Demonstration will increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in correctional facility settings prior to release.	Data will be drawn from a variety of sources including: • 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 Reentry Demonstration will improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry.	
	The Reentry Demonstration will improve coordination and communication between correctional systems, Medicaid and CHIP systems, managed care plans (as applicable), and community-based providers	
	The Reentry Demonstration will increase additional investments in health care and related services, aimed at improving the quality of care for individuals in correctional facility settings, and in the community to maximize successful reentry post-release.	
	The Reentry Demonstration will improve connections between correctional facility settings and community services upon release to address physical and behavioral health needs, and health-related social needs.	

	The Reentry Demonstration will reduce all-cause deaths in the near-term post-release.	
	The Reentry Demonstration will reduce the number of emergency department visits and inpatient hospitalizations among recently incarcerated Medicaid and CHIP individuals through increased receipt of preventive and routine physical and behavioral health care.	
	The Reentry Demonstration will provide interventions for certain behavioral health conditions, including use of stabilizing medications like long-acting injectable antipsychotics and medication for addiction treatment for SUDs where appropriate, with the goal of reducing overdose and overdose-related death in the near-term post-release.	
ECR Timeliness Waiver		
The ECR Timeliness Waiver will improve clinical appropriateness and consistency of service authorizations, reduce administrative burden, and ensure beneficiaries receive timely access to medically necessary services.	The ECR timeliness Waiver will promote ECR exception service authorization requests in having a lower rate of overturned denials and fewer beneficiary appeals and grievances.	Data will be drawn from a variety of sources including: • 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 ECR timeliness waiver will yield improved member satisfaction.	
	The ECR timeliness waiver will yield cost-effective care for members.	
Modifications to Hospital Presumptive Eligibility and Accepting Self-Attestation		
The requests to modify Hospital Presumptive Eligibility and use of self-attestation will strengthen program integrity and the Medicaid eligibility determination process.	The implementation of the proposal will not adversely affect access to care.	Data will be drawn from a variety of sources including: • Member survey • State eligibility and enrollment data • Claims/encounter data • Administrative program
	The implementation of the proposal will not reduce member satisfaction.	
	The implementation of the proposal will not adversely affect health outcomes.	

		data (PMMIS) • T-MSIS • National/regional benchmarks

VII. Requested Waiver and Expenditure Authorities

The following table identifies the waiver and expenditure authorities Arizona requests to continue, modify, discontinue, or newly establish under this renewal.

Figure 30 – Status of Existing Demonstration Authorities

Waiver #	Title	Summarized Description	Status Under Extension
Waiver Authorities			
1.	**Eligibility Based on Institutional Status** Section 1902(a)(10)(A)(ii)(V) (42 CFR 435.236)	Allows the state 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
2.	**Comparability; Amount, Duration, Scope of Services** Section 1902(a)(10)(B); 1902(a)(17) (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
3.	**Estate Recovery** Section 1902(a)(18) (42 CFR 433.36)	Relieves the state from creating an estate recovery program for acute care enrollees age 55 and older who receive long term care services.	Continue
4.	**Freedom of Choice**	Permits the state to operate a statewide mandatory	Continue

	Section 1902(a)(23)(A) (42 CFR 431.51)	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 ensure 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 noncovered activities.	
5.	**Retroactive Eligibility** Section 1902(a)(10) and (a)(34) (42 CFR 435.915)	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.	Modify
6.	**Coverage of Certain Screening, Diagnostic, and Targeted Case Management Services for Eligible Juveniles in the 30 Days Prior to Release** Section 1902(a)(84)(D)	Permits the state to provide coverage of screening, diagnostic, and targeted case management services as required by section 1902(a)(84)(D) of the Act at a level equal to or greater than would be required under the state plan through the Reentry Demonstration.	Continue
7.	**Coverage of Certain Screening, Diagnostic, Referral, and Case Management Services for Targeted Low-Income Children in the 30 Days Prior to Release** Section 2102(d)(2)	Permits the state to provide coverage of screening, diagnostic, referral, and targeted case management services as required by section 2102(d)(2) of the Act at a level equal to or greater than would be required under the state plan through the Reentry Demonstration.	Continue
Medicaid Expenditures Related to Administrative Simplification and Delivery Systems			
1.	**Managed Care Freedom of Choice**	Permits the state to claim as medical assistance payments to MCOs who do not meet requirements of 1903(m)(2)(A) and 1932(a) to limit the choice of managed care plans for individuals enrolled in ACC, ACC-RBHA, DCS CHP, and ALTCS. This authority also permits the state to restrict	Continue

		beneficiary disenrollment based on 42 CFR 438.56(d)(2)(v) for causes.	
2.	**Managed Care Re-Enrollment**	Allows the state 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.	**Managed Care Tribal Providers**	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 and 42 CFR 438.14, 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.	**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
5.	**Fee-For-Service Upper Payment Limit**	Permits AHCCCS to claim federal financial participation for items and services provided to AHCCCS fee-for service members 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).	Continue
6.	**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.	Continue

Medicaid Expenditures Related to Expansion of Existing Eligibility Groups based on Eligibility Simplification			
7a.	**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
7b.	**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
7c.	**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
7d.	**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
7e.	**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
7f.	**Disregard of Interest –**	Permits AHCCCS to claim federal financial participation	Continue

	Eligibility Groups	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.	
7g.	**Disregard of Interest – Post Eligibility Calculations**	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
7h.	**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
7i.	**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
8.	**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
9.	**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	Continue

		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.	
10.	**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
11.	**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 Medicaid Expenditure Authorities Related to Arizona's Demonstration			
12.	**HCBS Parents and Spouses as Paid Caregivers**	Permits AHCCCS to claim federal financial participation for expenditures associated with the provision of personal care services provided by spouses of eligible ALTCS beneficiaries, and personal care and habilitation services provided by legally responsible parents for eligible minor ALTCS beneficiaries.	Continue
13.	**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, excluding AI/AN beneficiaries addressed in expenditure 15 below.	Continue
14.	**Hospital Presumptive Eligibility**	Permits AHCCCS to claim federal financial participation for all state plan and demonstration covered services for pregnant women during their hospital presumptive eligibility period. AHCCCS is seeking to discontinue this authority.	Discontinue
15.	**Tribal Dental and Tribal Uncompensated Care**	Permits AHCCCS to claim federal financial participation for medically necessary diagnostic, therapeutic, and preventative dental services provided to AI/AN members by IHS and tribal 638 facilities.	Continue

		Also permits payments to IHS and tribal 638 facilities for any Medicaid coverable services that were eliminated from, reduced, or limited in the Arizona Medicaid State Plan on or after September 2010 provided by such facilities.	
16.	**Targeted Investment (TI) 2.0 Program**	Permits AHCCCS to claim federal financial participation for expenditures under contracts with managed care entities that pay incentive payments to providers that meet targets specified in the contract as described in the Demonstrations STCs. AHCCCS is seeking to discontinue this authority.	Discontinue
17.	**Designated State Health Programs (DSHP)**	Permits AHCCCS to claim federal financial participation for expenditures for designated programs which are otherwise state-funded, and not otherwise eligible for Medicaid payment. AHCCCS is seeking to discontinue this authority in alignment with the April 10, 2025, CMS State Medicaid Director Letter.	Discontinue
18.	**Health-Related Social Needs (HRSN) Services**	Permits AHCCCS to claim federal financial participation for expenditures related to H2O services not otherwise eligible for Medicaid payments.	Continue
19.	**HRSN Infrastructure**	Permits AHCCCS to claim federal financial participation for expenditures related to H2O administrative costs and infrastructure not otherwise eligible for Medicaid payments.	Continue
20.	**Traditional Health Care Practices (THCP)**	Permits AHCCCS to claim federal financial participation for expenditures for THCP received through HIS or tribal 638 facilities. AHCCCS is seeking to modify this authority to also authorize expenditures for THCP delivered by UIOs without the use of a care coordination agreement.	Modify
21.	**Pre-Release Services**	Permits AHCCCS to claim federal financial participation for expenditures for pre-release services provided to qualifying Medicaid individuals for up to 90 days immediately prior to the expected date of release	Continue

		from a correctional facility that is participating in the Reentry Demonstration.	
22.	**Pre-Release Administrative Cost**	Permits AHCCCS to claim federal financial participation for capped expenditures for payments for allowable administrative costs, supports, transitional non-service expenditures, infrastructure and interventions, which may not be recognized as medical assistance under section 1905(a) and may not otherwise qualify for federal matching funds under section 1903.	Continue
23.	**Non-Medical Transportation**	Permits AHCCCS to claim federal financial participation for expenditures for non-medical transportation not otherwise covered under title XIX of the Act for qualified individuals.	Continue
24.	**Out of State Former Foster Care Youth**	Permits AHCCCS to claim federal financial participation for expenditures to extend eligibility for Medicaid state plan benefits to former foster care youth (FFCY) who are under age 26, who turned 18 on or before December 31, 2022, who were in foster care under the responsibility of another state or a tribe in such other state on the date of attaining 18 years of age, were enrolled in Medicaid on the date of aging out of foster care, and are now applying for Medicaid in Arizona.	Continue
Medicaid Requirements Not Applicable to These Demonstration Expenditures			
26.	**Comparability; Amount, Duration, Scope of Services** Section 1902(a)(10)(B); Section 1902(a)(17)	Permits the state to offer the applicable benefits package to an individual who meets the qualifying eligibility criteria for the H2O program HRSN services, including during a phase in process.	Continue
27.	**Comparability; Amount, Duration, Scope of Services; Freedom of Choice** Section 1902(a)(10)(B); Section 1902(a)(17); Section 1902(a)(23)	Permits the state to offer the coverage described in Expenditure Authority 15 (Tribal Dental and Tribal Uncompensated Care) only to American Indian/Alaskan Native (AI/AN) beneficiaries and only if the covered services are provided by participating IHS or tribal 638 facilities.	Continue
28.	**Statewideness**	Permits the state to provide pre-release services, as authorized under this demonstration, to qualifying	Continue

	Section 1902(a)(1)	individuals on a geographically limited basis, in accordance with the Reentry Demonstration Implementation Plan.	
29.	**Amount, Duration, and Scope of Services and Comparability** Section 1902(a)(10)(B)	Permits the state to provide only a limited set of pre-release services to qualifying individuals that is different than the services available to all other individuals outside of correctional facility settings in the same eligibility groups.	Continue
30.	**Freedom of Choice** Section 1902(a)(23)(A)	Permits the state to require qualifying individuals receive pre-release services, as authorized under this demonstration, through only certain providers.	Continue
Children's Health Insurance Program (CHIP) Expenditure Authorities			
31.	**KidsCare Expansion**	Permits AHCCCS to claim federal financial participation for expenditures for all state plan and demonstrations services for individuals under age 19 who meet all eligibility criteria for the Children's Health Insurance Program (CHIP) with incomes above 200 percent up to and including 300 percent of the federal poverty level (FPL) who are not otherwise covered as of February 16, 2024, subject to approval by the state legislature.	Continue
32.	**Pre-Release Services**	Permits AHCCCS to claim federal financial participation for expenditures for pre-release services provided to qualifying CHIP individuals who are or would be eligible for CHIP if not for their incarceration status, for up to 90 days immediately prior to the expected date of release from a correctional facility that is participating in the Reentry Demonstration.	Continue

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

Figure 31 – Newly Requested Waiver Authorities

Proposed Demonstration	Waiver Authority Requested	Summarized Description
Long Term Services and Supports (LTSS) Extraordinary Care Review	42 CFR 438.210(d)	AHCCCS is seeking Section 1115 waiver authority to waive existing service authorization timeframe requirements to allow for an additional ECR review. This authority would provide additional time for clinicians to conduct thorough evaluations and for HCDMs to collect and review necessary documentation to support informed determinations.

Timeliness Waiver		
Elimination of Residency Self-Attestation	42 CFR 435.952(c)(3)	Pursuant to HB 4160 (Laws 2026, Chapter 132), AHCCCS seeks Section 1115 waiver authority to no longer accept residency self-attestation and rather require independent verification of Arizona residency before Medicaid coverage is approved. The change would strengthen program integrity by ensuring accurate eligibility determinations and reducing potential duplicate enrollment across states while preserving existing eligibility protections.
Elimination of Hospital Presumptive Eligibility (HPE)	42 CFR 435.1110	Pursuant to HB 4160 (Laws 2026, Chapter 132), AHCCCS is seeking Section 1115 waiver authority to eliminate Arizona's Hospital Presumptive Eligibility (HPE) program. This is intended to strengthen program integrity by ensuring eligibility determinations are based on complete and verified information while reducing the administrative burden associated with maintaining a minimally utilized 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 Social Security 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 7/23/2026 at: https://www.azahcccs.gov/Resources/Federal/waiverrenewalrequest.html

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 will use social media, newsletters, and electronic mail to notify interested parties about Arizona's Demonstration renewal proposal.

Stakeholder Meetings:

To solicit feedback on this Demonstration renewal proposal AHCCCS will host two public forums and one Tribal Consultation to engage with the public, stakeholders, providers, and Tribal stakeholders. In addition, AHCCCS will present and share details of this renewal at various standing meetings including but not limited to the AHCCCS Office of Individual and Family Affairs (OIFA) Advisory Council, the State Medicaid Advisory Committee (SMAC), and other healthcare association meetings.

In addition to these forums and Tribal Consultation, the public will have the opportunity to submit written feedback on AHCCCS' Waiver Renewal Proposal by email at waiverpublicinput@azahcccs.gov or by mail to AHCCCS, c/o Division of Public Policy and Strategic Planning; 150 N. 18th Ave., Phoenix, AZ 85007. Details regarding the public forum meetings can be found in figure 32 below.

To ensure consideration of comments, AHCCCS is asking for all public comments to be received by Sunday, September 6, 2026.

Figure 32 - Goals and Objectives of the Proposed Demonstration Renewal by Program

Public Forum Meeting	Meeting Dates & Times	Meeting Web Link & Call-in Information
Special Tribal Consultation	**Date**: July 15, 2026 **Time**: 9:00 a.m. - Noon AZ Time	Tribal Stakeholders may email TribalRelations@azahcccs.gov for additional information.
AHCCCS Waiver Renewal Public Forum #1	**Date**: July 23, 2026 **Time**: 10:00 a.m. - 1:00 p.m. AZ Time	Meeting Registration Link: https://ahcccs.zoom.us/webinar/register/WN_3E3Ohn2cTuulaA-iEvD_Vw#/registration Call-in Information: US: +1.346.248.7799 | +1.408.638.0968 | +1.669.444.9171 | +1.669.900.6833 | +1.719.359.4580 | +1.253.205.0468 | +1.253.215.8782 | +1.386.347.5053 | +1.507.473.4847 | +1.564.217.2000 | +1.646.876.9923 | +1.646.931.3860 | +1.689.278.1000 | +1.301.715.8592 | +1.305.224.1968 | +1.309.205.3325 | +1.312.626.6799 | +1 360 209 5623
AHCCCS Waiver Renewal Public Forum #2	**Date**: August 7, 2026 **Time**: 1:00 -4:00 p.m. AZ Time	Meeting Registration Link: https://ahcccs.zoom.us/webinar/register/WN_KdBXarixQwmAlyX-5TJlRg#/registration Call-in Information: (US): +1.719.359.4580 | +1.253.205.0468 | +1.253.215.8782 |+1.346.2487799 | +1.408.638.0968 | +1.669.444.9171 |+1.669.900.6833 | +1.564.217.2000 | +1.646.876.9923 | +1.646.931.3860 | +1.689.278.1000 | +1.301.715.8592 | +1.305.224.1968 | +1.309.205.3325 | +1.312.626.6799 | +1.360.209.5623 | +1.386.347.5053 | +1.507.473.4847

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

APPENDIX A:

ARIZONA SECTION 1115 WAIVER EVALUATION

INTERIM EVALUATION REPORT

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Arizona's Medicaid Section 1115 Waiver Evaluation

Interim Evaluation Report

July 2026

HSAG HEALTH SERVICES ADVISORY GROUP

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Commonly Used Abbreviations, Acronyms, and Definitions

The following list contains commonly used abbreviations, acronyms, and definitions used throughout the report.

- Affordable Care Act (ACA)
- Arizona Department of Health Services (ADHS)
- Adult Family Survey (AFS)
- Arizona Health Care Cost Containment System (AHCCCS)
- AHCCCS Housing Program (AHP)
- American Indian/Alaska Native (AI/AN)
- American Indian Health Program (AIHP)
- AHCCCS Complete Care (ACC)
- Arizona Long Term Care System (ALTCS)
- Arizona State Immunization Information System (ASIIS)
- Behavioral Health (BH)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Community-Based Organization (CBO)
- Centers for Medicare & Medicaid Services (CMS)
- Children's Health Insurance Program (CHIP)
- Closed-Loop Referral System (CLRS)
- Comprehensive Health Plan (CHP)
- Comprehensive Medical and Dental Program (CMDP)
- Confidence Interval (CI)
- Coronavirus Disease 2019 (COVID-19)
- Calendar Year (CY)
- Department of Child Safety (DCS)
- Direct Care Worker (DCW)
- Department of Economic Security/Division of Developmental Disabilities (DES/DDD)
- Developmental Disabilities (DD)
- Difference-in-Differences (DiD)
- Elderly and/or have Physical Disabilities (EPD)
- Emergency Department (ED)
- Extended Family Support Services (EFSS)
- External Quality Review Organization (EQRO)
- Fee-For-Service (FFS)
- Federal Fiscal Year (FFY)

- Federal Poverty Level (FPL)
- Former Foster Care Youth (FFCY)
- Freedom to Work (FTW)
- General Mental Health/Substance Use (GMHSU)
- Geographical Service Areas (GSA)
- Home- and Community-Based Services (HCBS)
- Healthcare Common Procedure Coding System (HCPCS)
- Healthcare Cost Report Information System (HCRIS)
- Health Information Exchange (HIE)
- Health-Related Social Needs (HRSN)
- Health Services Advisory Group, Inc. (HSAG)
- Housing and Health Opportunities (H2O)
- Intellectually and Developmentally Disabled (IDD)
- Indian Health Services (IHS)
- Institution for Mental Disease (IMD)
- Inpatient (IP)
- Integrated Public Use Microdata Series (IPUMS)
- Interrupted Time Series (ITS)
- Long-Term Care (LTC)
- Long-Term Services and Supports (LTSS)
- Mercy Maricopa Integrated Care (MMIC)
- National Committee for Quality Assurance (NCQA)
- National Core Indicators (NCI)
- Non-Emergency Medical Transportation (NEMT)
- Non-Medical Transportation (NMT)
- Obstetrician Gynecologist (OB/GYN)
- Opioid Use Disorder (OUD)
- Outpatient (OP)
- Program Administrator (PA)
- Per-Member Per-Month (PMPM)
- Prepaid Medical Management Information System (PMMIS)
- Primary Care Provider (PCP)
- Physical Health (PH)
- Public Health Emergency (PHE)
- Parents as Paid Caregivers (PPCG)
- Prior Quarter Coverage (PQC)

- Regional Behavioral Health Agreement (RBHA)
- Research Question (RQ)
- Serious Mental Illness (SMI)
- Skilled Nursing Facility (SNF)
- Special Terms and Conditions (STCs)
- Social Determinants of Health (SDOH)
- State Plan Amendment (SPA)
- Substance Use Disorder (SUD)
- State Fiscal Year (SFY)
- Traditional Health Care Practices (THCP)
- Targeted Investments (TI)
- Transformed Medicaid Statistical Information System (T-MSIS)

Executive Summary

The Centers for Medicare & Medicaid Services (CMS) approved Arizona's request to extend its Section 1115 Arizona Health Care Cost Containment System (AHCCCS) Demonstration Waiver (referred to as the Waiver in this report) on October 14, 2022.[1] The extension was approved for an additional five-year period, effective October 14, 2022, through September 30, 2027. The Waiver was initially amended on February 16, 2024, to include eligibility expansions. The following Waiver programs have been implemented or extended under this authority:

- AHCCCS Complete Care (ACC)
- ACC-Regional Behavioral Health Agreement (ACC-RBHA)
- Arizona Long Term Care System (ALTCS)[2,3]
- Department of Child Safety Comprehensive Health Plan (DCS CHP)
- Former Foster Care Youth (FFCY)[4,5]
- Housing and Health Opportunities (H2O)[6]
- KidsCare Eligibility Expansion
- Non-Medical Transportation (NMT)[7,8]
- Prior Quarter Coverage (PQC) Waiver
- Reentry[9,10]
- Targeted Investments (TI) 2.0[11]
- Tribal Dental Authority
- Traditional Health Care Practices (THCP)[12,13]

Pursuant to the Waiver's Special Terms and Conditions (STCs), AHCCCS contracted with an independent evaluator to conduct a comprehensive evaluation of the Waiver.[14] This evaluation ensures compliance with

1 Centers for Medicare & Medicaid Services. AHCCCS Demonstration Extension and Housing & Health Opportunities Amendment Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-ca-10142022.pdf. Accessed on: Mar 4, 2026.

2 ALTCS was amended on February 16, 2024, to include Parents as Paid Caregivers.

3 Centers for Medicare & Medicaid Services. Demonstration Approval–CHIP Expansion and Parents as Paid Caregivers Amendment. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-dmns-pdftn-aprvl-chip-expn-prnts-paid-crgvrs-amndmnt.pdf. Accessed on: Mar 4, 2026.

4 Centers for Medicare & Medicaid Services. Former Foster Care Youth Amendment Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-ffcy-appvl-06132025.pdf. Accessed on: Mar 5, 2026.

5 The FFCY amendment is excluded from this report and is pending an Evaluation Design.

6 H2O was implemented on October 1, 2024.

7 NMT is excluded from this report.

8 Centers for Medicare & Medicaid Services. Reentry and NMT Amendment Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-dmnstrn-apprvl-12272024.pdf. Accessed on: Mar 5, 2026.

9 Ibid.

10 Reentry is excluded from this report and is pending an Evaluation Design.

11 TI 2.0 is being evaluated separately under a CMS-approved Evaluation Design by another independent evaluator.

12 Centers for Medicare & Medicaid Services. Traditional Health Care Practices Amendment Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-dmnstrn-apprvl-10162024.pdf. Accessed on: Mar 5, 2026.

13 THCP is excluded from this report but will be included in the Summative Evaluation Report. The THCP Evaluation Design was submitted to CMS on January 29, 2026.

14 Centers for Medicare & Medicaid Services. Special Terms and Conditions. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hcccs-demon-apprvl-amndmn-eval-desdn.pdf. Accessed on: Mar 3, 2026.

Section 1115 Demonstration Waiver requirements; informs State and federal decision-making regarding the program's effectiveness; and supports the development of clinically appropriate, fiscally responsible, and effective Medicaid demonstration programs.

The Waiver includes several program goals designed to improve access, quality, and care coordination for Medicaid members. The broad goals for each program are as follows:

- **ACC:** Provide quality health care to members by ensuring access to care, maintaining or improving member satisfaction, and operating as a cost-effective managed care delivery model.
- **ACC-RBHA:** Provide quality health care to members with a serious mental illness (SMI) by ensuring access to care, maintaining or improving member satisfaction, and operating as a cost-effective managed care delivery model.
- **ALTCS:** Provide quality health care to members with long-term services and supports (LTSS) needs by ensuring access to care, maintaining or improving member satisfaction, and operating as a cost-effective managed care delivery model. The ALTCS program covers two distinct populations: members who are elderly and/or have physical disabilities (EPD) and/or individuals with developmental disabilities (DD). ALTCS-EPD members are served through plans contracted with AHCCCS. ALTCS-DD members are served through a statewide managed care organization (MCO) operated by The Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD). Additionally, DDD is contracted by AHCCCS to serve as an MCO for delivery of LTSS services.
  - **ALTCS-Parents as Paid Caregivers (PPCG):** Address workforce shortages by allowing legally responsible parents to be reimbursed for providing direct care to their minor children enrolled in ALTCS up to 40 hours a week.
- **DCS CHP:** Provide quality health care to eligible foster children by ensuring access to care, maintaining or improving member satisfaction, and operating as a cost-effective managed care delivery model.
- **H2O:** Enhance and expand housing services and interventions for AHCCCS members with SMI and experiencing homelessness or are at risk of homelessness, who have either a chronic physical health condition or are involved with the justice system. This program ensures members attain safe housing and integrated services.
- **KidsCare Eligibility Expansion:** Increase the number of children eligible for KidsCare coverage.
- **PQC:** Promote continuity of care and reduce coverage gaps that may occur when individuals wait until they experience medical emergencies to apply for Medicaid.
- **Tribal Dental Authority:** Improve oral health among tribal members and reduce the disproportionate number of American Indian/Alaska Native (AI/AN) population members affected by oral disease, improving members' outcomes and experience.

Results

The independent evaluation of the Waiver assessed a range of programs and populations to identify successes, challenges, and opportunities for future improvement. Table 1 through Table 7 present a summary of performance measures and beneficiary survey statistical testing results. Most measures have a defined desired direction, for which an increase or decrease in rates indicates a favorable change. Other measures are dependent on context and do not necessarily have a favorable direction. For example, emergency department (ED) visit rates may reflect unnecessary utilization when rates are high, while low rates may indicate inadequate access to care. Results for

the H2O and Tribal Dental Authority programs are not presented at a hypothesis level due data limitations caused by insufficient time since implementation to conduct formal statistical testing.[15]

Table 1—ACC Summary of Measure Rate Changes Between Baseline and Evaluation Periods

Hypothesis	Number of Measures			
	Improving	No Significant Change	Worsening	N/A[1]
Hypothesis 1: Health plans encourage and/or facilitate care coordination among PCPs and BH practitioners.	1	2	0	0
Hypothesis 2: Member access to appropriate care for routine medical conditions will be maintained or improved during the renewal period.	5	5	3	0
Hypothesis 3: Quality of care will be maintained or improved during the renewal period.	7	3	3	3
Hypothesis 4: Member self-assessed health outcomes will be maintained or improved during the renewal period.	0	4	0	0
Hypothesis 5: Member satisfaction with their health care will be maintained or improved during the renewal period.	0	4	0	0
Total	**13**	**18**	**6**	**3**

Note: BH: behavioral health; N/A: not applicable; PCP: primary care provider.
[1] Measures did not have a desired directionality or require additional context to describe the outcome.

Table 2—ACC-RBHA Summary of Measures Rate Changes Between Baseline and Evaluation Periods

Hypothesis	Number of Measures			
	Improving	No Significant Change	Worsening	N/A[1]
Hypothesis 1: Member access to appropriate care for routine medical conditions will be maintained or improved during the renewal period.	2	4	1	0
Hypothesis 2: Quality of care will be maintained or improved during the renewal period.	5	4	5	4
Hypothesis 3: Health outcomes for adult members with an SMI enrolled in an ACC-RBHA will be maintained or improved during the renewal period.	0	1	1	0
Hypothesis 4: Adult member satisfaction in ACC-RBHA health plans will be maintained or improved over the renewal period.	0	2	1	0
Hypothesis 5: ACC-RBHAs encourage and/or facilitate care coordination among PCPs and BH practitioners.	0	1	0	0
Hypothesis 6: ACC-RBHAs will provide cost-effective care for members with an SMI.	0	0	0	0
Total	**7**	**12**	**8**	**4**

Note: ACC: AHCCCS Complete Care; BH: behavioral health; N/A: not applicable; PCP: primary care provider; RBHA: Regional Behavioral Health Agreement; SMI: serious mental illness.
[1] Measures did not have a desired directionality or require additional context to describe the outcome.

[15] The results tables summarize the number of measures that compare either baseline to evaluation period data, or an intervention group to a comparison group. Interim results for the H2O and Tribal Dental Authority programs do not contain sufficient data to make these comparisons and conduct formal statistical testing due to limited time since program implementation. Sufficient data are anticipated to be available for the Summative Evaluation Report.

Table 3—ALTCS Summary of Measure Rate Changes Between Baseline and Evaluation Periods

	ALTCS-DD				ALTCS-EPD			
	Number of Measures				Number of Measures			
Hypothesis	Improving	No Significant Change	Worsening	N/A[1]	Improving	No Significant Change	Worsening	N/A[1]
Hypothesis 1: Member access to appropriate care for routine medical conditions will be maintained or improved during the renewal period.	4	3	0	3	1	1	0	4
Hypothesis 2: Quality of care will be maintained or improved during the renewal period.	0	5	3	3	0	8	0	4
Hypothesis 3: Quality of life for members will be maintained or improved during the renewal period.	1	4	0	2	1	0	0	6
Hypothesis 4: ALTCS encourages and/or facilitates care coordination among PCPs and BH practitioners.	1	1	0	0	2	0	0	0
Total	**6**	**13**	**3**	**8**	**4**	**9**	**0**	**14**

Note: ALTCS: Arizona Long Term Care System; BH: behavioral health; DD: developmental disabilities; EPD: elderly and/or have physical disabilities; N/A: not applicable; PCP: primary care provider.

[1] Measures did not have a desired directionality or require additional context to describe the outcome.

Table 4—ALTCS-PPCG Summary of Measure Rate Changes Between Ramp-Up and Evaluation Periods

	PPCG-DD				PPCG-EPD			
	Number of Measures				Number of Measures			
Hypothesis	Improving	No Significant Change	Worsening	N/A[1]	Improving	No Significant Change	Worsening	N/A[1]
Hypothesis 5: The PPCG service model and EFSS will maintain or increase the rate of members being served in the home.	0	0	0	2	0	0	0	3
Hypothesis 6: The PPCG service model will maintain or improve access to quality health services for the target population.	0	2	0	3	0	2	0	3
Hypothesis 7: The PPCG service model and EFSS will improve self-assessed health outcomes.	0	2	0	0	0	0	0	0
Hypothesis 8: The PPCG service model will mitigate the DCW shortage by increasing timely accessibility to care providers.	2	0	0	3	0	1	0	3

Hypothesis	PPCG-DD Number of Measures				PPCG-EPD Number of Measures			
	Improving	No Significant Change	Worsening	N/A[1]	Improving	No Significant Change	Worsening	N/A[1]
Hypothesis 9: The PPCG service model will improve ongoing care stability for the target population.	1	1	0	0	0	0	1	0
Hypothesis 10: The PPCG service model and EFSS will increase member and family unit stability through increased ability to navigate the health care system and decrease stress and burnout.	1	1	0	0	0	1	0	0
Hypothesis 11: The PPCG service model and EFSS will maintain or improve community integration and well-being for members.	1	0	0	6	0	0	0	1
Hypothesis 12: ALTCS provides cost-effective care.	0	0	0	1	0	0	0	1
Total	**6**	**6**	**0**	**14**	**0**	**4**	**1**	**11**

Note: ALTCS: Arizona Long Term Care System; DCW: direct care worker; DD: developmental disabilities; EFSS: Extended Family Support Services; EPD: elderly and/or have physical disabilities; N/A: not applicable; PPCG: Parents as Paid Caregivers.
[1] Measures did not have a desired directionality or require additional context to describe the outcome.

Table 5—DCS CHP Summary of Rate Changes Between Baseline and Evaluation Periods

Hypothesis	Number of Measures			
	Improving	No Significant Change	Worsening	N/A[1]
Hypothesis 1: Member access to appropriate care for routine medical conditions will be maintained or improved during the integration period.	3	1	0	0
Hypothesis 2: Quality of care will be maintained or improved during the integration period.	1	6	1	3
Hypothesis 3: DCS CHP encourages and/or facilitates care coordination among PCPs and BH practitioners.	0	0	0	2
Total	**4**	**7**	**1**	**5**

Note: BH: behavioral health; CHP: Comprehensive Health Plan; DCS: Department of Child Safety; N/A: not applicable; PCP: primary care provider.
[1] Measures did not have a desired directionality or require additional context to describe the outcome.

Table 6—KidsCare Eligibility Expansion Summary of Measure Rate Differences Between Expansion and Non-Expansion Members

Hypothesis	Number of Measures			
	Improving	No Significant Change	Worsening	N/A[1]
Hypothesis 1: Expanding KidsCare eligibility will increase the number of members eligible for and enrolled in KidsCare and reduce the number of children losing eligibility for procedural reasons.	3	2	1	1
Hypothesis 2: Expanding KidsCare eligibility will improve access to care and increase primary care service utilization for CHIP members.	4	5	0	3
Hypothesis 3: Expanding KidsCare eligibility will improve member care satisfaction.	2	0	0	0

Hypothesis	Number of Measures			
	Improving	No Significant Change	Worsening	N/A[1]
Hypothesis 4: Expanding KidsCare eligibility will improve quality of care for members.	1	7	0	3
Hypothesis 5: Expanding KidsCare will improve self-assessed health outcomes.	2	0	0	0
Hypothesis 6: Expanding KidsCare will yield cost-effective care for members.	0	0	1	1
Total	**12**	**14**	**2**	**8**

Note: The determination of support is based on performance relative to the comparison group. CHIP: Children's Health Insurance Program; N/A: not applicable.
[1] Measures did not have a desired directionality or require additional context to describe the outcome.

Table 7—PQC Summary of Measure Rate Changes Between Baseline and Evaluation Periods

Hypothesis	Number of Measures			
	Improving	No Significant Change	Worsening	N/A[1]
Hypothesis 1: Eliminating PQC will increase the likelihood and continuity of enrollment.	4	0	4	2
Hypothesis 5: Eliminating PQC will not adversely affect access to appropriate care for routine medical conditions.	0	2	1	0
Hypothesis 7: Eliminating PQC will generate cost savings over the term of the waiver.	0	0	1	0
Total	**4**	**2**	**6**	**2**

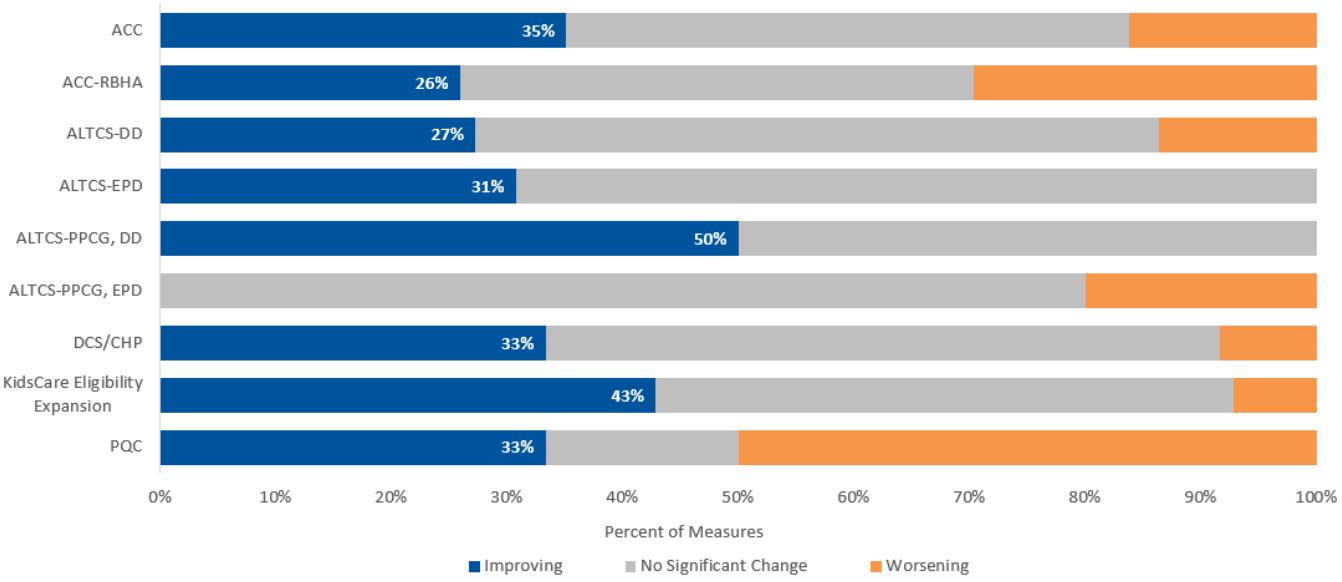
Note: Hypotheses 2, 3, 4, and 6 were not included due to no results with significant changes. N/A: not applicable; PQC: Prior Quarter Coverage.
[1] Measures did not have a desired directionality or require additional context to describe the outcome.

Conclusions

The results from the statistical analysis of performance measure rate changes between the baseline and evaluation periods show general support across hypotheses and programs. Similarly, results from comparing KidsCare expansion members to KidsCare non-expansion members show support across hypotheses. Of the 168 measures evaluated with a desired direction, 33 percent of the measures showed improvement, 51 percent of the measures showed no significant change, and 16 percent of the measures worsened. An additional 69 measure results were not applicable or were dependent on additional context, indicating that a desired direction was not appropriate or statistical testing was not conducted for these measures. The Waiver programs demonstrated substantial variability in the proportion of measures consistent with research hypotheses, as illustrated in Figure 1. Results for the H2O and Tribal Dental Authority programs are not presented at a hypothesis level due to data limitations caused by insufficient time since implementation to conduct formal statistical testing.[16]

[16] Interim results for the H2O and Tribal Dental Authority programs do not contain sufficient data to conduct formal statistical testing due to limited time since program implementation. Sufficient data are anticipated to be available for the Summative Evaluation Report.

Figure 1—Percentage of Measures Consistent with Research Hypotheses



ACC: Results for ACC indicate generally stable performance across evaluated measures. More than 80 percent of measures either supported their respective hypotheses or showed no significant change between the baseline and evaluation periods. Measures demonstrating improvement were primarily related to substance use disorder (SUD) treatment and management of opioid prescriptions or chronic conditions. However, access to care for adult members may have declined slightly, as indicated by a decrease in the proportion of members with a preventive care visit.

Key informant interviews indicated that ACC plans and providers implemented several strategies to strengthen coordination between physical health (PH) and behavioral health (BH) care, including leveraging member data, establishing dedicated care management teams, and collaborating with external partners. Despite these efforts, plans and providers reported ongoing challenges related to care coordination, particularly data sharing limitations and workforce shortages.

ACC-RBHA: Results for ACC-RBHA indicate generally stable performance across evaluation measures. Among the 27 measures assessed with a desired direction, 70 percent supported the hypothesis or showed no significant change between the baseline and evaluation periods. Improvements were observed in opioid prescription management and engagement with and adherence to SUD and mental health treatment. Although access to SUD and mental health treatment improved, follow-up care after hospitalizations and ED visits for these conditions highlights an area for continued improvement, as some follow-up metrics worsened during the evaluation period.

Key informant interviews indicated that integration of PH and BH services improved care coordination for members with SMI. AHCCCS strengthened the ACC-RBHA and BH systems by supporting care coordination for members with SMI. Plans reported coordinating services with external stakeholders, including community-based organizations (CBOs), health homes (HHs), justice agencies, providers, and first responders to ensure coordinated services. Providers similarly enhanced care coordination through dedicated staff and use of technology to support member management.

ALTCS: Results for ALTCS indicate generally stable or improving performance across evaluation measures. Among measures for members with developmental disabilities (DDs), 86 percent either supported the hypothesis

or showed no significant change between the baseline and evaluation periods. Adult and minor members demonstrated higher rates of preventive and well-child visits during the evaluation period compared with the baseline period. For the ALTCS-elderly and/or have physical disabilities (EPD) population, all measures with a desired direction either improved or showed no significant change. Improvements were observed in access to preventive care, rates of members residing in their own home, and follow-ups after ED visits, suggesting enhanced health care access, quality of life, and care coordination efforts.

Key informant interviews identified several challenges to care coordination during the Waiver renewal period. DES/DDD reported barriers related to educating stakeholders on the needs of its member population and engaging foster youth. ALTCS plans noted challenges to member engagement, obtaining accurate contact information, workforce shortages, care team communication, and member transitions related to policy changes. AHCCCS also identified system-level challenges, including the needs of an aging population, an increase in enrollment of individuals with developmental disabilities, and workforce shortages. Providers similarly reported barriers related to transportation, the ALTCS application process, authorization requirements, reimbursement, and communication with AHCCCS. Despite these challenges, providers reported that the PPCG model expanded caregiver options and improved continuity of care.

ALTCS-PPCG: During the first year of the evaluation, 50 percent of measures with a desired direction improved and none declined, indicating that the PPCG model increased access to care and helped stabilize service delivery. Utilization of services through the PPCG model increased, and the average number of DCWs per member per year declined. However, the percentage of caregivers who reported high levels of burnout was higher among those providing services to ALTCS-DD members through the PPCG service model.

Key informant interview responses were generally supportive of the PPCG service model. Providers welcomed the stability the PPCG model provided, noting lower turnover among parent caregivers compared to agency caregivers, which supported improved continuity of care. However, providers highlighted challenges related to the weekly 40-hour limit for parent caregivers, which often required families to hire agency caregivers or identify other family members to cover additional hours needed.

DCS CHP: Results for DCS CHP indicate generally stable or improving performance across evaluated measures. Nearly all measures with a desired direction either improved or showed no significant change between the baseline and evaluation periods, with 33 percent supporting their respective hypotheses. Access to care improved as reflected by increases in the number of members meeting time and distance network standards and the rate of children accessing preventive care visits. Conversely, rates of asthma medication management declined significantly during the evaluation period, suggesting an area of continued attention in chronic condition management.

Key informant interviews indicated that DCS CHP implemented several strategies to strengthen care coordination, including proactive assignment of care coordinators, consistent internal coordination and collaboration, and collaboration with Mercy Care and other AHCCCS plans. Stakeholders also identified several barriers, including limited integration between PH and BH providers, ongoing BH workforce shortages, and challenges associated with the unique needs of the DCS CHP member population.

H2O: Since the H2O program was recently implemented on October 1, 2024, causal impacts cannot yet be assessed. Current results reflect baseline trends among the populations of interest using data from the three years prior to implementation. Members who were determined H2O eligible were identified as the intervention group, while members who remained on the AHCCCS Housing Program (AHP) waitlist, who were not determined H2O eligible, served as the comparison group. During the baseline period, members who later participated in the H2O

program had higher rates of inpatient (IP) stays and emergent and non-emergent ED visits compared with AHP waitlist members. Costs in the baseline period among members who later participated in the H2O program were also higher than those among AHP waitlist members. The results align with AHCCCS' approach of prioritizing H2O enrollment among members with chronic PH conditions, which are expected to be predictive of members with high cost, high need conditions.

Measures relying on Closed-Loop Referral System (CLRS) data were available for the first year of the evaluation period (federal fiscal year [FFY] 2025) and assessed screening among enrolled members. Results indicate that 32 percent of H2O members received screening using the CLRS, and 83 percent of those screened had health-related social needs (HRSNs) identified. These findings suggest an opportunity to increase HRSN screening within the CLRS to better connect members with services.

Upon H2O enrollment, 97.4 percent of members received a referral to an H2O provider. Among members who received a referral, 70.2 percent accessed any H2O service. Housing pre-tenancy and tenancy services were the most commonly accessed services. Approximately 83 percent of members who left H2O in the first year had a positive or neutral exit reason.

Although differences in survey results among the H2O and AHP waitlist populations were not statistically significant, some results may have been clinically meaningful, as measured through effect sizes. Specifically, H2O members reported comparatively lower rates of stress and anxiety and higher ratings of life satisfaction when compared to AHP waitlist members. At the same time, H2O members reported lower ratings of overall health and mental or emotional health compared to AHP waitlist members.

During key informant interviews, AHCCCS reported housing investments and support services evolved during the renewal period, including the use of H2O funding to support provider hiring incentives and the integration of long-term housing supports with H2O services. Case coordinators/managers and CBOs described both positive and negative effects of H2O on downstream services, with the definition of downstream services varying across informants and interviews. Case coordinators and CBOs worked together to provide services and monitor members throughout service delivery. Key services identified included pre-tenancy, tenancy, and member support, including rental assistance, eviction prevention, and housing education, among other services.

KidsCare Eligibility Expansion: The expansion of KidsCare eligibility to children in households with incomes between 200 and 225 percent of the federal poverty level (FPL) was associated with improved enrollment continuity. During the first year of the expansion, members experienced an increase in the number of months enrolled, higher rates of re-enrollment following gaps of up to six months, and a decrease in the number of days per gap in Medicaid coverage. When pre-implementation data were not available, outcomes for the KidsCare expansion population were compared with those of the KidsCare non-expansion population. Results indicate that the expansion population had higher rates of access to well-child visits and dental care.

PQC: Compared with the pre-implementation period, overall Medicaid enrollment declined, and members who disenrolled were less likely to reenroll. Among members who re-enrolled, the number of enrollment gaps increased. However, several indicators of enrollment continuity improved during the evaluation period: a greater proportion of members completed the renewal process, individuals remained enrolled in Medicaid for more months, and gaps in coverage were shorter.

Tribal Dental Authority: Due to unavailable fee-for-service (FFS) enrollment data in FFY 2022, baseline data were not included for most Tribal Dental Authority measures and statistical testing between the baseline and evaluation periods could not be conducted. Assessment of post-implementation trends indicated that the

percentage of members with effective management of chronic conditions decreased slightly during the evaluation period, while ED utilization increased slightly.

Key informant interviews indicated that Indian Health Service (IHS) and Tribal 638 facilities reported increases in dental provider capacity following the implementation of the Tribal Dental Authority. Facilities noted that increased revenue from adult dental benefit reimbursements supported hiring additional providers and expanding service availability.

Policy Recommendations

The evaluation identified several successes attributed to the Waiver, along with key lessons learned and opportunities for improvement. To address challenges encountered during the renewal period, the State should consider the following strategies.

- **Workforce Improvement Strategies.** To address the workforce shortages, AHCCCS should consider a comprehensive approach to improving provider capacity and retention, particularly in rural areas. Potential strategies could include LTSS and BH providers serving the pediatric population, and continued expansion of reimbursable provider roles, similar to what was done for the H2O program.
- **Data Sharing and Interoperability.** Improvements to care coordination could be supported through stronger data sharing and interoperability standards. Ensuring the availability of transition data, such as admission, discharge, and transfer alerts and discharge summaries, may improve care coordination across providers. In addition, promoting the use of CLRS, where not already implemented, could strengthen transitions for specialty care among vulnerable populations. For DCS CHP specifically, establishing clearer guidance regarding what health information may be shared and with which stakeholders may improve operational efficiency.
- **Risk Tiered- Care Coordination as a Standard.** Although plans reported targeting care coordination to high-risk populations, implementing a standardized, risk-tiered care coordination framework across all AHCCCS programs could help ensure members receive appropriate and timely care. Leveraging available electronic health record (EHR) data to identify member needs and utilization patterns may help direct care coordination resources to members with the greatest needs.
- **Member Data Infrastructure.** Outdated, incomplete, and/or missing member contact information created challenges for outreach and coordination. To mitigate these barriers, AHCCCS could implement periodic contact verification processes and support cross-system updates to member contact information when feasible. ACC-RBHA plans reported distributing cell phones to members to help maintain reliable contact information. Similar approaches could be considered for other member populations to improve outreach.
- **Transportation Reliability.** Addressing non-emergency medical transportation (NEMT) challenges could improve timely access to care, particularly for members with complex needs. Potential strategies could include updating NEMT rates, establishing on-time performance standards, and piloting ride-share programs with appropriate clinical safeguards. Additional efforts to strengthen rural NEMT capacity through targeted incentive programs may further improve access to care for members struggling to get to appointments.

1. Background

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- Reentry[25,26]
- Targeted Investments (TI) 2.0[27]
- Tribal Dental Authority
- Traditional Health Care Practices (THCP)[28,29]

17 Centers for Medicare & Medicaid Services. Approved Amended Evaluation Design. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hcccs-demon-apprvl-amndmn-eval-desdn.pdf. Accessed on: Mar 12, 2026.

18 ALTCS was amended on February 16, 2024, to include Parents as Paid Caregivers.

19 Centers for Medicare & Medicaid Services. Demonstration Approval–CHIP Expansion and Parents as Paid Caregivers Amendment. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-dmns-pdftn-aprvl-chip-expn-prnts-paid-crgvrs-amndmnt.pdf. Accessed on: Mar 4, 2026.

20 Centers for Medicare & Medicaid Services. Former Foster Care Youth Amendment Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-ffcy-appvl-06132025.pdf. Accessed on: Mar 5, 2026.

21 The Former Foster Care Youth amendment is excluded from this report and is pending an Evaluation Design.

22 H2O was implemented on October 1, 2024.

23 NMT is excluded from this report.

24 Centers for Medicare & Medicaid Services. Reentry and NMT Amendment Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-dmnstrn-apprvl-12272024.pdf. Accessed on: Mar 5, 2026.

25 Ibid.

26 Reentry is excluded from this report and is pending an Evaluation Design.

27 TI 2.0 is being evaluated separately under a CMS-approved Evaluation Design by another independent evaluator.

28 Centers for Medicare & Medicaid Services. Traditional Health Care Practices Amendment Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-dmnstrn-apprvl-10162024.pdf. Accessed on: Mar 5, 2026.

29 THCP is excluded from this report but will be included in the Summative Evaluation Report. The THCP Evaluation Design was submitted to CMS on January 29, 2026.

The following section outlines the history and implementation of the Waiver, including its goals and the demographics of members impacted, in accordance with the Special Terms and Conditions (STCs) and CMS guidance.[30,31]

Historical Background of Arizona's 1115 Demonstration Waiver

AHCCCS was implemented in 1982 under a Section 1115 Waiver and is one of the longest running Waivers in the country. Arizona was the first state to implement Medicaid through a statewide managed care model, which remains the foundation of its delivery system today. Since its inception, AHCCCS has relied on the flexibility of Section 1115 authority to expand and improve its programs through numerous amendments and extensions, while maintaining its core managed care model to deliver high-quality health care statewide.

The original AHCCCS Acute Care program established a statewide managed care system covering acute care services and up to 90 days post-hospital skilled nursing facility (SNF) care. All individuals eligible for Medicaid, as well as children in the Children's Health Insurance Program (CHIP) population, were required to enroll. As part of the AHCCCS Acute Care program, AHCCCS created two programs specifically for children with special needs. The Comprehensive Medical and Dental Program (CMDP) (implemented in 1982) provided health care for children in foster care. The Children's Rehabilitative Services (CRS) program, originally created in 1929 but implemented as part of Medicaid in 1982, offered specialized services for children with significant health needs, utilizing an interdisciplinary team approach to care.[32]

Table 1-1 describes the history of the extensions of and amendments to the Waiver.

Table 1-1—History of the Waiver

Extension/Amendment/Legislation[1]	Description
Amendment in 1988	• Created the ALTCS program, a capitated long-term care program for members in the EPD and DD populations. • In 1989, ALTCS began providing acute, LTC and BH services to the Medicaid-eligible EPD population at risk of institutionalization. The program focused on supporting members in the community by covering the delivery of a wide array of HCBS.
Phase-in of BH services in 1990	• BH services were phased in over five years, beginning with children with serious emotional disabilities. • While BH services were integrated as a part of the benefit package for the ALTCS-EPD population, services were also made available to all other members and managed by ADHS DBHS. • AHCCCS entered into managed care contracts with individual BH organizations, referred to as RBHAs, to deliver BH services.

30 Centers for Medicare & Medicaid Services. Approved Amended Evaluation Design. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hcccs-demon-apprvl-amndmn-eval-desdn.pdf. Accessed on: Mar 12, 2026.

31 Centers for Medicare & Medicaid Services. Evaluation Design and Reporting for Section 1115 Demonstrations. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/section-1115-demo-eval-design-reporting.pdf. Accessed on: Mar 12, 2026.

32 Arizona Health Care Cost Containment System, "What is a Children's Rehabilitative Services (CRS) Designation?" Available at https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/CRS.html. Accessed on: Mar 12, 2026.

Extension/Amendment/Legislation[1]	Description
Proposition 204 in 2001	• Expanded Arizona Medicaid eligibility to childless adults with incomes up to 100% of the FPL. • Enrollment for these members was frozen in 2011 as a cost-containment measure to address budget deficits.
HIFA established in 2003	• Established an eligibility program for parents of CHIP children with household incomes up to 100% of the FPL. • The HIFA program was eliminated in 2009.
Medicaid expansion under the ACA in 2013	• Effective January 2014, Arizona implemented the ACA. • Expanded Medicaid eligibility included children up to 133 percent of the FPL, childless adults up to 100 percent of the FPL, and adults up to 133 percent of the FPL.
Waiver extension (2016)[2]	• Approved on September 30, 2016, and effective October 1, 2016, to September 30, 2021. • Allowed AHCCCS to continue providing many of the existing Waiver initiatives like the statewide mandatory managed care, provision of HCBS in ALTCS, and integrated PH and BH plans for individuals with an SMI designation.
Temporary waiver extension (2021)[3]	• Approved on September 30, 2021. • Extended the Waiver through September 30, 2022.
Temporary waiver extension (2022)	• Approved on September 27, 2022. • Extended the Waiver through October 28, 2022.
Waiver extension (2022)[4]	• Approved on October 14, 2022, and effective through September 30, 2027. • Allowed AHCCCS to continue many existing Waiver initiatives. • Authorized payment to participating IHS facilities and tribal facilities operating under the ISDEAA for services previously covered under the State plan.[5] • Enacted the TI 2.0 program, requiring MCOs to make specific incentive payments to providers with the goal of improving health equity for targeted populations through addressing HRSNs. • Authorized the H2O amendment to cover services such as member outreach, pre-tenancy and tenancy supports, move-in supports, short term rental assistance, and enhanced shelter services.

[1]Arizona Health Cost Containment System. A Brief History of AHCCCS Highlights. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/ABriefHistoryOfAHCCCS.pdf. Accessed on: Mar 12, 2026.

[2]Arizona Health Care Cost Containment System. Arizona Section 1115 Demonstration Waiver. Available at: https://www.azahcccs.gov/Resources/Federal/waiver.html. Accessed on: Mar 12, 2026.

[3]Centers for Medicare & Medicaid Services. Waiver extension [letter] September 30, 2021. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-temp-extension-approval-letter.pdf. Accessed on: Mar 12, 2026.

[4]Centers for Medicare & Medicaid Services. Waiver extension and Health and Housing Opportunities Amendment Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-ca-10142022.pdf. Accessed on: Mar 12, 2026.

[5]This component of the waiver extension is not included in this evaluation.

Note: ACA: Affordable Care Act; ADHS: Arizona Department of Health Services; AHCCCS: Arizona Health Cost Containment System; ALTCS: Arizona Long Term Care System; BH: behavioral health; CHIP: Children's Health Insurance Program; DBHS: Division of Behavioral Health Services; DD: developmental disabilities; EPD: elderly and/or have physical disabilities; FPL: federal poverty level; HCBS: home- and community-based services; HIFA: Health Insurance Flexibility and Accountability; HRSN: health-related social needs; H2O: Housing and Health Opportunities; IHS: Indian Health Services; ISDEAA: Indian Self-Determination and Education Assistance Act; LTC: long-term care; MCO: managed care organization; PH: physical health; RBHA: Regional Behavioral Health Agreement; SMI: serious mental illness; TI: Targeted Investments.

Prior to and during the Waiver renewal period, AHCCCS took steps to integrate physical health (PH) and behavioral health (BH) coverage. In 2013, most AHCCCS members received PH services through Acute Care health plans, while BH services were provided by RBHAs. The only group receiving integrated care at that time was the ALTCS-elderly and/or have physical disabilities (EPD) population. Table 1-2 describes the timeline of the integration of PH and BH coverage.

Table 1-2—PH and BH Coverage Timeline

Year	Description
2013	• Integration of CRS program and award of the RBHA contract for MMIC.
2014	• Effective in April, MMIC began providing integrated PH and BH coverage for individuals with an SMI in Maricopa County.
2015	• In October, RBHA contractors statewide began providing integrated care for their members with an SMI.[1]
2018	• On October 1, AHCCCS enacted its largest care integration initiative by transitioning all acute care members without an SMI designation to seven ACC integrated health plans, which provided integrated coverage for PH and BH services.
2019	• On October 1, AHCCCS began providing partially integrated coverage for all ALTCS members enrolled with DES/DDD. Under the DDD model, members received integrated care, but this care was subcontracted by DDD, who provided the LTSS.
2021	• On April 1, AHCCCS integrated coverage for children in the custody of DCS and replaced CMDP with CHP.
2022	• Effective October 1, RBHA contracts were renamed and updated to ACC-RBHA, aligning ACC contracts with RBHA services. Similar to legacy RBHA contracts, under ACC-RBHA, individuals with an SMI designation received both PH and BH services under one plan. GSAs for ACC-RBHA were aligned to match previous ACC and ALTCS GSAs.[2]

[1]Arizona Health Care Cost Containment System. Draft Quality Strategy, Assessment and Performance Improvement Report. July 1, 2018. Available at: https://www.azahcccs.gov/PlansProviders/Downloads/DraftQualityStrategyJuly2018.pdf. Accessed on: Mar 12, 2026.

[2]Arizona Health Care Cost Containment System. ACC-RBHA/TRBHA Map. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/behavioralhealth.html. Accessed on: Mar 12, 2026.

Note: ACC: AHCCCS Complete Care; ALTCS: Arizona Long Term Care System; BH: behavioral health; CHP: Comprehensive Health Plan; CMDP: Comprehensive Medical and Dental Program; DCS: Department of Child Safety; DES/DDD: Department of Economic Security/Division of Developmental Disabilities; GSA: geographic service area; LTSS: long-term services and supports; MMIC: Mercy Maricopa Integrated Care; PH: physical health; RBHA: Regional Behavioral Health Agreement; SMI: serious mental illness.

With Arizona's implementation of the Affordable Care Act (ACA) on January 1, 2014, individuals applying for Medicaid coverage became eligible for retroactive coverage for up to three months prior (the prior quarter) to the month of the application, provided they met Medicaid eligibility requirements during that time. On January 18, 2019, CMS approved Arizona's request to amend the Waiver to waive PQC retroactive eligibility.[33] Under this amendment, AHCCCS was allowed to limit retroactive coverage to the month of application, consistent with AHCCCS' historical waiver authority prior to the ACA. The terms of the amendment allowed AHCCCS to implement the PQC waiver no earlier than April 1, 2019, with an effective date of July 1, 2019. The Waiver applied to all Medicaid members except pregnant women, women who are 60 days or less postpartum, infants, and children under 19 years of age.

[33] Centers for Medicare & Medicaid Services. *CMS Approval Letter*. Jan 18, 2019. Available at: https://www.azahcccs.gov/Resources/Downloads/CMSApprovalLetter.pdf. Accessed on: Mar 17, 2026.

The current Waiver builds on this history and reflects Arizona's focus on long-term sustainability, population-focused innovation, and delivery system improvement. The current Waiver includes new components such as the H2O program and expanded caregiver support policies. These changes highlight AHCCCS' commitment to addressing the needs of its populations while maintaining budget neutrality.

COVID-19 PHE

On March 13, 2020, the President of the United States declared the coronavirus disease 2019 (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"). This declaration authorized the United States Department of Health and Human Services (HHS) to enhance states' ability to respond to the COVID-19 public health emergency (PHE), including the authority to temporarily waive or modify Medicaid and CHIP requirements under Section 1135 of the Social Security Act.

During the COVID-19 PHE, HHS granted states the flexibility to modify Medicaid and CHIP policies to address health care needs resulting from the pandemic and to mitigate disruptions in care for AHCCCS members. These temporary "flexibilities" were implemented through various legal authorities, including Section 1135 waivers (established to address PHEs), Appendix K amendments to Section 1115 waivers, and State Plan Amendments (SPAs).[34,35]

AHCCCS' response included streamlining provider enrollment and preadmission screening for Medicaid-certified nursing facilities, ensuring continuous eligibility for enrolled members, waiving premiums and co-payments, reimbursing COVID-19 testing, and expanding respite care.

Program Background

ACC: On October 1, 2018, AHCCCS transitioned approximately 1.5 million members to seven health plans providing coverage for both PH and BH services. By combining PH and BH services under a single health plan, providers are better able to facilitate care coordination and achieve better health outcomes. ACC plans are responsible for delivering integrated PH and BH services to the following populations:

1. Adults determined not to have a serious mental illness (SMI), excluding members enrolled with the Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD).
2. Children, including those with special health care needs (SHCN), excluding members enrolled with DES/DDD and DCS CHP.
3. Members determined to have an SMI who opt out of their RBHA and transfer to an ACC for the provision of PH services.[36]

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34 Centers for Medicare & Medicaid Services. Section 1135 Waiver Flexibilities – Arizona Coronavirus Disease 2019. Available at: https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/100221. Accessed on: Mar 12, 2026.

35 Centers for Medicare & Medicaid Services. Arizona State Plan Amendment #20-0014. Available at: https://www.medicaid.gov/medicaid/spa/downloads/AZ-20-0014.pdf. Accessed on: Mar 12, 2026.

36 Arizona Health Care Cost Containment System. AHCCCS Contractor Operations Manual: Opt Out Request for a Member With a Serious Mental Illness Designation. Available at: https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/442.pdf. Accessed on: Mar 12, 2026.

Seven ACC contracts were awarded to health plans across three geographical service areas (GSAs). All seven plans serve the Central GSA (Maricopa, Pinal, and Gila counties); two plans serve the North GSA (Coconino, Yavapai, Mohave, Navajo, and Apache counties); and two plans serve the South GSA (Cochise, Greenlee, Graham, La Paz, Pima, Santa Cruz, and Yuma counties), with an additional plan operating in Pima County.[37]

On November 26, 2018, AHCCCS submitted an amendment request to the STCs of its previously approved Section 1115 Demonstration Waiver to "reflect delivery system changes that resulted from the ACC managed care contract award."[38] Effective October 1, 2022, AHCCCS updated its contracts with ACC health plans to include RBHA responsibilities for members with an SMI designation, called ACC-RBHAs. Following this update, four plans serve only the ACC population, while three plans assume RBHA responsibilities to serve both the ACC and SMI populations.

ACC-RBHA: Historically, adult members received BH services through a geographically designated RBHA contracted with AHCCCS, with few exceptions. BH services were covered separately from PH services. To improve care coordination, health outcomes, and program efficiencies, AHCCCS took its first step toward integrated care by awarding a single health plan the RBHA contract for Maricopa County, effective April 2014. The contract required the RBHA to add PH services for the SMI population it already covered for BH services.

In October 2015, RBHA contractors statewide began providing integrated care for members with an SMI.[39] AHCCCS implemented its largest integration initiative in 2018 by transitioning all acute care members without an SMI designation to seven ACC integrated health plans that provided both PH and BH coverage.

Effective October 1, 2022, the RBHA contracts expired and were replaced with an integrated health system, ACC-RBHA, a program that combined ACC contracts with RBHA responsibilities. Three health plans were awarded ACC-RBHA contracts: Mercy Care in the Central GSA, Arizona Complete Health—Complete Care Plan in the South GSA, and Care1st Health Plan in the North GSA. Under the ACC-RBHA structure, individuals with an SMI designation receive both PH and BH benefits through a single health plan. Additionally, the ACC-RBHA GSAs align with the existing ACC and ALTCS GSAs.[40]

ALTCS: In 1988, Arizona's original Section 1115 Demonstration Waiver was amended to allow the State to implement the ALTCS program, a long-term care (LTC) program for members who are elderly or have a physical or intellectual disability. ALTCS provides PH services, long-term services and supports (LTSS), BH services, and home- and community-based services (HCBS) to Medicaid members at risk for institutionalization. ALTCS is a managed care program administered separately from the AHCCCS Acute Care Program (AACP) and provides services through prepaid, capitated arrangements with managed care organizations (MCOs). ALTCS members with intellectual disabilities are served through a statewide MCO operated by DES/DDD. ALTCS aims to ensure

37 Arizona Health Care Cost Containment System. AHCCCS Complete Care: The Future of Integrated Healthcare. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/AHCCCSCompleteCare/. Accessed on: Mar 12, 2026.

38 Arizona Health Care Cost Containment System. AHCCCS Complete Care Technical Clarification [email]. November 26, 2018. https://www.azahcccs.gov/Resources/Downloads/ACC_TechnicalAmendmentCorrection_11262018.pdf. Accessed on: Mar 12 ,2026.

39 Arizona Health Care Cost Containment System. Behavioral Health, AHCCCS Complete Care (ACC) Began October 1, 2018. Available at: https://www.azahcccs.gov/Members/BehavioralHealthServices/. Accessed on: Mar 12, 2026.

40 Arizona Health Care Cost Containment System. *ACC-RBHA/TRBHA Map.* Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/behavioralhealth.html. Accessed on: Mar 12, 2026.

that members live in the least restrictive, most integrated settings possible and are actively engaged with and participating in their communities.

Under the Waiver renewal, the ALTCS program aims to provide quality health care to members with LTSS needs, ensuring access to care and maintaining or improving member satisfaction while continuing to operate as a cost-effective managed care delivery model. The Waiver extension allows the new authority to accept verbal consent in lieu of a 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. This authority was temporarily granted to AHCCCS under its Section 1135 Demonstration Waiver to ensure a reliable and timely process for ALTCS members to obtain prompt authorization of critically needed health services while reducing the risk of COVID-19 transmission or infection through the document signature process. Following communication with community stakeholders, AHCCCS requested that this authority be continued following the termination of the COVID-19 PHE. In addition to the authority allowed by the Waiver, the simultaneous extension of the Appendix K authority impacted ALTCS members. The extension of Appendix K allowed for the provision of personal care in acute care hospitals and included coverage for home-delivered meals for the subset of the ALTCS population that serves individuals with intellectual disabilities.

On February 16, 2024, CMS approved an amendment to the ALTCS program, authorizing the Parents as Paid Caregivers (PPCG) service delivery model, which was initially approved under Appendix K authority on April 6, 2020, to address workforce shortages during the COVID-19 PHE. [41] PPCG allows legally responsible parents to be reimbursed for providing direct care to their minor children enrolled in ALTCS up to 40 hours a week.[42] Additionally, CMS approved Extended Family Support Services (EFSS) to help primary caregivers and families adjust to members' disabilities and navigate significant life transitions within the health care system. The EFSS will be available to ALTCS members residing at home once the service is developed and implemented.

DCS CHP: On April 1, 2021, AHCCCS integrated PH and BH by replacing CMDP with Mercy Care DCS CHP. The goal of this integration was to simplify health care coverage and improve care coordination for foster children. DCS CHP operates as a single acute health plan under contract with AHCCCS for children who are Medicaid-eligible and in DCS custody. DCS CHP provides PH, BH, and dental services for children under the purview of DCS placed in foster homes, with a relative, in a certified adoptive home prior to the entry of the final order of adoption, in independent living programs, or in the custody of a probation department and placed in out-of-home care. Through the Waiver extension, the DCS CHP program seeks to provide quality health care to eligible foster children, ensuring access to care, maintaining and improving member satisfaction, and operating a cost-effective managed care delivery model.

H2O: Prior to the implementation of the H2O program, AHCCCS plans operated a Permanent Supportive Housing (PSH) Program designed to assist AHCCCS members with SMI experiencing homelessness access a

41 Arizona Health Care Containment System. CMS Amendment Approval: PPCG and KidsCare Expansion. Available at: https://www.azahcccs.gov/Resources/Downloads/Federal/AZ_AHCCCS_PPCG_CHIP_ExpansionApprovalLetter.pdf. Accessed on: Mar 12, 2026.

42 The 40 hour weekly maximum was not implemented until June 2025.

supportive housing subsidy and support services.[43,44] Housing subsidies, combined with integrated wraparound services and housing tenancy support, help ensure members secure and maintain stable housing while simultaneously addressing their health and service needs. In state fiscal year (SFY) 2020, AHCCCS determined that the PSH model decreased emergency department (ED) visits, inpatient (IP) admissions, and BH residential facility admissions, as well as reduced per-member per-month (PMPM) costs. In 2021, AHCCCS awarded the Statewide Housing Administrator (SHA) the contract to operate the AHCCCS Housing Program subsidies, while the provision of supportive services remained the responsibility of the RBHA MCOs.

On May 26, 2021, AHCCCS applied for the H2O amendment to the Waiver to address continuing gaps in Arizona's housing delivery system, including increasing PSH availability and expanding services.[45] On October 14, 2022, CMS approved the H2O amendment to the Waiver, effective October 14, 2022, through September 30, 2027. The program was officially implemented on October 1, 2024. The H2O program is enhancing and expanding housing services and interventions for members with an SMI and those who are homeless or at risk of becoming homeless, who have either a chronic physical health condition or are involved with the justice system. This program ensures members attain safe housing and integrated services.[46] The H2O program aims to achieve its goals through three core strategies:

1. Strengthening homeless outreach and service engagement.
2. Securing housing funding for members who are homeless or at risk of homelessness.
3. Enhancing wraparound services and supports to ensure housing stability for improved health outcomes, reduced recidivism, and reduced decompensation.

Under the H2O program, housing administrative functions are subcontracted to a single statewide H2O-Program Administrator (H2O-PA). The H2O-PA provides oversight for H2O health-related social needs (HRSN) interventions and assists plans with care coordination for members. Services covered under the H2O program include outreach and education services, transitional housing services, one-time transition and moving costs, and housing pre-tenancy and tenancy services. AHCCCS' strategy utilizes evidence-based PSH practices to improve health outcomes for target members; reduce the cost of care for housed members; decrease homelessness; strengthen members' skills to maintain housing stability; and integrate, support, and leverage existing AHCCCS and community initiatives, programs, and expertise to ensure a full continuum of services and supports.

KidsCare Eligibility Expansion: On November 1, 1999, KidsCare, Arizona's version of the CHIP, began.[47] Starting in 2010, Arizona made several changes to its coverage programs for children. Following major State

43 Arizona State University Morrison Institute for Public Policy. Housing is Health Care: The Impact of Supportive Housing on the Costs of Chronic Mental Illness. Available at: https://morrisoninstitute.asu.edu/sites/g/files/litvpz841/files/housing_is_health_care_report_2021.pdf. Accessed on: Mar 12, 2026.

44 Arizona Health Care Cost Containment System. AHCCCS Treatment and Housing Continuum. Available at: https://www.azahcccs.gov/Resources/Downloads/SystemOversiteStructure/HousingandTreatmentContinuum.pdf. Accessed on: Mar 12, 2026.

45 Centers for Medicare and Medicaid Services. Amendment Application – Housing and Health Opportunities Amendment. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-pa9.pdf. Accessed on: Mar 12, 2026.

46 A member is considered justice-involved if they are currently in a correctional facility with a release date scheduled within 90 days or were released from a correctional facility in the last 90 days.

47 Arizona Health Care Cost Containment System. A Brief History of AHCCCS Highlights. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/ABriefHistoryOfAHCCCS.pdf. Accessed on: Mar 12, 2026.

budget cuts, KidsCare enrollment was frozen in January 2010.[48] In May 2012, enrollment opened for KidsCare II, a time-limited alternative CHIP program for children up to 175 percent of the federal poverty level (FPL). KidsCare II reached its capacity of 25,000 members in September 2012, with enrollment reopening in November 2012. In May 2013, KidsCare II increased the eligibility limit to 200 percent of the FPL due to the ACA's alignment of Medicaid eligibility for children at 138 percent of the FPL. The majority of KidsCare members were transitioned to Medicaid on January 1, 2014.[49] KidsCare ended on January 31, 2013, and the KidsCare enrollment freeze continued until 2016. On February 16, 2024, CMS approved an amendment to Arizona's Section 1115 Waiver expanding KidsCare eligibility from 200 percent of the FPL up to and including 225 percent of the FPL. AHCCCS initially sought to expand KidsCare through a State Plan Amendment (SPA); however, AHCCCS maxed out eligibility levels using Title XXI funding. As a result, AHCCCS applied for a Waiver amendment to increase KidsCare eligibility. The approved amendment allows AHCCCS to further expand eligibility up to 300 percent of the FPL, subject to State legislature approval. This expansion is expected to make approximately 9,700 additional children under 19 years of age eligible for KidsCare.[50]

PQC: On January 18, 2019, CMS approved Arizona's request to amend the Waiver to allow the State to waive PQC retroactive eligibility.[51] The renewal continues this authorization, allowing AHCCCS to limit retroactive coverage for all Medicaid members to the first day of the month of application, excluding pregnant women, women who are less than 60 days postpartum, and children under 19 years of age. Pregnant women, women less than 60 days postpartum, and children under 19 years of age remain eligible for Medicaid coverage for up to three months prior to the month in which their application was submitted.

The waiver of retroactive coverage is consistent with AHCCCS' historical practice prior to January 2014.[52] The PQC waiver was designed to promote continuity of care and discourage coverage gaps that can occur when individuals wait until they experience medical emergencies to apply for Medicaid. The PQC waiver also allows AHCCCS to evaluate the progress toward the Waiver's goals of promoting continuity of care and personal responsibility by encouraging members to maintain continuous coverage and reducing gaps when members "churn" (individuals moving on and off Medicaid repeatedly), thereby improving health outcomes, reducing costs to AHCCCS, and supporting long-term sustainability of the Medicaid program.

Tribal Dental Authority: Since the 2016 legislative session, Arizona has worked to restore limited dental coverage for benefits that were eliminated during the Great Recession. In 2016, the Arizona Legislature authorized AHCCCS to provide a limited dental benefit of $1,000 per contract year for members enrolled in

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48 Georgetown University Health Policy Institute Center for Children and Families. Children's health Coverage in Arizona: A Cautionary Tale for the Future of the Children's Health Insurance Program (CHIP). Available at: https://ccf.georgetown.edu/wp-content/uploads/2015/01/Childrens-Coverage-in-Arizona-A-Cautionary-Tale-for-the-Future-of-Childrens-Health-Insurance-Program.pdf. Accessed on: Mar 12, 2026.

49 Georgetown University Health Policy Institute Center for Children and Families. Dismantling CHIP in Arizona: How Losing KidsCare Impacts a Child's Health Care Costs. Available at: https://www.kff.org/wp-content/uploads/sites/2/2014/05/dismantling-chip-in-arizona.pdf. Accessed on: Mar 12, 2026.

50 Arizona Health Care Containment System. CMS Amendment Approval: PPCG and KidsCare Expansion. Available at: https://www.azahcccs.gov/Resources/Downloads/Federal/AZ_AHCCCS_PPCG_CHIP_ExpansionApprovalLetter.pdf. Accessed on: Mar 12, 2026.

51 Centers for Medicare & Medicaid Services. Approved Demonstration. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-appvd-demo-01182019.pdf. . Accessed on: Mar 12, 2026.

52 Arizona Health Care Cost Containment System. Proposal to Waive Prior Quarter Coverage. Available at: https://www.azahcccs.gov/Resources/Downloads/PriorQuarterCoverageWaiverToCMS_04062018.pdf. Accessed on: Mar 12, 2026.

ALTCS. The Governor of Arizona restored the emergency dental benefit for adult AHCCCS members in 2017 through the 2018 fiscal year budget. In 2020, the Governor and State Legislature authorized AHCCCS to request CMS approval to reimburse Indian Health Services (IHS) and Tribal 638 facilities for the cost of adult dental services that qualify for a 100 percent federal medical assistance percentage (FMAP). This applies to services that exceed AHCCCS' $1,000 emergency dental limit for adult members in the State Plan and the $1,000 dental limit for individuals 21 years of age or older enrolled in the ALTCS program.[53]

American Indians/Alaska Natives (AIs/ANs) are among the racial and ethnic groups in the United States with the poorest oral health, a disparity that is exacerbated by the geographic isolation of tribal populations and the limited number of practicing dentists in IHS or tribal health facilities in rural and frontier locations.[54] On December 21, 2020, AHCCCS applied for approval to allow the State to reimburse for dental services for AI/AN members provided in, at, or as a part of services offered by facilities and clinics operated by IHS or a tribe or tribal organization. On October 14, 2022, CMS approved the expenditure authority for medically necessary diagnostic, therapeutic, and preventive dental services for AI/AN members beyond the current $1,000 emergency dental limit for adult members in Arizona's State plan and beyond the $1,000 dental limit for individuals 21 years of age or older enrolled in ALTCS, when these services are provided by participating IHS facilities or by tribal facilities under the Indian Self Determination and Education Assistance Act (ISDEAA).[55]

The Tribal Dental Authority enables AHCCCS to improve oral health among tribal members and reduce the disproportionate number of AI/AN individuals affected by oral disease, improving members' outcomes and experience. The Waiver also provides IHS and tribal facilities with financial resources to attract more dentists to work on tribal reservations and in rural areas.

Demographics

Table 1-3 displays program enrollment from 2016 through 2024. During this period, most AHCCCS members were enrolled in ACC plans. In 2016, the ALTCS-DD and ALTCS-EPD populations were similar in size; however, by 2022 the ALTCS-DD population had grown by 31 percent, while the ALTCS-EPD population remained relatively stable. Since 2022, the ALTCS-DD population has continued to grow, reaching 44,367 in 2024. Enrollment in DCS CHP has steadily declined, dropping from 17,142 members enrolled in 2016 to 8,146 members enrolled in 2024. Among other Waiver authorities, 1,371 members who ultimately enrolled in H2O in FFY 2025 were enrolled as of 2024. The number of members considered eligible for the Tribal Dental Authority decreased slightly by 12,720 members between 2023 and 2024.

Table 1-3—Enrollment by Program

Program	2016	2017	2018	2019	2020	2021	2022	2023	2024
ACC	1,525,894	1,533,639	1,478,443	1,488,240	1,623,185	1,822,960	1,921,606	1,760,830	1,672,326
ACC-RBHA	42,020	43,146	41,806	42,532	45,020	49,057	48,984	46,460	45,692

53 Centers for Medicare & Medicaid Services. Pending Extension Application. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-pa8.pdf. Accessed on: Mar 12, 2026.

54 US Department of Health and Human Services: National Institutes of Health. Oral Health in America: Advances and Challenges. Available at: https://www.nidcr.nih.gov/sites/default/files/2021-12/Oral-Health-in-America-Advances-and-Challenges.pdf. Accessed on: Mar 12, 2026.

55 Centers for Medicare & Medicaid Services. AHCCCS Demonstration Extension Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-ca-10142022.pdf. Accessed on: Mar 12, 2026.

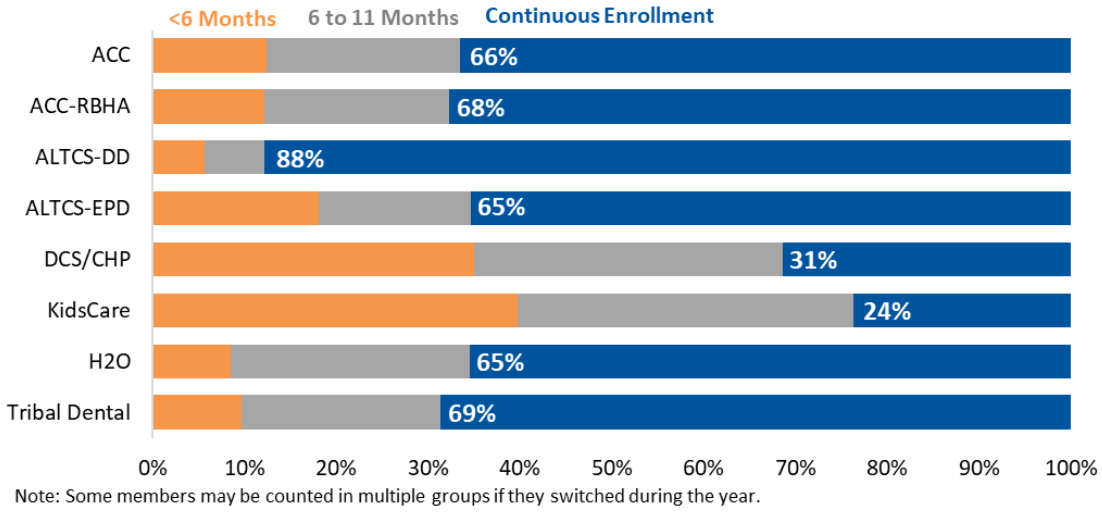
Program	2016	2017	2018	2019	2020	2021	2022	2023	2024
ALTCS-DD	29,774	31,191	32,857	34,598	36,120	37,681	38,995	41,270	44,367
ALTCS-EPD	27,086	27,496	28,401	29,520	27,677	28,186	26,275	26,408	26,320
DCS CHP	17,142	14,753	13,158	13,216	13,643	15,997	12,643	10,058	8,146
KidsCare Eligibility Expansion	–	–	–	–	–	–	–	57,759	59,952
Total*	**1,641,916**	**1,650,225**	**1,594,665**	**1,608,106**	**1,745,645**	**1,953,881**	**2,048,503**	**1,942,785**	**1,856,803**
H2O	–	–	–	–	–	–	–	–	1,371
Tribal Dental Authority	–	–	–	–	–	–	–	125,981	113,261

* Due to the fact that members can receive H2O or Tribal Dental Authority services while being enrolled in other AHCCCS programs, the Total field only includes counts for the programs listed above.

"–" indicates that enrollment data are not available because KidsCare was not under Waiver authority during the evaluation years.

Figure 1-1 shows that ACC and ACC-RBHA had high levels of continuous enrollment in federal fiscal year (FFY) 2024. In FFY 2024, 66 percent of ACC members and 68 percent of ACC-RBHA members were continuously enrolled. About a quarter of KidsCare members were continuously enrolled, while ALTCS-DD had the highest continuity overall. ALTCS-EPD had 65 percent of members continuously enrolled compared to 88 percent of ALTCS-DD members. DCS CHP had 31 percent of members continuously enrolled in FFY 2024. Members who later enrolled in H2O upon program implementation, had high levels of continuous enrollment in FFY 2024. Notably, there is substantial overlap between H2O eligible members and those enrolled in an ACC-RBHA plan. Among those eligible for the Tribal Dental benefit, 69 percent of members had continuous enrollment in FFY 2024.

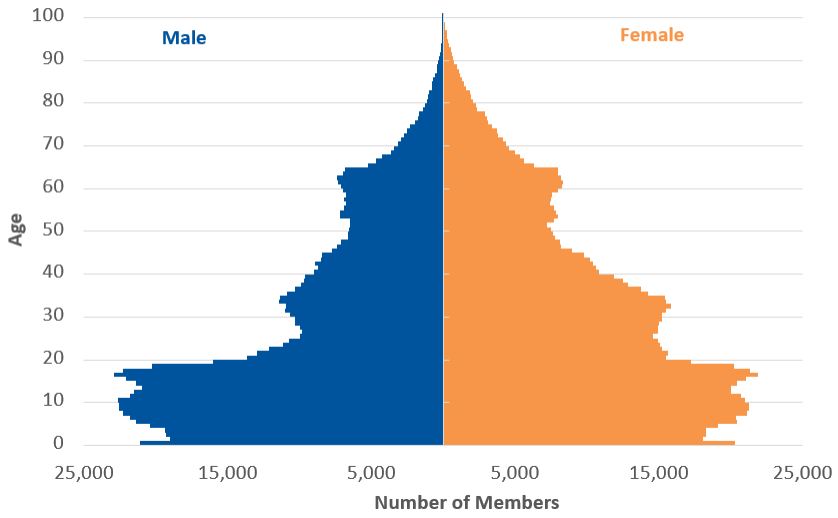
Figure 1-1—Enrollment Continuity by Program in FFY 2024



Note: Some members may be counted in multiple groups if they switched during the year.

Figure 1-2 compares the age distribution of all AHCCCS members by gender. Similar to most state Medicaid populations, children are distributed almost equally between males and females.

Figure 1-2—AHCCCS Age Distribution by Gender
Approximately 44 percent of males on AHCCCS are children compared to 37 percent for females



Previous Evaluation Report Findings

For all programs that are a continuation of the prior Waiver period (October 1, 2016, through October 28, 2022), results from the September 2024 Summative Evaluation Report, approved by CMS on November 13, 2024, indicated general improvement in health care outcomes and delivery.[56] Results from the statistical analysis of performance measure rate changes between baseline and evaluation periods generally supported the research questions. Of the 104 measures with a defined desired direction evaluated for the integration of care, 51 percent of the measures showed a change in the desired direction and supported the hypothesis, 5 percent of the measures did not support the hypothesis, and 44 percent of the measures were inconclusive. It is important to note that declines among many service-based measures were driven by the COVID-19 PHE, which may have contributed to observed declines or worsening rates, with impacts that extended beyond FFY 2020.[57]

The AHCCCS programs evaluated demonstrated substantial variability in the proportion of measures consistent with research hypotheses. In addition to the evaluation of the integration period, separate analyses were conducted to evaluate the renewal periods for the ALTCS-DD, ALTCS-EPD, and DCS CHP Waiver groups. Key findings included the following:

- Non-inferiority (NI) statistical testing revealed that the DCS CHP and ACC programs demonstrated the greatest success in maintaining or improving rates during the FFY 2017-2022 Waiver period.

[56] Arizona Health Care Cost Containment System. CMS Approved Summative Evaluation Report. Available at: https://www.azahcccs.gov/Resources/Downloads/QuarterlyProgressReports/2024/AZ_SummativeEvaluationReport.pdf. Accessed on: Mar 12, 2026.

[57] Statistical analyses included an indicator variable for FFY 2020 to control for the peak impact of COVID-19 on quantitative outcomes.

- Certain measures primarily dependent on member action that had worsened in the Interim Evaluation Report appeared to have stabilized or reversed.[58]
- The COVID-19 PHE had a profound impact on measured outcomes, particularly those related to preventive visits and access to care during the initial months and quarters of the COVID-19 PHE, as both patients and health care systems adjusted. Although some impacts persisted in the following years, findings suggest that DCS CHP and ALTCS-DD members may have been insulated from long-term effects due to maintaining routine care, particularly for dental visits and well-child visits.
- Rural members utilized telehealth at higher rates compared to their urban counterparts prior to the COVID-19 PHE but did not increase their usage to the same degree during the COVID-19 PHE. This may indicate access and technological limitations, as rural members who had capabilities to use telehealth may have already been doing so prior to the COVID-19 PHE.
- Prior to the Waiver, rural members had substantially higher rates of concurrent use of opioids and benzodiazepines. By the end of the Waiver, this gap had closed, with rates similar to those of urban members.
- Disparities in rates of cervical and breast cancer screenings narrowed among the ALTCS-EPD and developmental disabilities (DD) populations.
- Measures related to preventive care and child or adolescent well-care visits, which showed disparities within rural areas, also demonstrated disparities within AI/AN members. This may be due in part to the high proportion of AI/AN members residing in rural counties. Disparities for AI/AN members were not equal across Waiver programs. The ACC-RBHA and ALTCS-EPD groups showed rates more closely aligned with other racial categories, providing a potential framework for other Waiver programs to follow in addressing these disparities.[59]
- Measures related to management of opioid prescriptions continued to improve throughout the Waiver period. Substantial reductions were observed in the use of opioids at high dosage and concurrent use of opioids and benzodiazepines across all relevant Waiver groups, with the exception of the rate of concurrent use for the ALTCS-DD population, which was not significantly lower and remained approximately at the same level as the ALTCS-EPD population by the end of the Waiver period.

Qualitative analysis of transcripts from key informant interviews and limited focus group data provided critical context for interpreting the Waiver results. Two main points emerged from the qualitative analysis, which were originally reported in the Interim Evaluation Report and remained relevant for the Summative Evaluation Report.

First, there was a general consensus that during the planning and development phases of the Waiver, AHCCCS provided stakeholders with clear information and communication, maintaining transparency about each program's expectations and issues to be addressed. AHCCCS also facilitated collaboration among all stakeholders and encouraged health plans to work together to develop solutions for data sharing. One exception was the implementation of the DCS CHP program, where key informants described some confusion and lengthy

[58] For example, the *Percentage of adult beneficiaries who remained on an antidepressant medication treatment* (AMM) increased among the ACC population from 2019 through 2022, and the *Percentage of beneficiaries with a follow-up visit within 7 days after hospitalization for mental illness* (FUH) increased among the ACC population from 2020 through 2022.

[59] Racial data should be interpreted with caution. Measure calculations in the Summative Evaluation Report were based on encounter data, which may not capture all services rendered to AI/AN members also served under a fee-for-service system. Additionally, approximately 30 percent of racial data were classified as "unknown", which may introduce further uncertainty or bias when stratified by race.

communication processes; however, after collaboration with other involved entities, AHCCCS developed a plan forward and successfully implemented the program.

ACC focus group participants indicated that operational differences across health plans created challenges that affected providers and were particularly detrimental to smaller provider organizations. While providers generally agreed that increased competition was beneficial in the marketplace, they also noted that operational differences and flexibility allowed under health plan contracts created administrative burdens that limited progress toward AHCCCS' goals of improving integration and health care delivery.

2. Evaluation Questions and Hypotheses

The purpose of the Interim Evaluation Report is to assess whether the Arizona Health Care Cost Containment System (AHCCCS) Section 1115 Waiver Demonstration (the Waiver) is achieving the goals described in the Background section. This section outlines each program's logic model, hypotheses, and research questions, which were designed to evaluate progress toward those goals.[60] The logic models presented below depict how the Waiver components, programs, and policy changes interact and affect the populations covered by AHCCCS. A complete list of measures and their specifications is available in the Evaluation Design linked in the Appendix.

ACC

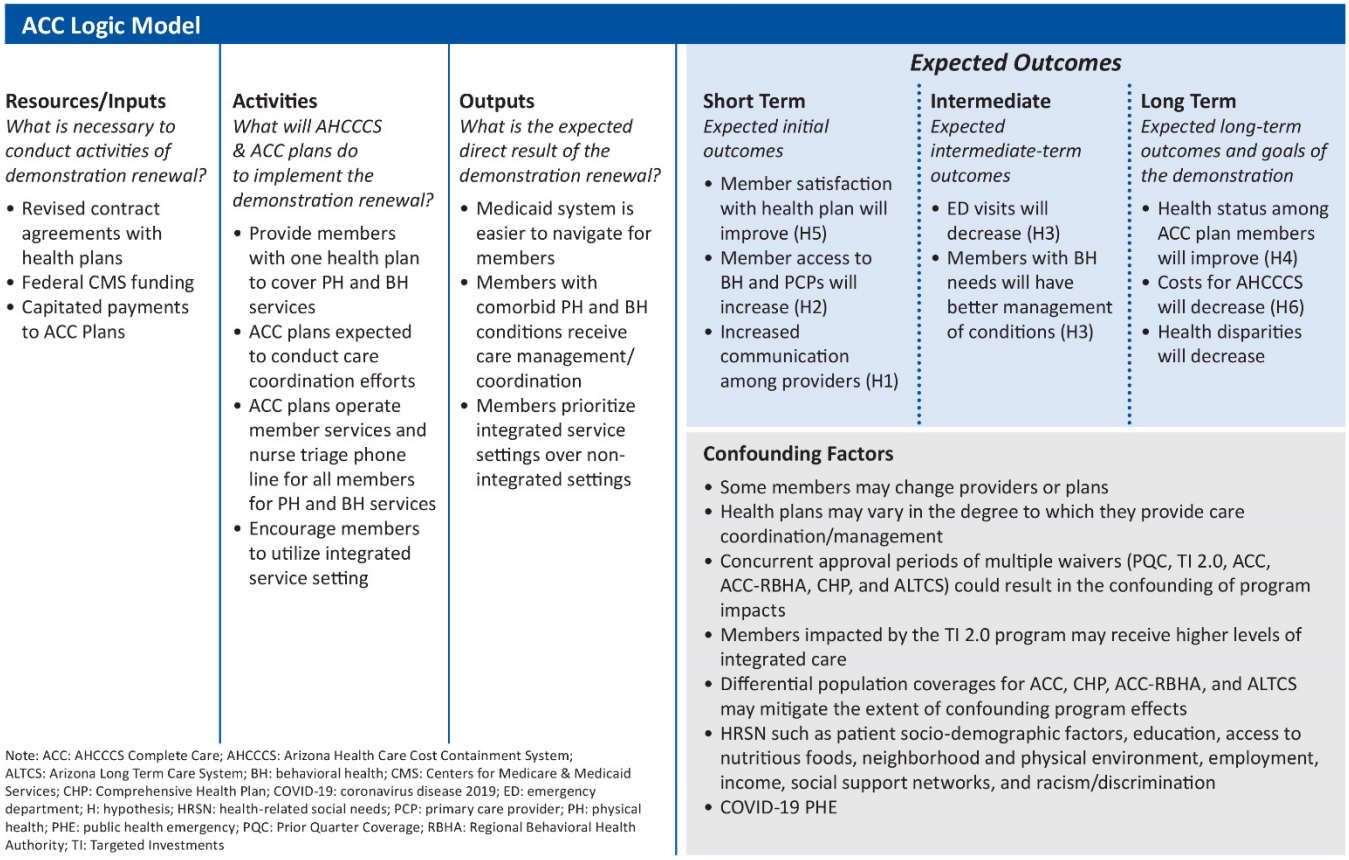
Logic Model

Figure 2-1 illustrates that AHCCCS Complete Care (ACC) members, including the ACC population served by three AHCCCS Complete Care-Regional Behavioral Health Agreement (ACC-RBHA) plans, should expect to find the Medicaid system easier to navigate. ACC members with both physical health (PH) and behavioral health (BH) conditions will receive effective care coordination and will prefer providers offering integrated services over those offering non-integrated services.[61] A more streamlined Medicaid system should lead to higher member satisfaction. Improved care coordination/management are expected to enhance health outcomes for members with complex needs, initially reflected by increased access to care and reduced emergency department (ED) utilization. Over time, these improvements are anticipated to support better overall health and well-being while providing cost-effective care. Hypotheses associated with these outcomes are denoted in parentheses in the logic model.

[60] Centers for Medicare & Medicaid Services. Approved Evaluation Design. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-cms-aprvd-amndmnd-evlutn-dsgn.pdf. Accessed on: Mar 12, 2026.

[61] Care provided to members with a serious mental illness (SMI) was evaluated in a separate component dedicated to the impacts of ACC-RBHA plans on this population.

Figure 2-1—ACC Logic Model



Note: ACC: AHCCCS Complete Care; AHCCCS: Arizona Health Care Cost Containment System; ALTCS: Arizona Long Term Care System; BH: behavioral health; CMS: Centers for Medicare & Medicaid Services; CHP: Comprehensive Health Plan; COVID-19: coronavirus disease 2019; ED: emergency department; H: hypothesis; HRSN: health-related social needs; PCP: primary care provider; PH: physical health; PHE: public health emergency; PQC: Prior Quarter Coverage; RBHA: Regional Behavioral Health Authority; TI: Targeted Investments

Hypotheses and Research Questions

To comprehensively evaluate the ACC program, six hypotheses were tested using 16 research questions. Table 2-1 lists the six hypotheses and associated research questions.

Table 2-1—ACC Hypotheses and Research Questions

Hypothesis	Research Question(s)
Hypothesis 1: Health plans encourage and/or facilitate care coordination among PCPs and BH practitioners.	• **RQ 1.1:** What care coordination strategies or activities have ACC plans been conducting during the renewal period? • **RQ 1.2:** What care coordination strategies or activities have providers been conducting during the renewal period? • **RQ 1.3:** Did care coordination strategies improve or maintain patient engagement and follow up care after an IP stay or ED visit during the renewal period? • **RQ 1.4:** Do members perceive their doctors to have better care coordination as a result of ACC renewal?
Hypothesis 2: Member access to appropriate care for routine medical conditions will be maintained or improved during the renewal period.	• **RQ 2.1:** Do members enrolled in an ACC plan have the same or better access to primary care services compared to prior to the renewal period? • **RQ 2.2:** Do members enrolled in an ACC plan have the same or better access to substance abuse treatment compared to prior to the renewal period?

Hypothesis	Research Question(s)
Hypothesis 3: Quality of care will be maintained or improved during the renewal period.	• **RQ 3.1:** Do members enrolled in an ACC plan have the same or higher rates of appropriate immunizations compared to prior to the renewal period? • **RQ 3.2:** Do members enrolled in an ACC plan have the same or better management of chronic conditions compared to prior to the renewal period? • **RQ 3.3**: Do members enrolled in an ACC plan have the same or better management of BH conditions compared to prior to the renewal period? • **RQ 3.4:** Do members enrolled in an ACC plan have the same or better management of opioid prescriptions compared to prior to the renewal period? • **RQ 3.5:** Do members enrolled in an ACC plan have equal or lower ED or hospital utilization compared to prior to ACC renewal?
Hypothesis 4: Member self-assessed health outcomes will be maintained or improved during the renewal period.	• **RQ 4.1:** Do members enrolled in an ACC plan have the same or higher overall health rating compared to prior to the renewal period? • **RQ 4.2:** Do members enrolled in an ACC plan have the same or higher overall mental or emotional health rating compared to prior to the renewal period?
Hypothesis 5: Member satisfaction with their health care will be maintained or improved during the renewal period.	• **RQ 5.1:** Are members equally or more satisfied with their health care as a result of integrated care during the renewal period?
Hypothesis 6: The ACC program provides cost-effective care.	• **RQ 6.1:** What are the costs associated with the integration of care under ACC during the renewal period? • **RQ 6.2:** What are the benefits/savings associated with the integration of care under ACC during the renewal period?

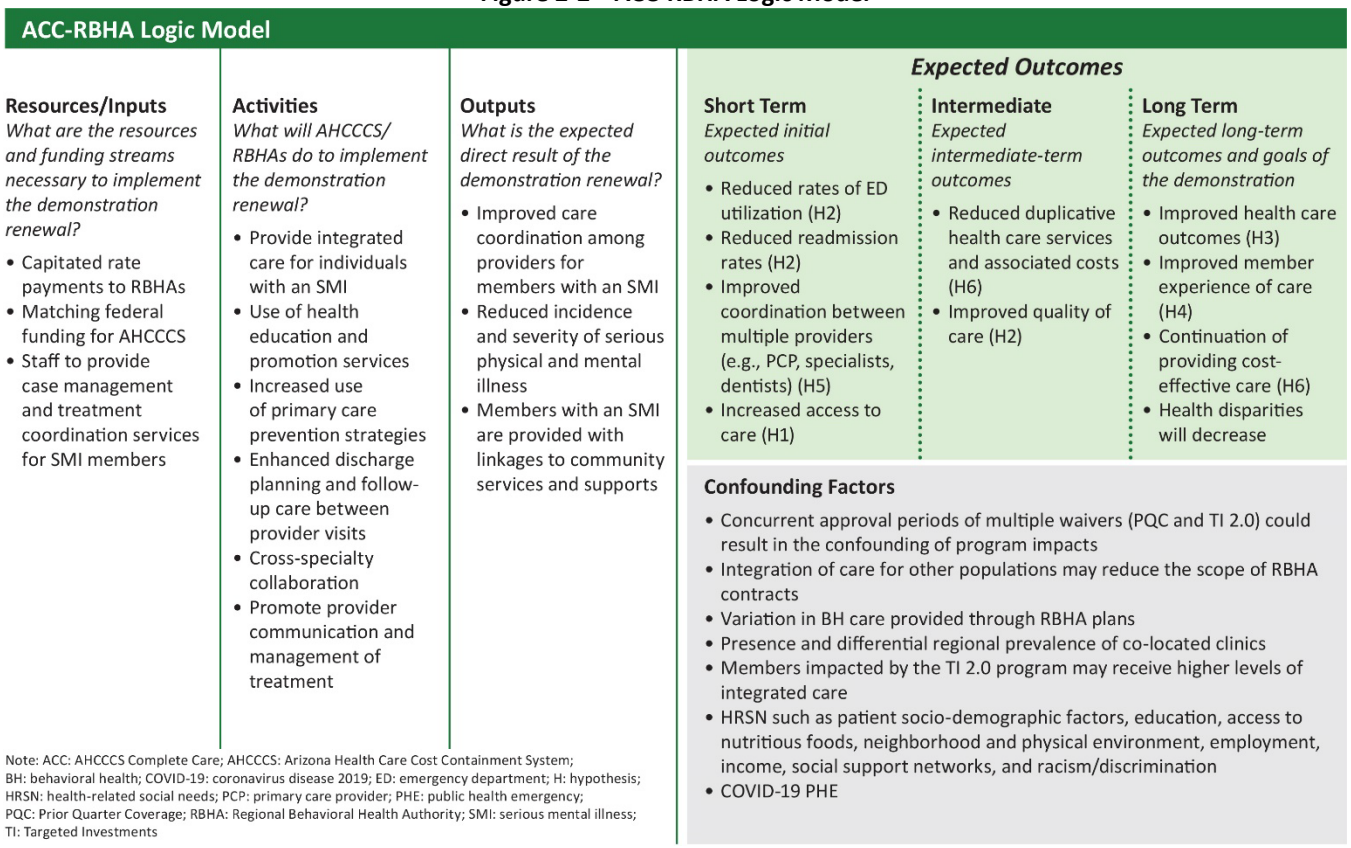
Note: ACC: AHCCCS Complete Care; BH: behavioral health; ED: emergency department; IP: inpatient; PCP: primary care provider; RQ: research question.

ACC-RBHA

Logic Model

Figure 2-2 illustrates that with continued resources to fund the ACC-RBHA program, adult members with an SMI are expected to continue receiving care coordination/management. Their providers should follow enhanced discharge planning guidelines and engage in cross-specialty collaboration to promote communication among providers. Through integration of PH and BH services, member satisfaction is anticipated to be maintained or improved during the Waiver period. With improved care coordination/management, members should experience equal or better access to care and reduced ED utilization, resulting in equal or improved health outcomes, overall health, and satisfaction with their health care experiences. Over time, these efforts are expected to improve members' health and well-being while providing cost-effective care. Hypotheses associated with these outcomes are denoted in parentheses in the logic model.

Figure 2-2—ACC-RBHA Logic Model



Hypotheses and Research Questions

To comprehensively evaluate the ACC-RBHA program, six hypotheses were tested using 18 research questions. Table 2-2 lists the six hypotheses and associated research questions.

Table 2-2—ACC-RBHA Hypotheses and Research Questions

Hypothesis	Research Question(s)
Hypothesis 1: Member access to appropriate care for routine medical conditions will be maintained or improved during the renewal period.	• **RQ 1.1:** Do adult members with an SMI enrolled in an ACC-RBHA have the same or increased access to primary care services compared to prior to the waiver renewal? • **RQ 1.2:** Do adult members with an SMI enrolled in an ACC-RBHA have the same or increased access to substance abuse treatment compared to prior to the waiver renewal?

Hypothesis	Research Question(s)
Hypothesis 2: Quality of care will be maintained or improved during the renewal period.	• **RQ 2.1:** Do adult members with an SMI enrolled in an ACC-RBHA have the same or higher rates of appropriate immunizations compared to prior to waiver renewal? • **RQ 2.2:** Do adult members with an SMI enrolled in an ACC-RBHA have the same or better management of chronic conditions compared to prior to the waiver renewal? • **RQ 2.3:** Do adult members with an SMI enrolled in an ACC-RBHA have the same or better management of BH conditions compared to prior to the waiver renewal? • **RQ 2.4:** Do adult members with an SMI enrolled in an ACC-RBHA have the same or better management of opioid prescriptions compared to prior to the waiver renewal? • **RQ 2.5:** Do adult members with an SMI enrolled in an ACC-RBHA have the same or lower tobacco usage compared to prior to the waiver renewal? • **RQ 2.6:** Do adult members with an SMI enrolled in an ACC-RBHA have the same or lower hospital utilization compared to prior to the waiver renewal?
Hypothesis 3: Health outcomes for adult members with an SMI enrolled in an ACC-RBHA will be maintained or improved during the renewal period.	• **RQ 3.1:** Do adult members with an SMI enrolled in an ACC-RBHA have the same or higher rating of health compared to prior to the waiver renewal?
Hypothesis 4: Adult member satisfaction in ACC-RBHA health plans will be maintained or improved over the renewal period.	• **RQ 4.1:** Do adult members with an SMI enrolled in an ACC-RBHA have the same or higher satisfaction in their health care compared to prior to the waiver renewal? • **RQ 4.2:** Do adult members with an SMI enrolled in an ACC-RBHA perceive their doctors to have the same or better care coordination compared to prior to the waiver renewal?
Hypothesis 5: ACC-RBHAs encourage and/or facilitate care coordination among PCPs and BH practitioners.	• **RQ 5.1:** What care coordination strategies are the ACC-RBHAs conducting for their members with an SMI? • **RQ 5.2:** Have care coordination strategies for members with an SMI changed as a result of ACC? • **RQ 5.3:** What care coordination strategies is AHCCCS conducting for its members with an SMI? • **RQ 5.4:** What care coordination strategies and/or activities are providers conducting for their Medicaid patients with an SMI served by the ACC-RBHAs? • **RQ 5.5:** Did care coordination strategies improve or maintain patient engagement and follow-up care for substance use and BH conditions during the renewal period?
Hypothesis 6: ACC-RBHAs will provide cost-effective care for members with an SMI.	• **RQ 6.1:** What are the costs associated with providing care for members with an SMI through the ACC-RBHAs during the renewal period? • **RQ 6.2:** What are the benefits/savings associated with providing care for members with an SMI through the ACC-RBHAs during the renewal period?

Note: ACC: AHCCCS Complete Care; ACC-RBHA: ACC-Regional Behavioral Health Agreement; BH: behavioral health; PCP: primary care provider; RQ: research question; SMI: serious mental illness.

ALTCS

Logic Model

Figure 2-3 illustrates that with additional funding to support integration and operation of Arizona Long Term Care System (ALTCS) plans, members are expected to find the Medicaid system easier to navigate, continue receiving case management, and prioritize practices with integrated services over those without integration. As navigation of the Medicaid system improves, member access to care should increase. With better case management, members are expected to experience better health outcomes, initially reflected through improved quality and access to care. Over time, these improvements are anticipated to support members' health outcomes and well-being while providing cost-effective care. Hypotheses associated with these outcomes are denoted in parentheses in the logic model.

Figure 2-3—ALTCS Logic Model

ALTCS Logic Model

Resources/Inputs
What are the resources and funding streams necessary to implement the demonstration renewal?

- Matching federal funding for AHCCCS
- Capitated payments to contracted health plans
- Staff to provide case management, treatment coordination services, and family support for those providing compensated and uncompensated care

Activities
What will AHCCCS & ALTCS health plans do to implement the demonstration renewal?

- AHCCCS will provide integrated PH, BH, and LTSS care (including HCBS) for the DD and EPD populations
- Health plans will provide services specified in the AHCCCS-provided contracts
- AHCCCS will continue to allow parents of minor children to receive payment for attendant care and habilitation services
- AHCCCS will establish EFSS as part of the HCBS benefit package

Outputs
What is the expected direct result of implementing the demonstration renewal?

- Medicaid system is easier to navigate for members
- Members to receive case management services, including outreach, education, assessments, and follow-ups with case managers
- Members will have greater access to care, as workforce recruitment and retention within HCBS is expected to improve
- The DCW shortage and other access to care challenges will be mitigated
- Member satisfaction and health outcomes will improve for members receiving PPCG or EFSS
- EFSS will assist families in learning skills, adjusting to significant life events, and navigating the health care system
- Family functioning will be restored, enhanced, and maintained

Expected Outcomes

Short Term
Expected initial outcomes

- Member access to BH providers and PCPs will be maintained or increased (H1)
- Improved coordination between PH and BH providers (H4)
- Increased or maintained rate of minors in the ALTCS program being served in the home (H5)
- Mitigated DCW shortage to increase timely access to care providers (H8)

Intermediate
Expected intermediate-term outcomes

- Increased or maintained access to care (H1)
- Increased or maintained quality of care (H2, H10)
- Improved primary care service utilization for members receiving PPCG or Extended Family Support services (H6)
- Improved ongoing care stability for members receiving PPCG services (H9)

Long Term
Expected long-term outcomes and goals of the demonstration

- Improved or maintained health care outcomes (H1, H2, H7)
- Improved or maintained quality of life (H3)
- Cost-effective care for ALTCS members (H13)
- Health disparities will decrease
- Increased member and family unit stability (H11)
- Improved community integration for members (H12)

Confounding Factors

- Change in coverage after the BH integration for members serviced by DES/DDD
- Health plans may vary in the degree and consistency of the application of needs assessments and care coordination/management
- HRSN such as member socio-demographic factors, education, access to nutritious foods, neighborhood and physical environment, employment, income, social support networks, and racism/ discrimination
- COVID-19 PHE
- Workforce recruitment and retention challenges exacerbated by COVID-19 PHE

Note: AHCCCS: Arizona Health Care Cost Containment System; ALTCS: Arizona Long Term Care System; BH: behavioral health; COVID-19: coronavirus disease 2019; DCW: direct care worker; DD: developmental disability; DDD: Division of Developmental Disabilities; DES: Department of Economic Security; EFFS: Extended Family Support Services; EPD: Elderly and/or have Physical Disabilities; H: hypothesis; HCBS: home– and community-based services; HRSN: health-related social needs; LTSS: Long Term Services and Supports; PCP: primary care provider; PH: physical health; PHE: public health emergency; PPCG: Parents as Paid Caregivers

Hypotheses and Research Questions

To comprehensively evaluate the ALTCS program, 12 hypotheses were tested using 31 research questions. Table 2-3 lists the 12 hypotheses and associated research questions.

Table 2-3—ALTCS Hypotheses and Research Questions

Hypothesis	Research Question(s)
Hypothesis 1: Member access to appropriate care for routine medical conditions will be maintained or improved during the renewal period.	• **RQ 1.1:** Do members who are EPD and/or members with a DD have the same or higher rates of access to care and primary care services compared to prior to waiver renewal? • **RQ 1.2:** Do adult members who are EPD and/or members with DD have the same or improved rates of access to care as a result of the waiver renewal?
Hypothesis 2: Quality of care will be maintained or improved during the renewal period.	• **RQ 2.1:** Do members who are EPD, and/or members with DD have the same or higher rates of preventive care compared to prior to waiver renewal? • **RQ 2.2:** Do members who are EPD, and/or members with DD have the same or better management of BH conditions compared to prior to waiver renewal? • **RQ 2.3:** Do adult members who are EPD have the same or better management of prescriptions compared to prior to waiver renewal? • **RQ 2.4:** Do members who are EPD, and/or members with DD have the same or higher rates of utilization of care compared to prior to waiver renewal?
Hypothesis 3: Quality of life for members will be maintained or improved during the renewal period.	• **RQ 3.1:** Do members have the same or higher rates of living in their own home as a result of the ALTCS waiver renewal? • **RQ 3.2:** Do adult members have the same or higher rates of feeling satisfied with their living arrangements as a result of the waiver renewal for members who are EPD, and/or members with DD? • **RQ 3.3:** Do adult members have the same or higher rates of feeling engaged as a result of the waiver renewal for members who are EPD and/or members with DD?
Hypothesis 4: ALTCS encourages and/or facilitates care coordination among PCPs and BH practitioners.	• **RQ 4.1:** Did DES/DDD, ALTCS-EPD or their contracted plans encounter barriers during the waiver renewal period of care for members with DD or EPD? • **RQ 4.2:** What care coordination strategies did DES/DDD and its contracted plans implement as a result of the waiver renewal? • **RQ 4.3:** Did DES/DDD or its contracted plans encounter barriers to renewal of the waiver for care coordination strategies? • **RQ 4.4:** Did AHCCCS encounter barriers related to the waiver renewal for members with DD or EPD? • **RQ 4.5:** Did providers encounter barriers related to the waiver renewal for members with DD? • **RQ 4.6:** Did care coordination strategies improve or maintain patient engagement and follow up care for substance use and BH conditions during the renewal period?
Hypothesis 5: The PPCG service model and EFSS will maintain or increase the rate of members being served in the home.	• **RQ 5.1:** Is the percentage of members receiving services at home the same or higher after the implementation of the PPCG service model or EFSS? • **RQ 5.2:** What is the frequency and types of services provided to ALTCS members receiving services through the PPCG service model or EFSS at home?

Hypothesis	Research Question(s)
Hypothesis 6: The PPCG service model will maintain or improve access to quality health services for the target population.	• **RQ 6.1:** Did minor members receiving services through the PPCG service model maintain or improve their access to health services? • **RQ 6.2:** Did the PPCG service model impact hospital utilization among ALTCS minors?
Hypothesis 7: The PPCG service model and EFSS will improve self-assessed health outcomes.	• **RQ 7.1:** Do members receiving services through the PPCG service model or EFSS experience improved self-assessed health outcomes?
Hypothesis 8: The PPCG service model will mitigate the DCW shortage by increasing timely accessibility to care providers.	• **RQ 8.1:** Did the PPCG service model alleviate the shortage of DCWs and increase timely access to needed care?
Hypothesis 9: The PPCG service model will improve ongoing care stability for the target population.	• **RQ 9.1:** Did the PPCG service model improve or maintain care stability for ALTCS minors?
Hypothesis 10: The PPCG service model and EFSS will increase member and family unit stability through increased ability to navigate the health care system and decrease stress and burnout.	• **RQ 10.1:** Has EFSS restored, enhanced, or maintained family functioning by preserving effective care for members in the home and community? • **RQ 10.2:** Has the PPCG service model and EFSS reduced burnout and provided alternate supports for caregivers?
Hypothesis 11: The PPCG service model and EFSS will maintain or improve community integration and well-being for members.	• **RQ 11.1:** Do members receiving services through the PPCG service model and EFSS have the same or lower rates of social isolation? • **RQ 11.2:** Do members receiving services through the PPCG service model have the same or lower rates of reported cases of child maltreatment?
Hypothesis 12: ALTCS provides cost-effective care.	• **RQ 12.1:** What are the costs associated with the waiver renewal? • **RQ 12.2:** What are the benefits/savings associated with the waiver renewal? • **RQ 12.3:** What are the costs associated with the PPCG service model? • **RQ 12.4:** What are the benefits/savings associated with the PPCG service model? • **RQ 12.5:** Did utilization of services increase after the introduction of the PPCG service model?

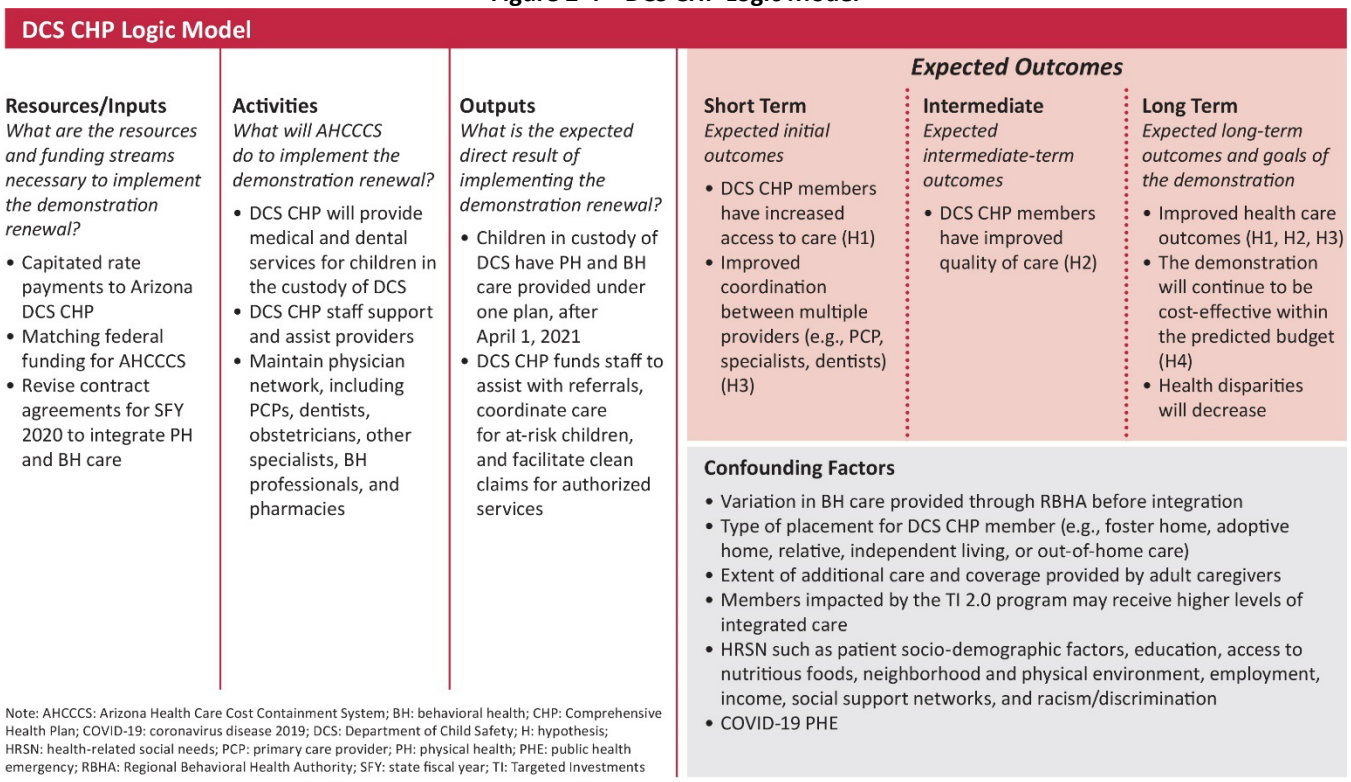
Note: ALTCS: Arizona Long Term Care System; BH: behavioral health; DCW: direct care worker; DD: developmental disability; DES/DDD: Department of Economic Security/Division of Developmental Disabilities; EFSS: Extended Family Support Services; EPD: elderly and/or have physical disabilities; PCP: primary care provider; PPCG: Parents as Paid Caregivers; RQ: research question.

DCS CHP

Logic Model

Figure 2-4 illustrates that with additional funding to support the integration and operation of the Comprehensive Health Plan (CHP) program, children in custody of the Department of Child Safety (DCS) received physical and dental care provided under a single plan prior to April 1, 2021, and integrated PH and BH services under a single plan thereafter. With improved access to and integration of care, children covered by DCS CHP are expected to experience better health outcomes within a cost-effective care model. Hypotheses associated with these outcomes are denoted in parentheses in the logic model.

Figure 2-4—DCS CHP Logic Model



Note: AHCCCS: Arizona Health Care Cost Containment System; BH: behavioral health; CHP: Comprehensive Health Plan; COVID-19: coronavirus disease 2019; DCS: Department of Child Safety; H: hypothesis; HRSN: health-related social needs; PCP: primary care provider; PH: physical health; PHE: public health emergency; RBHA: Regional Behavioral Health Authority; SFY: state fiscal year; TI: Targeted Investments

Hypotheses and Research Questions

To comprehensively evaluate the DCS CHP program, four hypotheses were tested using 10 research questions. Table 2-4 lists the four hypotheses and associated research questions.

Table 2-4—DCS CHP Hypotheses and Research Questions

Hypothesis	Research Question(s)
Hypothesis 1: Member access to appropriate care for routine medical conditions will be maintained or improved during the integration period.	• **RQ 1.1:** Do DCS CHP members have the same or increased access to PCPs and specialists in the remeasurement period as compared to the baseline?
Hypothesis 2: Quality of care will be maintained or improved during the integration period.	• **RQ 2.1:** Do DCS CHP members have the same or higher rates of appropriate immunizations in the remeasurement period as compared to the baseline? • **RQ 2.2:** Do DCS CHP members have the same or better management of chronic conditions in the remeasurement period as compared to the baseline? • **RQ 2.3:** Do DCS CHP members have the same or better management of BH conditions in the remeasurement period as compared to the baseline? • **RQ 2.4:** Do DCS CHP members have the same or lower hospital utilization in the remeasurement period as compared to the baseline?

Hypothesis	Research Question(s)
Hypothesis 3: DCS CHP encourages and/or facilitates care coordination among PCPs and BH practitioners.	• **RQ 3.1:** What barriers did DCS CHP anticipate/encounter during the integration? • **RQ 3.2:** What care coordination strategies did DCS CHP plan/implement during integration? • **RQ 3.3:** What barriers to implementing care coordination strategies did DCS CHP anticipate/encounter?
Hypothesis 4: DCS CHP provides cost-effective care.	• **RQ 4.1:** What are the costs associated with the integration of care in DCS CHP? • **RQ 4.2:** What are the benefits/savings associated with the integration of care in the DCS CHP?

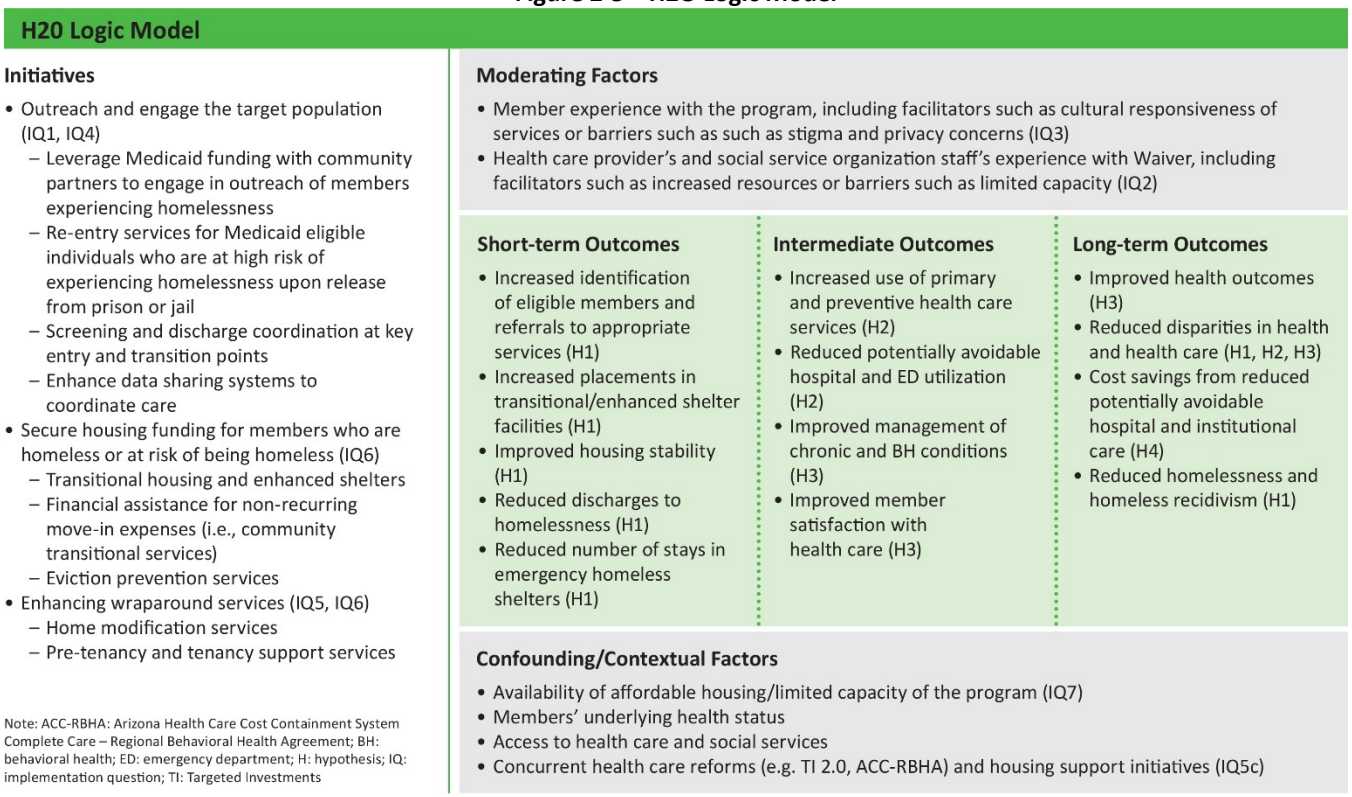
Note: BH: behavioral health; CHP: Comprehensive Health Plan; DCS: Department of Child Safety; PCP: primary care provider; RQ: research question.

H2O

Logic Model

Figure 2-5 illustrates that with funding for the Housing and Health Opportunities (H2O) program, increased outreach and engagement are expected to improve the identification of eligible members and referrals to appropriate services by securing housing for members who are homeless or at risk of being homeless and by enhancing wraparound services. As housing stability improves, the number of stays in emergency shelters and discharges to homelessness should be decreased. With more housing, members are expected to increase their use of primary and preventive services, reduce avoidable ED visits, better manage chronic and BH conditions, and experience high satisfaction with their care. Over time, these improvements are anticipated to enhance health outcomes, reduce disparities in health and health care, lower costs, and decrease rates of homelessness. Hypotheses associated with these outcomes are denoted in parentheses in the logic model.

Figure 2-5—H2O Logic Model



Hypotheses and Research Questions

To comprehensively evaluate H2O, four hypotheses were tested using 22 research questions. Table 2-5 lists the six hypotheses and associated research questions.

Table 2-5—H2O Hypotheses and Research Questions

Hypothesis	Research Question(s)
Hypothesis 1: The demonstration will meet or reduce the severity of HRSN for members overall and among subpopulations who experience disparities in HRSN.	• **RQ 1.1:** How does the H2O demonstration impact the use of HRSN services? • **RQ 1.2:** How do State and local government investments in housing supports change in relation to H2O demonstration funding? • **RQ 1.3:** How does the H2O demonstration impact rates of HRSN and their severities? • **RQ 1.4:** How does the H2O demonstration impact members' use of HRSN services reflecting crisis events, such as stays in emergency homeless shelters? • **RQ 1.5:** Is the H2O demonstration associated with increased positive health and wellbeing outcomes? • **RQ 1.6:** How does the H2O demonstration impact disparities in HRSN? – **RQ 1.6.1:** Does the H2O demonstration mitigate or reduce HRSN among groups who had high rates at baseline? – **RQ 1.6.2:** Do any groups experience increasing or worsening HRSN compared to the baseline with the implementation of the H2O demonstration?

Hypothesis	Research Question(s)
Hypothesis 2: By meeting or reducing the severity of HRSN, the demonstration will increase members' use of preventive and routine care and reduce their use of potentially avoidable hospital and institutional care (ED visits, IP care, and nursing facilities), leading to reduced health care spending over time. Impacts will be realized overall and among subpopulations who experience disparities in hospital and institutional care use.	• **RQ 2.1:** How does the H2O demonstration impact the use of preventive and routine care? • **RQ 2.2:** How does the H2O demonstration impact the use of BH services? • **RQ 2.3:** How does the H2O demonstration impact the use of hospital and institutional care? • **RQ 2.4:** How does the H2O demonstration impact disparities in the use of hospital and institutional care? – **RQ 2.4.1:** Does the demonstration reduce the use of hospital and institutional care among groups who had high rates at baseline? – **RQ 2.4.2:** Do any groups experience increasing use of hospital and institutional care compared to the baseline with the implementation of the HRSN demonstration?
Hypothesis 3: By meeting or reducing HRSN, the demonstration will improve physical and mental health outcomes among members overall and among subpopulations who experience disparities in physical and mental health outcomes.	• **RQ 3.1:** How does the H2O demonstration impact members' physical and mental health outcomes? • **RQ 3.2:** How does the H2O demonstration impact members' management of chronic conditions? • **RQ 3.3:** How does the H2O demonstration impact rates of mortality? • **RQ 3.4:** How does the H2O demonstration impact the quality and effectiveness of downstream services? • **RQ 3.5:** How does the H2O demonstration impact disparities in health outcomes? – **RQ 3.5.1:** Does the H2O demonstration improve the physical and mental health outcomes of groups who had poor health outcomes at baseline? – **RQ 3.5.2:** Do any groups experience worsening physical and mental health outcomes compared to the baseline with the implementation of the H2O demonstration?
Hypothesis 4: The H2O demonstration will reduce cost of care for members who utilize H2O services.	• **RQ 4.1:** How does the H2O demonstration impact the total cost of care among H2O members compared to members who are eligible but not participating in the H2O demonstration?

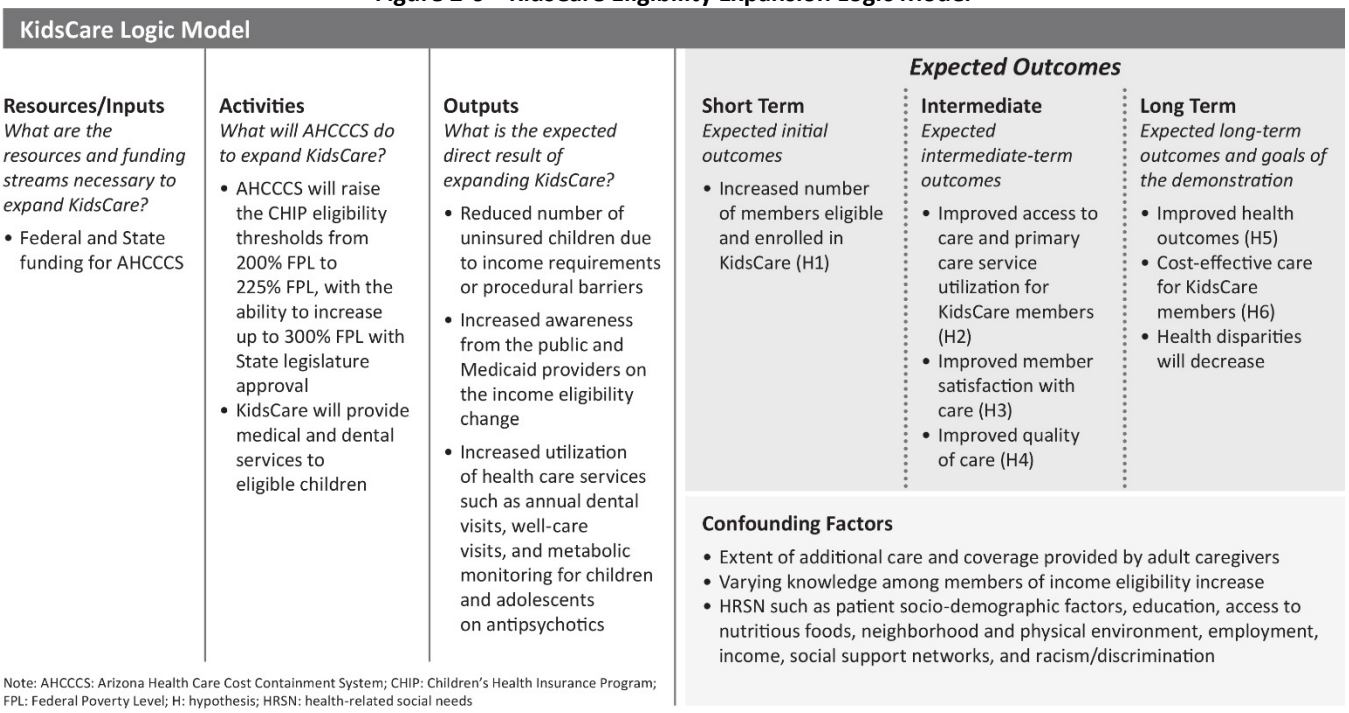
Note: BH: behavioral health; ED: emergency department; HRSN: health-related social needs; H2O: Housing and Health Opportunities; IP: inpatient; PCP: primary care provider; RQ: research question.

KidsCare Eligibility Expansion

Logic Model

Figure 2-6 shows that expanding KidsCare eligibility will result in more members becoming eligible for and enrolled in KidsCare in the short term. In the long term, AHCCCS expects to see improved health outcomes and cost-effective care among the KidsCare population. Hypotheses associated with these outcomes are denoted in parentheses in the logic model.

Figure 2-6—KidsCare Eligibility Expansion Logic Model



Note: AHCCCS: Arizona Health Care Cost Containment System; CHIP: Children's Health Insurance Program; FPL: Federal Poverty Level; H: hypothesis; HRSN: health-related social needs

Hypotheses and Research Questions

To comprehensively evaluate the KidsCare Eligibility Expansion program, six hypotheses were tested using 13 research questions. Table 2-6 lists the six hypotheses and associated research questions.

Table 2-6—KidsCare Eligibility Expansion Hypotheses and Research Questions

Hypothesis	Research Question(s)
Hypothesis 1: Expanding KidsCare eligibility will increase the number of members eligible for and enrolled in KidsCare and reduce the number of children losing eligibility for procedural reasons.	• **RQ 1.1:** Did expanding KidsCare eligibility increase the number of members enrolled in KidsCare? • **RQ 1.2:** Did expanding KidsCare eligibility reduce the number of uninsured children? • **RQ 1.3:** Does the KidsCare program promote continuity of care for its members?
Hypothesis 2: Expanding KidsCare eligibility will improve access to care and increase primary care service utilization for CHIP members.	• **RQ 2.1:** Did expanding KidsCare eligibility improve access to health care for CHIP members? • **RQ 2.2:** Did expanding KidsCare eligibility maintain or increase the utilization of primary care and preventative health services? • **RQ 2.3:** Did expanding KidsCare eligibility improve access to dental care for CHIP members?
Hypothesis 3: Expanding KidsCare eligibility will improve member care satisfaction.	• **RQ 3.1:** Did expanding KidsCare eligibility improve member satisfaction with the care received?

Hypothesis	Research Question(s)
Hypothesis 4: Expanding KidsCare eligibility will improve quality of care for members.	• **RQ 4.1:** Did expanding KidsCare eligibility improve the management of BH conditions? • **RQ 4.2:** Did expanding KidsCare eligibility impact hospital utilization? • **RQ 4.3:** Did expanding KidsCare eligibility maintain or improve the management of chronic conditions for members? • **RQ 4.4:** Did expanding KidsCare eligibility improve parental understanding of their child's care?
Hypothesis 5: Expanding KidsCare will improve self-assessed health outcomes.	• **RQ 5.1:** Did expanding KidsCare improve member perception of health outcomes?
Hypothesis 6: Expanding KidsCare will yield cost-effective care for members.	• **RQ 6.1:** Did the KidsCare program provide cost-effective care for members?

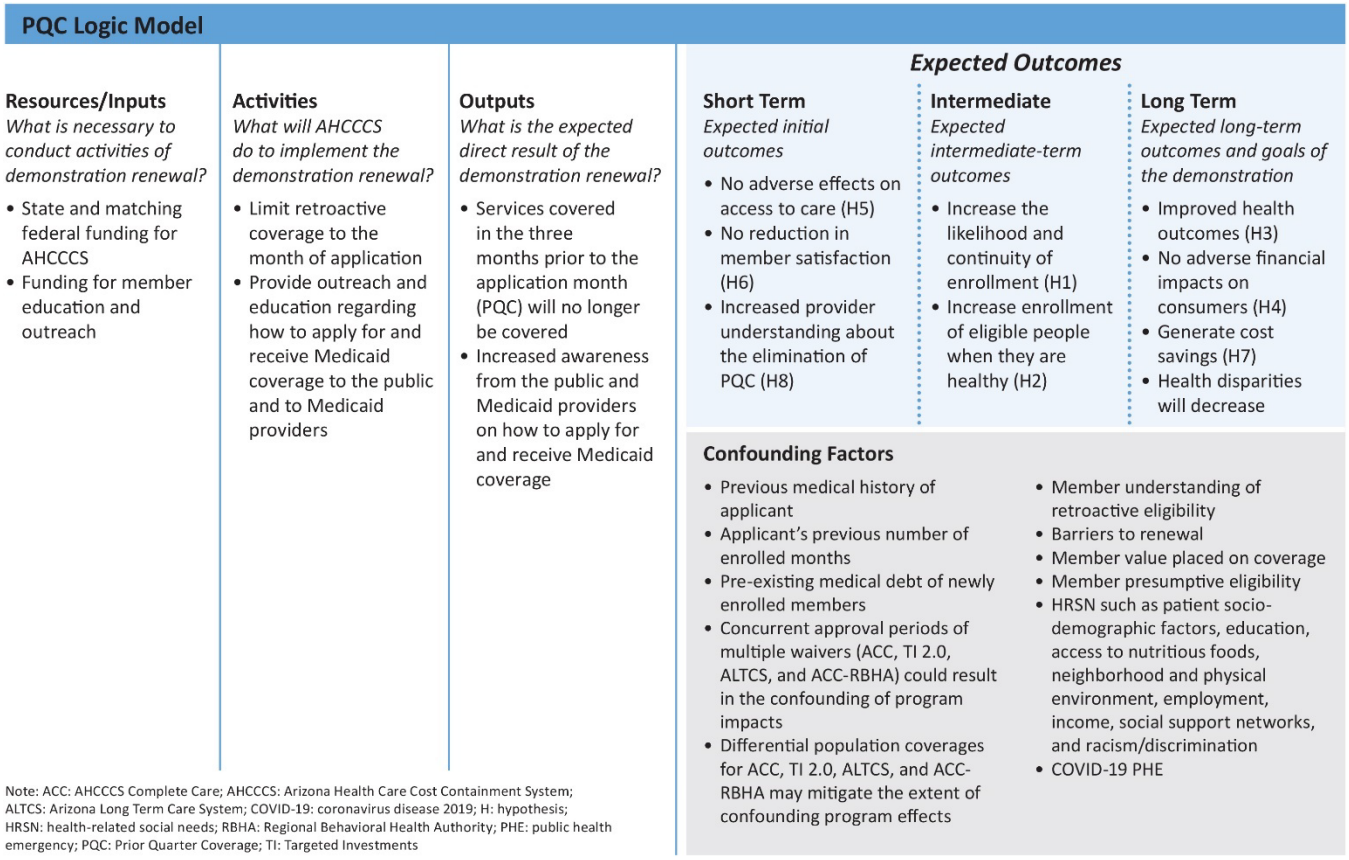
Note: BH: behavioral health; CHIP: Children's Health Insurance Program; RQ: research question.

PQC

Logic Model

Figure 2-7 illustrates that providing outreach and education to the public and providers about the Waiver, along with limiting retroactive eligibility to the month of application, is expected to improve health outcomes without negatively affecting access to care and member satisfaction, or members' financial stability. These outcomes are not anticipated to occur simultaneously. Initial effects are expected in access to care and member satisfaction, followed by increases in the likelihood and continuity of enrollment and in the enrollment of healthy eligible people. In the long term, there should be no financial impact on members while generating cost savings and promoting Arizona Medicaid sustainability. Ultimately, these changes are expected to improve health outcomes among members. Hypotheses associated with these outcomes are denoted in parentheses in the logic model.

Figure 2-7—PQC Logic Model



Note: ACC: AHCCCS Complete Care; AHCCCS: Arizona Health Care Cost Containment System; ALTCS: Arizona Long Term Care System; COVID-19: coronavirus disease 2019; H: hypothesis; HRSN: health-related social needs; RBHA: Regional Behavioral Health Authority; PHE: public health emergency; PQC: Prior Quarter Coverage; TI: Targeted Investments

Hypotheses and Research Questions

To comprehensively evaluate the Prior Quarter Coverage (PQC) Waiver program, seven hypotheses were tested using 12 research questions. Table 2-7 lists the seven hypotheses and associated research questions.

Table 2-7—PQC Hypotheses and Research Questions

Hypothesis	Research Question(s)
Hypothesis 1: Eliminating PQC will increase the likelihood and continuity of enrollment.	• **RQ 1.1:** Do eligible people without PQC enroll in Medicaid at the same rates as other eligible people with PQC? • **RQ 1.2:** What is the likelihood of enrollment continuity for those without PQC compared to other Medicaid members with PQC? • **RQ 1.3:** Do members without PQC who disenroll from Medicaid have shorter enrollment gaps than other members with PQC?
Hypothesis 2: Eliminating PQC will increase enrollment of eligible people when they are healthy.	• **RQ 2.1:** Do newly enrolled members without PQC have higher self-assessed health status?
Hypothesis 3: Health outcomes will be better for those without PQC compared to Medicaid members with PQC.	• **RQ 3.1:** Do members without PQC have better health outcomes when compared to outcomes prior to the renewal period rates and out-of-state outcomes for those with PQC?

Hypothesis	Research Question(s)
Hypothesis 4: Eliminating PQC will not have adverse financial impacts on consumers.	• **RQ 4.1:** Does the PQC waiver lead to changes in the incidence of member medical debt?
Hypothesis 5: Eliminating PQC will not adversely affect access to appropriate care for routine medical conditions.	• **RQ 5.1:** Do members without PQC have the same or higher rates of office visits compared to members with PQC? • **RQ 5.2:** Do members without PQC have the same or higher rates of service and facility utilization compared to rates prior to waiver renewal with PQC?
Hypothesis 6: Eliminating PQC will not result in reduced member satisfaction.	• **RQ 6.1:** Do members without PQC have the same or higher satisfaction with their health care compared to prior to waiver renewal with PQC?
Hypothesis 7: Eliminating PQC will generate cost savings over the term of the waiver.	• **RQ 7.1:** What are the costs associated with eliminating PQC? • **RQ 7.2:** What are the benefits/savings associated with eliminating PQC? • **RQ 7.3:** Do costs to non-AHCCCS entities stay the same or decrease after implementation of the waiver compared to before?

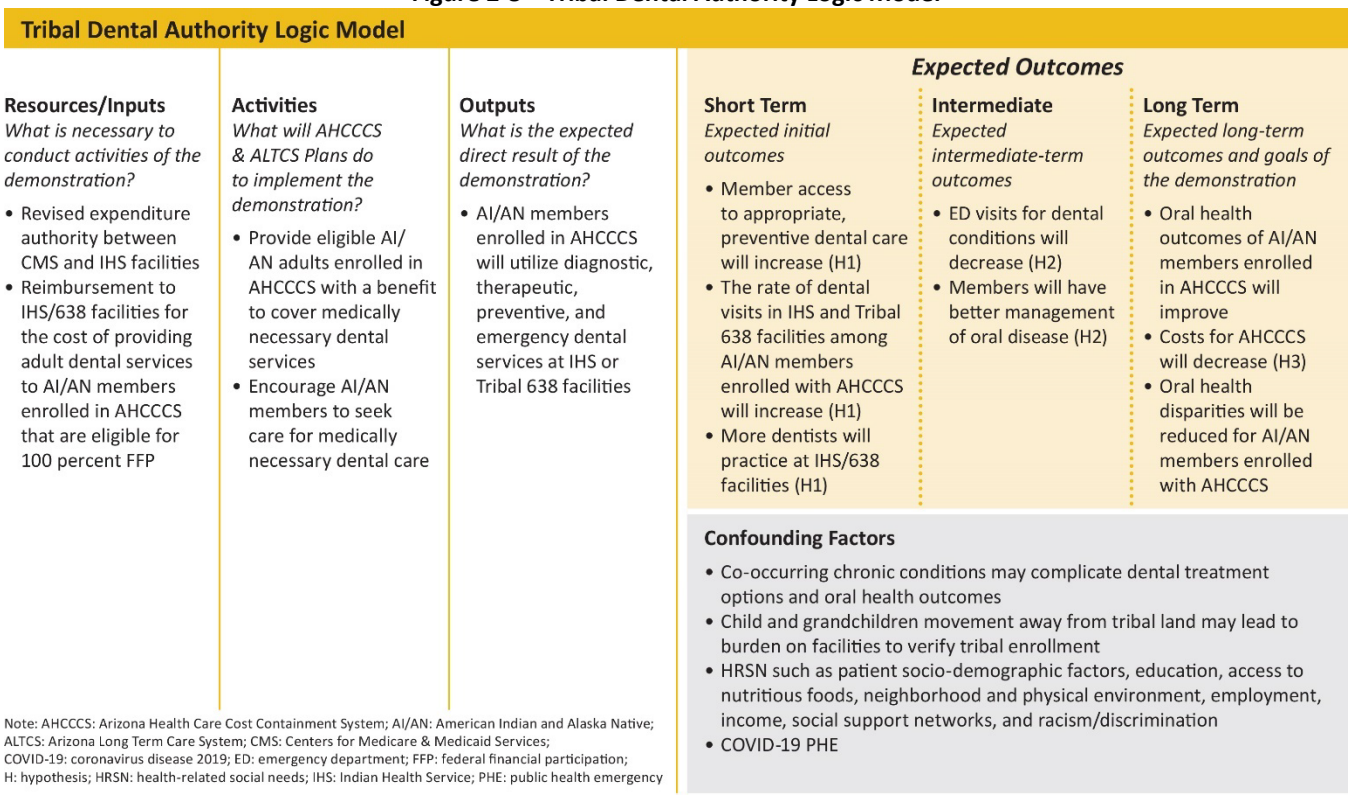
Note: AHCCCS: Arizona Health Care Cost Containment System; PQC: prior quarter coverage; RQ: research question.

Tribal Dental Authority

Logic Model

Figure 2-8 illustrates how reimbursing Indian Health Service (IHS) and Tribal 638 facilities for the cost of providing adult dental services to American Indian/Alaska Native (AI/AN) members enrolled in AHCCCS managed care plans or the fee-for-service (FFS) American Indian Health Program (AIHP), that are eligible for 100 percent federal financial participation (FFP), is expected to improve oral health outcomes and generate cost savings for AHCCCS. By offering eligible AI/AN adults coverage for medically necessary dental services and encouraging utilization of those services, AHCCCS anticipates increased access to dental care and greater provider participation in IHS and Tribal 638 facilities in the short term. These improvements are expected to reduce ED visits and enhance the management of oral disease, ultimately leading to better oral health outcomes and reduced disparities among targeted members over the long term. Hypotheses associated with these outcomes are denoted in parentheses in the logic model.

Figure 2-8—Tribal Dental Authority Logic Model



Hypotheses and Research Questions

To comprehensively evaluate the Tribal Dental Authority program, four hypotheses were tested using six research questions. Table 2-8 lists the four hypotheses and associated research questions.

Table 2-8—Tribal Dental Hypotheses and Research Questions

Hypothesis	Research Question(s)
Hypothesis 1: Member access to appropriate, routine dental care will be maintained or improved during the renewal period.	• **RQ 1.1:** Did the waiver result in an increased number of dental providers practicing in IHS and 638 facilities? • **RQ 1.2:** Do members have the same or better access to routine, preventive dental services compared to prior to the demonstration?
Hypothesis 2: Quality of care will be maintained or improved during the renewal period.	• **RQ 2.1:** Do members have the same or better management of chronic dental conditions compared to prior to the demonstration? • **RQ 2.3:** Do members have equal or lower ED or hospital utilization compared to prior to the demonstration?

Hypothesis	Research Question(s)
Hypothesis 3: Member oral health outcomes will be maintained or improved during the renewal period.	• **RQ 3.1:** Do members have the same or better oral health outcomes compared to prior to the demonstration? • **RQ 3.2:** Has the rate of emergency dental services decreased following implementation of the waiver?
Hypothesis 4: The Tribal Dental program provides cost-effective care.	• **RQ 4.1:** What are the costs associated with providing care under the Tribal Dental Authority? • **RQ 4.2:** What are the benefits/savings associated with providing care under the Tribal Dental Authority?

Note: ED: emergency department; IHS: Indian Health Service; RQ: research question.

3. Methodology

This chapter describes the methods used to conduct the evaluation of the Arizona Health Care Cost Containment System (AHCCCS) Section 1115 Waiver Demonstration (the Waiver). It summarizes the analytic approaches, data sources, and measures used to assess waiver outcomes. Any deviations from the approved Evaluation Designs are noted and explained below.[62,63] The Centers for Medicare & Medicaid Services (CMS)-approved Evaluation Designs, including detailed descriptions of measures, data sources, and analytic methods, are linked in Appendix A.

Evaluation Design Summary

The Waiver Evaluation Designs employed a mixed-methods approach. Quantitative analyses included descriptive statistics to examine changes over time in both counts and rates for specific metrics, as well as pre/post-tests, trend analyses, difference-in-differences (DiD), and interrupted time series (ITS) analyses to assess the effects of Waiver interventions on outcomes. Surveys were administered to evaluate members' experiences with their personal doctor, health plan, and overall health care. The qualitative component complemented the quantitative findings by capturing stakeholder perspectives. Provider organizations, health plans, community-based organizations (CBOs), and State staff were interviewed to gather insights on program implementation, perceived impacts, and opportunities for improvement.

Intervention and Comparison Populations

ACC, ACC-RBHA, ALTCS, and DCS CHP: Member identification for the AHCCCS Complete Care (ACC), ACC-Regional Behavioral Health Agreement (RBHA), Arizona Long Term Care System (ALTCS), and Department of Child Safety Comprehensive Health Plan (DCS CHP) programs was determined using Medicaid eligibility and health plan enrollment data. There was no viable in-state comparison group.[64] Comparisons to national benchmarks were used when available to provide context for interpreting results.

ALTCS-PPCG: The intervention population consisted of eligible minor members who were identified as receiving services through the Parents as Paid Caregivers (PPCG) service model, as identified in the PPCG utilization data. The comparison population was comprised of minor members enrolled in an ALTCS plan who were identified as living at home, based on ALTCS placement data, who did not receive services through the PPCG service model. As such the comparison group reflected members who were similarly situated in a home-based setting but received home- and community-based services through a traditional, non-parent provider service model.

H2O: The intervention population consisted of members participating in the Housing and Health Opportunities (H2O) program. Members were identified as eligible through the H2O exception codes available in the Prepaid

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62 Centers for Medicare & Medicaid Services. CMS-Approved Evaluation Design. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-cms-aprvd-amndmnd-evlutn-dsgn.pdf. Accessed on: Oct 20, 2025.

63 Centers for Medicare & Medicaid Services. CMS-Approved H2O Evaluation Design. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hcccs-appvd-h2o-eval-des-08302024.pdf. Accessed on: Oct 20, 2025.

64 Additional details are outlined in the Methodological Limitations chapter.

Medical Management Information System (PMMIS) data. When developing the sample frame for beneficiary surveys, PMMIS data were available through March 2025, which resulted in only 415 members identified through the H2O exception code. Measures that did not rely on beneficiary surveys identified H2O members using H2O-Program Administrator (PA) data, which also used H2O exception codes, but was available through September 2025 and therefore identified a broader cohort of members. The comparison population consisted of members who were on the AHCCCS Housing Program (AHP) waitlist but were not enrolled in H2O at any point during the evaluation period. Members on the AHP waitlist represent a broader cohort than H2O-eligible members. For example, within the AHP, a majority of resources are allocated to members with an SMI, though members on the AHP waitlist may include those with a General Mental Health or Substance Use (GMHSU) need. Although GMHSU members may receive housing supports, members with an SMI are generally prioritized for these interventions.[65] Therefore, the membership of the AHP waitlist may represent members with less complex health conditions than those enrolled in H2O. The baseline period identified rates among intervention group members for the three years prior to their enrollment in H2O and for the three years prior to H2O implementation for members who remained on the AHP waitlist.

KidsCare Eligibility Expansion: The intervention population, or the KidsCare expansion group, consisted of members enrolled in KidsCare with incomes above 200 percent of the federal poverty level (FPL). Members with at least one day of enrollment in the KidsCare expansion group (i.e., incomes above 200 percent of the FPL) were categorized as KidsCare expansion members for the duration of the evaluation period. Comparisons were made, when appropriate, to KidsCare members with incomes under 200 percent of the FPL, as well as to uninsured children or children in other states were made when data were available.

PQC: The intervention group consisted of all eligible members who applied for coverage after the implementation of Prior Quarter Coverage (PQC) on July 1, 2019, excluding pregnant or postpartum women, and infants and children under 19 years of age. There was no viable in-state comparison group for measures that relied on PMMIS data. For measures utilizing beneficiary surveys, rates for members who were new to Medicaid (i.e., no prior Medicaid enrollment in the last six months) were presented alongside rates for members who were continuously enrolled or had prior Medicaid enrollment within the last six months. However, no formal comparisons were made between the two groups.

Tribal Dental Authority: The Tribal Dental Authority population consisted of all adult AHCCCS tribal members eligible to receive medically necessary dental services at an Indian Health Service (IHS) or Tribal 638 facility.[66] Eligible members were identified as those with a valid Tribal Affiliation code in the member-level data, those enrolled in an American Indian Health Plan or Tribal Long-Term Care (LTC) plan, or those with a paid claim from an IHS facility. Given that the Tribal Dental Authority impacted all members who sought care at an IHS or Tribal 638 facility, an in-state comparison group of similar members was not feasible. For additional details, see the Methodological Limitations section. When applicable, Behavioral Risk Factor Surveillance System (BRFSS) data were used to identify American Indian/Alaska Native (AI/AN) Medicaid respondents from other states as an out-of-state comparison group.

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65 Arizona Health Care Cost Containment System. AHCCCS Housing Programs. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/AHP/. Accessed on: May 5, 2026.

66 Arizona Health Care Cost Containment System. Codes & Values 2021. Available at: https://www.azahcccs.gov/PlansProviders/Downloads/HealthPlans/FeeForService/HealthPlanIDNumbers.pdf. Accessed on: Feb 27, 2026.

Performance Measure Rates Weighted Calculations

All members enrolled in their respective programs (ACC, ACC-RBHA, ALTCS, and DCS CHP) during each baseline year who met defined continuous enrollment requirements were included in measure calculations. Continuous enrollment requirements were applied based on overall enrollment in Medicaid, regardless of program enrollment. Because members could switch programs during the year and still meet continuous enrollment criteria, rates presented in this report were weighted based on the duration of enrollment in each program. For example, an individual enrolled in DCS CHP for six months and in an Acute Care plan as part of the ACC population would contribute 50 percent to DCS CHP and 50 percent to ACC rates. Measures without continuous enrollment criteria, such as inpatient (IP) utilization, emergency department (ED) utilization, and all-cause readmissions, are excluded from this weighting approach, and unweighted rates are reported.

Evaluation Periods

The baseline and evaluation periods are presented in Table 3-1.

Table 3-1—Evaluation Periods

Program	Baseline	Ramp-Up	Evaluation
ACC	10/1/2018–9/30/2022	—	10/1/2022–9/30/2024
ACC-RBHA	10/1/2016–9/30/2022	—	10/1/2022–9/30/2024
ALTCS-EPD	10/1/2016–9/30/2022	—	10/1/2022–9/30/2024
ALTCS-DD	10/1/2019–9/30/2022	—	10/1/2022–9/30/2024
ALTCS-PPCG	4/1/2018–4/5/2020	4/6/2020–2/16/2024	2/16/2024–9/30/2024
ALTCS-EFSS	2/16/2022–2/16/2024	—	2/16/2024–9/30/2024
DCS CHP	10/1/2016–9/30/2020	10/1/2020–9/30/2021	10/1/2022–9/30/2024
H2O	10/1/2021–9/30/2024	—	10/1/2024–9/30/2025
KidsCare Eligibility Expansion	—	—	4/1/2024–3/31/2025
PQC	7/1/2016–6/30/2019	—	7/1/2019–6/3/2024
Tribal Dental Authority	10/1/2016–9/30/2022[a]	—	10/1/2022–9/30/2024

[a] Baseline MMIS data were not available to assess rates prior to implementation of the Tribal Dental Authority program; however, BRFSS rates were available during the baseline period.

— Indicates that a baseline or ramp-up period were not applicable for that program.

Evaluation Measures

The measures assessed in this Interim Evaluation Report were selected from data sources that provided valid and reliable data. Each data source was reviewed to ensure completeness and accuracy. Additional details regarding the data sources selected for this evaluation are provided in the Data Sources section. Table 3-2 through Table 3-9 present the evaluation measures along with the respective hypotheses, research questions, comparison groups, data sources, and analytic approaches for each of the Waiver programs.

Table 3-2—ACC Evaluation Measures

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
Hypothesis 1: Health plans encourage and/or facilitate care coordination among PCPs and BH practitioners.				
Research Question 1.1: What care coordination strategies or activities have ACC plans been conducting during the renewal period?	1-1: Health plans' reported evolution of care coordination since the integration period and remaining barriers during the renewal period	N/A	Key informant interviews	Qualitative synthesis
Research Question 1.2: What care coordination strategies or activities have providers been conducting during the renewal period?	1-2: Providers' reported evolution of care coordination since the integration period and remaining barriers during the renewal period	N/A	Provider focus groups	Qualitative synthesis
Research Question 1.3: Did care coordination strategies improve or maintain patient engagement and follow-up care after an IP stay or ED visit during the renewal period?	1-3: Percentage of members with follow-up after an ED visit for members with multiple high-risk chronic conditions	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/Post-test - ITS
Research Question 1.4: Do members perceive their doctors to have better care coordination as a result of ACC renewal?	1- 4: Percentage of members who reported their doctor seemed informed about the care they received from other health providers	N/A	- Beneficiary survey - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - Subgroup analysis of children and adults
Hypothesis 2: Member access to appropriate care for routine medical conditions will be maintained or improved during the renewal period.				
Research Question 2.1: Do members enrolled in an ACC plan have the same or better access to primary care services compared to prior to the renewal period?	2-1: Percentage of members meeting minimum time/distance network standards	N/A	Member and provider data	- Pre-test/post-test - ITS - Subgroup analysis of children and adults - Subgroup analysis by county and/or urbanicity
	2-2: Percentage of adults who accessed preventive/ambulatory health services	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - ITS

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	2-3: Percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - Subgroup analysis of children and adults - ITS
	2-4: Percentage of members who had a well-child visit in the first 30 months of life	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - ITS
	2-5: Percentage of members 3–21 years of age who had a well-care visit with a PCP or OB/GYN	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - ITS
	2-6: Percentage of members who reported they received care as soon as they needed	N/A	- Beneficiary survey - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - Subgroup analysis of children and adults
	2-7: Percentage of members who reported they were able to schedule an appointment for a checkup or routine care at a doctor's office or clinic as soon as they needed	N/A	- Beneficiary survey - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - Subgroup analysis of children and adults
	2-8: Percentage of members who reported they were able to schedule an appointment with a specialist as soon as they needed	N/A	- Beneficiary survey - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - Subgroup analysis of children and adults
Research Question 2.2: Do members enrolled in an ACC plan have the same or better access to substance abuse treatment compared to prior to the renewal period?	2-9: Percentage of members who had initiation of SUD treatment	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - ITS - Subgroup analysis of children and adults

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	2-10: Percentage of members who had engagement of SUD treatment	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - ITS - Subgroup analysis of children and adults
Hypothesis 3: Quality of care will be maintained or improved during the renewal period.				
Research Question 3.1: Do members enrolled in an ACC plan have the same or higher rates of appropriate immunizations compared to prior to the renewal period?	3-1: Percentage of children 2 years of age with appropriate immunization status	N/A	- State eligibility and enrollment data - ASIIS - Claims/encounter data	- Comparison to national/regional benchmarks - Pre-test/post-test
	3-2: Percentage of adolescents 13 years of age with appropriate immunizations	N/A	- State eligibility and enrollment data - ASIIS - Claims/encounter data	- Comparison to national/regional benchmarks - Pre-test/post-test
	3-3: Percentage of adult members who reported having a flu shot or nasal flu spray	N/A	- Beneficiary survey - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test
Research Question 3.2: Do members enrolled in an ACC plan have the same or better management of chronic conditions compared to prior to the renewal period?	3-4: Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - ITS - Subgroup analysis of children and adults
Research Question 3.3: Do members enrolled in an ACC plan have the same or better management of BH conditions compared to prior to the renewal period?	3-5: Percentage of adult members who remained on an antidepressant medication treatment	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - ITS
	3-6: Percentage of members with a follow-up visit after hospitalization for mental illness	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - ITS - Subgroup analysis of children and adults

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	3-7: Percentage of members with a follow-up visit after an ED visit for mental illness	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - ITS - Subgroup analysis of children and adults
	3-8: Percentage of members with a follow-up visit after an ED visit for SUD	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - ITS - Subgroup analysis of children and adults
	3-9: Percentage of members diagnosed with a mental health disorder	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - ITS - Subgroup analysis of children and adults
Research Question 3.4: Do members enrolled in an ACC plan have the same or better management of opioid prescriptions compared to prior to the renewal period?	3-10: Percentage of adult members who have prescriptions for opioids at a high dosage	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - ITS
	3-11: Percentage of adult members with concurrent use of opioids and benzodiazepines	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - ITS
Research Question 3.5: Do members enrolled in an ACC plan have equal or lower ED or hospital utilization compared to prior to ACC renewal?	3-12: Number of emergent ED visits per 1,000 member months	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - Subgroup analysis of children and adults - ITS

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	3-13: Number of non-emergent ED visits per 1,000 member months	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - Subgroup analysis of children and adults - ITS
	3-14: Number of IP stays per 1,000 member months	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - ITS - Subgroup analysis of children and adults
	3-15: Percentage of adult IP discharges with an unplanned readmission within 30 days	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - ITS
Hypothesis 4: Member self-assessed health outcomes will be maintained or improved during the renewal period.				
Research Question 4.1: Do members enrolled in an ACC plan have the same or higher overall health rating compared to prior to the renewal period?	4-1: Percentage of members who reported a rating of overall health as very good or excellent	N/A	- Beneficiary survey - National/regional benchmarks - BRFSS	- Comparison to national/regional benchmarks - Pre-test/post-test - Subgroup analysis of children and adults
Research Question 4.2: Do members enrolled in an ACC plan have the same or higher overall mental or emotional health rating compared to prior to the renewal period?	4-2: Percentage of members who reported a rating of overall mental or emotional health as very good or excellent	N/A	- Beneficiary survey - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - Subgroup analysis of children and adults
Hypothesis 5: Member satisfaction with their health care will be maintained or improved during the renewal period.				
Research Question 5.1: Are members equally or more satisfied with their health care as a result of integrated care during the renewal period?	5-1: Percentage of members who reported a high rating of health plan (8, 9, or 10 out of 10)	N/A	- Beneficiary survey - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - Subgroup analysis of children and adults

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	5-2: Percentage of members who reported a high rating of overall health care (8, 9, or 10 out of 10)	N/A	- Beneficiary survey - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - Subgroup analysis of children and adults
Hypothesis 6: The ACC program provides cost-effective care.				
Research Question 6.1: What are the costs associated with the integration of care under ACC during the renewal period?	There are no specific measures associated with this hypothesis; see Cost Effectiveness Analysis Section for additional detail	N/A	N/A	Cost effectiveness analysis
Research Question 6.2: What are the benefits/savings associated with the integration of care under ACC during the renewal period?				

Note: ACC: AHCCCS Complete Care; ASIIS: Arizona State Immunization Information System; BH: behavioral health; BRFSS: Behavioral Risk Factor Surveillance System; ED: emergency department; IP: inpatient; ITS: interrupted time series; N/A: not applicable; OB/GYN: obstetrician gynecologist; PCP: primary care provider; SUD: substance use disorder.

Table 3-3—ACC-RBHA Evaluation Measures

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
Research Question 1.1: Do adult members with an SMI enrolled in an ACC-RBHA have the same or increased access to primary care services compared to prior to the waiver renewal?	1-1: Percentage of members meeting minimum time/distance network standards	N/A	Member and provider data	- Pre-test/post-test - ITS - Subgroup analysis by county and/or urbanicity -Subgroup analysis of children and adults
	1-2: Percentage of adults who accessed preventive/ambulatory health services	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	1-3: Percentage of members who reported they received care as soon as they needed	N/A	Beneficiary survey	Pre-test/post-test
	1-4: Percentage of members who reported they were able to schedule an appointment for a checkup or routine care at a doctor's office or clinic as soon as they needed	N/A	Beneficiary Survey	Pre-test/post-test

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	1-5: Percentage of members who reported they were able to schedule an appointment with a specialist as soon as they needed	N/A	Beneficiary survey	Pre-test/post-test
Research Question 1.2: Do adult members with an SMI enrolled in an ACC-RBHA have the same or increased access to substance abuse treatment compared to prior to the waiver renewal?	1-6: Percentage of members who had initiation of SUD treatment	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	1-7: Percentage of members who had engagement of SUD treatment	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
Hypothesis 2: Quality of care will be maintained or improved during the renewal period.				
Research Question 2.1: Do adult members with an SMI enrolled in an ACC-RBHA have the same or higher rates of appropriate immunizations compared to prior to waiver renewal?	2-1: Percentage of members who reported having a flu shot or nasal flu spray	N/A	Beneficiary Survey	Pre-test/post-test
Research Question 2.2: Do adult members with an SMI enrolled in an ACC-RBHA have the same or better management of chronic conditions compared to prior to the waiver renewal?	2-2: Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	2-3: Percentage of members with schizophrenia or bipolar disorder using antipsychotic medications who had a diabetes screening test	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	2-4: Percentage of members with schizophrenia who adhered to antipsychotic medications	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
Research Question 2.3: Do adult members with an SMI enrolled in an ACC-RBHA have the same or better	2-5: Percentage of members who remained on antidepressant medication treatment	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
management of BH conditions compared to prior to the waiver renewal?	2-6: Percentage of members with a follow-up visit after hospitalization for mental illness	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	2-7: Percentage of members with a follow-up visit after an ED visit for mental illness	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	2-8: Percentage of members with a follow-up visit after an ED visit for SUD	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	2-9: Percentage of members diagnosed with a mental health disorder	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	2-10: Percentage of members receiving mental health services (total and by IP, IOP or partial hospitalization, OP, ED, or telehealth)	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
Research Question 2.4: Do adult members with an SMI enrolled in an ACC-RBHA have the same or better management of opioid prescriptions compared to prior to the waiver renewal?	2-11: Percentage of members who have prescriptions for opioids at a high dosage	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	2-12: Percentage of members with concurrent use of opioids and benzodiazepines	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
Research Question 2.5: Do adult members with an SMI enrolled in an ACC-RBHA have the same or lower tobacco usage compared to prior to the waiver renewal?	2-13: Percentage of members who indicated smoking cigarettes or using tobacco	N/A	Beneficiary Survey	Pre-test/post-test
Research Question 2.6: Do adult members with an SMI enrolled in an ACC-RBHA have the same or lower	2-14: Number of emergent ED visits per 1,000 member months	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
hospital utilization compared to prior to the waiver renewal?	2-15: Number of non-emergent ED visits per 1,000 member months	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	2-16: Number of IP stays per 1,000 member months	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	2-17: Percentage of IP discharges with an unplanned readmission within 30 days	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
Hypothesis 3: Health outcomes for adult members with an SMI enrolled in an ACC-RBHA will be maintained or improved during the renewal period.				
Research Question 3.1: Do adult members with an SMI enrolled in an ACC-RBHA have the same or higher rating of health compared to prior to the waiver renewal?	3-1: Percentage of members who reported a rating of overall health as very good or excellent	N/A	Beneficiary survey	Pre-test/post-test
	3-2: Percentage of members who reported a rating of overall mental or emotional health as very good or excellent	N/A	Beneficiary survey	Pre-test/post-test
Hypothesis 4: Adult member satisfaction in ACC-RBHA health plans will be maintained or improved over the renewal period.				
Research Question 4.1: Do adult members with an SMI enrolled in an ACC-RBHA have the same or higher satisfaction in their health care compared to prior to the waiver renewal?	4-1: Percentage of members who reported a high rating of overall health care (8, 9, or 10 out of 10)	N/A	Beneficiary survey	Pre-test/post-test
	4-2: Percentage of members who reported a high rating of health plan (8, 9, or 10 out of 10)	N/A	Beneficiary survey	Pre-test/post-test
Research Question 4.2: Do adult members with an SMI enrolled in an ACC-RBHA perceive their doctors to have the same or better care coordination compared to prior to the waiver renewal?	4-3: Percentage of members who reported their doctor seemed informed about the care they received from other health providers	N/A	Beneficiary survey	Pre-test/post-test

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
Hypothesis 5: ACC-RBHAs encourage and/or facilitate care coordination among PCPs and BH practitioners.				
Research Question 5.1: What care coordination strategies are the ACC-RBHAs conducting for their members with an SMI?	5-1: ACC-RBHAs' reported evolution of care coordination since the integration period and remaining barriers during the renewal period	N/A	Key informant interviews	Qualitative synthesis
	5-2: ACC-RBHAs' reported challenges from any workforce shortages	N/A	Key informant interviews	Qualitative synthesis
Research Question 5.2: Have care coordination strategies for members with an SMI changed as a result of ACC?	5-3: Reported changes in health plans' care coordination strategies for members with an SMI	N/A	Key informant interviews	Qualitative synthesis
Research Question 5.3: What care coordination strategies is AHCCCS conducting for its members with an SMI?	5-4: AHCCCS' reported care coordination strategies and activities for members with an SMI served by the ACC-RBHAs	N/A	Key informant interviews	Qualitative synthesis
	5-5: AHCCCS' reported challenges from any workforce shortages	N/A	Key informant interviews	Qualitative synthesis
Research Question 5.4: What care coordination strategies and/or activities are providers conducting for their Medicaid patients with an SMI served by the ACC-RBHAs?	5-6: Providers' reported evolution of care coordination since the integration period and remaining barriers during the renewal period	N/A	Provider focus groups	Qualitative synthesis
Research Question 5.5: Did care coordination strategies improve or maintain patient engagement and follow up care for substance use and BH conditions during the renewal period?	5-7: Percentage of members with follow-up after an ED visit for members with multiple high-risk chronic conditions	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/Post-test - ITS

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
Hypothesis 6: ACC-RBHAs will provide cost-effective care for members with an SMI.				
Research Question 6.1: What are the costs associated with providing care for members with an SMI through the ACC-RBHAs during the renewal period?	There are no specific measures associated with this hypothesis; see the Cost Effectiveness Analysis Section for details	N/A	N/A	Cost effectiveness analysis
Research Question 6.2: What are the benefits/savings associated with providing care for members with an SMI through the ACC-RBHAs during the renewal period?				

Note: ACC-RBHA: AHCCCS Complete Care-Regional Behavioral Health Agreement; BH: behavioral health; ED: emergency department; IP: inpatient; IOP: intensive outpatient program; ITS: interrupted time series; N/A: not applicable; OP: outpatient; PCP: primary care provider; SMI; serious mental illness; SUD: substance use disorder.

Table 3-4—ALTCS Evaluation Measures

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
Hypothesis 1: Member access to appropriate care for routine medical conditions will be maintained or improved during the renewal period.				
Research Question 1.1: Do members who are EPD, and/or members with a DD have the same or higher rates of access to care and primary care services compared to prior to waiver renewal?	1-1: Percentage of members meeting minimum time/distance network standards	N/A	Member and provider data	- Pre-test/post-test - ITS - Subgroup analysis by county and/or urbanicity - Subgroup analysis of children and adults
	1-2: Percentage of members who accessed preventive/ambulatory health services	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	1-3: Percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	1-4: Percentage of members who had well-child visits in the first 30 months of life	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	1-5: Percentage of members 3–21 years of age who had a well-care visit with a PCP or OB/GYN	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
Research Question 1.2: Do adult members who are EPD, and/or members with DD have the same or improved rates of access to care as a result of the waiver renewal?	1-6: Percentage of members who have a primary care doctor or practitioner	Weighted national average of all other NCI-participating states	- NCI-IDD AFS - NCI-IDD FGS	- Pre-test/post-test - DiD
	1-7: Percentage of members who had a complete physical exam in the past year	Weighted national average of all other NCI-participating states	- NCI-AD survey	- Pre-test/post-test - DiD
	1-8: Percentage of members who had a dental exam in the past year	Weighted national average of all other NCI-participating states	- NCI-IDD AFS - NCI-IDD FGS - NCI-AD survey	- Pre-test/post-test - DiD
	1-9: Percentage of members who had an eye exam in the past year	Weighted national average of all other NCI-participating states	- NCI-AD survey	- Pre-test/post-test - DiD
	1-10: Percentage of members who had an influenza vaccine in the past year	Weighted national average of all other NCI-participating states	- NCI-AD survey	- Pre-test/post-test - DiD
Hypothesis 2: Quality of care will be maintained or improved during the renewal period.				
Research Question 2.1: Do members who are EPD, and/or members with DD have the same or higher rates of preventive care compared to prior to waiver renewal?	2-1: Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
Research Question 2.2: Do members who are EPD, and/or members with DD have the same or better management of BH conditions compared to prior to waiver renewal?	2-2: Percentage of members with a follow-up visit after hospitalization for mental illness	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	2-3: Percentage of adult members who remained on an antidepressant medication treatment	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	2-4: Percentage of members with a follow-up visit after an ED visit for SUD	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Comparison to national/regional benchmarks - Pre-test/post-test - ITS - Subgroup analysis of children and adults
	2-5: Percentage of members diagnosed with a mental health disorder	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
Research Question 2.3: Do adult members who are EPD have the same or better management of prescriptions compared to prior to waiver renewal?	2-6: Percentage of members with dispensing events of high-risk medications	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	2-7: Percentage of members who know what prescription medications are for	Weighted national average of all other NCI-participating states	NCI-AD survey	- Pre-test/post-test - DiD
Research Question 2.4: Do members who are EPD, and/or members with DD have the same or higher rates of utilization of care compared to prior to waiver renewal?	2-8: Number of emergent ED visits per 1,000 member months	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	2-9: Number of non-emergent ED visits per 1,000 member months	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	2-10: Number of IP stays per 1,000 member months	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	2-11: Percentage of adult IP discharges with an unplanned readmission within 30 days	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
Hypothesis 3: Quality of life for members will be maintained or improved during the renewal period.				
Research Question 3.1: Do members have the same or higher rates of living in their own home as a result of the ALTCS waiver renewal?	3-1: Percentage of members residing in their own home	N/A	- PMMIS - HEAplus	- Pre-test/post-test - DiD
	3-2: Type of residence for adult members with DD	Weighted national average of all other NCI-participating states	- NCI-IDD FGS - NCI-AD survey	- Pre-test/post-test - DiD

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
Research Question 3.2: Do adult members have the same or higher rates of feeling satisfied with their living arrangements as a result of the waiver renewal for members who are EPD, and/or members with DD?	3-3: Percentage of members who want to live somewhere else	Weighted national average of all other NCI-participating states	- NCI-AD survey	- Pre-test/post-test - DiD
	3-4: Percentage of members who believe services and supports help them live a good life	Weighted national average of all other NCI-participating states	- NCI-IDD AFS - NCI-IDD FGS - NCI-AD survey	- Pre-test/post-test - DiD
Research Question 3.3: Do adult members have the same or higher rates of feeling engaged as a result of the waiver renewal for members who are EPD and/or members with DD?	3-5: Percentage of members able to go out and do things they like to do in the community	Weighted national average of all other NCI-participating states	- NCI-IDD AFS - NCI-IDD FGS - NCI-AD survey	- Pre-test/post-test - DiD
	3-6: Percentage of members who have friends who are not staff or family members	Weighted national average of all other NCI-participating states	- NCI-IDD AFS - NCI-IDD FGS - NCI-AD survey	- Pre-test/post-test - DiD
	3-7: Percentage of members who decide or have input in deciding their daily schedule	Weighted national average of all other NCI-participating states	NCI-IDD IPS	- Pre-test/post-test - DiD
	3-8: Percentage of members who usually like how they spend their time during the day	Weighted national average of all other NCI-participating states	NCI-AD survey	- Pre-test/post-test - DiD
Hypothesis 4: ALTCS encourages and/or facilitates care coordination among PCPs and BH practitioners.				
Research Question 4.1: Did DES/DDD, ALTCS-EPD, or their contracted plans encounter barriers during the waiver renewal period of care for members with DD or EPD?	4-1: DES/DDD and its contracted plans' reported barriers that persisted beyond the initial integration of care	N/A	Key informant interview	Qualitative synthesis
	4-2: DES/DDD and its contracted plans' reported challenges from any workforce shortages	NA	Key informant interview	Qualitative synthesis
	4-3: ALTCS-EPD and its contracted plans' reported challenges from any workforce shortages	N/A	Key informant interview	Qualitative synthesis

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
Research Question 4.2: What care coordination strategies did DES/DDD and its contracted plans implement as a result of the waiver renewal?	4-4: DES/DDD's reported evolution of care coordination since the integration period	N/A	Key informant interview	Qualitative synthesis
Research Question 4.3: Did DES/DDD or its contracted plans encounter barriers to renewal of the waiver for care coordination strategies?	4-5: DES/DDD and its contracted plans' reported barriers to implementing care coordination strategies	N/A	Key informant interview	Qualitative synthesis
Research Question 4.4: Did AHCCCS encounter barriers related to the waiver renewal for members with DD?	4-6: AHCCCS' reported barriers during the waiver renewal period	N/A	Key informant interview	Qualitative synthesis
	4-7: AHCCCS' reported challenges from any workforce shortages	N/A	Key informant interview	Qualitative synthesis
Research Question 4.5: Did providers encounter barriers related to the waiver renewal for members with DD?	4-8: Providers' reported evolution of care coordination since the integration period and remaining barriers during the renewal period	N/A	Key informant interview	Qualitative synthesis
Research Question 4.6: Did care coordination strategies improve or maintain patient engagement and follow-up care for substance use and BH conditions during the renewal period?	4-9: Percentage of members with multiple high-risk chronic conditions with follow-up after ED visit	N/A	- State eligibility and enrollment data - Claims/encounter data	-Pre-test/post-test - ITS
	4-10: Percentage of members with patient engagement after discharge	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
Hypothesis 5: The PPCG service model and EFSS will maintain or increase the rate of members being served in the home.				
Research Question 5.1: Is the percentage of members receiving services at home the same or higher after the implementation of the PPCG service model or EFSS?	5-1: Percentage of minor members receiving services through the PPCG service model	N/A	- AHCCCS reports - State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	5-2: Percentage of members receiving EFSS	N/A	AHCCCS reports	- Pre-test/post-test - ITS
Research Question 5.2: What is the frequency and types of services provided to ALTCS members receiving services	5-3: Types and percentage of services provided to minor members by parents	N/A	- AHCCCS reports - State eligibility and enrollment data	- Pre-test/post-test - ITS

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
through the PPCG service model or EFSS at home?			- Claims/encounter data	
	5-4: Average number of PPCG services per utilizing member	N/A	- AHCCCS reports - State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	5-5: Average number of EFSS per utilizing member	N/A	- AHCCCS reports - State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
Hypothesis 6: The PPCG service model will maintain or improve access to quality health services for the target population.				
Research Question 6.1: Did minor members receiving services through the PPCG service model maintain or improve their access to health services?	6-1: Percentage of members with well-child visits in the first 30 months of life	- ALTCS minors who live at home and receive HCBS – National/ regional benchmarks	- State eligibility and enrollment data - Claims/encounter data	DiD
	6-2: Percentage of members 3–21 years of age with a well-care visit with a PCP or OB/GYN	- ALTCS minors who live at home and receive HCBS -National/ regional benchmarks	- State eligibility and enrollment data - Claims/encounter data	DiD
	6-3: Diagnosed mental health disorders	ALTCS minors who live at home and receive HCBS	- State eligibility and enrollment data - Claims/encounter data	DiD
Research Question 6.2: Did the PPCG service model impact hospital utilization among ALTCS minors?	6-4: Number of emergent ED visits per 1,000 member months	ALTCS minors who live at home and receive HCBS	- State eligibility and enrollment data - Claims/encounter data	DiD
	6-5: Number of non-emergent ED visits per 1,000 member months	ALTCS minors who live at home and receive HCBS	- State eligibility and enrollment data - Claims/encounter data	DiD
	6-6: Number of IP stays per 1,000 member months	- ALTCS minors who live at home and receive HCBS	- State eligibility and enrollment data - Claims/encounter data	DiD

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
		-National/ regional benchmarks		
Hypothesis 7: The PPCG service model and EFSS will improve self-assessed health outcomes.				
Research Question 7.1: Do members receiving services through the PPCG service model or EFSS experience improved self-assessed health outcomes?	7-1: Member rating of overall health	ALTCS members who do not receive services at home	Beneficiary survey	Post implementation trend
	7-2: Member rating of overall mental or emotional health	ALTCS members who do not receive services at home	Beneficiary survey	Post implementation trend
Hypothesis 8: The PPCG service model will mitigate the DCW shortage by increasing timely accessibility to care providers.				
Research Question 8.1: Did the PPCG service model alleviate the shortage of DCWs and increase timely access to needed care?	8-1: Average time from identification of service needs to receipt of service	ALTCS minors who live at home and receive HCBS	- State eligibility and enrollment data - Claims/encounter data - Needs assessment	DiD
	8-2: Reported challenges from workforce shortages	N/A	Key informant interview	Qualitative synthesis
	8-3: Reported changes in recruitment and retention of DCW workforce	N/A	Key informant interview	Qualitative synthesis
	8-4: Proportion of parent DCWs of the total DCW population	N/A	AHCCCS reports	- Pre-test/post-test - ITS
	8-5: Percentage of members receiving respite services	ALTCS minors who live at home and receive HCBS	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	8-6: Number of hours paid weekly to parents providing PPCG services	N/A	AHCCCS reports	- Pre-test/post-test - ITS
	8-7: Number of weekly hours non-parent DCWs provide services to minors	N/A	AHCCCS reports	- Pre-test/post-test - ITS
Hypothesis 9: The PPCG service model will improve ongoing care stability for the target population.				

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
Research Question 9.1: Did the PPCG service model improve or maintain care stability for ALTCS minors?	9-1: Average number of DCWs per member per year	N/A	AHCCCS reports	- Pre-test/post-test - ITS
	9-2: Percentage of members or caregivers who reported care stability as good or excellent	ALTCS minors who live at home and receive HCBS	Beneficiary survey	Post implementation trend
	9-3: DES/DDD and EPD's and providers' reported barriers to care stability	N/A	Key informant interview	Qualitative synthesis
Hypothesis 10: The PPCG service model and Extended Family Support Services will increase member and family unit stability through increased ability to navigate the health care system and decrease stress and burnout.				
Research Question 10.1: Has EFSS restored, enhanced, or maintained family functioning by preserving effective care for members in the home and community?	10-1: Percentage of members or caregivers who reported high levels of stress	- ALTCS members who do not receive services at home - ALTCS minors who live at home and receive HCBS	Beneficiary survey	Post implementation trend
	10-2: Percentage of members or caregivers who reported their ability to navigate the health care system as good or excellent	- ALTCS members who do not receive services at home - ALTCS minors who live at home and receive HCBS	Beneficiary survey	Post implementation trend
	10-3: Percentage of members or caregivers who reported their adjustment to disability as good or excellent	- ALTCS members who do not receive services at home - ALTCS minors who live at home and receive HCBS	Beneficiary survey	Post implementation trend
Research Question 10.2 Has the PPCG service model and EFSS reduced burnout and provided alternate supports for caregivers?	10-4: Percentage of caregivers that report high levels of burnout	- ALTCS members who do not receive services at home - ALTCS minors who live at home and receive HCBS	Beneficiary survey	Post implementation trend

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	10-5: Percentage of parent caregivers who utilize respite services	ALTCS minors who live at home and receive HCBS	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
Hypothesis 11: The PPCG service model and EFSS will maintain or improve community integration and well-being for members.				
Research Question 11.1: Do members receiving services through the PPCG service model and EFSS have the same or lower rates of social isolation?	11-1: Percentage of members or caregivers who reported low rates of social isolation	- ALTCS members who do not receive services at home - ALTCS minors who live at home and receive HCBS	Beneficiary survey	Post implementation trend
	11-2: Average time spent outside the home	- ALTCS members who do not receive services at home - ALTCS minors who live at home and receive HCBS	Beneficiary survey	Post implementation trend
	11-3: Relationships outside of the home	- ALTCS members who do not receive services at home - ALTCS minors who live at home and receive HCBS	Beneficiary survey	Post implementation trend
	11-4: Socialization outside of the home	- ALTCS members who do not receive services at home - ALTCS minors who live at home and receive HCBS	Beneficiary survey	Post implementation trend
	11-5: Type of schooling	- ALTCS members who do not receive services at home - ALTCS minors who live at home and receive HCBS	Beneficiary survey	Post implementation trend
	11-6: Percentage of members engaging with day program services	- ALTCS members who do not receive services at home	- State eligibility and enrollment data - Claims/encounter data	DiD

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
		- ALTCS minors who live at home and receive HCBS		
	11-7: The percentage of respondents who report having friendships with people other than staff or family members	Weighted national average of all other NCI-participating states	- NCI-IDD AFS - NCI-AD	- Pre-test/post-test - DiD
	11-8: The percentage of respondents who report that they would like help to meet new people, make new friends, or keep in contact with friends	Weighted national average of all other NCI-participating states	NCI-IDD AFS	- Pre-test/post-test - DiD
	11-9: The percentage of respondents who report often feeling lonely	Weighted national average of all other NCI-participating states	NCI-IDD AFS	- Pre-test/post-test - DiD
	11-10: Community inclusion scale	Weighted national average of all other NCI-participating states	NCI-IDD AFS	- Pre-test/post-test - DiD
Research Question 11.2: Do members receiving services through the PPCG service model have the same or lower rates of reported cases of child maltreatment?	11-11: Percentage of members with substantiated cases of abuse or neglect	ALTCS minors who live at home and receive HCBS	AHCCCS Reports	- Pre-test/post-test - DiD
Hypothesis 12: ALTCS provides cost-effective care.				
Research Question 12.1: What are the costs associated with the waiver renewal?	There are no specific measures associated with this these research questions; see Cost Effectiveness Analysis Section for additional detail	N/A	N/A	Cost effectiveness analysis
Research Question 12.2: What are the benefits/savings associated with the waiver renewal?				
Research Question 12.3: What are the costs associated with the PPCG service model?				
Research Question 12.4: What are the benefits/savings associated with the PPCG service model?				

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
Research Question 12.5: Did utilization of services increase after the introduction of the PPCG service model?	12-1: Number of billed hours for services provided under the PPCG service model	N/A	- State eligibility and enrollment data - Claims/encounter data - AHCCCS Reports	- Pre-test/post-test - ITS

Note: AD: aging and disabilities; AHCCCS: Arizona Health Care Cost Containment System; ALTCS: Arizona Long Term Care System; BH: behavioral health; DD: developmental disability; DES/DDD: Department of Economic Security/Division of Developmental Disabilities; DiD: difference-in-differences; ED: emergency department; EPD: elderly and/or have physical disabilities; HEAplus: Health-e-Arizona Plus; IDD: intellectual and developmental disabilities; IOP: intensive outpatient; IP: inpatient; IPS: in-person survey; ITS: interrupted time series; NCI: National Core Indicators; OB/GYN: obstetrician/gynecologist; OP: outpatient; PCP: primary care provider; PMMIS: Pre-Paid Medical Management Information System; PPCG: Parents as Paid Caregivers; SUD: substance use disorder

Table 3-5—DCS CHP Evaluation Measures

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
Hypothesis 1: Member access to appropriate care for routine medical conditions will be maintained or improved during the integration period.				
Research Question 1.1: Do DCS CHP members have the same or increased access to PCPs and specialists in the remeasurement period as compared to the baseline?	1-1: Percentage of members meeting minimum time/distance network standards	N/A	Member and provider data	- Pre-test/post-test - ITS - Subgroup analysis by county and/or urbanicity
	1-2: Percentage of members 3–21 years of age who had a well-care visit with a PCP or OB/GYN	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Pre-test/post-test - ITS
	1-3: Percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Pre-test/post-test - ITS
	1-4: Percentage of members who had well-child visits in the first 30 months of life	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Pre-test/post-test - ITS
Hypothesis 2: Quality of care will be maintained or improved during the integration period.				
Research Question 2.1: Do DCS CHP members have the same or higher rates of appropriate immunizations in	2-1: Percentage of children 2 years of age with appropriate immunization status	N/A	- State eligibility and enrollment data - ASIIS - Claims/encounter data	- Pre-test/post-test - ITS

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
the remeasurement period as compared to the baseline?	2-2: Percentage of adolescents 13 years of age with appropriate immunizations	N/A	- State eligibility and enrollment data - ASIIS - Claims/encounter data	- Pre-test/post-test - ITS
Research Question 2.2: Do DCS CHP members have the same or better management of chronic conditions in the remeasurement period as compared to the baseline?	2-3: Percentage of members ages 5 to 18 years who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Pre-test/post-test - ITS
Research Question 2.3: Do DCS CHP members have the same or better management of BH conditions in the remeasurement period as compared to the baseline?	2-4: Percentage of children and adolescents on antipsychotics with metabolic monitoring	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Pre-test/post-test - ITS
	2-5: Percentage of members diagnosed with a mental health disorder	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Pre-test/post-test - ITS
	2-6: Percentage of members with follow-up after an ED visit for mental illness	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	2-7: Percentage of members with follow-up after hospitalization for mental illness	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	2-8: Percentage of members with a follow-up visit after an ED visit for SUD	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
Research Question 2.4: Do DCS CHP members have the same or lower hospital utilization in the remeasurement period as compared to the baseline?	2-9: Number of emergent ED visits per 1,000 member months	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Pre-test/post-test - ITS

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	2-10: Number of non-emergent ED visits per 1,000 member months	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Pre-test/post-test - ITS
	2-11: Number of IP stays per 1,000 member months	N/A	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	- Pre-test/post-test - ITS
Hypothesis 3: DCS CHP encourages and/or facilitates care coordination among PCPs and BH practitioners.				
Research Question 3.1: What barriers did DCS CHP anticipate/encounter during the integration?	3-1: DCS CHP's anticipated/reported barriers during transition	N/A	- Key informant interviews - Provider focus groups	Qualitative synthesis
	3-2: DCS CHP's reported challenges from any workforce shortages	N/A	- Key informant interviews - Provider focus groups	Qualitative synthesis
Research Question 3.2: What care coordination strategies did DCS CHP plan/implement during integration?	3-3: DCS CHP's planned/reported care coordination activities	N/A	- Key informant interviews - Provider focus groups	Qualitative synthesis
Research Question 3.3: What barriers to implementing care coordination strategies did DCS CHP anticipate/encounter?	3-4: DCS CHP's anticipated/reported barriers in implementing care coordination strategies	N/A	- Key informant interviews - Provider focus groups	Qualitative synthesis
Hypothesis 4: CHP provides cost-effective care.				
Research Question 4.1: What are the costs associated with the integration of care in DCS CHP?	There are no specific measures associated with this hypothesis; see Cost Effectiveness Analysis Section for additional detail	N/A	N/A	Cost effectiveness analysis
Research Question 4.2: What are the benefits/savings associated with the integration of care in DCS CHP?				

Note: ASIIS: Arizona State Immunization Information System; BH: behavioral health; CHP: Comprehensive Health Plan; DCS: Department of Child Safety; ED: emergency department; IOP: intensive outpatient; IP: inpatient; ITS: interrupted time series; OB/GYN: obstetrician/gynecologist; OP: outpatient; PCP: primary care provider; SUD: substance use disorder

Table 3-6—H2O Evaluation Measures

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
Hypothesis 1: The demonstration will meet or reduce the severity of HRSN for members overall and among subpopulations who experience disparities in HRSN.				
Research Question 1.1: How does the H2O demonstration impact the use of HRSN services?	1-1: Percentage of members experiencing homelessness who were contacted	N/A	Deliverable submitted to AHCCCS by the H2O-PA	Descriptive time series
	1-2: Percentage of members participating in H2O who completed an intake and received a service within seven days of enrollment	N/A	Deliverable submitted to AHCCCS by the H2O-PA	Descriptive time series
	1-3: Percentage of members eligible for H2O, who are participating in the H2O program	N/A	Claims/encounter data	Descriptive time series
	1-4: Percentage of members participating in H2O who completed an assessment who established a housing care plan	N/A	Deliverable submitted to AHCCCS by the H2O-PA	Descriptive time series
	1-5: Percentage of members participating in H2O, who are receiving H2O services (any service and by service category) – Outreach and education services – Enhanced shelter – Short term rental assistance – One-time transition and move-in costs – Housing pre-tenancy and tenancy services – Medically necessary home accessibility modifications and remediation	N/A	- AHCCCS/H2O list of members receiving services - Claims/encounter data - Outreach is through provider invoicing process	Descriptive time series
	1-6: Number of members on the AHP waitlist who are also H2O eligible	N/A	AHP housing waitlist	Descriptive time series
	1-7: Percentage of members referred to receive short term rental assistance who locate housing within 120 days	N/A	Deliverable submitted to AHCCCS by the H2O-PA	Descriptive time series

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	1-8: Number of enhanced shelter bed inventory statewide	N/A	HUD HDX HIC and PIT data	- Pre-test/post-test - ITS
Research Question 1.2: How do State and local government investments in housing supports change in relation to H2O demonstration funding?	1-9: Change in investment of housing interventions outside of the demonstration	N/A	- Key informant interviews - AHCCCS reports	- Qualitative synthesis - Descriptive analysis
Research Question 1.3: How does the H2O demonstration impact rates of HRSN and their severities?	1-10: Percentage of members who participated in H2O services that received an HRSN/SDOH screening with the PRAPARE screening tool or other appropriate screening tool	N/A	- Claims/encounter data (G codes, Z codes, and HCPCS codes) - CLRS - Other standardized screening tools - Supplemental data from AHCCCS as appropriate	- Repeated cross-sectional design - Descriptive time series - ITS
	1-11: Percentage of members who participated in H2O services that had an HRSN identified, among those who received an HRSN/SDOH screening	N/A	- Claims/encounter data (G codes, Z codes, and HCPCS codes) - CLRS - Other standardized screening tools - Supplemental data from AHCCCS as appropriate	- Repeated cross-sectional design - Descriptive time series - ITS
	1-12: Percentage of members who had a housing-related need identified, among those who received an HRSN/SDOH screening	N/A	- Claims/encounter data (G codes, Z codes, and HCPCS codes) - CLRS - Other standardized screening tools - Supplemental data from AHCCCS as appropriate	- Repeated cross-sectional design - Descriptive time series - ITS

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	1-13: Number of unique H2O referrals sent to providers by H2O-PA (any referral and referral type) – Outreach and education services – Enhanced shelter – Short term rental assistance – One-time transition and move-in costs – Housing pre-tenancy and tenancy services – Medically necessary home accessibility modifications and remediation	N/A	- H2O referral lists (H2O-PA) - CLRS - Supplemental data from AHCCCS as appropriate	- Pre-test/post-test - ITS
	1-14: Percentage of members participating in H2O who were connected to a RBHA PSH provider for ongoing supportive services	N/A	Deliverable submitted to AHCCCS by the H2O-PA	- Pre-test/post-test - ITS
	1-15: Percent of members with SUD diagnosis participating in H2O who connect to OP SUD/recovery services	N/A	- Deliverable submitted to AHCCCS by the H2O-PA - Claims/encounter data	- Pre-test/post-test - ITS
	1-16: Percent of members indicating they were not able to pay mortgage, rent or utility bills in the last three months	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	Beneficiary survey	- Chi-square - Comparison of means
	1-17: Percent of members indicating that a utility company threatened to shut off services in the past three months	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	Beneficiary survey	- Chi-square - Comparison of means
	1-18: Percent of members who are enrolled in SNAP or WIC	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- ADHS and DES SNAP and WIC data - Claims/encounter data	Repeated cross-sectional design

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
Research Question 1.4: How does the H2O demonstration impact members' use of HRSN services reflecting crisis events, such as stays in emergency homeless shelters?	1-19: Number of stays in an emergency shelter per 1,000 members	N/A	- HUD HDX HIC and PIT data - Data from COCs	- Pre-test/post-test - ITS
	1-20: Number of days in an emergency shelter or state of unsheltered homelessness per 1,000 members	N/A	HUD HDX HIC and PIT data	- Pre-test/post-test - ITS
	1-21: Percentage of members reporting they used an emergency shelter in the last six months	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- Beneficiary survey - Deliverable submitted to AHCCCS by the H2O-PA	- Chi-square - Comparison of means
	1-22: Percentage of members reporting they slept in a place not meant for human habitation in the last six months	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	Beneficiary survey	- Chi-square - Comparison of means
Research Question 1.5: Is the H2O demonstration associated with increased positive health and wellbeing outcomes?	1-23: Percentage of members with housing retention, among members participating in H2O who utilize pre-tenancy/tenancy services	N/A	Deliverable submitted to AHCCCS by the H2O-PA	- Pre-test/post-test - ITS
	1-24: Percentage of members who exit to permanent housing, among members participating in H2O who utilize enhanced shelter services	N/A	Deliverable submitted to AHCCCS by the H2O-PA	- Pre-test/post-test - ITS
	1-25: Percentage of members participating in H2O whose housing condition was upgraded during the past month	N/A	Deliverable submitted to AHCCCS by the H2O-PA	- Pre-test/post-test - ITS

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	1-26: Percentage of members participating in H2O who are leaving the H2O program, stratified by the following reasons: – Positive exit reasons: Completed Program, Voluntary Withdrawal – Negative exit reasons: Abandonment, Failure to Locate Housing, Non-Compliance, Failure to Recertify, Incarcerated, Unknown – Neutral: Higher Level of Care, Deceased	N/A	Deliverable submitted to AHCCCS by the H2O-PA	- Pre-test/post-test - ITS
	1-27: Percentage of members participating in H2O who reported employment during engagement	N/A	Deliverable submitted to AHCCCS by the H2O-PA	- Pre-test/post-test - ITS
	1-28: Percentage of members participating in H2O who increased employment during past month	N/A	Deliverable submitted to AHCCCS by the H2O-PA	- Pre-test/post-test - ITS
	1-29: Change in income among members participating in H2O who utilize pre-tenancy/tenancy services	N/A	Deliverable submitted to AHCCCS by the H2O-PA	- Pre-test/post-test - ITS
Research Question 1.6: How does the H2O demonstration impact disparities in HRSN?	All the above Hypothesis 1 measures for use of HRSN services by key subpopulations	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data - Contexture race and ethnicity data	Disparities analysis
Research Question 1.6.1: Does the H2O demonstration mitigate or reduce HRSN among groups who had high rates at baseline?				
Research Question 1.6.2: Do any groups experience increasing or worsening HRSN compared to the baseline with the implementation of the H2O demonstration?				

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
Hypothesis 2: By meeting or reducing the severity of HRSN, the demonstration will increase members' use of preventive and routine care and reduce their use of potentially avoidable hospital and institutional care (ED visits, IP care, and nursing facilities), leading to reduced health care spending over time. Impacts will be realized overall and among subpopulations who experience disparities in hospital and institutional care use.				
Research Question 2.1: How does the H2O demonstration impact the use of preventive and routine care?	2-1: Percentage of adults who accessed preventive/ambulatory health services	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - DiD
	2-2: Percentage of members who have a PCP visit since their intake date, among members participating in H2O who utilize enhanced shelter services	N/A	Deliverable submitted to AHCCCS by the H2O-PA	- Pre-test/post-test - ITS
	2-3: Percentage of adults with a flu vaccine	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	Beneficiary survey	- Chi-square - Comparison of means
	2-4: Percentage of adult members with a cervical cancer screening	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - DiD
	2-5: Percentage of adult members with a breast cancer screening	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - DiD
	2-6: Percent of adult members with a colorectal cancer screening	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - DiD

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	2-7: Percentage of members that were provided a most effective or moderately effective method of contraception	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - DiD
	2-8: Percentage of members that received a prenatal and/or postpartum care visit	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - DiD
	2-9: Percentage of members with a diagnosis of HIV who did not have a medical visit in the last six months of the measurement year	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - DiD
Research Question 2.2: How does the H2O demonstration impact the use of BH services?	2-10: Percentage of members who had initiation of alcohol and other drug abuse or dependence treatment	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - DiD
	2-11: Percentage of members who had engagement of alcohol and other drug abuse or dependence treatment	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - DiD
	2-12: Percentage of members with a follow-up visit after hospitalization for mental illness	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - DiD
	2-13: Percentage of members with a follow-up visit after ED visit for members with multiple high-risk chronic conditions	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - DiD

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	2-14: Percentage of members with follow-up after ED visit for alcohol and other drug abuse or dependence	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - DiD
	2-15: Percentage of members who remained on antidepressant medication treatment	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - DiD
	2-16: Percentage of members with OUD who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - DiD
	2-17: Percentage of members with schizophrenia who adhered to antipsychotic medications	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - DiD
	2-18: Percentage of members who reported a substance use problem who experienced improvement on BARC-10	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	Deliverable from RBHA	- Pre-test/post-test - ITS
Research Question 2.3: How does the H2O demonstration impact the use of hospital and institutional care?	2-19: Number of emergent ED visits per 1,000 member months	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - DiD
	2-20: Number of non-emergent ED visits per 1,000 member months	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - DiD

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	2-21: Number of IP stays per 1,000 member months	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - DiD
	2-22: Risk-adjusted ratio of observed to expected acute IP and observation stay discharges	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - DiD
	2-23: Chronic conditions composite	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - DiD
	2-24: Percentage of members with an ED visit for hypoglycemia among older adults with diabetes	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - DiD
	2-25: Percentage of members with admission to an institution from the community	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - DiD
	2-26: Percent of members who were hospitalized for potentially preventable complications	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	2-27: Percentage of adult IP discharges with an unplanned readmission within 30 days	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - DiD

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
Research Question 2.4: How does the H2O demonstration impact disparities in the use of hospital and institutional care?	All the above Hypothesis 2 measures for hospital and institutional care by key subpopulations	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data - Contexture race and ethnicity data	Disparities analysis
Research Question 2.4.1: Does the demonstration reduce the use of hospital and institutional care among groups who had high rates at baseline?				
Research Question 2.4.2: Do any groups experience increasing use of hospital and institutional care compared to the baseline with the implementation of the HRSN demonstration?				
Hypothesis 3: By meeting or reducing HRSN, the demonstration will improve physical and mental health outcomes among members overall and among subpopulations who experience disparities in physical and mental health outcomes.				
Research Question 3.1: How does the H2O demonstration impact members' physical and mental health outcomes?	3-1: Percentage of members who reported a rating of overall health as very good or excellent	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	Beneficiary survey	- Chi-square - Comparison of means
	3-2: Percentage of members who reported a rating of overall mental or emotional health as very good or excellent	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	Beneficiary survey	- Chi-square - Comparison of means
	3-3: Percentage of members who reported a rating of life satisfaction as "Satisfied" or "Very Satisfied"	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	Beneficiary survey	- Chi-square - Comparison of means
	3-4: Percentage of members who reported "Always" or "Usually" feeling stressed or anxious	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	Beneficiary survey	- Chi-square - Comparison of means

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	3-5: Percentage of births with low birth weight	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Vital records	- Pre-test/post-test - ITS
Research Question 3.2: How does the H2O demonstration impact members' management of chronic conditions?	3-6: Percentage of members with diabetes with poor hemoglobin control	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	3-7: Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
	3-8: Percentage of members with clinical atherosclerotic cardiovascular disease who received and adhered to statin therapy	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS
Research Question 3.3: How does the H2O demonstration impact rates of mortality among members with SMI?	3-9: All-cause mortality rate among AHCCCS members with SMI	N/A	- State eligibility and enrollment data - Vital records	ITS
	3-10: Maternal mortality rate among AHCCCS members with SMI	N/A	- State eligibility and enrollment data - Medicaid administrative - Vital records	ITS
Research Question 3.4: How does the H2O demonstration impact the quality and effectiveness of downstream services?	3-11: Quality and effectiveness of key downstream services of the H2O program	N/A	- Key informant interviews with care coordinators, case managers, and members - AHCCCS reports	- Qualitative synthesis - Descriptive analysis

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
Research Question 3.5: How does the H2O demonstration impact disparities in health outcomes?	All the above Hypothesis 3 measures for physical and mental health outcomes by key subpopulations	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data - Contexture race and ethnicity data - Beneficiary survey	Disparities analysis
Research Question 3.5.1: Does the H2O demonstration improve the physical and mental health outcomes of groups who had poor health outcomes at baseline?				
Research Question 3.5.2: Do any groups experience worsening physical and mental health outcomes compared to the baseline with the implementation of the H2O demonstration?				
Hypothesis 4: The H2O demonstration will reduce cost of care for members who utilize H2O services.				
Research Question 4.1: How does the H2O demonstration impact the total cost of care among H2O members compared to members who are eligible but not participating in the H2O demonstration?	4-1: Total cost of care, stratified by the following categories: – All facility costs – IP facility costs – Professional services costs – Pharmacy costs – PH costs – BH costs	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - DiD
	4-2: Total cost of care by key subpopulations (age, sex, sexual orientation, gender identity, race/ethnicity, English language proficiency, primary language, disability status, geography, eligibility category, HRSN domains, high-cost high-needs)	Members eligible for H2O who did not participate in the program or members on the AHP housing waitlist	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - DiD

Note: ADHS: Arizona Department of Health Services; AHCCCS: Arizona Health Care Cost Containment System; AHP: AHCCCS Housing Program; BARC: Brief Assessment of Recovery Capital; BH: behavioral health; CLRS: closed loop referral system; COC: continuum of care; DES: Department of Economic Security; DiD: difference-in-differences; ED: emergency department; FDA: United States Food and Drug Administration; IP: inpatient; ITS: interrupted time series; HCPCS: Healthcare Common Procedure Coding System; HDX: Homelessness Data Exchange; HIC: housing inventory count; HIV: human immunodeficiency virus; HRSN: health-related social needs; HUD: United States Department of Housing and Urban Development; H2O: Housing and Health Opportunities; H2O-PA: H2O Program Administrator; IQ: implementation question; OP: outpatient; OUD: opioid use disorder; PIT: point-in-time count; PCP: primary care provider; PH: physical health; PRAPARE: Protocol for Responding to and Assessing Patients' Assets Risks, and Experiences; PSH: permanent supportive housing; RBHA: Regional Behavioral Health Agreement; SDOH: social determinants of health; SMI: serious mental illness; SNAP: Supplemental Nutrition Assistance Program; SUD: substance use disorder; WIC: Special Supplemental Nutrition Program for Women, Infants, and Children

Table 3-7—KidsCare Eligibility Expansion Evaluation Measures

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
Hypothesis 1: Expanding KidsCare eligibility will increase the number of members eligible for and enrolled in KidsCare and reduce the number of children losing eligibility for procedural reasons.				
Research Question 1.1: Did expanding KidsCare eligibility increase the number of members enrolled in KidsCare?	1-1: Number of members enrolled in the KidsCare program	N/A	- AHCCCS reports - State eligibility and enrollment data	Descriptive analysis
	1-2: Percentage of KidsCare members out of estimated children eligible for KidsCare	N/A	- AHCCCS reports - IPUMS ACS - State eligibility and enrollment data	Post implementation trend
Research Question 1.2: Did expanding KidsCare eligibility reduce the number of uninsured children?	1-3: Number of uninsured children in Arizona	National Rates	ACS	- Pre/post test - ITS
Research Question 1.3: Does the KidsCare program promote continuity of care for its members?	1-4: Average number of months enrolled	N/A	State eligibility and enrollment data	Post implementation trend
	1-5: Percentage of KidsCare members who re-enroll after a gap of up to six months	N/A	State eligibility and enrollment data	Post implementation trend
	1-6: Average number of gaps in Medicaid coverage for KidsCare members who re-enroll after a gap of up to six months	N/A	State eligibility and enrollment data	Post implementation trend
	1-7: Average number of days per gap in Medicaid coverage for KidsCare members who re-enroll after a gap of up to six months	N/A	State eligibility and enrollment data	Post implementation trend
	1-8: Percentage of KidsCare members due for renewal who complete the renewal process	N/A	- State eligibility and enrollment data - HEAplus	- Pre/post Test - ITS

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
Hypothesis 2: Expanding KidsCare eligibility will improve access to care and increase primary care service utilization for CHIP members.				
Research Question 2.1: Did expanding KidsCare eligibility improve access to health care for CHIP members?	2-1: Percentage of members meeting minimum time/distance network standards	KidsCare members under 200 percent of the FPL	Member and provider data	- Post implementation trend - Subgroup analysis by county and/or urbanicity
Research Question 2.2: Did expanding KidsCare eligibility maintain or increase the utilization of primary care and preventative health services?	2-2: Percentage of children 2 years of age with appropriate immunization status	- KidsCare members under 200 percent of the FPL - National/region-al benchmarks	- State eligibility and enrollment data - ASIIS - Claims/encounter data	Post implementation trend
	2-3: Percentage of adolescents 13 years of age with appropriate immunizations	- KidsCare members under 200 percent of the FPL - National/region-al benchmarks	- State eligibility and enrollment data - ASIIS - Claims/encounter data	Post implementation trend
	2-4: Percentage of members with well-child visits in the first 30 months of life	- KidsCare members under 200 percent of the FPL - National/region-al benchmarks	- State eligibility and enrollment data - Claims/encounter data	Post implementation trend
	2-5: Percentage of members 3-18 years of age with a well-care visit with a PCP or OB/GYN	- KidsCare members under 200 percent of the FPL - National/ region-al benchmarks	- State eligibility and enrollment data - Claims/encounter data	Post implementation trend
	2-6: Percentage of children who received any medical care in the past 12 months	- Uninsured children - National rates	National Survey of Children's Health	- Pre/post Test - ITS - Post implementation trend
	2-7: Percentage of children who did not receive needed health care in the past 12 months	- Uninsured children - National rates	National Survey of Children's Health	- Pre/post Test - ITS - Post implementation trend

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	2-8: Percentage of children who did not receive needed health care due to cost in the past 12 months	- Uninsured children - National rates	National Survey of Children's Health	- Pre/post Test - ITS - Post implementation trend
	2-9: Percentage of children screened for risk of developmental, behavioral, and social delays in the 12 months prior to third birthday	- KidsCare members under 200 percent of the FPL - National/regional benchmarks	- State eligibility and enrollment data - Claims/encounter data	Post implementation trend
	2-10: Percentage of children who had an outpatient visit with a PCP who received a weight assessment or nutrition counseling	- KidsCare members under 200 percent of the FPL - National/regional benchmarks	- State eligibility and enrollment data - Claims/encounter data - National/regional benchmarks	Post implementation trend
Research Question 2.3: Did expanding KidsCare eligibility improve access to dental care for CHIP members?	2-11: Percentage of members under 21 who received a comprehensive or periodic oral evaluation	KidsCare members under 200 percent of the FPL National/regional benchmarks	- State eligibility and enrollment data - Claims/encounter data	Post implementation trend
	2-12: Percentage of members under 21 who received a topical fluoride application	- KidsCare members under 200 percent of the FPL - National/regional benchmarks	- State eligibility and enrollment data - Claims/encounter data	Post implementation trend
Hypothesis 3: Expanding KidsCare eligibility will improve member care satisfaction.				
Research Question 3.1: Did expanding KidsCare eligibility improve member satisfaction with the care received?	3-1: Member rating of personal doctor	N/A	Beneficiary survey	Post implementation trend
	3-2: Member response to getting needed care right away	N/A	Beneficiary survey	Post implementation trend
	3-3: Member response to getting an appointment for a check-up or routine care at a doctor's office or clinic	N/A	Beneficiary survey	Post implementation trend

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
Hypothesis 4: Expanding KidsCare eligibility will improve quality of care for members.				
Research Question 4.1: Did expanding KidsCare eligibility improve the management of BH conditions?	4-1: Percentage of children and adolescents on antipsychotics with metabolic monitoring	- KidsCare members under 200 percent of the FPL - National/regional benchmarks	- State eligibility and enrollment data - Claims/encounter data	Post implementation trend
	4-2: Percentage of children on ADHD medication with a follow-up during the 30-day initiation phase and the 210-day continuation phase	- KidsCare members under 200 percent of the FPL - National/regional benchmarks	- State eligibility and enrollment data - Claims/encounter data	Post implementation trend
	4-3: Follow-up after ED visit for substance use	- KidsCare members under 200 percent of the FPL - National/regional benchmarks	- State eligibility and enrollment data - Claims/encounter data	Post implementation trend
	4-4: Follow-up after hospitalization for mental illness	- KidsCare members under 200 percent of the FPL - National/regional benchmarks	- State eligibility and enrollment data - Claims/encounter data	Post implementation trend
	4-5: Follow-up after ED visit for mental illness	- KidsCare members under 200 percent of the FPL - National/regional benchmarks	- State eligibility and enrollment data - Claims/encounter data	Post implementation trend
	4-6: Diagnosed mental health disorders	- KidsCare members under 200 percent of the FPL - National/regional benchmarks	- State eligibility and enrollment data - Claims/encounter data	Post implementation trend
Research Question 4.2: Did expanding KidsCare eligibility impact hospital utilization?	4-7: Number of emergent ED visits per 1,000 member months	KidsCare members under 200 percent of the FPL	- State eligibility and enrollment data - Claims/encounter data	Post implementation trend
	4-8: Number of non-emergent ED visits per 1,000 member months	KidsCare members under 200 percent of the FPL	- State eligibility and enrollment data - Claims/encounter data	Post implementation trend

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	4-9: Number of IP stays per 1,000 member months	- KidsCare members under 200 percent of the FPL - National/regional benchmarks	- State eligibility and enrollment data - Claims/encounter data	Post implementation trend
Research Question 4.3: Did expanding KidsCare eligibility maintain or improve the management of chronic conditions for members?	4-10: Percentage of members ages 5 to 18 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year	- KidsCare members under 200 percent of the FPL - National/regional benchmarks	- State eligibility and enrollment data - Claims/encounter data	Post implementation trend
	4-11: Number of children hospitalized for asthma conditions	KidsCare members under 200 percent of the FPL	- State eligibility and enrollment data - Claims/encounter data	Post implementation trend
	4-12: Number of children diagnosed with diabetes	KidsCare members under 200 percent of the FPL	- State eligibility and enrollment data - Claims/encounter data	Post implementation trend
	4-13: Number of hospitalizations or ED visits for diabetes	Children not enrolled in AHCCCS	- Arizona Department of Health Services/Bureau of Public Health Statistics Hospital Discharge Data - State eligibility and enrollment data - Claims/encounter data	Post implementation trend
	4-14: Percentage of children with diabetes whose lab tests indicate control of their conditions	KidsCare members under 200 percent of the FPL	- State eligibility and enrollment data - The independent evaluator will work with AHCCCS to determine if laboratory data will be available	Post implementation trend
Research Question 4.4: Did expanding KidsCare eligibility improve parental understanding of their child's care?	4-15: Parent understanding of their child's health	N/A	Beneficiary survey	Post implementation trend
	4-16: Parent understanding of their child's care needs	N/A	Beneficiary survey	Post implementation trend
	4-17: Parent knowledge of when to seek care for their child	N/A	Beneficiary survey	Post implementation trend

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
Hypothesis 5: Expanding KidsCare will improve self-assessed health outcomes.				
Research Question 5.1: Did expanding KidsCare improve member perception of health outcomes?	5-1: Percentage of members who reported a rating of overall health as very good or excellent	N/A	Beneficiary survey	Post implementation trend
	5-2: Percentage of members who reported a rating of overall mental or emotional health as very good or excellent	N/A	Beneficiary survey	Post implementation trend
Hypothesis 6: Expanding KidsCare will yield cost-effective care for members.				
Research Question 6.1: Did the KidsCare program provide cost-effective care for members?	6-1: Total cost of care for KidsCare expansion members and KidsCare members under 200 percent of the FPL	KidsCare members under 200 percent of the FPL	- State eligibility and enrollment data - Claims/encounter data	Post implementation trend
	6-2: Change in reported medical debt	National rates	- SIPP - Beneficiary survey	Post implementation trend

Note: ACS: American Community Survey; ADHD: attention-deficit hyperactivity disorder; AHCCCS: Arizona Health Care Cost Containment System; ASIIS: Arizona State Immunization Information System; BH: behavioral health; CHIP: Children's Health Insurance Program; ED: emergency department; FPL: federal poverty level; HEAplus: Health-e-Arizona Plus; ITS: interrupted time series; IP: inpatient; IPUMS: Integrated Public Use Microdata Series; OB/GYN: obstetrician/gynecologist; PCP: primary care provider; SIPP: Survey of Income and Program Participation

Table 3-8—PQC Evaluation Measures

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
Hypothesis 1: Eliminating PQC will increase the likelihood and continuity of enrollment.				
Research Question 1.1: Do eligible people without PQC enroll in Medicaid at the same rates as other eligible people with PQC?	1-1: Percentage of Medicaid enrollees per month by eligibility group out of estimated eligible Medicaid recipients	N/A	IPUMS ACS	Pre-test/post-test
	1-2: Percentage of new Medicaid enrollees per month by eligibility group, as identified by those without a recent spell of Medicaid coverage out of estimated eligible Medicaid recipients	N/A	- Eligibility and enrollment data - IPUMS ACS	- ITS - Pre-test/post-test

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	1-3: Number of Medicaid enrollees per month by eligibility group and/or per-capita of State	N/A	- Eligibility and enrollment data - State of Arizona Office of Economic Opportunity	Rapid-cycle reporting—statistical process control chart
	1-4: Number of new Medicaid enrollees per month by eligibility group, as identified by those without a recent spell of Medicaid coverage	N/A	Eligibility and enrollment data	Rapid-cycle reporting—statistical process control chart
Research Question 1.2: What is the likelihood of enrollment continuity for those without PQC compared to other Medicaid members with PQC?	1-5: Percentage of Medicaid members due for renewal who complete the renewal process	N/A	Eligibility and enrollment data	- Pre-test/post-test - ITS
	1-6: Average number of months with Medicaid coverage	N/A	Eligibility and enrollment data	- Pre-test/post-test - ITS
Research Question 1.3: Do members without PQC who disenroll from Medicaid have shorter enrollment gaps than other members with PQC?	1-7: Percentage of Medicaid members who re-enroll after a gap of up to six months	N/A	Eligibility and enrollment data	- Pre-test/post-test - ITS
	1-8: Average number of months without Medicaid coverage for members who re-enroll after a gap of up to six months	N/A	Eligibility and enrollment data	- Pre-test/post-test - ITS
	1-9: Average number of gaps in Medicaid coverage for members who re-enroll after a gap of up to six months	N/A	Eligibility and enrollment data	Pre-test/post-test
	1-10: Average number of days per gap in Medicaid coverage for members who re-enroll after a gap of up to six months	N/A	Eligibility and enrollment data	Pre-test/post-test
Hypothesis 2: Eliminating PQC will increase enrollment of eligible people when they are healthy.				
Research Question 2.1: Do newly enrolled members without PQC have higher self-assessed health status?	2-1: Member reported rating of overall health	N/A	State beneficiary survey	Chi-square
	2-2: Member reported rating of overall mental or emotional health	N/A	State beneficiary survey	Chi-square
	2-3: Percentage of members who reported prior year ED visit	N/A	State beneficiary survey	Chi-square

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	2-4: Percentage of members who reported prior year hospital admission	N/A	State beneficiary survey	Chi-square
	2-5: Percentage of members who reported getting health care three or more times for the same condition or problem	N/A	State beneficiary survey	Chi-square
Hypothesis 3: Health outcomes will be better for those without PQC compared to Medicaid members with PQC.				
Research Question 3.1: Do members without PQC have better health outcomes when compared to outcomes prior to the renewal period rates and out-of-state outcomes for those with PQC?	3-1: Member reported rating of overall health for all members	N/A	- State beneficiary survey - BRFSS	- Comparison to national benchmarks - Pre-test/post-test
	3-2: Member reported rating of overall mental or emotional health for all members	N/A	State beneficiary survey	- Comparison to national benchmarks - Pre-test/post-test
Hypothesis 4: Eliminating PQC will not have adverse financial impacts on consumers.				
Research Question 4.1: Does the PQC waiver lead to changes in the incidence of member medical debt?	4-1: Percentage of members who reported medical debt	N/A	- State beneficiary survey - BRFSS	Comparison to other states
Hypothesis 5: Eliminating PQC will not adversely affect access to appropriate care for routine medical conditions.				
Research Question 5.1: Do members without PQC have the same or higher rates of office visits compared to members with PQC?	5-1: Member response to getting needed care right away	N/A	State beneficiary survey	- Comparison to national benchmarks - Pre-test/post-test
	5-2: Member response to getting an appointment for a check-up or routine care at a doctor's office or clinic	N/A	State beneficiary survey	- Comparison to national benchmarks - Pre-test/post-test
Research Question 5.2: Do members without PQC have the same or higher rates of service and facility utilization compared to rates prior to waiver renewal with PQC?	5-3: Percentage of members with a visit to a specialist (e.g., eye doctor, ENT, cardiologist)	N/A	- Eligibility and enrollment data - Administrative claims data	- Comparison to national benchmarks - Pre-test/post-test

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
Hypothesis 6: Eliminating PQC will not result in reduced member satisfaction.				
Research Question 6.1: Do members without PQC have the same or higher satisfaction with their health care compared to prior to waiver renewal with PQC?	6-1: Member rating of overall health care	N/A	State beneficiary survey	Pre-test/post-test
Hypothesis 7: Eliminating PQC will generate cost savings over the term of the waiver.				
Research Question 7.1: What are the costs associated with eliminating PQC?	There are no specific measures associated with this hypothesis; see Cost Effectiveness Analysis Section for additional detail	N/A	N/A	Cost effectiveness analysis
Research Question 7.2: What are the benefits/savings associated with eliminating PQC?				
Research Question 7.3: Do costs to non-AHCCCS entities stay the same or decrease after implementation of the waiver compared to before?	7-1: Reported costs for uninsured and/or likely eligible Medicaid recipients among potentially impacted providers and/or provider networks	N/A	- Provider focus groups - HCRIS - HCUP-SID	- ITS - Qualitative synthesis

Note: ACS: American Community Survey; BRFSS: Behavioral Risk Factor Surveillance System; ED: emergency department; ENT: otolaryngologist; HCRIS: Healthcare Cost Report Information System; HCUP-SID: Healthcare Cost and Utilization Project State Inpatient Database; IPUMS: Integrated Public Use Microdata Series; ITS: interrupted time series; PQC: Prior Quarter Coverage.

Table 3-9—Tribal Dental Authority Evaluation Measures

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
Hypothesis 1: Member access to appropriate, routine dental care will be maintained or improved during the renewal period.				
Research Question 1.1: Did the waiver result in an increased number of dental providers practicing in IHS and 638 facilities?	1-1: Percentage of members meeting minimum time/distance network standards	N/A	Member and provider data	- Pre-test/post-test - ITS - Subgroup analysis by county and/or urbanicity - Post-implementation trend analysis
	1-2: Number of dental providers practicing in IHS facilities	N/A	Member and provider data	- Pre-test/post-test - ITS - Post-implementation trend analysis

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	1-3: IHS/Tribal 638 staff's reported change in practicing dental providers after the implementation of the expanded tribal dental benefit	N/A	Key informant interviews	Qualitative Synthesis
	1-4: IHS/Tribal 638 staff's reported barriers before, during, and shortly following the implementation of the expanded tribal dental benefit	N/A	Key informant interviews	Qualitative Synthesis
	1-5: IHS/Tribal 638 staff's reported changes in quality of care and access to care for tribal members after the implementation of the tribal dental benefit	N/A	Key informant interviews	Qualitative Synthesis
Research Question 1.2: Do members have the same or better access to routine, preventive dental services compared to prior to the demonstration?	1-6: Percentage of adult members who received a comprehensive or periodic oral evaluation	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - Post-implementation trend analysis
	1-7: Number of adult members receiving any covered service in the plan year	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - Post-implementation trend analysis
Hypothesis 2: Quality of care will be maintained or improved during the renewal period.				
Research Question 2.1: Do members have the same or better management of chronic dental conditions compared to prior to the demonstration?	2-1: Percentage of adult members with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - Post-implementation trend analysis
	2-2: Percentage of enrolled adults ages 30 years and older with a history of periodontitis who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - Post-implementation trend analysis

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	2-3: Percentage of enrolled adults ages 30 years and older with a history of periodontitis who received an oral prophylaxis or scaling/root planing or periodontal maintenance visit at least two times within the reporting year	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - Post-implementation trend analysis
	2-4: Percentage of enrolled adults ages 18 years and older who are at "elevated" risk (i.e., "moderate" or "high") and received at least two topical fluoride applications within the reporting year	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - Post-implementation trend analysis
Research Question 2.2: Do members have equal or lower ED or hospital utilization compared to prior to the demonstration?	2-5: Number of ED visits for ambulatory care sensitive dental conditions	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - Post-implementation trend analysis
	2-6: Percentage of ambulatory care sensitive dental condition ED visits among adults who visited a dentist after an ED visit	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - Post-implementation trend analysis
Hypothesis 3: Member oral health outcomes will be maintained or improved during the renewal period.				
Research Question 3.1: Do members have the same or better oral health outcomes compared to prior to the demonstration?	3-1: Percentage of members with permanent tooth loss	AI/AN Medicaid members responding to BRFSS survey from all other states that participated	BRFSS	- Pre-test/post-test - DiD
	3-2: Percentage of members with dental caries	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - Post-implementation trend analysis
	3-3: Percentage of members with periodontitis	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - Post-implementation trend analysis

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	3-4: Percentage of members with oral cancer	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - Post-implementation trend analysis
Research Question 3.2: Has the rate of emergency dental services decreased following implementation of the waiver?	3-5: Percentage/number of members that utilized an emergency dental service	N/A	- State eligibility and enrollment data - Claims/encounter data	- Pre-test/post-test - ITS - Post-implementation trend analysis
Hypothesis 4: The Tribal Dental Authority program provides cost-effective care.				
Research Question 4.1: What are the costs associated with providing care under the Tribal Dental Authority?	There are no specific measures associated with this hypothesis; see Cost-Effectiveness Analysis Section for additional detail	N/A	N/A	Cost-effectiveness analysis
Research Question 4.2: What are the benefits/savings associated with providing care under the Tribal Dental Authority?				

Note: AI/AN: American Indian/Alaska Native; BRFSS: Behavioral Risk Factor Surveillance System; ED: emergency department; IHS: Indian Health Service; ITS: interrupted time series

Deviations from the Evaluation Design

Table 3-10 displays the evaluation measures that deviated from the CMS-approved Evaluation Design due to data availability or methodological limitations encountered during the interim evaluation period.

Table 3-10—Evaluation Design Deviations

Program	Measure(s)	Deviation	Reason	Impact on Interpretation
ALTCS (EPD)	1-7, 1-8, 1-9, 1-10, 2-7, 3-2, 3-3, 3-4, 3-5, 3-6, 3-8	Analytic approach revised	NCI-AD survey was only conducted in 2023/2024 cycle	Pre-test/post-test analyses could not be conducted; descriptive analysis was utilized
ALTCS (DD)	1-6, 1-8, 3-2, 3-4, 3-5, 3-6	Utilized different data source	NCI-IDD In Person Survey (IPS) was not conducted; NCI-IDD AFS and NCI-IDD FGS were used instead	Responses collected from guardians of members with developmental disabilities rather than members themselves
ALTCS (DD)	1-7, 1-9, 1-10, 3-3, 3-7	Not reported	NCI-IDD AFS and NCI-IDD FGS surveys lacked required items	Measure omitted
ALTCS-PPCG (EPD)	8-1	Not reported	Required data was unavailable for the EPD population	EPD stratification was omitted for this measure

Program	Measure(s)	Deviation	Reason	Impact on Interpretation
ALTCS-PPCG	8-4	Not Reported	PPCG DCW data could not differentiate between parent and non-parent caregivers	Measure omitted
ALTCS-PPCG (EPD)	8-6	Not reported	EPD PPCG Utilization data did not identify the weekly hours for services provided through the PPCG service model	Measure omitted
ALTCS-PPCG (EPD)	8-7	Not reported	Required data was unavailable for the EPD population	EPD stratification was omitted for this measure
ALTCS-PPCG (EPD)	5-1, 5-3, 5-4, 6-1, 6-2, 6-3, 6-4, 6-5, 6-6, 8-4, 8-5, 10-5, 11-6, 12-1	Analytic approach revised	Limited and incomplete data	Pre-test/post-test testing could not be conducted; therefore, descriptive analysis was utilized
ALTCS-EFSS[1]	11-7, 11-10	Utilized different data source	NCI-IDD In Person Survey (IPS) was not conducted; NCI-IDD AFS and NCI-AD instead	Responses collected from guardians of members with developmental disabilities rather than members themselves
ALTCS-EFSS[1]	11-8	Not reported	NCI AFS and NCI-AD surveys lacked required items.	Measure omitted
H2O	1-8	Measure revised	Data limitations	Alternative calculation used (relying on the count of emergency shelter beds instead of enhanced shelter beds)
H2O	1-19	Not Reported	Data could not be limited to the H2O population and were only available to identify the rate of persons who stayed in an emergency shelter or unsheltered homelessness per 1,000 Arizona residents	Measure omitted
H2O	1-20	Not Reported	Data could not be limited to the H2O population and were only available to identify the average number of days in an emergency shelter or state of unsheltered homelessness statewide	Measure omitted
H2O	1-18, 2-9, 2-18	Not reported	Required data unavailable	Measures omitted

Program	Measure(s)	Deviation	Reason	Impact on Interpretation
KidsCare Eligibility Expansion	1-2	Not reported	Required data unavailable	Measure omitted
KidsCare Eligibility Expansion	4-14	Not reported	Required data unavailable	Measure omitted

Note: AFS: Adult Family Survey; ALTCS: Arizona Long Term Care System; DCW: direct care worker; DD: developmental disabilities; EFSS: Extended Family Support Services; EPD: elderly and/or have physical disabilities; FGS: Family Guardian Survey; H2O: Housing and Health Opportunities; NCI: National Core Indicators; NCI-AD; National Core Indicators-Aging and Disabilities; NCI-IDD: National Core Indicators-Intellectual and Developmental Disabilities; PA: Program Administrator; PPCG: Parents as Paid Caregivers.

[1]EFFS had not been operationalized or implemented at the time of this evaluation.

Data Sources

A combination of national survey, administrative, and qualitative data sources was used to evaluate the Waiver. Detailed descriptions of each data source, including data specifications, are available in the CMS-approved Evaluation Designs linked in Appendix A. Table 3-11 presents the data sources used to evaluate each program.

Table 3-11—Evaluation Data Sources

Data Source	Description	Program(s)
Administrative Claims	Administrative data extracted from the PMMIS were used to calculate most measures in this Interim Evaluation Report.	ACC, ACC-RBHA, ALTCS, ALTCS-PPCG, DCS CHP, H2O, KidsCare Eligibility Expansion, PQC, Tribal Dental Authority
AHCCCS Population Reports	AHCCCS Population Reports were used to determine enrollment in the KidsCare non-expansion and KidsCare expansion populations.	KidsCare Eligibility Expansion
ALTCS Placement Data	ALTCS placement data contained Medicaid residence codes for all ALTCS-HCBS members, including residency code start and end dates.	ALTCS, ALTCS-PPCG
Beneficiary Surveys	Customized surveys were developed to assess knowledge, access, and self-reported health status among adult and child Medicaid members.	ACC, ACC-RBHA, ALTCS-PPCG, H2O, KidsCare, PQC
BRFSS	The BRFSS is a health-focused telephone survey developed by the CDC that collects data from approximately 400,000 adults annually across all 50 states, Washington D.C., and three territories.	Tribal Dental Authority
H2O-PA	This file, which identifies members enrolled in H2O as well as needs identified, services received, and health/housing outcomes, was developed by Solari, AHCCCS' H2O-PA.	H2O
H2O Maternal Mortality and Low Birth Weight Data	This file identified the number of live births, birth weights, and newborn or mother dates of death, as applicable.	H2O
H2O CLRS Data	Data from the CLRS identified members who were screened for HRSNs.	H2O
HCRIS	Data reported by Medicare-certified institutions housed in the HCRIS were used to assess non-Medicare uncompensated care costs.	PQC
IPUMS ACS	IPUMS ACS data were used to estimate the number of Medicaid-eligible individuals in Arizona.	PQC
Key Informant Interviews	Interviews were conducted with AHCCCS staff, health care providers, non-provider stakeholders, and IHS facilities to collect qualitative information on implementation and impact of the different Waiver programs.	ACC, ACC-RBHA, ALTCS, DCS CHP, H2O, Tribal Dental Authority

Data Source	Description	Program(s)
KidsCare Expansion Enrollment Data	This file identified children who were enrolled as KidsCare expansion members at any point after the KidsCare expansion was implemented.	KidsCare Eligibility Expansion
KidsCare Disposition Data	This file identified children enrolled in KidsCare and the date they were identified as being eligible for Medicaid.	KidsCare Eligibility Expansion
Member and Provider Location Data	Member and provider data were used to calculate the number and percentage of providers within a pre-defined time or distance from members.	ACC, ACC-RBHA, ALTCS, DCS CHP, KidsCare Eligibility Expansion, Tribal Dental Authority
National Benchmarks	National or regional benchmarks were incorporated where possible to provide contextual references of performance for standardized measures.	ACC
NCI	The NCI surveys family members of Medicaid members with intellectual or developmental disabilities and members who are older adults or individuals with physical disabilities. Survey results were leveraged to approximate rates of access to care and community among the ALTCS population.	ALTCS, ALTCS-EFSS
NSCH	The NSCH surveys households to assess the physical and emotional health of children under the age of 18.	KidsCare Eligibility Expansion
PPCG Utilization Data	These files identified ALTCS DD and EPD members receiving services from the PPCG service model, including the number of service hours and the number of parents providing services through the PPCG service model.	ALTCS-PPCG
PPCG DCW Data	These files identified members receiving services from the PPCG service model, including the number of service hours and the number of parent and non-parent DCWs providing services. These data did not differentiate between parent and non-parent DCWs.	ALTCS-PPCG
PPCG DCW Utilization Data	This file identified the number of DCW service hours provided to ALTCS DD members. These data did not differentiate between parent and non-parent DCWs.	ALTCS-PPCG
PPCG QOC Data	This file identified the aggregated total of substantiated cases of abuse or neglect among the minor ALTCS-DD and ALTCS-EPD populations.	ALTCS-PPCG
PQC Renewals Data	Data were used to identify the percentage of PQC-eligible members who renewed their Medicaid coverage.	PQC

Note: ACC: AHCCCS Complete Care; ACS: American Community Survey; AHCCCS: Arizona Health Care Cost Containment System; ALTCS: Arizona Long Term Care System; BRFSS: Behavioral Risk Factor Surveillance System; CDC: Centers for Disease Control and Prevention; CHP: Comprehensive Health Plan; CLRS: Closed-Loop Referral System; DCS: Department of Child Safety; DCW: direct care worker; DD: developmental disabilities; EFSS: Extended Family Support Services; EPD: elderly and/or have physical disabilities; HCBS: home- and community-based services; HCRIS: Healthcare Provider Cost Reporting Information System; HRSN: health-related social needs; H2O: Housing and Health Opportunities; IHS: Indian Health Services; IPUMS: Integrated Public Use Microdata Series; NCI: National Core Indicators; NSCH: National Survey of Children's Health; PA: Program Administrator; PMMIS: Prepaid Medical Management Information System; PPCG: Parents as Paid Caregivers; PQC: Prior Quarter Coverage; QOC: Quality of Care; RBHA: Regional Behavioral Health Agreement.

The following data sources were used in this evaluation:

Administrative Claims Data: Administrative data extracted from the PMMIS were used to calculate most measures in this Interim Evaluation Report. These data included administrative claims and encounters, member eligibility, enrollment, and demographic data. Provider data were also used to identify provider type and member attribution. Fee-for-service (FFS) claims and managed care encounters were limited to final, paid status claims

and encounters. Interim, adjustment, and voided records were excluded from all analyses because these record types introduce a level of uncertainty related to claim matching adjustments and third-party liabilities that may affect reported rates and cost calculations.

Beneficiary Surveys: Customized surveys were developed to assess knowledge, access, and self-reported health status among adult and child Medicaid members. Two rounds of surveys were conducted for the ACC, ACC-RBHA, and PQC populations in 2021 and 2025. One round of surveys was conducted for newly implemented programs, including H2O, KidsCare, and ALTCS- PPCG in 2025.

The 2025 survey utilized a random sample of 4,064 members. For programs with a comparison group, a random sample of 2,032 members was selected for both the intervention and comparison populations. Due to the number of members identified as enrolled in H2O at the time of survey administration, the H2O intervention group survey was limited to 415 members.

Survey results were weighted using a raking algorithm to be representative of the general Medicaid population based on demographic variables, including age, health plan, gender, and three-digit ZIP Code. The overall response rate was 9.93 percent, with the H2O program having the highest response rate of 11.67 percent. Table 3-12 identifies the intervention and comparison populations for each survey.

Table 3-12—Beneficiary Survey Intervention and Comparison Groups

Program	Intervention Group	Comparison Group
ACC	Adult and child members enrolled in an ACC plan	N/A
ACC-RBHA	Members enrolled in an ACC-RBHA plan	N/A
H2O	Members enrolled in H2O	Members on the AHP waitlist who did not enroll in H2O
KidsCare Eligibility Expansion	Members enrolled in KidsCare (Expansion)	Members enrolled in KidsCare (Non-Expansion)
PPCG	ALTCS-DD minors receiving services from the PPCG service model	ALTCS-DD minors living at home, but not receiving services from the PPCG service model
PQC	Members newly enrolled in Medicaid	Members who were not newly enrolled in Medicaid[a]

[a] A comparison group was used for PQC, but no formal statistical testing was conducted.
Note: ACC: AHCCCS Complete Care; ACC-RBHA: ACC-Regional Behavioral Health Agreement; AHP: AHCCCS Housing Program; ALTCS: Arizona Long Term Care System; DD: developmental disabilities; H2O: Housing and Health Opportunities; N/A: not applicable; PPCG: Parents as Paid Caregivers; PQC: Prior Quarter Coverage.

H2O: Beneficiary surveys assessed members' reported health status, housing security, and life satisfaction. At the time of survey administration, the number of members identified as enrolled in H2O limited the available members for survey from 2,032 members to 415. As a result, members received both mailed and phone-based surveys to improve response rates.

PQC: Beneficiary surveys assessed changes in newly enrolled members' reported health status in 2021 and 2025. The 2021 and 2025 surveys employed different sampling strategies. In 2021, existing Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[67] surveys were cross-referenced with enrollment information to retrospectively identify members who were newly enrolled at the time of the PQC waiver. New enrollees were defined as members with an enrollment start date between July 1, 2019, (the start of the PQC waiver) and March 31, 2020, who did not have any Medicaid enrollment in the six months prior to their start date. March 2020 was

[67] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

selected as the end date because it represented the beginning of the coronavirus disease 2019 (COVID-19) public health emergency (PHE), which affected the volume and characteristics of newly enrolled members.

In 2025, members newly enrolled in Medicaid and existing members were identified as separate samples. Members subject to PQC (excluding members under age 19 years, members who were pregnant, or members less than 60 days postpartum) who were newly enrolled between December 28, 2024, and June 27, 2025 (i.e., six months before the survey) with no Medicaid enrollment history in the six months prior were identified as new enrollees for the survey.

National/Statewide Data Sources

The following national/statewide data sources were used in the evaluation:

BRFSS: The BRFSS is a health-focused telephone survey developed by the Centers for Disease Control and Prevention (CDC) that collects data from approximately 400,000 adults annually across all 50 states, Washington D.C., and three territories. Data from the BRFSS were utilized to calculate Tribal Dental Measure 3-1: *Percentage of members with permanent teeth lost*, which compares the results among Arizona respondents with national estimates.

HCRIS: Data reported by Medicare-certified institutions and housed in the Healthcare Cost Report Information System (HCRIS) were used to assess non-Medicare uncompensated care costs, including Medicaid shortfalls, as part of PQC Measure 7-1: *Reported costs for uninsured and/or likely eligible Medicaid recipients among potentially impacted providers and/or provider networks*. Institutions serving Medicare members are required to submit an annual cost report to CMS that includes data on non-Medicare uncompensated care costs, non-Medicare and non-reimbursable Medicare bad debts, indigent care costs, charity care, and Medicaid shortfalls.

IPUMS ACS: The Integrated Public Use Microdata Series (IPUMS) American Community Survey (ACS) is a database that provides access to more than 60 integrated, high-precision samples of the American population drawn from 16 federal censuses and the ACS from 2000–present.[68] The IPUMS ACS data were used to estimate the number of Medicaid-eligible individuals in Arizona, as part of the analysis of PQC Measure 1-1: *Percentage of Medicaid enrollees per month by eligibility group out of estimated eligible Medicaid recipients* and PQC Measure 1-2: *Percentage of new Medicaid enrollees per month by eligibility group, as identified by those without a recent spell of Medicaid coverage out of estimated eligible Medicaid recipients*.

National Benchmarks: National or regional benchmarks were incorporated, when available, to provide contextual references points for standardized measures. Because national benchmarks are developed for state Medicaid managed care populations as a whole, their applicability across individual Waiver programs is limited. The ACC program, which covers approximately 93.8 percent of adults and children on Medicaid, is the most representative of the overall population and therefore provides the most appropriate comparison to national benchmarks.

NCI: The National Core Indicators (NCI) surveys Medicaid members nationally with intellectual or developmental disabilities (DDs) and older adults or individuals with physical disabilities, and was leveraged to approximate rates of access to care and community among the ALTCS population. The NCI-Intellectual and

[68] The data executed included demographic information, employment, disability, income data, and program participation such as Medicaid enrollment information.

Developmental Disabilities (NCI-IDD) surveys are mailed to families or guardians and the NCI-Aging and Disabilities (NCI-AD) surveys are conducted in-person or via phone/video conference. Approximately half of all states participate each year, which supports a national comparison.

Additionally, the NCI-IDD administers two separate surveys: the Adult Family Survey (AFS) and the Family Guardian Survey (FGS). The AFS collects responses from family members or guardians who live with an adult family member receiving at least one service, in addition to case management from the Division of Developmental Disabilities (DDD). The FGS collects responses from families or guardians whose adult family members do not live with the respondent but receives at least one service, in addition to case management, from the DDD.

Survey periods for both the NCI-IDD and NCI-AD run annually between July 1 and June 30, with states submitting data by June 30. Each state is required to survey at least 400 individuals to allow for a robust comparison. Beginning in 2021, AHCCCS allocated funds to participate in the NCI-AD survey. NCI-IDD surveys are funded by DES/DDD. In addition to state-specific reports, NCI provides aggregate data that can be stratified by demographic characteristics, such as race/ethnicity, gender, and age, as well as certain diagnoses and living arrangements.

NSCH: The National Survey of Children's Health (NSCH) surveys households to assess the physical and emotional health of children under age 18. The survey is administered by the Health Resources and Services Administration and allows for a comparison between state-level data and national rates. NSCH data were used to identify rates of children's access to medical care among respondents in Arizona and nationally.

Key Informant Interviews

While administrative and beneficiary data provided insight into program performance, they did not fully capture stakeholders' perspectives on the Waiver. To address this gap, key informant interviews were conducted with AHCCCS staff, health care providers, non-provider stakeholders, and IHS facilities to collect qualitative information on the implementation and impact of the Waiver programs. A flexible interview protocol was developed using open-ended questions to maximize the diversity and richness of responses and to support a holistic understanding of interviewees' experiences. Responses were aggregated, summarized, and organized according to the protocol.

To engage with key informants, the independent evaluator collaborated with AHCCCS to identify appropriate stakeholders with experience related to the Waiver. Between August and November 2025, virtual key informant interviews were conducted. Participants shared perspectives on service expansion, access to and quality of care, care coordination, and program sustainability. The interviews provided additional context on how the Waiver evolved over time, highlighting drivers of success, challenges, and opportunities for improvement.

Additional Data Sources

The following additional data sources were used in the evaluation.

AHCCCS Population Reports: AHCCCS Population Reports are publicly available and are posted by AHCCCS to identify the overall count of members in each Medicaid category.[69] These files were used to determine total enrollment counts of the KidsCare non-expansion and KidsCare expansion populations.

ALTCS Placement Data: ALTCS placement data were provided by AHCCCS and contained Medicaid residence codes for all ALTCS home- and-community-based services (HCBS) members, including residence code start and end dates. These data were used to calculate ALTCS Measure 3-1: *Percentage of members residing in their own home* and to identify a comparison group for PPCG comprised of ALTCS members who live at home and did not receive services through the PPCG service model.

H2O MOE Report: Data from the Maintenance of Effort (MOE) report were provided by AHCCCS to determine changes in state and local investments in social services related to housing transition supports.

H2O-PA Data: This file, developed by the H2O-PA, Solari, identified members enrolled in H2O. The H2O-PA facilitated housing administrative functions and data collection. The H2O-PA data also included identified member needs, services received, and health and housing outcomes.

H2O Vital Records Data: This file was provided by AHCCCS and identified the number of live births, birth weights, and dates of death for newborn or mother, as applicable.

H2O CLRS Data: Data from the Closed-Loop Referral System (CLRS) identified members enrolled in the H2O program who were screened for health-related social needs (HRSNs). These data included the type of screening conducted, as well as the responses to each question on the screening questionnaire.

KidsCare Expansion Enrollment Data: The file provided by AHCCCS identified children enrolled in the KidsCare expansion at any point following implementation. This file did not include enrollment spans and could therefore only identify whether individual members were enrolled in the expansion eligibility threshold at a single point in time during federal fiscal year (FFY) 2024.

KidsCare Disposition Data: The file was provided by AHCCCS and identified children enrolled in KidsCare as well as the date they were determined to be eligible for Medicaid.

Member and Provider Location Data: Member and provider data were used to calculate the number and percentage of providers located within pre-defined time or distance standards from members. Data from the PMMIS provided member and provider addresses, and the Client Assessment and Tracking System (CATS) identified members living in their own homes for calculation of nursing facility time and distance standards. Plan-specific provider affiliation transmission (PAT) files were used to identify provider networks for each plan. These data supported analyses of provider network adequacy for the ACC, ACC-RBHA, ALTCS, DCS CHP, KidsCare Eligibility Expansion, and Tribal Dental populations.

PPCG Utilization Data: The PPCG Utilization files provided by AHCCCS identified ALTCS-DD and ALTCS-EPD members receiving services through the PPCG service model, including the number of service hours, the service type rendered (i.e., attendant care or habilitation), and the number of parents providing services.

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[69] Arizona Health Care Cost Containment System. AHCCCS Population by Category. Available at: https://archive.azahcccs.gov/archive/Resources/Reports/Population%20Statistics/2024/Apr/PopulationbyCategory_412024.pdf. Accessed on Mar 24, 2026.

PPCG DCW Data: The PPCG direct care worker (DCW) files provided by AHCCCS identified the number of DCWs providing attendant care or habilitation services to each member, separated by service type.

PPCG DCW Utilization Data: This file was provided by AHCCCS and identified DCW services provided to ALTCS-DD members, including the number of service hours and the service type rendered (i.e., attendant care or habilitation care). This file did not differentiate between parent and non-parent DCWs.

PPCG QOC Data: The PPCG quality of care (QOC) file provided by AHCCCS identified the aggregate total number of substantiated cases of abuse or neglect among the minor ALTCS-DD and ALTCS-EPD populations.

PQC Renewals Data: These data were provided by AHCCCS and were used to identify the percentage of PQC-eligible members who retained eligibility for Medicaid and those who renewed Medicaid coverage.

Analytic Methods

Multiple analytic techniques were applied based on the type and availability of data required for each measure. The primary analytic approaches used in this evaluation are summarized below. Additional details, including technical specifications and calculation methods, are provided in the Evaluation Designs linked in Appendix A. Throughout this Interim Evaluation Report, unrounded rates are used to calculate differences. Therefore, the differences shown in each applicable table may not align with calculations performed using the rounded values presented. Table 3-13 summarizes the analytic approaches used for each program.

Table 3-13—Analytic Methods

Method	ACC	ACC-RBHA	ALTCS	ALTCS-PPCG	DCS CHP	H2O	KidsCare Eligibility Expansion	PQC	Tribal Dental Authority
Qualitative Synthesis	X	X	X	X	X	X			X
ITS	X	X	X	X	X			X	
Pre-test/Post-test	X	X	X	X	X		X	X	X
DiD			X				X		
Comparison to National Benchmarks	X							X	
Cost-Effectiveness Analysis	X	X	X	X	X	X	X	X	X
Trend Analysis	X	X	X		X				X
Post Implementation Trend Analysis									X
Chi-Square				X		X	X		

Note: Blank cells indicate the analytic method was not used in the assessment of the given program.
ACC: AHCCCS Complete Care; ALTCS: Arizona Long Term Care System; AHCCCS: Arizona Health Care Cost Containment System; CHP: Children's Health Plan; DCS: Department of Child Safety; DiD: difference-in-differences; H2O: Housing and Health Opportunities; ITS: interrupted time series; PPCG: Parents as Paid Caregivers; PQC: Prior Quarter Coverage; RBHA: Regional Behavioral Health Agreement.

DiD

A DiD analysis was performed on all measures for which a suitable comparison group could be identified for the ALTCS and KidsCare Eligibility Expansion programs. The ALTCS-DD program evaluation compared the rates of the weighted national average of participating states to rates among AHCCCS members. The rate of uninsured children in Arizona was compared to the average rate among states with a similar FPL requirement for the Children's Health Insurance Program (CHIP) to contextualize the impact of KidsCare. Measures using a DiD approach compared the changes in outcome rates between the baseline period and the evaluation period across the intervention and comparison groups. For the DiD analysis to be valid, the comparison group must accurately represent the change in outcomes that would have been experienced by the intervention group in the absence of the program. The DiD analysis was conducted with member-level rates using a logistic regression model for measures with binary outcomes.

The logistic regression form of the DiD model is:

$$\ln\left(\frac{Y_{it}}{1-Y_{it}}\right) = \beta_0 + \beta_1 T + \beta_2\, post + \beta_3(post \times T) + \gamma \mathbf{D'}_{it} + \varepsilon$$

where Y is the probability of an outcome for group *i* in year *t*, *T* is a binary indicator of the intervention group, *post* is a binary indicator for the evaluation period, the vector **D'** represents any observed confounding variables that may account for differences between the intervention and comparison groups (see the intervention and comparison section below for more detail), γ is a coefficient vector, and ε is an error term. The intercept β_0 represents the log-odds of an outcome for the comparison group during the baseline. The coefficient β_1 identifies the average difference in the log-odds of an outcome between the groups during the baseline period prior to the implementation of the Waiver. The time period dummy coefficient β_2 captures the change in the log-odds of an outcome between the baseline and evaluation time periods for the non-intervention group. The coefficient on the interaction term β_3 represents the DiD estimate of interest in this evaluation. In other words, it is how the log-odds of an outcome for the intervention group changed in the implementation period compared to the pre-implementation period.

For the ALTCS NCI measures employing a DiD approach, member-level data from the NCI surveys were not publicly available; therefore, rates from the Arizona NCI survey were compared to a weighted national average of all other NCI-participating states. As such, the DiD model for NCI measures did not include any control variables to account for differences in the underlying population characteristics.

ITS

The ITS analysis included semiannual or monthly observations of each measure over time, beginning at least one year prior to the Waiver implementation. The counterfactual for the analysis was the trend as it would have happened without being "interrupted" by the Waiver. Specific outcome measures were collected for multiple time periods both before and after the first demonstration period, demonstration renewal, and related interventions. The measurements collected after the Waiver were then compared to the projected outcome to evaluate the impact the Waiver had on the outcome. The generic ITS model is:

$$Y_t = \beta_0 + \beta_1 time_t + \beta_2 post_t + \beta_3 time \times post_t + \gamma \mathbf{D'}_{it} + \varepsilon_t$$

where Y_t is the outcome of interest for the time period *t, time* represents a linear time trend, *post* is a dummy variable to indicate the time periods post-implementation, and $time \times post$ is the interaction term between *time*

and *post,* the vector **D'** represents the PHE and quarterly indicator covariates, where applicable, γ is a coefficient vector, and ε is an error term. The coefficient, β_0, identifies the starting level of outcome *Y*; β_1 is the slope of the outcome between the measurements before the program; β_2 is the change in the outcome when the program began; and β_3 is the change in the slope for the measurements after the program.

Pre-test/Post-test

Due to limitations of available and appropriate comparison groups, a one-group pre/post-analysis was utilized for ACC, ACC-RBHA, ALTCS, ALTCS-PPCG, DCS CHP, KidsCare Eligibility Expansion, and PQC. Average rates during the baseline period were compared against average rates during the evaluation period using a Chi-square test, t-test, or other statistical test appropriate for the given data. Specifically, comparisons were made using this model:

$$Y = \beta_0 + \beta_1 * post + \beta_2 * covid + \varepsilon$$

where *Y* is the rate of the outcome being measured each year; β_0 captures the average rate in the baseline years; the coefficient β_1 for the dummy variable, *post*, represents the evaluation years; the coefficient β_2 for the dummy variable, *covid*, represents the difference between the rate in FFY 2020 and the average during all other years in the post period, and ε is an error term. This model captures the change in average outcome between the baseline and evaluation time periods.

Binomial logistic regression was utilized to evaluate measures with binary outcomes, and a negative binomial or Poisson regression was used to evaluate measures that are count outcomes (e.g., IP stays or ED visits). Due to the lack of a comparison group, it is difficult to conclude whether the changes in rates are a direct result of the specific program, as simultaneous external factors occurring during the same time period may have also had an impact that could not be accounted for.

Trend Analysis

In addition to the pre/post analysis, a regression model incorporating both the linear trend in the baseline period and dummy variables for the evaluation period years was used for trend analysis. In this model, observed rates during the evaluation period were compared against the projected rates if the baseline trend had continued. Logistic regression was utilized to evaluate measures with binary outcomes, and negative binomial or Poisson regression with the log of the denominator as an offset was used to model measures that are count outcomes.

The logistic regression form of the model is:

$$\ln(Y) = \beta_0 + \beta_1 TIME + \sum \beta_t \delta_t$$

Where β_0 is the intercept representing the natural log of the rate at the first baseline year; β_1 is the average annual change in the logged rate during the baseline period, as a function of *TIME*; and $\sum \beta_t \delta_t$ represents the impact of a series of dummy variables representing each evaluation year *t*. The coefficients for these dummy variables represent the difference in the logged rate from the last year of the baseline period to the year represented by the dummy variable. $TIME$ is the piecewise trend parameter for the baseline period defined as a linear trend in the baseline period and is held constant in the evaluation period by setting it equal to the value of the last year of the baseline period.

A series of hypothesis tests of the linear combination of coefficients was performed to determine if the evaluation period rates were significantly different from the projected evaluation period rates based on the *TIME* coefficient and the intercept.

Chi-Square Test

A Chi-square test of independence allows for comparison between two groups that have a categorical outcome, such as survey results, to determine if there is an association between the two variables. A Chi-square test statistic compares the observed counts to the expected counts under a null hypothesis of independence between the two variables. The test statistic is compared to a critical value from a Chi-square distribution for a given degree of freedom and a *p*-value is obtained. A Chi-square analysis was leveraged to identify differences in rates among the intervention and comparison groups for KidsCare, H2O, and ALTCS-PPCG.

Post-Implementation Trend Analysis

When data were not available prior to implementation, data during the post-implementation period were analyzed to assess how measures changed over the course of the program. A regression line fit to the post-implementation data points tested for any statistically significant changes in measure rates.

Disparities Analysis

To explore the impact of health disparities between various demographic groups, a disparities analysis was conducted. Outcome measures for relevant demographic subgroups (e.g., age, sex, race, geography, and complexity of health needs) were compared to a reference group and assessed for statistically significant differences as well as clinically meaningful differences in relative percentages and effect sizes. A two-tailed *t*-test was conducted to determine the statistical significance between the reference and comparison groups. Clinically meaningful outcomes were assessed through effect sizes and relative percentage point differences between the groups of interest.

Cohen's *h* was utilized to determine the effect size between comparison and reference group rates. Effect sizes can fall into small, medium, or large categories.[70] This method is applicable to measures where the rate is bound between zero and one. The formula for Cohen's *h* is given by:

$$h = \left(2 * arcsin\sqrt{P_1}\right) - \left(2 * arcsin\sqrt{P_2}\right)$$

where P_1 is the annual rate for the comparison group and P_2 is the annual rate for the reference group.

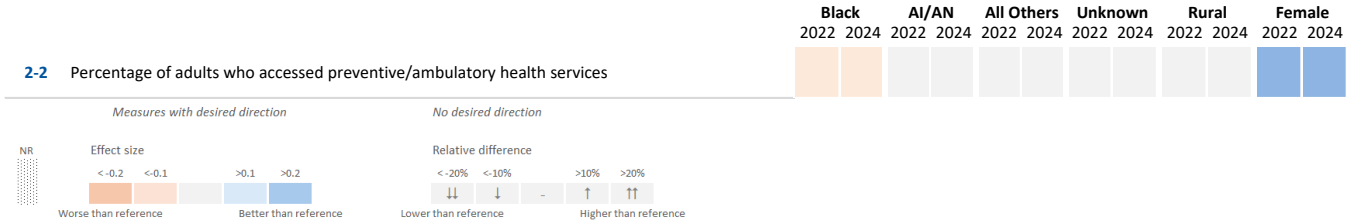
For measures where the rates are not bound between zero and one, the relative percent difference between each demographic stratification and reference category were calculated by subtracting the reference group rate from the comparison group rate, then dividing by the reference group rate.

For Table 3-14 two cells are shown for each demographic subgroup. The first (left-hand) cell represents rates for FFY 2022, as indicated in the table header. The second (right-hand) cell represents rates for FFY 2024. Each cell color represents the direction and degree of the effect size. Shades of blue represent effect size differences that were better than the reference group. Likewise, shades of orange represent effect size differences that were worse

[70] Cohen, J. Statistical Power Analysis for the Behavioral Sciences, 2nd Ed. Hillsdale, N.J.: L. Erlbaum Associates; 1988:25

than the reference group. For example, Black members had lower rates of preventive/ambulatory visits in both FFYs 2022 and 2024, with an effect size between -0.1 and -0.2, representing lower (worse) rates when compared to the reference group (i.e., White members). Conversely, the effect size among female members exceeded 0.2 in both FFYs 2022 and 2024, representing higher (better) rates than the reference group (i.e., male members). Gray shading indicates the differences in rates were not particularly meaningful (i.e., an absolute effect size of less than 0.1).

Table 3-14—Effect Size Example

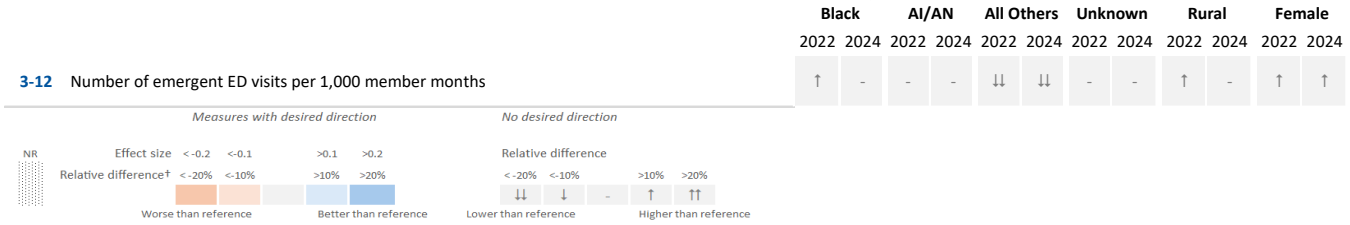


Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. NR: not reportable due to suppression guidelines. OB/GYN: obstetrician gynecologist; PCP: primary care practitioner.

Effect sizes could not be calculated among measures with no desired direction or those presented as rates per 1,000 member months. In these instances, the relative difference is presented. As displayed in Table 3-15, each cell arrow represents the degree of relative difference. The relative difference uses arrows to identify if the rates among each demographic group are relatively higher or lower than the reference group. A relative difference of 20 percent or greater is reflected by two "up" (↑↑) arrows and represents substantially higher rates than the reference group, while a relative difference between 10 and 20 percent is indicated by one "up" (↑) arrow.

For example, members in the All Others race category had lower rates of emergent emergency department (ED) visits, with a relative difference exceeding -20 percent, representing lower rates when compared to the reference group (i.e., White members). Conversely, the relative difference in emergent ED visits among female members was between 10 and 20 percent, representing higher rates than the reference group (i.e., male members).

Table 3-15—Relative Difference Example



Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. ED: emergency department. IP: Inpatient; NR: not reportable due to suppression guidelines.
↓Lower measure rates indicate better performance. Disparities analysis presented reflects the desired direction.
†Relative difference is used for this measure.

Other measures, such as those with no desired direction or presented as rates per 1,000 member months where effect sizes could not be calculated, use relative differences.

When applicable, rates were compared across reference and comparison demographic groups where data were available, accurate, and relevant for measures with data supporting a disparities analysis. Rates involving numerators greater than zero and less than 11 as well as denominators smaller than 30 members were suppressed due to potentially unreliable rate calculation and to ensure anonymity.

Qualitative Synthesis

AHCCCS staff, providers, and non-provider stakeholders such as CBOs, and IHS/Tribal 638 facilities, participated in virtual key informant interviews. A flexible interview protocol was developed using open-ended questions to capture diverse perspectives on access to care, quality of services, and program implementation. Each interview lasted approximately 45 minutes and was recorded to support accurate notetaking and transcription.

Interview notes and transcripts were analyzed in MAXQDA using open and axial coding techniques to identify themes and concepts raised by interviewees. The qualitative synthesis provided context for how the Waiver evolved over time, highlighting common successes, challenges, and areas for improvement. Although the results are not statistically representative, the findings reflect the depth and diversity of experiences among stakeholders involved in the Waiver.

Cost-Effectiveness Analysis

The cost-effectiveness analysis examined differences between actual and projected costs and trends during the evaluation period. This analysis did not replicate or replace the formal budget neutrality test. Costs were reported across the following settings: professional, IP, LTC, outpatient (OP) ED, OP (non-ED), and pharmacy. Professional costs represent all costs that do not align with an existing category of service and are not billed on a UB-04 claim form. Two programs include additional settings from those listed above:

1. Costs for the H2O program include a separate stratification for physical and behavioral health-specific costs.
2. Costs for the Tribal Dental Authority include a separate category of service for Dental services rendered.

Two cost analyses are presented in this Interim Evaluation Report: (1) per-member per-month (PMPM), which identifies the average PMPM costs, and (2) total aggregate costs, which calculate total monthly costs across all members. All costs represent cost of care as identified by plan payment amounts on Medicaid encounters or AHCCCS provider reimbursement on fee-for-service (FFS) claims.

An ITS approach was used for programs where pre- and post-implementation data were available (ACC, ACC-RBHA, ALTCS-DD, ALTCS-EPD, DCS CHP, and PQC). For the ALTCS-PPCG programs (DD and EPD), a comparative ITS model was used to compare costs among members receiving services through the PPCG service model with those receiving HCBS who did not receive PPCG services during the 24 months prior to program implementation and following Waiver implementation.

Cost analyses for H2O and KidsCare were limited to linear trend comparisons of PMPM and total aggregate costs between intervention and comparison groups over available time periods. A post-implementation trend analysis was utilized for the Tribal Dental Authority because no pre-implementation data were available and a comparison group could not be identified.

As the Waiver provided additional coverage and services to members, it is possible that there was an initial increase in costs. The overall cost-effectiveness of the program was assessed, in which any additional costs incurred through the program were contrasted and compared to observed benefits of the program. The cost-effectiveness analysis did not involve a direct comparison of costs and savings, as benefits of the program may be non-pecuniary in nature, such as provision of new services that previously were unavailable, increased employment opportunities leading to improved financial well-being, lower mortality rates and improved health

outcomes overall. Additionally, some benefits may manifest over the long term and were not measurable at the time of this report.

Disentangling Confounding Events

The COVID-19 PHE widely impacted the health care system and socioeconomic conditions beginning in approximately March 2020 and concluding in May 2023. The COVID-19 PHE exerted substantial effects on the State of Arizona, its health care system, and its Medicaid population. Increases in Medicaid enrollment during the COVID-19 PHE were associated with shifts in disease conditions and comorbidities among the Medicaid population and may have affected aggregate spending by AHCCCS. Social distancing efforts and stay-at-home orders interrupted routine care visits and reduced utilization of many health care services. This report leveraged the following methods to control for the effects of the COVID-19 PHE:

1. **Controlling for the COVID-19 PHE using model covariates:** Including covariates in the analytic models allowed for separation of demonstration effects from those attributable to the COVID-19 PHE. Adjustment was implemented through the creation of an indicator variable representing the PHE period. For measures calculated annually, an indicator variable for 2020 was included to adjust for PHE-related effects.
2. **Excluding years or quarters most impacted by the COVID-19 PHE from the baseline period:** For this evaluation, the most affected years of the PHE (2020–2021) occurred within the baseline period. When sufficient baseline data were available, analyses excluded these years as part of a sensitivity analysis.

4. Methodological Limitations

The Interim Evaluation Report presents baseline and evaluation period rates for performance measures selected to reflect key processes and outcomes associated with the Arizona Health Care Cost Containment System (AHCCCS) Demonstration Waiver (the Waiver). The evaluation incorporates multiple data sources and analytic approaches to assess program implementation and impact. The following summarizes key methodological strengths and limitations that should be considered when interpreting the findings:

- Use of standardized, nationally recognized performance measures, including metrics from the National Committee for Quality Assurance (NCQA) and the Centers for Medicare & Medicaid Services (CMS) Core Sets.
- Integration of multiple data sources, including administrative claims and encounter data, beneficiary surveys, qualitative interviews, and external benchmark data.
- Use of external data sources, including National Core Indicators (NCI) and Integrated Public Use Microdata Series–American Community Survey (IPUMS–ACS) data.

The following section details the methodological limitations of the interim evaluation.

Evaluation Design and Methods

There are two key limitations related to the evaluation design and analytic methods used in this evaluation report.

Availability of Comparison Groups: A primary limitation of the evaluation is the absence of comparison groups for five of the nine Waiver programs. An appropriate comparison group provides a counterfactual to estimate what may have occurred in the absence of the Waiver programs.

The Evaluation Design proposed the use of either the Transformed Medicaid Statistical Information System (T-MSIS) data from CMS or data from other states to construct counterfactual comparisons for statewide programs.[71] T-MSIS data were not available for this interim report, and comparable data from other states with similar population characteristics and Medicaid policies could not be obtained.

When a comparison group was unavailable, analyses relied on comparisons of performance measure rates between baseline and evaluation periods. Therefore, findings reflect whether rates increased or decreased over time and whether observed changes were statistically significant.

Impacts of the COVID-19 PHE: The coronavirus disease 2019 (COVID-19) public health emergency (PHE) substantially affected health care delivery, utilization, and Medicaid enrollment beginning in federal fiscal year (FFY) 2020. Health care utilization declined in 2020, and related impacts on performance measure rates are reflected in this report.

Although statistical models adjusted for FFY 2020 to account for immediate PHE effects, ongoing impacts beyond 2020 may influence findings, particularly for analyses without a comparison group. Measures related to

[71] Centers for Medicare & Medicaid Services. Approved Evaluation Design. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-cms-aprvd-amndmnd-evlutn-dsgn.pdf. Accessed on: Mar 11, 2026.

enrollment for Prior Quarter Coverage (PQC) (Hypothesis 1) and KidsCare Expansion Eligibility (Hypothesis 1) were especially affected by the introduction and sunset of the COVID-19 PHE continuous enrollment provision, which expanded Medicaid coverage. As a result, some findings may reflect broader PHE-related policy changes rather than Waiver-specific effects.

Data Sources and Data Collection

The Interim Evaluation Report relied on a variety of data sources and collection approaches to assess program implementation, utilization, and outcomes across Waiver programs. These data included: Prepaid Medical Management Information System (PMMIS) data (including administrative data, Medicaid enrollment, demographic data, claims and encounter data); national survey data obtained from the NCI, Behavioral Risk Factor Surveillance System (BRFSS), or ACS; and supplemental data identifying program-specific results from AHCCCS. This section presents the strengths and weaknesses associated with these data sources.

Data Strengths

The data sources used in the Interim Evaluation Report had several strengths that made them suitable for the evaluation. A variety of national data sources were leveraged to provide insight into health and well-being outcomes among Arizona respondents and those nationally, creating an opportunity to establish a comparison group for programs where a formal comparison group was not otherwise available.

Use of National Benchmark Data (BRFSS): For example, data derived from the BRFSS were used to identify the percentage of American Indian/Alaska Native (AI/AN) individuals in Arizona and nationwide who experienced permanent tooth loss as part of the evaluation of the Tribal Dental Authority program.

Identify the Medicaid-Eligible Population (IPUMS-ACS): Furthermore, data from the IPUMS–ACS are well-suited for identifying the size of the eligible Medicaid population in Arizona. While AHCCCS determines Medicaid eligibility during the member application and enrollment process, it does not routinely identify the population of Medicaid-eligible individuals on a statewide basis. Identifying the eligible Medicaid population within the State required a representative data source containing information about age, family income, the presence and number of children, disabilities, institutional group quarters, and pregnancy status.

IPUMS–ACS survey data meet this need by collecting the relevant data elements while representing approximately a 1 percent sample of the population. Data for the State of Arizona can be aggregated into a statewide estimate of the size of the Medicaid-eligible population. This data source was used for two measures in evaluating the PQC program.

NCI Comparative Survey Data: Finally, NCI data represent another national survey effort incorporated into this evaluation. NCI data are collected from states that choose to participate and include at least 400 randomly sampled respondents to yield statistically valid comparisons across states, typically at a 95 percent confidence level with a margin of error of ± 5 percent.

NCI surveys two relevant populations: adults with intellectual or developmental disabilities (IDD) and older adults or individuals with physical disabilities (AD). Among the IDD population, the Adult Family Survey (AFS) and the Family Guardian Survey (FGS) are administered annually. Similarly, the NCI-AD surveys are administered annually. NCI data therefore allow estimation of selected health and health care-related outcomes for the evaluation of the Arizona Long-Term Care System (ALTCS) program. Because data from participating

states are available both before and after Waiver renewal, a difference-in-differences (DiD) approach was utilized for the evaluation of ALTCS.

Data Challenges

While data sources used in this Interim Evaluation Report offer important strengths, each also has limitations that should be considered within the context of the evaluation.

Administrative Claims and Encounter Data: Claims and encounter data used to calculate performance metrics are generated as part of the Medicaid billing processes. As a result, they may not be as complete or sensitive in identifying specific health care processes and outcomes as information obtained through a comprehensive medical chart review.

This limitation may be partially mitigated if any lack of sensitivity in the claims and encounter data remains relatively stable over time and if the measures calculated from these data reflect trends consistent with the underlying processes and outcomes of interest.

Inconsistent Availability of NCI Survey Data: Several measures rely on survey data from NCI; however, data availability was inconsistent across the Waiver period. Measures for the ALTCS-elderly and/or have physical disabilities (EPD) population were developed using the NCI-AD Adult Consumer Survey, which was conducted only during the 2023–2024 cycle. Results are therefore reported only for the years in which data are available.

For the ALTCS-development disabilities (DD) population, measures were originally developed using the NCI-IDD In-Person Survey, which was last conducted in 2018–2019. Although the NCI-IDD In-Person Survey results were reported in the Summative Evaluation Report, this interim evaluation relied instead on two other surveys administered repeatedly during the Waiver period: the AFS and the FGS.[72] The AFS collects responses from family members or guardians who have an adult family member *who lives with the respondent* and receives at least one service, in addition to case management, from the Division of Developmental Disabilities (DDD). The FGS collects responses from families or guardians who have an adult family member *who does not live with the respondent* and receives at least one service, in addition to case management, from DDD.

The AFS and FGS do not include survey items related to corresponding ALTCS Measures 1-7, 1-9, 1-10, 3-3, 3-7, 11-8, and 11-9; therefore, these measures are not reported for the ALTCS-DD population. Survey items for ALTCS Measure 2-7 were not available in the NCI-IDD survey but were available in the FGS and are therefore reported for the ALTCS-DD population.

Furthermore, several items in the AFS and FGS were revised for the 2021–2022 cycle. Most revisions were not substantial, and this report presents averages across available baseline years. However, substantive revisions to items used for ALTCS Measures 1-6 and 2-7 prevent comparisons with prior years. As a result, 2021–2022 data are reported as a single baseline data point for these measures.

Finally, data from in-person surveys included a limited number of health outcome measures that could be used in the evaluation of the ALTCS-DD program. Although data were available both before and after Waiver renewal,

[72] Arizona Health Care Cost Containment System. Summative Evaluation Report. Available at: https://www.azahcccs.gov/Resources/Downloads/QuarterlyProgressReports/2024/AZ_SummativeEvaluationReport.pdf. Accessed on: Mar 11, 2026.

in-person survey data for Arizona were not collected during the COVID-19 PHE, limiting the ability to assess more recent changes in measured outcomes, particularly following integration of care efforts in October 2019. Subsequent evaluations may address this limitation if Arizona participates in future in-person survey cycles. Additionally, data collection relied on participation by individual states in each survey cycle; therefore, changes in state participation over time may influence DiD results.

Limitations in Survey and External Data: IPUMS–ACS data also did not include all covariates necessary to precisely identify the Medicaid-eligible population in Arizona. This limitation was particularly relevant when attempting to identify the proportion of individuals with serious mental illness (SMI), women who are currently pregnant, or individuals in long-term care (LTC) facilities. IPUMS–ACS data are self-reported and may be susceptible to measurement error, including inflation of income by respondents, and different definitions of what constitutes difficulty when ambulating, self-care, or independent living (e.g., running errands, going to a doctor's office). Additionally, IPUMS–ACS data do not include a set of health outcomes or health care process measures that could be used to directly test certain evaluation hypotheses or research questions.

Certain data sources outlined in the Evaluation Design were not used for this interim evaluation for a variety of reasons:

- Several data sources could not be provided by AHCCCS at the time of the development of the Interim Evaluation Report: Laboratory Data; Maternal Mortality Data; Arizona State Immunization Information System (ASIIS); Parents as Paid Caregivers (PPCG) Needs Assessment; PPCG Authorization; Arizona Department of Health Services (ADHS) supplemental nutrition program for Women Infants, Children (WIC); Department of Economic Security (DES) Supplemental Nutrition Assistance Program (SNAP); and the Regional Behavioral Health Agreement (RBHA) Brief Assessment of Recovery Capital (BARC)-10.[73] Many of these data are anticipated to be incorporated in the Summative Evaluation Report as they become available.
- IPUMS-ACS data intended to support the calculation of KidsCare Measure 1-2 were not used because the evaluation period data were not available at the time of development of the Interim Evaluation Report.
- Healthcare Cost and Utilization Project, State Inpatient (IP) Databases (HCUP-SID) data were not used because data were cost-prohibitive and required additional training. Instead, Healthcare Cost Report Information System (HCRIS) data were used because they were readily available and provided the necessary data to address PQC Measure 7-1.
- Survey of Income and Program Participation (SIPP) data were not used to assess KidsCare Eligibility Expansion Measure 6-2; however, a question assessing medical debt among children surveyed was incorporated into the beneficiary survey.

Program-Specific Challenges

Three of the nine programs had program-specific data challenges and limitations, detailed below.

ALTCS-PPCG

PPCG utilization data were used to identify ALTCS-DD and ALTCS-EPD members who received services through the PPCG service model and the time period that services were utilized. These data were provided in a

[73] The BARC-10 is no longer in use. An appropriate tool to support measure calculation will be identified for the Summative Evaluation Report.

single file for the ALTCS-DD population and in three separate plan-level files for the ALTCS-EPD population. For both populations, PPCG utilization data were available from January 2023 through March 2023 and April 2024 through September 2024. As a result, data provided for FFY 2024 were more complete in identifying the utilization of services through the PPCG service model and members who participated in this program.

Although utilization data were also provided for the EPD population, one of the three plans did not include an assessment PPCG service hours for FFY 2023. Therefore, results for the EPD population were not reported for FFY 2023 for nearly all PPCG measures. Furthermore, data for the EPD population were limited to identifying the average annual hours for services provided through the PPCG service model, instead of providing weekly summaries.

DCW utilization data was used to identify the number of hours paid weekly to non-parent DCWs. The number of hours for each service type represents the number of member-weeks where non-parent DCWs reported service hours for ALTCS-DD members, stratified by the number of hours of service provided in the week. Because the DCW-DD utilization data does not differentiate between parent and non-parent DCWs, HSAG excluded member-week observations in which a member received services through the PPCG service model, as indicated by the PPCG utilization data. This approach ensures the measure is capturing service hours provided by non-parent DCWs. These data were only provided for the ALTCS-DD population, therefore, results among the ALTCS-EPD population that rely on the DCW utilization data are not included in this report.

The PPCG quality of care (QOC) data could not be limited specifically to members receiving services through the PPCG service model and instead reflected substantiated cases of abuse or neglect among the minor ALTCS-DD and ALTCS-EPD populations.

H2O

Two approaches were used to identify the H2O intervention population. At the time of beneficiary survey administration, identification of the H2O intervention population relied on certain codes in PMMIS demographic data. These codes allowed accurate identification of members eligible for the H2O program at any point between October 1, 2024, through March 31, 2025. As a result, the PMMIS data did not allow for identification of all members eligible for H2O in FFY 2025.

For the remaining measures, the H2O intervention population was identified using data from the H2O-PA, which provided more granular enrollment information, including specific eligibility start and end dates.

Identification of the beneficiary survey sample frame was further limited by low enrollment counts. The total survey population included 415 members identified as eligible for H2O at the time of survey administration. Of these, 115 members received a mailed survey, and the population was further restricted by the number of members with valid deliverable addresses. To mitigate these limitations, a concurrent round of phone-based surveys was conducted. Phone surveys were administered to 245 members, increasing the sample size and overall response rate.

The comparison group was comprised of members on the AHP waitlist, which includes members with a General Mental Health or Substance Use (GMHSU) designation. Although these members are eligible for housing supports, they may have less complex health conditions than individuals who ultimately participate in H2O. As a result, there may be differences in health and housing needs between the H2O intervention and comparison populations.

Although phone-based surveys supported data collection efforts, differences may exist between responses collected through mailed or web-based surveys and those collected by phone. Research indicates that respondents may answer questions differently in self-guided surveys compared with interviewer-administer surveys, and the demographic composition of respondents may differ from those who do not respond.[74]

Additionally, due to the timing of the Interim Evaluation Report, PMMIS data for FFY 2025 were not available. Measures relying on PMMIS data were therefore limited to the three years prior to H2O implementation. Results reflect rates among members who were later enrolled in the H2O program and those who remained on the AHP waitlist, preventing identification of changes attributable to the H2O program. The Summative Evaluation Report will include PMMIS-based results for FFYs 2025–27 to assess the impact of H2O program implementation on measure performance.

Finally, although the program was implemented and members were eligible to participate beginning in FFY 2025, the initial implementation period reflects provider onboarding and training, which may impact the assessment of program effectiveness in the first year of the demonstration.

KidsCare Eligibility Expansion

Two data files were used to identify the intervention and comparison groups for KidsCare. First, PMMIS data were used to identify the start and end dates among members enrolled in a KidsCare plan. Among members enrolled in a KidsCare plan, the KidsCare expansion enrollment file was used to identify a subset of children enrolled in the KidsCare expansion population any point after implementation of the expansion.

A limitation of the KidsCare expansion enrollment file was that it did not identify enrollment spans for children in the expansion population and could therefore only determine whether members were enrolled at the expansion eligibility threshold at a single point in time. Therefore, members identified as KidsCare expansion members may not have been eligible for the KidsCare expansion throughout the entire evaluation period. As a result, there may be instances where members have a combination of KidsCare expansion and non-expansion enrollment that cannot be delineated.

The KidsCare disposition file did not identify members who became eligible after their disposition date. To calculate Measure 1-8, children with any enrollment after their disposition date were considered to have completed the renewal process.

National Survey of Children's Health (NSCH) results were limited by an inability to identify individuals specifically enrolled in KidsCare. Additionally, due to sample size limitations, reported results reflect responses among all children regardless of health insurance status.

Analyses

The methodology used in the Interim Evaluation Report relied primarily on the comparisons of performance measure rates representing average baseline and average evaluation period results. These analyses provide insight into whether measures exhibited statistically significant changes following implementation of AHCCCS programs. However, the analyses do not provide a sufficiently strong comparison to definitively conclude that the

[74] Gallup. Why Phone and Web Survey Results Aren't the Same. Available at: https://news.gallup.com/opinion/methodology/233291/why-phone-web-survey-results-aren.aspx. Accessed on: Mar 22, 2026.

Waiver caused observed changes in the performance measure rates. Other factors outside of the Waiver may have contributed to changes, including the COVID-19 PHE, changes in coding and reporting practices within claims and encounter data, and shifts in prescribing practices for certain medications, such as opioids.

Regarding the various cost analyses presented throughout this Interim Evaluation Report, increases in costs may be attributable to changes in available services, benefit packages, or for pharmacy costs, an increase in the number of covered prescription medications during the evaluation period. As such, results presented may be indicative of changing service arrays, rather than changes in costs for the same services.

An additional limitation of the methodology is the inability to determine why specific measures improved, worsened, or remain unchanged. Statistical analyses conducted in this Interim Evaluation Report characterize the direction, magnitude, and statistical significance of changes in measure rates. In contrast, qualitative analyses focused on the Waver implementation and the challenges or barriers experienced by relevant stakeholders, including AHCCCS and health plans. As a result, qualitative findings may provide context but cannot definitively explain observed changes in performance measures.

Furthermore, analysis of four of the nine programs (H2O, KidsCare Eligibility Expansion, ALTCS-PPCG, and the Tribal Dental Authority) were primarily based on assessments of the pre-implementation and post-implementation trends due to either limited pre-implementation data or insufficient post-implementation data being available at the time of this Interim Evaluation Report. Where possible, comparison groups were utilized to better assess the Waiver impacts. Future reports will incorporate formal pre/post testing or an assessment of the post-implementation trend will be included. As a result, conclusions drawn for measures within these programs remain limited in this interim evaluation period.

5. ACC Results

The following chapter describes the quantitative and qualitative results for the evaluation of the Arizona Health Care Cost Containment System (AHCCCS) Complete Care (ACC) Program. A complete list of measures and their specifications are available in Evaluation Designs linked in the Appendix.

Results Summary

Table 5-1 displays the number of measures by research question that showed improvement, worsened, did not change significantly, or were not applicable. The table also compares measure performance to national percentiles when applicable. The national percentiles are calculated based on performance among the ACC population relative to the National Committee for Quality Assurance (NCQA) and Medicaid Core Set benchmarks.[75]

Table 5-1—ACC Quantitative Measure Results Summary

Research Question	Number of Measures				National Percentiles				
	Worsening	No Significant Change	Improving	N/A[1]	Below 25th	25th to <50th	50th to <75th	75th and Above	N/A[2]
RQ 1.3: Did care coordination strategies improve or maintain patient engagement and follow up care after an IP stay or ED visit during the renewal period?	0	0	1	0	0	0	0	0	1
RQ 1.4: Do members perceive their doctors to have better care coordination as a result of ACC renewal?	0	2	0	0	0	0	0	0	2
RQ 2.1: Do members enrolled in an ACC plan have the same or better access to primary care services compared to prior to the renewal period?	3	5	3	0	1	0	1	1	8
RQ 2.2: Do members enrolled in an ACC plan have the same or better access to substance abuse treatment compared to prior to the renewal period?	0	0	2	0	0	0	2	0	0
RQ 3.1: Do members enrolled in an ACC plan have the same or higher rates of appropriate immunizations compared to prior to the renewal period?	2	1	0	0	0	0	0	0	3

[75] Centers for Medicare & Medicaid Services. Child and Adult Health Care Quality Measures. Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures. Accessed on: May 7, 2026.

Research Question	Number of Measures				National Percentiles				
	Worsening	No Significant Change	Improving	N/A[1]	Below 25th	25th to <50th	50th to <75th	75th and Above	N/A[2]
RQ 3.2: Do members enrolled in an ACC plan have the same or better management of chronic conditions compared to prior to the renewal period?	0	0	1	0	0	1	0	0	0
RQ 3.3: Do members enrolled in an ACC plan have the same or better management of BH conditions compared to prior to the renewal period?	1	0	4	1	2	1	3	0	0
RQ 3.4: Do members enrolled in an ACC plan have the same or better management of opioid prescriptions compared to prior to the renewal period?	0	0	2	0	0	1	0	1	0
RQ 3.5: Do members enrolled in an ACC plan have equal or lower ED or hospital utilization compared to prior to ACC renewal?	0	2	0	2	0	0	0	0	4
RQ 4.1: Do members enrolled in an ACC plan have the same or higher overall health rating compared to prior to the renewal period?	0	2	0	0	0	0	0	0	2
RQ 4.2: Do members enrolled in an ACC plan have the same or higher overall mental or emotional health rating compared to prior to the renewal period?	0	2	0	0	0	0	0	0	2
RQ 5.1: Are members equally or more satisfied with their health care as a result of integrated care during the renewal period?	0	4	0	0	1	1	2	0	0
Total	**6**	**18**	**13**	**3**	**4**	**4**	**8**	**2**	**22**

Note: ACC: AHCCCS Complete Care; BH: behavioral health; ED: emergency department; IP: inpatient; N/A: not applicable.
For measures stratified by "Adult" and "Child" populations that rely on PMMIS data, the "Total" stratification was used in developing the measure conclusion. For measures relying on survey data or measures that otherwise do not have a "Total" stratification, "Adult" and "Child" stratifications are totaled separately.
[1] Measures did not have a desired directionality or require additional context to describe the outcome.
[2] Measures did not have an associated national benchmark.

ACC Program Results

Hypothesis 1: Health plans encourage and/or facilitate care coordination among primary care physicians (PCPs) and behavioral health (BH) practitioners.

Hypothesis 1 assessed if ACC increased care coordination among PCPs and BH practitioners. Two research questions used key informant interviews to examine the experiences of ACC plans and providers. In August 2025, nine key informant interviews were conducted to identify the successes and barriers encountered during the integration of physical health (PH) and BH care. The remaining research questions leveraged Prepaid Medical Management Information System (PMMIS) and beneficiary survey data.

Research Question 1.1: What care coordination strategies or activities have ACC plans been conducting during the renewal period?

ACC plans described several approaches to strengthen care coordination between PH and BH providers. Plans highlighted the use of data, care management teams, and collaboration with external partners to support members' health and improve integration. Key themes included:

- **Established care coordination programs**: Plans operated structured programs supported by data, case management teams, and partnerships with State agencies, providers, community-based organizations (CBOs), and other plans.
- **Targeted support for high-risk members**: Plans implemented strategies targeted at specific groups, including members who were American Indian/Alaska Native (AI/AN), between settings of care, veterans, justice-involved, pregnant or postpartum, or had BH conditions.
- **Use of data to guide care**: Plans used member data to identify those who needed additional support and to guide outreach, referrals, and transitions of care. Plans utilized the health information exchange (HIE) to ensure stakeholders had access to up-to-date member information and to identify community resources to address member needs. Additionally, plans used real-time data from providers to identify members in crisis.
- **Collaboration across systems**: Plans established partnerships with external stakeholders such as CBOs, providers, and government departments to help reduce fragmentation and promote a more integrated system of care.
- **Ongoing barriers**: Plans noted continued challenges, including workforce shortages, data-sharing limitations, and administrative policy barriers that affected coordination efforts. Several plans noted that policy and requirement changes following integration were often unclear, which at times increased administrative burden for contracted providers.[76]

Research Question 1.2: What care coordination strategies or activities have providers been conducting during the renewal period?

ACC providers described a range of strategies and activities they implemented to support member care coordination during the renewal period. Providers emphasized the role of dedicated staff, data use, and collaboration across systems in improving coordination between PH and BH services. Key findings included:

[76] See Appendix A, Supplemental Results, for additional details on strategies, populations impacted, and continued barriers.

- **Dedicated care coordination staff**: Providers employed care managers, recovery coaches, population health managers, integrated health coordinators, and engagement specialists to oversee care coordination and member support activities.
- **Member-centered coordination**: Staff scheduled appointments; managed intake and referrals; conducted home visits; completed social determinants of health (SDOH), BH, and/or needs assessments; connected members to primary care; and provided education to help reduce hospitalization and emergency department (ED) utilization.
- **Targeted support for high-risk members**: Providers identified and addressed members' SDOH needs by connecting them with community resources and supports as needed. Providers screened for SDOH across all populations served to identify individuals who needed assistance with things like housing, food insecurity, and substance abuse.
- **Targeted education for specific populations**: Members with substance use disorders (SUDs), pregnant and postpartum members, and adults with BH needs benefited most from the additional resources and coordination efforts, which supported the reduction in hospital and ED utilization.
- **Improved coordination over time**: Providers reported that ACC member care coordination improved throughout the Waiver period. Coordination efforts focused on collaboration among members, health plans, family supports, and providers, including scheduling appointments; managing intake and referrals; conducting home visits; completing SDOH, BH, and/or needs assessments; connecting members to primary care; educating members to reduce hospital and ED utilization; addressing SDOH needs; and training internal staff on care coordination practices.
- **Barriers to effective care coordination**: Providers identified ongoing challenges that affected coordination efforts, including delays and inaccuracies in member data, plan preauthorization requirements, workforce shortages, and policy changes. Providers also experienced challenges coordinating with external stakeholders, citing that ACC care coordination requirements were not as strong as ACC-Regional Behavioral Health Agreement (ACC-RBHA) requirements, leading to providers not receiving sufficient notification about changes in ACC members' care, which hindered effective care coordination.[77]

Research Question 1.3: Did care coordination strategies improve or maintain patient engagement and follow up care after an inpatient (IP) stay or ED visit during the renewal period?

Table 5-2 utilized PMMIS data to examine changes in the rate of members with multiple high-risk chronic conditions with a follow-up after an ED visit.

Key Findings:

- The *Percentage of members with follow-up after an ED visit for members with multiple high-risk chronic conditions* increased between the baseline and evaluation periods by an average of 3.6 percentage points ($p<0.001$). Rates in 2023 and 2024 exceeded the baseline projections by 3.4 and 6.9 percentage points, respectively ($p<0.001$).

Follow-up care after an ED visit for members with multiple high-risk chronic conditions increased during the evaluation period, indicating potentially improved care coordination.

[77] See Appendix A, Supplemental Results, for additional details on strategies, populations impacted, and continued barriers.

Table 5-2—Research Question 1.3

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[3]	Trend Model Difference Between Actual and Projected (*p*-value)	
		Baseline Average[2]	Evaluation Average[2]	(*p*-value)	FFY 2023	FFY 2024
1-3	Percentage of members with a follow-up after an ED visit for members with multiple high-risk chronic conditions	50.7%	54.3%	3.6pp *** (<0.001)	3.4pp *** (<0.001)	6.9pp *** (<0.001)

*p<0.1, **p<0.05, ***p<0.001

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

[3]Change in Rate compares the rate or number in the baseline period (10/01/2018–09/30/2022) to the average rate or number in the evaluation period (10/1/2022–09/30/2024).

Table 5-3 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in federal fiscal years (FFYs) 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among ACC members. Each cell color or arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 5-3—Research Question 1.3, Disparities Analysis

		Black		AI/AN		All Others		Unknown		Rural		Female	
		2022	2024	2022	2024	2022	2024	2022	2024	2022	2024	2022	2024
1-3	Percentage of members with follow-up after an ED visit for members with multiple high-risk chronic conditions												

Measures with desired direction — *No desired direction*

NR

Effect size: < -0.2 | <-0.1 | >0.1 | >0.2 (Worse than reference — Better than reference)

Relative difference: < -20% | <-10% | - | >10% | >20% (↓↓ | ↓ | - | ↑ | ↑↑) (Lower than reference — Higher than reference)

Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. ED: emergency department. NR: not reportable due to suppression guidelines.

Research Question 1.4: Do members perceive their doctors to have better care coordination as a result of ACC renewal?

Table 5-4 utilized surveys to assess members' perceptions of care coordination.

Key Findings:

- The *Percentage of beneficiaries who reported their doctor seemed informed about the care they received from other health providers* decreased by 6.1 percentage points among adults (*p*=0.176) and increased 3.2 percentage points among children (*p*=0.500), though neither change was statistically significant.

Members' perception of care coordination improved slightly among parents/caretakers of children but declined among adults; however, neither change was statistically significant.

Table 5-4—Research Question 1.4, Measure 1.4

		Weighted Rate[1]		Pre/Post Change in Rate
		2021 Survey	2025 Survey	(*p*-value)
1-4	Percentage of beneficiaries who reported their doctor seemed informed about the care they received from other health			
	Adult	81.3% N=757	75.2% N=174	-6.1pp (0.176)
	Child	82.4% N=308	85.5% N=93	3.2pp (0.500)

*p <0.1, **p <0.05, ***p <0.001

Note: N represents the number of survey responses. Surveys were administered in calendar years (CYs) 2021 and 2025. pp: percentage point.

Data Source: Beneficiary surveys were used in the analysis of RQ 1.4.

[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP Code.

Hypothesis 2: Member access to appropriate care for routine medical conditions will be maintained or improved during the renewal period.

Research Question 2.1: Do members enrolled in an ACC plan have the same or better access to primary care services compared to prior to the renewal period?

Figure 5-1 displays the percentage of members enrolled in an ACC plan meeting time/distance standards by provider type.[78] Table 5-5 presents the results of the interrupted time series (ITS) analysis assessing the impact of the Waiver on provider network adequacy. It is important to note that this measure has high statistical power and may identify changes that are statistically significant but not practically meaningful. Table 5-6 utilized PMMIS data to determine the percentages of members accessing preventive services and well-care visits.

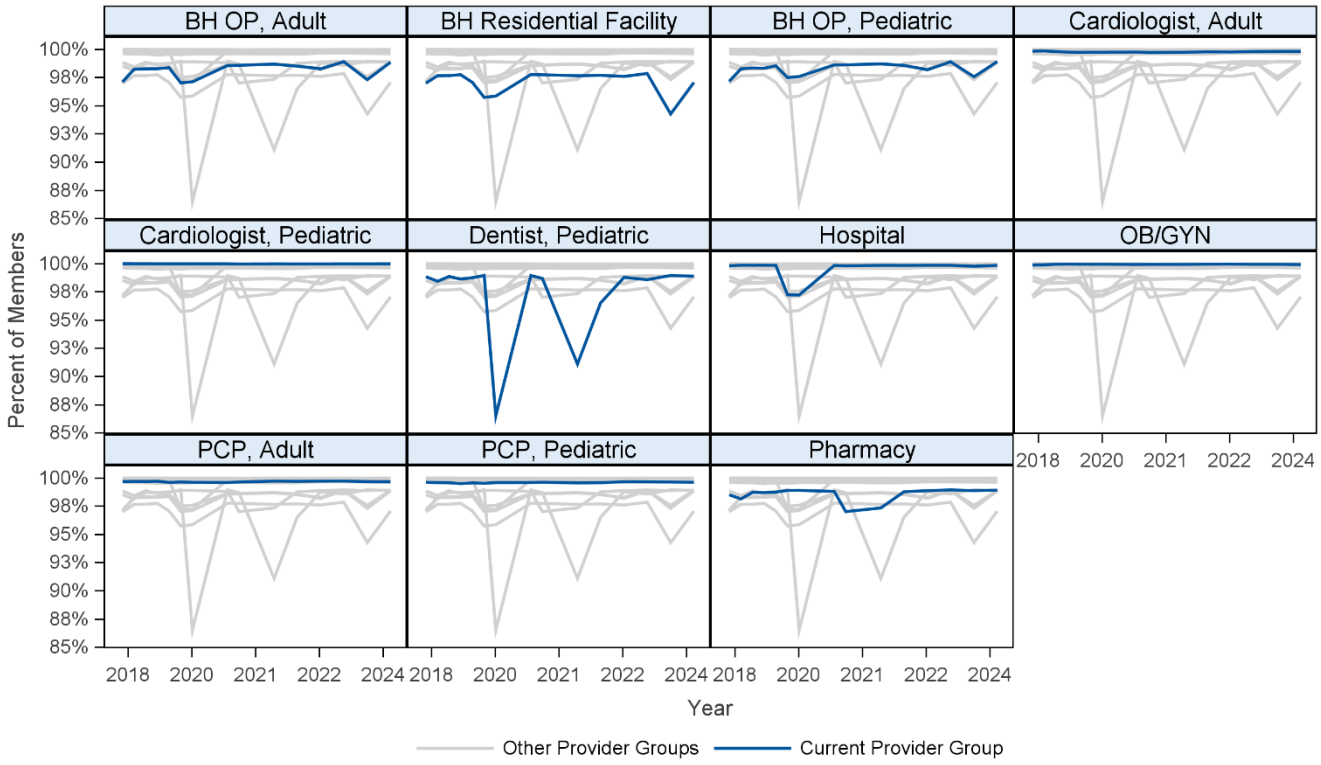
Key Findings:

- Across all provider types, the *Percentage of members within time/distance standards* for Pediatric Dentists exhibited the greatest change, declining from approximately 98.9 percent to 86.5 percent in quarter 3 (Q3) FFY 2020 and 91.1 percent in Q2 FFY 2022. Rates for other provider types remained stable, with 93.0 percent or more of members meeting standards. Although changes in time/distance trends were statistically significant due to high statistical power, none were clinically meaningful.
- The *Percentage of adults who accessed preventive/ambulatory health services* decreased 3.8 percentage points between the baseline and evaluation periods (p<0.001); however, the *Percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation*, the *Percentage of members who had a well-child visit in the first 30 months of life*, and the *Percentage of members 3–21 years of age who had a well-care visit with a PCP or obstetrician gynecologist (OB/GYN)* all increased between the baseline and evaluation periods (p<0.001 for all groups).
  - In 2022 and 2024, female members accessed preventive/ambulatory health services at higher rates compared to male members.
  - In 2022 and 2024, Black and AI/AN members had lower rates of well-child visits in the first 30 months of life compared to White/Caucasian members, with the gap widening among Black and White/Caucasian members between 2022 and 2024.
- Observed rates of access to care in the evaluation period exceeded baseline trend projections for all access to preventive care measures, with FFY 2024 rates particularly high relative to the baseline trend (p<0.001 for all groups). Notably, the largest difference was observed in the *Percentage of child members with 2 or more well-child visits between their 15-month birthday and 30-month birthday*, where the observed FFY 2024 rate exceeded the baseline projection by 16.3 percentage points (p<0.001).

78 Additional details on time/distance measure calculations and standards can be found in Appendix A, Attachments.

The Waiver was not associated with any meaningful changes in the percentage of members within the time/distance standards, as rates generally exceeded the 90 percent threshold for adequate access to care during the baseline period.[79] Although members had access to providers based on time/distance standards, the percentage of adult members who accessed preventive or ambulatory services declined during the evaluation period, suggesting potential barriers to care beyond provider time/distance. In contrast, access to well-child and well-care visits among children improved during the evaluation period, particularly in FFY 2024.

Figure 5-1—Research Question 2.1, Measure 2-1



Note: BH: behavioral health; OB/GYN: obstetrician gynecologist; OP: outpatient; PCP: primary care provider

[79] Ibid.

Table 5-5—Research Question 2.1, Measure 2-1

Provider Type	Percentage Change in Odds[1]		
	Baseline Annual Trend[2]	Level Change at Waiver Renewal[2]	Change in Annual Trend[2]
BH OP, Adult	15.7% *** (<0.001)	-21.3% *** (<0.001)	-12.8% *** (<0.001)
BH Residential Facility	6.1% *** (<0.001)	2.4% *** (<0.001)	-33.1% *** (<0.001)
BH OP, Pediatric	15.6% *** (<0.001)	-31.0% *** (<0.001)	-3.7% *** (<0.001)
Cardiologist, Adult	-7.0% *** (<0.001)	16.6% *** (<0.001)	25.2% *** (<0.001)
Cardiologist, Pediatric	-22.1% *** (<0.001)	17.4% ** (0.041)	60.8% *** (<0.001)
Dentist, Pediatric	-28.8% *** (<0.001)	426.5% *** (<0.001)	56.9% *** (<0.001)
Hospital	14.3% *** (<0.001)	181.3% *** (<0.001)	-22.0% *** (<0.001)
OB/GYN	11.7% *** (<0.001)	19.0% ** (0.021)	-35.3% *** (<0.001)
PCP, Adult	0.8% * (0.080)	24.9% *** (<0.001)	-13.4% *** (<0.001)
PCP, Pediatric	1.1% ** (0.010)	26.3% *** (<0.001)	-9.4% *** (<0.001)
Pharmacy	-11.4% *** (<0.001)	92.6% *** (<0.001)	14.3% *** (<0.001)

*p <0.1, **p <0.05, ***p <0.001

Note: Extremely large coefficients can occur when predicted probabilities approach 0 or 1. Results should be interpreted with caution. BH: behavioral health; OB/GYN: obstetrician gynecologist; OP: outpatient; PCP: primary care provider.

Data Source: Prepaid Medical Management Information System (PMMIS), Client Assessment and Tracking System (CATS), Provider Affiliation Transmission (PAT), and AHCCCS Contractor Operations Manual (ACOM) 436 were used in the analysis of RQ 2.1.

[1]Model utilizes semi-annual rates from the baseline period (10/01/2018–09/30/2022) and evaluation period (10/1/2022–09/30/2024).

[2]p -values are in parentheses.

Table 5-6—Research Question 2.1, Measures 2-2 through 2-5

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[3] (*p*-value)	Trend Model Difference Between Actual and Projected (*p*-value)	
		Baseline Average[2]	Evaluation Average[2]		FFY 2023	FFY 2024
2-2	Percentage of adults who accessed preventive/ambulatory health services	71.5%	67.7%	-3.8pp *** (<0.001)	0.7pp *** (<0.001)	4.0pp *** (<0.001)
2-3	Percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation	46.6%	46.9%	0.3pp *** (<0.001)	4.0pp *** (<0.001)	7.8pp *** (<0.001)
2-4	Percentage of members who had a well-child visit in the first 30 months of life					
	6 or more visits before the 15-month birthday	58.5%	62.7%	4.3pp *** (<0.001)	6.3pp *** (<0.001)	15.8pp *** (<0.001)
	2 or more visits between the 15-month and 30-month birthday	62.2%	64.2%	2.0pp *** (<0.001)	6.0pp *** (<0.001)	16.3pp *** (<0.001)
2-5	Percentage of members 3–21 years of age who had a well-care visit with a PCP or OB/GYN	45.3%	48.1%	2.8pp *** (<0.001)	5.9pp *** (<0.001)	11.1pp *** (<0.001)

*p <0.1, **p <0.05, ***p <0.001

Note: OB/GYN: obstetrician gynecologist; PCP: primary care practitioner; pp: percentage point.

Data Source: PMMIS data were used in the analysis of RQ 2.1.

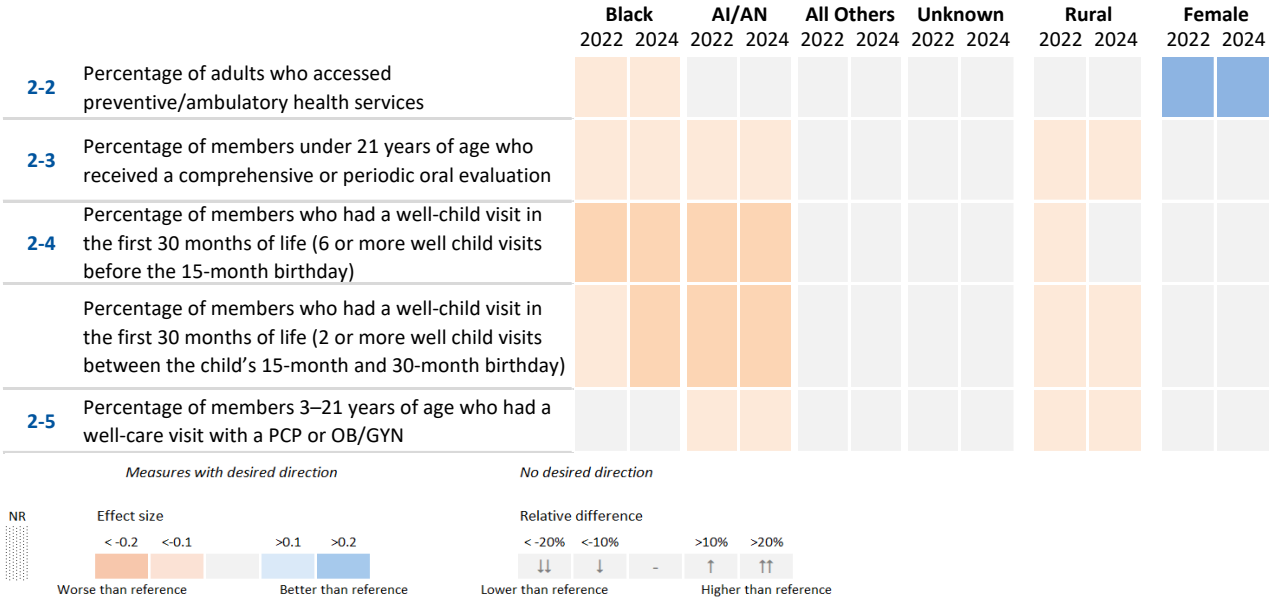
[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.

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

[3]Change in Rate compares the rate or number in the baseline period (10/01/2018–09/30/2022) to the average rate or number in the evaluation period (10/1/2022–09/30/2024).

Table 5-7 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in FFYs 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among ACC members. Each cell color or arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 5-7—Research Question 2.1, Disparities Analysis



Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. NR: not reportable due to suppression guidelines. OB/GYN: obstetrician gynecologist; PCP: primary care practitioner.

Table 5-8 utilized surveys to assess member-reported access to primary care services.

Key Findings:

- The *Percentage of beneficiaries who reported they received care as soon as they needed* decreased by 3.6 and 9.4 percentage points for adults and children, respectively (p=0.504 and p=0.003, respectively); however, this decrease was only statistically significant among child members.
- The *Percentage of beneficiaries who reported they were able to schedule an appointment for a checkup or routine care at a doctor's office or clinic as soon as they needed* decreased slightly for both adults and children by 1.0 and 1.1 percentage points, respectively (p=0.800 and p=0.712, respectively). Neither decrease was statistically significant.
- The *Percentage of beneficiaries who reported they were able to schedule an appointment with a specialist as soon as they needed* declined by 2.7 and 3.9 percentage points, respectively (p=0.553 and p=0.457, respectively). Neither decrease was statistically significant.

Although rates of member-reported access to care declined during the evaluation period, most findings were not statistically significant. The largest and only statistically significant decrease was the percentage of child members that reported they received care as soon as they needed.

Table 5-8—Research Question 2.1, Measures 2-6 through 2-8

		Weighted Rate[1]		Pre/Post Change in Rate (*p*-value)
		2021 Survey	2025 Survey	
2-6	Percentage of beneficiaries who reported they received care as soon as they needed			
	Adult	79.4% N=661	75.7% N=114	-3.6pp (0.504)
	Child	96.0% N=293	86.6% N=69	-9.4pp ** (0.003)
2-7	Percentage of beneficiaries who reported they were able to schedule an appointment for a checkup or routine care at a doctor's office or clinic as soon as they needed			
	Adult	77.2% N=1,223	76.2% N=218	-1.0pp (0.800)
	Child	86.4% N=906	85.3% N=170	-1.1pp (0.712)
2-8	Percentage of beneficiaries who reported they were able to schedule an appointment with a specialist as soon as they needed			
	Adult	79.0% N=981	76.2% N=174	-2.7pp (0.553)
	Child	80.9% N=318	77.1% N=79	-3.9pp (0.457)

*p<0.1, **p<0.05, ***p<0.001

Note: N represents the number of survey responses. Surveys were administered in calendar years (CYs) 2021 and 2025. pp: percentage point.

Data Source: Beneficiary surveys were used in the analysis of RQ 2.1.

[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP Code.

Research Question 2.2: Do members enrolled in an ACC plan have the same or better access to substance abuse treatment compared to prior to the renewal period?

Table 5-9 utilized PMMIS data to determine the percentage of members initiating and engaging in substance abuse treatment.

Key Findings:

- The *Percentage of members who had initiation of alcohol and other drug abuse dependence treatment* and the *Percentage of members who had engagement of alcohol and other drug abuse dependence treatment* increased by 1.2 percentage points and 2.1 percentage points, respectively, between the baseline and evaluation periods ($p<0.001$).
  - Initiation and engagement of opioid treatment worsened for female members between 2022 to 2024, relative to rates among male members.
- In FFY 2024, the observed percentage of total members who initiated and engaged in treatment was 5.7 and 2.3 percentage points lower than the baseline projection, respectively, indicating that the rate of increase observed during the baseline period was not sustained in 2024 ($p<0.001$).

The percentage of members who initiated or engaged in substance abuse treatment generally increased during the evaluation period.

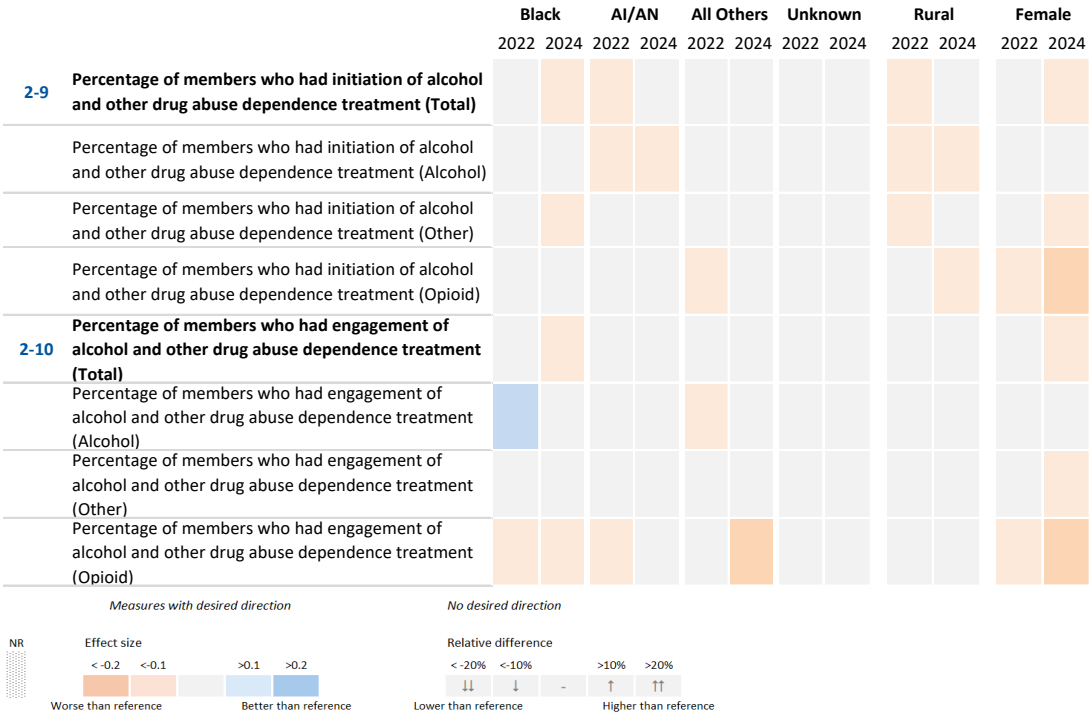
Table 5-9—Research Question 2.2, Measures 2-9 and 2-10

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[3] (*p*-value)	Trend Model Difference Between Actual and Projected (*p*-value)	
		Baseline Average[2]	Evaluation Average[2]		FFY 2023	FFY 2024
2-9	Percentage of members who had initiation of alcohol and other drug abuse dependence treatment (Total)	49.5%	50.6%	1.2pp *** (<0.001)	-1.0pp ** (0.001)	-5.7pp *** (<0.001)
	Adult	49.6%	50.8%	1.3pp *** (<0.001)	-0.8pp ** (0.013)	-5.5pp *** (<0.001)
	Child	47.9%	46.9%	-1.0pp (0.294)	-5.3pp ** (0.002)	-9.4pp *** (<0.001)
2-10	Percentage of members who had engagement of alcohol and other drug abuse dependence treatment (Total)	16.4%	18.5%	2.1pp *** (<0.001)	0.9pp *** (<0.001)	-2.3pp *** (<0.001)
	Adult	16.7%	18.9%	2.2pp *** (<0.001)	1.0pp *** (<0.001)	-2.1pp *** (<0.001)
	Child	11.6%	11.4%	-0.3pp (0.682)	-0.2pp (0.856)	-3.6pp ** (0.008)

*p <0.1, **p <0.05, ***p <0.001
Note: pp: percentage point.
Data Source: PMMIS data were used in the analysis of RQ 2.2.
[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.
[2]Rates are weighted by enrollment duration in ACC.
[3]Change in Rate compares the rate or number in the baseline period (10/01/2018–09/30/2022) to the average rate or number in the evaluation period (10/1/2022–09/30/2024).

Table 5-10 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in FFYs 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among ACC members. Each cell color or arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 5-10—Research Question 2.2, Disparities Analysis



Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. NR: not reportable due to suppression guidelines.

Hypothesis 3: Quality of care will be maintained or improved during the renewal period.

Research Question 3.1: Do members enrolled in an ACC plan have the same or higher rates of appropriate immunizations compared to prior to the renewal period?

Table 5-11 utilized PMMIS data to assess the percentage of children and adolescents with appropriate immunization status. It is important to note that State immunization registry data were unavailable during the evaluation; therefore, rates may not fully reflect vaccination status among the ACC-Child population.

Key Findings:

- The *Percentage of children 2 years of age with appropriate immunization status* for the measles, mumps, and rubella (MMR), varicella zoster virus (VZV), and hepatitis A vaccines increased by 1.8, 1.4, and 3.7 percentage points, respectively, between the baseline and evaluation periods (p<0.001). Immunization rates for all other vaccine types decreased between the baseline and evaluation periods ranging from 1.0 to 6.7 percentage points (p<0.001).
  - Although rates of immunizations among each vaccinees were generally lower among members in rural areas compared to members in urban areas, gaps in immunization status began to shrink between 2022 and 2024 for the MMR, VZV, and Influenza vaccinees. Notable improvements were demonstrated in rural members' immunizations for the hepatitis B vaccine. Disparities among the combination indicators are less pronounced, due to the low rates of reported appropriate immunization status among all demographic subgroups.
- The *Percentage of adolescents 13 years of age with the appropriate immunizations* decreased for all immunizations between the baseline and evaluation periods (p<0.001). However, observed rates in 2023 and 2024 exceeded the projections from the baseline trend, indicating that the rate of decrease during the baseline period lessened in the evaluation period (p=0.014 for Combination 2 in 2023, p=0.051 for Combination 1 in 2024, and p<0.001 for all others).

- AI/AN members and rural members consistently had lower rates of appropriate immunizations compared to the reference groups (i.e., White/Caucasian and urban members) in 2022 and 2024.

While the immunization status for some vaccines, including MMR, VZV, and hepatitis A, increased during the evaluation period for children 2 years of age, most immunization rates decreased following the Waiver renewal. However, for nearly all vaccines, observed rates during the evaluation period exceeded baseline projections, indicating that rates declined more slowly during the renewal period than during the baseline period.

Table 5-11—Research Question 3.1, Measures 3-1 and 3-2

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[3]	Trend Model Difference Between Actual and Projected	
		Baseline Average[2]	Evaluation Average[2]	(*p*-value)	FFY 2023	FFY 2024
3-1	Percentage of children 2 years of age with appropriate immunization status					
	DTaP	43.3%	38.2%	-5.1pp *** (<0.001)	3.7pp *** (<0.001)	6.6pp *** (<0.001)
	IPV	59.0%	52.3%	-6.7pp *** (<0.001)	3.1pp *** (<0.001)	4.8pp *** (<0.001)
	MMR	66.4%	68.2%	1.8pp *** (<0.001)	11.6pp *** (<0.001)	28.4pp *** (<0.001)
	HiB	61.7%	56.2%	-5.5pp *** (<0.001)	3.9pp *** (<0.001)	9.0pp *** (<0.001)
	Hepatitis B	24.4%	23.4%	-1.0pp *** (<0.001)	4.7pp *** (<0.001)	9.4pp *** (<0.001)
	VZV	66.0%	67.4%	1.4pp *** (<0.001)	11.1pp *** (<0.001)	27.6pp *** (<0.001)
	Pneumococcal Conjugate	44.3%	40.6%	-3.7pp *** (<0.001)	6.3pp *** (<0.001)	6.3pp *** (<0.001)
	Hepatitis A	67.7%	71.4%	3.7pp *** (<0.001)	14.6pp *** (<0.001)	31.1pp *** (<0.001)
	Rotavirus	46.8%	44.9%	-1.9pp *** (<0.001)	3.9pp *** (<0.001)	7.7pp *** (<0.001)
	Influenza	28.7%	22.6%	-6.1pp *** (<0.001)	-0.8pp ** (0.019)	4.1pp *** (<0.001)
	Combination 3	15.7%	13.6%	-2.1pp *** (<0.001)	3.0pp *** (<0.001)	4.6pp *** (<0.001)
	Combination 7	13.6%	11.8%	-1.8pp *** (<0.001)	2.4pp *** (<0.001)	4.0pp *** (<0.001)
	Combination 10	7.5%	4.9%	-2.6pp *** (<0.001)	0.0pp (0.879)	0.5pp ** (0.009)
3-2	Percentage of adolescents 13 years of age with appropriate immunizations					
	Meningococcal	65.4%	57.5%	-7.9pp *** (<0.001)	1.9pp *** (<0.001)	2.6pp *** (<0.001)
	Tdap	66.0%	62.2%	-3.8pp *** (<0.001)	3.0pp *** (<0.001)	8.2pp *** (<0.001)
	HPV	28.5%	25.8%	-2.7pp *** (<0.001)	1.4pp *** (<0.001)	5.0pp *** (<0.001)
	Combination 1 (Meningococcal, Tdap)	63.3%	56.0%	-7.3pp *** (<0.001)	1.6pp *** (<0.001)	1.0pp * (0.051)
	Combination 2 (Meningococcal, Tdap, HPV)	26.6%	23.0%	-3.7pp *** (<0.001)	0.8pp ** (0.014)	1.4pp *** (<0.001)

*p <0.1, **p <0.05, ***p <0.001

Note: DTaP: diphtheria, tetanus, pertussis; HiB: haemophilus influenzae type b; HPV: human papillomavirus; IPV: inactivated poliovirus vaccine; MMR: measles, mumps, and rubella; pp: percentage point; Tdap: tetanus, diphtheria, pertussis; VZV: varicella zoster virus.

Data Source: PMMIS data were used in the analysis of RQ 3.1.

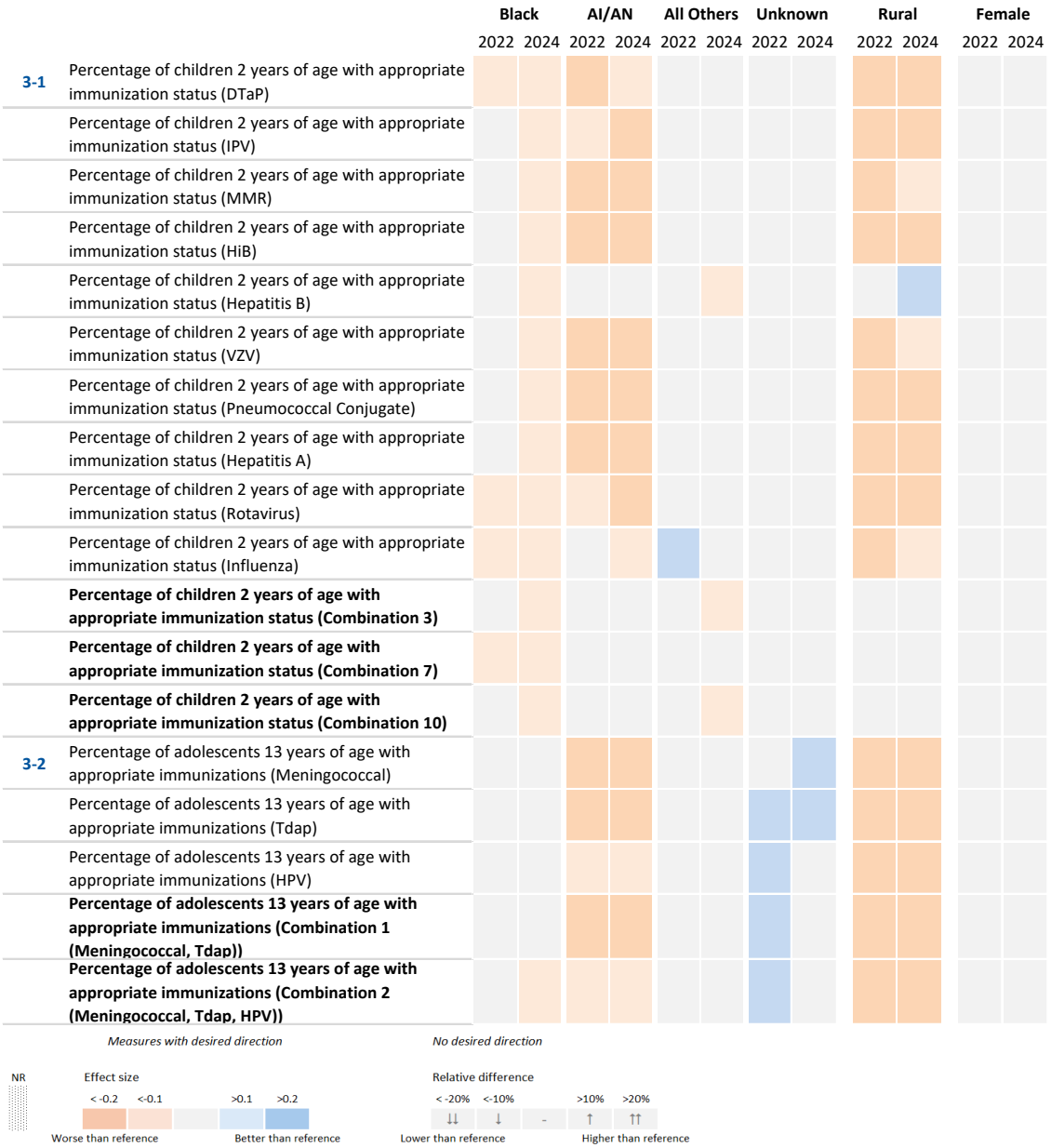
[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.

[2]Rates are weighted by enrollment duration in ACC.

[3]Change in Rate compares the rate or number in the baseline period (10/01/2018–09/30/2022) to the average rate or number in the evaluation period (10/1/2022–09/30/2024).

Table 5-12 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in FFYs 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among ACC members. Each cell color or arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 5-12—Research Question 3.1, Disparities Analysis



Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. DTap: diphtheria, tetanus, pertussis; HiB: haemophilus influenzae type b; HPV: human papillomavirus; IPV: inactivated poliovirus vaccine; MMR: measles, mumps, and rubella; NR: not reportable due to suppression guidelines; Tdap: tetanus, diptheria, pertussis; VZV: varicella zoster virus.

Table 5-13 utilized surveys to assess member-reported immunizations.

Key Findings:

- The *Percentage of adult beneficiaries who reported having a flu shot or nasal flu spray since July 1* decreased by 5.4 percentage points to 32.7 percent in the evaluation period (p=0.154); however, this change was not statistically significant.

Members enrolled in an ACC plan reported lower influenza immunization rates during the evaluation period, though the change was not statistically significant.

Table 5-13—Research Question 3.1, Measure 3-3

		Weighted Rate[1]		Pre/Post Change in Rate (p-value)
		2021 Survey	2025 Survey	
3-3	Percentage of adult beneficiaries who reported having a flu shot or nasal flu spray since July 1	38.1% N=2,039	32.7% N=300	-5.4pp (0.154)

*p <0.1, **p <0.05, ***p <0.001

Note: N represents the number of survey responses. Surveys were administered in calendar years (CYs) 2021 and 2025. pp: percentage point.

Data Source: Beneficiary surveys were used in the analysis of RQ 3.1.

[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP Code.

Research Question 3.2: Do members enrolled in an ACC plan have the same or better management of chronic conditions compared to prior to the renewal period?

Table 5-14 displays the percentage of members with persistent asthma whose medications were at least 50 percent controller medications.

Key Findings:

- The *Percentage of total and adult members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent* increased between the baseline and evaluation periods by 4.9 and 8.5 percentage points, respectively (p<0.001).

Among adults, asthma management as a chronic condition improved following the Waiver renewal, while results among children were inconclusive and showed mixed results.

Table 5-14—Research Question 3.2, Measure 3-4

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[3] (p-value)	Trend Model Difference Between Actual and Projected (p-value)	
		Baseline Average[2]	Evaluation Average[2]		FFY 2023	FFY 2024
3-4	Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent	62.0%	66.9%	4.9pp *** (<0.001)	7.4pp *** (<0.001)	-0.5pp (0.489)
	Adult	56.5%	65.0%	8.5pp *** (<0.001)	7.1pp *** (<0.001)	0.6pp (0.525)
	Child	70.4%	70.0%	-0.3pp (0.572)	5.0pp *** (<0.001)	-7.3pp *** (<0.001)

*p <0.1, **p <0.05, ***p <0.001

Note: pp: percentage point.

Data Source: PMMIS data were used in the analysis of RQ 3.2.

[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.

[2]Rates are weighted by enrollment duration in ACC.

[3]Change in Rate compares the rate or number in the baseline period (10/01/2018–09/30/2022) to the average rate or number in the evaluation period

Table 5-15 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in FFYs 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among ACC members. Each cell color or arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 5-15—Research Question 3.2, Disparities Analysis

		Black		AI/AN		All Others		Unknown		Rural		Female	
		2022	2024	2022	2024	2022	2024	2022	2024	2022	2024	2022	2024
3-4	Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent												

Measures with desired direction *No desired direction*

NR

Effect size: < -0.2 | <-0.1 | >0.1 | >0.2 — Worse than reference / Better than reference

Relative difference: < -20% (↓↓) | <-10% (↓) | - | >10% (↑) | >20% (↑↑) — Lower than reference / Higher than reference

Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. NR: not reportable due to suppression guidelines.

Research Question 3.3: Do members enrolled in an ACC plan have the same or better management of BH conditions compared to prior to the renewal period?

Table 5-16 displays the results identifying the changes in the management of BH conditions.

Key Findings:

- The *Percentage of adult members who remained on an antidepressant medication treatment* for 84 days and 180 days increased between the baseline and evaluation periods by 4.2 and 2.8 percentage points, respectively (p<0.001).
  - In 2022 and 2024, Black members and AI/AN members had lower rates of remaining on an antidepressant treatment for 84 days and 180 days compared to White/Caucasian members. Between 2022 and 2024 the gap between the rates of AI/AN and White/Caucasian members decreased.
- The *Percentage of (adult) members with a follow-up visit within 7 days after hospitalization for mental illness* and the *Percentage of (adult) members with a follow-up visit for mental illness within 7 days after an ED visit for SUD* increased between the baseline and evaluation periods by 4.1 and 2.0 percentage points, respectively (p<0.001).
  - The percentage of rural members with a follow-up visit within 7 days after an ED visit for mental illness improved relative to urban members between 2022 and 2024.
- By contrast, the *Percentage of (child) members with a follow-up visit within 7 days after hospitalization for mental illness*, the *Percentage of (child) members with a follow-up visit within 7 days after an ED visit for mental illness*, and *the Percentage of (child) members with a follow-up visit within 7 days after an ED visit for SUD* decreased between the baseline and evaluation periods by 4.9, 6.2, and 7.1 percentage points, respectively (p<0.001).
- The *Percentage of (child) members diagnosed with a mental health disorder* increased between the baseline and evaluation periods by 3.7 percentage points (p<0.001).

Adult members generally had better management of BH conditions following the Waiver renewal, with more members remaining on antidepressants and higher rates of follow-up care after hospitalizations for mental illness, ED visits for mental illness, and ED visits for SUD. In contrast, child members had lower rates of follow-up care following the Waiver renewal.

Table 5-16—Research Question 3.3, Measures 3-5 through 3-9

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[2] (*p*-value)	Trend Model Difference Between Actual and Projected (*p*-value)	
		Baseline Average[2]	Evaluation Average[2]		FFY 2023	FFY 2024
3-5	Percentage of adult members who remained on an antidepressant medication treatment					
	84 days	48.6%	52.7%	4.2pp *** (<0.001)	-3.0pp *** (<0.001)	-5.0pp *** (<0.001)
	180 days	27.2%	30.1%	2.8pp *** (<0.001)	-1.8pp *** (<0.001)	-2.5pp *** (<0.001)
3-6	Percentage of members with a follow-up visit within 7 days after hospitalization for mental illness	46.4%	49.1%	2.7pp *** (<0.001)	1.6pp ** (0.011)	-0.8pp (0.304)
	Adult	40.3%	44.4%	4.1pp *** (<0.001)	2.7pp *** (<0.001)	-0.4pp (0.645)
	Child	66.4%	61.5%	-4.9pp *** (<0.001)	-4.1pp *** (<0.001)	-5.7pp *** (<0.001)
3-7	Percentage of members with a follow-up visit within 7 days after an ED visit for mental illness	49.5%	47.4%	-2.1pp ** (0.014)	-4.2pp ** (0.003)	-0.8pp (0.659)
	Adult	40.6%	41.2%	0.6pp (0.539)	-2.4pp (0.138)	1.1pp (0.575)
	Child	71.7%	65.5%	-6.2pp *** (<0.001)	-7.6pp ** (0.003)	-4.7pp (0.127)
3-8	Percentage of members with a follow-up within 7 days after an ED visit for SUD	28.9%	30.4%	1.6pp *** (<0.001)	1.6pp ** (0.037)	4.4pp *** (<0.001)
	Adult	28.7%	30.7%	2.0pp *** (<0.001)	1.7pp ** (0.027)	4.6pp *** (<0.001)
	Child	32.8%	25.7%	-7.1pp *** (<0.001)	-1.8pp (0.577)	0.9pp (0.817)
3-9	Percentage of members diagnosed with a mental health disorder	22.5%	24.1%	1.6pp *** (<0.001)	1.3pp *** (<0.001)	2.2pp *** (<0.001)
	Adult	26.2%	26.1%	-0.1pp * (0.065)	1.4pp *** (<0.001)	3.1pp *** (<0.001)
	Child	17.2%	21.0%	3.7pp *** (<0.001)	1.9pp *** (<0.001)	2.2pp *** (<0.001)

*p <0.1, **p <0.05, ***p <0.001

Note: ED: emergency department; pp: percentage point; SUD: substance use disorder

Data Source: PMMIS data were used in the analysis of RQ 3.3.

[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.

[2]Rates are weighted by enrollment duration in ACC.

[3]Change in Rate compares the rate or number in the baseline period (10/01/2018–09/30/2022) to the average rate or number in the evaluation period (10/1/2022–09/30/2024).

Table 5-17 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in FFYs 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among ACC members. Each cell color or arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 5-17—Research Question 3.3, Disparities Analysis

		Black		AI/AN		All Others		Unknown		Rural		Female	
		2022	2024	2022	2024	2022	2024	2022	2024	2022	2024	2022	2024
3-5	Percentage of adult members who remained on an antidepressant medication treatment (84 days)												
	Percentage of adult members who remained on an antidepressant medication treatment (180 days)												
3-6	Percentage of members with a follow-up visit within 7 days after hospitalization for mental illness												
3-7	Percentage of members with a follow-up visit within 7 days after an ED visit for mental illness												
3-8	Percentage of members with a follow-up visit within 7 days after an ED visit for SUD												
3-9	Percentage of members diagnosed with a mental health disorder	↓↓	↓	↓	-	↓↓	↓↓	↓	↓	-	-	↑↑	↑

Measures with desired direction *No desired direction*

NR

Effect size: < -0.2 | <-0.1 | >0.1 | >0.2

Worse than reference — Better than reference

Relative difference: < -20% (↓↓) | <-10% (↓) | - | >10% (↑) | >20% (↑↑)

Lower than reference — Higher than reference

Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. ED: emergency department. NR: not reportable due to suppression guidelines. SUD: substance use disorder.

Research Question 3.4: Do members enrolled in an ACC plan have the same or better management of opioid prescriptions compared to prior to the renewal period?

Table 5-18 utilized PMMIS data to identify changes in the management of opioid prescriptions.

Key Findings:

- The *Percentage of adult members who have prescriptions for opioids at a high dosage* decreased between the baseline and evaluation periods by 3.3 percentage points ($p<0.001$).
  - Rural members had relatively lower rates of prescriptions for opioids at a high dosage when compared to members in urban areas.
- The *Percentage of adult members with concurrent use of opioids and benzodiazepines* decreased between the baseline and evaluation periods by 1.2 percentage points ($p<0.001$).
  - Compared to White/Caucasian members, Black members and AI/AN members had lower concurrent use of opioids and benzodiazepines in 2022 and 2024.

The percentage of members with high-dose opioid prescriptions and concurrent use of opioids and benzodiazepines both decreased following the Waiver renewal, indicating improved management of opioid prescribing.

Table 5-18—Research Question 3.4, Measures 3-10 and 3-11

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[3] (*p*-value)	Trend Model Difference Between Actual and Projected (*p*-value)	
		Baseline Average[2]	Evaluation Average[2]		FFY 2023	FFY 2024
3-10	Percentage of adult members who have prescriptions for opioids at a high dosage (lower is better)	11.3%	8.0%	-3.3pp *** (<0.001)	-2.6pp *** (<0.001)	-2.2pp *** (<0.001)
3-11	Percentage of adult members with concurrent use of opioids and benzodiazepines (lower is better)	6.1%	4.9%	-1.2pp *** (<0.001)	0.5pp ** (0.012)	1.1pp *** (<0.001)

*p <0.1, **p <0.05, ***p <0.001

Note: pp: percentage point.

Data Source: PMMIS data were used in the analysis of RQ 3.4.

[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.

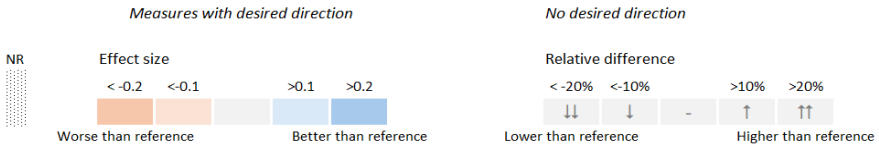
[2]Rates are weighted by enrollment duration in ACC.

[3]Change in Rate compares the rate or number in the baseline period (10/01/2018–09/30/2022) to the average rate or number in the evaluation period (10/1/2022–09/30/2024).

Table 5-19 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in FFYs 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among ACC members. Each cell color or arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 5-19—Research Question 3.4, Disparities Analysis

		Black		AI/AN		All Others		Unknown		Rural		Female	
		2022	2024	2022	2024	2022	2024	2022	2024	2022	2024	2022	2024
3-10	Percentage of adult members who have prescriptions for opioids at a high dosage↓												
3-11	Percentage of adult members with concurrent use of opioids and benzodiazepines↓												



Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. NR: not reportable due to suppression guidelines.
↓Lower measure rates indicate better performance. Disparities analysis presented reflects the desired direction.

Research Question 3.5: Do members enrolled in an ACC plan have equal or lower ED or hospital utilization compared to prior to ACC renewal?

Table 5-20 utilized PMMIS data to assess changes in ED and IP utilization.

Key Findings:

- The *Number of (adult) IP stays per 1,000 member months* decreased by 1.81 stays between the baseline and evaluation periods (p=0.025).
- There were minimal changes in emergent and non-emergent ED visits and IP readmissions between the baseline and evaluation periods. Non-emergent ED visits per 1,000 member months decreased by 0.07 percentage points, emergent ED visits per 1,000 member months decreased by 1.97 percentage points, and the percentage of adult IP discharges with an unplanned readmission within 30 days increased by 0.1 percentage points; however, none of these changes were statistically significant (p=0.848, p=0.599, and p=0.246, respectively).
  - In 2022 and 2024, female members and Black members had higher rates of non-emergent ED visits per 1,000 member months compared to the reference group (i.e., male and White/Caucasian members, respectively).

While both emergent and non-emergent ED visit rates were largely unchanged between the baseline and evaluation periods, the rate of IP stays decreased slightly.

Table 5-20—Research Question 3.5, Measures 3-12 through 3-15

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[2] (p-value)	Trend Model Difference Between Actual and Projected (p-value)	
		Baseline Average	Evaluation Average		FFY 2023	FFY 2024
3-12	Number of emergent ED visits per 1,000 member months (no desired direction)	41.37	39.40	-1.97 (0.599)	5.46 ** (0.036)	11.03 *** (<0.001)
	Adult	49.67	43.83	-5.83 (0.169)	4.23 ** (0.007)	10.53 *** (<0.001)
	Child	29.94	32.37	2.43 (0.543)	7.51 * (0.077)	12.70 ** (0.014)
3-13	Number of non-emergent ED visits per 1,000 member months (lower is better)	2.81	2.74	-0.07 (0.848)	0.62 ** (0.007)	1.10 *** (<0.001)
	Adult	3.88	3.62	-0.26 (0.593)	0.78 *** (<0.001)	1.44 *** (<0.001)
	Child	1.34	1.35	0.01 (0.974)	0.37 (0.132)	0.68 ** (0.021)
3-14	Number of IP stays per 1,000 member months (no desired direction)	6.99	6.19	-0.81 ** (0.046)	0.11 *** (<0.001)	0.92 *** (<0.001)
	Adult	10.89	9.08	-1.81 ** (0.025)	0.06 (0.152)	1.63 *** (<0.001)
	Child	1.61	1.60	-0.01 (0.940)	0.33 ** (0.037)	0.36 ** (0.042)
3-15	Percentage of adult IP discharges with an unplanned readmission within 30 days (lower is better)	9.0%	9.1%	0.1pp (0.246)	-0.1pp (0.573)	-0.1pp (0.581)

*p <0.1, **p <0.05, ***p <0.001

Note: ED: emergency department; IP: inpatient; pp: percentage point.

Data Source: PMMIS data were used in the analysis of RQ 3.5.

[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.

[2]Change in Rate compares the rate or number in the baseline period (10/01/2018–09/30/2022) to the average rate or number in the evaluation period (10/1/2022–09/30/2024).

Table 5-21 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in FFYs 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among ACC members. Each cell color or arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 5-21—Research Question 3.5, Disparities Analysis

		Black		AI/AN		All Others		Unknown		Rural		Female	
		2022	2024	2022	2024	2022	2024	2022	2024	2022	2024	2022	2024
3-12	Number of emergent ED visits per 1,000 member months	↑	-	-	-	⇊	⇊	-	-	↑	-	↑	↑
3-13	Number of non-emergent ED visits per 1,000 member months†↓												
3-14	Number of IP stays per 1,000 member months	-	-	-	-	-	-	-	-	-	-	↑↑	↑↑
3-15	Percentage of adult IP discharges with an unplanned readmission within 30 days↓												

Measures with desired direction

NR

Effect size	< -0.2	<-0.1		>0.1	>0.2
Relative difference†	< -20%	<-10%		>10%	>20%

Worse than reference — Better than reference

No desired direction

Relative difference					
	< -20%	<-10%		>10%	>20%
	⇊	↓	-	↑	↑↑

Lower than reference — Higher than reference

Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. ED: emergency department. IP: Inpatient; NR: not reportable due to suppression guidelines.
↓Lower measure rates indicate better performance. Disparities analysis presented reflects the desired direction.
†Relative difference is used for this measure.

Hypothesis 4: Member self-assessed health outcomes will be maintained or improved during the renewal period.

Research Question 4.1: Do members enrolled in an ACC plan have the same or higher overall health rating compared to prior to the renewal period?

Table 5-22 displays member-reported overall health rating from surveys.

Key Findings:

- The *Percentage of beneficiaries who reported a high rating of overall health* increased slightly by 1.0 percentage point among adults (p=0.809) between the baseline and evaluation period but decreased by 4.3 percentage points among children (p=0.136). Neither change was statistically significant.

Members' ratings of overall health were consistent among adults but decreased among children; however, none of the changes were statistically significant.

Table 5-22—Research Question 4.1, Measure 4-1

		Weighted Rate[1] 2021 Survey	Weighted Rate[1] 2025 Survey	Pre/Post Change in Rate (*p*-value)
4-1	Percentage of beneficiaries who reported a high rating of overall health			
	Adult	36.5% N=2,094	37.5% N=315	1.0pp (0.809)
	Child	81.1% N=1,725	76.8% N=225	-4.3pp (0.136)

*p <0.1, **p <0.05, ***p <0.001

Note: N represents the number of survey responses. Surveys were administered in calendar years (CYs) 2021 and 2025. pp: percentage point.

Data Source: Beneficiary surveys were used in the analysis of RQ 4.1.

[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP Code.

Research Question 4.2: Do members enrolled in an ACC plan have the same or higher overall mental or emotional health rating compared to prior to the renewal period?

Table 5-23 utilized surveys to assess member-reported mental or emotional health ratings.

Key Findings:

- The *Percentage of beneficiaries who reported a high rating of overall mental or emotional health* decreased for adults and children by 3.9 percentage points and 3.0 percentage points, respectively, between the baseline and evaluation periods (p=0.336 and p=0.357, respectively). Neither change was statistically significant.

Although member-assessed ratings of overall emotional or mental health declined during the renewal period, the changes were not statistically significant.

Table 5-23—Research Question 4.2, Measure 4-2

		Weighted Rate[1] 2021 Survey	Weighted Rate[1] 2025 Survey	Pre/Post Change in Rate (*p*-value)
4-2	Percentage of beneficiaries who reported a high rating of overall mental or emotional health			
	Adult	43.2% N=2,104	39.2% N=315	-3.9pp (0.336)
	Child	74.0% N=1,726	71.0% N=224	-3.0pp (0.357)

*p <0.1, **p <0.05, ***p <0.001

Note: N represents the number of survey responses. Surveys were administered in calendar years (CYs) 2021 and 2025. pp: percentage point.

Data Source: Beneficiary surveys were used in the analysis of RQ 4.2.

[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP Code.

Hypothesis 5: Member satisfaction with their health care will be maintained or improved during the renewal period.

Research Question 5.1: Are members equally or more satisfied with their health care as a result of integrated care during the renewal period?

Table 5-24 utilized surveys to assess member satisfaction with their health plans and health care.

Key Findings:

- The *Percentage of beneficiaries who reported a high rating of health plan* increased by 4.3 and 0.8 percentage points between the baseline and evaluation periods for adults and children, respectively (p=0.200 and p=0.727, respectively). Neither change was statistically significant.
- The *Percentage of beneficiaries who reported a high rating of overall health care* was stable near 73 percent among adults between the baseline and evaluation periods (p=0.973) but decreased by 1.9 percentage points to 87.4 percent among children (p=0.428). Neither change was statistically significant.

There were no statistically significant changes in the percentage of members satisfied with their health plan or health care during the evaluation period.

Table 5-24—Research Question 5.1, Measures 5-1 and 5-2

		Weighted Rate[1]		Pre/Post Change in Rate (p-value)
		2021 Survey	2025 Survey	
5-1	Percentage of beneficiaries who reported a high rating of health plan			
	Adult	74.8% N=2,057	79.1% N=311	4.3pp (0.200)
	Child	86.9% N=1,699	87.8% N=224	0.8pp (0.727)
5-2	Percentage of beneficiaries who reported a high rating of overall health care			
	Adult	73.4% N=1,274	73.5% N=313	0.1pp (0.973)
	Child	89.3% N=938	87.4% N=230	-1.9pp (0.428)

*p <0.1, **p <0.05, ***p <0.001

Note: N represents the number of survey responses. Surveys were administered in calendar years (CYs) 2021 and 2025. pp: percentage point.

Data Source: Beneficiary surveys were used in the analysis of RQ 5.1.

[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP Code.

Hypothesis 6: The ACC program provides cost-effective care.

There are no specific measures associated with this hypothesis. To assess the cost-effectiveness of care provided, an ITS analysis was conducted on the cost of care to analyze the differences between actual and projected costs during the evaluation period, which is intended to address RQs 6.1 and 6.2. Separate analyses are conducted at the per-member per-month (PMPM) level and at the total aggregated cost level. Costs were adjusted for medical inflation and are presented in terms of September 2024 dollars.

It is important to note that the cost analyses do not refer to or attempt to replicate the formal Budget Neutrality test required for Section 1115 Waiver Demonstrations. Additionally, the cost-effectiveness analysis does not involve a direct comparison of costs and savings, as program benefits may be non-pecuniary in nature, such as provision of new services that previously were unavailable, increased employment opportunities leading to improved financial well-being, lower mortality rates, and improved health outcomes overall. Furthermore, some outcomes may manifest over an extended period of time and may not be measurable at the time of the evaluation.

Research Question 6.1: What are the costs associated with the integration of care under ACC during the renewal period?

The results related to Research Questions 6.1 and 6.2 assessing the costs and associated benefits/savings with ACC during the renewal period are addressed jointly in Research Question 6.2 below.

Research Question 6.2: What are the benefits/savings associated with the integration of care under ACC during the renewal period?

Table 5-25 and Figure 5-2 utilized PMMIS data to examine the changes in PMPM costs for the ACC-Adult population before and after Waiver renewal through an ITS analysis. Inflation adjusted average PMPM costs were approximately $472.71 at the beginning of the baseline period, and the inflation-adjusted trend in costs increased during both the baseline and evaluation periods. Pharmacy costs contributed the greatest to the increasing PMPM cost trend, at an additional $1.33 per month relative to the baseline period.

Table 5-26 and Figure 5-3 utilized PMMIS data to assess the changes in aggregated costs among the ACC-Adult population before and after Waiver renewal through an ITS analysis. Total cost of care for the ACC-Adult population averaged approximately $362.7 million in the first month of the baseline period and continued to increase by approximately $2.6 million per month during the baseline period. However, in contrast to the PMPM costs, aggregate costs declined by $3.9 million per month during the evaluation period relative to the baseline period. This resulted in a decline in aggregate spending across the ACC-Adult population during the evaluation period.

Key Findings (ACC-Adult):

- **PMPM Costs**
  - Total PMPM costs averaged $472.71 at the beginning of the baseline period and decreased by $1.34 per month ($p<0.001$) during the baseline. Following Waiver renewal, average total PMPM costs declined by $15.59 ($p=0.306$); however, this was not statistically significant. Meanwhile, the trend in costs increased by $3.96 ($p<0.001$) during the evaluation period relative to the baseline trend.
  - The primary driver of PMPM costs were professional and pharmacy, in which the trend increased by $1.00 ($p=0.002$) and $1.33 ($p=0.023$) per month relative to the baseline trend, respectively.
  - The trend in PMPM costs among all categories of service increased by a statistically significant degree during the evaluation period relative to the baseline trend.
  - IP PMPM costs declined by $8.85 upon Waiver renewal ($p<0.001$).
- **Total Aggregate Costs**
  - Total inflation-adjusted costs among the ACC-Adult population averaged $362,666.7 thousand (or approximately $362.67 million) at the beginning of the baseline period. Although costs increased by approximately $2.56 million per month during the baseline period ($p<0.001$), this trend reversed during the evaluation period with a decrease of approximately $3.89 million per month ($p<0.001$) relative to the baseline trend.
  - All categories of service except pharmacy showed a statistically significant reduction in the relative monthly trend following the Waiver renewal, with professional costs showing the greatest degree of change at approximately -$2.30 million per month ($p<0.001$).

Table 5-25—ACC-Adult PMPM Costs

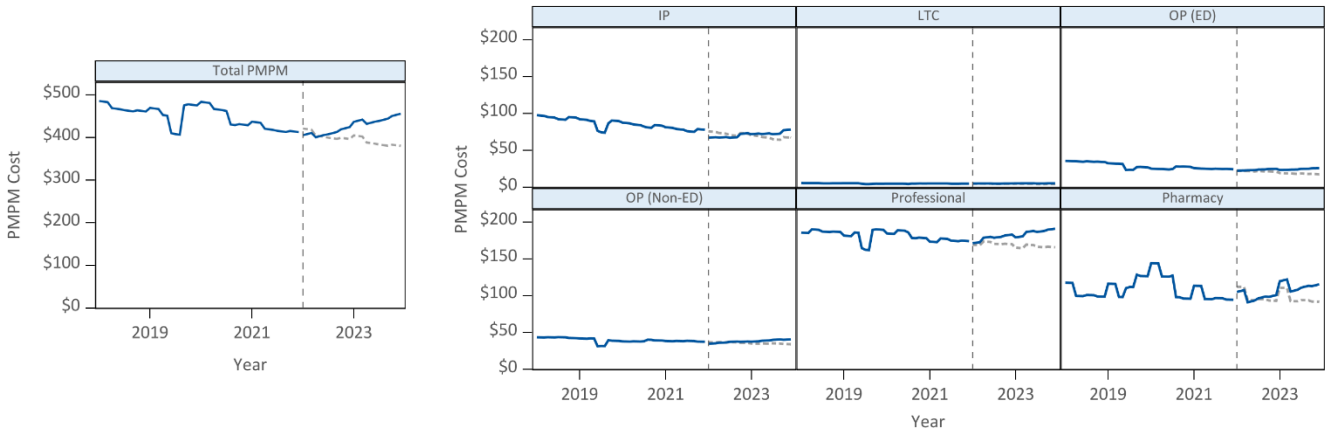
Variable	Estimate (*p*-value) Total	Professional	IP	LTC	OP (ED)	OP (Non-ED)	Pharmacy
Intercept	$472.71 *** (<0.001)	$190.96 *** (<0.001)	$96.55 *** (<0.001)	$5.56 *** (<0.001)	$35.83 *** (<0.001)	$43.91 *** (<0.001)	$99.89 *** (<0.001)
Baseline monthly trend	$-1.34 *** (<0.001)	$-0.34 ** (0.002)	$-0.45 *** (<0.001)	$-0.02 *** (<0.001)	$-0.28 *** (<0.001)	$-0.14 *** (<0.001)	$-0.12 (0.545)
Level change at implementation	$-15.59 (0.306)	$2.04 (0.696)	$-8.85 *** (<0.001)	$0.10 (0.650)	<$0.01 (0.997)	$-1.92 (0.197)	$-6.96 (0.460)
Change in monthly trend	$3.96 *** (<0.001)	$1.00 ** (0.002)	$0.86 *** (<0.001)	$0.04 ** (0.006)	$0.35 *** (<0.001)	$0.37 *** (<0.001)	$1.33 ** (0.023)

*p <0.1, **p <0.05, ***p <0.001

Note: Full model results are presented in Appendix A, Attachments. Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

Data Source: PMMIS data were used in the analysis of RQ 6.1 and 6.2.

Figure 5-2—ACC-Adult PMPM Costs



Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. This figure presents the model-based average rate in each month (blue line) and the projected rates had the baseline trend continued (grey dashed line). The grey vertical dashed line indicates the Waiver renewal (October 1, 2022). ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient; PMPM: per-member per-month.

Table 5-26—ACC-Adult Total Aggregate Costs (in Thousands)

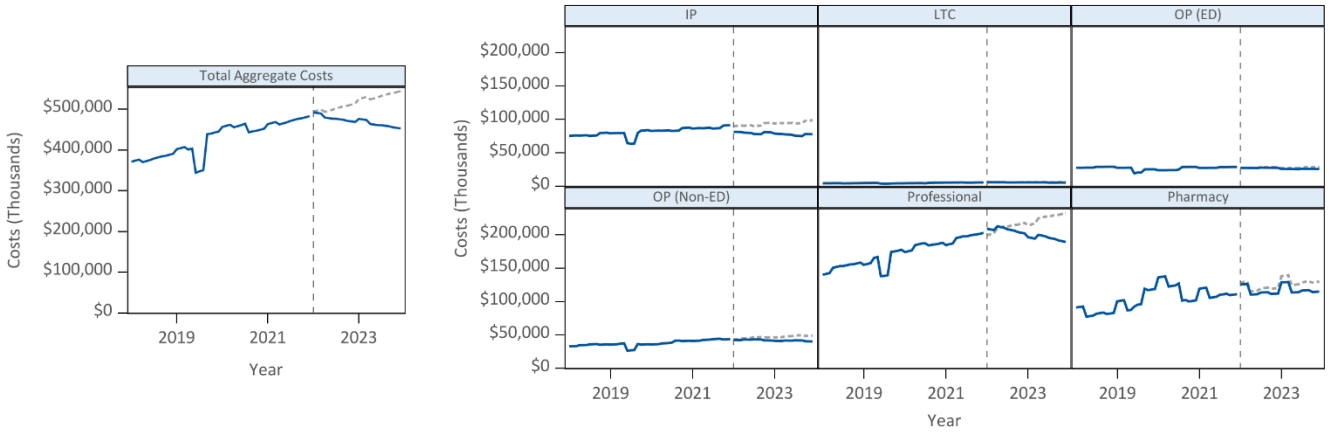
Variable	Estimate in Thousands (*p*-value) Total	Professional	IP	LTC	OP (ED)	OP (Non-ED)	Pharmacy
Intercept	$362,666.7 *** (<0.001)	$146,958.3 *** (<0.001)	$74,706.4 *** (<0.001)	$4,309.3 *** (<0.001)	$27,841.4 *** (<0.001)	$33,827.1 *** (<0.001)	$75,024.2 *** (<0.001)
Baseline monthly trend	$2,565.7 *** (<0.001)	$1,235.6 *** (<0.001)	$308.3 *** (<0.001)	$27.0 *** (<0.001)	-$10.0 (0.579)	$221.5 *** (<0.001)	$783.3 *** (<0.001)
Level change at implementation	-$2,231.6 (0.889)	$9,642.7 * (0.094)	-$8,637.1 ** (0.004)	$311.8 (0.183)	$262.4 (0.766)	-$1,027.1 (0.494)	-$2,784.3 (0.762)
Change in monthly trend	-$3,891.9 *** (<0.001)	-$2,296.4 *** (<0.001)	-$536.6 ** (0.003)	-$52.9 *** (<0.001)	-$132.5 ** (0.016)	-$338.9 *** (<0.001)	-$534.5 (0.341)

*p <0.1, **p <0.05, ***p <0.001

Note: Full model results are presented in Appendix A, Attachments. Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

Data Source: PMMIS data were used in the analysis of RQ 6.1 and 6.2.

Figure 5-3—ACC-Adult Total Aggregate Costs (in Thousands)



Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. This figure presents the model-based average rate in each month (blue line) and the projected rates had the baseline trend continued (grey dashed line). The grey vertical dashed line indicates the Waiver renewal date (October 1, 2022). ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

Table 5-27 and Figure 5-4 utilized PMMIS data to examine the changes in PMPM costs for the ACC-Child population before and after Waiver renewal through an ITS analysis. Average PMPM costs were approximately $211 at the beginning of the baseline period, and the inflation-adjusted trend in costs increased during evaluation period relative to the baseline trend. Professional costs contributed the greatest to the increasing cost trend at an additional $0.79 relative to the baseline period.

Table 5-28 and Figure 5-5 utilized PMMIS data to assess the total costs of the integration of care for the ACC-Child population before and after Waiver renewal through an ITS analysis. Total cost of care for the ACC-Child population averaged approximately $135.3 million in the first month of the baseline period. Similar to the ACC-Adult population, the total cost of care increased during the baseline period by approximately $0.26 million per month; however, following the Waiver renewal, total costs declined by an average of $0.39 million per month relative to the baseline trend. This reduced the pace at which cost of care for the ACC-Child population was increasing.

Key Findings (ACC-Child):

- **PMPM Costs**
  - Total PMPM costs averaged $210.56 at the beginning of the baseline period and decreased by $0.28 per month ($p$=0.043) during the baseline. PMPM costs increased by $6.40 ($p$=0.337) following Waiver renewal; however, this was not statistically significant. Similar to the ACC-Adult population, the trend in costs increased by a statistically significant degree relative to the baseline trend with a change of $1.64 ($p$<0.001) per month.
  - The primary drivers of the overall increasing cost trend in the evaluation period were professional and pharmacy, with an increase of $0.79 ($p$<0.001) and $0.40 ($p$=0.010) per month relative to the baseline trend, respectively.
- **Total Aggregate Costs**
  - Total costs among the ACC-Child population averaged $135,271.8 thousand (or approximately $135.27 million) at the beginning of the baseline period and increased by $0.23 million ($p$=0.021) per month during the baseline. Following Waiver renewal, however, the increase in the trend effectively stopped, with a relative decline of $0.26 million ($p$=0.360) per month compared to the baseline trend.
  - Although costs generally increased each month during the baseline across all categories of service, only pharmacy costs increased at a higher rate during the evaluation period, with a relative increase in the cost trend of approximately $0.08 million ($p$=0.416) per month.

Table 5-27—ACC-Child PMPM Costs

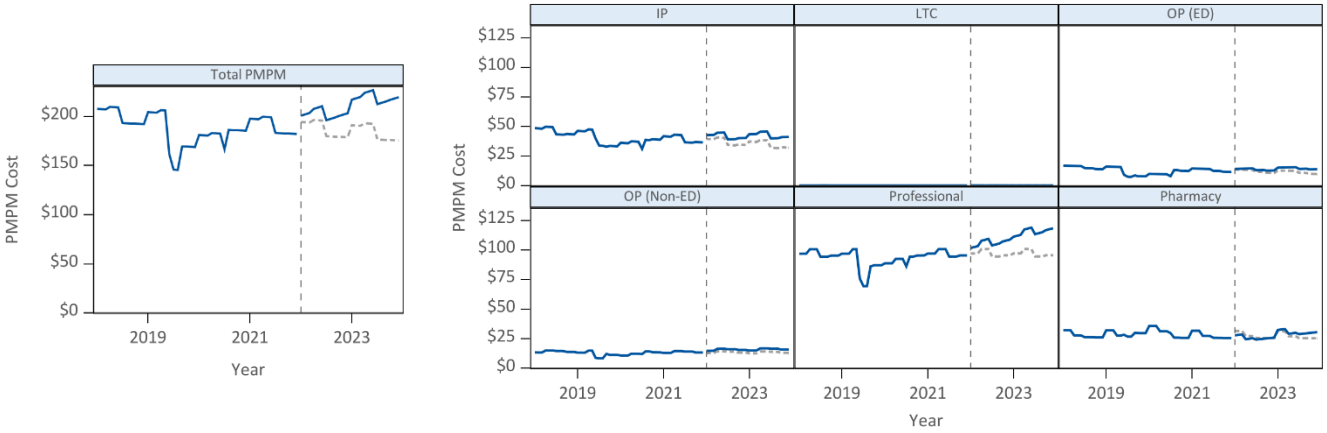
Variable	Estimate (*p*-value)						
	Total	Professional	IP	LTC	OP (ED)	OP (Non-ED)	Pharmacy
Intercept	$210.56 *** (<0.001)	$100.62 *** (<0.001)	$50.33 *** (<0.001)	$0.01 (0.426)	$16.83 *** (<0.001)	$14.97 *** (<0.001)	$27.79 *** (<0.001)
Baseline monthly trend	$-0.28 ** (0.043)	<$0.01 (0.951)	$-0.19 *** (<0.001)	>-$0.01 (0.549)	$-0.07 *** (<0.001)	$-0.01 (0.435)	$-0.01 (0.794)
Level change at implementation	$6.40 (0.337)	$4.62 (0.154)	$3.13 (0.179)	$0.04 (0.178)	$0.50 (0.609)	$1.90 ** (0.016)	$-3.78 (0.127)
Change in monthly trend	$1.64 *** (<0.001)	$0.79 *** (<0.001)	$0.26 * (0.070)	>-$0.01 (0.441)	$0.16 ** (0.009)	$0.04 (0.409)	$0.40 ** (0.010)

*p <0.1, **p <0.05, ***p <0.001

Note: Full model results are presented in Appendix A, Attachments. Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. <$0.01 indicates the value was a non-zero, positive amount and less than $0.01; >-$0.01 indicates the value was a non-zero, negative amount and greater than -$0.01. ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

Data Source: PMMIS data were used in the analysis of RQ 6.1 and 6.2.

Figure 5-4—ACC-Child PMPM Costs



Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. This figure presents the model-based average rate in each month (blue line) and the projected rates had the baseline trend continued (grey dashed line). The grey vertical dashed line indicates the Waiver renewal date (October 1, 2022). ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient; PMPM: per-member per-month.

Table 5-28—ACC-Child Total Aggregate Costs (in Thousands)

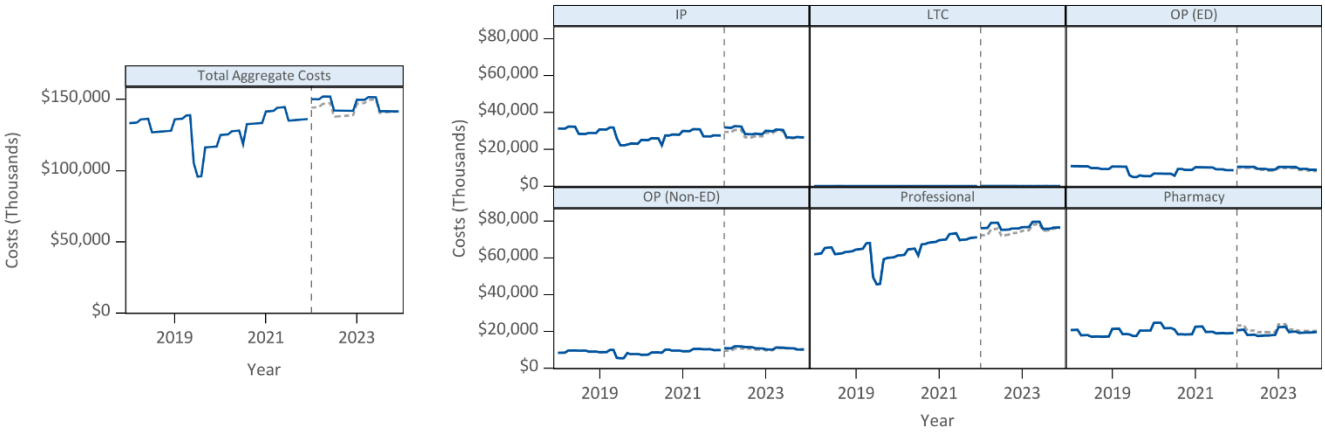
Variable	Estimate in Thousands (*p*-value)						
	Total	Professional	IP	LTC	OP (ED)	OP (Non-ED)	Pharmacy
Intercept	$135,271.8 *** (<0.001)	$64,646.8 *** (<0.001)	$32,408.3 *** (<0.001)	$9.0 (0.496)	$10,836.1 *** (<0.001)	$9,622.1 *** (<0.001)	$17,749.5 *** (<0.001)
Baseline monthly trend	$227.7 ** (0.021)	$210.9 *** (<0.001)	-$38.3 (0.244)	-$0.2 (0.598)	-$17.4 (0.201)	$22.0 ** (0.044)	$50.7 (0.150)
Level change at implementation	$5,946.7 (0.211)	$4,080.3 * (0.084)	$2,466.1 (0.127)	$26.1 (0.176)	$462.5 (0.486)	$1,448.3 ** (0.007)	-$2,536.6 (0.142)
Change in monthly trend	-$264.1 (0.360)	-$168.2 (0.239)	-$114.4 (0.242)	-$1.0 (0.410)	$11.2 (0.782)	-$76.6 ** (0.019)	$85.0 (0.416)

*p <0.1, **p <0.05, ***p <0.001

Note: Full model results are presented in Appendix A, Attachments. ED: emergency department. Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

Data Source: PMMIS data were used in the analysis of RQ 6.1 and 6.2.

Figure 5-5—ACC-Child Total Aggregate Costs (in Thousands)



Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. This figure presents the model-based average rate in each month (blue line) and the projected rates had the baseline trend continued (grey dashed line). The grey vertical dashed line indicates the Waiver renewal date (October 1, 2022). ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

6. ACC-RBHA Results

The following chapter describes the quantitative and qualitative results for the evaluation of the Arizona Health Care Cost Containment System (AHCCCS) Complete Care (ACC) Regional Behavioral Health Agreement (ACC-RBHA) Program. A complete list of measures and their specifications is available in Evaluation Designs linked in the Appendix.

Results Summary

Table 6-1 displays the number of measures by research question that showed improvement, worsened, did not change significantly, or were not applicable.

Table 6-1—ACC-RBHA Quantitative Measure Results Summary

Research Questions	Number of Measures			
	Worsening	No Significant Change	Improving	N/A[1]
RQ 1.1: Do adult members with an SMI enrolled in an ACC-RBHA have the same or increased access to primary care services compared to prior to the waiver renewal?	1	3	1	0
RQ 1.2: Do adult members with an SMI enrolled in an ACC-RBHA have the same or increased access to substance abuse treatment compared to prior to the waiver renewal?	0	1	1	0
RQ 2.1: Do adult members with an SMI enrolled in an ACC-RBHA have the same or higher rates of appropriate immunizations compared to prior to waiver renewal?	1	0	0	0
RQ 2.2: Do adult members with an SMI enrolled in an ACC-RBHA have the same or better management of chronic conditions compared to prior to the waiver renewal?	0	1	2	0
RQ 2.3: Do adult members with an SMI enrolled in an ACC-RBHA have the same or better management of BH conditions compared to prior to the waiver renewal?	3	2	0	2
RQ 2.4: Do adult members with an SMI enrolled in an ACC-RBHA have the same or better management of opioid prescriptions compared to prior to the waiver renewal?	0	0	2	0
RQ 2.5: Do adult members with an SMI enrolled in an ACC-RBHA have the same or lower tobacco usage compared to prior to the waiver renewal?	0	0	1	0
RQ 2.6: Do adult members with an SMI enrolled in an ACC-RBHA have the same or lower hospital utilization compared to prior to the waiver renewal?	1	1	0	2
RQ 3.1: Do adult members with an SMI enrolled in an ACC-RBHA have the same or higher rating of health compared to prior to the waiver renewal?	1	1	0	0
RQ 4.1: Do adult members with an SMI enrolled in an ACC-RBHA have the same or higher satisfaction in their health care compared to prior to the waiver renewal?	1	1	0	0
RQ 4.2: Do adult members with an SMI enrolled in an ACC-RBHA perceive their doctors to have the same or better care coordination compared to prior to the waiver renewal?	0	1	0	0

Research Questions	Number of Measures			
	Worsening	No Significant Change	Improving	N/A[1]
RQ 5.5: Did care coordination strategies improve or maintain patient engagement and follow-up care for substance use and BH conditions during the renewal period?	0	1	0	0
Total	**8**	**12**	**7**	**4**

Note: ACC-RBHA: AHCCCS Complete Care-Regional Behavioral Health Agreement; BH: behavioral health; N/A: not applicable; SMI: serious mental illness.
[1] Measures did not have a desired directionality or require additional context to describe the outcome.

ACC-RBHA Program Results

Hypothesis 1: Member access to appropriate care for routine medical conditions will be maintained or improved during the renewal period.

Research Question 1.1: Do adult members with an serious mental illness (SMI) enrolled in an ACC-RBHA have the same or increased access to primary care services compared to prior to the waiver renewal?

Figure 6-1 presents the percentage of members enrolled in an ACC-RBHA plan who met time/distance standards by provider type.[80] Table 6-2 presents the interrupted time series (ITS) results assessing the impact of the Waiver on provider network adequacy. It is important to note that this measure had high statistical power and may highlight changes that are statistically significant but not practically meaningful. Table 6-3 utilized Prepaid Medical Management Information System (PMMIS) data to assess changes in the percentage of members accessing preventive care.

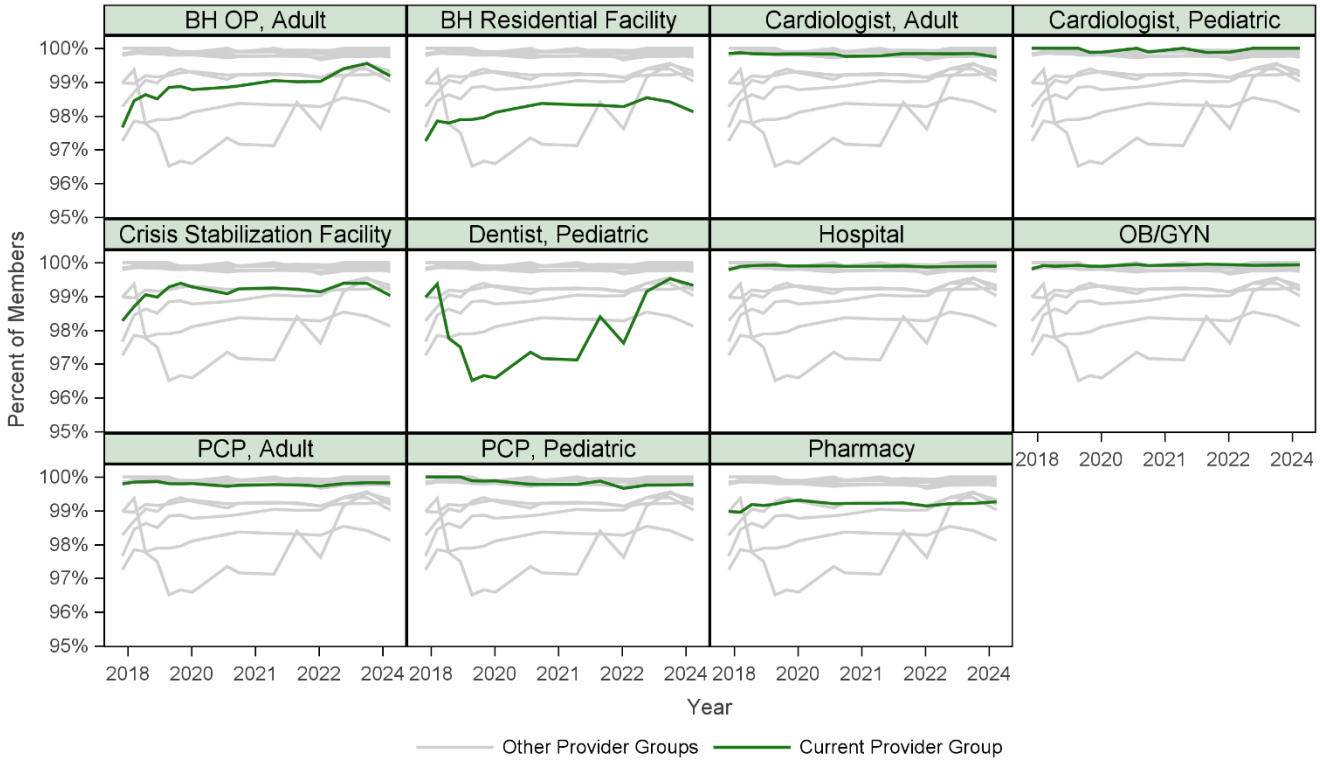
Key Findings:

- The percentage of ACC-RBHA members meeting time/distance standards across all provider types was over 96 percent during the baseline and evaluation periods, suggesting consistent access to care.
- Access to behavioral health (BH) outpatient (OP) and BH residential providers increased slightly from 97.7 percent and 97.3 percent meeting standards in quarter (Q) 1 of federal fiscal year (FFY) 2019 to 99.2 percent and 98.1 percent by the end of the evaluation period, respectively. While access to pediatric dentists declined in late FFY 2019 and FFY 2020, rates gradually improved to FFY 2019 levels by the end of the evaluation period.
- The *Percentage of adults who accessed preventive/ambulatory health services* declined from 89.8 percent in the baseline period to 87.1 percent in the evaluation period, a decline of 2.7 percentage points (p<0.001).

Overall, ACC-RBHA members had high levels of access to each measured provider type when assessing time/distance standards across the Waiver. Where there was room for meaningful improvement, such as for OP BH, BH residential facilities, and pediatric dentists, rates increased during the evaluation period. Although network adequacy was either maintained or modestly improved, rates of access to preventive services declined on average during the evaluation period.

[80] Additional details on time/distance measure calculations and standards can be found in the Appendix.

Figure 6-1—Research Question 1.1, Measure 1-1



Note: BH: behavioral health; OB/GYN: obstetrician gynecologist; OP: outpatient; PCP: primary care provider

Table 6-2—Research Question 1.1, Measure 1-1

Provider Type	Percentage Change in Odds[1] Baseline Annual Trend[2]	Level Change at Waiver Renewal[2]	Change in Annual Trend[2]
BH OP, Adult	20.8% *** (<0.001)	-6.0% (0.317)	0.4% (0.944)
BH Residential Facility	13.0% *** (<0.001)	-5.7% (0.242)	-17.2% *** (<0.001)
Cardiologist, Adult	-7.9% ** (0.004)	61.3% *** (<0.001)	-21.5% ** (0.017)
Cardiologist, Pediatric	—	—	—
Crisis Stabilization Facility	18.6% *** (<0.001)	-14.9% ** (0.015)	-22.2% *** (<0.001)
Dentist, Pediatric	-8.0% (0.139)	9.5% (0.772)	222.4% *** (<0.001)
Hospital	7.6% * (0.053)	-31.3% ** (0.026)	5.5% (0.672)
OB/GYN	27.6% ** (0.006)	-27.4% (0.475)	-23.8% (0.411)
PCP, Adult	-11.7% *** (<0.001)	-0.4% (0.976)	54.1% *** (<0.001)
PCP, Pediatric	-41.2% ** (0.047)	-7.2% (0.929)	123.3% (0.217)
Pharmacy	6.6% *** (<0.001)	-19.4% *** (<0.001)	3.4% (0.494)

*p <0.1, **p <0.05, ***p <0.001

Note: — indicates rates reached 100 percent in the evaluation period, yielding unstable model results. Extremely large coefficients can occur when predicted probabilities approach 0 or 1. Results should be interpreted with caution. BH: Behavioral Health; OB/GYN: obstetrician gynecologist; OP: outpatient; PCP: primary care provider.

Data Source: Prepaid Medical Management Information System (PMMIS), Client Assessment and Tracking System (CATS), Provider Affiliation Transmission (PAT), and AHCCCS Contractor Operations Manual (ACOM) 436 were used in the analysis of RQ 1.1.

[1]Model utilizes semi-annual rates from the baseline period (10/01/2018–09/30/2022) and evaluation period (10/01/2022–09/30/2024).

[2]p -values are in parentheses.

Table 6-3—Research Question 1.1, Measure 1-2

		Regression-Adjusted Rates[1] Baseline Average[2]	Evaluation Average[2]	Pre/Post Change in Rate[3] (p -value)	Trend Model Difference Between Actual and Projected (p -value) FFY 2023	FFY 2024
1-2	Percentage of adults who accessed preventive/ambulatory health	89.8%	87.1%	-2.7pp *** (<0.001)	-1.4pp *** (<0.001)	-0.2pp (0.400)

*p <0.1, **p <0.05, ***p <0.001

Note: FFY: federal fiscal year; pp: percentage point.

Data Source: PMMIS data were used in the analysis of RQ 1.1.

[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.

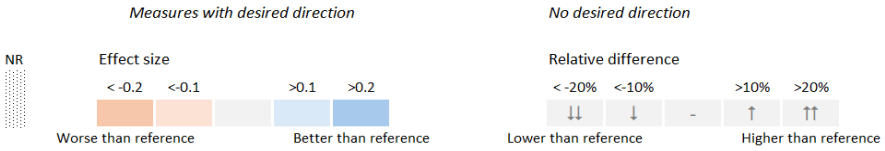
[2]Rates are weighted by enrollment duration in ACC-RBHA.

[3]Change in Rate compares the rate or number in the baseline period (10/01/2016–09/30/2022) to the average rate or number in the evaluation period (10/1/2022–09/30/2024).

Table 6-4 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in FFYs 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among ACC-RBHA members. Each cell color or arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 6-4—Research Question 1.1, Disparities Analysis

		Black		AI/AN		All Others		Unknown		Rural		Female	
		2022	2024	2022	2024	2022	2024	2022	2024	2022	2024	2022	2024
1-2	Percentage of adults who accessed preventive/ambulatory health services												



Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. NR: not reportable due to suppression guidelines.

Table 6-5 utilized surveys to assess member-reported access to primary care services.

Key Findings:

- The *Percentage of beneficiaries who reported they received care as soon as they needed* rose by 4.5 percentage points; however, this change was not statistically significant (*p*=0.278).
- The *Percentage of beneficiaries who reported they were able to schedule an appointment for a checkup or routine care at a doctor's office or clinic as soon as they needed* saw a non-statistically significant increase of 2.5 percentage points (*p*=0.465).
- The *Percentage of beneficiaries who reported they were able to schedule an appointment with a specialist as soon as they needed* increased by 4.7 percentage points; however, this change was not statistically significant (*p*=0.145).

Member-reported access to care was consistently higher in the evaluation period, suggesting that access to care was at least maintained, although none of the increases were statistically significant. These results contrast with the ACC population (both child and adult), which exhibited consistent decreases in access to care.

Table 6-5—Research Question 1.1, Measures 1-3 through 1-5

		Weighted Rate[1]		Pre/Post Change in Rate
		2021 Survey	2025 Survey	(*p*-value)
1-3	Percentage of beneficiaries who reported they received care as soon as they needed	76.3% N=439	80.8% N=217	4.5pp (0.278)
1-4	Percentage of beneficiaries who reported they were able to schedule an appointment for a checkup or routine care at a doctor's office or clinic as soon as they needed	77.0% N=754	81.7% N=341	4.7pp (0.145)
1-5	Percentage of beneficiaries who reported they were able to schedule an appointment with a specialist as soon as they needed	77.5% N=621	80.1% N=291	2.5pp (0.465)

*p <0.1, **p <0.05, ***p <0.001

Note: N represents the number of survey responses. Surveys were administered in calendar years (CYs) 2021 and 2025. pp: percentage point.

Data Source: Beneficiary surveys were used in the analysis of RQ 1.1.

[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP Code.

Research Question 1.2: Do adult members with an SMI enrolled in an ACC-RBHA have the same or increased access to substance abuse treatment compared to prior to the waiver renewal?

Table 6-6 utilized PMMIS data to assess changes in the percentage of members who initiated and engaged in substance use disorder (SUD) treatment.

Key Findings:

- Both the *Percentage of members who had initiation of SUD treatment* and the *Percentage of members who had engagement of SUD treatment* increased from baseline, rising by 0.5 and 1.1 percentage points, respectively (p=0.276 and p<0.001, respectively). Additionally, rates were significantly higher than the baseline projections for both the initiation and engagement in SUD treatment indicators.
  - The rate of female members initiating *opioid* abuse dependence treatment was lower compared to male members, and rates worsened among female members from 2022 to 2024.
  - Compared to urban members, rural members had lower rates of initiating *opioid* and *other drug abuse* dependence treatment in 2022 and 2024.
  - In 2022 and 2024, American Indian/Alaska Native (AI/AN) members had higher rates of engagement of alcohol and other drug abuse dependence treatment compared to White/Caucasian members, with the largest difference demonstrated among *alcohol* treatment.

Access to substance abuse treatment improved during the evaluation period for ACC-RBHA members, and rates increased faster than projections from baseline.

Table 6-6—Research Question 1.2, Measures 1-6 and 1-7

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[3]	Trend Model Difference Between Actual and Projected (p-value)	
		Baseline Average[2]	Evaluation Average[2]	(p-value)	FFY 2023	FFY 2024
1-6	Percentage of members who had initiation of SUD treatment	47.0%	47.5%	0.5pp (0.276)	2.4pp ** (0.002)	2.0pp ** (0.020)
1-7	Percentage of members who had engagement of SUD treatment	11.2%	12.3%	1.1pp *** (<0.001)	1.4pp ** (0.003)	1.5pp ** (0.006)

*p <0.1, **p <0.05, ***p <0.001

Note: FFY: federal fiscal year; pp: percentage point.

Data Source: PMMIS data were used in the analysis of RQ 1.2.

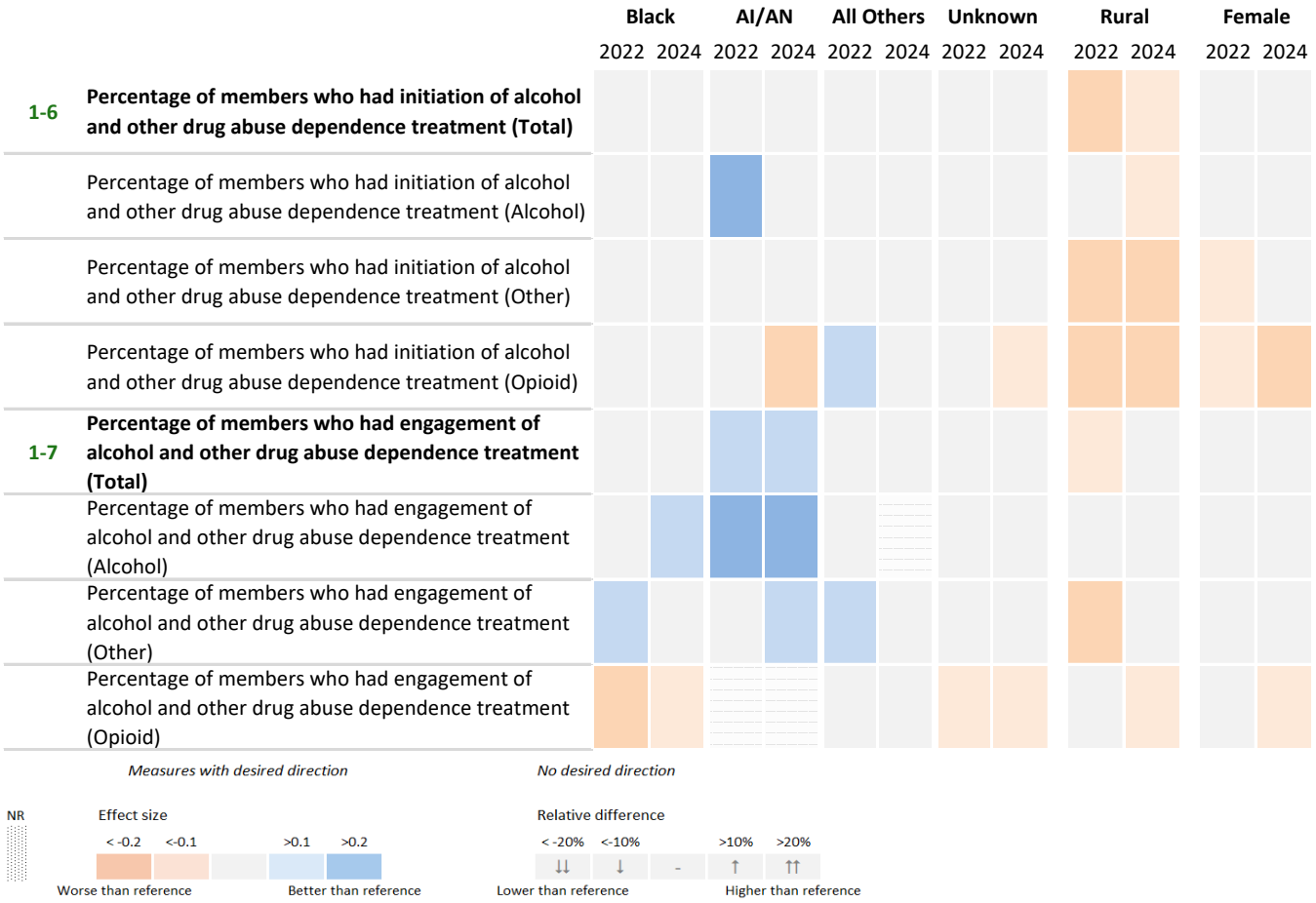
[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.

[2]Rates are weighted by enrollment duration in ACC-RBHA.

[3]Change in Rate compares the rate or number in the baseline period (10/01/2016–09/30/2022) to the average rate or number in the evaluation period (10/1/2022–09/30/2024).

Table 6-7 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in FFYs 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among ACC-RBHA members. Each cell color or arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 6-7—Research Question 1.2, Disparities Analysis



Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. NR: not reportable due to suppression guidelines.

Hypothesis 2: Quality of care will be maintained or improved during the renewal period.

Research Question 2.1: Do adult members with an SMI enrolled in an ACC-RBHA have the same or higher rates of appropriate immunizations compared to prior to waiver renewal?

Table 6-8 utilized surveys to assess member-reported immunizations.

Key Findings:

- The *Percentage of beneficiaries who reported having a flu shot or nasal flu spray since July 1* decreased by 8.4 percentage points to 38.3 percent in the evaluation period, a statistically significant decrease (p=0.012).

Members with a SMI enrolled in an ACC-RBHA reported decreased influenza (flu) immunization rates during the evaluation period, declining by nearly 18 percent ([38.3 percent / 46.7 percent] - 1) relative to flu vaccination rates in the 2021 survey.

Table 6-8—Research Question 2.1, Measure 2-1

		Weighted Rate[1]		Pre/Post Change in Rate
		2021 Survey	2025 Survey	(*p*-value)
2-1	Percentage of beneficiaries who reported having a flu shot or nasal flu spray since July 1	46.7% N=1,153	38.3% N=412	-8.4pp ** (0.012)

*p <0.1, **p <0.05, ***p <0.001

Note: N represents the number of survey responses. Surveys were administered in calendar years (CYs) 2021 and 2025. pp: percentage point.

Data Source: Beneficiary surveys were used in the analysis of RQ 2.1.

[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP Code.

Research Question 2.2: Do adult members with an SMI enrolled in an ACC-RBHA have the same or better management of chronic conditions compared to prior to the waiver renewal?

Table 6-9 utilized PMMIS data to assess changes in chronic condition management for ACC-RBHA members during the evaluation period.

Key Findings:

- The *Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent* markedly increased by 9.8 percentage points to 61.5 percent in the evaluation period (p<0.001). Fluctuating rates in the evaluation period led to mixed but statistically significant differences from baseline projections.
  - The percentage of Black members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent was lower compared to White/Caucasian members and worsened between 2022 and 2024.
- Management of measured mental health conditions was mixed, as the *Percentage of members with schizophrenia or bipolar disorder using antipsychotic medications who had a diabetes screening test* decreased by 0.6 percentage points to 77.6 percent in the evaluation period (p=0.053).
- Conversely, the *Percentage of members with schizophrenia who adhered to antipsychotic medications* increased by 5.3 percentage points to 64.5 percent in the evaluation period (p<0.001).
  - In 2022 and 2024, members with schizophrenia in the All Others race category had better adherence to antipsychotic medications compared to White/Caucasian members.

The management of chronic conditions for ACC-RBHA members was improved or maintained over the evaluation period. Although a statistically significant decline was seen in the *Percentage of members with schizophrenia or bipolar disorder using antipsychotic medications who had a diabetes screening test,* the decrease was minor overall.

Table 6-9—Research Question 2.2, Measures 2-2 through 2-4

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[3]	Trend Model Difference Between Actual and Projected (*p*-value)	
		Baseline Average[2]	Evaluation Average[2]	(*p*-value)	FFY 2023	FFY 2024
2-2	Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent	51.7%	61.5%	9.8pp *** (<0.001)	6.1pp ** (0.019)	-6.3pp ** (0.040)
2-3	Percentage of members with schizophrenia or bipolar disorder using antipsychotic medications who had a diabetes screening test	78.3%	77.6%	-0.6pp * (0.053)	-5.7pp *** (<0.001)	-2.8pp *** (<0.001)
2-4	Percentage of members with schizophrenia who adhered to antipsychotic medications	59.2%	64.5%	5.3pp *** (<0.001)	-0.5pp (0.499)	-2.5pp ** (0.001)

*p <0.1, **p <0.05, ***p <0.001

Note: FFY: federal fiscal year; pp: percentage point.

Data Source: PMMIS data were used in the analysis of RQ 2.2.

[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.

[2]Rates are weighted by enrollment duration in ACC-RBHA.

[3]Change in Rate compares the rate or number in the baseline period (10/01/2016–09/30/2022) to the average rate or number in the evaluation period (10/1/2022–09/30/2024).

Table 6-10 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in FFYs 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among ACC-RBHA members. Each cell color or arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 6-10—Research Question 2.2, Disparities Analysis

		Black		AI/AN		All Others		Unknown		Rural		Female	
		2022	2024	2022	2024	2022	2024	2022	2024	2022	2024	2022	2024
2-2	Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent												
2-3	Percentage of members with schizophrenia or bipolar disorder using antipsychotic medications who had a diabetes screening test												
2-4	Percentage of members with schizophrenia who adhered to antipsychotic medications												

Measures with desired direction

NR

Effect size

< -0.2 <-0.1 >0.1 >0.2

Worse than reference — Better than reference

No desired direction

Relative difference

< -20% <-10% >10% >20%

↓↓ ↓ - ↑ ↑↑

Lower than reference — Higher than reference

Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. NR: not reportable due to suppression guidelines.

Research Question 2.3: Do adult members with an SMI enrolled in an ACC-RBHA have the same or better management of BH conditions compared to prior to the waiver renewal?

Table 6-11 utilized PMMIS data to assess the management of BH conditions among ACC-RBHA members.

Key Findings:

- The *Percentage of members who remained on antidepressant medication treatment* improved for both the 84-day and 180-day indicators, rising from 44.6 and 26.6 percent in the baseline period to 46.2 and 27.8 percent in the evaluation period, respectively, although only the change for the 84-day indicator was statistically significant (p=0.076 and p=0.166, respectively).
  - In 2022, compared to urban members, rural members had higher rates of adult members who remained on an antidepressant medication treatment for 84 and 180 days; however, performance decreased to align with urban members by 2024.
- All measures assessing follow-up rates for ACC-RBHA members declined from baseline.
  - The *Percentage of members with a follow-up visit within 7 days after hospitalization for mental illness* declined by 1.1 percentage points (p=0.011).
  - The *Percentage of members with a follow-up visit within 7 days after an emergency department (ED) visit for mental illness* declined by 5.7 percentage points (p<0.001). In 2022, Black, AI/AN, and All Other members had higher percentages of members with a follow-up visit within 7 days after hospitalization for mental illness; however, performance decreased to align with White/Caucasian members by 2024. In 2024, female members had higher rates of follow-up visits compared to male members.
  - The *Percentage of members with a follow-up visit within 7 days after an ED visit for SUD* declined by 3.2 percentage points (p=0.015). In 2022, Black members had higher rates of members with a follow-up visit within 7 days after an ED visit for SUD compared to White/Caucasian members. This trend reversed in 2024, as Black members had lower rates of follow-up visits than White/Caucasian members.
- Both the *Percentage of members diagnosed with a mental health disorder* and the *Percentage of members receiving mental health services—Any* declined from baseline falling from 89.5 and 80.6 percent to 87.3 and 76.4 percent in the evaluation period, respectively (p<0.001 for both).

The management of BH conditions declined on average for ACC-RBHA members over the evaluation period. Measured follow-up rates for mental illness and SUD-related visits and rates of any mental health service utilization all significantly decreased from the baseline period. Conversely, rates of antidepressant medication management increased, although the increases were relatively modest.

Table 6-11—Research Question 2.3, Measures 2-5 through 2-10

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[3]	Trend Model Difference Between Actual and Projected (*p*-value)	
		Baseline Average[2]	Evaluation Average[2]	(*p*-value)	FFY 2023	FFY 2024
2-5	Percentage of members who remained on antidepressant medication					
	84 days	44.6%	46.2%	1.6pp * (0.076)	-1.2pp (0.400)	-2.3pp (0.169)
	180 days	26.6%	27.8%	1.1pp (0.166)	-2.3pp * (0.089)	-2.0pp (0.195)
2-6	Percentage of members with a follow-up visit within 7 days after hospitalization for mental illness	67.8%	66.7%	-1.1pp ** (0.011)	1.7pp ** (0.015)	1.0pp (0.214)
2-7	Percentage of members with a follow-up visit within 7 days after an ED visit for mental illness	60.6%	54.9%	-5.7pp *** (<0.001)	-3.3pp (0.139)	4.2pp * (0.092)
2-8	Percentage of members with a follow-up visit within 7 days after an ED visit for SUD	53.0%	49.8%	-3.2pp ** (0.015)	-1.8pp (0.406)	1.6pp (0.530)
2-9	Percentage of members diagnosed with a mental health disorder	89.5%	87.3%	-2.2pp *** (<0.001)	0.1pp (0.732)	1.2pp *** (<0.001)
2-10	Percentage of members receiving mental health services					
	Any	**80.6%**	**76.4%**	-4.2pp *** (<0.001)	0.0pp (0.899)	2.2pp *** (<0.001)
	ED	0.8%	0.4%	-0.4pp *** (<0.001)	0.1pp *** (<0.001)	0.2pp *** (<0.001)
	Intensive outpatient or partial hospitalization	13.8%	14.5%	0.7pp *** (<0.001)	1.1pp *** (<0.001)	3.6pp *** (<0.001)
	IP	16.0%	16.6%	0.5pp *** (<0.001)	-0.7pp ** (0.005)	0.9pp ** (0.001)
	OP	79.6%	74.6%	-5.0pp *** (<0.001)	0.3pp (0.308)	2.9pp *** (<0.001)
	Telehealth	11.2%	17.3%	6.0pp *** (<0.001)	-6.3pp *** (<0.001)	-10.2pp *** (<0.001)

*p <0.1, **p <0.05, ***p <0.001

Note: ED: emergency department; FFY: federal fiscal year; IP: inpatient; OP: outpatient; pp: percentage point; SUD: substance use disorder.

Data Source: PMMIS data were used in the analysis of RQ 2.3.

[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.

[2]Rates are weighted by enrollment duration in ACC-RBHA.

[3]Change in Rate compares the rate or number in the baseline period (10/01/2016–09/30/2022) to the average rate or number in the evaluation period (10/1/2022–09/30/2024).

Table 6-12 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in FFYs 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among ACC-RBHA members. Each cell color or arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 6-12—Research Question 2.3, Disparities Analysis

		Black		AI/AN		All Others		Unknown		Rural		Female	
		2022	2024	2022	2024	2022	2024	2022	2024	2022	2024	2022	2024
2-5	Percentage of adult members who remained on an antidepressant medication treatment (84 days)												
	Percentage of adult members who remained on an antidepressant medication treatment (180 days)												
2-6	Percentage of members with a follow-up visit within 7 days after hospitalization for mental illness												
2-7	Percentage of members with a follow-up visit within 7 days after an ED visit for mental illness												
2-8	Percentage of members with follow-up visit within 7 days after an ED visit for SUD												
2-9	Percentage of members diagnosed with a mental health disorder	-	-	-	-	-	-	-	-	-	-	-	-
2-10	**Percentage of members receiving mental health services (Any)**	-	-	-	-	-	-	-	-	↓	-	-	-
	Percentage of members receiving mental health services (ED)	↑↑	↑					↑↑	↑↑			↓↓	↓↓
	Percentage of members receiving mental health services (IOP or partial hospitalization)	↑↑	↑↑	↑↑	↑↑	↑	-	↑↑	↑↑	↓↓	↓↓	↓↓	↓↓
	Percentage of members receiving mental health services (IP)	↑↑	↑↑	↑↑	↑↑	-	-	↑↑	↑↑	↓↓	↓↓	↓↓	↓↓
	Percentage of members receiving mental health services (OP)	-	-	-	-	-	-	-	-	↓	-	-	-
	Percentage of members receiving mental health services (Telehealth)	-	-	↑↑	-	-	-	-	-	↓	↓	-	-

Measures with desired direction

NR

Effect size

< -0.2	<-0.1		>0.1	>0.2
Worse than reference				Better than reference

No desired direction

Relative difference

< -20%	<-10%		>10%	>20%
↓↓	↓	-	↑	↑↑
Lower than reference				Higher than reference

Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. ED: emergency department; IOP: intensive outpatient; IP: inpatient; OP: Outpatient; SUD: substance use disorder.

Research Question 2.4: Do adult members with an SMI enrolled in an ACC-RBHA have the same or better management of opioid prescriptions compared to prior to the waiver renewal?

Table 6-13 utilized PMMIS data to assess the management of opioid prescriptions for ACC-RBHA members.

Key Findings:

- The *Percentage of members who have prescriptions for opioids at a high dosage* and the *Percentage of members with concurrent use of opioids and benzodiazepines* significantly decreased by 3.5 and 4.7 percentage points between the baseline and evaluation periods, respectively (p<0.001 for both).
  - The percentage of Black members who had a prescription for opioids had a high dosage was higher compared to White/Caucasian members, and this disparity worsened between 2022 and 2024.

The management of opioid prescriptions improved for ACC-RBHA members during the evaluation period.

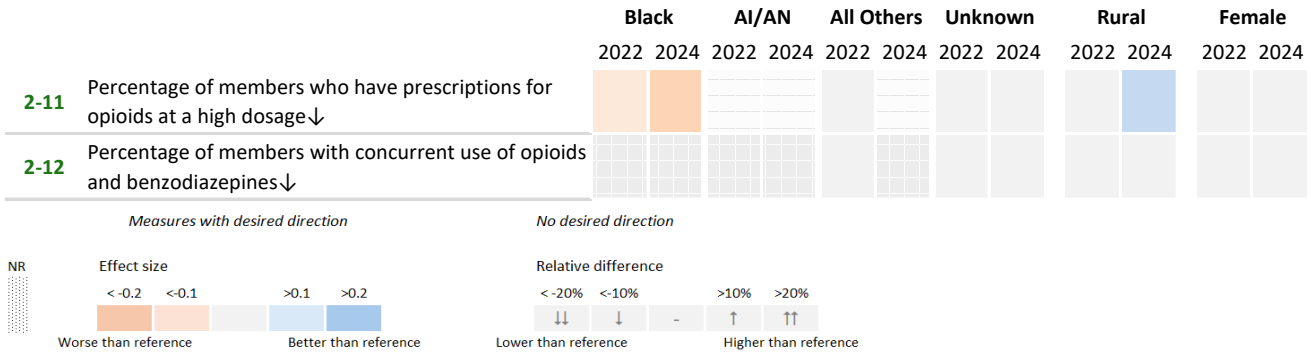
Table 6-13—Research Question 2.4, Measures 2-11 and 2-12

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[3]	Trend Model Difference Between Actual and Projected (*p*-value)	
		Baseline Average[2]	Evaluation Average[2]	(*p*-value)	FFY 2023	FFY 2024
2-11	Percentage of members who have prescriptions for opioids at a high dosage (lower is better)	12.7%	9.3%	-3.5pp *** (<0.001)	-5.3pp *** (<0.001)	-5.2pp *** (<0.001)
2-12	Percentage of members with concurrent use of opioids and benzodiazepines (lower is better)	14.2%	9.5%	-4.7pp *** (<0.001)	1.6pp ** (0.037)	3.5pp *** (<0.001)

*p <0.1, **p <0.05, ***p <0.001
Note: FFY: federal fiscal year; pp: percentage point.
Data Source: PMMIS data were used in the analysis of RQ 2.4.
[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.
[2]Rates are weighted by enrollment duration in ACC-RBHA.
[3]Change in Rate compares the rate or number in the baseline period (10/01/2016–09/30/2022) to the average rate or number in the evaluation period (10/1/2022–09/30/2024).

Table 6-14 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in FFYs 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among ACC-RBHA members. Each cell color or arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 6-14—Research Question 2.4, Disparities Analysis



Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. NR: not reportable due to suppression guidelines.
↓Lower measure rates indicate better performance. Disparities analysis presented reflects the desired direction.

Research Question 2.5: Do adult members with an SMI enrolled in an ACC-RBHA have the same or lower tobacco usage compared to prior to the waiver renewal?

Table 6-15 utilized surveys to assess member-reported tobacco usage.

Key Findings:

- The *Percentage of beneficiaries who indicated smoking cigarettes or using tobacco* decreased by 15.2 percentage points between the baseline and evaluation periods, a change that is both statistically significant and clinically meaningful (p<0.001).

Adult members with an SMI enrolled in an ACC-RBHA reported a clinically meaningful reduction in tobacco usage during the evaluation period, with rates more than 15 percentage points lower than during the baseline period.

Table 6-15—Research Question 2.5, Measure 2-13

		Weighted Rate[1]		Pre/Post Change in Rate (p-value)
		2021 Survey	2025 Survey	
2-13	Percentage of beneficiaries who indicated smoking cigarettes or using tobacco (lower is better)	45.8% N=1,180	30.6% N=427	-15.2pp *** (<0.001)

*p <0.1, **p <0.05, ***p <0.001

Note: N represents the number of survey responses. Surveys were administered in calendar years (CYs) 2021 and 2025. pp: percentage point.

Data Source: Beneficiary surveys were used in the analysis of RQ 2.5.

[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP Code.

Research Question 2.6: Do adult members with an SMI enrolled in an ACC-RBHA have the same or lower hospital utilization compared to prior to the waiver renewal?

Table 6-16 utilized PMMIS data to assess changes in hospital utilization for ACC-RBHA members.

Key Findings:

- Rates of emergent ED and non-emergent ED visits declined by 10.44 and 0.23 visits per 1,000 member months, respectively, during the evaluation period, but neither decline was statistically significant (p=0.174 and p=0.785, respectively).
  - In 2022 and 2024, Black members and female members had higher rates of emergent and non-emergent ED visits per 1,000 member months compared to the reference groups (i.e., White/Caucasian and male members, respectively).
- The *Percentage of IP discharges with an unplanned readmission within 30 days* increased from 12.7 percent in the baseline period to 13.9 percent in the evaluation period, an increase of 1.2 percentage points (p<0.001).

Findings related to hospital utilization rates for ACC-RBHA members were mixed. While the rate of non-emergent ED visits declined, the change was not statistically significant and conversely, the *Percentage of IP discharges with an unplanned readmission within 30 days* increased by a statically significant margin.

Table 6-16—Research Question 2.6, Measures 2-14 through 2-17

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[2]	Trend Model Difference Between Actual and Projected (*p*-value)	
		Baseline Average	Evaluation Average	(*p*-value)	FFY 2023	FFY 2024
2-14	Number of emergent ED visits per 1,000 member months (no desired direction)	104.01	93.57	-10.44 (0.174)	7.43 ** (0.001)	18.76 *** (<0.001)
2-15	Number of non-emergent ED visits per 1,000 member months (lower is better)	8.35	8.12	-0.23 (0.785)	1.59 *** (<0.001)	2.75 *** (<0.001)
2-16	Number of IP stays per 1,000 member months (no desired direction)	15.82	15.34	-0.49 (0.258)	-1.71 *** (<0.001)	-0.28 (0.524)
2-17	Percentage of IP discharges with an unplanned readmission within 30 days (lower is better)	12.7%	13.9%	1.2pp *** (<0.001)	0.0pp (0.980)	0.9pp * (0.070)

*p <0.1, **p <0.05, ***p <0.001

Note: ED: emergency department; FFY: federal fiscal year; IP: inpatient; pp: percentage point.

Data Source: PMMIS data were used in the analysis of RQ 2.6.

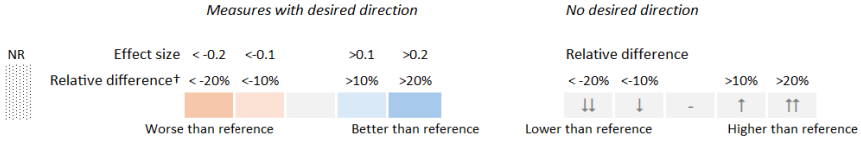
[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.

[2]Change in Rate compares the rate or number in the baseline period (10/01/2016–09/30/2022) to the average rate or number in the evaluation period (10/1/2022–09/30/2024).

Table 6-17 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in FFYs 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among ACC-RBHA members. Each cell color or arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 6-17—Research Question 2.6, Disparities Analysis

		Black		AI/AN		All Others		Unknown		Rural		Female	
		2022	2024	2022	2024	2022	2024	2022	2024	2022	2024	2022	2024
2-14	Number of emergent ED visits per 1,000 member months	↑	↑	↑	-	-	-	-	-	-	-	↑	↑
2-15	Number of non-emergent ED visits per 1,000 member months†↓												
2-16	Number of IP stays per 1,000 member months	-	-	-	-	↓	-	-	-	⇊	⇊	-	↑
2-17	Percentage of IP discharges with an unplanned readmission within 30 days↓												



Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. ED: emergency department. IP: inpatient; NR: not reportable due to suppression guidelines.

↓Lower measure rates indicate better performance. Disparities analysis presented reflects the desired direction.

†Relative difference is used for this measure.

Hypothesis 3: Health outcomes for adult members with an SMI enrolled in an ACC-RBHA will be maintained or improved during the renewal period.

Research Question 3.1: Do adult members with an SMI enrolled in an ACC-RBHA have the same or higher rating of health compared to prior to the waiver renewal?

Table 6-18 utilized beneficiary surveys to assess member-reported health ratings.

Key Findings:

- The *Percentage of beneficiaries who reported a high rating of overall health* decreased by 6.7 percentage points to 16.5 percent in the evaluation period (p=0.017).
- The *Percentage of beneficiaries who reported a high rating of overall mental or emotional health* decreased by 3.7 percentage points between the baseline and evaluation periods, but this change was not statistically significant (p=0.129).

Member-reported health status decreased between the baseline and evaluation periods. Although only the decrease in overall health rating was statistically significant, the rating of mental or emotional health declined by over 20 percent ([13.8 percent / 17.5 percent] – 1) relative to the 2021 surveys.

Table 6-18—Research Question 3.1, Measures 3-1 and 3-2

		Weighted Rate[1]		Pre/Post Change in Rate (p-value)
		2021 Survey	2025 Survey	
3-1	Percentage of beneficiaries who reported a high rating of overall health	23.2% N=1,192	16.5% N=432	-6.7pp ** (0.017)
3-2	Percentage of beneficiaries who reported a high rating of overall mental or emotional health	17.5% N=1,189	13.8% N=433	-3.7pp (0.129)

*p <0.1, **p <0.05, ***p <0.001

Note: N represents the number of survey responses. Surveys were administered in calendar years (CYs) 2021 and 2025. pp: percentage point.

Data Source: Beneficiary surveys were used in the analysis of RQ 3.1.

[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP Code.

Hypothesis 4: Adult member satisfaction in ACC-RBHA health plans will be maintained or improved over the renewal period.

Research Question 4.1: Do adult members with an SMI enrolled in an ACC-RBHA have the same or higher satisfaction in their health care compared to prior to the waiver renewal?

Table 6-19 utilized beneficiary surveys to assess members' satisfaction with their health plans and health care.

Key Findings:

- The *Percentage of beneficiaries who reported a high rating of overall health care* remained consistent around 64 percent between the baseline and evaluation periods (p=0.981).
- The *Percentage of beneficiaries who reported a high rating of health plan* decreased by 7.0 percentage points between the baseline and evaluation periods (p=0.023).

While member satisfaction with overall health care was consistent between the baseline and evaluation periods, members' satisfaction with their health plan decreased.

Table 6-19—Research Question 4.1, Measures 4-1 and 4-2

		Weighted Rate[1]		Pre/Post Change in Rate (*p*-value)
		2021 Survey	2025 Survey	
4-1	Percentage of beneficiaries who reported a high rating of overall health care	64.3% N=839	64.4% N=432	0.1pp (0.981)
4-2	Percentage of beneficiaries who reported a high rating of health plan	71.8% N=1,179	64.7% N=433	-7.0pp ** (0.023)

*p <0.1, **p <0.05, ***p <0.001
Note: N represents the number of survey responses. Surveys were administered in calendar year (CY) 2025. pp: percentage point.
Data Source: Beneficiary surveys were used in the analysis of RQ 4.1.
[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP Code.

Research Question 4.2: Do adult members with an SMI enrolled in an ACC-RBHA perceive their doctors to have the same or better care coordination compared to prior to the waiver renewal?

Table 6-20 utilized beneficiary surveys to assess members' perceptions of care coordination.

Key Findings:

- The *Percentage of beneficiaries who reported their doctor seemed informed about the care they received from other health providers* decreased slightly by 0.8 percentage points, a change that was not statistically significant (p=0.849).

Adult members with an SMI enrolled in an ACC-RBHA reported slightly lower perceptions of care coordination in the evaluation period than the baseline period, but the changes were neither statistically nor practically significant.

Table 6-20—Research Question 4.2, Measure 4-3

		Weighted Rate[1]		Pre/Post Change in Rate (*p*-value)
		2021 Survey	2025 Survey	
4-3	Percentage of beneficiaries who reported their doctor seemed informed about the care they received from other health providers	74.2% N=520	73.4% N=276	-0.8pp (0.849)

*p <0.1, **p <0.05, ***p <0.001
Note: N represents the number of survey responses. Surveys were administered in calendar years (CYs) 2021 and 2025. pp: percentage point.
Data Source: Beneficiary surveys were used in the analysis of RQ 4.2.
[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables

Hypothesis 5: ACC-RBHAs encourage and/or facilitate care coordination among PCPs and BH practitioners.

Hypothesis 5 was designed to identify care coordination activities conducted by ACC-RBHAs, as well as barriers and facilitators related to care coordination. Qualitative interviews were conducted with AHCCCS staff and ACC-RBHA plans and providers between August and October 2025 to discuss the Waiver, including care integration,

implementation, successes and challenges, and workforce shortages. The following sections summarize the results of the key informant interviews.[81]

Research Question 5.1: What care coordination strategies are the ACC-RBHAs conducting for their members with an SMI?

ACC-RBHA plans supported care coordination for members with an SMI by implementing a wide array of care coordination strategies. Key strategies included the following:

- **Collaboration with external stakeholders**: Plans collaborated with stakeholders such as community-based organizations (CBOs), business partners, first responders, providers, health homes (HHs), and the justice system to coordinate all aspects of members' care.[82]
- **Robust internal coordination activities**: Plans employed dedicated care coordination and management teams to effectively coordinate members' care. Activities included developing individualized care plans, assessing members' social determinants of health (SDOH) needs, monitoring at-risk members, meeting regularly to review member cases and resolve issues, conducting member outreach, and coordinating care.
- **High-needs coordination**: Plans proactively identified high-needs members for referral to Assertive Community Treatment (ACT) teams or permanent supportive housing (PSH) and operated targeted care management programs for specific populations. Target populations included members experiencing a first episode of psychosis, justice-involved members, and individuals with SMI or SUD. Plans coordinated with providers, peer support staff, ACT teams, and care management staff to maintain connection with these vulnerable members.

Plans reported that care coordination and the expansion of integrated care helped ensure members access to physical health (PH) and BH services, ultimately improving member outcomes. However, barriers to successful care coordination continued during the Waiver. Key barriers included the following:

- **Provider workforce shortages**: Providers experienced high caseload ratios and staff turnover due to statewide provider workforce shortages. Providers closed locations and reduced service arrays, including high-need case management. Plans partnered with stakeholders and providers to support the existing workforce and address shortages when possible.[83]
- **Data limitations**: Federal regulations restricted plans' abilities to share SUD data with providers. Additionally, electronic medical records (EMRs) and health exchange platforms limitations, along with general fragmentation of health care data systems, hindered access to information needed to effectively coordinate care, such as hospital discharge records. To improve data integration, one plan developed a dashboard and worked with providers and CBOs to promote the use of the Closed-Loop Referral System (CLRS).
- **Member outreach**: Plans faced challenges contacting members to engage them in care coordination, in part due to inaccurate member contact information. Plans improved outreach and engagement by distributing cell phones to ensure accurate member telephone numbers and conducting mass text messaging campaigns.

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81 Additional detailed results can be found in Appendix A.

82 See Appendix A for additional details on how plans worked with external stakeholders to implement robust care coordination strategies.

83 See Appendix A for additional details on how plans worked with external stakeholders and providers to address workforce shortages.

Research Question 5.2: Have care coordination strategies for members with an SMI changed as a result of ACC-RBHA?

ACC-RBHA plans reported that integrating PH and BH care improved care coordination for members with an SMI. The reported evolution of care coordination strategies included the following:

- **Integration impacts**: Integration strengthened plans' and providers' abilities to consider members' PH and BH needs together when developing and implementing care plans.
- **Collaboration with external stakeholders**: Plans reported an increased focus on external collaboration compared to the previous demonstration period, working with CBOs, business partners, first responders, providers, HHs, and the justice system to coordinate members' care.[84]
- **Internal strategies**: Plans reported developing several strategies for ensuring and enhancing care coordination, including monitoring members for elevated risk; assessing members for SDOH needs to support holistic care, and outreaching to SMI members following crisis to support follow-up, connection, and stability.

Research Question 5.3: What care coordination strategies is AHCCCS conducting for its members with an SMI?

AHCCCS staff reinforced the ACC-RBHA and BH system of care by supporting the care coordination strategies for ACC-RBHA members with an SMI during the Waiver renewal period. Key strategies identified included:

- **Care coordination for target populations**: AHCCCS emphasized care coordination for target populations, such as justice-involved members or members experiencing a BH crisis. AHCCCS partnered with health plans and stakeholders to ensure these members were connected to appropriate services, including coordinating care for members prior to release from the justice system, conducting care coordination for justice-involved members on-site, and ensuring that SMI or high-needs members were assigned to HHs or ACT teams for care coordination services, as needed.
- **Coordination for general SMI ACC-RBHA members**: ACC-RBHA members were assigned to HHs to receive services, treatment, assessments, referrals, and ACT team support when needed.
- **Monitoring and support**: AHCCCS ensured that HHs involved the necessary family members and other stakeholders in care coordination, appropriated care management workforce funding, met with providers to discuss administrative and uncompensated burdens and to reduce spending not covered by Medicaid, met with plans to address concerns and financial needs, and met with the Governor's office and legislators to discuss ongoing challenges.

Research Question 5.4: What care coordination strategies and/or activities are providers conducting for their Medicaid patients with an SMI served by the ACC-RBHAs?

ACC-RBHA providers outlined the care coordination strategies conducted during the Waiver renewal period. Providers highlighted the use of dedicated staff and technology to strengthen care coordination activities. Key themes included:

[84] See Appendix A for additional details on how plans worked with external stakeholders to implement robust care coordination strategies.

- **Dedicated care coordination staff**: Providers employed case managers, peer support workers, and recovery coaches to ensure members had access to integrated PH and BH services.
- **Member-centered coordination**: Staff scheduled appointments; managed intake and referrals; conducted home visits; provided SDOH, BH, and/or needs assessments; connected members to primary care; educated members on strategies to reduce hospitalization and ED utilization; addressed SDOH needs; and trained internal staff on care coordination practices.
- **Technology utilization**: Providers reported continued enhancement of their care coordination processes through increased use of technology. Providers received plan reimbursements to purchase tablets for members to promote virtual communication, used social media to spread awareness of events, developed algorithms to identify gaps in care and support data-based decision making, and used telehealth to connect with members.

Research Question 5.5: Did care coordination strategies improve or maintain patient engagement and follow-up care for substance use and BH conditions during the renewal period?

Table 6-21 utilized PMMIS data to assess follow-up rates after ED visits for ACC-RBHA members with multiple high-risk chronic conditions.

Key Findings:

- The *Percentage of members with follow-up after an ED visit for members with multiple high-risk chronic conditions* was on average approximately the same between the baseline and evaluation periods, with a non-statistically significant 0.1 percentage point increase from the baseline period to the evaluation period (p=0.734).
  - In 2022, rural members had lower rates of follow-up after an ED visit for members with multiple high-risk chronic conditions compared to urban members; this disparity worsened by 2024.

Baseline rates of follow-up after ED visits for ACC-RBHA members with multiple high-risk chronic conditions were maintained throughout the evaluation period.

Table 6-21—Research Question 5.5, Measure 5-7

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[3] (p-value)	Trend Model Difference Between Actual and Projected (p-value)	
		Baseline Average[2]	Evaluation Average[2]		FFY 2023	FFY 2024
5-7	Percentage of members with a follow-up after an ED visit for members with multiple high-risk chronic conditions	78.6%	78.8%	0.1pp (0.734)	0.1pp (0.821)	1.2pp * (0.062)

*p <0.1, **p <0.05, ***p <0.001

Note: ED: emergency department; FFY: federal fiscal year; pp: percentage point.

Data Source: PMMIS data were used in the analysis of RQ 5.5.

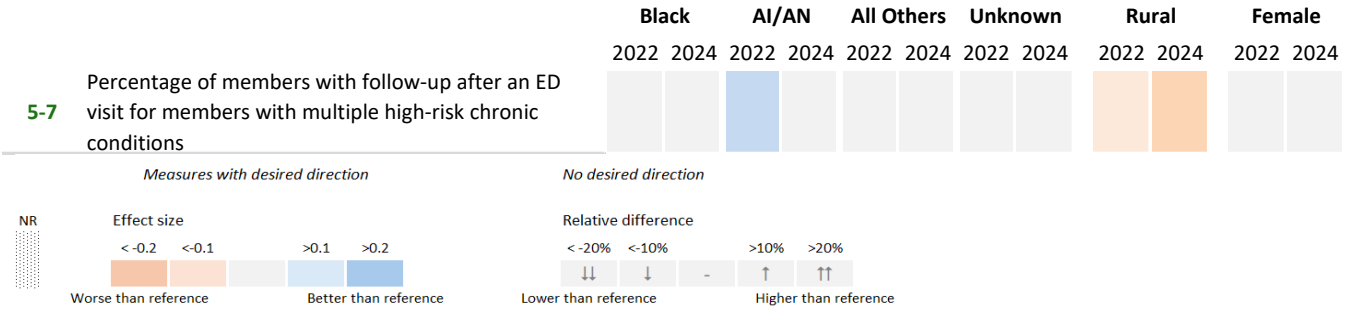
[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.

[2]Change in Rate compares the rate or number in the baseline period (10/01/2016–09/30/2022) to the average rate or number in the evaluation period (10/1/2022–09/30/2024).

Table 6-22 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in FFYs 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among ACC-RBHA members. Each cell color or

arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 6-22—Research Question 5.5, Disparities Analysis



Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. ED: emergency department. NR: not reportable due to suppr

Hypothesis 6: ACC-RBHAs will provide cost-effective care for members with an SMI.

There are no specific measures associated with this hypothesis. To assess the cost-effectiveness of care provided, an ITS analysis was conducted on the cost of care to analyze the differences between actual and projected costs during the evaluation period, which is intended to address research questions 6.1 and 6.2. Separate analyses are conducted at the per-member per-month (PMPM) level and at the total aggregated cost level. Costs were adjusted for medical inflation and are presented in terms of September 2024 dollars.

It is important to note that the cost analyses do not refer to or attempt to replicate the formal Budget Neutrality test required for Section 1115 Waiver Demonstrations.[85] Additionally, the cost-effectiveness analysis does not involve a direct comparison of costs and savings, as program benefits may be non-pecuniary in nature, such as provision of new services that previously were unavailable, increased employment opportunities leading to improved financial well-being, lower mortality rates, and improved health outcomes overall. Furthermore, some outcomes may manifest over an extended period of time and may not be measurable at the time of the evaluation.

Research Question 6.1: What are the costs associated with providing care for members with an SMI through the ACC-RBHAs during the renewal period?

The results related to Research Questions 6.1 and 6.2 assessing the costs and associated benefits/savings with ACC-RBHA during the renewal period are addressed jointly in Research Question 6.2 below.

Research Question 6.2: What are the benefits/savings associated with providing care for members with an SMI through the ACC-RBHAs during the renewal period?

Table 6-23 and Figure 6-2 utilized PMMIS data to examine the changes in PMPM costs for the ACC-RBHA population before and after Waiver renewal through an ITS analysis. Average PMPM costs were approximately $1,242 at the beginning of the baseline period, and the inflation-adjusted trend in costs increased

[85] Centers for Medicare & Medicaid Services. Budget Neutrality SMDL for Section 1115(a) Medicaid Demonstration Project. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd24003.pdf. Accessed on: Jan 26, 2026.

during both the baseline and evaluation periods. Professional costs contributed the greatest to the increasing PMPM cost trend at an additional $11.51 per month relative to the baseline trend.

Table 6-24 and Figure 6-3 utilized PMMIS data to assess the changes in aggregated costs among the ACC-RBHA population before and after Waiver renewal through an ITS analysis. Total cost of care for the ACC-RBHA population averaged approximately $50.2 million in the first month of the baseline period and continued to increase by approximately $0.33 million per month throughout the baseline period. Following renewal of the Waiver, costs increased further by approximately $0.26 million per month relative to the baseline trend. Professional costs contributed the greatest to the increase in costs, particularly during the evaluation period.

Key Findings:

- **PMPM Costs**
  - Total PMPM costs averaged $1,241.95 at the beginning of the baseline and increased by $4.09 per month during the baseline (p<0.001). Following Waiver renewal, the average total PMPM costs increased by $78.78 (***p***=0.142); however, this change was not statistically significant. The trend continued increasing by $16.72 per month (***p***<0.001) more than the projected baseline trend.
  - The primary driver of the increase in PMPM costs was professional, which increased by $112.50 upon Waiver renewal and increased by $11.51 per month during the evaluation period relative to the baseline trend (p<0.001 for both).
  - Pharmacy and inpatient (IP) costs also contributed substantially to overall PMPM costs, with an average of $348.23 and $304.92 at the beginning of the baseline period, respectively.
  - The trend in long-term care (LTC) costs declined by an average of $1.18 per month (***p***<0.001) relative to the baseline trend, leading to an overall declining trend in LTC PMPM costs.
- **Total Costs**
  - Similar to PMPM costs, aggregate costs among the ACC-RBHA population increased during the baseline period and evaluation period, increasing by $325.5 thousand per month in the baseline period and an additional $257.8 thousand per month during the evaluation period relative to the baseline trend (p<0.001 and p=0.066, respectively).
  - Aggregate professional costs increased significantly upon Waiver renewal and saw a sustained increase in the monthly trend following renewal. Professional costs increased by $6,802.1 thousand upon renewal and the trend increased by $296.2 thousand per month relative to the baseline trend (p<0.001 for both).
  - LTC costs saw a decline of $63.0 thousand per month in the trend following Waiver renewal relative to baseline projections (p<0.001).

Table 6-23—ACC-RBHA PMPM Costs

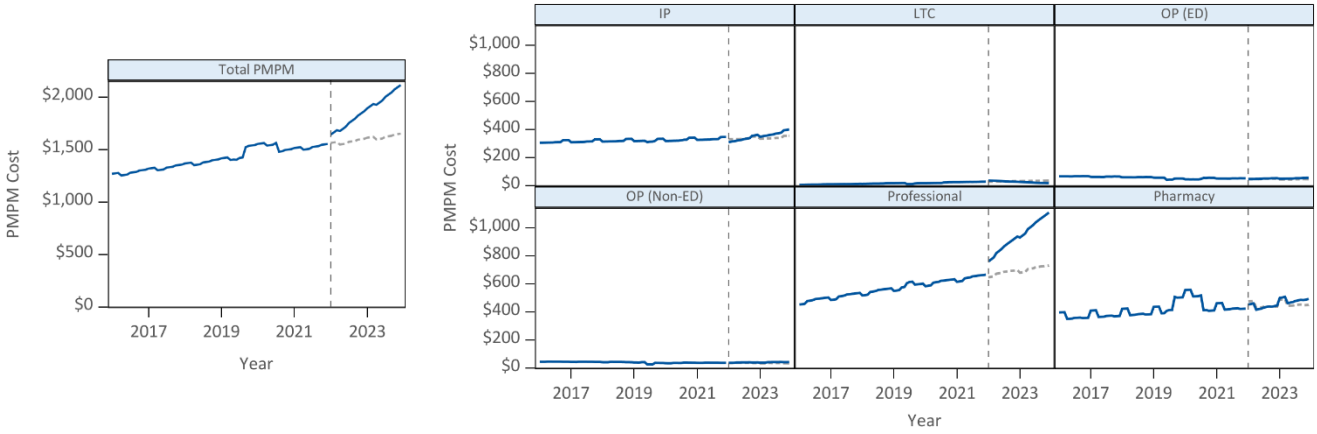
Variable	Estimate (p-value)						
	Total	Professional	IP	LTC	OP (ED)	OP (Non-ED)	Pharmacy
Intercept	1,241.95 *** (<0.001)	$470.40 *** (<0.001)	$304.92 *** (<0.001)	$4.98 *** (<0.001)	$65.65 *** (<0.001)	$47.78 *** (<0.001)	$348.23 *** (<0.001)
Baseline monthly trend	$4.09 *** (<0.001)	$2.71 *** (<0.001)	$0.35 ** (0.020)	$0.32 *** (<0.001)	$-0.26 *** (<0.001)	$-0.13 *** (<0.001)	$1.10 ** (0.005)
Level change at implementation	$78.78 (0.142)	$112.50 *** (<0.001)	$-20.57 * (0.097)	$7.98 *** (<0.001)	$-0.85 (0.707)	$2.02 (0.306)	$-22.30 (0.483)
Change in monthly trend	$16.72 *** (<0.001)	$11.51 *** (<0.001)	$2.87 *** (<0.001)	$-1.18 *** (<0.001)	$0.44 ** (0.002)	$0.28 ** (0.024)	$2.79 (0.161)

*p <0.1, **p <0.05, ***p <0.001

Note: Full model results are presented in Appendix A, Attachments. Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

Data Source: PMMIS data were used in the analysis of RQ 6.1 and 6.2.

Figure 6-2—ACC-RBHA PMPM Costs



Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. This figure presents the model-based average rate in each month (blue line) and the projected rates had the baseline trend continued (grey dashed line). The grey vertical dashed line indicates the Waiver renewal date (October 1, 2022). ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient; PMPM: per-member per-month.

Table 6-24—ACC-RBHA Total Aggregate Costs (in Thousands)

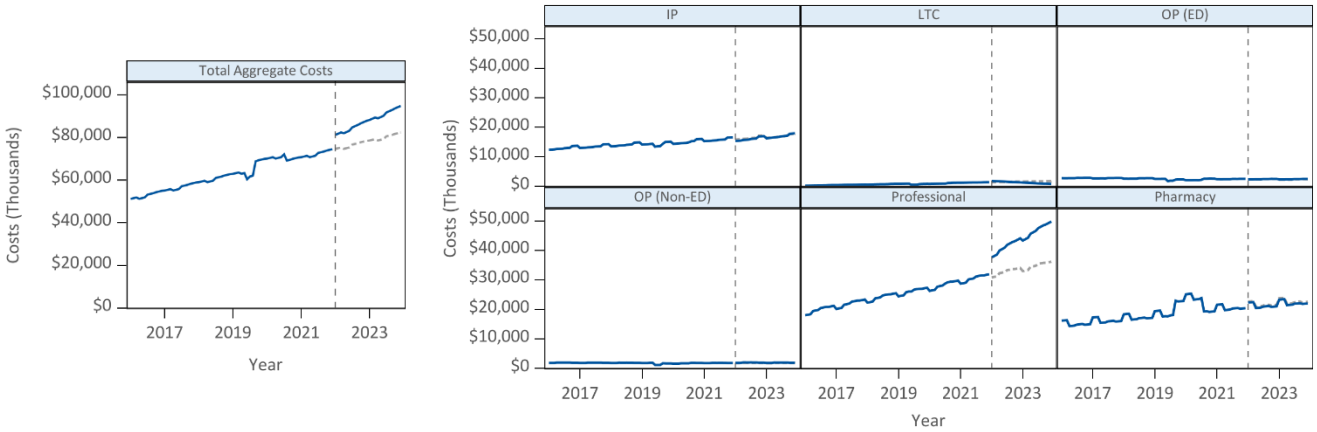
Variable	Estimate in Thousands (*p*-value)						
	Total	Professional	IP	LTC	OP (ED)	OP (Non-ED)	Pharmacy
Intercept	$50,247.6 *** (<0.001)	$18,912.0 *** (<0.001)	$12,430.7 *** (<0.001)	$166.4 *** (<0.001)	$2,709.4 *** (<0.001)	$1,973.7 *** (<0.001)	14,055.3 *** (<0.001)
Baseline monthly trend	$325.5 *** (<0.001)	$178.4 *** (<0.001)	$48.0 *** (<0.001)	$16.4 *** (<0.001)	-$5.8 *** (<0.001)	-$1.7 (0.141)	$90.3 *** (<0.001)
Level change at implementation	$6,534.3 ** (0.004)	$6,802.1 *** (<0.001)	-$511.1 (0.347)	$425.2 *** (<0.001)	$12.5 (0.897)	$145.1 (0.123)	-$339.5 (0.813)
Change in monthly trend	$257.8 * (0.066)	$296.2 *** (<0.001)	$30.1 (0.375)	-$63.0 *** (<0.001)	$4.3 (0.478)	-$0.2 (0.974)	-$9.7 (0.914)

*p <0.1, **p <0.05, ***p <0.001

Note: Full model results are presented in Appendix A, Attachments. Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. ED: emergency department. ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

Data Source: PMMIS data were used in the analysis of RQ 6.1 and 6.2.

Figure 6-3—ACC-RBHA Total Aggregate Costs (in Thousands)



Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. This figure presents the model-based average rate in each month (blue line) and the projected rates had the baseline trend continued (grey dashed line). The grey vertical dashed line indicates the Waiver renewal date (October 1, 2022). ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

7. ALTCS Results

The following chapter describes the quantitative and qualitative results for the evaluation of the Arizona Long Term Care System (ALTCS) Program. A complete list of measures and their specifications is available in Evaluation Designs linked in the Appendix.

Results Summary

Table 7-1 and Table 7-2 display the number of measures by research question that showed improvement, worsened, did not change significantly, or were not applicable.

Table 7-1—ALTCS DD/EPD Quantitative Measure Conclusions

Research Questions	ALTCS-DD				ALTCS-EPD			
	Number of Measures				Number of Measures			
	Worsening	No Significant Change	Improving	N/A[1]	Worsening	No Significant Change	Improving	N/A[1]
RQ 1.1: Do members who are EPD, and/or members with a DD have the same or higher rates of access to care and primary care services compared to prior to waiver renewal?	0	1	4	0	0	1	1	0
RQ 1.2: Do adult members who are EPD and/or members with DD have the same or improved rates of access to care as a result of the waiver renewal?	0	2	0	3	0	0	0	4
RQ 2.1: Do members who are EPD, and/or members with DD have the same or higher rates of preventive care compared to prior to waiver renewal?	0	1	0	0	0	1	0	0
RQ 2.2: Do members who are EPD, and/or members with DD have the same or better management of BH conditions compared to prior to waiver renewal?	1	3	0	1	0	4	0	1
RQ 2.3: Do adult members who are EPD have the same or better management of prescriptions compared to prior to waiver renewal?	1	0	0	0	0	1	0	1
RQ 2.4: Do members who are EPD, and/or members with DD have the same or higher rates of utilization of care compared to prior to waiver renewal?	1	1	0	2	0	2	0	2

Research Questions	ALTCS-DD				ALTCS-EPD			
	Number of Measures				Number of Measures			
	Worsening	No Significant Change	Improving	N/A[1]	Worsening	No Significant Change	Improving	N/A[1]
RQ 3.1: Do members have the same or higher rates of living in their own home as a result of the ALTCS waiver renewal?	0	1	1	0	0	0	1	1
RQ 3.2: Do adult members have the same or higher rates of feeling satisfied with their living arrangements as a result of the waiver renewal for members who are EPD, and/or members with DD?	0	1	0	1	0	0	0	2
RQ 3.3: Do adult members have the same or higher rates of feeling engaged as a result of the waiver renewal for members who are EPD and/or members with DD?	0	2	0	1	0	0	0	3
RQ 4.6: Did care coordination strategies improve or maintain patient engagement and follow up care for substance use and BH conditions during the renewal period?	0	1	1	0	0	0	2	0
Total	**3**	**13**	**6**	**8**	**0**	**9**	**4**	**14**

Note: ALTCS: Arizona Long Term Care System; BH: behavioral health; DD: developmental disabilities; EPD: elderly and/or have physical disabilities; N/A: not applicable.
[1] Measures did not have a desired directionality or require additional context to describe the outcome.

Table 7-2—ALTCS PPCG Quantitative Measure Conclusions

Research Questions	PPCG-DD				PPCG-EPD			
	Number of Measures				Number of Measures			
	Worsening	No Significant Change	Improving	N/A[1]	Worsening	No Significant Change	Improving	N/A[1]
RQ 5.1: Is the percentage of members receiving services at home the same or higher after the implementation of the PPCG service model or EFSS?	0	0	1	0	0	0	0	1
RQ 5.2: What is the frequency and types of services provided to ALTCS members receiving services through the PPCG service model or EFSS at home?	0	0	0	2	0	0	0	2
RQ 6.1: Did minor members receiving services through the PPCG service model maintain or improve their access to health services?	0	1	0	1	0	1	0	1
RQ 6.2: Did the PPCG service model impact hospital	0	1	0	2	0	1	0	2

Research Questions	PPCG-DD				PPCG-EPD			
	Number of Measures				Number of Measures			
	Worsening	No Significant Change	Improving	N/A[1]	Worsening	No Significant Change	Improving	N/A[1]
utilization among ALTCS minors?								
RQ 7.1: Do members receiving services through the PPCG service model or EFSS experience improved self-assessed health outcomes?	0	2	0	0	0	0	0	0
RQ 8.1: Did the PPCG service model alleviate the shortage of DCWs and increase timely access to needed care?	0	0	2	3	0	1	0	3
RQ 9.1: Did the PPCG service model improve or maintain care stability for ALTCS minors?	0	1	1	0	1	0	0	0
RQ 10.1: EFSS restored, enhanced, or maintained family functioning by preserving effective care for members in the home and community?	0	0	0	0	0	0	0	0
RQ 10.2: Has the PPCG service model and EFSS reduced burnout and provided alternate supports for caregivers?	0	1	1	0	0	1	0	0
RQ 11.1: Do members receiving services through the PPCG service model and EFSS have the same or lower rates of social isolation?	0	0	0	6	0	0	0	1
RQ 11.2: Do members receiving services through the PPCG service model have the same or lower rates of reported cases of child maltreatment?	0	0	1	0	0	0	0	0
RQ 12.5: Did utilization of services increase after the introduction of the PPCG service model?	0	0	0	1	0	0	0	1
Total	**0**	**6**	**6**	**14**	**1**	**4**	**4**	**11**

Note: ALTCS: Arizona Long Term Care System; DCW: direct care worker; DD; developmental disabilities; EFSS: Extended Family Support Services; EPD: elderly and/or have physical disabilities; N/A: not applicable; PPCG: Parents as Paid Caregivers.
When pre-intervention data were not available, the determination of support is based on performance relative to the comparison group.
[1] Measures did not have a desired directionality or require additional context to describe the outcome.

ALTCS Program Results

Hypothesis 1: Member access to appropriate care for routine medical conditions will be maintained or improved during the renewal period.

Two research questions and 10 measures assessed Hypothesis 1. Prepaid Medical Management Information System (PMMIS), supplemental State Medicaid, and the National Core Indicators (NCI) data were used to assess whether ALTCS-elderly and/or have physical disabilities (EPD) and/or developmental disabilities (DD) members had the same or higher rates of access to care compared to before the Waiver.

As described in the Methodology chapter, the Adult Family Survey (AFS) and Family Guardian Survey (FGS) do not include questions related to Measure 1-7: *Percentage of members who had a complete physical exam in the past year*, Measure 1-9: *Percentage of members who had an eye exam in the past year*, and Measure 1-10: *Percentage of members who had an influenza vaccine in the past year*. Therefore, these measures are not reported for the ALTCS-DD population.

Additionally, several items in the AFS and FGS were revised for the 2021/2022 cycle. The survey question used to assess Measure 1-6: *Percentage of members who have a primary care doctor or practitioner* was revised substantially, preventing comparisons to prior years. The 2021/2022 data are reported as a single baseline data point.

Furthermore, to ensure accuracy of reporting and alignment with the NCI results, some measure names throughout this Hypothesis have been updated to align with the exact wording of the respective NCI survey. Table 7-3 details this information.

Table 7-3—NCI Survey Crosswalk

Measure		Survey	Survey Language	Numerator Criteria
1-6	Percentage of members who have a primary care doctor or practitioner	NCI-IDD AFS	Can your family member see a primary care provider (doctor, registered nurse, etc.) when needed?	Respondent answered "Usually" or "Always"
1-6	Percentage of members who have a primary care doctor or practitioner	NCI-IDD FGS	Can your family member see a primary care provider (doctor, registered nurse, etc.) when needed?	Respondent answered "Usually" or "Always"
1-7	Percentage of members who had a complete physical exam in the past year	NCI-AD	Had a physical exam or wellness visit in the past 12 months	Respondent answered "Yes"
1-8	Percentage of members who had a dental exam in the past year	NCI-IDD AFS	Can your family member go to the dentist when needed?	Respondent answered "Usually" or "Always"
1-8	Percentage of members who had a dental exam in the past year	NCI-IDD FGS	Can your family member go to the dentist when needed?	Respondent answered "Usually" or "Always"
1-8	Percentage of members who had a dental exam in the past year	NCI-AD	Percentage of members who had a dental exam in the past year	Respondent answered "Yes"
1-9	Percentage of members who had an eye exam in the past year	NCI-AD	Had a vision exam in the past year	Respondent answered "Yes"
1-10	Percentage of members who had an influenza vaccine in the past year	NCI-AD	Had a flu shot in the past 12 months	Respondent answered "Yes"

Note: AFS: Adult Family Survey; AD: Aging and Disabilities; FGS: Family Guardian Survey; NCI: National Core Indicators; N/A: not applicable.

Research Question 1.1: Do members who are EPD, and/or members with a DD have the same or higher rates of access to care and primary care services compared to prior to waiver renewal?

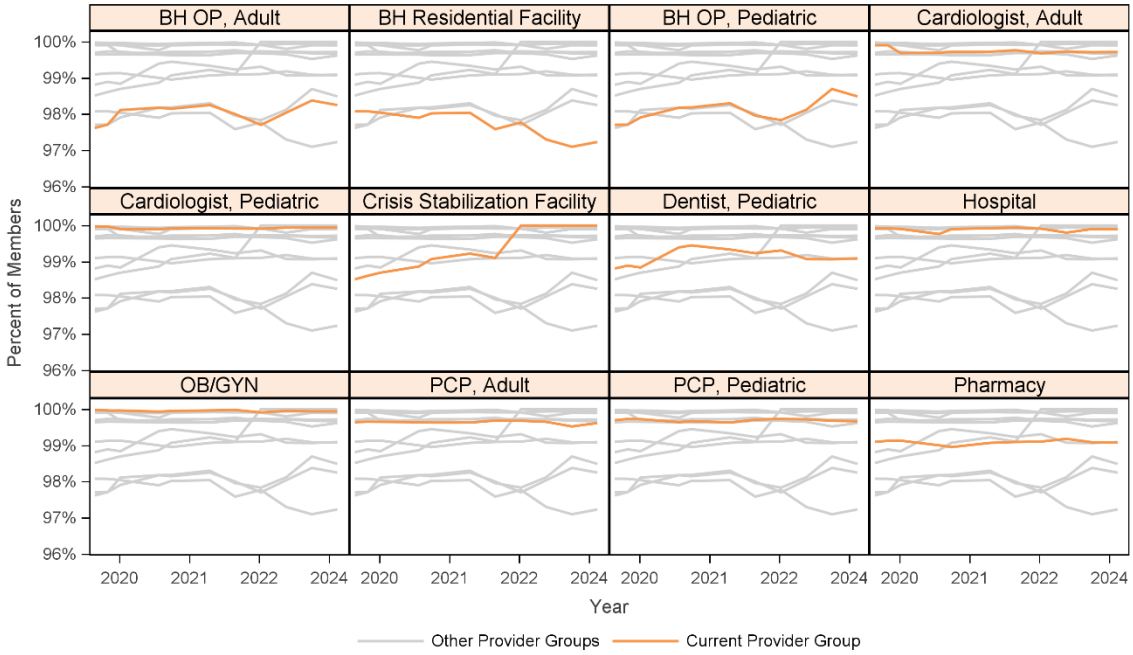
Figure 7-1 and Figure 7-2 display the percentage of ALTCS-DD and ALTCS-EPD members meeting time/distance standards by provider type. Table 7-4 displays the interrupted time series (ITS) results assessing changes in provider network adequacy during the Waiver. This measure has high statistical power and may highlight changes that are statistically significant but not practically meaningful. Table 7-5 utilized PMMIS data to examine the percentage of members who accessed preventive and primary care services.

Key Findings:

- **ALTCS-DD**
  - Overall access to care was high, with over 97 percent of members meeting time/distance standards for all provider types. The percentage of members meeting time/distance standards for Crisis Stabilization Facilities rose to 100 percent by the evaluation period.
  - All rates of primary care access increased between the baseline and evaluation periods. The *Percentage of members with six or more well-child visits before their 15-month birthday* and the *Percentage of members 3–21 years of age who had a well-care visit with a primary care provider (PCP) or obstetrician gynecologist (OB/GYN)* increased the most, by 10.8 and 4.9 percentage points, respectively (p=0.049 and p<0.001).
  - Black members had higher rates of access to two or more well-child visits in the first 30 months of life compared to White/Caucasian members in 2022 and 2024. Female members had higher rates relative to male members in 2022; however, this trend reversed in 2024.
  - The *Percentage of adults who accessed preventive/ambulatory health services* increased to nearly 90 percent during the evaluation period (p<0.001); however, federal fiscal year (FFY) 2023 and FFY 2024 rates were 1.9 and 2.5 percentage points below the baseline projection (p<0.001). This indicated that the rate of increase was not sustained in the evaluation period, which may be because baseline period rates already exceeded the national 90th percentile.
    - The rate of female members accessing preventive/ambulatory health services increased relative to male members between 2022 and 2024.
- **ALTCS-EPD**
  - The percentage of members meeting time/distance standards exceeded 93 percent with few exceptions. The percentage of members meeting Pediatric Dentistry time/distance standards decreased from approximately 99 percent in January 2020 to 80.4 percent and 90.4 percent in April 2020 and January 2022, respectively. The percentage of members within Nursing Facility time/distance standards decreased from approximately 99 percent to approximately 88 percent from January to April 2020, before returning to pre-coronavirus disease 2019 (COVID-19) public health emergency (PHE) levels. Furthermore, ALTCS generally has low rates of members in skilled nursing facility (SNF) placements.
  - The *Percentage of adults who accessed preventive/ambulatory services* increased by 1.6 percentage points between the baseline and evaluation periods (p<0.001), with the FFY 2024 rate exceeding the baseline projection by 1.4 percentage points, indicating additional growth (p<0.001).
    - In 2022 and 2024, Black members had better rates of accessing preventive/ambulatory health services compared to White/Caucasian members.

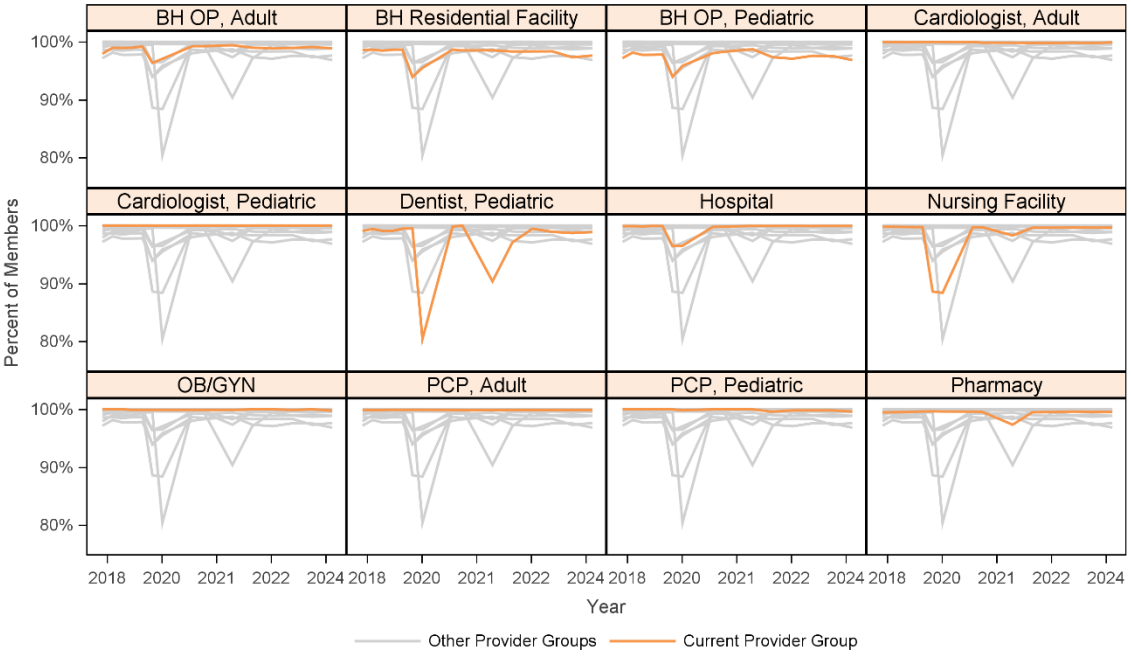
ALTCS-DD and ALTCS-EPD members' access to appropriate care for routine medical conditions was generally maintained or improved during the evaluation period. The percentage of members meeting time/distance standards remained high throughout the evaluation period.

Figure 7-1—Research Question 1.1, Measure 1-1 (DD Population)



Note: BH: behavioral health; OB/GYN: obstetrician gynecologist; OP: outpatient; PCP: primary care provider

Figure 7-2—Research Question 1.1, Measure 1-1 (EPD Population)



Note: BH: behavioral health; OB/GYN: obstetrician gynecologist; OP: outpatient; PCP: primary care provider

Table 7-4—Research Question 1.1, Measure 1-1

Provider Type	Percentage Change in Odds[1] ALTCS-DD Baseline Annual Trend[2]	ALTCS-DD Level Change at Waiver Renewal[2]	ALTCS-DD Change in Annual Trend[2]	ALTCS-EPD Baseline Annual Trend[2]	ALTCS-EPD Level Change at Waiver Renewal[2]	ALTCS-EPD Change in Annual Trend[2]
BH OP, Adult	8.2% *** (<0.001)	-26.2% *** (<0.001)	14.1% ** (0.010)	18.3% *** (<0.001)	-14.6% ** (0.036)	-12.2% ** (0.022)
BH Residential Facility	-5.8% *** (<0.001)	-2.5% (0.601)	-7.5% ** (0.024)	1.3% (0.294)	39.5% *** (<0.001)	-27.5% *** (<0.001)
BH OP, Pediatric	8.7% *** (<0.001)	-24.4% *** (<0.001)	24.1% *** (<0.001)	8.8% (0.310)	-15.9% (0.658)	-13.2% (0.617)
Cardiologist, Adult	-18.5% ** (0.003)	4.6% (0.817)	30.8% * (0.068)	-38.3% *** (<0.001)	-4.5% (0.816)	125.0% *** (<0.001)
Cardiologist, Pediatric	-20.5% ** (0.026)	20.3% (0.553)	72.3% ** (0.030)	8.5% (1.000)	-27.6% (1.000)	-9.4% (1.000)
Crisis Stabilization Facility	—	—	—	†	†	†
Dentist, Pediatric	28.5% *** (<0.001)	-27.9% ** (0.001)	-32.9% *** (<0.001)	-29.0% *** (<0.001)	1037.7% *** (<0.001)	-5.3% (0.890)
Hospital	6.2% (0.363)	-30.4% * (0.069)	4.6% (0.756)	6.4% *** (<0.001)	804.3% *** (<0.001)	-3.8% (0.852)
OB/GYN	1.6% (0.954)	-57.1% (0.242)	29.0% (0.621)	-16.4% (0.564)	772.2% (0.296)	-74.6% (0.303)
Nursing Facility	†	†	†	-0.7% (0.601)	609.1% *** (<0.001)	8.1% (0.546)
PCP, Adult	1.4% (0.807)	6.4% (0.726)	-16.1% (0.165)	-3.8% (0.397)	-0.3% (0.990)	-2.8% (0.857)
PCP, Pediatric	-5.4% (0.260)	36.6% * (0.051)	-10.4% (0.343)	-67.9% * (0.071)	158.1% (0.483)	86.1% (0.548)
Pharmacy	-2.2% (0.319)	14.2% * (0.060)	-2.2% (0.675)	-30.7% *** (<0.001)	223.4% *** (<0.001)	43.4% *** (<0.001)

*p <0.1, **p <0.05, ***p <0.001

Note: Extremely large coefficients can occur when predicted probabilities approach 0 or 1. Results should be interpreted with caution. — indicates rates reached 100 percent in the evaluation period, yielding unstable model results. † indicates that provider group is not reported for the population. ALTCS: Arizona Long Term Care System; BH: behavioral health; DD: developmental disabilities; EPD: elderly and physically disabled; OB/GYN: obstetrician gynecologist; OP: outpatient; PCP: primary care provider.

Data Source: Prepaid Medical Management Information System (PMMIS), Client Assessment and Tracking System (CATS), Provider Affiliation Transmission (PAT), and AHCCCS Contractor Operations Manual (ACOM) 436 were used in the analysis of RQ 1.1.

[1]Model utilizes semi-annual rates from the baseline period (10/01/2019–09/30/2022) and evaluation period (10/01/2022–09/30/2024).

[2]p-values are in parentheses.

Table 7-5—Research Question 1.1, Measures 1-2, 1-3, 1-4, and 1-5

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[3]	Trend Model Difference Between Actual and Projected	
		Baseline Average[2]	Evaluation Average[2]	(*p*-value)	FFY 2023	FFY 2024
ALTCS-DD Population						
1-2	Percentage of adults who accessed preventive/ambulatory health services	89.0%	89.9%	1.0pp *** (<0.001)	-1.9pp *** (<0.001)	-2.5pp *** (<0.001)
1-3	Percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation	46.0%	47.4%	1.4pp *** (<0.001)	0.0pp (0.996)	0.0pp (0.980)
1-4	Percentage of members who had a well-child visit in the first 30 months of life					
	6 or more well-child visits before the 15-month birthday	18.1%	28.8%	10.8pp ** (0.049)	8.8pp (0.497)	20.3pp (0.34)
	2 or more well-child visits between the child's 15-month and 30-month birthday	60.9%	65.6%	4.7pp (0.154)	-3.7pp (0.647)	0.5pp (0.968)
1-5	Percentage of members 3–21 years of age who had a well-care visit with a PCP or OB/GYN	48.4%	53.3%	4.9pp *** (<0.001)	-1.2pp (0.145)	0.3pp (0.790)
ALTCS-EPD Population						
1-2	Percentage of adults who accessed preventive/ambulatory health services	92.4%	94.0%	1.6pp *** (<0.001)	0.3pp (0.189)	1.4pp *** (<0.001)

*p <0.1, **p <0.05, ***p <0.001

Data Source: PMMIS data were used in the analysis of RQ.1.1.

Note: ALTCS: Arizona Long Term Care System; DD: developmental disabilities; EPD: elderly and physically disabled; FFY: federal fiscal year; OB/GYN: obstetrician gynecologist; PCP: primary care provider; pp: percentage point.

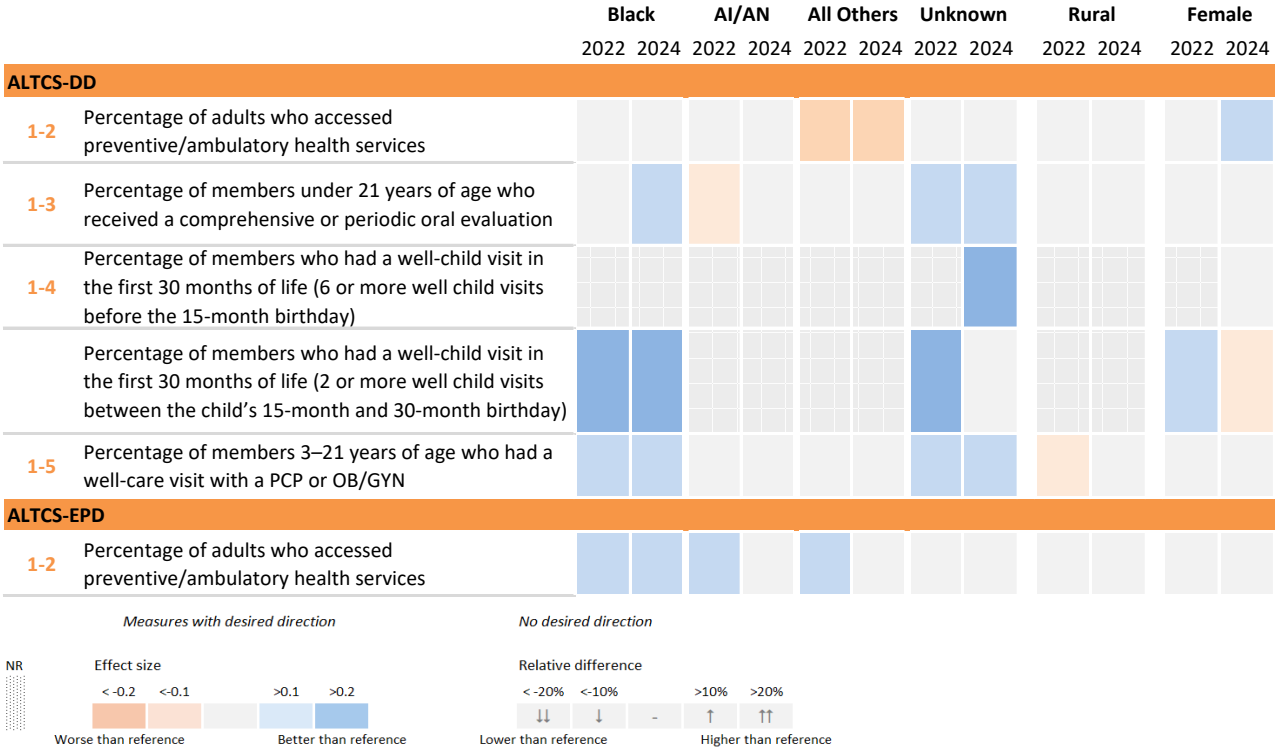
[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.

[2]Rates are weighted by enrollment duration in ALTCS EPD and ALTCS DD.

[3]Change in Rate compares the rate or number in the baseline period (10/01/2019–09/30/2022 for the DD population and 10/01/2016–09/30/2022 for the EPD population) to the average rate or number in the evaluation period (10/1/2022–09/30/2024).

Table 7-6 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in FFYs 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among ALTCS members. Each cell color or arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 7-6—Research Question 1.1 Disparities Analysis



Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. NR: not reportable due to suppression guidelines. OB/GYN: obstetrician gynecologist; PCP: primary care practitioner.

Research Question 1.2: Do adult members who are EPD and/or members with DD have the same or improved rates of access to care as a result of the waiver renewal?

Two surveys assessed ALTCS-DD members. Table 7-7 and Table 7-8 display member-reported access to care measures collected from the NCI-Intellectual and Developmental Disabilities (IDD) AFS, FGS, and NCI-Aging and Disabilities (AD) surveys, respectively. Comparable baseline data were not available for the ALTCS-EPD population because surveys were not conducted in the baseline period; therefore, 2023/2024 rates were compared to the national average with a Chi-Squared test.

Key Findings:

- **ALTCS-DD**
  - Over 90 percent of respondents reported that their family members could see a PCP when needed in all years. The 2023/2024 AFS and FGS rates increased by 3 percentage points from the baseline relative to the national average; however, this was not statistically significant (p=0.143 and p=0.242, respectively).
  - Approximately 85 percent and 92 percent of Arizona and nationwide 2023/2024 AFS and FGS respondents reported that their family members were able to see the dentist when needed, respectively. Rates from baseline through the evaluation period were largely unchanged.

- **ALTCS-EPD**
  - Arizona members received wellness exams, dental visits, or vision exams at rates equal to or slightly lower than the national average; however, the differences were not statistically significant.
  - Seventy percent of Arizona members reported a flu shot within the past 12 months, which was 5 percentage points higher than the national average (p=0.046).

Reported access to care was generally comparable between Arizona and nationwide respondents. Among Arizona NCI-AD respondents, 70 percent reported receiving a flu shot, which was 5 percentage points higher than the national average.

Table 7-7—Research Question 1.2, Measures 1-6 and 1-8 (ALTCS-DD Population)

				Baseline Period	Evaluation Period		2022/2023 DiD (p-value)	2023/2024 DiD (p-value)
				†	2022/2023	2023/2024		
ALTCS-DD Population								
1-6	Can your family member see a PCP (doctor, registered nurse, etc.) when needed?	AFS[1]	Arizona	94%	-	97%	-	3pp (0.143)
			National	92%	-	92%		
		FGS	Arizona	91%	97%	93%	4pp (0.168)	3pp (0.242)
			National	94%	96%	93%		
1-8	Can your family member go to the dentist when needed?	AFS[1]	Arizona	85%	-	85%	-	0pp (0.932)
			National	85%	-	85%		
		FGS	Arizona	90%	86%	92%	-4pp (0.163)	1pp (0.699)
			National	91%	91%	92%		

*p <0.1, **p <0.05, ***p <0.001

Note: AFS: Adult Family Survey; ALTCS: Arizona Long Term Care System; DD: developmental disabilities; DiD: difference-in-differences; FGS: Family/Guardian Survey; PCP: primary care provider; pp: percentage point.

Data Source: NCI-IDD AFS and NCI-IDD FGS data were used in the analysis of RQ 1.2.

†The baseline periods were 2021/2022 for Measure 1-6 and 2018/2019, 2020/2021, and 2021/2022 for Measure 1-8.

[1]The AFS was not conducted in 2022/2023.

Table 7-8—Research Question 1.2, Measures 1-7, 1-8, 1-9, and 1-10 (ALTCS-EPD Population)

		Arizona Rate 2023/2024	National Rate 2023/2024	Difference	p-value
ALTCS-EPD Population					
1-7	Had a physical exam or wellness visit in the past 12 months	80% N=368	83% N=19,364	-3pp	0.130
1-8	Percentage of members who had a dental exam in the past year	45% N=350	46% N=18,881	-1pp	0.710
1-9	Had a vision exam in the past year	58% N=368	58% N=19,308	0pp	1.000
1-10	Had a flu shot in the past 12 months	70% N=369	65% N=19,237	5pp	0.046**

*p <0.1, **p <0.05, ***p <0.001

Note: No baseline data are available for the the EPD population because the survey was not conducted. N represents the number of responses. ALTCS: Arizona Long Term Care System; EPD: elderly and physically disabled; pp: percentage point.

Data Source: NCI-AD Adult Consumer Survey data were used in the analysis of RQ 1.2.

Hypothesis 2: Quality of care will be maintained or improved during the renewal period.

Survey data assessed multiple Hypothesis 2 research questions. As described in the Methodology chapter, two surveys assessed the ALTCS-DD population: the AFS and FGS. A difference-in-differences (DiD) analysis compared Arizona rates to those reported by family members of individuals with developmental disabilities nationally.

Several items in the AFS and FGS were revised for the 2021/2022 cycle. The survey questions used for Measure 2-7: *Percentage of members who know what prescription medications are for* were revised substantially, preventing comparisons with results from prior years. The 2021/2022 data are reported as a single baseline data point. Furthermore, to ensure accuracy of reporting and alignment with the NCI results, some measure names throughout this Hypothesis have been updated to align with the exact wording of the respective NCI survey. Table 7-9 details this information.

Table 7-9—NCI Survey Crosswalk

Measure		Survey	Survey Language	Numerator Criteria
2-7	Percentage of members who know what prescription medications are for	NCI-AD	If your family member takes prescription medications, do you know what they're for?	Respondent answered "Usually" or "Always"
2-7	Percentage of members who know what prescription medications are for	NCI-AD	If your family member takes prescription medications, do you know what they're for?	Respondent answered "Usually" or "Always"
2-7	Percentage of members who know what prescription medications are for	NCI-AD	Knows what prescription medications are for	Respondent answered "Yes"

Note: AD: Aging and Disabilities; FGS: Family Guardian Survey; NCI: National Core Indicators; N/A: not applicable.

Research Question 2.1: Do members who are EPD and/or members with DD have the same or higher rates of preventive care compared to prior to waiver renewal?

Table 7-10 utilized PMMIS data to determine the percentage of members with persistent asthma whose medications were at least 50 percent controller medications.

Key Findings:

- **ALTCS-DD**
  - The *Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent* decreased among the ALTCS-DD population between the baseline and evaluation periods by 2.2 percentage points, though this change was not statistically significant (p=0.207). Notably, the observed rates in both evaluation years were higher than projections from the baseline, indicating that the rate did not decrease as fast as expected during the evaluation period.
- **ALTCS-EPD**
  - The *Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent* increased between the baseline and evaluation periods by 3.5 percentage points; however, this change was not statistically significant (p=0.548).

Rates of asthma management as preventive care were generally maintained among ALTCS-DD and ALTCS-EPD members.

Table 7-10—Research Question 2.1, Measure 2-1

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[3]	Trend Model Difference Between Actual and Projected (*p*-value)	
		Baseline Average[2]	Evaluation Average[2]	(*p*-value)	FFY 2023	FFY 2024
ALTCS-DD Population						
2-1	Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent	81.2%	79.0%	-2.2pp (0.207)	13.1pp ** (0.003)	13.7pp (0.101)
ALTCS-EPD Population						
2-1	Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent	64.6%	68.1%	3.5pp (0.548)	7.9pp (0.372)	-10.9pp (0.312)

*p <0.1, **p <0.05, ***p <0.001

Note: ALTCS: Arizona Long Term Care System; DD: developmental disabilities; EPD: elderly and physically disabled; FFY: federal fiscal year; pp: percentage point.

Data Source: PMMIS data were used in the analysis of RQ.2.1.

[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.

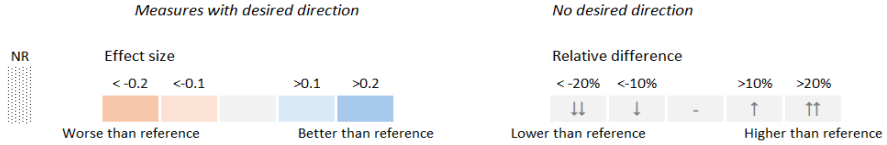
[2]Rates are weighted by enrollment duration in ALTCS EPD and ALTCS DD.

[3]Change in Rate compares the rate or number in the baseline period (10/01/2019–09/30/2022 for the DD population and 10/01/2016–09/30/2022 for the EPD population) to the average rate or number in the evaluation period (10/1/2022–09/30/2024).

Table 7-11 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in FFYs 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among ALTCS members. Each cell color or arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 7-11—Research Question 2.1, Disparities Analysis

		Black		AI/AN		All Others		Unknown		Rural		Female	
		2022	2024	2022	2024	2022	2024	2022	2024	2022	2024	2022	2024
ALTCS-DD													
2-1	Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent												
ALTCS-EPD													
2-1	Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent												



Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. NR: not reportable due to suppression guidelines.

Research Question 2.2: Do members who are EPD and/or members with DD have the same or better management of BH conditions compared to prior to waiver renewal?

Table 7-12 utilized PMMIS data to identify the changes in behavioral health (BH) condition management.

Key Findings:

- **ALTCS-DD**
  - The *Percentage of members with a follow-up visit within 7 days after hospitalization for mental illness* decreased between the baseline and evaluation periods by 3.7 percentage points (p=0.046).
  - The *Percentage of adult members who remained on an antidepressant medication treatment* for 84 days and 180 days declined by 5.1 and 5.8 percentage points, respectively. Although this was not a statistically significant difference (p=0.257 and p=0.199), it represents a relative decline of 8.1 percent ([57.4 percent / 62.5 percent] -1) and 13.2 percent ([38.0 percent / 43.8 percent] -1), respectively.
    - In 2022, members in the Unknown race category had better rates of remaining on an antidepressant medication treatment for 84 days compared to White/Caucasian members; however, performance decreased to below that of White/Caucasian members by 2024.
  - The *Percentage of members with a follow-up after an emergency department (ED) visit for substance use disorder (SUD)* was virtually unchanged between the baseline and evaluation periods, with an average difference of less than 0.01 percentage points (p=0.998).
  - The *Percentage of members diagnosed with a mental health disorder* increased by 5.5 percentage points between the baseline and evaluation periods (p<0.001); however, FFY 2023 and FFY 2024 rates were significantly lower than baseline projections.
- **ALTCS-EPD**
  - The *Percentage of members with a follow-up visit within 7 days after hospitalization for mental illness* decreased by 2.3 percentage points between the baseline and evaluation periods; however, this change was not statistically significant (p=0.530).
    - In 2022, female members had better rates of follow-up visits within 7 days after hospitalization for mental illness compared to male members; however, performance decreased to below that of male members by 2024.
  - The *Percentage of adult members who remained on an antidepressant medication treatment* for 84 days and 180 days did not change significantly between the baseline and evaluation periods.
  - The *Percentage of members with a follow-up within 7 days after an ED visit for SUD* increased by 6.7 percentage points between the baseline and evaluation periods (p=0.092).
  - The *Percentage of members diagnosed with a mental health disorder* increased by 2.4 percentage points between the baseline and evaluation periods (p<0.001).

BH condition management results were mixed for ALTCS-DD members and generally favorable for ALTCS-EPD members. ALTCS-DD members had lower rates of follow-up care after hospitalization for mental illness during the Waiver. ALTCS-EDP members experienced similar or better rates of BH condition management during the Waiver.

Table 7-12—Research Question 2.2, Measures 2-3 through 2-5

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[3]	Trend Model Difference Between Actual and Projected (*p*-value)	
		Baseline Average[2]	Evaluation Average[2]	(*p*-value)	FFY 2023	FFY 2024
ALTCS-DD Population						
2-2	Percentage of members with a follow-up visit within 7 days after hospitalization for mental illness	72.8%	69.1%	-3.7pp ** (0.046)	-1.0pp (0.837)	0.8pp (0.917)
2-3	Percentage of adult members who remained on an antidepressant medication treatment					
	84 days	62.5%	57.4%	-5.1pp (0.257)	-4.3pp (0.708)	7.9pp (0.649)
	180 days	43.8%	38.0%	-5.8pp (0.199)	12.0pp (0.24)	17.5pp (0.207)
2-4	Percentage of members with a follow-up visit within 7 days after an ED visit for SUD	28.4%	28.4%	0.0pp (0.998)	13.6pp (0.505)	9.6pp (0.705)
2-5	Percentage of members diagnosed with a mental health disorder	73.4%	79.0%	5.5pp *** (<0.001)	-4.3pp *** (<0.001)	-6.7pp *** (<0.001)
ALTCS-EPD Population						
2-2	Percentage of members with a follow-up visit within 7 days after hospitalization for mental illness	40.7%	38.5%	-2.3pp (0.53)	-8.7pp (0.141)	-11.7pp * (0.084)
2-3	Percentage of adult members who remained on an antidepressant medication treatment					
	84 days	59.8%	63.7%	3.9pp (0.123)	-3.9pp (0.323)	4.2pp (0.367)
	180 days	45.5%	45.0%	-0.5pp (0.862)	-5.2pp (0.204)	3.5pp (0.485)
2-4	Percentage of members with a follow-up visit within 7 days after an ED visit for SUD	23.9%	30.7%	6.7pp * (0.092)	12.8pp * (0.053)	8.0pp (0.282)
2-5	Percentage of members diagnosed with a mental health disorder	64.3%	66.7%	2.4pp *** (<0.001)	1.0pp ** (0.031)	2.0pp *** (<0.001)

*p <0.1, **p <0.05, ***p <0.001

Note: ALTCS: Arizona Long Term Care System; DD: developmental disabilities; EPD: elderly and physically disabled; ED: emergency department; FFY: federal fiscal year; pp: percentage point; SUD: substance use disorder.

Data Source: PMMIS data were used in the analysis of RQ.2.1.

[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.

[2]Rates are weighted by enrollment duration in ALTCS EPD and ALTCS DD.

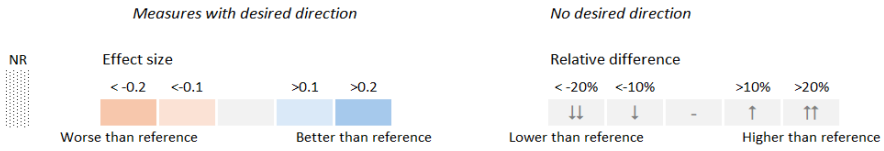
[3]Change in Rate compares the rate or number in the baseline period (10/01/2019–09/30/2022 for the DD population and 10/01/2016–09/30/2022 for the EPD population) to the average rate or number in the evaluation period (10/1/2022–09/30/2024).

Table 7-13 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in FFYs 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among ALTCS members. Each cell color or

arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 7-13—Research Question 2.2, Disparities Analysis

		Black		AI/AN		All Others		Unknown		Rural		Female	
		2022	2024	2022	2024	2022	2024	2022	2024	2022	2024	2022	2024
ALTCS-DD													
2-2	Percentage of members with a follow-up visit within 7 days after hospitalization for mental illness												
2-3	Percentage of adult members who remained on an antidepressant medication treatment (84 days)												
	Percentage of adult members who remained on an antidepressant medication treatment (180 days)												
2-4	Percentage of members with follow-up visit within 7 days after an ED visit for SUD												
2-5	Percentage of members diagnosed with a mental health disorder	-	-	↓	↓	-	-	-	-	↓	↓	↓	-
ALTCS-EPD													
2-2	Percentage of members with a follow-up visit within 7 days after hospitalization for mental illness												
2-3	Percentage of adult members who remained on an antidepressant medication treatment (84 days)												
	Percentage of adult members who remained on an antidepressant medication treatment (180 days)												
2-4	Percentage of members with follow-up visit within 7 days after an ED visit for SUD												
2-5	Percentage of members diagnosed with a mental health disorder	-	-	-	-	↓↓	↓↓	↓	↓	-	-	-	-



Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. ED: emergency department. NR: not reportable due to suppression guidelines. SUD: substance use disorder.

Research Question 2.3: Do adult members who are EPD have the same or better management of prescriptions compared to prior to waiver renewal?

Table 7-14 utilized PMMIS data to determine the rates of use of high-risk medications in older ALTCS-EPD adults. Table 7-15 and Table 7-16 display NCI-IDD and NCI-AD survey results on respondents' prescription management.

Key Findings:

- **ALTCS-DD**
  - The *Percentage of members who know what their medications are for*, as reported by their guardian, decreased from 95 percent to 89 percent in reporting cycle 2022/2023, representing a 6 percentage point decrease relative to the change in the national rate in the same period (p=0.047). At least 94 percent of AFS and FGS respondents reported understanding their prescription medications in 2023/2024.
- **ALTCS-EPD**
  - The *Percentage of members aged 67 years or older who received at least two dispensing events of high-risk medications for the same drug class except for appropriate diagnosis* decreased by 0.1 percentage points (p=0.012).
  - The *Percentage of members who know what prescription medications are for* was equal to the national rate at 87 percent in the 2023/2024 reporting cycle.

ALTCS-DD and ALTCS-EPD member prescription management rates were mixed. Rates of ALTCS-DD members' medication use knowledge decreased during the evaluation period compared to national rates. However, ALTCS-EPD members' potentially inappropriate medication use in older adults decreased.

Table 7-14—Research Question 2.3, Measure 2-6

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[3]	Trend Model Difference Between Actual and Projected (p-value)	
		Baseline Average[2]	Evaluation Average[2]	(p-value)	FFY 2023	FFY 2024
ALTCS-EPD Population						
2-6	Percentage of members with dispensing events of high-risk medications					
	Percentage of members aged 67 years or older who received at least two dispensing events for high-risk medications from the same drug class	2.0%	1.9%	-0.1pp (0.263)	-0.1pp (0.532)	-0.3pp (0.193)
	Percentage of members aged 67 years or older who received at least two dispensing events for high-risk medications from the same drug class except for appropriate diagnosis.	0.4%	0.3%	-0.1pp ** (0.012)	0.0pp (0.861)	0.1pp (0.318)

*p <0.1, **p <0.05, ***p <0.001

Note: ALTCS: Arizona Long Term Care System; EPD: elderly and physically disabled; FFY: federal fiscal year; pp: percentage point;
Data Source: PMMIS data were used in the analysis of RQ.2.3.

[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.

[2]Rates are weighted by enrollment duration in ALTCS EPD.

[3]Change in Rate compares the rate or number in the baseline period (10/01/2016–09/30/2022) to the average rate or number in the evaluation period (10/1/2022–09/30/2024).

Table 7-15—Research Question 2.3, Measure 2-7 (DD Population)

				Baseline Period	Evaluation Period		2022/2023 DiD (p-value)	2023/2024 DiD (p-value)
				2021/2022	2022/2023	2023/2024		
ALTCS-DD Population								
2-7	If your family member takes prescription medications, do you know what they're for?	AFS	Arizona	96%	—	97%	—	-1pp (0.675)
			National	95%	—	97%		
		FGS	Arizona	95%	89%	94%	-6pp ** (0.047)	-3pp (0.274)
			National	92%	92%	94%		

*p <0.1, **p <0.05, ***p <0.001

Note: AFS: Adult Family Survey; ALTCS: Arizona Long Term Care System; DD: developmental disabilities; FGS: Family/Guardian Survey; pp: percentage point.
Data Source: NCI-IDD AFS and NCI-IDD FGS data were used in the analysis of RQ 2.3.
— indicates that the AFS was not conducted in 2022/2023.

Table 7-16—Research Question 2.3, Measure 2-7 (EPD Population)

		Arizona Rate 2023/2024	National Rate 2023/2024	Difference	*p*-value
ALTCS-EPD Population					
2-7	Percentage of members who know what prescription medications are for	87% N=195	87% N=14,971	0pp	1.000

*p<0.1, **p<0.05, ***p<0.001

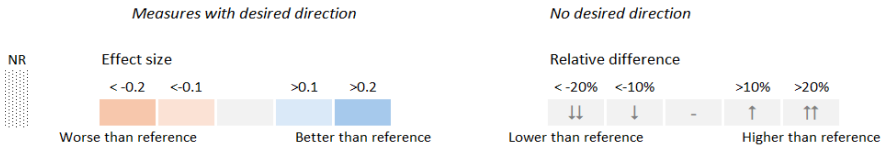
Note: No baseline data are available for the EPD population because the survey was not conducted. N represents the number of responses. ALTCS: Arizona Long Term Care System; EPD: elderly and physically disabled; pp: percentage point.

Data Source: NCI-AD Adult Consumer Survey data were used in the analysis of RQ 2.3.

Table 7-17 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in FFYs 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among ALTCS members. Each cell color or arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 7-17—Research Question 2.3, Disparities Analysis

		Black		AI/AN		All Others		Unknown		Rural		Female	
		2022	2024	2022	2024	2022	2024	2022	2024	2022	2024	2022	2024
ALTCS-EPD													
2-6	Percentage of members aged 67 years or older who received at least two dispensing events for high-risk medications from the same drug class												
	Percentage of members aged 67 years or older who received at least two dispensing events for high-risk medications from the same drug class except for appropriate diagnosis												



Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. NR: not reportable due to suppression guidelines.

Research Question 2.4: Do members who are EPD, and/or members with DD have the same or higher rates of utilization of care compared to prior to waiver renewal?

Table 7-18 utilized MMIS data to assess ED and inpatient (IP) utilization rates.

Key Findings:

- **ALTCS-DD**
  - Among the ALTCS-DD population, the *Number of emergent* and *non-emergent ED visits* per 1,000 member months increased by 5.68 and 0.63 visits, respectively, between the baseline and evaluation periods (p=0.007 and p=0.004).
    - In 2022 and 2024, American Indian/Alaska Native (AI/AN) members, rural members, and female members had higher (worse) rates of non-emergent ED visits per 1,000 member months compared to their reference group (i.e., White/Caucasian, urban, and male, respectively).

  - ALTCS-DD members' *Number of IP stays per 1,000 member months* and the *Percentage of adult IP discharges with an unplanned readmission within 30 days* did not change significantly between the baseline and evaluation periods.
- **ALTCS-EPD**
  - The *Number of emergent ED visits per 1,000 member months* and the *Number of non-emergent ED visits per 1,000 member months* did not change significantly between the baseline and evaluation periods; however, the observed evaluation period rates were consistently higher than the baseline projection.
    - In 2022 and 2024, Black members, rural members, and female members had higher (worse) rates of non-emergent ED visits per 1,000 member months compared to their reference group (i.e., White/Caucasian, urban, and male, respectively).
  - ALTCS-EPD members' *Number of IP stays per 1,000 member months* and the *Percentage of adult IP discharges with an unplanned readmission within 30 days* did not change significantly between the baseline and evaluation periods.

While ALTCS-DD and ALTCS-EPD members' rates of IP stays remained largely unchanged, ALTCS-DD rates of emergent and non-emergent ED visits increased.

Table 7-18—Research Question 2.4, Measures 2-8, 2-9, 2-10, and 2-11

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[2]	Difference Between Actual and Projected (*p*-value)	
		Baseline Average	Evaulation Average	(*p*-value)	FFY 2023	FFY 2024
ALTCS-DD Population						
2-8	Number of emergent ED visits per 1,000 member months (no desired direction)	30.55	36.23	5.68 ** (0.007)	-5.16 (0.955)	-9.27 (0.953)
2-9	Number of non-emergent ED visits per 1,000 member months (lower is better)	1.74	2.37	0.63 ** (0.004)	-0.55 (0.930)	-1.51 (0.898)
2-10	Number of IP stays per 1,000 member months (no desired direction)	8.08	8.11	0.03 (0.905)	-1.35 (0.950)	-2.18 (0.950)
2-11	Percentage of adult IP discharges with an unplanned readmission within 30 days (lower is better)	8.5%	9.4%	0.8pp (0.209)	0.8pp (0.636)	0.4pp (0.864)
ALTCS-EPD Population						
2-8	Number of emergent ED visits per 1,000 member months (no desired direction)	58.28	56.79	-1.49 (0.673)	6.50 * (0.072)	7.52 * (0.056)
2-9	Number of non-emergent ED visits per 1,000 member months (lower is better)	8.99	8.88	-0.11 (0.920)	2.37 ** (0.016)	2.47 ** (0.017)
2-10	Number of IP stays per 1,000 member months (no desired direction)	42.84	43.06	0.22 (0.909)	2.70 (0.315)	4.26 (0.156)
2-11	Percentage of adult IP discharges with an unplanned readmission within 30 days (lower is better)	11.1%	10.5%	-0.6pp (0.290)	0.4pp (0.696)	-1.0pp (0.298)

*p <0.1, **p <0.05, ***p <0.001

Note: ALTCS: Arizona Long Term Care System; DD: developmental disabilities; EPD: elderly and physically disabled; ED: emergency department; FFY: federal fiscal year; IP: inpatient; pp: percentage point.

Data Source: PMMIS data were used in the analysis of RQ.2.4.

[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.

[2]Change in Rate compares the rate or number in the baseline period (10/01/2019–09/30/2022 for the DD population and 10/01/2016–09/30/2022 for the EPD population) to the average rate or number in the evaluation period (10/1/2022–09/30/2024).

Table 7-19 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in FFYs 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first

column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among ALTCS members. Each cell color or arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 7-19—Research Question 2.4, Disparities Analysis

		Black		AI/AN		All Others		Unknown		Rural		Female	
		2022	2024	2022	2024	2022	2024	2022	2024	2022	2024	2022	2024
ALTCS-DD													
2-8	Number of emergent ED visits per 1,000 member months	-	↑	↑↑	↑	↓↓	↓↓	-	-	↑↑	↑	↑↑	↑↑
2-9	Number of non-emergent ED visits per 1,000 member months†↓												
2-10	Number of IP stays per 1,000 member months	-	-	↑↑	↑↑	↓↓	↓↓	-	↓	-	↑	↑↑	↑↑
2-11	Percentage of adult IP discharges with an unplanned readmission within 30 days↓												
ALTCS-EPD													
2-8	Number of emergent ED visits per 1,000 member months	↑↑	↑↑	↑	↑	↓	-	-	-	↑↑	-	-	↑
2-9	Number of non-emergent ED visits per 1,000 member months†↓												
2-10	Number of IP stays per 1,000 member months	↑↑	↑↑	↑↑	↑	↓↓	-	-	-	↓↓	↓↓	-	-
2-11	Percentage of adult IP discharges with an unplanned readmission within 30 days↓												

Measures with desired direction

NR

Effect size < -0.2 <-0.1 >0.1 >0.2

Relative difference† < -20% <-10% >10% >20%

Worse than reference — Better than reference

No desired direction

Relative difference

< -20% <-10% >10% >20%

↓↓ ↓ - ↑ ↑↑

Lower than reference — Higher than reference

Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. ED: emergency department. IP: Inpatient; NR: not reportable due to suppression guidelines.
↓Lower measure rates indicate better performance. Disparities analysis presented reflects the desired direction.
†Relative difference is used for this measure.

Hypothesis 3: Quality of life for members will be maintained or improved during the renewal period.

Survey data assessed multiple Hypothesis 3 research questions. As described in the Methodology chapter, two survey administrations covered the ALTCS-DD population: the AFS and FGS. To contextualize outcomes for ALTCS-DD members, these measures utilized a DiD analysis to compare Arizona rates to those reported by individuals with developmental disabilities nationally. The ALTCS-EPD population was surveyed using the NCI-AD instrument.

As described in the Methodology chapter, the AFS and FGS do not include survey items related to Measure 3-3: *Percentage of members who want to live somewhere else* and Measure 3-7: *Percentage of members who decide or have input in deciding their daily schedule.* Therefore, these measures are not reported for the ALTCS-DD population. Furthermore, to ensure accuracy of reporting and alignment with the NCI results, some measure

names throughout this Hypothesis have been updated to align with the exact wording of the respective NCI survey. Table 7-20 details this information.

Table 7-20—NCI Survey Crosswalk

Measure		Survey	Survey Language	Numerator Criteria
3-2	Type of residence for adult members with DD	NCI-IDD FGS	Family Member's Residence	Respondent indicates "Independent Home or Apartment"
3-2	Type of residence for adult members with DD	NCI-AD	Type of Residence	Respondent indicates "Own Home"
3-2	Percentage of members who want to live somewhere else	NCI-IDD	Not Reported	N/A
3-3	Percentage of members who want to live somewhere else	NCI-AD	Wants to live somewhere else	Respondent answered "Yes"
3-4	Percentage of members who believe services and supports help them live a good life	NCI-IDD AFS	Are services and supports helping your family member to live a good life?	Respondent answered "Yes"
3-4	Percentage of members who believe services and supports help them live a good life	NCI-IDD FGS	Are services and supports helping your family member to live a good life?	Respondent answered "Yes"
3-4	Percentage of members who believe services and supports help them live a good life	NCI-AD	Services and supports help them live the life they want	Respondent answered "Yes"
3-5	Percentage of members able to go out and do things they like to do in the community	NCI-IDD AFS	Does your family member do things in the community?	Respondent answered "Yes"
3-5	Percentage of members able to go out and do things they like to do in the community	NCI-IDD FGS	Does your family member do things in the community?	Respondent answered "Yes"
3-5	Percentage of members able to go out and do things they like to do in the community	NCI-AD	Gets to do things outside of their home as much as they want to	Respondent answered "Yes"
3-6	Percentage of members who have friends who are not staff or family members	NCI-IDD AFS	Does your family member have friends other than paid support workers or family?	Respondent answered "Yes"
3-6	Percentage of members who have friends who are not staff or family members	NCI-IDD FGS	Does your family member have friends other than paid support workers or family?	Respondent answered "Yes"
3-6	Percentage of members who have friends who are not staff or family members	NCI-AD	Has friends or family they do not live with who are a part of their life	Respondent answered "Yes"
3-7	Percentage of members who decide or have input in deciding their daily schedule	NCI-IDD	Not Reported	N/A
3-8	Percentage of members who usually like how they spend their time during the day	NCI-AD	Usually likes how they spend their time during the day	Respondent answered "Yes," "Always," or "Almost Always"

Note: AFS: Adult Family Survey; AD: Aging and Disabilities; FGS: Family Guardian Survey; IDD: Intellectual and Developmental Disabilities; NCI: National Core Indicators; N/A: not applicable.

Research Question 3.1: Do members have the same or higher rates of living in their own home as a result of the ALTCS waiver renewal?

Table 7-21 utilized Health-e-Arizona Plus (HEAPlus) data to assess the percentage of member-days a member resided in their home and compare the evaluation period observed values to the baseline projection.

Table 7-22 utilized information collected from NCI-IDD surveys to assess family/guardian-reported place of residence for members with developmental disabilities. Two surveys covered ALTCS-DD members; however, only the FGS instrument contained a question about where the member lived. Table 7-23 used NCI-AD survey results to display the place of residence for ALTCS-EPD members. Rates were not available prior to 2023/2024; therefore, rates are compared to the national averages.

Key Findings:

- **ALTCS-DD**
  - The *Percentage of members residing in their own home* increased by 1.4 percentage points between the baseline and evaluation periods (p<0.001), and the FFY 2023 and FFY 2024 rates exceeded the baseline projections by 0.9 and 1.4 percentage points, respectively.
  - The percentage of members who lived at home, as reported by guardians, remained at approximately 3 percent between the baseline and evaluation periods for Arizona members; however, the national rate fluctuated, declining from 21 percent in the baseline period to 10 percent in 2022/2023 then rebounding back to 21 percent in 2023/2024.
- **ALTCS-EPD**
  - The *Percentage of members residing in their own home* increased by 1.6 percentage points between the baseline and evaluation periods (p<0.001), and the FFY 2023 and FFY 2024 observed rates exceeded the baseline projection by 0.1 and 1.5 percentage points, respectively (p=0.025 and p<0.001).
  - The percentage of members living at home was 26 percentage points lower for Arizona members than their counterparts nationwide (p<0.001).

Among Arizona NCI-IDD and NCI-AD survey respondents, the percentage of members who reported living at home was below the national average. However, the percentage of ALTCS-EPD and ALTCS-DD members who lived at home increased between the baseline and evaluation periods.

Table 7-21—Research Question 3.1, Measure 3-1

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[2]	Trend Model Difference between actual and projected (p-value)	
		Baseline Average	Evaluation Average	(p-value)	FFY 2023	FFY 2024
ALTCS-DD Population						
3-1	Percentage of members residing in their own home	86.1%	87.5%	1.4pp *** (<0.001)	0.9pp *** (<0.001)	1.4pp *** (<0.001)
ALTCS-EPD Population						
3-1	Percentage of members residing in their own home	52.2%	53.8%	1.6pp *** (<0.001)	0.1pp * (0.025)	1.5pp *** (<0.001)

*p <0.1, **p <0.05, ***p <0.001

Note: ALTCS: Arizona Long Term Care System; DD: developmental disabilities; EPD: eldely and physically disabled; FFY: federal fiscal year; pp: percentage point.
Data Source: HEAPlus data were used in the analysis of RQ 3.1.

[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.

[2]Change in Rate compares the average rate in the baseline period (10/01/2019–09/30/2022 for the DD population and 10/01/2016–09/30/2022 for the EPD population) to the average rate in the evaluation period (10/01/2022–09/30/2024 for both groups).

Table 7-22—Research Question 3.1, Measure 3-2 (DD Population)

				Baseline Period	Evaluation Period		2022/2023 DiD	2023/2024 DiD
				†	2022/2023	2023/2024	(*p*-value)	(*p*-value)
ALTCS-DD Population								
3-2	Type of residence: Home	FGS	Arizona	3%	4%	3%	12pp **	0pp
			National	21%	10%	21%	(0.007)	(0.841)

*p <0.1, **p <0.05, ***p <0.001

Note: ALTCS: Arizona Long Term Care System; DD: developmental disabilities; FGS: Family/Guardian Survey; pp: percentage point.
Data Source: NCI-IDD AFS and NCI-IDD FGS data were used in the analysis of RQ 3.1.
†Baseline periods: 2018/2019, 2020/2021, and 2021/2022.

Table 7-23—Research Question 3.1, Measure 3-2 (EPD Population)

		Arizona Rate 2023/2024	National Rate 2023/2024	Difference	*p*-value
ALTCS-EPD Population					
3-2	Type of Residence: Home	46% N=402	72% N=20,306	-26pp	<0.001 ***

*p <0.1, **p <0.05, ***p <0.001

Note: No baseline data are available for the the EPD population because the survey was not conducted. N represents the number of responses. ALTCS: Arizona Long Term Care System; EPD: elderly and physically disabled; pp: percentage point.
Data Source: NCI-AD Adult Consumer Survey data were used in the analysis of RQ 3.1.

Research Question 3.2: Do adult members have the same or higher rates of feeling satisfied with their living arrangements as a result of the waiver renewal for members who are EPD and/or members with DD?

Table 7-24 utilized NCI-IDD surveys to assess ALTCS-DD member satisfaction with living arrangements. A DiD analysis compared Arizona rates and national rates. The AFS and FGS for ALTCS-DD members did not include questions related to Measure 3-3: *Percentage of members who want to live somewhere else*; therefore, this measure is not reported for ALTCS-DD members.

Table 7-25 used NCI-AD surveys responses to examine ALTCS-EPD member satisfaction with living arrangements.

Key Findings:

- **ALTCS-DD**
  - The *Percentage of family members responding on behalf of the member who believe services and supports help them live a good life* among Arizona respondents remained high and were generally aligned with national rates; however, there was a slight decrease in the 2023/2024 FGS survey, declining by 3 percentage points relative to the national change (p=0.078).
- **ALTCS-EPD**
  - The *Percentage of members who wanted to live somewhere else* was 3 percentage points higher in Arizona compared to the national rate in 2023/2024, although this difference was not statistically significant (p=0.345).
  - The *Percentage of members who believed services and supports help them live a good life* was 4 percentage points lower in Arizona compared to the national rate in 2023/2024, although this difference was not statistically significant (p=0.138).

Overall, Arizona NCI survey respondents' rates of satisfaction with their living arrangements were generally comparable to those nationwide.

Table 7-24—Research Question 3.2, Measure 3-4 (DD Population)

				Baseline Period	Evaluation Period		2022/2023	2023/2024
				†	2022/2023	2023/2024	DiD	DiD
ALTCS-DD Population								
3-4	Are services and supports helping your family member to live a good life?	AFS[1]	Arizona	96%	-	96%	-	0pp (0.896)
			National	93%	-	93%		
		FGS	Arizona	96%	94%	93%	0pp (0.773)	-3pp * (0.078)
			National	95%	93%	95%		

*p <0.1, **p <0.05, ***p <0.001

Note: Measure 3-3 was not available for the DD population because the surveys conducted did not contain the relevant item. AFS: Adult Family Survey; ALTCS: Arizona Long Term Care System; DD: developmental disabilities; DiD: difference-in-differences; FGS: Family/Guardian Survey; pp: percentage point.

Data Source: NCI-IDD AFS and NCI-IDD FGS data were used in the analysis of RQ 3.2.

†Baseline periods: 2018/2019, 2020/2021, and 2021/2022.

[1]The AFS was not conducted in 2022/2023.

Table 7-25—Research Question 3.2, Measures 3-3 and 3-4 (EPD Population)

		Arizona Rate 2023/2024	National Rate 2023/2024	Difference	p-value
ALTCS-EPD Population					
3-3	Wants to live somewhere else	33% N=211	30% N=15,997	3pp	0.345
3-4	Services and supports help them live the life they want	84% N=147	88% N=13,011	-4pp	0.138

*p <0.1, **p <0.05, ***p <0.001

Note: No baseline data were available for the the EPD population because the survey was not conducted. N represents the number of responses. ALTCS: Arizona Long Term Care System; EPD: elderly and physically disabled; pp: percentage point.

Data Source: NCI-AD Adult Consumer Survey data were used in the analysis of RQ 3.2.

Research Question 3.3: Do adult members have the same or higher rates of feeling engaged as a result of the waiver renewal for members who are EPD and/or members with DD?

Table 7-26 utilized NCI-DD surveys to assess guardian-reported community engagement. Table 7-27 utilized NCI-AD surveys to assess rates of respondents feeling engaged in the community. The AFS and FGS for ALTCS-DD members did not include survey items related to Measure 3-7: *Percentage of members who decide or have input in deciding their daily schedule*; therefore, this measure is not reported for ALTCS-DD members and was not applicable to ALTCS-EPD members. Additionally, Measure 3-8: *Percentage of members who usually like how they spend their time during the day* was developed specifically for ALTCS-EPD members and is not included in Table 7-26.

Key Findings:

- **ALTCS-DD**
  - When asked "*Does your family member do things in the community*?", Arizona FGS respondents reported consistently lower rates than their counterparts nationwide. Arizona respondent rates were 6 percentage points lower than the national average; however, the changes between the baseline and evaluation periods were not statistically significant.
  - Similarly, when asked "*Does your family member have friends other than paid support workers or family*?", Arizona FGS respondents reported consistently lower rates compared to their counterparts nationwide. Arizona respondent rates were 3 percentage points lower than the national average; however, changes between the baseline and evaluation periods were not statistically significant.

- The percentage of Arizona AFS respondents who reported having friends other than paid support workers or family increased by 8 percentage points relative to the national average (p=0.053).

- **ALTCS-EPD**
  - The *Percentage of members who are able to do things outside of their home as much as they want to* among Arizona respondents was 8 percentage points lower than the national average in 2023/2024 at 58 percent (p=0.017).
  - The *Percentage of members who have friends or family they do not live with who are a part of their life* and was within approximately 1 percentage point of the national rates at 92 percent in 2023/2024 (p=0.570).
  - The *Percentage of members who usually like how they spend their time during the day* was within approximately 1 percentage point of the national rates at 64 percent in 2023/2024 (p=0.767).

Arizona respondents generally had similar rates of feeling engaged in their communities compared to their counterparts nationwide. However, ALTCS-DD members' rates of having friends other than paid support workers or family increased relative to the national average.

Table 7-26—Research Question 3.3, Measures 3-5 and 3-6 (DD Population)

				Baseline Period †	Evaluation Period 2022/2023	Evaluation Period 2023/2024	2022/2023 DiD	2023/2024 DiD
ALTCS-DD Population								
3-5	Does your family member do things in the community?	AFS[1]	Arizona	84%	-	85%	-	0pp (0.961)
			National	82%	-	83%		
		FGS	Arizona	78%	86%	81%	4pp (0.341)	0pp (0.895)
			National	85%	88%	87%		
3-6	Does your family member have friends other than paid support workers or family?	AFS[1]	Arizona	60%	-	65%	-	8pp * (0.053)
			National	61%	-	59%		
		FGS	Arizona	56%	50%	60%	0pp (0.990)	4pp (0.361)
			National	62%	57%	63%		

*p <0.1, **p <0.05, ***p <0.001

Note: AFS: Adult Family Survey; ALTCS: Arizona Long Term Care System; DD: developmental disabilities; DiD: difference-in-differences; FGS: Family/Guardian Survey; pp: percentage point.

Data Source: NCI-IDD AFS and NCI-IDD FGS data were used in the analysis of RQ 3.3.

†Baseline period: 2018/2019, 2020/2021, and 2021/2022.

[1]The AFS was not conducted in 2022/2023.

Table 7-27—Research Question 3.3, Measures 3-5, 3-6, and 3-8 (EPD Population)

		Arizona Rate 2023/2024	National Rate 2023/2024	Difference	p-value
ALTCS-EPD Population					
3-5	Gets to do things outside of their home as much as they want to	58% N=202	66% N=15,580	-8pp	0.017 **
3-6	Has friends or family they do not live with who are a part of their life	92% N=213	93% N=16,256	-1pp	0.570
3-8	Usually likes how they spend their time during the day	64% N=207	63% N=15,507	1pp	0.767

*p <0.1, **p <0.05, ***p <0.001

Note: No baseline data are available for the the EPD population because the survey was not conducted. N represents the number of responses. ALTCS: Arizona Long Term Care System; EPD: elderly and physically disabled; pp: percentage point.

Data Source: NCI-AD Adult Consumer Survey data were used in the analysis of RQ 3.3.

Hypothesis 4: ALTCS encourages and/or facilitates care coordination among PCPs and BH practitioners.

Hypothesis 4 assessed if ALTCS increased care coordination among PCPs and BH practitioners. Five research questions used key informant interviews to examine the experiences of Arizona's Department of Economic Security/Division of Developmental Disabilities (DES/DDD), plans, providers, and AHCCCS. In September 2025, 13 key informant interviews were conducted to identify the successes and barriers encountered during the integration of physical health (PH) and BH care. Research Question 4.6 leveraged PMMIS data.

Research Question 4.1: Did DES/DDD, ALTCS-EPD, or their contracted plans encounter barriers during the waiver renewal period of care for members with DD or EPD?

DES/DDD experienced barriers related to educating other stakeholders on the needs of its member population and challenges related to the specialized needs of ALTCS-DD and ALTCS-EPD members. ALTCS-EPD plans encountered several barriers to care coordination during the Waiver renewal period, including member engagement challenges, difficulty obtaining accurate contact information, workforce shortages, difficulties with care team communication, and member challenges with transitions related to policy changes that disrupted care teams and contributed to a lack of consistency in member relationships.

Research Question 4.2: What care coordination strategies did DES/DDD and its contracted plans implement as a result of the waiver renewal?

DES/DDD shared several care coordination strategies to support ALTCS members' health, including:[86]

- Holding care coordination meetings to discuss hospital readmissions and member needs.
- Working with other programs, families, and organizations to keep members in their homes and out of institutional settings.
- Collaborating with the Department of Child Safety (DCS) to support children entering care who may be covered by ALTCS.
- Providing incentive funding for providers.
- Collaborating with health plans to improve responsiveness to members and providers

ALTCS plans also reported implementing several care coordination strategies, such as:

- Providing person-centered care plans tailored to individual members.
- Involving family members, friends, and providers in care planning meetings.
- Integrating PH and BH care.
- Expanding telehealth and incorporating technology to support members' care.
- Screening for social determinants of health (SDOH), health-related social needs (HRSN), and potential overmedication.
- Providing support for family caregivers or other informal caregivers.

[86] See Appendix A for additional details.

- Determining the appropriate level of care with a focus on keeping members in their homes.
- Soliciting feedback from members and their families.
- Monitoring performance using Healthcare Effectiveness Data and Information Set (HEDIS®)[87] measures.

Research Question 4.3: Did DES/DDD or its contracted plans encounter barriers to renewal of the waiver for care coordination strategies?

DES/DDD encountered several barriers to care coordination, including determining service coverage responsibilities, coordinating safe discharges, and workforce shortages, particularly in rural areas. ALTCS plans encountered barriers such as challenges with provider reimbursement, limited training and insufficient time to prepare for policy changes, communication across organizations, and increased workload without corresponding increases in workforce capacity.[88]

Research Question 4.4: Did AHCCCS encounter barriers related to the waiver renewal for members with DD or EPD?

AHCCCS identified several barriers related to the Waiver renewal period. Key barriers included:

- **Caring for an Aging Population:** As the ALTCS population aged, members experienced more complex medical diagnoses and needs. Staff expressed concern about the rapid growth of the aging population, particularly in the context of statewide workforce shortages.
- **Perceived Increase in members with developmental disabilities:** AHCCS staff reported an increase in members with developmental disabilities requiring long-term care (LTC), while family support for these members decreased. This increased pressure on the workforce and reduced advocacy for members' care.
- **Workforce Shortages:** AHCCCS staff reported a lack of gerontologists in the State, noting that demand is expected to increase as the ALTCS population continues to age. Staff also indicated that the workforce was operating at capacity despite increasing workloads, which affected the quality of care. Additional concerns included low provider and direct care worker (DCW) pay, shortages of licensed professionals, and limited services in rural communities.

Research Question 4.5: Did providers encounter barriers related to the waiver renewal for members with DD?

ALTCS providers encountered several barriers related to providing care during the evaluation period, including:

- **Transportation:** Providers expressed concern about the reliability of transportation, the feasibility of offering transportation services in-house, and the difficulty of arranging transportation for members.
- **ALTCS Application Process:** Providers reported that applications took a significant amount of time to process and eligibility evaluations were time-intensive to schedule and complete. Providers noted that the application process increased workload due to limited member understanding of how to apply and eligibility criteria that were unclear and difficult to find.
- **Authorizations:** Providers indicated that authorization requirements increased workload and delayed treatment for members due to the lengthy approval time frames.

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87 HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
88 See Appendix A, Supplemental Results, for additional details.

- **Reimbursement and Lack of Funding:** Providers highlighted a gap between service delivery costs and reimbursement rates and noted increased costs without corresponding rate increases. Providers also expressed concerns about Medicaid funding and financial sustainability.
- **Communication with AHCCCS:** Providers reported not always receiving timely responses from AHCCCS and reported communication with members and providers was lacking when policy changes were implemented.

Research Question 4.6: Did care coordination strategies improve or maintain patient engagement and follow-up care for substance use and BH conditions during the renewal period?

Table 7-28 utilized PMMIS data to assess the percentage of members with multiple high-risk chronic conditions who had follow-up care following an ED visit and the percentage of members with engagement after discharge.

Key Findings:

- **ALTCS-DD**
  - The *Percentage of members with patient engagement after discharge* increased by 2.4 percentage points (a relative increase of 3 percent [(81.1 percent / 78.7 percent) – 1]) between the baseline and the evaluation periods (p=0.009). Additionally, FFY 2023 and FFY 2024 rates exceeded the projection from baseline by 5.5 and 8.3 percentage points (p=0.021 and p=0.026), respectively, indicating that the slight decrease in the baseline period was reversed in the evaluation period.
- **ALTCS-EPD**
  - The *Percentage of members with multiple high-risk conditions who had follow-up after an ED visit* increased between the baseline and evaluation periods by 8.6 percentage points (p<0.001). Observed rates were 9.7 and 13.8 percentage points higher (p<0.001) than the baseline projections in both evaluation years, indicating a reversal of the baseline trend.
    - The percentage of rural members with multiple high-risk chronic conditions who had follow-up after an ED visit was lower compared to urban members in 2024.
  - Similarly, the *Percentage of members with patient engagement after discharge* increased between the baseline and evaluation periods by 8.0 percentage points (p<0.001). Observed rates were 9.8 and 16.6 percentage points higher (p<0.001) than the baseline projections in both evaluation years, indicating a rebound in rates relative to the baseline trend.

Patient engagement and follow-up care generally improved during the evaluation period. Rates of ALTCS-DD member follow-up care and ALTCS-EPD member follow-up care and patient engagement increased faster in the evaluation period than the baseline projection, indicating additional growth.

Table 7-28—Research Question 4.6, Measures 4-9 and 4-10

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[3]	Trend Model Difference Between Actual and Projected (*p*-value)	
		Baseline Average[2]	Evaulation Average[2]	(*p*-value)	FFY 2023	FFY 2024
ALTCS-DD Population						
4-9	Percentage of members with multiple high-risk chronic conditions who had follow-up after an ED visit	69.9%	70.5%	0.6pp (0.716)	-0.8pp (0.840)	1.8pp (0.764)
4-10	Percentage of members with patient engagement after discharge	78.7%	81.1%	2.4pp ** (0.009)	5.5pp ** (0.021)	8.3pp ** (0.026)
ALTCS-EPD Population						
4-9	Percentage of members with multiple high-risk chronic conditions who had follow-up after an ED visit	47.7%	56.3%	8.6pp *** (<0.001)	9.7pp *** (<0.001)	13.8pp *** (<0.001)
4-10	Percentage of members with patient engagement after discharge	60.4%	68.4%	8.0pp *** (<0.001)	9.8pp *** (<0.001)	16.6pp *** (<0.001)

*p <0.1, **p <0.05, ***p <0.001

Note: ALTCS: Arizona Long Term Care System; DD: developmental disabilities; EPD: elderly and physically disabled; ED: emergency department; FFY: federal fiscal year; pp: percentage point.

Data Source: PMMIS data were used in the analysis of RQ.4.6.

[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.

[2]Rates are weighted by enrollment duration in ALTCS EPD and ALTCS DD.

[3]Change in Rate compares the rate or number in the baseline period (10/01/2019–09/30/2022 for the DD population and 10/01/2016–09/30/2022 for the EPD population) to the average rate or number in the evaluation period (10/1/2022–09/30/2024).

Table 7-29 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in FFYs 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among ALTCS members. Each cell color or arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 7-29—Research Question 4.6, Disparities Analysis

		Black		AI/AN		All Others		Unknown		Rural		Female	
		2022	2024	2022	2024	2022	2024	2022	2024	2022	2024	2022	2024
ALTCS-DD													
4-9	Percentage of members with multiple high-risk chronic conditions who had follow-up after an ED visit												
4-10	Percentage of members with patient engagement after discharge												
ALTCS-EPD													
4-9	Percentage of members with multiple high-risk chronic conditions who had follow-up after an ED visit												
4-10	Percentage of members with patient engagement after discharge												

Measures with desired direction

NR

Effect size

< -0.2 <-0.1 >0.1 >0.2

Worse than reference Better than reference

No desired direction

Relative difference

< -20% <-10% - >10% >20%

↓↓ ↓ - ↑ ↑↑

Lower than reference Higher than reference

Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. ED: emergency department. NR: not reportable due to suppression guidelines.

Hypothesis 5: The Parents as Paid Caregivers (PPCG) service model and Extended Family Support Services (EFSS) will maintain or increase the rate of members being served in the home.

Research Question 5.1: Is the percentage of members receiving services at home the same or higher after the implementation of the PPCG service model or EFSS?

Table 7-30 and Figure 7-3 utilized PMMIS, PPCG utilization, and ALTCS placement data to identify the number and types of services provided to members through the PPCG service model, which provides services to minor children enrolled in ALTCS.[89,90]

Figure 7-3 illustrates ALTCS-DD members who utilized services under the PPCG service model. Data were unavailable from May 2023 to February 2024, as indicated by gray dashed lines, which may lead to lower average rates during this period.

Key Findings:

- **ALTCS-DD**
  - The *Percentage of ALTCS-DD members who received habilitation and attendant care services* through the PPCG service model increased by nearly 10 percentage points between the ramp-up and evaluation periods ($p<0.001$) for both.
- **ALTCS-EPD**
  - Among the 448 minor members enrolled in an ALTCS-EPD plan in SFY 2024, 43.3 percent received attendant care services and 7.4 percent received habilitation care services through the PPCG service model. All members who received habilitation care services received attendant care services, and utilization of habilitation care among members with physical disabilities is rare.

Overall, the percentage of minor ALTCS-DD members receiving services through the PPCG service model increased by over 10 percent between the ramp-up and evaluation periods.[91]

89 The number of services is defined as the number of hours billed under the PPCG service model.

90 The EFSS model was not operationalized at the time of this Interim Evaluation Report and is not included in the analysis.

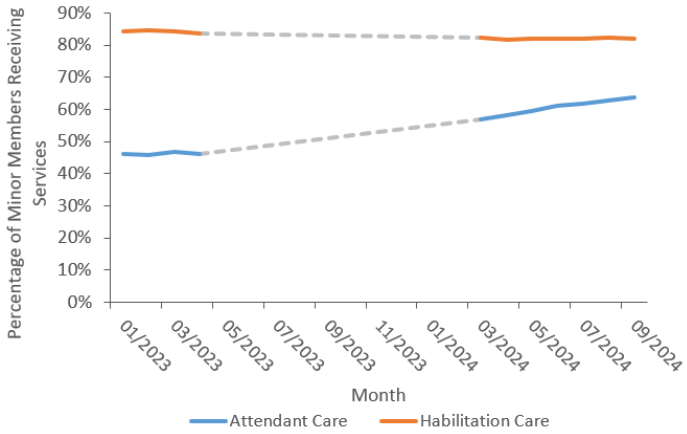
91 The PPCG service model was approved through Appendix K authority in March 2020. On February 16, 2024, CMS approved the PPCG service model under Waiver authority. As such, results prior to 2024 represent a "ramp-up" period prior to the transition to Waiver authority.

Table 7-30—Research Question 5.1, Measures 5-1 and 5-2

Is the percentage of members receiving services at home the same or higher after the implementation of the PPCG service model or EFSS?			Ramp-Up Period 2023	Evaluation Period 2024	Pre/Post Change in Rate[1] (*p*-value)
ALTCS-DD Population					
5-1	Percentage of minor members receiving services through the PPCG service model	Habilitation Care	14.3% N=19,519	24.7% N=21,849	10.4pp *** (<0.001)
		Attendant Care	7.8% N=19,519	18.9% N=21,849	11.1pp *** (<0.001)
5-2	Percentage of members receiving EFSS	—	—	—	—
ALTCS-EPD Population					
5-1	Percentage of minor members receiving services through the PPCG service model	Habilitation Care	N/A	3.1% N=448	N/A
		Attendant Care	N/A	43.3% N=448	N/A
5-2	Percentage of members receiving EFSS	—	—	—	

*p<0.1, **p<0.05, ***p<0.001
Note: N represents the denominator count. ALTCS: Arizona Long Term Care System; DD: developmental disabilities; EFSS: Extended Family Support services; EPD: elderly and physically disabled; PP: percentage points; PPCG: Parents as Paid Caregivers.
— indicates that the program has not been implemented.
N/A indicates that data provided for the ALTCS-EPD ramp-up period were not included in the analysis due to potential bias in reporting, which prevented statistical testing.
Data Source: PMMIS, PPCG-DD utilization data, PPCG-EPD utilization data, and ALTCS Placement files were used in the analysis of RQ 5.1.
[1]Change in Rate compares the rate in the ramp-up period to the evaluation period.
ALTCS-DD: Ramp-up period (01/01/2023–03/31/2023) and evaluation period (04/01/2024–09/30/2024).
ALTCS-EPD: Evaluation period (04/01/2024–09/30/2024).

Figure 7-3—Research Question 5.1, Measure 5-3



Note: Grey dashed lines indicate missing data for that time period.
Data Source: PMMIS, PPCG-DD utilization data, and ALTCS Placement files were used in the analysis of RQ 5.1.

Research Question 5.2: What is the frequency and types of services provided to ALTCS members receiving services through the PPCG service model or EFSS at home?

Table 7-31 utilized PMMIS, PPCG utilization data, and ALTCS placement data to identify the types of and average number of services provided to members through the PPCG service model.

Key Findings:

- **ALTCS-DD**
  - Among members who received services from the PPCG service model, the number of members who received habilitation care services decreased by approximately 1.5 percentage points (p=0.065), while the number of habilitation service hours increased by an average of 23 hours per member per year (p<0.001).
  - The number of members who received attendant care services from the PPCG service model increased by 17.4 percentage points (p<0.001), while the average number of hours billed increased by 30.7 hours between the ramp-up and evaluation periods (p<0.001).
- **ALTCS-EPD**
  - All ALTCS-EPD members who received services from the PPCG service model received attendant care services, while only 7.2 percent of members received habilitation services.[92]

Among minor ALTCS-DD members who received services under the PPCG service model, the percentage of members who utilized attendant services and the average number of habilitation and attendant service hours increased. ALTCS-EPD members primarily sought attendant care services under the PPCG service model.

Table 7-31—Research Question 5.2, Measures 5-3, 5-4, and 5-5

Is the percentage of members receiving services at home the same or higher after the implementation of the PPCG service model or EFSS?					
			Ramp-Up Period	Evaluation Period	Pre/Post Change in Rate[1] (p-value)
			2023	2024	
ALTCS-DD Population					
5-3	Types and percentage of services provided to minor members by parents	Habiliation Care	85.1% N=3,271	83.6% N=6,451	-1.5pp * (0.065)
		Attendant Care	46.8% N=3,271	64.1% N=6,451	17.4pp *** (<0.001)
5-4	Average number of PPCG services per utilizing member	Habiliation Care	45.7	68.7	23.0 *** (<0.001)
ALTCS-EPD Population					
5-3	Types and percentage of services provided to minor members by parents	Habiliation Care	N/A	7.2% N=194	N/A
		Attendant Care	N/A	100.0% N=194	N/A
5-4	Average number of PPCG services per utilizing member	Habiliation Care	N/A	10.79	N/A
		Attendant Care	N/A	25.63	N/A
5-5	Average number of EFSS per utilizing member	—	—	—	—

Note: N represents the denominator count. The PPCG-EPD utilization data identified the average number of hours provided to each member between March 2024–September 2024. ALTCS: Arizona Long Term Care System; DD: developmental disabilities; EFSS: Extended Family Support services; EPD: elderly and physically disabled; PP: percentage points; PPCG: Parents as Paid Caregivers.
— indicates that the program has not yet been implemented.
N/A indicates that data provided for the ALTCS-EPD ramp-up period were not included in the analysis due to potential bias in reporting, which prevented statistical testing.
Data Source: PMMIS, PPCG-DD utilization data, PPCG-EPD utilization data, and ALTCS Placement files were used in the analysis of RQ 5.2.
[1]Change in Rate compares the rate in the ramp-up period to the evaluation period.
ALTCS- DD: Ramp-up period (01/01/2023-03/31/2023) and evaluation period (04/01/2024-09/30/2024).
ALTCS-EPD: Evaluation period (04/01/2024–06/30/2024).

92 The ALTCS-EPD totals are based on a single average number of services provided to each member from April 1, 2024, to September 30, 2024.

Hypothesis 6: The PPCG service model will maintain or improve access to quality health services for the target population.

As described in the Data Sources section in the Methodology chapter, data used to identify ALTCS-DD members who received services through the PPCG service model were incomplete for 15 months in FFY 2023 and FFY 2024. Therefore, rates do not include members who only received services exclusively during this time period and may not represent the full PPCG population. Similarly, the data used to identify ALTCS-EPD members who received services through the PPCG service model were incomplete for 15 months, and one plan did not report FFY 2023 member-level utilization data. Therefore, FFY 2023 ALTCS-EPD rates are not reported.

Research Question 6.1: Did minor members receiving services through the PPCG service model maintain or improve their access to health services?

Table 7-32 utilized PMMIS, PPCG utilization, and ALTCS placement data to assess preventive health care access. Outcomes among ALTCS members who received services through the PPCG service model are compared to those enrolled in ALTCS who also lived at home and received HCBS through a traditional, non-parent provider service model.

Key Findings:

- **ALTCS-DD**
  - ALTCS-DD minors utilizing services through the PPCG service model accessed well-care visits within the first 30 months of life and between ages 3 and 18 years at slightly lower rates (1.68 and 0.23 percentage points lower, respectively) than ALTCS-DD minors also living at home and accessing home- and community-based services (HCBS) through a traditional, non-parent provider service model; however, results were not statistically significant (p=0.774 and p=0.766, respectively).
  - In FFYs 2023 and 2024, ALTCS-DD minors utilizing services through the PPCG service model were diagnosed with a mental health disorder at a higher rate, by 2.23 and 1.30 percentage points, respectively, compared to ALTCS-DD minors also living at home and accessing HCBS (p<0.001).
- **ALTCS-EPD**
  - In FFY 2024, the percentage of ALTCS-EPD minors with a well-care visit through the PPCG service model was 1.23 percentage points lower than ALTCS-EPD minors also living at home and accessing HCBS through a traditional, non-parent provider service model (p=0.825).
  - In FFY 2024, ALTCS-EPD minors utilizing services through the PPCG service model were diagnosed with a mental health disorder at a slightly higher rate, 0.77 percentage points, than ALTCS-EPD minors also living at home and accessing HCBS, although this difference was not statistically significant (p=0.880).

Although both ALTCS-DD and ALTCS-EPD members who received services through the PPCG service model accessed preventive care at lower rates than ALTCS-DD and ALTCS-EPD minors also living at home and accessing HCBS, differences were minor and not statistically significant. Members who received services through the PPCG service model were more likely to be diagnosed with a mental health disorder; however, this difference was only significant for the ALTCS-DD population.

Table 7-32—Research Question 6.1, Measures 6-1, 6-2, and 6-3

Did minor members receiving services through the PPCG service model maintain or improve their access to health services?			Ramp-Up Period		Evaluation Period	
			2023	Difference in Rates (*p*-value)	2024	Difference in Rates (*p*-value)
ALTCS-DD Population						
6-1	Percentage of members with well-child visits in the first 30 months of life					
	2 or more visits between the 15-month and 30-month birthday	PPCG service model	S	S	70.89%	-1.68pp (0.774)
		PPCG comparison	60.00%		72.57%	
	6 or more visits before the 15-month birthday	PPCG service model	S	S	S	S
		PPCG comparison	24.44%		38.10%	
6-2	Percentage of members 3–21 years of age with a well-care visit with a PCP or OB/GYN	PPCG service model	53.59%	0.00pp (1)	59.36%	-0.23pp (0.766)
		PPCG comparison	53.59%		59.59%	
6-3	Diagnosed mental health disorders	PPCG service model	94.62%	2.23pp *** (<0.001)	94.94%	1.30pp *** (<0.001)
		PPCG comparison	92.39%		93.63%	
ALTCS-EPD Population						
6-1	Percentage of members with well-child visits in the first 30 months of life					
	2 or more visits between the 15-month and 30-month birthday	PPCG service model		N/A	S	S
		PPCG comparison		N/A	S	
	6 or more visits before the 15-month birthday	PPCG service model		N/A	S	S
		PPCG comparison		N/A	S	
6-2	Percentage of members 3–21 years of age with a well-care visit with a PCP or OB/GYN	PPCG service model		N/A	49.69%	-1.23pp (0.825)
		PPCG comparison		N/A	50.92%	
6-3	Diagnosed mental health disorders	PPCG service model		N/A	65.91%	0.77pp (0.880)
		PPCG comparison		N/A	65.14%	

*p <0.1, **p <0.05, ***p <0.001

Note: S refers to rates involving denominators or numerators smaller than 11 members, which are suppressed due to potentially unreliable statistical testing and rate calculation and to ensure anonymity. ALTCS: Arizona Long Term Care System; DD: developmental disabilities; EPD: elderly and physically disabled; HCBS: home and community-based services; OB/GYN: obstetrician gynecologist; PCP: primary care provider; pp: percentage point; PPCG: Parents as Paid Caregivers. N/A indicates that data provided for the ALTCS-EPD ramp-up period were not included in the analysis due to potential bias in reporting.
Data Source: PMMIS, PPCG utilization data, and ALTCS Placement files were used in the analysis of RQ 6.1.
Ramp-up period (01/01/2023–03/31/2023) and evaluation period (04/01/2024–09/30/2024).

Research Question 6.2: Did the PPCG service model impact hospital utilization among ALTCS minors?

Table 7-33 utilized PMMIS, PPCG utilization, and ALTCS placement data to identify differences in hospital utilization. Outcomes among ALTCS members who received services through the PPCG service model are compared to ALTCS members also who lived at home and received HCBS through a traditional, non-parent provider service model.

Key Findings:

- **ALTCS-DD**
  - In FFY 2024, the *Number of emergent ED visits per 1,000 member months* and the *Number of non-emergent ED visits per 1,000 member months* among members who received services through the PPCG service model were nearly identical to the comparison group and no difference was statistically significant.

  - The *Number of IP stays per 1,000 member months* among members receiving services through the PPCG service model was lower than ALTCS-DD members also living at home receiving HCBS through a traditional, non-parent provider service model by 1.45 and 1.95 IP stays per 1,000 member months in FFYs 2023 and 2024, respectively (p=0.073 and p<0.001).
- **ALTCS-EPD**
  - Among ALTCS-EPD minors receiving services through the PPCG service model, the *Number of emergent ED visits per 1,000 member months* and the *Number of IP stays per 1,000 member months* were higher than ALTCS-EPD members also living at home receiving HCBS by 8.74 visits and 6.95 stays per 1,000 member months, respectively, though these differences were not statistically significant (p=0.496 and p=0.535).
  - The *Number of non-emergent ED visits* for members receiving services through the PPCG service model was 2.30 visits per 1,000 member months lower than members also living at home receiving HCBS through a traditional, non-parent provider service model (p=0.452).

In FFY 2024, ALTCS-DD members who received services through the PPCG service model had lower rates of IP stays compared to ALTCS-DD members who also lived at home and received HCBS. ALTCS-EPD members who received services through the PPCG service model had lower rates of non-emergent ED visits relative to the comparison population; however, this result was not statistically significant.

Table 7-33—Research Question 6.2, Measures 6-4, 6-5, and 6-6

Did the PPCG service model impact hospital utilization among ALTCS minors?			Ramp-Up Period		Evaluation Period	
			2023	Difference in Rates (p-value)	2024	Difference in Rates (p-value)
ALTCS-DD Population						
6-4	Number of emergent ED visits per 1,000 member months	PPCG service model	33.58	1.82	38.04	-0.15
		PPCG comparison	31.76	(0.266)	38.19	(0.909)
6-5	Number of non-emergent ED visits per 1,000 member months	PPCG service model	1.51	0.07	1.93	0.15
		PPCG comparison	1.44	(0.790)	1.78	(0.507)
6-6	Number of IP stays per 1,000 member months	PPCG service model	6.31	-1.45 *	5.79	-1.95 ***
		PPCG comparison	7.76	(0.073)	7.74	(<0.001)
ALTCS-EPD Population						
6-4	Number of emergent ED visits per 1,000 member months	PPCG service model		N/A	73.89	8.74
		PPCG comparison			65.15	(0.496)
6-5	Number of non-emergent ED visits per 1,000 member months	PPCG service model		N/A	4.99	-2.30
		PPCG comparison			7.29	(0.452)
6-6	Number of IP stays per 1,000 member months	PPCG service model		N/A	49.00	6.95
		PPCG comparison			42.05	(0.535)

*p <0.1, **p <0.05, ***p <0.001

Note: ALTCS: Arizona Long Term Care System; DD: developmental disabilities; ED: emergency department; EPD: elderly and physically disabled; HCBS: home and community-based services; IP: inpatient; PPCG: Parents as Paid Caregivers.
N/A indicates that data provided for the ALTCS-EPD ramp-up period were not included in the analysis due to potential bias in reporting.
Data Source: PMMIS, PPCG-EPD utilization data, and ALTCS Placement files were used in the analysis of RQ 6.2.
Ramp-up period (01/01/2023–03/31/2023) and Evaluation period (04/01/2024–09/30/2024).

Hypothesis 7: The PPCG service model and EFSS will improve self-assessed health outcomes.

Research Question 7.1: Do members receiving services through the PPCG service model or EFSS experience improved self-assessed health outcomes?

Table 7-34 utilized beneficiary surveys to assess members' parent's perceptions of their health outcomes. The survey results among members who are receiving services through the PPCG service model are limited to members enrolled in ALTCS-DD. The comparison population is comprised of ALTCS-DD minors who did not receive services from the PPCG service model. Due to concerns about low sample sizes, the ALTCS-EPD population was not surveyed.

Key Findings:

- ALTCS-DD members who received services through the PPCG service model had lower *Member rating of overall health* by 0.8 percentage points compared to ALTCS-DD children who did not receive services through the PPCG service model; however, this difference was not statistically significant (p=0.879).
- ALTCS-DD members who received services through the PPCG service model had higher *Member rating of overall mental or emotional health* by 7.4 percentage points compared to ALTCS-DD children who did not receive services through the PPCG service model (p=0.158).

ALTCS-DD members who received services through the PPCG service model reported higher ratings of overall mental or emotional health compared to ALTCS-DD children who did not receive services through the PPCG service model during the evaluation period.

Table 7-34—Research Question 7.1, Measures 7-1 and 7-2

Do members receiving services through the PPCG service model or EFSS experience improved self-assessed health outcomes?

		Evaluation Period Weighted Rate[1]		
		ALTCS-DD	PPCG-DD	Difference in Rates (p-value)
7-1	Member rating of overall health	51.1% N=146	50.3% N=217	-0.8pp (0.879)
7-2	Member rating of overall mental or emotional health	30.5% N=146	37.9% N=216	7.4pp (0.158)

*p <0.1, **p <0.05, ***p <0.001

Note: N represents the number of survey responses. Surveys were administered in calendar year (CY) 2025. ALTCS: Arizona Long Term Care System; DD: developmental disabilities; EFSS: Extended Family Support Services; pp: percentage point; PPCG: Parents as Paid Caregivers.
Data Source: Beneficiary surveys were used in the analysis of RQ 7.1.

[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP code.

Hypothesis 8: The PPCG service model will mitigate the DCW shortage by increasing timely accessibility to care providers.

Hypothesis 8 assessed if the PPCG service model enhanced ALTCS members' access to DCWs through paid DCW services provided by parent caregivers. Seven measures under one research question addressed this hypothesis utilizing a variety of data sources, including key informant interviews, PMMIS, PPCG utilization, DCW utilization, DCW relationship, and ALTCS placement data.

PPCG utilization data contains aggregated weekly units of DCW services rendered by parents to their children. DCW utilization data includes parent and non-parent DCW services rendered. DCW relationship data identifies if members receiving DCW services resided with their families. The use of modifiers was infrequent and may not fully represent the percentage of children living at home. ALTCS placement data consists of placement start/end dates among all ALTCS members, including members placed at home.

Due to limitations and discrepancies across data sources, several measures either could not be calculated or deviated from the Evaluation Design.

- Measure 8-4: *Proportion of parent DCWs of the total DCW population* could not be calculated with data currently available. Data to support measure calculation are anticipated to be available for the forthcoming Summative Evaluation Report.
- ALTCS-EPD Measures 8-1 and 8-7 could not be calculated due to DCW utilization data not being available for the EPD population. These data are anticipated to be available for the forthcoming Summative Evaluation Report.
- ALTCS-EPD Measure 8-5*: Percentage of members receiving respite services* relied on PPCG utilization data and was reported as an annual average due to data limitations.

Research Question 8.1: Did the PPCG service model alleviate the shortage of DCWs and increase timely access to needed care?

To examine Measure 8-2: *Reported challenges from workforce shortages* and Measure 8-3: *Reported changes in recruitment and retention of DCW workforce*, seven key informant interviews were conducted during September 2025. ALTCS providers reported that the PPCG service model expanded caregiver options by allowing parents to serve as formal caregivers, provided greater flexibility in care delivery, and improved continuity of care that may otherwise have been disrupted by workforce shortages and staff turnover. However, providers noted that PPCG did not fully eliminate the need for agency caregivers.

Table 7-35 used AHCCCS authorization data and DCW utilization data to identify the percentage of members authorized to receive DCW services who received those services. Table 7-36 utilized PMMIS, PPCG utilization data, and ALTCS placement data to identify the percentage of members who received respite services. Table 7-37 utilized PMMIS and PPCG utilization data to identify the number of hours paid weekly to parent DCWs. For each service type, the reported hours represent the number of member-weeks in which parent DCWs reported service hours for ALTCS-DD members, stratified by the number of hours worked in the week.

Additionally, Table 7-37 used PMMIS, PPCG utilization, and DCW-DD utilization data to identify the number of hours paid weekly to non-parent DCWs. Due to the member-week structure of the DCW data and the inability to distinguish between parent and non-parent DCW hours, weeks in which a member received services through the PPCG service model, as identified in the PPCG utilization data, were excluded from the analysis. Although this approach ensured the measure captured only service hours provided by non-parent DCWs, some non-parent DCW hours may have been excluded inadvertently. Therefore, the results may understate the number of non-parent DCW hours reported.

Key Findings:

- **ALTCS-DD**
  - The *Percentage of members authorized for and receiving DCW services* increased between the ramp-up and evaluation periods for attendant and habilitation care by 5.9 and 7.7 percentage points, respectively (p<0.001 for both).
  - The *Percentage of members receiving respite services* was 11.5 and 10.0 percentage points higher among members receiving services from the PPCG service model compared to ALTCS-DD minors who also live at home and receive HCBS through a traditional, non-parent provider service model in the ramp-up and evaluation periods, respectively (p<0.001 for both).
  - The *Number of hours paid weekly to parents providing services through the PPCG service model* increased among habilitation and attendant care services between the ramp-up and evaluation periods; however, additional months of data were provided during the evaluation period. Among both categories of service, parents predominantly provided 11 to 20 hours of DCW services, on average, each week[93].
  - The *Number of weekly hours non-parent DCWs provide services to minors* increased for habilitation and attendant care services between the ramp-up and evaluation periods. During the ramp-up and evaluation periods, the most common number of weekly hours provided by non-parent DCWs to minors ranged between 11 to 20 service hours weekly.
- **ALTCS-EPD**
  - ALTCS-EPD minors who received services from the PPCG service model utilized respite services at rates 4.2 percentage points lower than ALTCS-EPD minors also living at home and receiving HCBS through a traditional, non-parent provider service model (p=0.388).

The increase in the percentage of members authorized for and receiving DCW services indicates that members were increasingly able to access DCW services following the implementation of the PPCG service model.

Compared to ALTCS members living at home and receiving HCBS, rates of respite care utilization were higher among ALTCS-DD members who received services from the PPCG service model, while respite care utilization was lower among ALTCS-EPD members. This result indicates that alternative care options, such as respite care, are a notable piece of the overall DCW workforce. Utilization of both parent and non-parent DCW services increased among the ALTCS-DD population between the baseline and evaluation periods.

Table 7-35—Research Question 8.1, Measure 8-1

Did the PPCG service model alleviate the shortage of DCWs and increase timely access to care?			Ramp-Up Period Average	Evaluation Period 2024	Pre/Post Change in Rate[1] (p-value)
ALTCS-DD					
8-1	Percentage of members authorized for and receiving DCW services	Attendant Care	80.4%	86.3%	5.9pp *** (<0.001)
		Habilitation Care	77.6%	85.3%	7.7pp *** (<0.001)
ALTCS-EPD					
8-1	Percentage of members authorized for and receiving DCW services		N/A	N/A	N/A

*p <0.1, **p <0.05, ***p <0.001

Note: — indicates that data were not available to identify DCWs for habilitation care. N/A indicates that data provided for the ALTCS-EPD ramp-up period were not included in the analysis due to potential bias in reporting. N represents the denominator count. Modifiers were used to identify the number of members residing with their families. ALTCS: Arizona Long Term Care System; DCW: direct care worker; DD: developmental disabilities; EPD: elderly and physically disabled; HCBS: home and community-based services; PPCG: Parents as Paid Caregivers.

Data Source: AHCCCS Authorization, DCW Utilization, DCW, PPCG-DD utilization, PPCG-EPD uilization, and PMMIS data were used in the analysis of RQ 8.1.

[1]Pre/Post in Rate compares the average in the ramp-up period to the evaluation period.

Measure 8-1: Ramp-up period (10/01/2021–09/30/2023) and evaluation period (10/01/2023–09/30/2024).

Measure 8-4: Ramp-up period (CYs 2021, 2022, 2023) and evaluation period (01/01/2024–10/31/2024).

93 The 40 hour weekly maximum was not implemented until June 2025.

Table 7-36—Research Question 8.1, Measures 8-5

Did the PPCG service model impact hospital utilization among ALTCS minors?			Ramp-Up Period	Evaluation Period	
			Difference in Rates (*p*-value)	2024	Difference in Rates (*p*-value)
ALTCS-DD Population					
8-5	Percentage of members receiving respite services	PPCG service model	11.5pp *** (<0.001)	64.5%	10.0pp *** (<0.001)
		PPCG comparison		54.6%	
ALTCS-EPD Population					
8-5	Percentage of members receiving respite services	PPCG service model	N/A	31.6%	-4.2pp (0.388)
		PPCG comparison		35.8%	

*p <0.1, **p <0.05, ***p <0.001

Note: N/A indicates that data provided for the ALTCS-EPD ramp-up period were not included in the analysis due to potential bias in reporting. ALTCS: Arizona Long Term Care System; DD: developmental disabilities; EPD: elderly and physically disabled; PPCG: Parents as Paid Caregivers.
Data Source: PMMIS, PPCG-EPD utilization data, and ALTCS Placement files were used in the analysis of RQ 8.1.
ALTCS-DD: Ramp-up period (10/01/2022–09/30/2023) and evaluation period (10/01/2023–09/30/2024).
ALTCS-EPD: Evaluation period (01/01/2024–10/31/2024).

Table 7-37—Research Question 8.1, Measures 8-6 and 8-7

Did the PPCG service model improve or maintain care stability for ALTCS minors?			Ramp-Up Period Average		Evaluation Period	
		Weekly Hours Provided to Members	Habilitation Care Hours	Attendant Care Hours	Habilitation Care Hours	Attendant Care Hours
ALTCS-DD Population						
8-6	Number of hours paid weekly to parents providing PPCG services	1 to 10	11,201	2,870	39,472	14,702
		11 to 20	14,485	6,648	59,506	32,802
		21 to 30	4,508	4,306	23,003	25,210
		31 to 40	1,389	2,607	9,476	19,265
		40 +	250	1,266	1,667	7,666
8-7	Number of weekly hours non-parent DCWs provide services to minors	1 to 10	44,975	7,955	35,026	11,062
		11 to 20	48,191	18,899	46,666	22,005
		21 to 30	14,669	13,748	17,788	16,283
		31 to 40	4,759	9,481	7,313	13,264
		40 +	829	5,253	1,088	7,683

Note: ALTCS: Arizona Long Term Care System; DCW: direct care worker; PPCG: Parents as Paid Caregivers.
Data Source: DCW Utilization and PMMIS Data were used in the analysis of RQ 8.1.
Measure 8-6: Ramp-up Period (01/01/2023-03/31/2023) and Evaluation period (04/01/2024-09/30/2024).
Measure 8-7: Ramp-up Period (10/01/2020-09/30/2023) and Evaluation period (10/01/2023-09/30/2024).

Hypothesis 9: The PPCG service model will improve ongoing care stability for the target population.

Research Question 9.1: Did the PPCG service model improve or maintain care stability for ALTCS minors?

Table 7-38 utilized DCW data to identify the average number of parent and non-parent DCWs among members who utilized services through the PPCG service model.[94] The available data for Measure 9-1: *Average number of DCWs per member per year* were aggregated by calendar years (CYs) and did not include pre-implementation

94 The PPCG service model was approved through Appendix K authority in March 2020. On February 16, 2024, CMS approved the PPCG service model under Waiver authority. Programmatic changes based on Waiver requirements, such as the 40 hour weekly limitation, were not implemented until June 2025.

data to compare outcomes prior to PPCG implementation. A full year of post-implementation data were unavailable, which limited the ability to draw conclusions regarding changes in DCW stability.

Key Findings:

- **ALTCS-DD**
  - The *Average number of DCWs per member per year* declined among ALTCS-DD members who received attendant and habilitation care through the PPCG service model. In the ramp-up period, an average of 1.69 DCWs per member provided attendant care services, which decreased to an average of 1.56 in the evaluation period (p=0.022). Habilitation care followed a similar trend, decreasing from an average of 1.50 DCWs providing services in the ramp-up period to 1.40 DCWs in the evaluation period (p=0.027).
- **ALTCS-EPD**
  - The *Average number of DCWs per member per year* providing attendant care services to ALTCS-EPD members who received care through the PPCG service model increased by an average of 0.09 DCWs from the ramp-up period to the evaluation period (p=0.034).

The average number of unique DCWs providing services per member decreased for the ALTCS-DD minor population for both service types and increased among ALTCS-EPD minors receiving attendant care services. The decline in unique DCWs per ALTCS-DD member may indicate that members increasingly received services from a parent caregiver, which may improve care stability.

Table 7-38—Research Question 9.1, Measure 9-1

Did the PPCG service model improve or maintain care stability for ALTCS minors?			Ramp-Up Period Average	Evaluation Period 2024	Pre/Post Change in Rate[1] (p-value)
ALTCS-DD Population					
9-1	Average number of DCWs per member per year	Habilitation Care	1.50	1.40	0.03 ** (0.027)
		Attendant Care	1.70	1.56	-0.14 ** (0.022)
ALTCS-EPD Population					
9-1	Average number of DCWs per member per year	Habilitation Care	S	S	S
		Attendant Care	1.37	1.47	0.09 ** (0.034)

Note: S refers to rates involving denominators or numerators smaller than 11 members, which are suppressed due to potentially unreliable statistical testing and rate calculation and to ensure anonymity. DCW: direct care worker.
Data Source: DCW data were used in the analysis of RQ 9.1.
[1]Change in Rate compares the average in the ramp-up period to the evaluation period.
ALTCS-DD: Ramp-up period (CYs 2021, 2022, 2023) and evaluation period (01/01/2024–10/31/2024).
ALTCS-EPD: Ramp-up period (CYs 2021, 2022, 2023) and evaluation period (CY 2024).
Results are limited to members who were enrolled in and receiving services from the PPCG service model at any point between CY 2023–2025.

Table 7-39 utilized beneficiary surveys to assess members' perception of care stability.

Key Findings:

- The *Percentage of members or caregivers who reported that turnover among paid workers "Usually" or "Always" negatively impacted their child's care* was 11.4 percentage points higher among ALTCS-DD members who received services through the PPCG service model compared to ALTCS-DD children who did not receive services through the PPCG service model (p=0.028).
- The *Percentage of members or caregivers who reported that care needs were "Usually" or "Always" not met by paid caregivers* was 3.3 percentage points higher among ALTCS-DD members who received services through the PPCG service model compared to ALTCS-DD children who did not receive services through the PPCG service model (p=0.327).

ALTCS-DD members who received services through the PPCG service model reported higher rates of care instability compared to ALTCS-DD children who did not receive services through the PPCG service model.

Table 7-39—Research Question 9.1, Measure 9-2

Did the PPCG service model improve or maintain care stability for ALTCS minors?		Evaluation Period Weighted Rate[1]		
		ALTCS-DD	PPCG-DD	Difference in Rates (*p*-value)
9-2	Percentage of members or caregivers who reported care stability as good or excellent			
	Percentage of members or caregivers who received caregiver support through their health care plan	60.6% N=150	55.3% N=223	-5.2pp (0.330)
	Percentage of members or caregivers who reported that turnover among paid care workers "Usually" or "Always" negatively impacted their child's care (lower is better)	27.1% N=150	38.5% N=221	11.4pp ** (0.028)
	Percentage of members or caregivers who reported that care needs were "Usually" or "Always" not met by paid care workers	9.4% N=149	12.7% N=219	3.3pp (0.327)

*p <0.1, **p <0.05, ***p <0.001

Note: N represents the number of survey responses. Surveys were administered in calendar year (CY) 2025. ALTCS: Arizona Long Term Care System; DD: developmental disabilities; pp: percentage point; PPCG: Parents as Paid Caregivers.
Data Source: Beneficiary surveys were used in the analysis of RQ 9.1.
[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP code.

To examine Measure 9-3, *DES/DDD/EPD's and providers' reported barriers to care stability*, five key informant interviews were conducted in September 2025. Providers reported that the PPCG service model allowed them to accept referrals for some ALTCS minors that would otherwise have declined due to the availability of a parent caregiver through PPCG. Providers highlighted that the PPCG service model improved stability for ALTCS minors, as parent caregivers were less likely to experience turnover than agency caregivers, supporting continuity of care. However, providers noted challenges related to the 40 hour a week limit for parent caregivers, which often required additional caregivers, such as other family members or agency caregivers, to meet members' full care needs. DES/DDD reported that the PPCG service model showed promise due to improved care stability for ALTCS minors; however, DES/DDD noted that the service model has led to increased and more consistent utilization, which requires close monitoring of budget implications.

Hypothesis 10: The PPCG service model and EFSS will increase member and family unit stability through increased ability to navigate the health care system and decrease stress and burnout.

Research Question 10.1: Has EFSS restored, enhanced, or maintained family functioning by preserving effective care for members in the home and community?

The EFSS program had not been implemented at the time of developing this Interim Evaluation Report. In lieu of responses specific to the EFSS population, relevant survey questions were asked among members who received services through the PPCG service model. The responses from the surveys do not directly answer Research Question 10.1, which is specific to the EFSS population, but instead provide additional context to the broader themes of burnout and stress addressed under Hypothesis 10.

Table 7-40 utilized surveys to assess members' perceptions of family functioning.

Key Findings:

- The *Percentage of members or caregivers who reported high levels of stress* was 6.9 percentage points higher among ALTCS-DD members who received services through the PPCG service model compared to ALTCS-DD children who did not receive services through the PPCG service model (*p*=0.171).
- The *Percentage of members or caregivers who reported their ability to navigate the health care system* as good or excellent was 2.5 percentage points higher among ALTCS-DD members who received services through the PPCG service model compared to ALTCS-DD children who did not receive services through the PPCG service model (*p*=0.664).
- The *Percentage of members or caregivers who reported their adjustment to disability* as good or excellent was 5.6 percentage points higher among ALTCS-DD members who received services through the PPCG service model compared to ALTCS-DD children who did not receive services through the PPCG service model (*p*=0.303).

ALTCS-DD members or caregivers who received or provided services through the PPCG service model had higher reported levels of stress compared to ALTCS-DD children who did not receive services through the PPCG service model; however, ALTCS-DD members or caregivers who received or provided services through the PPCG service model reported higher rates of ability navigating the health care system and adjustment to disability.

Table 7-40—Research Question 10.1, Measures 10-1 through 10-3

Has EFSS restored, enhanced, or maintained family functioning by preserving effective care for members in the home and		Evaluation Period Weighted Rate[1]		
		ALTCS-DD	PPCG-DD	Difference in Rates (*p*-value)
10-1	Percentage of members or caregivers who reported high levels of stress (lower is better)	26.4% N=150	33.3% N=218	6.9pp (0.171)
10-2	Percentage of members or caregivers who reported their ability to navigate the healthcare system as good or excellent	58.4% N=132	60.9% N=192	2.5pp (0.664)
10-3	Percentage of members or caregivers who reported their adjustment to disability as good or excellent	41.6% N=149	47.2% N=218	5.6pp (0.303)

*p <0.1, **p <0.05, ***p <0.001

Note: N represents the number of survey responses. Surveys were administered in calendar year (CY) 2025. ALTCS: Arizona Long Term Care System; DD: developmental disabilities; EFSS: Extended Family Support Services; pp: percentage point; PPCG: Parents as Paid Caregivers.
Data Source: Beneficiary surveys were used in the analysis of RQ 10.1.

[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP code.

Research Question 10.2: Has the PPCG service model and EFSS reduced burnout and provided alternate supports for caregivers?

Table 7-41 utilized surveys to assess caregivers' perceptions of burnout.

Key Findings:

- The *Percentage of caregivers that report caregiving is physically tiring* was 4.7 percentage points higher among those providing services to ALTCS-DD members who received services through the PPCG service model compared to those providing services to ALTCS-DD children who did not receive services through the PPCG service model (*p*=0.375).
- The *Percentage of caregivers that report that caregiving required them to change their personal plans* was 5.6 percentage points higher among those providing services to ALTCS-DD members who received services through the PPCG service model compared to those providing services to ALTCS-DD children who did not receive services through the PPCG service model (*p*=0.303).

- The *Percentage of caregivers that report that caregiving takes a lot of their strength* was 9.5 percentage points higher among those providing services to ALTCS-DD members who received services through the PPCG service model compared to those providing services to ALTCS-DD children who did not receive services through the PPCG service model (*p*=0.083).
- The *Percentage of caregivers that report feeling overwhelmed from caregiving* was 6.5 percentage points higher among those providing services to ALTCS-DD members who received services through the PPCG service model compared to those providing services to ALTCS-DD children who did not receive services through the PPCG service model (*p*=0.199).
- The *Percentage of caregivers that report being able to take care of themselves and recharge* was 3.3 percentage points lower among those providing services to ALTCS-DD members who received services through the PPCG service model compared to those providing services to ALTCS-DD children who did not receive services through the PPCG service model (p=0.514).

The percentage of caregivers that reported high levels of burnout was higher for caregivers providing services to ALTCS-DD members receiving services through the PPCG service model.

Table 7-41—Research Question 10.2, Measure 10-4

Has the PPCG service model and EFSS reduced burnout and provided alternate supports for caregivers?		Evaluation Period Weighted Rate[1]		
		ALTCS-DD	PPCG-DD	Difference in Rates (*p*-value)
10-4	Percentage of caregivers that report high levels of burnout			
	Percentage of caregivers that report caregiving is physically tiring (lower is better)	34.1% N=148	38.7% N=217	4.7pp (0.375)
	Percentage of caregivers that report that caregiving required them to change their personal plans (lower is better)	41.6% N=149	47.2% N=218	5.6pp (0.303)
	Percentage of caregivers that report caregiving takes a lot of their strength (lower is better)	42.6% N=147	52.1% N=217	9.5pp * (0.083)
	Percentage of caregivers that report feeling overwhelmed from caregiving (lower is better)	26.4% N=147	32.9% N=217	6.5pp (0.199)
	Percentage of caregivers that report being able to take care of themselves and recharge (lower is better)	31.5% N=145	28.2% N=217	-3.3pp (0.514)

*p <0.1, **p <0.05, ***p <0.001

Note: N represents the number of survey responses. Surveys were administered in calendar year (CY) 2025. ALTCS: Arizona Long Term Care System; DD: developmental disabilities; EFSS: Extended Family Support Services; pp: percentage point.

Data Source: Beneficiary surveys were used in the analysis of RQ 10.2.

[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP code.

Table 7-42 utilized PMMIS and utilization data to identify the percentage of members receiving services from the PPCG service model who utilized respite services.[95] Respite care utilization can provide insight into the options available to, and used by, parents of minor children to assist with caretaking. Rates among ALTCS-DD and ALTCS-EPD minors also living at home who received HCBS through a traditional, non-parent provider service model are presented as a comparison.

[95] Respite care is a short-term care option available to ALTCS enrollees to "relieve primary caregivers" by providing a respite provider when a need is identified. Department of Economic Security. Respite Project FAQs. Available at: https://des.az.gov/sites/default/files/Respite_Project_FAQs.pdf. Accessed on: Mar 12, 2026.

Key Findings:

- **ALTCS-DD**
  - Members receiving services from the PPCG service model utilized respite services at a higher rate than ALTCS-DD minors also living at home and receiving HCBS through a traditional, non-parent provider service model in SFYs 2023 and 2024; however, rates declined by 5.1 percentage points and 3.5 percentage points between the ramp-up and evaluation periods for both groups, respectively.
- **ALTCS-EPD**
  - Among members receiving services from the PPCG service model, 31.6 percent utilized respite services, which was 3.2 percentage points lower than the rate among ALTCS-EPD minors also living at home and receiving HCBS through a traditional, non-parent provider service model.

Respite service utilization declined among ALTCS-DD and ALTCS-EPD members. Respite care services were available to ensure parents have alternative care options for their minor children, and a decline in these rates may indicate that a service need was not fulfilled.

Table 7-42—Research Question 10.2, Measure 10-5

Has the PPCG service model and EFSS reduced burnout and provided alternate supports for caregivers?			Ramp-Up Period		Evaluation Period	
			2023	Difference in Rates (*p* -value)	2024	Difference in Rates (*p* -value)
ALTCS-DD Population						
10-5	Percentage of parent caregivers who utilize respite services	PPCG service model	69.6%	11.5pp *** (<0.001)	64.5%	10.0pp *** (<0.001)
		PPCG comparison	58.1%		54.6%	
ALTCS-EPD Population						
10-5	Percentage of parent caregivers who utilize respite services	PPCG service model	N/A	N/A	31.6%	-4.2pp (0.388)
		PPCG comparison	N/A		35.8%	

*p <0.1, **p <0.05, ***p <0.001

Note: ALTCS: Arizona Long Term Care System; DD: developmental disabilities; EFSS: Extended Family Support Services; EPD: elderly and physically disabled; PPCG: Parents as Paid Caregivers.

N/A indicates that data provided for the ALTCS-EPD ramp-up period were not included in the analysis due to potential bias in reporting.

Data Source: PMMIS, PPCG-EPD utilization data, and ALTCS Placement files were used in the analysis of RQ 10.2.

ALTCS-DD: Ramp-up period (10/01/2022–09/30/2023) and evaluation period (10/01/2023–09/30/2024).

ALTCS-EPD: Evaluation period (01/01/2024–10/31/2024).

Hypothesis 11: The PPCG service model and EFSS will maintain or improve community integration and well-being for members.

Hypothesis 11 measured if the PPCG service model maintained or improved community integration and member well-being. EFSS baseline rates are provided, where possible by leveraging NCI-IDD AFS and NCI-AD results, as the program was not operationalized at the time of this Interim Evaluation Report. PMMIS, PPCG utilization, NCI-IDD AFS, NCI-AD, and AHCCCS Quality of Care data assessed Hypothesis 11.

Measure 11-8: *The percentage of respondents who report that they would like help to meet new people, make new friends, or keep in contact with friends* and Measure 11-9: *The percentage of respondents who report often feeling lonely* could not be reported for the to address baseline rates among those who may be eligible for the EFSS, as the NCI AFS data did not include the relevant survey items for 2023/2024.

AHCCCS Quality of Care data were utilized to identify substantiated cases of abuse or neglect among ALTCS-DD and ALTCS-EPD members. This measure was anticipated to be reported as a rate among members receiving

services from the PPCG service model; however, the number of cases among the entire ALTCS minor population were reported based on data availability.

Furthermore, to ensure accuracy of reporting and alignment with the NCI results, some measure names throughout this Hypothesis have been updated to align with the exact wording of the respective NCI survey. Table 7-43 details this information.

Table 7-43—NCI Survey Crosswalk

Measure		Survey	Survey Language	Numerator Criteria
11-7	The percentage of respondents who report having friendships with people other than staff or family members	NCI-AFS	Does your family member have friends other than paid support workers or family?	Respondent answered "Yes"
11-8	The percentage of respondents who report that they would like help to meet new people, make new friends, or keep in contact with friends	NCI-AFS	Not Reported	N/A
11-9	The percentage of respondents who report often feeling lonely	NCI-AFS	Not Reported	N/A
11-9	The percentage of respondents who report often feeling lonely	NCI-AD	Often feels lonely	Respondent answered "Yes" or "Often"
11-10	Community inclusion scale	NCI-AFS	Does your family member do things in the community?	Respondent answered "Yes"

Note: AFS: Adult Family Survey; AD: Aging and Disabilities; FGS: Family Guardian Survey; NCI: National Core Indicators; N/A: not applicable.

Research Question 11.1: Do members receiving services through the PPCG service model and EFSS have the same or lower rates of social isolation?

Table 7-44, Figure 7-4, and Figure 7-5 utilized beneficiary surveys conducted in 2025 to assess member's rates of social isolation. Four measures are used to examine social isolation through a variety of survey questions. Measure 11-1 (*Percentage of members or caregivers who reported low rates of social isolation*) uses one survey question assessing the percentage of members with relationships with family members their age. Measure 11-2 (*Average time spent outside the home*) was measured through one survey question assessing approximate number of hours members spent outside the home. Measure 11-3 (*Relationships outside of the home*) uses two survey questions assessing the percentage of members who have friends that are not paid support workers or are outside of the family. Measure 11-4 (*Socialization outside of the home*) is measured through identifying the number of respondents who indicated time was spent in a variety of social settings.

Key Findings:

- The *Percentage of members with relationships with family members their age* was 0.3 percentage points higher among ALTCS-DD members who received services through the PPCG service model compared to ALTCS-DD members who did not receive services through the PPCG service model (p=0.942).
- *Average time spent outside the home* is reported as the percentage of among members using services through the PPCG service model and ALTCS-DD members who did not receive services through the PPCG service model who reported spending time outside the home with friends or peers their age. Generally, members who received services through the PPCG service model spent more hours per week outside of the home on average compared to ALTCS-DD members who did not receive services from the PPCG service model. No statistical testing was conducted for this measure.
- To measure *Relationships outside of the home*, the percentage of members who have friends that are not paid support workers were 8.4 percentage points higher (p=0.121) among the PPCG-aligned group than ALTCS-DD members who did not receive services through the PPCG service model. Similarly, the percentage of members who have friends outside of the family was 6.2 percentage points higher (p=0.193) among PPCG-aligned members compared to ALTCS-DD members were not.

- *Socialization outside of the home* was assessed through identifying the number of respondents who indicated time was spent in a variety of social settings. Overall, ALTCS-DD members who received services from the PPCG service model reported higher rates of spending time with friends or peers among all settings compared to ALTCS-DD members who did not receive services from the PPCG service model, except shopping. Type of schooling is assessed through the percentage of respondents who reported attending each school setting and the average number of hours spent in school each week. Members receiving services through the PPCG service model were homeschooled and attended charter schools at a slightly higher rate compared to ALTCS-DD members who did not receive services through the PPCG service model. Furthermore, members who received services through the PPCG service model reported spending more than 20 hours a week in a school setting compared to ALTCS-DD minors who did not receive services through the PPCG service model.

Rates of social isolation were generally lower among members receiving services through the PPCG service model compared to ALTCS-DD minors who did not receive services through the PPCG service model. Specifically, members receiving services through the PPCG service model had higher rates of friendships outside of the family and socialization in settings outside of the home.

Table 7-44—Research Question 11.1, Measures 11-1, 11-3, and 11-4

Do members receiving services through the PPCG service model and EFSS have the same or lower rates of social isolation?		Evaluation Period Weighted Rate[1]		
		ALTCS-DD	PPCG-DD	Difference in Rates (*p*-value)
11-1	Percentage of members or caregivers who reported low rates of social isolation			
	Percentage of members with relationships with family members their age	86.4% N=91	86.8% N=146	0.3pp (0.942)
11-3	Relationships outside of the home			
	Relationships outside of the home	86.4% N=91	86.8% N=146	0.3pp *** (<0.001)
	Percentage of members who have friends that are not paid support workers	52.9% N=147	61.3% N=213	8.4pp (0.121)
	Percentage of members who have friends outside of the family	83.6% N=86	89.8% N=140	6.2pp (0.193)
11-4	Socialization outside of the home	82.1% N=161	85.4% N=229	3.2pp (0.394)
	Number of members who spent time with friends or peers, shopping	15.2% N=161	11.8% N=229	-3.4pp (0.334)
	Number of members who spent time with friends or peers, entertainment	22.6% N=161	23.1% N=229	0.6pp (0.895)
	Number of members who spent time with friends or peers, parks/recreation	38.0% N=161	41.4% N=229	3.4pp (0.506)
	Number of members who spent time with friends or peers, coffee shop/restaurant	6.6% N=161	11.2% N=229	4.7pp (0.128)
	Number of members who spent time with friends or peers, religious/spiritual services	20.4% N=161	32.2% N=229	11.8pp ** (0.013)
	Number of members who spent time with friends or peers, other groups, organizations, or communities	38.4% N=161	40.4% N=229	2.0pp (0.698)

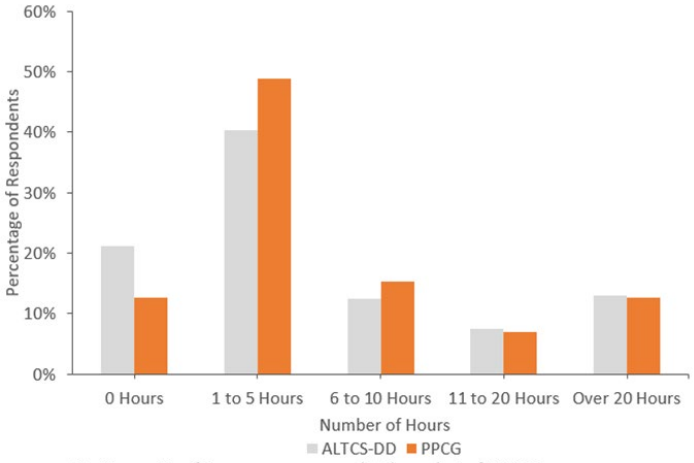
*p <0.1, **p <0.05, ***p <0.001

Note: S refers to rates involving numerators between 1 and 10 members or denominators smaller than 30 members, which are suppressed due to potentially unreliable statistical testing and rate calculation and to ensure anonymity. N represents the number of survey responses. Surveys were administered in calendar year (CY) 2025. ALTCS: Arizona Long Term Care System; DD: developmental disabilities; EFSS: Extended Family Support Services; pp: percentage point; PPCG: Parents as Paid Caregivers.

Data Source: Beneficiary surveys were used in the analysis of RQ 11.1.

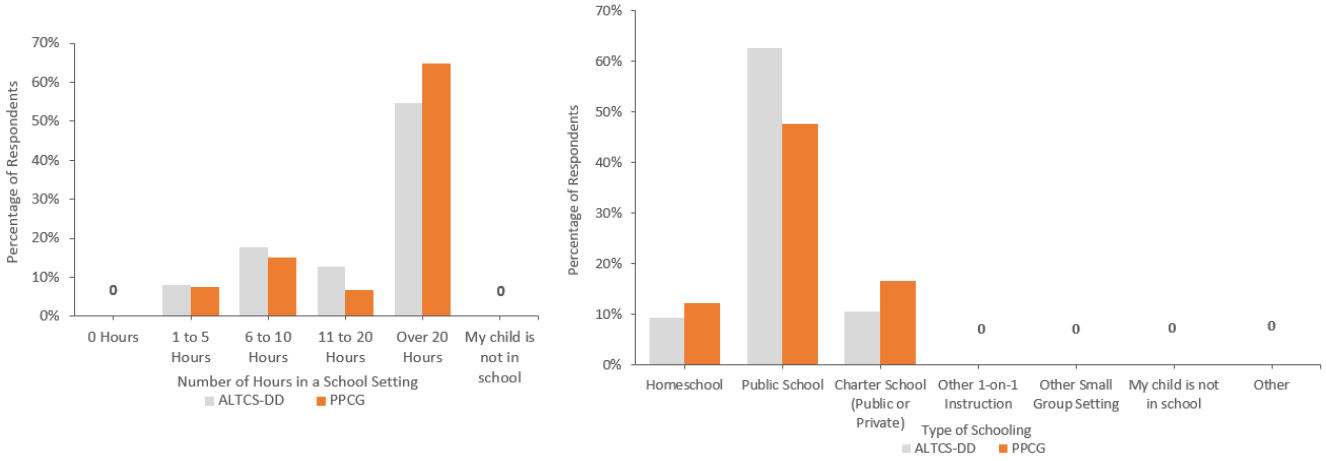
[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP code.

Figure 7-4—Research Question 11.1, Measure 11-2



Data Source: Beneficiary surveys were used in the analysis of RQ 11.1.

Figure 7-5—Research Question 11.1, Measure 11-5



Data Source: Beneficiary surveys were used in the analysis of RQ 11.1.

Analysis of NCI-DD surveys and claims/encounter data for day program service utilization indicated that members receiving services through the PPCG service model had slightly higher rates of social isolation; however, ALTCS-DD members generally had higher rates of community participation than members nationally, indicating lower rates of social isolation. Day program services provided assistance to children to strengthen daily living and social skills in a community setting. Declining day program services may indicate that members were not accessing a service that could improve community integration.

Key Findings:

- **ALTCS-DD**
  - Day program utilization among members receiving care through the PPCG service model declined by 1.8 percentage points between SFYs 2023 and 2024. During the same period, utilization declined by 1.1 percentage points among members living at home receiving HCBS.

- **ALTCS-EFSS**
  - The 2023/2024 NCI AFS survey reported that 65 percent of Arizona respondents indicated that their family member had friends other than paid support workers or family, which was 6 percentage points higher than the national average (*p*=0.088).
  - The 2023/2024 NCI AFS survey reported that 85 percent of Arizona respondents indicated "Yes" to the question "*Does your family member do things in the community*", which was 2 percentage points higher than the national average (*p*=0.448).
  - The 2023/2024 NCI-AD survey reported that 14 percent of Arizona respondents indicated they often felt lonely, which was 7 percentage points lower than the national average (*p*=0.014).

Table 7-45 utilized PMMIS and PPCG utilization data to identify the percentage of members who received services from the PPCG service model and utilized day program services. Rates among ALTCS-DD and ALTCS-EPD minors illustrate utilization among minor members living at home who received HCBS but did not receive services through the PPCG service model.

Table 7-45—Research Question 11.1, Measure 11-6

Do members receiving services through the PPCG service model and Extended Family Support services have the same or lower rates of social isolation?				
			Ramp-Up Period	Evaluation Period
			2023	2024
ALTCS-DD Population				
11-6	Percentage of members engaging with day program services	PPCG service model	9.1%	7.4%
		PPCG comparison	9.3%	8.2%
ALTCS-EPD Population				
11-6	Percentage of members engaging with day program services	PPCG service model	N/A	S
		PPCG comparison	N/A	S

Note: S refers to rates involving denominators or numerators smaller than 11 members, which are suppressed due to potentially unreliable statistical testing and rate calculation and to ensure anonymity. ALTCS: Arizona Long Term Care System; DD: developmental disabilities; EPD: elderly and physically disabled; HCBS: home and community-based services; PPCG: Parents as Paid Caregivers.
Data Source: PMMIS and PPCG Utilization data were used in the analysis of RQ 11.1.
ALTCS-DD: Ramp-up period (10/01/2022–09/30/2023) and evaluation period (10/01/2023–09/30/2024).
ALTCS-EPD: Evaluation period (01/01/2024–10/31/2024).

Table 7-46 displays NCI-IDD AFS and NCI-AD results to contextualize statewide rates of community integration prior to EFSS implementation. The AFS represents responses from individuals completing the survey on behalf of their adult family members who lived at home and received at least one service in addition to case management from the DDD. The NCI-AD represents members answering on their own behalf, although proxy respondents may be used. Since EFSS was not operationalized at the time of this evaluation, results provided insight into social isolation and community inclusion among adults with developmental or physical disabilities as well as those who are elderly statewide prior to EFSS. Responses were not limited to EFSS members but provided insight into the overall rate of community inclusion among individuals with developmental or physical disabilities as well as those who are elderly statewide. Analyses assessing changes in community integration will be included in the Summative Evaluation Report.

Table 7-46—Research Question 11.1, Measures 11-7, 11-9, and 11-10

Do members receiving services through the PPCG service model and EFSS have the same or lower rates of social isolation?			2023/2024			
			Number of Responses	Rate	Difference	*p* -value
ALTCS-DD						
11-7	Does your family member have friends other than paid support workers or family?	Arizona	198	65%	6pp	0.088 *
		National	17,419	59%		
11-10	Does your family member do things in the community?	Arizona	205	85%	2pp	0.448 *
		National	17,917	83%		
ALTCS-EPD						
11-9	Often feels lonely	Arizona	205	14%	-7pp	0.014 **
		National	15,084	21%		

*p <0.1, **p <0.05, ***p <0.001

Note: Measures 11-8 and 11-9 are not available for the EFSS population because the NCI-IDD AFS conducted did not contain the relevant survey items. Results were presented from the NCI-AD survey for the ALTCS-EPD population when available. AD: Aging and Disabled; AFS: Adult Family Survey; EFSS: Extended Family Support Services; pp: percentage point; NCI: National Core Indicators; PPCG: Parents as Paid Caregivers.
Data Source: NCI-IDD Adult Family Survey (2023–2024) and NCI-AD Survey (2023-2024) data were used in the analysis of RQ 11.1.

Research Question 11.2: Do members receiving services through the PPCG service model have the same or lower rates of reported cases of child maltreatment?

Table 7-47 leverages data from AHCCCS to identify the number of ALTCS-DD or ALTCS-EPD minors who had a substantiated case of abuse or neglect.[96]

Key Findings:

- **ALTCS-DD (PPCG)**
  - During the ramp-up period, there was an average of 349 substantiated cases of abuse or neglect among ALTCS-DD minor members. This count increased to 360 cases in the evaluation period (p=0.948). When accounting for shifts in enrollment, the rate of substantiated cases of abuse or neglect declined by 2.1 cases per 1,000 members between the ramp-up and evaluation periods (p=0.034).
- **ALTCS-EPD (PPCG)**
  - The count of substantiated cases of abuse or neglect generally could not be reported due to suppression standards.

In CY 2024, ALTCS-DD members' reported counts of abuse or neglect declined from their highest point in CY 2023.

[96] To ensure anonymity, results were provided in an aggregate format and were not limited to members who received services from the PPCG service model.

Table 7-47—Research Question 11.2, Measure 11-11

Do members receiving services through the PPCG service model have the same or lower rates of reported cases of child maltreatment?			Ramp-Up Period			Ramp-Up Period Average	Evaluation Period	Pre/Post Change[1] (*p*-value)
			2021	2022	2023		2024	
ALTCS-DD								
11-11	Number of members with substantiated cases of abuse or neglect	Count	297	254	496	349	360	11 (0.948)
		Rate per 1,000 members	15.4	12.7	23.0	17.0	15.1	-2.1 ** (0.034)
ALTCS-EPD								
11-11	Number of members with substantiated cases of abuse or neglect	Count	13	S	S	13	S	S
		Rate per 1,000 members	30.5	S	S	30.5	S	S

*p <0.1, **p <0.05, ***p <0.001

Note: S refers to rates involving denominators or numerators smaller than 11 members, which are suppressed due to potentially unreliable statistical testing and rate calculation and to ensure anonymity. Displayed average values are built upon unsupressed values. ALTCS: Arizona Long Term Care System; DD: developmental disabilities; EPD: elderly and physically disabled; PPCG: Parents as Paid Caregivers.

Data Source: AHCCCS Quality of Care data were used in the analysis of RQ 11.2.

[1]The pre/post change reflects the average count or rate in the ramp-up period to the evaluation period.
ALTCS-DD, ALTCS-EPD: Ramp-up period (10/01/2021–09/30/2023) and evaluation period (10/01/2023–09/30/2024).

Hypothesis 12: ALTCS provides cost-effective care.

There are no specific measures associated with this hypothesis. To assess the cost-effectiveness of care provided, an interrupted time series (ITS) analysis was conducted on the cost of care to analyze the differences between actual and projected costs during the evaluation period, which is intended to address RQs 12.1, 12.2, 12.3, and 12.4. Separate analyses are conducted at the per-member per-month (PMPM) level and at the total aggregated cost level. Costs were adjusted for medical inflation and are presented in terms of September 2024 dollars.

It is important to note that the cost analyses do not refer to or attempt to replicate the formal Budget Neutrality test required for Section 1115 Waiver Demonstrations.[97] Additionally, the cost-effectiveness analysis does not involve a direct comparison of costs and savings, as program benefits may be non-pecuniary in nature, such as provision of new services that previously were unavailable or lower mortality rates and improved health outcomes overall. ALTCS members are provided with case management and services specific to their care needs, which is intended to provide person-centered and cost-effective care to each member. ALTCS plans are required to evaluate the cost-effectiveness of provided care on an individual level. Furthermore, some outcomes may manifest over an extended period of time and may not be measurable at the time of the evaluation.

As described in the Data Sources section in Chapter 4, data used to identify ALTCS-DD who received services through the PPCG service model were incomplete for 15 months in FFY 2023 and FFY 2024. Therefore, rates do not include members who only received services exclusively during this time period and may not represent the full PPCG population. Similarly, the data used to identify ALTCS-EPD members who received services through

97 Centers for Medicare & Medicaid Services. Budget Neutrality SMDL for Section 1115(a) Medicaid Demonstration Project. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd24003.pdf. Accessed on: Jan 26, 2026.

the PPCG service model were incomplete for 15 months, and one plan did not report FFY 2023 member-level utilization data. Therefore, FFY 2023 ALTCS-EPD rates are not reported.

Research Question 12.1: What are the costs associated with the waiver renewal?

The results related to Research Questions 12.1 and 12.2 assessing the costs and associated benefits/savings with ALTCS during the renewal period are addressed jointly in Research Question 12.2 below.

Research Question 12.2: What are the benefits/savings associated with the waiver renewal?

Table 7-48 and Figure 7-6 utilized PMMIS data to examine the changes in PMPM costs for the ALTCS-DD population before and after Waiver renewal through an ITS analysis. Average PMPM costs were approximately $4,128.35 in the first month of the baseline period, and the inflation-adjusted trend in costs increased during both the baseline and evaluation periods. Professional costs were the primary driver of costs among the ALTCS-DD population.

Table 7-49 and Figure 7-7 utilized PMMIS data to assess the changes in aggregated costs among the ALTCS-DD population before and after Waiver renewal through an ITS analysis. Total cost of care for the ALTCS-DD population averaged nearly $143.0 million in the first month of the baseline period and continued to increase by approximately $0.8 million per month during the baseline period. Following Waiver renewal, the cost of care trend increased by an additional $2.4 million per month relative to the baseline period. Professional costs were the primary driver of total costs.

Key Findings (ALTCS-DD):

- **PMPM Costs**
  - Total PMPM costs averaged $4,128.35 at the beginning of the baseline period and increased by $8.41 per month ($p$=0.021) during the baseline. Following Waiver renewal, average total PMPM costs increased by $227.75 ($p$=0.031). The trend in costs increased by an additional $41.34 per month ($p$<0.001) during the evaluation period relative to the baseline trend.
  - The primary driver of costs were professional, which increased by $8.25 per month ($p$=0.019) during the baseline period. Upon renewal of the Waiver, average PMPM costs increased by $273.38 ($p$=0.007) and the trend in costs increased by $36.91 per month (***p***<0.001) more than the baseline trend.
- **Total Costs**
  - Total aggregated costs among the ALTCS-DD population averaged $142,976.8 thousand (approximately $142.0 million) at the beginning of the baseline period. Similar to the increases among PMPM costs, the trend in aggregated costs increased during the baseline period at a rate of $794.9 thousand per month (p<0.001), increased by an average of $8,096.3 thousand ($p$=0.045) upon Waiver renewal, and increased by an additional $2,431.2 thousand per month (p<0.001) relative to the baseline trend.
  - The primary driver of this increase was professional costs, which increased significantly throughout the baseline period and increased further during the evaluation period.

Table 7-48—ALTCS-DD PMPM Costs

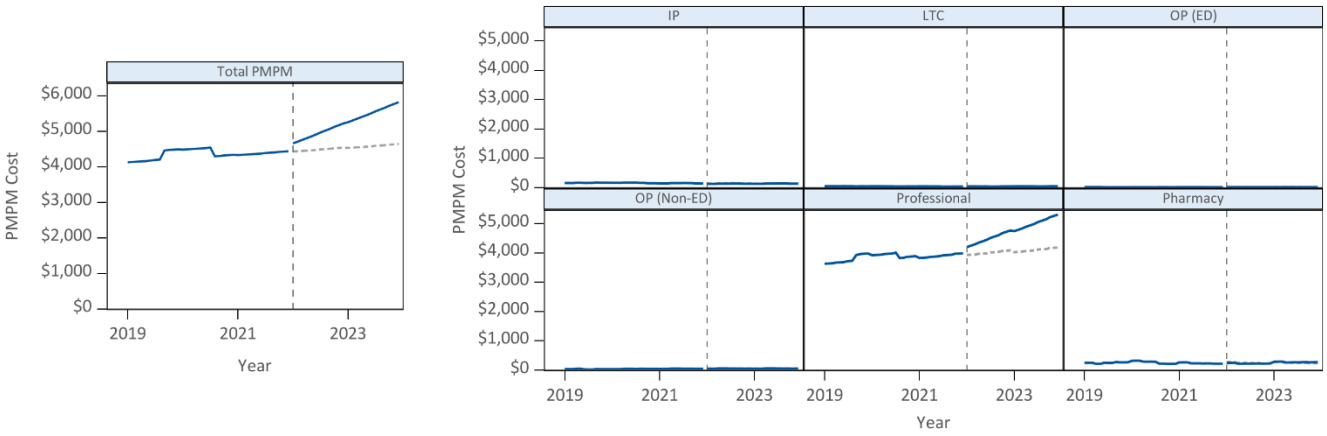
Variable	Estimate (*p*-value)						
	Total	Professional	IP	LTC	OP (ED)	OP (Non-ED)	Pharmacy
Intercept	$4,128.35 *** (<0.001)	$3,643.14 *** (<0.001)	$162.63 *** (<0.001)	$45.57 *** (<0.001)	$17.03 *** (<0.001)	$46.89 *** (<0.001)	$213.08 *** (<0.001)
Baseline monthly trend	$8.41 ** (0.021)	$8.25 ** (0.019)	$-0.42 (0.540)	$-0.30 ** (0.015)	$-0.07 ** (0.026)	$0.23 (0.109)	$0.72 (0.396)
Level change at implementation	$227.75 ** (0.031)	$273.38 ** (0.007)	$-14.94 (0.456)	$0.21 (0.951)	$0.61 (0.462)	$1.72 (0.675)	$-33.23 (0.180)
Change in monthly trend	$41.34 *** (<0.001)	$36.91 *** (<0.001)	$0.81 (0.515)	$0.65 ** (0.004)	$0.13 ** (0.012)	$-0.13 (0.597)	$2.96 * (0.057)

*p <0.1, **p <0.05, ***p <0.001

Note: Full model results are presented in Appendix A, Attachments. Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. <$0.01 indicates the value was a non-zero, positive amount and less than $0.01. ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

Data Source: PMMIS data were used in the analysis of RQ 12.1 and RQ 12.2.

Figure 7-6—ALTCS-DD PMPM Costs



Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. This figure presents the model-based average rate in each month (blue line) and the projected rates had the baseline trend continued (grey dashed line). The grey vertical dashed line indicates the Waiver renewal date (October 1, 2022). ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient; PMPM: per-member per-month.

Table 7-49—ALTCS-DD Total Aggregate Costs (in Thousands)

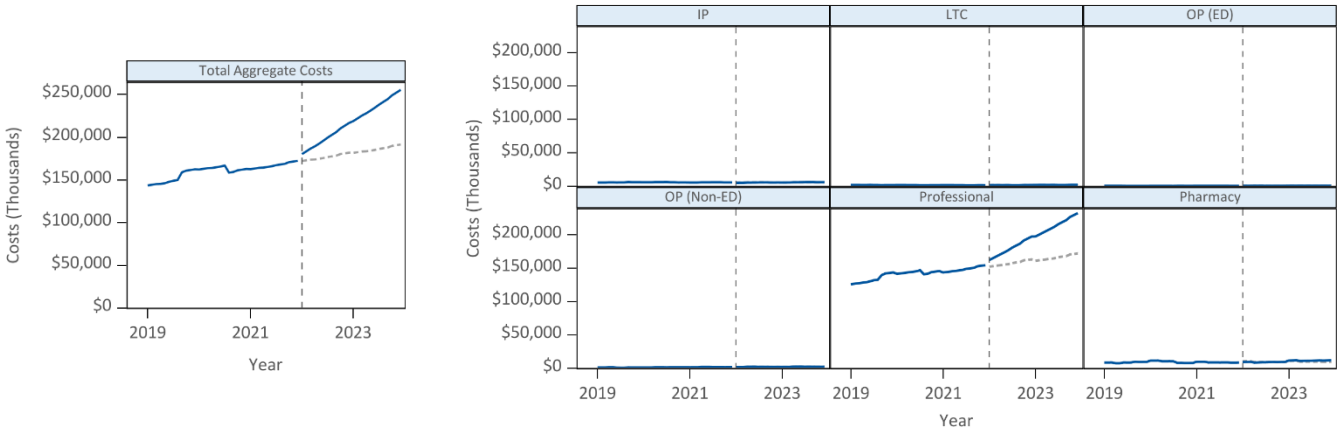
Variable	Estimate in Thousands (*p*-value)						
	Total	Professional	IP	LTC	OP (ED)	OP (Non-ED)	Pharmacy
Intercept	$142,976.8 *** (<0.001)	$126,172.1 *** (<0.001)	$5,624.6 *** (<0.001)	$1,586.7 *** (<0.001)	$592.2 *** (<0.001)	$1,637.8 *** (<0.001)	$7,363.5 *** (<0.001)
Baseline monthly trend	$794.9 *** (<0.001)	$733.0 *** (<0.001)	$2.5 (0.925)	-$6.4 (0.185)	-$0.6 (0.576)	$13.9 ** (0.013)	$52.5 (0.101)
Level change at implementation	$8,096.3 ** (0.045)	$9,883.0 ** (0.011)	-$598.3 (0.434)	-$4.8 (0.972)	$22.3 (0.479)	$65.2 (0.680)	-$1,271.0 (0.168)
Change in monthly trend	$2,431.2 *** (<0.001)	$2,202.5 *** (<0.001)	$42.1 (0.376)	$29.0 ** (0.001)	$6.5 ** (0.002)	$1.5 (0.877)	$149.6 ** (0.011)

*p <0.1, **p <0.05, ***p <0.001

Note: Full model results are presented in Appendix A, Attachments. Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

Data Source: PMMIS data were used in the analysis of RQ 12.1 and RQ 12.2.

Figure 7-7—ALTCS-DD Total Aggregate Costs (in Thousands)



Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. This figure presents the model-based average rate in each month (blue line) and the projected rates had the baseline trend continued (grey dashed line). The grey vertical dashed line indicates the Waiver renewal date (October 1, 2022). ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

Figure 7-8 utilized PMMIS data to examine the changes in PMPM costs for the ALTCS-EPD population before and after Waiver renewal through an ITS analysis. The average PMPM costs were approximately $3,676 at the beginning of the baseline period, and increased throughout both the baseline and evaluation periods. Professional and LTC costs were the primary drivers of the overall PMPM costs and increasing trend. Notably, the trend in inpatient PMPM costs declined during the evaluation period by a statistically significant degree (at the 0.10 level) relative to the baseline trend, which resulted in declining PMPM IP costs.

Table 7-51 and Figure 7-9 utilized PMMIS data to assess the changes in aggregated costs among the ALTCS-EPD population before and after Waiver renewal through an ITS analysis. Total cost of care for the ALTCS-EPD population averaged approximately $103.9 million in the first month of the baseline period and increased by approximately $0.2 million per month during the baseline period. During the evaluation period, total cost of care increased by approximately an additional $0.4 million per month relative to the baseline trend.

Key Findings (ALTCS-EPD):

- **PMPM Costs**
  - Total PMPM costs among the ALTCS-EPD population averaged $3,676.45 at the beginning of the baseline period and increased by $8.82 per month ($p<0.001$) during the baseline period. Following Waiver renewal, average total PMPM costs increased by $358.94 ($p<0.001$) and the trend in costs continued to increase by an additional $11.84 per month ($p=0.014$) relative to the baseline trend.
  - The primary driver of PMPM costs were professional and LTC costs, which averaged $1,773.17 and $1,506.78 at the beginning of the baseline period. Both of these categories of service significantly increased in level and the trend following Waiver renewal.
  - The trend of IP and OP (ED) reversed following Waiver renewal, with a decline of $1.93 PMPM ($p=0.070$) and $0.08 ($p=0.172$) relative to the baseline trend; however, the decline among OP (ED) costs was not statistically significant.

- **Aggregate Costs**
  - Total aggregate costs averaged $103,857.2 thousand at the beginning of the baseline period. Similar to PMPM costs, aggregate costs increased significantly during the baseline and evaluation periods, with an increase in the trend of $163.2 thousand per month (p<0.001) during the baseline and an increase of an additional $389.4 thousand per month (p=0.020) during the evaluation period relative to baseline projections.
  - The primary driver of aggregated costs during the evaluation period were LTC costs, which increased significantly relative to the baseline trend.
  - The trend among IP costs reversed during the evaluation period, declining by $47.4 thousand per month (p=0.100) relative to the baseline trend, which had been increasing by $9.7 thousand per month ($p$=0.083).

Table 7-50—ALTCS-EPD PMPM Costs

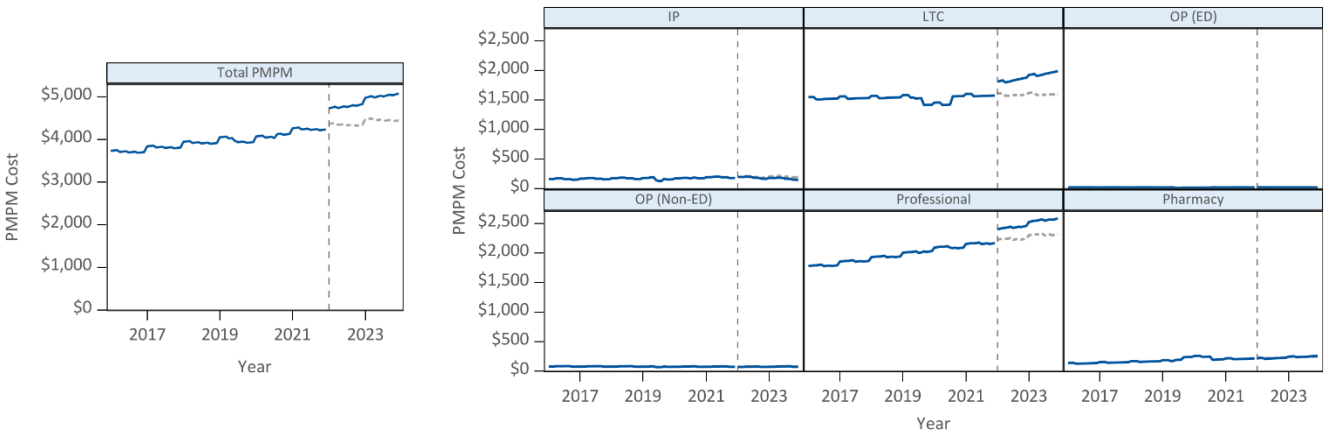
	Estimate (p-value)						
Variable	**Total**	**Professional**	**IP**	**LTC**	**OP (ED)**	**OP (Non-ED)**	**Pharmacy**
Intercept	$3,676.45 *** (<0.001)	$1,773.17 *** (<0.001)	$170.80 *** (<0.001)	$1,506.78 *** (<0.001)	$19.70 *** (<0.001)	$83.80 *** (<0.001)	$122.19 *** (<0.001)
Baseline monthly trend	$8.82 *** (<0.001)	$6.24 *** (<0.001)	$0.49 ** (0.020)	$0.88 ** (0.018)	>-$0.01 (0.757)	$-0.06 * (0.099)	$1.28 *** (<0.001)
Level change at implementation	$358.94 *** (<0.001)	$173.72 *** (<0.001)	$0.82 (0.962)	$201.26 *** (<0.001)	$0.76 (0.439)	$-4.69 (0.137)	$-12.93 (0.450)
Change in monthly trend	$11.84 ** (0.014)	$4.09 * (0.077)	$-1.93 * (0.070)	$8.26 *** (<0.001)	$-0.08 (0.172)	$0.40 ** (0.045)	$1.11 (0.300)

*p <0.1, **p <0.05, ***p <0.001

Note: Full model results are presented in Appendix A, Attachments. Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

Data Source: PMMIS data were used in the analysis of RQ 12.1 and RQ 12.2.

Figure 7-8—ALTCS-EPD PMPM Costs



Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. This figure presents the model-based average rate in each month (blue line) and the projected rates had the baseline trend continued (grey dashed line). The grey vertical dashed line indicates the Waiver renewal date (October 1, 2022). ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient; PMPM: per-member per-month.

Table 7-51—ALTCS-EPD Total Aggregate Costs (in Thousands)

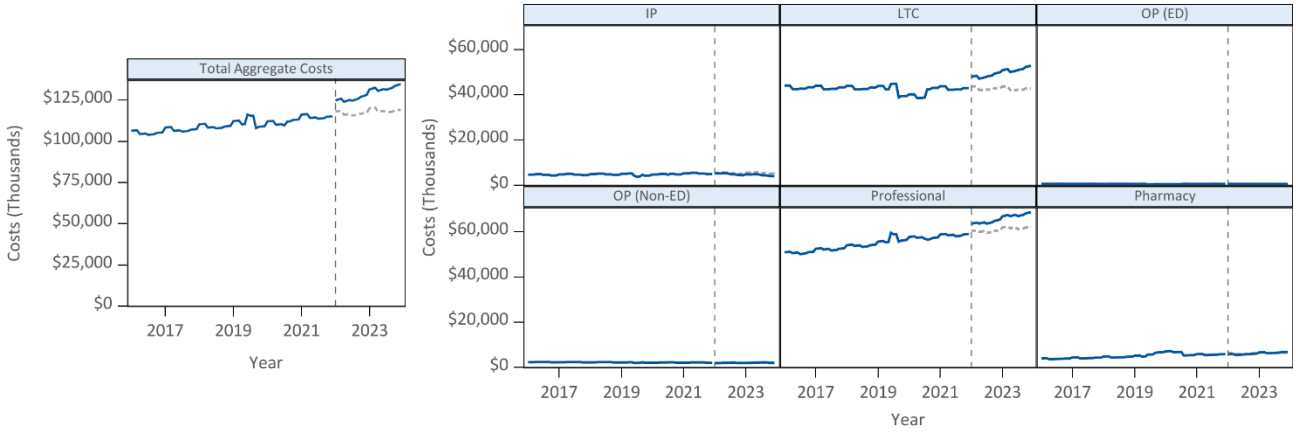
Variable	Estimate in Thousands (*p*-value)						
	Total	Professional	IP	LTC	OP (ED)	OP (Non-ED)	Pharmacy
Intercept	$103,857.2 *** (<0.001)	$50,141.0 *** (<0.001)	$4,809.1 *** (<0.001)	$42,512.1 *** (<0.001)	$555.3 *** (<0.001)	$2,360.4 *** (<0.001)	$3,479.3 *** (<0.001)
Baseline monthly trend	$163.2 *** (<0.001)	$131.2 *** (<0.001)	$9.7 * (0.083)	-$5.4 (0.665)	-$0.4 (0.254)	-$3.1 ** (0.016)	$31.2 *** (<0.001)
Level change at implementation	$6,668.6 ** (0.013)	$3,160.1 ** (0.018)	-$100.5 (0.826)	$4,247.2 *** (<0.001)	$5.0 (0.873)	-$179.6 * (0.090)	-$463.6 (0.321)
Change in monthly trend	$389.4 ** (0.020)	$145.3 * (0.079)	-$47.4 * (0.100)	$249.0 *** (<0.001)	-$1.8 (0.354)	$11.9 * (0.072)	$32.4 (0.268)

*p <0.1, **p <0.05, ***p <0.001

Note: Full model results are presented in Appendix A, Attachments. Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

Data Source: PMMIS data were used in the analysis of RQ 12.1 and RQ 12.2.

Figure 7-9—ALTCS-EPD Total Aggregate Costs (in Thousands)



Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. The dashed line represents the Waiver renewal date (October 1, 2022). ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

Research Question 12.3: What are the costs associated with the PPCG service model?

The results related to Research Questions 12.3 and 12.4 assessing the costs and associated benefits/savings with the PPCG service model during the renewal period are addressed jointly in Research Question 6.2 below.

Research Question 12.4: What are the benefits/savings associated with the PPCG service model?

Table 7-52 and Figure 7-10 utilized PMMIS data to examine the changes in PMPM costs among ALTCS-DD members associated with the PPCG service model against those of members receiving HCBS through a traditional, non-parent provider service model and placed at home (a comparison group) through a comparative ITS model. Members associated with the PPCG service model were those with any recorded hours of PPCG services between March and September 2024. Costs for these members were examined for the 24 months prior to February 2022. Similarly, the comparison group was comprised of members residing at home and receiving HCBS services between March and September 2024, with costs examined for these members for the 24 months prior.

Because a comparative ITS model examines differences in the total costs and changes in the cost trend between two groups, aggregated costs are not reported, given the disparate sizes of members aligned with the PPCG service model and the comparison group.

Key Findings (ALTCS-DD):

- **PMPM Costs**
  - Total PMPM costs averaged $2,697.98 at the beginning of the baseline period for the comparison group and increased by an average of $24.38 per month ($p$<0.001) during the baseline. Following implementation, the trend in the average total PMPM costs increased by an additional $51.71 ($p$=0.085) for the comparison group relative to the baseline trend.
  - Total PMPM costs among PPCG-aligned members were an average of $343.16 higher than the comparison members at the beginning of the baseline period (p=0.002) and had an average baseline trend of $51.19 greater than that of the comparison group (p<0.001). Following implementation, there was a further increase in the trend among PPCG-aligned members of $59.45 relative to the change in trend for the comparison group (p=0.159); however, this change was not statistically significant.
  - The primary driver of costs were professional, which were an average of $467.84 PMPM higher among the PPCG-aligned members than the comparison group members at the beginning of the baseline period (p<0.001). Additionally, the baseline trend among the PPCG group was $47.98 per month higher than the comparison group (p<0.001) and increased by an average of $48.98 per month more than the comparison group following implementation (p=0.081).

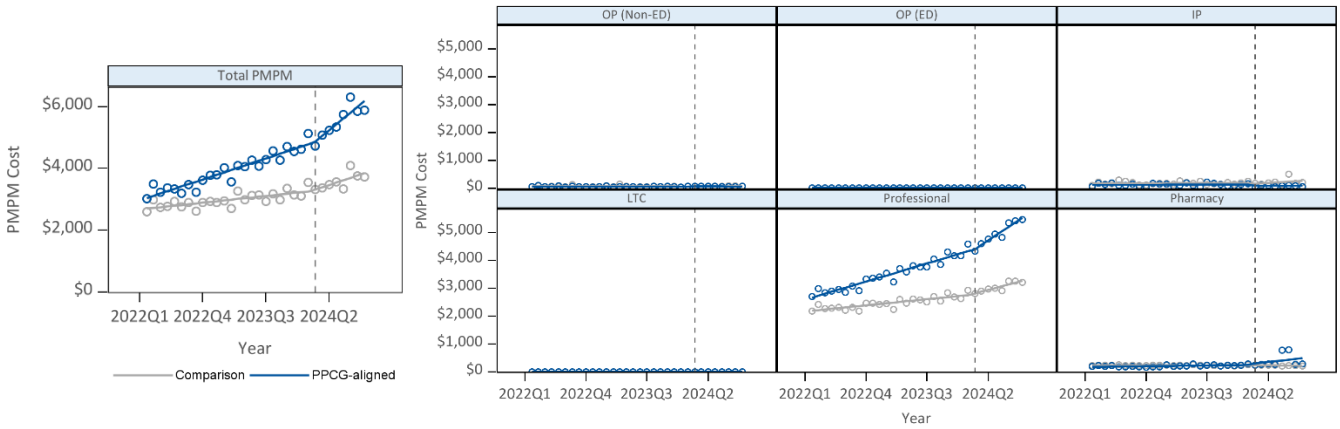
Table 7-52—PPCG-DD PMPM Costs

	Estimate (p-value)						
Variable	**Total**	**Professional**	**IP**	**LTC**	**OP (ED)**	**OP (Non-ED)**	**Pharmacy**
Intercept	$2,697.98 *** (<0.001)	$2,191.78 *** (<0.001)	$178.60 *** (<0.001)	$-0.89 ** (0.005)	$15.05 *** (<0.001)	$76.22 *** (<0.001)	$237.21 *** (<0.001)
Baseline monthly trend for Comparison	$24.38 *** (<0.001)	$24.29 *** (<0.001)	$0.67 (0.713)	$0.13 *** (<0.001)	$0.16 ** (0.034)	$-0.42 (0.441)	$-0.45 (0.855)
Level change at implementation for Comparison	$34.78 (0.811)	$36.11 (0.707)	$-23.76 (0.616)	$-1.72 ** (0.005)	$1.48 (0.444)	$4.53 (0.752)	$18.14 (0.776)
Change in monthly trend for Comparison	$51.71 * (0.085)	$40.18 ** (0.044)	$14.22 (0.144)	$0.35 ** (0.006)	$-0.77 * (0.053)	$1.68 (0.566)	$-3.94 (0.762)
Difference in intercept for PPCG Group	$343.16 ** (0.002)	$467.84 *** (<0.001)	$-57.15 (0.100)	$0.89 ** (0.043)	$-0.28 (0.843)	$-11.12 (0.287)	$-57.02 (0.222)
Difference in baseline monthly trend for PPCG Group	$51.19 *** (<0.001)	$47.98 *** (<0.001)	$-0.17 (0.948)	$-0.13 *** (<0.001)	$0.02 (0.858)	$0.13 (0.872)	$3.36 (0.332)
Difference in level change at implementation for PPCG Group	$-18.41 (0.929)	$-37.97 (0.780)	$-20.93 (0.754)	$1.72 ** (0.044)	$-0.41 (0.881)	$10.75 (0.596)	$28.44 (0.753)
Difference in change in the monthly trend at implementation for PPCG Group	$59.45 (0.159)	$48.98 * (0.081)	$-15.25 (0.266)	$-0.35 ** (0.046)	$-0.29 (0.599)	$-2.84 (0.492)	$29.21 (0.116)

*p <0.1, **p <0.05, ***p <0.001

Note: Full model results are presented in Appendix A, Attachments. ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient; PPCG: Parents as Paid Caregivers.

Figure 7-10—PPCG-DD PMPM Costs



Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. The dashed line represents the Waiver implementation date (February 16, 2022). ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient; PMPM: per-member per-month; PPCG: Parents as Paid Caregivers.

Table 7-53 and Figure 7-11 utilized PMMIS data to examine the changes in PMPM costs among ALTCS-EPD members associated with the PPCG service model against those of members receiving HCBS through a traditional, non-parent provider service model and placed at home (a comparison group) through a comparative ITS model. Members associated with the PPCG service model were those with any recorded hours of PPCG services between March and September 2024. Costs for these members were examined for the 24 months prior to February 2022. Similarly, the comparison group was comprised of members residing at home and receiving HCBS services between March and September 2024, with costs examined for these members for the 24 months prior. It is also important to note that the size of the PPCG-aligned and comparison groups among the ALTCS-EPD population were relatively small, at approximately 175 members per month. This may lead to unstable estimates and/or high variance in costs.

Because a comparative ITS model examines differences in the total costs and changes in the cost trend between two groups, aggregated costs are not reported, given the disparate sizes of members aligned with the PPCG service model and the comparison group.

Key Findings (ALTCS-EPD):

- **PMPM Costs**
  - Total PMPM costs averaged $8,086.56 at the beginning of the baseline period for the comparison group and increased slightly by an average of $79.42 per month ($p$=0.577) during the baseline. Following implementation, the trend in the average total PMPM costs decreased by $628.22 per month ($p$=0.408) among the comparison group relative to the baseline trend.
  - Total PMPM costs among PPCG-aligned members were an average of $5,618.46 higher than the comparison group at the beginning of the baseline period (p=0.041); however, PMPM costs declined throughout the baseline by $97.25 per month relative to the comparison group (p=0.629). Following implementation, there was an increase in the trend of $548.87 per month ($p$=0.609) relative to the comparison group (which had declined by $628.22 per month).
  - The primary driver of costs were pharmacy, which were an average PMPM of $3,389.31 higher at the start of the baseline period among PPCG-aligned members than the comparison group; however, this difference was not statistically significant (p=0.125).

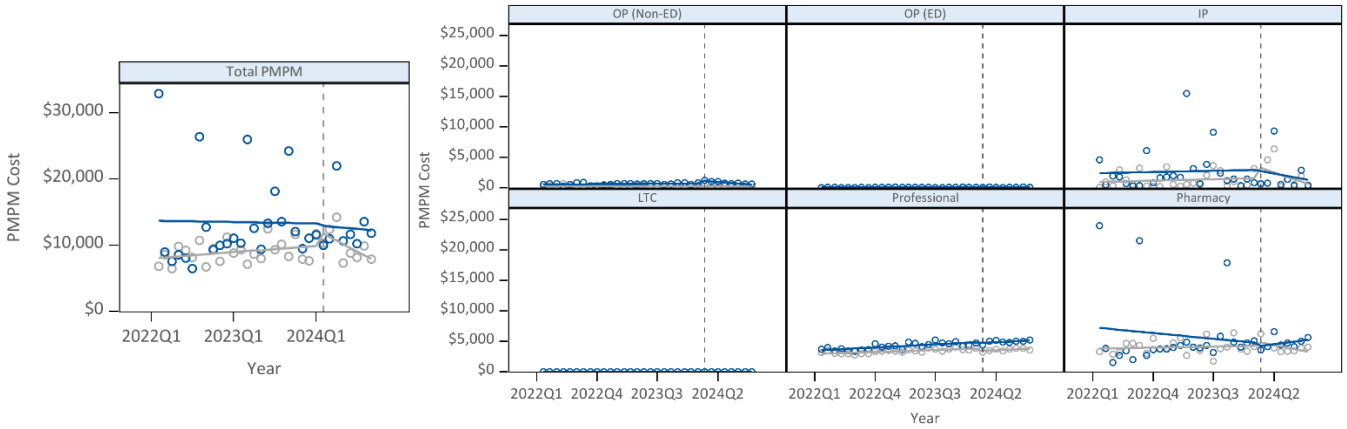
Table 7-53—PPCG-EPD PMPM Costs

Variable	Estimate (*p*-value)						
	Total	Professional	IP	LTC	OP (ED)	OP (Non-ED)	Pharmacy
Intercept	$8,086.56 *** (<0.001)	$2,950.93 *** (<0.001)	$953.46 (0.370)	<$0.01 (1.000)	$58.22 *** (<0.001)	$312.77 *** (<0.001)	$3,811.17 ** (0.016)
Baseline monthly trend for Comparison	$79.42 (0.577)	$36.05 *** (<0.001)	$26.39 (0.738)	$0.00 (1.000)	$-0.11 (0.886)	$-1.55 (0.709)	$18.64 (0.872)
Level change at implementation for Comparison	$1,812.61 (0.626)	$-411.65 * (0.065)	$1,702.16 (0.410)	$1.56 (0.488)	$-22.58 (0.269)	$11.38 (0.916)	$531.74 (0.860)
Change in monthly trend for Comparison	$-628.22 (0.408)	$19.46 (0.664)	$-406.35 (0.336)	$0.86 * (0.064)	$3.06 (0.460)	$-11.64 (0.598)	$-233.62 (0.704)
Difference in intercept for PPCG Group	$5,618.46 ** (0.041)	$594.79 *** (<0.001)	$1,440.89 (0.338)	>-$0.01 (1.000)	$-23.03 (0.122)	$216.50 ** (0.008)	$3,389.31 (0.125)
Difference in baseline monthly trend for PPCG Group	$-97.25 (0.629)	$19.30 (0.109)	$-3.40 (0.976)	$0.00 (1.000)	$2.22 ** (0.047)	$9.35 (0.114)	$-124.72 (0.445)
Difference in level change at implementation for PPCG Group	$-2,143.78 (0.684)	$256.57 (0.411)	$-1,890.48 (0.518)	$-1.56 (0.623)	$-0.89 (0.975)	$416.36 ** (0.008)	$-923.78 (0.828)
Difference in change in the monthly trend at implementation for PPCG Group	$548.87 (0.609)	$-17.73 (0.780)	$175.97 (0.767)	$-0.86 (0.187)	$-1.16 (0.843)	$-87.00 ** (0.007)	$479.65 (0.581)

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Full model results are presented in Appendix A, Attachments. ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient; PPCG: Parents as Paid Caregivers.

Figure 7-11—PPCG-EPD PMPM Costs



Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. The dashed line represents the Waiver implementation date (February 16, 2022). ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient; PMPM: per-member per-month; PPCG: Parents as Paid Caregivers.

Research Question 12.5: Did utilization of services increase after the introduction of the PPCG service model?

Table 7-54 utilized PMMIS and PPCG utilization data to identify the average number of hours billed under the PPCG service model.[98]

[98] PPCG ALTCS-DD results reflect the average number of hours billed in months where data were available and no not reflect the total number of hours billed during the baseline or evaluation periods. PPCG ALTCS-EPD results reflect the average number of hours billed among the entire population, among the weekly average.

Key Findings:

- **ALTCS-DD**
  - Based on the PPCG utilization data, the average service hours per month provided by parents under the PPCG service model more than doubled for habilitation care and more than tripled for attendant care between the ramp-up and evaluation periods (p<0.001 for both).
- **ALTCS-EPD**
  - In SFY 2024, there was an average of 151 habilitation care hours and 5,301 attendant care hours billed per month among all ALTCS-EPD members receiving services from the PPCG service model.

ALTCS-DD member utilization of services provided through the PPCG service model increased; however, full data were not available for FFYs 2023 and 2024. This trend mirrors Hypothesis 5 results, as the number and percentage of members accessing services through the PPCG service model steadily increased from FFY 2023 to FFY 2024.

Table 7-54—Research Question 12.1, Measure 12-1

Did utilization of services increase after the introduction of the PPCG service model?			Hours Per Month		Pre/Post Change in Average[1] (p-value)
			Ramp-Up Period Average	Evaluation Period Average	
			2023	2024	
ALTCS-DD Population					
12-1	Number of billed hours for services provided under the PPCG service model	Habilitation Care	117,477	309,695	238,076 *** (<0.001)
		Attendant Care	99,581	337,657	192,218 *** (<0.001)
ALTCS-EPD Population					
12-1	Number of billed hours for services provided under the PPCG service model	Habilitation Care	N/A	151	N/A
		Attendant Care	N/A	5,301	N/A

Note: ALTCS: Arizona Long Term Care System; DD: developmental disabilities; EPD: elderly and physically disabled; PPCG: Parents as Paid Caregivers.
N/A indicates that data provided for the ALTCS-EPD ramp-up period were not included in the analysis due to potential bias in reporting.
Data Source: PPCG-DD and PPCG-EPD utilization data were used in the analysis of RQ 12.5. The PPCG-EPD utilization data identified the average number of hours provided to each member between 03/2024–09/2024.
[1]Change in Average compares the average in the ramp-up period to the evaluation period.
ALTCS-DD: Ramp-up period (01/01/2023–03/31/2023) and evaluation period (04/01/2024–09/30/2024).
ALTCS-EPD: Evaluation period (04/01/2024–06/30/2024).

8. DCS CHP Results

The following chapter describes the quantitative and qualitative results for the evaluation of the Department of Child Safety Comprehensive Health Plan (DCS CHP). A complete list of measures and their specifications is available in Evaluation Designs linked in the Appendix.

Results Summary

Table 8-1 displays the number of measures by research question that showed improvement, worsened, did not change significantly, or were not applicable.

Table 8-1—DCS CHP Quantitative Measure Conclusions

Research Questions	Number of Measures			
	Worsening	No Significant Change	Improving	N/A[1]
RQ 1.1: Do DCS CHP members have the same or increased access to PCPs and specialists in the remeasurement period as compared to the baseline?	0	1	3	0
RQ 2.1: Do DCS CHP members have the same or higher rates of appropriate immunizations in the remeasurement period as compared to the baseline?	0	2	0	0
RQ 2.2: Do DCS CHP members have the same or better management of chronic conditions in the remeasurement period as compared to the baseline?	1	0	0	0
RQ 2.3: Do DCS CHP members have the same or better management of BH conditions in the remeasurement period as compared to the baseline?	0	3	1	1
RQ 2.4: Do DCS CHP members have the same or lower hospital utilization in the remeasurement period as compared to the baseline?	0	1	0	2
RQ 3.1: What barriers did DCS CHP anticipate/encounter during the integration?	0	0	0	2
Total	**1**	**7**	**4**	**5**

Note: BH: behavioral health; CHP: Comprehensive Health Plan; DCS: Department of Child Safety; N/A: not applicable; PCP: primary care provider.
[1] Measures did not have a desired directionality or require additional context to describe the outcome.

DCS CHP Program Results

Hypothesis 1: Member access to appropriate care for routine medical conditions will be maintained or improved during the integration period.

Research Question 1.1: Do DCS CHP members have the same or increased access to primary care providers (PCPs) and specialists in the remeasurement period as compared to the baseline?

Figure 8-1 displays the percentage of members enrolled in DCS CHP meeting time/distance standards by provider type.[99,100] Table 8-2 displays the results of the interrupted time series (ITS) analysis assessing the impact of the Arizona Health Care Cost Containment System (AHCCCS) Section 1115 Waiver Demonstration (the Waiver) on provider network adequacy. This measure had high statistical power and may highlight changes that are statistically significant but not practically meaningful. Table 8-3 utilized Prepaid Medical Management Information System (PMMIS) data to assess changes in the percentage of members accessing preventive care.

Key Findings:

- The *Percentage of members meeting time/distance standards* for all provider groups remained above 90 percent during the demonstration period and above 95 percent for all provider groups during the evaluation period.
  - The *Percentage of members meeting time/distance standards* exhibited a significant level increase after DCS CHP implementation for several provider groups. The odds of a member residing within time/distance standards rose 289.9 percent, 6,038.0 percent, 202.9 percent, and 199.6 percent for behavioral health (BH) Residential Facilities, Pediatric Cardiologists, Pediatric Dentists, and Pediatric Primary Care Providers (PCP), respectively (p<0.001).
  - The annual trend in the *Percentage of members meeting time/distance standards* decreased following DCS CHP implementation for BH Residential Facilities and Pediatric Cardiologists by 11.5 and 73.3 percent, respectively (p=0.034 and p<0.001). Conversely, the Pediatric PCP provider annual trend increased by 72.6 percent following implementation (p<0.001).
  - *The Percentage of members meeting time/distance standards* for Pediatric BH Outpatient (OP) providers increased from 93.9 percent in quarter (Q) 4 federal fiscal year (FFY) 2019 to 98.4 percent in Q4 FFY 2024; however, no significant changes from the baseline trend following DCS CHP implementation were identified (p=0.786).
- The *Percentage of members age 3–21 with a well-care visit* increased by 1.6 percentage points between the baseline and evaluation periods (p<0.001); however, the observed rates in FFY 2022, FFY 2023, and FFY 2024 were lower than the baseline projection, indicating that the rate did not increase as fast as expected in the evaluation period (p<0.001 for all years).
  - In 2024, rural members age 3–21 had lower rates of well-care visits compared to urban members.
- Between the baseline and evaluation periods, the *Percentage of members with well-child visits in the first 30 months of life* increased by 17.6 and 4.9 percentage points for *6 or more visits before the 15-month birthday* and *2 or more visits between the 15-month and 30-month birthday*, respectively (p<0.001 for both).

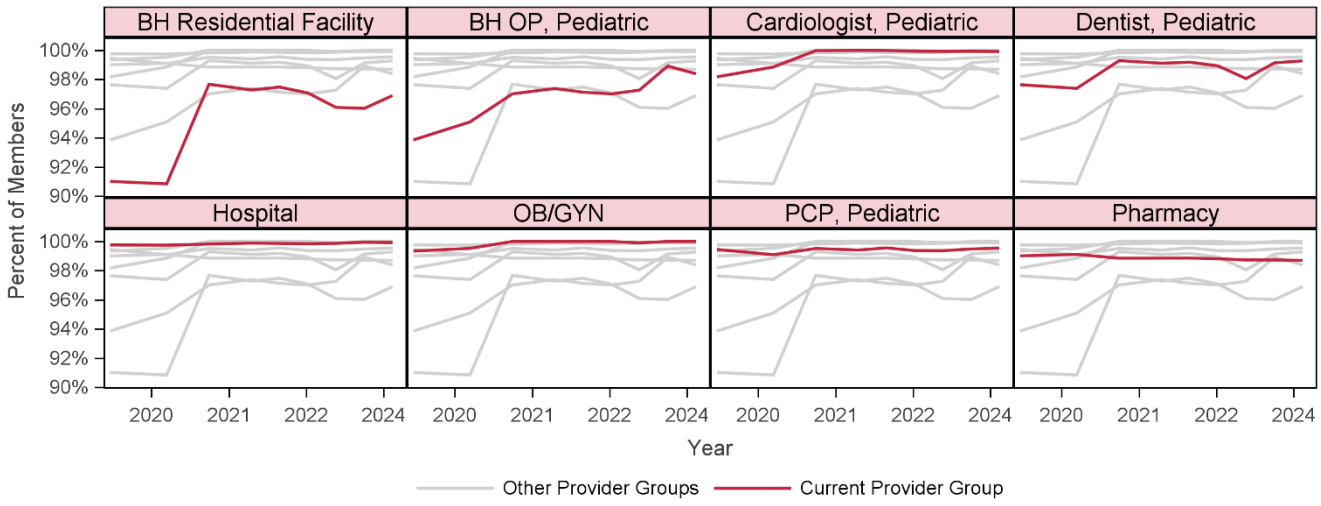
[99] Additional details on time distance measure calculations and standards can be found in Appendix A, Attachments.

[100] Historical network adequacy validation was not performed for the Comprehensive Medical and Dental Program (CMDP) prior to DCS CHP, limiting CMDP provider network data availability. CMDP foster care children received BH services through the Regional Behavioral Health Agreement (RBHA), and the Mercy Care RBHA provider network was used to assess time/distance standards for BH OP, Integrated Clinic (Pediatric), and BH Residential Facility services. Additionally, CMDP pharmacy provider network data were incomplete prior to FFY 2021, as few CMDP pharmacy providers were identified. Therefore, the Mercy Arizona Health Care Cost Containment System (AHCCCS) Complete Care (ACC) pharmacy network was used in FFY 2019 and FFY 2020. Finally, there were no CMDP provider data available in Q4 2020 and the Q3 2020 provider network was used with Q4 2020 address information to evaluate Q4 2020 time/distance standards.

- In 2024, Black members, American Indian/Alaska Native (AI/AN) members, and rural members had a lower rate of well-child visits in the first 30 months of life (2 or more well child visits between the child's 15-month and 30-month birthday) compared to their reference group (i.e., White/Caucasian and urban, respectively).

The percentage of members meeting time/distance standards for each provider type was generally maintained or improved during the evaluation period. BH services (BH Residential Facility and BH OP, Pediatric) exhibited the most substantial increase, providing evidence that children in foster care had improved access to BH providers under DCS CHP than the Regional Behavioral Health Agreement (RBHA). Children's primary care access, measured by the percentage of children with well-child and well-care visits, was generally maintained or improved during the evaluation period; however, the rate of increase was lower in the evaluation period than the baseline, as shown in the trend model findings.

Figure 8-1—Research Question 1.1, Measure 1-1 [101]



Note: BH: behavioral health; OB/GYN: obstetrician gynecologist; OP: outpatient; PCP: primary care provider

[101] Additional details on time/distance measure calculations and standards can be found in Appendix A, Attachments.

Table 8-2—Research Question 1.1, Measure 1-1

Provider Type	Percentage Change in Odds[1] Baseline Annual Trend[2]	Level Change at Waiver Renewal[2]	Change in Annual Trend[2]
BH Residential Facility	-2.0% (0.671)	289.9% *** (<0.001)	-11.5% ** (0.034)
BH OP, Pediatric	26.7% *** (<0.001)	13.8% (0.255)	1.8% (0.786)
Cardiologist, Pediatric	60.0% *** (<0.001)	6038.0% *** (<0.001)	-73.3% *** (<0.001)
Dentist, Pediatric	-9.9% (0.195)	202.9% *** (<0.001)	6.6% (0.493)
Hospital	-6.3% (0.797)	84.8% (0.225)	34.8% (0.309)
OB/GYN	39.0% (0.574)	4237.9% (0.143)	-54.2% (0.558)
PCP, Pediatric	-39.9% *** (<0.001)	199.6% *** (<0.001)	72.6% *** (<0.001)
Pharmacy	11.2% (0.413)	-30.1% (0.151)	-15.3% (0.225)

*p <0.1, **p <0.05, ***p <0.001

Note: Extremely large coefficients can occur when predicted probabilities approach 0 or 1. Results should be interpreted with caution. BH: behavioral health; OB/GYN: obstetrician gynecologist; OP: outpatient; PCP: primary care provider.

Data Source: prepaid medical management information system (PMMIS), client assessment and tracking system (CATS), provider affiliation transmission (PAT), and AHCCCS contractor operations manual (ACOM) 436.

[1]Model utilizes annual rates from the baseline period (10/01/2018–09/30/2020) and semi-annual rates from the evaluation period (10/01/2021–09/30/2024). Rates from the ramp-up period (10/01/2020–09/30/2021) are excluded from analysis.

[2]p -values are in parentheses.

Table 8-3—Research Question 1.1, Measures 1-2 through 1-4

		Regression-Adjusted Rates[1] Baseline Average[2]	Evaluation Average[2]	Pre/Post Change in Rate[3] (p -value)	Trend Model Difference Between Actual and Projected (p -value) FFY 2022	FFY 2023	FFY 2024
1-2	Percentage of members 3–21 years of age who had a well-care visit with a PCP or OB/GYN	68.7%	70.4%	1.6pp *** (<0.001)	-9.3pp *** (<0.001)	-5.6pp *** (<0.001)	-5.7pp *** (<0.001)
1-3	Percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation	61.8%	61.9%	0.1pp (0.853)	-9.3pp *** (<0.001)	-4.0pp ** (0.008)	-3.0pp * (0.081)
1-4	Percentage of members who had a well-child visit in the first 30 months of life						
	6 or more well-child visits before the 15-month birthday	42.8%	60.4%	17.6pp *** (<0.001)	-5.1pp (0.251)	-4.8pp (0.362)	-6.4pp (0.280)
	2 or more well-child visits between the child's 15-month and 30-month	68.2%	73.1%	4.9pp *** (<0.001)	5.4pp (0.256)	6.0pp (0.301)	6.6pp (0.335)

*p <0.1, **p <0.05, ***p <0.001

Note: FFY: federal fiscal year; OB/GYN: obstetrician gynecologist; PCP: primary care practitioner; pp: percentage point.

Data Source: PMMIS data were used in the analysis of RQ 1.1.

[1]Rates are adjusted for the effect of the coronavirus diease 2019 (COVID-19) public health emergency (PHE) in 2020.

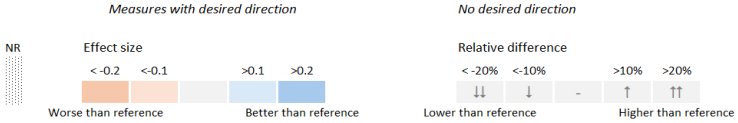
[2]Rates are weighted by enrollment duration in CHP.

[3]Change in Rate compares the rate or number in the baseline period (10/01/2016–09/30/2020) to the average rate or number in the evaluation period (10/1/2021–09/30/2024). Rates from the ramp-up period (10/01/2020–09/30/2021) are excluded from analysis.

Table 8-4 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in FFYs 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among DCS CHP members. Each cell color or arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 8-4—Research Question 1.1, Disparities Analysis

		Black		AI/AN		All Others		Unknown		Rural		Female	
		2022	2024	2022	2024	2022	2024	2022	2024	2022	2024	2022	2024
1-2	Percentage of members 3–21 years of age who had a well-care visit with a PCP or OB/GYN												
1-3	Percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation												
1-4	Percentage of members who had a well-child visit in the first 30 months of life (6 or more well child visits before the 15-month birthday)												
	Percentage of members who had a well-child visit in the first 30 months of life (2 or more well child visits between the child's 15-month and 30-month birthday)												



Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. NR: not reportable due to suppression guidelines. OB/GYN: obstetrician gynecologist; PCP: primary care practitioner.

Hypothesis 2: Quality of care will be maintained or improved during the integration period.

Research Question 2.1: Do DCS CHP members have the same or higher rates of appropriate immunizations in the remeasurement period as compared to the baseline?

Table 8-5 utilized PMMIS data to assess changes in the percentage of children and adolescents with appropriate immunizations.

Key Findings:

- The *Percentage of children 2 years of age with appropriate immunization status* increased for 11 out of 13 indicators. Three indicators—measles, mumps, and rubella (MMR); pneumococcal conjugate; and rotavirus—increased by statistically significant margins of 2.5, 4.4, and 6.5 percentage points, respectively, between the baseline and evaluation periods (p=0.025, p=0.001, and p<0.001).
  - Rates of childhood immunizations improved among Black members relative to White/Caucasian members between 2022 and 2024.
- The *Percentage of adolescents 13 years of age with the appropriate immunizations* decreased for all immunizations between the baseline and evaluation periods; however, only meningococcal and combination 1 changed significantly, decreasing by 3.8 and 3.0 percentage points, respectively (p=0.026 and p=0.094).
  - Rates of adolescents with appropriate immunizations among Black members worsened relative to White/Caucasian members between 2022 and 2024. Adolescents in rural areas consistently had lower rates of appropriate immunizations in 2022 and 2024 compared to members in urban areas.

- The Combination 2 evaluation period rates of the *Percentage of adolescents 13 years of age with the appropriate immunizations* were below baseline projections, indicating that increased immunization during the baseline period was not sustained in the evaluation period.

The percentage of DCS CHP members under 2 years of age with appropriate immunization status was generally maintained or increased during the evaluation period compared to the baseline; however, the percentage of DCS CHP members 13 years of age with appropriate immunization decreased.

Table 8-5—Research Question 2.1, Measures 2-1 and 2-2 [102]

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[3]	Trend Model Difference Between Actual and Projected (*p*-value)		
		Baseline Average[2]	Evaluation Average[2]	(*p*-value)	FFY 2022	FFY 2023	FFY 2024
2-1	Percentage of children 2 years of age with appropriate immunization status						
	DTaP	42.4%	44.7%	2.2pp * (0.096)	3.7pp (0.451)	-3.6pp (0.543)	-3.3pp (0.642)
	IPV	59.3%	60.3%	1.0pp (0.455)	0.2pp (0.959)	-8.7pp (0.133)	-12.5pp * (0.068)
	MMR	77.8%	80.3%	2.5pp ** (0.025)	-1.5pp (0.692)	-2.6pp (0.565)	0.4pp (0.931)
	HiB	66.5%	67.1%	0.6pp (0.630)	-0.8pp (0.846)	-10.2pp * (0.066)	-7.8pp (0.217)
	Hepatitis B	29.5%	28.1%	-1.4pp (0.247)	0.0pp (1.000)	-3.1pp (0.554)	0.4pp (0.954)
	VZV	77.6%	79.0%	1.5pp (0.191)	-1.1pp (0.777)	-3.3pp (0.488)	-0.5pp (0.925)
	Pneumococcal Conjugate	41.9%	46.3%	4.4pp ** (0.001)	5.2pp (0.296)	2.8pp (0.649)	-2.6pp (0.720)
	Hepatitis A	82.0%	83.7%	1.7pp * (0.100)	-3.7pp (0.265)	-4.7pp (0.229)	-3.6pp (0.399)
	Rotavirus	37.6%	44.1%	6.5pp *** (<0.001)	8.2pp * (0.097)	5.1pp (0.394)	4.6pp (0.521)
	Influenza	37.9%	37.0%	-1.0pp (0.461)	5.9pp (0.225)	-1.7pp (0.770)	-3.0pp (0.650)
	Combination 3	16.5%	16.7%	0.2pp (0.836)	0.4pp (0.923)	-2.2pp (0.624)	-2.4pp (0.662)
	Combination 7	12.2%	13.8%	1.6pp * (0.089)	2.9pp (0.403)	0.4pp (0.924)	0.8pp (0.869)
	Combination 10	7.7%	8.3%	0.6pp (0.409)	1.6pp (0.608)	-2.4pp (0.470)	-3.3pp (0.402)
2-2	Percentage of adolescents 13 years of age with appropriate						
	Meningococcal	73.6%	69.8%	-3.8pp ** (0.026)	-7.9pp (0.191)	-6.0pp (0.402)	-8.3pp (0.333)
	Tdap	73.2%	71.7%	-1.5pp (0.374)	-7.6pp (0.204)	-4.9pp (0.487)	-4.2pp (0.600)
	HPV	35.7%	34.3%	-1.3pp (0.463)	-16.1pp ** (0.016)	-15.0pp * (0.074)	-15.4pp (0.125)
	Combination 1 (Meningococcal, Tdap)	70.2%	67.3%	-3.0pp * (0.094)	-4.9pp (0.438)	-3.2pp (0.670)	-5.7pp (0.531)
	Combination 2 (Meningococcal, Tdap, HPV)	31.0%	30.9%	-0.1pp (0.942)	-17.8pp ** (0.008)	-18.8pp ** (0.027)	-22.5pp ** (0.028)

*p <0.1, **p <0.05, ***p <0.001

Note: DTaP: diphtheria, tetanus, pertussis; FFY: federal fiscal year; HiB: haemophilus influenzae type b; HPV: human papillomavirus; IPV: inactivated poliovirus vaccine; MMR: measles, mumps, and rubella; pp: percentage point; Tdap: tetanus, diptheria, pertussis; VZV: varicella zoster virus.

Data Source: PMMIS data were used in the analysis of RQ 2.1.

[1]Rates are adjusted for the effect of the COVID-19 PHE in 2020.

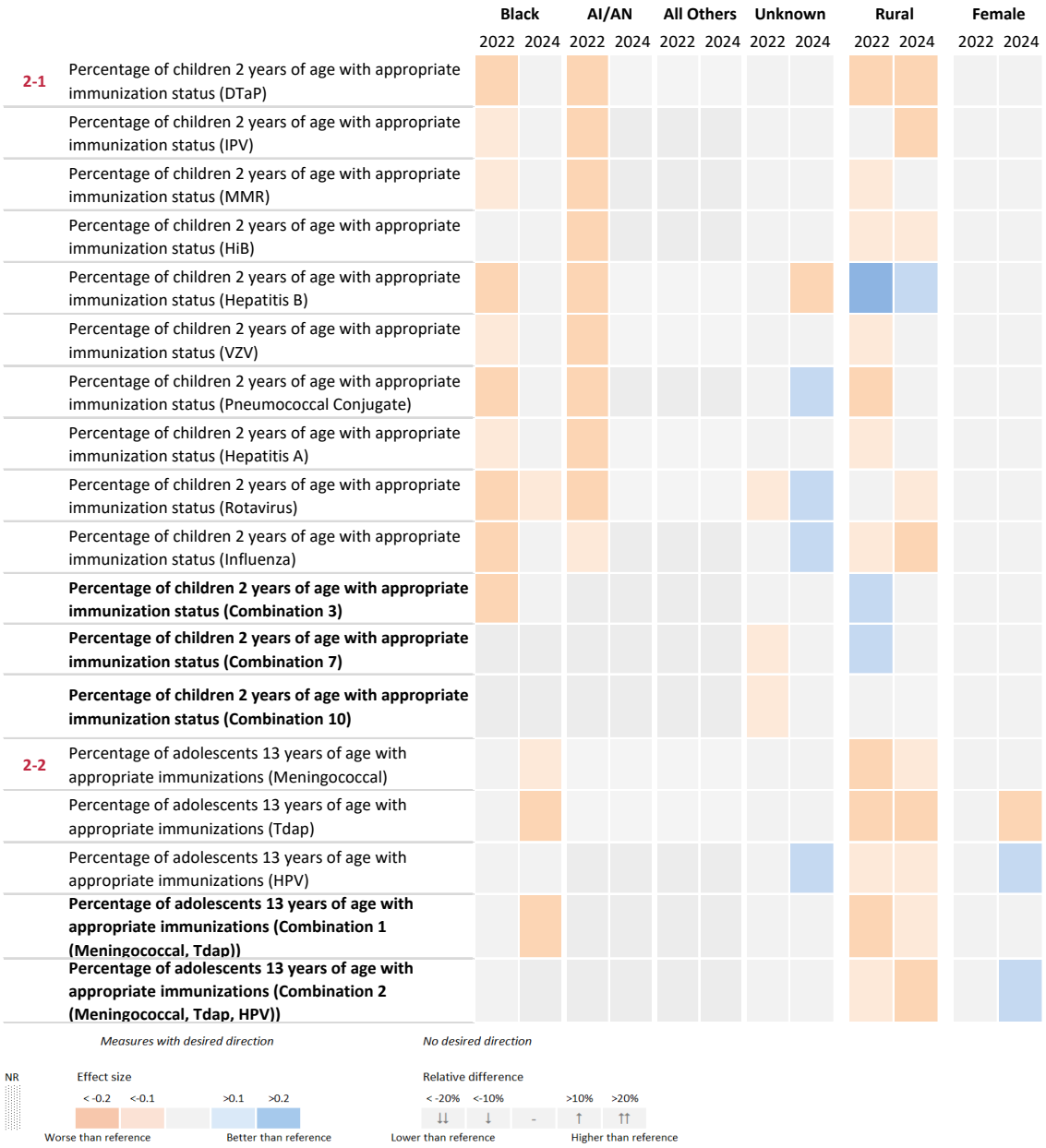
[2]Rates are weighted by enrollment duration in CHP.

[3]Change in Rate compares the rate or number in the baseline period (10/01/2016–09/30/2020) to the average rate or number in the evaluation period (10/1/2021–09/30/2024). Rates from the ramp-up period (10/01/2020–09/30/2021) are excluded from analysis.

102 Calculated rates may be artificially low due to the use of PMMIS data.

Table 8-6 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in FFYs 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among DCS CHP members. Each cell color or arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 8-6—Research Question 2.1, Disparities Analysis



Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. DTap: diphtheria, tetanus, pertussis; HiB: haemophilus influenzae type b; HPV: human papillomavirus; IPV: inactivated poliovirus vaccine; MMR: measles, mumps, and rubella; NR: not reportable due to suppression guidelines; Tdap: tetanus, diptheria, pertussis; VZV: varicella zoster virus.

Research Question 2.2: Do DCS CHP members have the same or better management of chronic conditions in the remeasurement period as compared to the baseline?

Table 8-7 utilized PMMIS data to assess the percentage of members with persistent asthma who had appropriate medication management.

Key Findings:

- The *Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent* decreased between the baseline and evaluation periods by 8.1 percentage points (p=0.044).

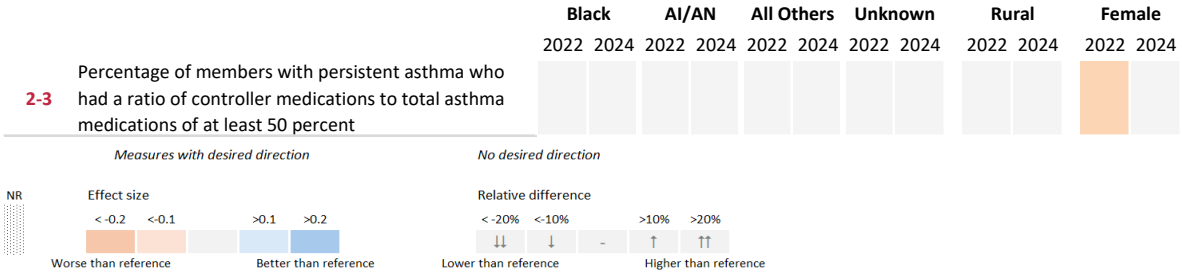
Table 8-7—Research Question 2.2, Measure 2-3

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[3] (p-value)	Trend Model Difference Between Actual and Projected (p-value)		
		Baseline Average[2]	Evaluation Average[2]		FFY 2022	FFY 2023	FFY 2024
2-3	Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent	71.0%	62.9%	-8.1pp ** (0.044)	-16.6pp (0.214)	-2.1pp (0.876)	-34.3pp * (0.094)

*p <0.1, **p <0.05, ***p <0.001
Note: FFY: federal fiscal year; pp: percentage point.
Data Source: PMMIS data were used in the analysis of RQ 2.2.
[1]Rates are adjusted for the effect of the COVID-19 PHE in 2020.
[2]Rates are weighted by enrollment duration in CHP.
[3]Change in Rate compares the rate or number in the baseline period (10/01/2016–09/30/2020) to the average rate or number in the evaluation period (10/1/2021–09/30/2024). Rates from the ramp-up period (10/01/2020–09/30/2021) are excluded from analysis.

Table 8-8 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in FFYs 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among DCS CHP members. Each cell color or arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 8-8—Research Question 2.2, Disparities Analysis



Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. NR: not reportable due to suppression guidelines.

Research Question 2.3: Do DCS CHP members have the same or better management of BH conditions in the remeasurement period as compared to the baseline?

Table 8-9 utilized PMMIS data to assess the changes in members' management of BH conditions between the baseline and evaluation periods.

Key Findings:

- The *Percentage of children and adolescents on antipsychotics with metabolic monitoring* decreased by 2.3 percentage points between the baseline and evaluation periods (p=0.085); however, the evaluation period observed rates exceeded the baseline trend projection, indicating the rate of decline was not sustained in the evaluation period (p<0.001 for FFY 2022 and FFY 2023, and p=0.006 for FFY 2024).
  - In 2022 and 2024, female child and adolescent members had higher rates of antipsychotics with metabolic monitoring compared to male members.
- The *Percentage of members diagnosed with a mental health disorder* increased between the baseline and evaluation periods by 15.3 percentage points (p<0.001); however, the evaluation period observed rates were lower than the baseline trend projection by 13.9 percentage points or more, indicating that the rate did not increase as fast as expected in the evaluation period (p<0.001 for all years).
- The *Percentage of members with a follow-up visit within 7 days after a hospitalization for mental illness* increased by 5.2 percentage points between the baseline and evaluation periods (p=0.001).

DCS CHP members generally exhibited improved BH condition management during the evaluation period, although not all changes were statistically significant. The percentage of DCS CHP members diagnosed with mental health disorders increased, which may indicate increased access to diagnostic care, but is also consistent with the growing prevalence of mental health disorders among youth nationwide.[103]

Table 8-9—Research Question 2.3, Measures 2-4 through 2-8

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[3]	Trend Model Difference Between Actual and Projected (p-value)		
		Baseline Average[2]	Evaluation Average[2]	(p-value)	FFY 2022	FFY 2023	FFY 2024
2-4	Percentage of children and adolescents on antipsychotics with metabolic monitoring	53.1%	50.8%	-2.3pp * (0.085)	16.3pp *** (<0.001)	20.9pp *** (<0.001)	18.1pp ** (0.006)
2-5	Percentage of members diagnosed with a mental health disorder	58.2%	73.4%	15.3pp *** (<0.001)	-15.5pp *** (<0.001)	-13.9pp *** (<0.001)	-14.2pp *** (<0.001)
2-6	Percentage of members with a follow-up visit within 7 days after an ED visit for mental	81.8%	83.5%	1.7pp (0.563)	6.9pp (0.495)	10.9pp (0.377)	7.4pp (0.651)
2-7	Percentage of members with a follow-up visit within 7 days after a hospitalization for	64.8%	70.0%	5.2pp ** (0.001)	4.0pp (0.491)	4.2pp (0.545)	-3.4pp (0.691)
2-8	Percentage of members with follow-up within 7 days after an ED visit for SUD	60.9%	66.2%	5.3pp (0.285)	-5.3pp (0.743)	-10.3pp (0.594)	-14.7pp (0.515)

*p <0.1, **p <0.05, ***p <0.001

Note: ED: emergency department; FFY: federal fiscal year; pp: percentage point; SUD: substance use disorder.

Data Source: PMMIS data were used in the analysis of RQ 2.3.

[1]Rates are adjusted for the effect of the COVID-19 PHE in 2020.

[2]Rates are weighted by enrollment duration in CHP.

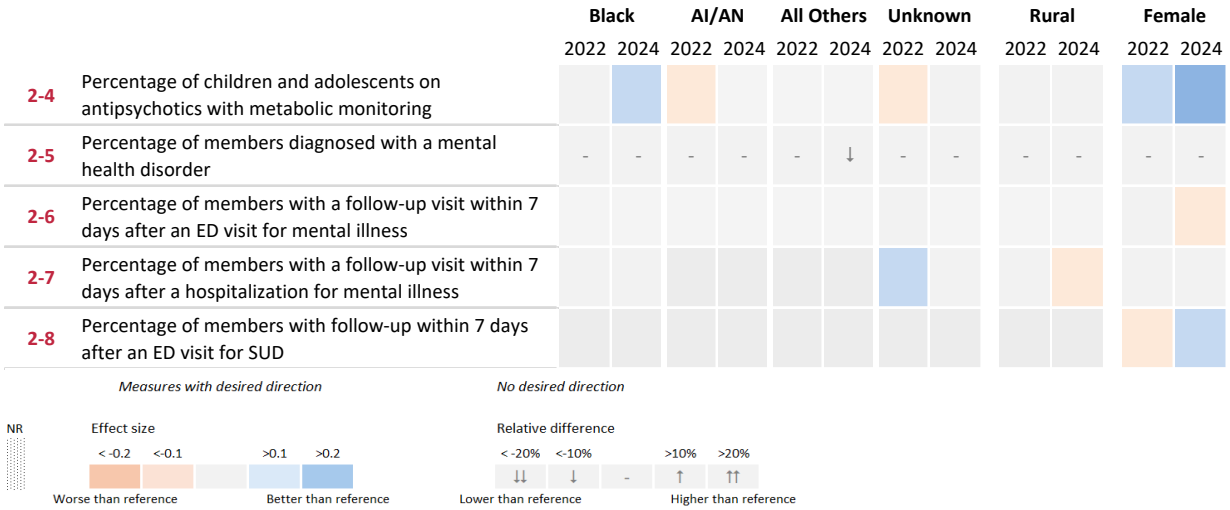
[3]Change in Rate compares the rate or number in the baseline period (10/01/2016–09/30/2020) to the average rate or number in the evaluation period (10/1/2021–09/30/2024). Rates from the ramp-up period (10/01/2020–09/30/2021) are excluded from analysis.

Table 8-10 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in FFYs 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among DCS CHP members. Each cell color or

[103] Sappenfield O, Alberto C, Minnaert J, et al. Adolescent Mental and Behavioral Health, 2023. National Survey of Children's Health. Available at: https://www.ncbi.nlm.nih.gov/books/NBK608531/. Accessed on: Dec 22, 2025.

arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 8-10—Research Question 2.3, Disparities Analysis



Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. ED: emergency department. NR: not reportable due to suppression guidelines. SUD: substance use disorder.

Research Question 2.4: Do DCS CHP members have the same or lower hospital utilization in the remeasurement period as compared to the baseline?

Table 8-11 utilized PMMIS data to compare members' emergency department (ED) and hospital utilization between the baseline and evaluation periods.

Key Findings:

- The *Number of emergent ED visits* and the *Number of non-emergent ED visits* per 1,000 member months exhibited minimal changes between the baseline and evaluation periods, and no changes were statistically significant; however, the emergent ED visit rates each year were at least 11.97 visits lower than the baseline projection, indicating the rate of increase slowed during the evaluation period (p<0.001 for all years).
  - In 2022 and 2024, rural members had lower (better) rates of non-emergent ED visits per 1,000 member months compared to urban members. Female members had higher (worse) rates of non-emergent ED visits per 1,000 member months compared to male members in 2022 and 2024.
- The *Number of IP stays per 1,000 member months* increased by 0.79 stays, a 25 percent ([3.96 / 3.17] – 1) relative increase between the baseline and evaluation periods (p<0.001); however, the inpatient (IP) stay rates each year were lower than the baseline projection, indicating the rate of increase slowed during the evaluation period (p=0.020, p=0.178, and p=0.034, respectively).

DCS CHP members had similar rates of ED and hospital utilization in the baseline and evaluation periods; however, the rates of emergent ED visits and IP stays were lower in the evaluation period than the baseline projection, indicating that the increase in emergent ED and IP rates in the baseline period began to slow in the evaluation period.

Table 8-11—Research Question 2.4, Measures 2-9 through 2-11

		Regression-Adjusted Rates[1]		Pre/Post Change in Rate[2]	Trend Model Difference Between Actual and Projected (*p*-value)		
		Baseline Average	Evaluation Average	(*p*-value)	FFY 2022	FFY 2023	FFY 2024
2-9	Number of emergent ED visits per 1,000 member months (no desired direction)	41.37	43.45	2.09 (0.429)	-15.42 *** (<0.001)	-14.14 *** (<0.001)	-11.97 *** (<0.001)
2-10	Number of non-emergent ED visits per 1,000 member months (lower is better)	1.78	1.77	-0.01 (0.931)	<0.01 (0.992)	0.27 (0.458)	0.58 (0.195)
2-11	Number of IP stays per 1,000 member months (no desired direction)	3.17	3.96	0.79 *** (<0.001)	-1.26 ** (0.020)	-1.03 (0.178)	-1.96 ** (0.034)

*p <0.1, **p <0.05, ***p <0.001

Note: ED: emergency department; FFY: federal fiscal year; IP: inpatient; pp: percentage point.

Data Source: PMMIS data were used in the analysis of RQ 2.4.

[1]Rates are adjusted for the effect of the COVID-19 PHE in 2020.

[2]Change in Rate compares the rate or number in the baseline period (10/01/2016–09/30/2020) to the average rate or number in the evaluation period (10/1/2021–09/30/2024). Rates from the ramp-up period (10/01/2020–09/30/2021) are excluded from analysis.

Table 8-12 displays results from a disparities analysis for measures utilizing PMMIS data based on rates calculated in FFYs 2022 and 2024. For each stratification, results from FFY 2022 are presented in the first column, followed by results from FFY 2024 in the second. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group among DCS CHP members. Each cell color or arrow represents the degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Table 8-12—Research Question 2.4, Disparities Analysis

		Black		AI/AN		All Others		Unknown		Rural		Female	
		2022	2024	2022	2024	2022	2024	2022	2024	2022	2024	2022	2024
2-9	Number of emergent ED visits per 1,000 member months	-	↓	↓	↓	⇊	-	↓	↓	-	-	-	↑
2-10	Number of non-emergent ED visits per 1,000 member months†↓												
2-11	Number of IP stays per 1,000 member months	-	↑↑	-	↑		⇊	-	↓	-	⇊	-	-

Measures with desired direction *No desired direction*

NR Effect size < -0.2 <-0.1 >0.1 >0.2 Relative difference

Relative difference† < -20% <-10% >10% >20% < -20% <-10% >10% >20%

⇊ ↓ - ↑ ↑↑

Worse than reference Better than reference Lower than reference Higher than reference

Note: Reference groups are White/Caucasian, Urban, Male. AI/AN: American Indian/Alaska Native. ED: emergency department. IP: Inpatient; NR: not reportable due to suppression guidelines.

↓Lower measure rates indicate better performance. Disparities analysis presented reflects the desired direction.

†Relative difference is used for this measure.

Hypothesis 3: DCS CHP encourages and/or facilitates care coordination among PCPs and BH practitioners.

Hypothesis 3 was designed to identify the activities conducted by DCS CHP to further integrate care by supporting care coordination and management. Qualitative interviews were conducted with DCS CHP staff in October 2025 to discuss the Waiver, including care integration, implementation successes and challenges, and workforce shortages. The following sections summarize the results of the key informant interviews. Additional detailed results can be found in Appendix A, Supplemental Results.

Research Question 3.1: What barriers did DCS CHP anticipate/encounter during the integration?

DCS CHP reported several approaches to support members' health and well-being, and promote the integration of BH and physical health (PH) care, including identifying key barriers encountered. Key themes related to these barriers included:

- **Levels of provider integration**: DCS CHP shared that there is room for growth in PH and BH integration among providers, particularly at higher levels of care. For example, child family teams primarily discussed BH needs, with no formal mechanism to involve PH providers.
- **Provider workforce shortages**: DCS CHP reported shortages in the BH provider workforce due to limited interest in working with the DCS CHP population's unique and challenging health care needs.

Research Question 3.2: What care coordination strategies did DCS CHP plan/implement during integration?

DCS CHP described several approaches to robust care coordination for its members, with an emphasis on stakeholder collaboration and automatic care coordination enrollment. Key themes included:

- **Proactive care coordination assignment and involvement**: All members were assigned to care coordination without exception. Coordination teams proactively reached out to caregivers, screened for PH conditions, and assessed BH needs.[104]
- **Consistent internal coordination and collaboration**: DCS CHP met internally to discuss cases or events and actions taken, sharing awareness of potential barriers such as ensuring the appropriate level of care and solutions such as automatically assigning all members to participate in care coordination.
- **Collaboration with DCS CHP and other AHCCCS plans**: DCS CHP met regularly with their subcontractor, Mercy Care Plan, to discuss discharges, members waiting for an alternative level of care placement, and target populations including transition-age youth, children's rehabilitative services, and maternity. In addition, DCS CHP collaborated with other AHCCCS plans to promote successful transitions for members who were adopted and moved to another plan.

Research Question 3.3: What barriers to implementing care coordination strategies did DCS CHP anticipate/encounter?

DCS CHP described several barriers encountered while coordinating care for DCS CHP members. Key themes included:

- **Challenges due to the unique DCS CHP member population**: DCS CHP reported that the plan is often more informed on members' care plans and histories than guardians, adding a unique layer to care coordination processes that typically rely on guardian involvement. In addition, DCS CHP functions as the members' custodial agent and plan, which created unique challenges in determining what health information can be shared and with which stakeholders.[105]
- **Workforce shortages**: DCS CHP reported workforce shortages, which exacerbated challenges with care coordination and disrupted continuity of care for members.

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104 See Appendix A for additional details on strategies, populations impacted, and continued barriers.
105 See Appendix A for additional details on continued barriers to successful care coordination.

Hypothesis 4: DCS CHP provides cost-effective care.

There are no specific measures associated with this hypothesis. To assess the cost-effectiveness of care provided, an ITS analysis was conducted on the cost of care to analyze the differences between actual and projected costs during the evaluation period, which is intended to address research questions 4.1 and 4.2. Separate analyses are conducted at the per-member per-month (PMPM) level and at the total aggregated cost level. Costs were adjusted for medical inflation and are presented in terms of September 2024 dollars.

It is important to note that the cost analyses do not refer to or attempt to replicate the formal Budget Neutrality test required for Section 1115 Waiver Demonstrations. Additionally, the cost-effectiveness analysis does not involve a direct comparison of costs and savings, as program benefits may be non-pecuniary in nature, such as provision of new services that previously were unavailable, increased employment opportunities leading to improved financial well-being, lower mortality rates, and improved health outcomes overall. Furthermore, some outcomes may manifest over an extended period of time and may not be measurable at the time of the evaluation.

Research Question 4.1: What are the costs associated with the integration of care in the DCS CHP?

The results related to Research Questions 4.1 and 4.2 assessing the costs and associated benefits/savings with DCS CHP during the renewal period are addressed jointly in Research Question 4.2 below.

Research Question 4.2: What are the benefits/savings associated with the integration of care in the DCS CHP?

Table 8-13 and Figure 8-2 utilized PMMIS data to examine the changes in PMPM costs for the DCS CHP population before and after integration of care in April 2021 through an ITS analysis. Average PMPM costs were approximately $525, and the inflation-adjusted trend in costs increased during both the baseline and evaluation periods. Professional and IP costs contributed the greatest to the increasing PMPM cost trend. Notably, both inpatient and OP (ED) PMPM declined at the time of DCS CHP integration, which lead to an overall reduction in average PMPM costs of approximately $174.

Table 8-14 and Figure 8-3 utilized PMMIS data to assess the changes in aggregated costs among the DCS CHP population before and after integration through an ITS analysis. Total cost of care for the DCS CHP population averaged approximately $8.6 million in the first month of the baseline period and increased by nearly $0.09 million per month during the baseline period. Although there was an increase in the average aggregated cost upon integration of approximately $0.8 million (which was driven primarily by professional costs), the trend in total costs declined by approximately $0.1 million per month relative to the baseline trend. This led to overall decline in aggregate spending across the DCS CHP population during the evaluation period.

Key Findings:

- **PMPM Costs**
  - Total PMPM costs averaged $525.12 at the beginning of the baseline period and increased by $10.26 per month during the baseline (p<0.001). Following DCS CHP integration, average total PMPM costs decreased by $173.64 (***p***<0.001).Although the trend in costs increased by $2.00 per month during the evaluation period relative to the baseline trend, this was not statistically significant (***p***=0.140).
  - The primary driver of PMPM costs were professional and IP, which increased by $5.63 and $4.17 per month, respectively, during the baseline period (p<0.001 for both).
  - Although IP costs increased during both the baseline and evaluation periods, average PMPM IP costs declined by $153.08 ($p$<0.001) upon implementation of DCS CHP. Similarly, OP (ED) costs declined by $6.22 ($p$<0.001) upon implementation and declined by $0.14 ($p$=0.030) per month during the evaluation period relative to the baseline trend.
- **Aggregate Costs**
  - Total costs among the DCS CHP population averaged $8,614.0 thousand at the beginning of the baseline period. Although costs increased by $86.9 thousand per month during the baseline period, this trend reversed during the evaluation period with a decrease of $140.9 thousand per month relative to the baseline period trend (p<0.001 for both).
  - The primary driver of costs were professional with an average of $4,793.2 thousand at the beginning of the baseline period and saw an increase of $1,570.1 thousand on average upon DCS CHP integration (p<0.001).
  - The monthly trend among several categories of service increased significantly during the baseline period but saw significant a relative decline following implementation. Professional costs declined by an average of $103.0 thousand per month relative to the baseline trend and inpatient costs declined by an average of $34.8 thousand per month relative to the baseline trend (p<0.001 and p=0.002, respectively). Both ED and non-ED OP costs also experienced significant declines in the trend.

Table 8-13—DCS CHP PMPM Costs

	Estimate (p-value)						
Variable	Total	Professional	IP	LTC	OP (ED)	OP (Non-ED)	Pharmacy
Intercept	$525.12 *** (<0.001)	$289.84 *** (<0.001)	$147.15 *** (<0.001)	$0.00 —	$10.44 *** (<0.001)	$9.12 *** (<0.001)	$68.57 *** (<0.001)
Baseline monthly trend	$10.26 *** (<0.001)	$5.63 *** (<0.001)	$4.17 *** (<0.001)	$0.00 —	$0.31 *** (<0.001)	$0.42 *** (<0.001)	$-0.27 (0.441)
Level change at implementation	$-173.64 *** (<0.001)	$-17.06 (0.418)	$-153.08 *** (<0.001)	$0.00 —	$-6.22 *** (<0.001)	$2.85 (0.340)	$-0.14 (0.993)
Change in monthly trend	$2.00 (0.140)	$-0.37 (0.621)	$1.43 (0.102)	$0.00 —	$-0.14 ** (0.030)	$-0.42 *** (<0.001)	$1.51 ** (0.005)

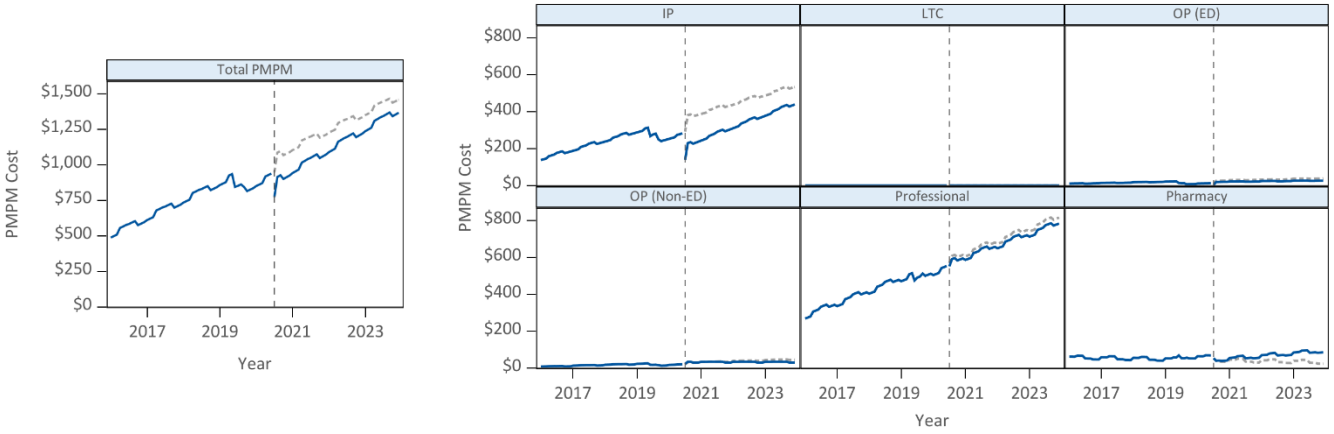
*p <0.1, **p <0.05, ***p <0.001

Note: Full model results are presented in Appendix A, Attachments. Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

— Indicates there were no costs associated with the category of service for this population and statistical testing was not conducted.

Data Source: PMMIS data were used in the analysis of RQ 4.1 and 4.2.

Figure 8-2—DCS CHP PMPM Costs



Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. This figure presents the model-based average rate in each month (blue line) and the projected rates had the baseline trend continued (grey dashed line). The grey vertical dashed line indicates the DCS CHP integration date (October 1, 2021). ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient; PMPM: per-member per-month.

Table 8-14—DCS CHP Total Aggregate Costs (in Thousands)

Variable	Estimate in Thousands (*p*-value)						
	Total	Professional	IP	LTC	OP (ED)	OP (Non-ED)	Pharmacy
Intercept	$8,614.0 *** (<0.001)	$4,793.2 *** (<0.001)	$2,438.2 *** (<0.001)	$0.0 —	$172.8 *** (<0.001)	$151.5 *** (<0.001)	$1,058.2 *** (<0.001)
Baseline monthly trend	$86.9 *** (<0.001)	$46.6 *** (<0.001)	$41.7 *** (<0.001)	$0.0 —	$3.1 *** (<0.001)	$4.6 *** (<0.001)	-$9.0 ** (0.009)
Level change at implementation	$760.3 * (0.075)	$1,570.1 *** (<0.001)	-$1,129.4 *** (<0.001)	$0.0 —	-$17.2 (0.427)	$100.1 ** (0.012)	$236.7 * (0.093)
Change in monthly trend	-$140.9 *** (<0.001)	-$103.0 *** (<0.001)	-$34.8 ** (0.002)	$0.0 —	-$5.2 *** (<0.001)	-$9.7 *** (<0.001)	$11.8 ** (0.021)

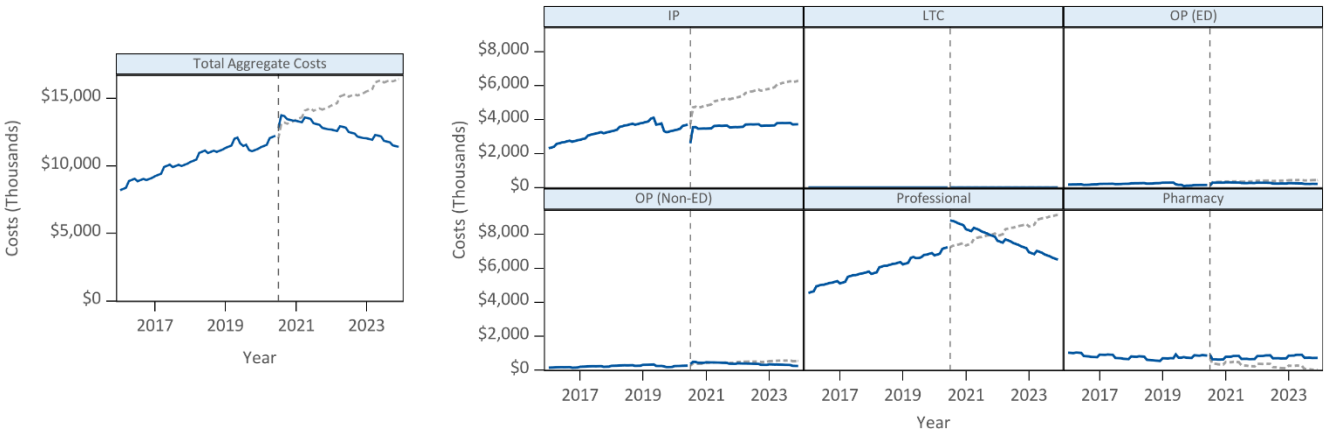
*p <0.1, **p <0.05, ***p <0.001

Note: Full model results are presented in Appendix A, Attachments. Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

— Indicates there were no costs associated with the category of service for this population and statistical testing was not conducted.

Data Source: PMMIS data were used in the analysis of RQ 4.1 and 4.2.

Figure 8-3—DCS CHP Total Aggregate Costs (in Thousands)



Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. This figure presents the model-based average rate in each month (blue line) and the projected rates had the baseline trend continued (grey dashed line). The grey vertical dashed line indicates the DCS CHP integration date (October 1, 2021). ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

9. H2O Results

This chapter describes the quantitative and qualitative results for the evaluation of the Housing and Health Opportunities (H2O) program evaluation. A complete list of measures and their specifications is available in the Evaluation Designs linked in the Appendix.

On October 14, 2022, CMS approved the H2O amendment to the Waiver, effective October 14, 2022, through September 30, 2027.[106] The program was officially implemented on October 1, 2024. As a result, findings are largely informational and some cannot yet be reported in this Interim Evaluation Report.

The H2O evaluation was limited to (1) assessing pre-implementation trends among measures that relied on Prepaid Medical Management Information System (PMMIS) data, and (2) evaluating a single year for measures that used H2O program data.

When interpreting H2O results, it is important to note that member enrollment was identified using the *Eligibility Determination Date* in the H2O-PA data, which reflects when members were first identified as eligible for H2O services. Additionally, the comparison population consisted of members on the Arizona Health Care Cost Containment System (AHCCCS) Housing Program (AHP) waitlist who had not been determined eligible for the H2O program. The AHP waitlist was not limited to members eligible for H2O services and therefore represents a broader cohort with generally less complex needs than the H2O intervention population.

All measure results that relied on PMMIS data were calculated only during the baseline period, as complete claims were available through September 30, 2024. Therefore, only pre-intervention trends are presented, and no causal relationships can be drawn between the changes in the rates and the H2O program. When possible, post-implementation data derived from the H2O-Program Administrator (PA) and beneficiary surveys were used for the evaluation period (federal fiscal year [FFY] 2025).

Survey results among H2O members and members on the AHP waitlist were largely suppressed, or statistically significant differences between the groups could not be identified because of small sample sizes.

Furthermore, results obtained from the H2O-PA data represent a single report that consolidates information from a variety of data systems (e.g., electronic health record [EHR], Homeless Management Information System [HMIS], and data collected by the H2O Program Administrator [Solari]). Substantial challenges with data completeness and quality are expected to be resolved before the development of the Summative Evaluation Report. Solari, H2O-PA, has developed a live dashboard that provides additional information on program performance and member outcomes and can be used to access more up-to-date data on H2O program performance.[107] At the time of this Interim Evaluation Report, H2O-PA data were available only through FFY 2025, limiting the evaluation to a single year after implementation. The Summative Evaluation Report will assess changes in health-related social needs (HRSN) from program implementation through FFY 2027.

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106 Centers for Medicare & Medicaid Services. H2O Amendment Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-ca-10142022.pdf. Accessed on: Jun 10, 2026.

107 Solari Crisis & Human Services. H2O Dashboards. Available at: https://community.solari-inc.org/h2o-dash/. Accessed on: Jun 15, 2026.

H2O Program Results

Hypothesis 1: The demonstration will meet or reduce the severity of HRSN for members overall and among subpopulations who experience disparities in HRSN.

Hypothesis 1 assessed whether H2O reduced HRSN severity among participating members. Data sources used to address eight research questions included H2O-PA, AHP waitlist enrollment, Closed-Loop Referral System (CLRS), maintenance of effort (MOE) reports, PMMIS, United States Department of Housing and Urban Development Continuum of Care (HUD CoC), American Community Survey (ACS), key informant interview, and survey data. Key informant interviews conducted with AHCCCS in October 2025 examined changes in State investments in housing supports. Due to data availability limitations, several measures were either modified or could not be calculated. Deviations from the Evaluation Design included the following:

- Measure 1-2: *Percentage of members participating in H2O who completed an intake and received a service within seven days* of enrollment was modified to reflect services received within 22 days of eligibility. This modification allows for the contract expectation of assigning a member to a provider within seven business days of establishing eligibility, and accounts for 15 additional days for the provider to intake each member and administer a service.
- Measure 1-6: *Number of members on the AHP waitlist who are also H2O eligible* was modified to reflect the percentage of members on the AHP waitlist who have an H2O exception code.
- Measure 1-7: *Percentage of members referred to receive short term rental assistance who locate housing within 120 days*, was not reported due to a lack of available data. Results for this measure are anticipated to be included in the Summative Report.
- Measure 1-8: *Number of enhanced shelter bed inventory statewide* was modified to reflect the number of emergency shelter beds.
- Measure 1-13: *Number of unique H2O referrals sent to providers by H2O-PA (H2O-Program Administrator) (any referral and referral type)* was modified to focus on the number of unique members eligible for H2O, who received each referral type, rather than the number of referrals overall. The measure name has been updated to the *percentage of unique H2O members referred to any service*.
- Measure 1-15: *Percent of members with substance use disorder (SUD) diagnosis participating in H2O who connect to outpatient (OP) SUD/recovery services* was originally intended to be calculated by identifying the percentage of members with an SUD diagnosis who access services; however, this measure was limited to members participating in housing pre-tenancy and tenancy services, regardless of formal SUD diagnosis. Therefore, results reported reflect utilization of OP SUD services among H2O members who participate in housing pre-tenancy and tenancy services.
- Data were not available at the time of the Interim Evaluation Report to calculate Measure 1-18*, Percent of members who are enrolled in Supplemental Nutrition Assistance Program (SNAP) or Women, Infants, and Children (WIC)*; however, these data are anticipated to be available for the Summative Evaluation Report.
- Measure 1-19: *Number of stays in an emergency shelter per 1,000 members* was modified to examine the rate of persons who stayed in an emergency shelter or unsheltered homelessness per 1,000 Arizona residents because data were not available to identify emergency shelter utilization specifically among H2O members. Therefore, results for this measure are not presented in this Interim Report but are anticipated to be included in the forthcoming Summative Report.
- Measure 1-20: *Number of days in an emergency shelter or state of unsheltered homelessness per 1,000 members* was modified to *Number of days in an emergency shelter or state of unsheltered homelessness*

because data were not available to identify the days spent in an emergency shelter among H2O members. Therefore, results for this measure are not presented in this Interim Report but are anticipated to be included in the forthcoming Summative Report.

- Measure 1-23: *Percentage of members with housing retention, among members participating in H2O who utilize pre-tenancy/tenancy services* was not reported due to a lack of available data. Results for this measure are anticipated to be included in the Summative Report.
- Measure 1-24: *Percentage of members who exit to permanent housing, among members participating in H2O who utilize enhanced shelter services* was not updated to reflect the percentage of participating in H2O who utilize enhanced shelter services, who completed the program or exited to a positive housing destination.
- Measure 1-25: *Percentage of members participating in H2O whose housing condition was upgraded during the past month* was updated to reflect the percentage of members participating in H2O whose housing condition was upgraded since intake.
- Measure 1-27: *Percentage of members participating in H2O who reported employment during engagement (no desired direction)*, was modified to limit to H2O members who participated in enhanced shelter services, short-term rental assistance, or housing pre-tenancy and tenancy services.
- Measure 1-28: *Percentage of members participating in H2O who increased employment during past month* was not reported due to a lack of available data. Results for this measure are anticipated to be included in the Summative Report.
- Measure 1-29: *Change in income among members participating in H2O who utilize pre-tenancy/tenancy services* was not reported due to a lack of available data. Results for this measure are anticipated to be included in the Summative Report.

Research Question 1.1: How does the H2O demonstration impact the use of HRSN services?

Table 9-1 utilized H2O-PA data to identify the percentage of members receiving services within the program in federal fiscal year (FFY) 2025. At the time of this Interim Evaluation Report, H2O-PA data were only available through FFY 2025, limiting the evaluation to a single year after implementation. Additionally, the H2O-PA data are known to have some challenges with completeness and data quality, which are anticipated to be resolved by the Summative Evaluation Report. Table 9-2 and Table 9-3 utilized H2O-PA enrollment and AHP waitlist data to identify the number of members eligible for and participating in H2O. Table 9-2 utilized Continuum of Care (COC) data to identify the number of emergency shelter bed inventory available statewide.

Key Findings:

Evaluation Period:

- The data provided to identify members contacted by H2O were limited to members who ultimately enrolled in H2O, which resulted in a rate of 100 percent among members identified as experiencing homelessness who were contacted by H2O.
- Approximately 10 percent of members participating in H2O received services within twenty-two days of eligibility determination.[108]
- In FFY 2025, 65.7 percent of members eligible for H2O were participating in the H2O program.
- Nearly all members enrolled in H2O who completed a housing assessment established a housing care plan (95.7 percent).
- Among members enrolled in H2O, 65.7 percent received services from at least one of the six service categories. Housing pre-tenancy and tenancy services was the most common category, with 61.6 percent of members receiving services, while no members

[108] A supplemental analysis identified that 22.3 percent of members were referred to a service within seven days of H2O eligibility.

received medically necessary home accessibility modifications and remediation. Among all members eligible for H2O, 13.3 percent were referred to the RBHA higher level of care.

- The percentage of AHP waitlist members who were also eligible for H2O was 9.6 percent in FFY 2025.

Baseline Period:

- The number of emergency shelter beds available statewide decreased by 4,367 beds between calendar years (CYs) 2023 and 2024. This decrease was partially attributable to the expiration of federal funds in 2024, which previously funded over 1,000 shelter beds in the State.[109] The sharp decline in shelter beds may have exacerbated the need for alternative State housing support, such as H2O.

The percentage of members on the AHP waitlist who were also H2O eligible was 9.6 percent during the first year of H2O implementation (FFY 2025). During calendar year 2024, statewide resources, such as emergency shelter beds, declined dramatically. Members enrolled in H2O were often connected to pre-tenancy and tenancy services, with 65.7 percent of members receiving such services during enrollment.

Table 9-1—Research Question 1.1, Measures 1-1 through 1-6

How does the H2O demonstration impact the use of HRSN services?		
		Evaluation Period
		2025
1-1	Percentage of members experiencing homelessness who were contacted	100% N=1,508
1-2	Percentage of members participating in H2O who completed an intake and received a service within 22 days of eligibility	9.8% N=1,508
1-3	Percentage of members eligible for H2O, who are participating in the H2O program	65.7% N=1,308
1-4	Percentage of members participating in H2O who completed an assessment who established a housing care plan	95.7% N=47
1-5	Percentage of members participating in H2O, who are receiving H2O services (any service and by service category)	
	Any service	65.7% N=1,308
	Housing pre-tenancy and tenancy services	61.6% N=1,308
	Short term rental assistance	11.1% N=1,308
	Outreach and education services	9.5% N=1,308
	One-time transition and move-in costs	6.4% N=1,308
	Enhanced shelter	3.4% N=1,308
	Medically necessary home accessibility modifications and remediation	0.0% N=1,308
1-5a	Percentage of members participating in H2O, who were referred to RBHA higher level of care	13.3% N=1,508
1-6	Percentage of members on the AHP waitlist who are also H2O eligible	9.6% N=7,111

Note: AHP: Arizona Health Care Cost Containment System Housing Program; HRSN: health-related social needs; H2O: Housing and Health Opportunities; PA: Program Administrator; RBHA: Regional Behavioral Health Agreement.
Evaluation Period: 09/30/2025.
Data Source: H2O-PA and AHP waitlist data were used in the analysis of RQ 1.1.

[109] Maricopa Association of Governments. Point in Time Homelessness Count Sees Increase in People Living Unsheltered. Available at: https://azmag.gov/Newsroom/News-Releases/point-in-time-homeless-count-sees-increase-in-people-living-unsheltered. Accessed on: Mar 11, 2026.

Table 9-2—Research Question 1.1, Measure 1-8

How does the H2O demonstration impact the use of HRSN services?					
		Baseline Period			Baseline Average
		2022	2023	2024	
1-8	Number of emergency shelter beds statewide	4,272	5,694	1,327	3,764

Note: HRSN: health-related social needs; H2O: Housing and Health Opportunities.
Baseline period: CY 2022–CY 2024.
Data Source: Arizona Continuum of Care Homeless Assistance Programs Housing Inventory Count Report data were used in the analysis of

Research Question 1.2: How do State and local government investments in housing supports change in relation to H2O demonstration funding?

Table 9-3 utilized MOE reports provided by AHCCCS to assess State investments in housing supports external to the Waiver during the evaluation period. The MOE reports contained information regarding funding for different State agency programs. Several State agencies reported continued or expanded investments aligned with H2O implementation.

Table 9-3—State Investments in Housing Support

Agency/Department Name	Investment Description
AHCCCS (General Fund Appropriation)	Funded rental assistance, eviction prevention, and move-in assistance for members with an SMI.
DES	Funded rental assistance operations and essential services for shelters, eviction prevention, and move-in services; additionally funded housing assistance for individuals at least age 60 years.

Note: ADOH: Arizona Department of Housing; AHCCCS: Arizona Health Care Cost Containment System; DES: Department of Economic Security; DPS: Department of Public Safety; OP: outpatient; SMI: serious mental illness; SUD: substance use disorder.

AHCCCS also described ways in which housing support changed due to H2O. Key investments included the following:

- **Infrastructure**: AHCCCS utilized H2O funding to provide hiring incentives for providers to recruit, and train dedicated staff on H2O service delivery.
- **Integration**: AHCCCS emphasized integrating existing long-term housing support with H2O services, given the six-month service limit, enhanced shelter services, and short-term rental assistance provided through the Waiver.

Additionally, the H2O-PA shared that the State prioritized investments in housing trust funds, which expanded opportunities for affordable housing development and housing vouchers.

Research Question 1.3: How does the H2O demonstration impact rates of HRSN and their severities?

Table 9-4 utilized H2O-PA data to identify H2O-eligible members and H2O-specific referrals as well as CLRS data to identify the rate of CLRS-specific screenings among H2O members. The CLRS data provides insight into the prevalence of needs identified from screenings and the H2O-PA data identifies H2O service referrals. At the time of this Interim Evaluation Report, H2O-PA data were only available through FFY 2025, limiting the evaluation to a single year after implementation. The CLRS does not identify all screenings that members may receive, therefore, the results presented here reflect a subset of screenings. Table 9-5 utilized beneficiary surveys to assess the impact of H2O on members' HRSN.

Key Findings:

Evaluation Period:

- In FFY 2025, 32.9 percent of H2O members received HRSN/social determinants of health (SDOH) screenings using the CLRS screening tool. Among the members who received a screening, 83.3 percent identified an HRSN or SDOH need and 79.2 percent identified a housing-related need.
- Among all members participating in H2O, 97.4 percent received a referral to an H2O provider, with housing pre-tenancy and tenancy services being the most common referral type (84.0 percent). Members were also commonly referred to outreach and education services, Regional Behavioral Health Authority (RBHA) higher level of care, and short-term rental assistance.
- During the evaluation period, 21.8 percent of members participating in H2O were connected to a RBHA permanent supportive housing (PSH) provider.
- Approximately 19 percent of members participating in H2O, who received housing pre-tenancy and tenancy services were connected to OP SUD recovery services. Notably, not all members have a formal SUD diagnosis or require SUD-related treatment.
- The *Percent of members indicating they were not able to pay mortgage, rent, or utility bills in the last three months* was 9.6 percentage points lower for H2O members enrolled in H2O compared to those on the AHP waitlist; however, this difference was not statistically significant (p=0.266). Although the difference in the rates was not statistically significant, the difference suggests a small positive effect, with an effect size of 0.19. The *Percent of members indicating that a utility company threatened to shut off services in the past three months* could not be reported due to suppression rules.[110]

Most screened H2O members had a HRSN, SDOH, or housing-specific need identified; however, only 32.9 percent of H2O members were screened using the CLRS in FFY 2025, highlighting an opportunity to enhance screening efforts among this population. Nearly all members participating in H2O received a referral to an H2O service provider, often for pre-tenancy and tenancy services.

[110] Suppression criteria follow the Centers for Medicare & Medicaid Services (CMS) Cell Size Suppression Policy and rates with denominators less than 30 are not reported. Available at: https://resdac.org/articles/cms-cell-size-suppression-policy. Accessed on: Mar 11, 2026.

Table 9-4—Research Question 1.3, Measures 1-10 through 1-15

How does the H2O demonstration impact rates of HRSN and their severities?		Evaluation Period
		2025
1-10	Percentage of members who participated in H2O services that received a HRSN/SDOH screening with the PRAPARE screening tool or other appropriate screening tool	32.9% N=1,508
1-11	Percentage of members who participated in H2O services that had an HRSN identified, among those who received an HRSN/SDOH screening (no desired direction)	83.3% N=496
1-12	Percentage of members who had a housing-related need identified, among those who received an HRSN/SDOH screening (no desired direction)	79.2% N=496
1-13	Percentage of unique H2O members referred to any service	
	Any Referral	97.4% N=1,508
	Housing pre-tenancy and tenancy services	84.0% N=1,508
	Outreach and education services	18.1% N=1,508
	RBHA Higher Level of Care	13.3% N=1,508
	Short term rental assistance	11.1% N=1,508
	One-time transition and move-in costs	7.8% N=1,508
	Enhanced shelter	3.6% N=1,508
	Medically necessary home accessibility modifications and remediation	0.0% N=1,508
1-14	Percentage of members participating in H2O who were connected to a RBHA PSH provider for ongoing supportive services	21.8% N=1,508
1-15	Percent of members participating in housing pre-tenancy and tenancy services who connect to OP SUD/recovery services	18.6% N=826

Note: HRSN: health-related social needs; H2O: Housing and Health Opportunities; OP: outpatient; PA: Program Administrator; PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences; PSH: permanent supportive housing; RBHA: Regional Behavioral Health Agreement; SDOH: social determinants of health; SUD: substance use disorder.
Evaluation Period: 09/30/2025.
Data Source: H2O-PA data and CLRS data were used in the analysis of RQ 1.3.

H2O members indicated that they were unable to pay mortgage, rent, or utility bills in the last three months at a lower rate than those on the AHP waitlist.

Table 9-5—Research Question 1.3, Measures 1-16 and 1-17

How does the H2O demonstration impact rates of HRSN and their severities?				
		Evaluation Period Weighted Rate[1]		
		H2O	AHP Waitlist	Difference in Rates (*p*-value)
1-16	Percent of members indicating they were not able to pay mortgage, rent or utility bills in the last three months (lower is better)	34.8% N=47	44.5% N=166	-9.6pp (0.266)
1-17	Percent of members indicating that a utility company threatened to shut off services in the past three months (lower is better)	S N=47	21.7% N=165	S

*p <0.1, **p <0.05, ***p <0.001

Note: N represents the number of survey responses. S indicates rates with numerators between 0 and 10 members or denominators smaller than 30 members, which are suppressed due to potentially unreliable statistical testing and rate calculation and to ensure anonymity. Surveys were administered in calendar year (CY) 2025. AHP: AHCCCS Housing Program; HRSN: health-related social needs; H2O: Housing and Health Opportunities; pp: percentage point.

Data Source: Beneficiary surveys were used in the analysis of RQ 1.3.

[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health

Research Question 1.4: How does the H2O demonstration impact members' use of HRSN services reflecting crisis events, such as stays in emergency homeless shelters?

Table 9-6 utilized beneficiary survey data to assess the impact of H2O on members' HRSN service utilization in crisis events. Table 9-7 utilized H2O-PA data to assess the member's housing and employment outcomes in the first year of H2O participation. At the time of this Interim Evaluation Report, H2O-PA data were only available through FFY 2025, limiting the evaluation to a single year after implementation. Additionally, the H2O-PA data is known to have some challenges with completeness and data quality, which are anticipated to be resolved by the Summative Evaluation Report.

Key Findings:

Evaluation Period:

- The *Percentage of members reporting they used an emergency shelter in the last six months* was 29.9 percent among members who were ultimately enrolled in H2O at a later time, a result 11.6 percentage points lower for the H2O baseline compared to those on the AHP waitlist; a statistically significant difference (p=0.098). Although there is no desired direction for this measure, the difference suggests a large effect, with a relative percent difference of 63.4 percent ([29.9 percent / 18.3 percent] -1). The *Percentage of members reporting they slept in a place not meant for human habitation in the last six months* was 5.4 percentage points higher for the H2O baseline compared to AHP waitlist members; however, this difference was not statistically significant (p=0.487). Although the difference in the rates was not statistically significant, the difference suggests a small negative effect, with an effect size of -0.12.
- Among members participating in H2O who exited the enhanced shelter services program, 89.7 percent completed the program or exited to a positive housing destination.

- During FFY 2025, the first year of program operation, 15.7 percent of members had their housing condition upgraded from their housing status at intake. Although the results presented in this Interim Report represent a static insight into the H2O program, the H2O-PA, Solari, developed a live dashboard which includes a variety of outcomes related to the H2O program. At the time of the Interim Report, the dashboard identifies that 37.4 percent of H2O members had their housing condition upgraded between entry into H2O and the most recent contact.[111]
- Among members participating in H2O, 26.7 percent left the program within the first year. Of these members, 29.1 percent had a positive exit reason, while 17.2 percent had a negative exit reason.

Outcomes related to employment, housing conditions, and housing retention improved in the first year of the H2O demonstration. H2O members reported lower use of emergency shelters in the last six months compared to those on the AHP waitlist, a statistically significant difference. Additionally, H2O members reported higher rates of instances of sleeping in a place not meant for human habitation in the last six months compared to AHP waitlist members, although this difference was not statistically significant. A supplemental question assessed whether members believed that they would have support from friends or family during a crisis. Among members on the AHP waitlist, 41.0 percent believed they would "Usually" or "Always" have support, while the rate was 6.9 percentage points lower among H2O members (p=0.430).

Table 9-6—Research Question 1.4, Measures 1-21 and 1-22

How does the H2O demonstration impact members' use of HRSN services reflecting crisis events, such as stays in emergency homeless shelters?		Evaluation Period Weighted Rate[1]		
		H2O	AHP Waitlist	Difference in Rates (p-value)
1-21	Percentage of members reporting they used an emergency shelter in the last six months (no desired direction)	29.9% N=54	18.3% N=168	11.6pp * (0.098)
1-22	Percentage of members reporting they slept in a place not meant for human habitation in the last six months (lower is better)	27.1% N=49	21.8% N=168	5.4pp (0.487)

*p <0.1, **p <0.05, ***p <0.001

Note: N represents the number of survey responses. Surveys were administered in calendar year (CY) 2025. AHP: AHCCCS Housing Program; HRSN: health-related social needs; H2O: Housing and Health Opportunities; pp: percentage point.

Data Source: Beneficiary surveys were used in the analysis of RQ 1.4.

[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP Code.

111 Solari Crisis & Human Services. H2O Dashboards. Available at: https://community.solari-inc.org/h2o-dash/. Accessed on: Jun 15, 2026.

Table 9-7—Research Question 1.4, Measures 1-24, 1-25 through 1-27

Is the H2O demonstration associated with increased positive health and wellbeing outcomes?		Evaluation Period
		2025
1-24	Percentage of participating in H2O who utilize enhanced shelter services, who completed the program or exited to a positive housing destination	89.7% N=39
1-25	Percentage of members participating in H2O whose housing condition was upgraded since intake	15.7% N=883
1-26	Percentage of members participating in H2O who are leaving the H2O program (no desired direction)	26.7% N=1,508
	Positive exit reason	29.1% N=402
	Negative exit reason (lower is better)	17.2% N=402
	Neutral exit reason (no desired direction)	53.7% N=402
1-27	Percentage of members who participating in enhanced shelter services, short-term rental assistance, or housing pre-tenancy and tenancy services, who reported employment during engagement (no desired direction)	6.5% N=835

Note: HRSN: health-related social needs; H2O: Housing and Health Opportunities; PA: Program Administrator.
Evaluation Period: 09/30/2025.
Data Source: H2O-PA data were used in the analysis of RQ 1.5.

Research Question 1.5: Is the H2O demonstration associated with increased positive health and wellbeing outcomes?

Table 9-8 through Table 9-10 display results from a disparities analysis for measures utilizing H2O-PA data, with results presented in the first year of the evaluation period (FFY 2025). Additionally, the H2O-PA data is known to have some challenges with completeness and data quality, which are anticipated to be resolved by the Summative Evaluation Report. Rates for certain demographic characteristics (i.e., race, urbanicity, and gender) are compared to a reference group and are limited to members enrolled in H2O. Each cell color or arrow represents the direction and degree of difference indicated in the legend below each figure. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Key Findings

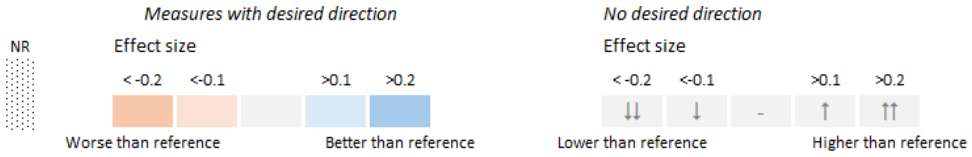
Evaluation Period:

- AI/AN members, members ages 18–24 years, 25–34 years, 55–64 years, and members older than 64 years, and rural members had lower rates of receiving any H2O services, relative to the reference groups (i.e., White/Caucasian members, those ages 35–44 years, and urban members, respectively). Black members and members of an unknown race had relatively higher rates of referrals to RBHA higher level of care services relative to the reference group (i.e., White/Caucasian members).
- Black H2O members had higher rates of upgraded housing conditions between intake and their most recent housing status, compared to White/Caucasian members.
- Members ages 45–54 and 55–64 years had lower rates of exiting the H2O program with a positive reason compared to members ages 35–44 years. Compared to male members, female members had higher rates of exiting the H2O program with a positive reason.
- Rural members had similar rates of referrals to housing pre-tenancy and tenancy services as urban members; however, rural members had lower rates of referrals to enhanced shelter services. Similarly, rural members had lower rates of H2O service receipt.

Access to and utilization of H2O services varied by demographic category, particularly by age group. Rural members often had less favorable rates when compared to urban members, a disparity that may be driven by limited resources outside of urban areas.

Table 9-8—Research Question 1.5, Research Question 1.1 Demographics

		Black	AI/AN	All Others	Unknown	18-24	25-34	45-54	55-64	65+	Rural	Female
1-1	Percentage of members experiencing homelessness who were contacted											
1-2	Percentage of members participating in H2O who completed an intake and received a service within twenty-two days of enrollment	Insufficient data for subgroup analysis										
1-4	Percentage of members participating in H2O who completed an assessment who established a housing care plan											
1-5	Percentage of members participating in H2O, who are receiving H2O services (any service and by service category)											
	Housing pre-tenancy and tenancy services											
	Short term rental assistance											
	Outreach and education services											
	One-time transition and move-in costs											
	Enhanced shelter											
	Medically necessary home accessibility modifications and remediation											
1-5a	Percentage of members participating in H2O, who are receiving RBHA higher level of care services											



Note: Reference groups are White/Caucasian, ages 35–44, Urban, Male, Not Highly Complex. AI/AN: American Indian/Alaskan Native; H2O: Housing and Health Opportunities; NR: not reportable; RBHA: Regional Behavioral Health Agreement.
The rate among all demographic groups for Measure 1-1: *Percentage of members experiencing homelessness who were contacted* was 100 percent. The rate among all demographic groups for Measure 1-5: *Medically necessary home accessibility modifications and remediation* was 0 percent.

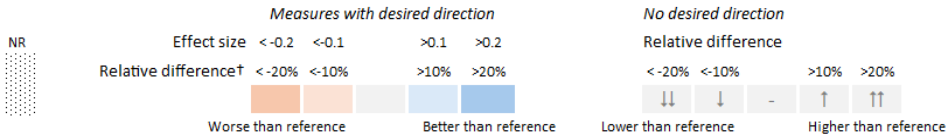
Table 9-9—Research Question 1.5, Research Question 1.3 Demographics



Note: Reference groups are White/Caucasian, ages 35–44, Urban, Male, Not Highly Complex. AI/AN: American Indian/Alaskan Native. H2O: Housing and Health Opportunities; NR: not reportable; OP: outpatient; PA: Program Administrator; PSH: Permanent Supportive Housing; RBHA: Regional Behavioral Health Agreement; SUD: Substance Use Disorder.

Table 9-10—Research Question 1.5, Research Question 1.4 Demographics

		Black	AI/AN	All Others	Unknown	18-24	25-34	45-54	55-64	65+	Rural	Female
1-24	Percentage of participating in H2O who utilize enhanced shelter services, who completed the program or exited to a positive housing destination	Insufficient data for subgroup analysis										
1-25	Percentage of members participating in H2O whose housing condition was upgraded during since intake											
1-26	Percentage of members participating in H2O who are leaving the H2O program†	-	-	↑	-	↑	-	-	-	↑	↑	-
	Positive exit reason											
	Neutral exit reason†	-			-		↑	-	↑	-		↓↓
	Negative exit reason↓											
1-27	Percentage of members who participating in enhanced shelter services, short-term rental assistance, or housing pre-tenancy and tenancy services, who reported employment during engagement†						↑↑	-		↓↓		-



Note: Reference groups are White/Caucasian, ages 35–44, Urban, Male, Not Highly Complex. AI/AN: American Indian/Alaskan Native. H2O: Housing and Health Opportunities; NR: not reportable; PSH: Permanent Supportive Housing; RBHA: Regional Behavioral Health Agreement.
↓Lower measure rates indicate better performance. Disparities analysis presented reflects the desired direction.

Research Question 1.6: How does the H2O demonstration impact disparities in HRSN?

Research Question 1.6 is addressed through subsidiary Research Questions 1.6.1 and 1.6.2, which assess disparities among members with high acuity setting utilization and various demographic characteristics. Given that only a single post-implementation data point was available for this Interim Evaluation Report, the forthcoming Summative Evaluation Report will assess how disparities evolved over the course of the evaluation period.

Research Question 1.6.1: Does the H2O demonstration mitigate or reduce HRSN among groups who had high rates at baseline?

Research Question 1.6.1 utilized H2O-PA data to identify H2O-eligible members and CLRS data to identify HRSN among H2O members. At the time of this Interim Evaluation Report, H2O-PA data were only available through FFY 2025, limiting the evaluation to a single year after implementation. To address this research question, FFY 2025 HRSN-related measures were calculated for H2O members with high rates of emergency department (ED) and inpatient (IP) utilization in the last year of the baseline period (FFY 2024). The rates of HRSN screening and HRSN identification among high utilizing members were compared to the rates among low

or average utilizers of ED or IP settings in Table 9-11.[112] The Summative Evaluation Report will leverage additional post-implementation data points to assess changes in disparities from program implementation through FFY 2027. The screening results presented are based on data from FFY 2025. These results are limited to screenings conducted through the CLRS screening tool and do not include screening results from other appropriate tools.

Key Findings

Evaluation Period:

- Members enrolled in H2O who had high rates of ED or IP utilization at baseline had higher rates of HRSN screenings compared to lower utilizing members. Among members on the AHP waitlist, the rate of HRSN screenings were nearly identical between the two groups.
- The *Percentage of members who participated in H2O services that had an HRSN-related need identified, among those who received an HRSN/SDOH screening* and the *Percentage of members who participated in H2O services that had a housing-related need identified, among those who received an HRSN/SDOH screening* was similar among high utilizing members and low utilizing members.

HRSN screening rates were higher among H2O members who had high rates of ED or IP utilization; however, the rate of identified needs was similar between high utilizers of these settings and low/average utilizers.

Table 9-11—Research Question 1.6.1, Disparities Analysis

Does the H2O demonstration mitigate or reduce HRSN among groups who had high rates at baseline?					
		High-Utilizers	Low-Utilizers	Difference in Rates	Effect Size
1-10	Percentage of members who participated in H2O services that received a HRSN/SDOH screening with the PRAPARE screening tool or other appropriate screening tool	39.46%	30.90%	8.56%	0.18
1-11	Percentage of members who participated in H2O services that had an HRSN identified, among those who received an HRSN/SDOH screening	84.09%	82.97%	1.12%	0.03
1-12	Percentage of members who had a housing-related need identified, among those who received an HRSN/SDOH screening	81.25%	78.86%	2.39%	0.06

Note: HRSN; health related social needsl; H2O: Housing and Health Opportunities; SDOH; social determinants of health.

Research Question 1.6.2: Do any groups experience increasing or worsening HRSN compared to the baseline with the implementation of the H2O demonstration?

Research Question 1.6.2 identifies HRSN among H2O members, which primary relies on H2O-PA data to identify H2O-eligible members and CLRS data to identify HRSN screenings. Additionally, AHP waitlist data were used to identify the comparison population. At the time of this Interim Evaluation Report, H2O-PA data were only available through FFY 2025, limiting the evaluation to a single year after implementation. The Summative Evaluation Report will assess changes in HRSN from program implementation through FFY 2027.

[112] A high utilizer was defined as one of the following: five or more emergent ED visits, two or more non-emergent ED visits, or two or more IP visits in a single year. This criterion represents utilization patterns that exceeded the 75th percentile among utilizers of each setting, which corresponds to approximately the top 25 percent of ED or IP utilizers.

Table 9-12 displays disparities analysis results for measures utilizing CLRS, H2O-PA, and AHP waitlist data based on rates calculated in the final year of the baseline period (FFY 2024). The CLRS is one of many screening tools leveraged for the H2O and AHP waitlist populations and does not identify all screenings conducted. For each stratification, AHP waitlist member results are presented in the first (left-hand) cell, followed by H2O member results in the second (right-hand) cell. Rates for certain demographic characteristics (i.e., race, age, urbanicity, gender, and Chronic Illness and Disability Payment System [CDPS] risk score) are compared to a reference group among members. Each cell color or arrow represents the direction and degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

Key Findings

Evaluation Period:

- Members in each demographic category generally had similar rates of HRSNs identified through the CLRS screening tool, with notable exceptions. Specifically, Black and AI/AN H2O members had lower rates of HRSN screenings compared to the reference group (e.g., White/Caucasian members). Conversely, H2O members living in a rural county and those ages 55–64 years had higher screening rates than the reference groups (e.g., urban members and those ages 35–44 years, respectively).
- The *Percentage of members who participated in H2O services that had an HRSN-related need identified, among those who received an HRSN/SDOH screening* was the same or higher among H2O members in each demographic stratification apart from Black members, who had lower rates than the reference group (e.g., White/Caucasian members). AHP waitlist member rates were generally the same or lower than members in the respective reference group.
- The *Percentage of members who had a housing-related need identified, among those who received an HRSN/SDOH screening* was generally the same or lower among H2O members and AHP waitlist members in each demographic stratification compared to members in the respective reference group.

HRSN screening disparities were evident among Black and AI/AN H2O members.

Table 9-12—Research Question 1.6, Disparities Analysis

		Black		AI/AN		All Others		Unknown		18–24		25–34		45–54		55–64		65+		Rural		Female	
		AHP Waitlist	H2O Enrollees	AHP Waitlist	H2O Enrollees	AHP Waitlist	H2O Enrollees	AHP Waitlist	H2O Enrollees	AHP Waitlist	H2O Enrollees	AHP Waitlist	H2O Enrollees	AHP Waitlist	H2O Enrollees	AHP Waitlist	H2O Enrollees	AHP Waitlist	H2O Enrollees	AHP Waitlist	H2O Enrollees	AHP Waitlist	H2O Enrollees
1-10	Percentage of members who participated in H2O services that received a HRSN/SDOH screening with the PRAPARE screening tool or other appropriate screening tool																						
1-11	Percentage of members who participated in H2O services that had an HRSN identified, among those who received an HRSN/SDOH screening	↓↓	↓					-	↑↑			↓	-	↓	-	↓	↑		↑↑			↓	↑
1-12	Percentage of members who had a housing-related need identified, among those who received an HRSN/SDOH screening	↓↓	↓					-	↑			↓	-	↓	-	↓	-		-			-	-

Measures with desired direction

NR

Effect size

< -0.2 | <-0.1 | >0.1 | >0.2

Worse than reference | Better than reference

No desired direction

Effect size

< -0.2 | <-0.1 | >0.1 | >0.2

↓↓ | ↓ | - | ↑ | ↑↑

Lower than reference | Higher than reference

Note: Reference groups are White/Caucasian, ages 35–44, Urban, Male. AI/AN: American Indian/Alaskan Native; ED: emergency department; IP; inpatient; H2O: Housing and Health Opportunities; HRSN: health-related social needs; SDOH: social determinants of healh; PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences; NR: not reportable.

Hypothesis 2: By meeting or reducing the severity of HRSN, the demonstration will increase members' use of preventive and routine care and reduce their use of potentially avoidable hospital and institutional care (ED visits, IP care, and nursing facilities), leading to reduced health care spending over time. Impacts will be realized overall and among subpopulations who experience disparities in hospital and institutional care use.

Hypothesis 2 assessed access to preventive care and utilization of hospital and institutional care among members who were ultimately enrolled in H2O at a later time and AHP waitlist members in FFY 2022 and FFY 2024. Because H2O was not implemented until October 2024, **before and after comparisons cannot be made in this Interim Evaluation Report**. Instead, members who were ultimately enrolled in H2O at a later time and AHP waitlist member access to preventive and acute care rates are compared during the baseline period.

Surveys were conducted in FFY 2025, as such, the results reflect member responses during the evaluation period.

Due to data availability limitations, two measures were not calculated:

- Measure 2-2 relies on FFY 2025 PMMIS data, which were not available at the time of this Interim Evaluation Report, to assess the rate of preventive visits in the first year after enrollment in H2O. Results for this measure will be included in the Summative Evaluation Report.
- Data from the RBHA Brief Assessment of Recovery Capital (BARC)-10 were not available to assess Measure 2-18, *Percentage of members who reported a substance use problem who experienced improvement on BARC-10* at the time of the Interim Evaluation Report. The BARC-10 is not anticipated to be used for this purpose, and other relevant tools are currently being assessed. Results will be included in the Summative Evaluation Report if data become available.

Research Question 2.1: How does the H2O demonstration impact the use of preventive and routine care?

Table 9-13 utilized PMMIS, H2O-PA, and AHP waitlist data to identify members who ultimately enrolled in H2O at a later time and members on the AHP waitlist to determine their access to preventive and routine care in the three years prior to H2O implementation.

Table 9-14 utilized beneficiary surveys to assess if H2O impacted member use of preventive and routine care based on surveys conducted in FFY 2025.

Key Findings

Baseline Period:

- The *Percentage of adults who accessed preventive/ambulatory health services* increased throughout the baseline period among members who were ultimately enrolled in H2O at a later time, while AHP waitlist member rates remained fairly stable. By FFY 2024, H2O baseline rates surpassed AHP waitlist members by 3.1 percentage points ($p<0.001$).
- Similarly, the *Percentage of adult members with a cervical cancer screening* increased throughout the baseline period among members who were ultimately enrolled in H2O at a later time and remained relatively stable for AHP waitlist members. In FFY 2022, the H2O baseline rate was 4.7 percentage points lower than AHP waitlist members ($p=0.097$). By FFY 2024, the H2O baseline rate was 2.7 percentage points higher than AHP waitlist members; however, this difference was not statistically significant ($p=0.367$).
- The *Percentage of members with a breast cancer screening* was consistently lower for members who were ultimately enrolled in H2O at a later time than AHP waitlist members; however, H2O baseline rates increased throughout the baseline period and

remained relatively stable for AHP waitlist members. The difference in the rates decreased from 10.1 percentage points in FFY 2022 (p=0.018) to 5.1 percentage points in FFY 2024 (p=0.213).

- The *Percentage of adult members with a colorectal cancer screening* was consistently lower for members who were ultimately enrolled in H2O at a later time compared to AHP waitlist members, with slight increases during the baseline period for both groups. In FFY 2023, the rate among H2O baseline members was 4.1 percentage points lower than AHP waitlist members (p=0.080)
- The *Percentage of members that were provided a most effective or moderately effective method of contraception* was lower for members who were ultimately enrolled in H2O at a later time than AHP waitlist members throughout the baseline period; however, the difference decreased from 4.1 percentage points in FFY 2022 (p=0.183) to 1.8 percentage points in FFY 2024 (p=0.627). These differences were not statistically significant.

Evaluation Period:

- The *Percentage of adults with a flu vaccine* could not be reported due to suppression rules.

Although the rates of access to preventive/ambulatory health services and cervical cancer screenings were lower for members who were ultimately enrolled in H2O at a later time than AHP waitlist members in FFY 2022, while rates were higher for H2O baseline members in FFY 2024. Conversely, throughout the baseline period, rates of breast cancer screening, colorectal cancer screening, and provision of an effective method of contraception were lower for H2O members. However, difference in rates in the baseline period between members who were ultimately enrolled in H2O at a later time and AHP waitlist members for these three measures decreased. This result indicates that members who were later identified as H2O eligible were connected to more screening and contraception services over time.

Table 9-13—Research Question 2.1, Measures 2-1 and 2-2, and Measures 2-4 through 2-9

How does the H2O demonstration impact the use of preventive and routine care?

			Baseline Period					
			2022	Difference in Rates (*p* -value)	2023	Difference in Rates (*p* -value)	2024	Difference in Rates (*p* -value)
2-1	Percentage of adults who accessed preventive/ambulatory health services	H2O	92.8%	-0.9pp (0.271)	94.6%	0.9pp (0.305)	97.6%	3.1pp *** (<0.001)
		AHP Waitlist	93.8%		93.8%		94.5%	
2-2	Percentage of members who have a PCP visit since their intake date, among members participating in H2O who utilize enhanced shelter services	H2O	N/A	N/A	N/A	N/A	N/A	N/A
		AHP Waitlist	N/A		N/A		N/A	
2-4	Percentage of adult members with a cervical cancer screening	H2O	36.7%	-4.7pp * (0.097)	39.6%	0.0pp (1.000)	44.0%	2.7pp (0.367)
		AHP Waitlist	41.4%		39.6%		41.4%	
2-5	Percentage of adult members with a breast cancer screening	H2O	23.5%	-10.1pp ** (0.018)	23.1%	-8.8pp ** (0.034)	28.5%	-5.1pp (0.213)
		AHP Waitlist	33.6%		31.9%		33.6%	
2-6	Percent of adult members with a colorectal cancer screening	H2O	28.5%	-3.4pp (0.149)	28.5%	-4.1pp * (0.080)	30.8%	-1.8pp (0.451)
		AHP Waitlist	31.9%		32.7%		32.6%	
2-7	Percentage of members that were provided a most effective or moderately effective method of contraception							
	Provided a most effective or moderately effective method of contraception	H2O	12.8%	-4.1pp (0.183)	13.0%	-4.2pp (0.185)	17.4%	-1.8pp (0.627)
		AHP Waitlist	16.9%		17.3%		19.2%	
	Provided a long-acting reversible method of contraception	H2O	S	S	S	S	S	S
		AHP Waitlist	2.4%		3.0%		2.9%	
2-8	Percentage of members that received a prenatal and/or postpartum care visit							
	Prenatal Care	H2O	S	S	S	S	S	S
		AHP Waitlist	46.8%		75.6%		70.0%	
	Post Partum Care	H2O	S	S	S	S	S	S
		AHP Waitlist	34.0%		51.2%		32.5%	
2-9	Percentage of members with a diagnosis of HIV who did not have a medical visit in the last six months of the measurement year	H2O	S	S	S	S	S	S
		AHP Waitlist	S		S		S	

*p<0.1, **p<0.05, ***p<0.001

Note: N/A indicates the measure is not calculated in the baseline period, as it requires evaluation period data (FFY 2025) that was not yet available. S refers to rates involving numerators between 0 and 10 members or denominators smaller than 30 members, which are suppressed due to potentially unreliable statistical testing and rate calculation and to ensure anonymity. AHP: AHCCCS Housing Program; HIV: Human Immunodeficiency virus; H2O: Housing Health Opportunities; PCP: primary care provider; pp: percentage points.

Data Source: PMMIS, H2O-PA, and H2O Waitlist data were used in the analysis of RQ 2.1.

Baseline Period: 10/01/2021–09/30/2024.

Table 9-14—Research Question 2.1, Measure 2-3

How does the H2O demonstration impact the use of preventive and routine care?

		Evaluation Period Weighted Rate[1]		
		H2O	AHP Waitlist	Difference in Rates (*p* -value)
2-3	Percentage of adults with a flu vaccine	S N=47	36.3% N=166	S

*p<0.1, **p<0.05, ***p<0.001

Note: N represents the number of survey responses. S refers to rates involving numerators between 0 and 10 members or denominators smaller than 30 members, which are suppressed due to potentially unreliable statistical testing and rate calculation and to ensure anonymity. Surveys were administered in calendar year (CY) 2025. AHP: AHCCCS Housing Program; H2O: Housing and Health Opportunities; pp: percentage point.

Data Source: Beneficiary surveys were used in the analysis of RQ 2.1.

[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP Code.

Research Question 2.2: How does the H2O demonstration impact the use of behavioral health (BH) services?

Table 9-15 utilized PMMIS, H2O-PA, and AHP waitlist data to identify members who ultimately enrolled in H2O at a later time and members on the AHP waitlist in FFY 2025. PMMIS data were used to identify rates of BH service utilization in the three years prior to H2O implementation were examined among members who ultimately enrolled in H2O at a later time and those on the AHP waitlist. As the H2O program was not implemented until October 2024, before and after comparisons cannot be made in this Interim Evaluation Report, therefore results presented reflect baseline trends and do not directly address the Research Question. Instead, H2O and AHP waitlist member utilization of hospital and institutional care rates are compared during the baseline period.

Key Findings

Baseline Period:

- The *Percentage of members who had initiation of alcohol and other drug abuse or dependence treatment* for members who ultimately enrolled in H2O at a later time were 10.9 and 12.7 percentage points higher in FFYs 2023 and 2024 compared to members on the AHP waitlist ($p<0.001$). The *Percentage of members who had engagement of alcohol and other drug abuse or dependence treatment* were similar between the two groups, differing by 0.3 and 1.3 percentage points in FFYs 2023 and 2024, neither a statistically significant finding ($p=0.882$ and $p=0.562$, respectively).
- In FFY 2024, the *Percentage of members with a follow-up visit after hospitalization for mental illness* was 3.5 percentage points lower among members who ultimately enrolled in H2O at a later time compared to AHP waitlist members ($p=0.066$).
- Prior to H2O implementation, the *Percentage of members with a follow-up visit after ED visit for members with multiple high-risk chronic conditions* was 3.6 percentage points higher in FFY 2024 ($p=0.014$) for members who ultimately enrolled in H2O at a later time.
- Although the *Percentage of members with follow-up after ED visit for alcohol and other drug abuse or dependence* was 3.8 percentage points higher in FFY 2024 among members who ultimately enrolled in H2O at a later time, this difference was not statistically significant ($p=0.614$).
- The *Percentage of members who remained on antidepressant medication treatment* for 84 and 180 days was lower in FFY 2022 and 2023 among members who ultimately enrolled in H2O at a later time than the AHP waitlist members; in 2023, the rate was 19.7 and 13.7 percentage points lower for members who ultimately enrolled in H2O at a later time, respectively ($p<0.001$ and $p=0.004$, respectively). Although rates remained lower in FFY 2024 for members who ultimately enrolled in H2O at a later time, they increased substantially from 2022 and 2023 to differences of 3.9 and 2.4 percentage points for the 84- and 180-days indicators and were not statistically significant ($p=0.426$ and $p=0.580$, respectively).
- The *Percentage of members with schizophrenia who adhered to antipsychotic medications* was significantly lower for members who ultimately enrolled in H2O enrolled at a later time in all baseline years with rates 7.4, 13.8, and 14.4 percentage points lower in FFYs 2022, 2023, and 2024, respectively ($p=0.017$, $p<0.001$, and $p<0.001$, respectively).
- Overall, the *Percentage of members with opioid use disorder (OUD) who filled a prescription for or were administered or dispensed a United States Food and Drug Administration (FDA)-approved medication for the disorder* were generally comparable between members who ultimately enrolled in H2O at a later time and AHP waitlist members, with consistent relative improvements among H2O members throughout the baseline period.
- In the baseline period, members who ultimately enrolled in H2O at a later time utilized buprenorphine at a higher rate than AHP waitlist members, with the largest difference in FFY 2024 at 8.2 percentage points ($p=0.005$), a relative difference of 34 percent ([31.8 percent – 23.6 percent] -1).
- In contrast, members who ultimately enrolled in H2O at a later time utilized methadone at a lower rate than AHP waitlist members by 4.7 percentage points ($p=0.097$) by FFY 2024, a relative difference of approximately 19 percent ([20.4 percent / 25.1 percent] - 1).

Prior to H2O enrollment, BH service utilization rates were generally similar or worse for members who ultimately enrolled in H2O compared to AHP waitlist members, with some exceptions. Rates of medication management for BH conditions were considerably lower for members who ultimately enrolled in H2O at a later time than those on the AHP waitlist. Conversely, who were later determined to be H2O eligible generally had higher rates of

initiation in alcohol and other drug abuse or dependence treatment compared to those on the AHP waitlist. Similarly, members who ultimately enrolled in H2O at a later time with OUD had higher rates of filling a prescription for, or being administered or dispensed, buprenorphine than those on the AHP waitlist. These findings suggest that, although members who ultimately enrolled in H2O at a later time were connected to needed SUD treatment, their complex health needs may adversely impact their ability to adhere to medication treatment.

Table 9-15—Research Question 2.2, Measures 2-10 through 2-18

How does the H2O demonstration impact the use of BH services?									
			Baseline Period						
			2022	Difference in Rates (*p* -value)	2023	Difference in Rates (*p* -value)	2024	Difference in Rates (*p* -value)	
2-10	Percentage of members who had initiation of alcohol and other drug abuse or dependence treatment	H2O	57.2%	1.4pp (0.614)	65.3%	10.9pp *** (<0.001)	66.2%	12.7pp *** (<0.001)	
		AHP Waitlist	55.8%		54.4%		53.5%		
2-11	Percentage of members who had engagement of alcohol and other drug abuse or dependence treatment	H2O	19.2%	1.1pp (0.592)	18.9%	0.3pp (0.882)	17.9%	-1.3pp (0.562)	
		AHP Waitlist	18.1%		18.5%		19.2%		
2-12	Percentage of members with a follow-up visit after hospitalization for mental illness	H2O	63.6%	-3.1pp (0.160)	64.8%	-4.7pp ** (0.020)	64.3%	-3.5pp * (0.066)	
		AHP Waitlist	66.6%		69.5%		67.7%		
2-13	Percentage of members with a follow-up visit after ED visit for members with multiple high-risk chronic conditions	H2O	77.7%	-3.0pp * (0.095)	83.3%	1.0pp (0.544)	86.5%	3.6pp ** (0.014)	
		AHP Waitlist	80.8%		82.3%		82.8%		
2-14	Percentage of members with follow-up after ED visit for alcohol and other drug abuse or dependence	H2O	56.6%	2.6pp (0.690)	58.0%	4.0pp (0.507)	57.7%	3.8pp (0.614)	
		AHP Waitlist	54.0%		54.0%		53.9%		
2-15	Percentage of members who remained on antidepressant medication treatment								
	Percentage of members who remained on antidepressant medication treatment (84 Days)	H2O	35.4%	-12.2pp ** (0.017)	27.6%	-19.7pp *** (<0.001)	42.8%	-3.9pp (0.426)	
		AHP Waitlist	47.6%		47.3%		46.6%		
	Percentage of members who remained on antidepressant medication treatment (180 Days)	H2O	18.9%	-11.7pp ** (0.011)	14.7%	-13.8pp ** (0.004)	26.3%	-2.4pp (0.580)	
		AHP Waitlist	30.6%		28.4%		28.7%		
2-16	Percentage of members with OUD who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder								
	Buprenorphine	H2O	27.3%	4.3pp (0.145)	26.3%	4.4pp (0.113)	31.8%	8.2pp ** (0.005)	
		AHP Waitlist	23.0%		21.8%		23.6%		
	Long-acting, injectable naltrexone	H2O	S	S	S	S	S	S	
		AHP Waitlist	3.4%		2.5%		3.2%		
	Methadone	H2O	19.8%	-5.4pp * (0.067)	20.9%	-0.7pp (0.787)	20.4%	-4.7pp * (0.097)	
		AHP Waitlist	25.2%		21.7%		25.1%		
	Oral naltrexone	H2O	6.5%	-0.8pp (0.638)	5.3%	-0.2pp (0.876)	6.4%	0.4pp (0.801)	
		AHP Waitlist	7.3%		5.5%		6.0%		
	Total	H2O	46.1%	-3.2pp (0.354)	45.0%	0.7pp (0.822)	51.6%	1.4pp (0.681)	
		AHP Waitlist	49.3%		44.3%		50.2%		
2-17	Percentage of members with schizophrenia who adhered to antipsychotic medications	H2O	51.0%	-7.4pp ** (0.017)	47.2%	-13.8pp *** (<0.001)	46.4%	-14.4pp *** (<0.001)	
		AHP Waitlist	58.4%		60.9%		60.9%		
2-18	Percentage of members who reported a substance use problem who experienced improvement on BARC-10	H2O	—	—	—	—	—	—	
		AHP Waitlist	—		—		—		

*p <0.1, **p <0.05, ***p <0.001

Note: —indicates data from the BARC-10 were not available to calculate the measure. S refers to rates involving numerators between 0 and 10 members or denominators smaller than 30 members, which are suppressed due to potentially unreliable statistical testing and rate calculation and to ensure anonymity. AHP: AHCCCS Housing Program; ED: emergency department; FDA: United States Food and Drug Administration; H2O: Housing Health Opportunities; pp: percentage points; OUD: opioid use disorder.

Data Source: PMMIS, H2O-PA, and H2O waitlist data were used in the analysis of RQ 2.2.

Baseline Period: 10/01/2021–09/30/2024.

Research Question 2.3: How does the H2O demonstration impact the use of hospital and institutional care?

Table 9-16 and Table 9-17 utilized PMMIS, H2O-PA, and AHP waitlist data to identify H2O members and members on the AHP waitlist in FFY 2025 to determine their hospital and institutional care utilization in the three years prior to H2O implementation. As the H2O program was not implemented until October 2024, before and after comparisons cannot be made in this Interim Evaluation Report, therefore results presented reflect baseline trends and do not directly address the Research Question. Instead, H2O and AHP waitlist member utilization of hospital and institutional care rates are compared during the baseline period.

Key Findings:

Baseline Period:

- The *Number of emergent* and *non-emergent ED visits per 1,000 member months* were higher for members who ultimately enrolled in H2O at a later time compared to AHP waitlist members. For emergent ED visits, differences between the two groups increased from 116.5 visits per 1,000 member months (p<0.001) in FFY 2022 to 184.8 visits per 1,000 member months (p<0.001) in FFY 2024. Similarly, differences in the number of non-emergent ED visits per 1,000 member months increased from 9.3 (p<0.001) in FFY 2022 to 18.7 (p<0.001) in FFY 2024.
- The *Number of IP stays per 1,000 member months* was greater for members who ultimately enrolled in H2O at a later time compared to AHP waitlist members, and the difference increased throughout the baseline period. The difference increased by 17 stays per 1,000 member months (p<0.001) in FFY 2022 to 38 stays per 1,000 member months (p<0.001) in FFY 2024.
- The *Risk-adjusted ratio of observed to expected acute IP and observation stay discharges* was higher among members who ultimately enrolled in H2O at a later time than AHP waitlist members by between 0.4 and 0.7 (p<0.001), representing relative differences of 38 percent ([1.8 / 1.3] -1) and approximately 54 percent ([2.0 / 1.3] -1).
- The *Chronic conditions composite (Prevention Quality Indicator [PQI]-92)* rates were higher for members who ultimately enroll in H2Oat a later time than AHP waitlist members and increased throughout the baseline period by 2.4 discharges per 1,000 members in FFY 2022 to 6.5 in FFY 2024; however, these differences were not statistically significant (p=0.525 and p=0.267, respectively*).*
- The *Number of members with admission to an institution from the community* per 1,000 member months was higher for members who ultimately enrolled in H2O at a later time compared to AHP waitlist members throughout the baseline period and continued to increase for short- and medium-term stays; however, none of the differences were statistically significant.
- The difference in short-term stays increased from 60.5 per 1,000 member months among members who ultimately enrolled in H2O at a later time (p=0.573) in FFY 2022, more than double the rate of AHP waitlist members, to 98.4 (p=0.433) in FFY 2024, or over three times the rate of AHP waitlist members.
- The difference in medium-term stays increased from 5.0 per 1,000 member months (p=0.671) in FFY 2022, nearly double the rate of AHP waitlist members, to 12.7 (p=0.517) in FFY 2024, or over 2.5 times the rate of AHP waitlist members.
- The *Percentage of adult IP discharges with an unplanned readmission within 30 days* was 1.2 percentage points lower for members who ultimately enrolled in H2O at a later time compared to AHP waitlist members in FFY 2022; however, this difference was not statistically significant (p=0.483). By FFY 2023 and FFY 2024, rates were 4.8 percentage points (p=0.003) and 5.8 percentage points (p<0.001) higher among H2O baseline members, respectively.

ED stays, IP stays, and the risk-adjusted ratio observed to expected acute IP and observation stay discharges were significantly higher among members who ultimately enrolled in H2O at a later time when compared to those on the AHP waitlist throughout the baseline period. Additionally, unplanned readmissions were significantly higher in FFY 2023 and FFY 2024 for members who ultimately enrolled in H2O at a later time. These differences may indicate that members who ultimately enrolled in H2O at a later time had higher demands for hospital care due to their unique health needs, or that members were placed into the H2O program based on high and increasing rates of utilizing high-acuity care settings.

Table 9-16—Research Question 2.3, Measures 2-19 through 2-23, 2-25, and 2-27

How does the H2O demonstration impact the use of hospital and institutional care?

			Baseline Period					
			2022	Difference in Rates (*p*-value)	2023	Difference in Rates (*p*-value)	2024	Difference in Rates (*p*-value)
2-19	Number of emergent ED visits per 1,000 member months	H2O	236.7	116.5 ***	294.1	174.3 ***	305.4	184.8 ***
		AHP Waitlist	120.1	(<0.001)	119.8	(<0.001)	120.6	(<0.001)
2-20	Number of non-emergent ED visits per 1,000 member months	H2O	17.8	9.3 ***	25.9	17.1 ***	28.9	18.7 ***
		AHP Waitlist	8.4	(<0.001)	8.8	(<0.001)	10.2	(<0.001)
2-21	Number of IP stays per 1,000 member months	H2O	34.8	17.4 ***	47.0	31.7 ***	56.4	38.4 ***
		AHP Waitlist	17.4	(<0.001)	15.3	(<0.001)	18.0	(<0.001)
2-22	Risk-adjusted ratio of observed to expected acute IP and observation stay discharges	H2O	1.8	0.4 ***	2.0	0.7 ***	1.9	0.5 ***
		AHP Waitlist	1.3	(<0.001)	1.3	(<0.001)	1.4	(<0.001)
2-23	Chronic conditions composite (PQI-92) (discharges per 1,000 member months)	H2O	4.1	2.4	5.8	4.2	8.2	6.5
		AHP Waitlist	1.7	(0.525)	1.6	(0.357)	1.7	(0.267)
2-25	Number of members with admission to an institution from the community, per 1,000 member months							
	Short-term	H2O	110.1	60.5	125.5	77.2	146.9	98.4
		AHP Waitlist	49.6	(0.573)	48.3	(0.500)	48.5	(0.433)
	Medium-term	H2O	10.9	5.0	13.0	6.8	21.1	12.7
		AHP Waitlist	6.0	(0.671)	6.2	(0.602)	8.4	(0.517)
	Long-term	H2O	S	S	0.9	0.3	0.7	0.1
		AHP Waitlist	0.4		0.6	(0.807)	0.6	(0.935)
2-27	Percentage of adult IP discharges with an unplanned readmission within 30 days	H2O	14.4%	-1.2pp	21.7%	4.8pp **	22.6%	5.8pp ***
		AHP Waitlist	15.5%	(0.483)	16.9%	(0.003)	16.8%	(<0.001)

*p <0.1, **p <0.05, ***p <0.001

Note: AHP: AHCCCS Housing Program; ED: emergency department; H2O: Housing Health Opportunities; IP: inpatient; pp: percentage points; PQI: Prevention Quality Indicator.
Data Source: PMMIS, H2O-PA, and AHP Waitlist data were used in the analysis of RQ 2.3.
Baseline Period: 10/01/2021–09/30/2024.

Table 9-17—Research Question 2.3, Measures 2-24 and 2-26

How does the H2O demonstration impact the use of hospital and institutional care?

		Baseline Period Pooled Rate[1]		
		H2O	AHP Waitlist	Difference in Rates (*p*-value)
2-24	Percentage of members with an ED visit for hypoglycemia in older adults with diabetes			
	Observed ED visits for hypoglycemia	S	S	S
	Observed ED visits for hypoglycemia, among members who had at least one dispensing event of insulin	S	S	S
2-26	Percent of members who were hospitalized for potentially preventable complications			
	Acute Hospitalization	S	2.9%	S
	Chronic Hospitalization	S	2.1%	S
	Total Hospitalization	S	2.6%	S

*p <0.1, **p <0.05, ***p <0.001

Note: S indicates rates with numerators between 0 and 10 members or denominators smaller than 30 members, which are suppressed due to potentially unreliable statistical testing and rate calculation and to ensure anonymity. AHP: AHCCCS Housing Program; ED: emergency department; HRSN: health-related social needs; H2O: Housing Health Opportunities.

[1]Due to small denominators and member counts in each year, results are presented as a pooled average of the baseline period.
Data Source: PMMIS, H2O-PA, and H2O waitlist data were used in the analysis of RQ 2.3.
Baseline Period: 10/01/2021–09/30/2024.

Research Question 2.4: How does the H2O demonstration impact disparities in the use of hospital and institutional care?

Table 9-18 displays results from a disparities analysis for measures utilizing PMMIS, H2O-PA, and AHP waitlist data based on rates calculated in the final year of the baseline period (FFY 2024). As the H2O program was not implemented until October 2024, before and after comparisons cannot be made in this Interim Evaluation Report, therefore results presented reflect baseline trends and do not directly address the Research Question. Instead, the disparities analysis among H2O and AHP waitlist are compared during the baseline period. For each stratification, AHP waitlist member results are presented in the first (left-hand) cell, followed by results among members who were ultimately enrolled in H2O at a later time in the second (right-hand) cell. Rates for certain demographic characteristics (i.e., race, age, urbanicity, gender, and CDPS risk score) are compared to a reference group among members. Each cell color or arrow represents the direction and degree of difference indicated in the legend below each table. Additional information on interpreting the demographic results can be found in the Disparities Analysis section of the Methodology chapter.

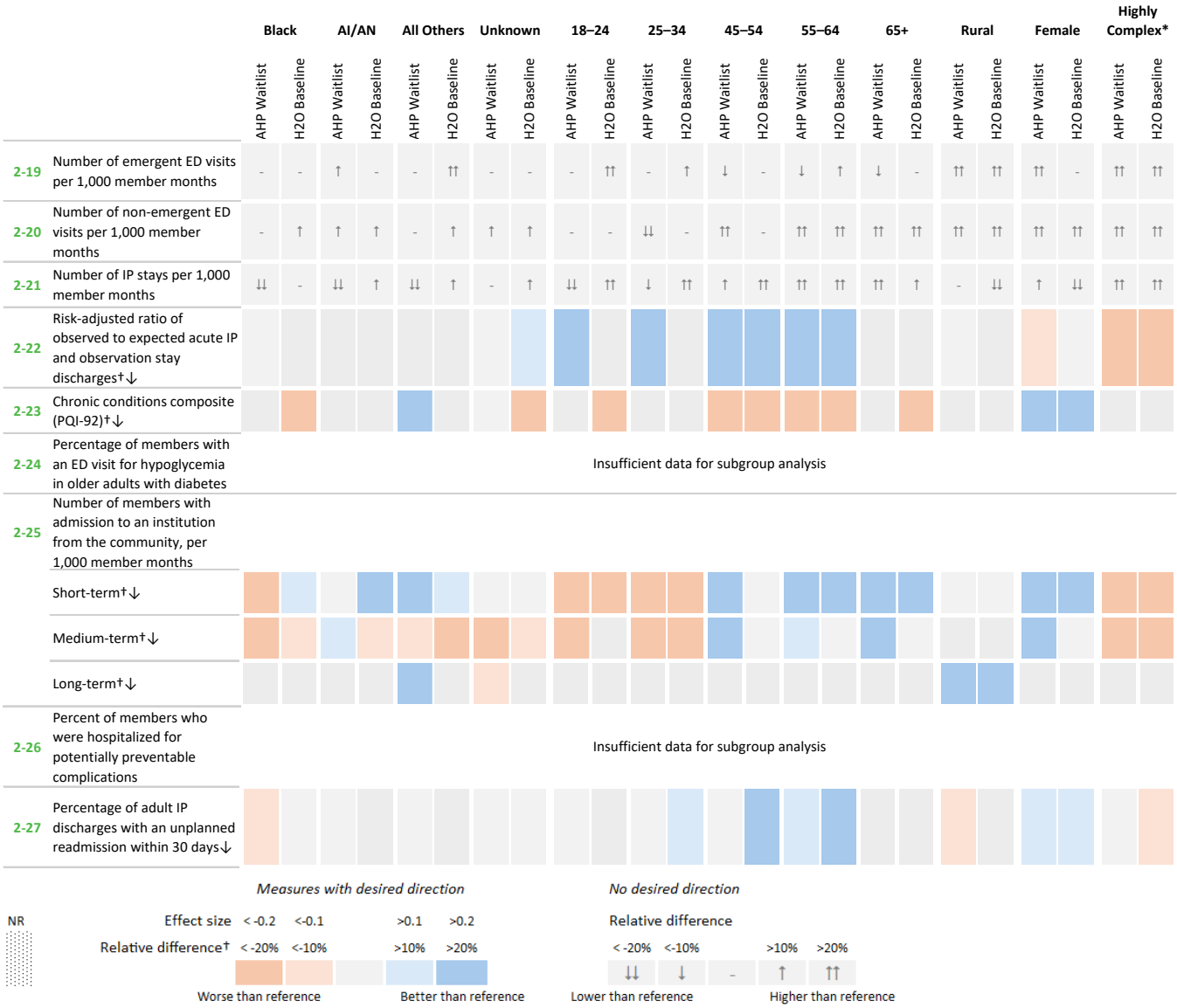
Key Findings:

Baseline Period:

- Across all hospital and institutional care measures with sufficient data, Black AHP waitlist members had similar or worse rates compared to White/Caucasian AHP waitlist members. AI/AN members had the same or higher ED utilization rates compared to White/Caucasian members.
- For both members who ultimately enrolled in H2O at a later time and AHP waitlist members, members ages 18 to 24 years and 25 to 34 years generally had less favorable rates of admission to an institution from the community compared to members ages 35 to 44 years, while members ages 45 years and older had similar or better rates compared to members 35 to 44.
- Members who ultimately enrolled in H2O at a later time living in rural areas had higher rates of ED visits and lower rates of IP visits compared to members in urban areas. AHP waitlist members living in rural areas had higher rates of ED visits and similar rates of IP visits when compared to members in urban areas.
- For most measures with a desired direction and available data, female H2O and AHP waitlist members had similar or better rates compared to male members in the baseline period.
- For nearly all measures with a desired direction, members who ultimately enrolled in H2O at a later time and AHP waitlist members with highly complex health needs had worse rates than members without highly complex needs. Among measures without a desired direction, the baseline rates among H2O and AHP waitlist members with highly complex health needs were higher than members without complex health needs.

During the baseline period, Black members who ultimately enrolled in H2O at a later time and AHP waitlist members generally had less favorable rates compared to the reference race group, indicating a possible racial disparity. Female members generally had more favorable rates compared to male members among measures with a desired direction. As expected, members with highly complex needs had less favorable rates for most measures compared to those without highly complex needs.

Table 9-18—Research Question 2.4, Measures 2-19 through 2-27



Note: Reference groups are White/Caucasian, ages 35–44, Urban, Male, Not Highly Complex. AI/AN: American Indian/Alaskan Native; IP: inpatient; ED: emergency department; PQI: prevention quality indicator; NR: not reportable.
*Highly Complex members are identified as those with six or more CDPS risk condition categories in FFY 2024.
↓Lower measure rates indicate better performance. Disparities analysis presented reflects the desired direction.
†Relative difference is used for these measures.

Research Question 2.4.1: Does the demonstration reduce the use of hospital and institutional care among groups who had high rates at baseline?

Table 9-19 utilized PMMIS data to measure rates of hospital and institutional care and H2O-PA data to identify members who ultimately enrolled in H2O at a later time. Rates of hospital and institutional care among high-

utilizing and low-utilizing members are presented in the three years prior to H2O implementation.[113] As the H2O program was not implemented until October 2024, before and after comparisons cannot be made in this Interim Evaluation Report; therefore, results presented reflect baseline trends and do not directly address the Research Question. Instead, hospital and institutional care rates are presented among high-utilizing and low-utilizing members during the baseline period to provide context and an assessment of trends. The Summative Evaluation Report is expected to provide an assessment of hospital utilization during the evaluation period and identify changes among these groups following participation in the H2O program.

Table 9-19 below identifies changes in the rate of various hospital and institutional care settings among members who ultimately enroll in H2O at a later time, stratified by acute setting frequency.

Key Findings:

Baseline Period:

- Members who were ultimately enrolled in H2O at a later time and had high rates of ED or IP utilization at baseline, engaged with emergent and non-emergent ED settings over four times as often when compared to rates among low-utilizing members.
  - Between FFY 2022 high-utilizing members accessed emergent ED settings at a rate of 406.4 visits per 1,000 member months and increased to 512.1 visits per 1,000 member months in 2024, representing a 26 percent relative increase in visits [(512.1/406.4)-1)].
- High-utilizing members who ultimately enrolled in H2O at a later time accessed IP settings at a rate nearly five times greater than low-utilizing members in the baseline period.
  - Between FFYs 2022 and 2024, the rate of high-utilizing members who accessed IP settings increased from a rate of 63.3 to 96.0 visits per 1,000 member months, representing a 52 percent relative increase in admissions [(96.0/63.3)-1)]. The rate of IP admissions among low-utilizing members more than doubled between FFYs 2022 and 2024.
- High-utilizing members who ultimately enrolled in H2O at a later time experienced a 7 percent relative decline [(2.3/2.5)-1)] in the rate of risk-adjusted ratio of expected IP and observation stay discharges between FFYs 2022 and 2024. Meanwhile, low-utilizing members who ultimately enrolled in H2O at a later time had a 41 percent relative increase [(1.2/0.8)-1)] in discharges.
- The rate of IP discharges for chronic conditions nearly doubled between FFY 2022 and FFY 2024 among high-utilizing members who ultimately enrolled in H2O at a later time, increasing from 8.3 visits per 1,000 member months to 15.8 visits per 1,000 member months.
- The percentage of high-utilizing members who ultimately enrolled in H2O at a later time with a discharge from an IP setting with an unplanned readmission doubled between FFYs 2022 and FFY 2024. Discharges increased relatively by 22 percent between FFYs 2022 and 2024 among low-utilizing members [(20.4 percent/16.7 percent)-1)].

Members who were ultimately enrolled in H2O at a later time, who had high rates of ED or IP utilization at baseline, had higher rates of hospital and institutional care in the baseline period across a variety of settings compared to low-utilizing members. The rate of members interacting with hospital and institutional care settings increased consistently among most measures for both groups between FFY 2022 and FFY 2024.

[113] A high utilizer was defined as one of the following: five or more emergent ED visits, two or more non-emergent ED visits, or two or more IP visits in a single year. This criterion represents utilization patterns that exceeded the 75th percentile among utilizers of each setting, which corresponds to approximately the top 25 percent of ED or IP utilizers.

Table 9-19—Research Question 2.4.1, Measures 2-19 through 2-23, Measure 2-25, and Measure 2-27

How does the H2O demonstration impact the use of hospital and institutional care?						
			Baseline Period			Relative Percent Differnce
			2022	2023	2024	
2-19	Number of emergent ED visits per 1,000 member months	High-Utilizers	406.4	507.8	512.1	26%
		Low-Utilizers	84.4	96.5	113.0	34%
2-20	Number of non-emergent ED visits per 1,000 member months	High-Utilizers	30.9	47.3	51.3	66%
		Low-Utilizers	5.9	6.1	8.0	36%
2-21	Number of IP stays per 1,000 member months	High-Utilizers	63.3	83.2	96.0	52%
		Low-Utilizers	9.1	13.6	19.2	112%
2-22	Risk-adjusted ratio of observed to expected acute IP and observation stay discharges	High-Utilizers	2.5	2.7	2.3	-7%
		Low-Utilizers	0.8	1.0	1.2	41%
2-23	Chronic conditions composite (PQI-92) (discharges per 1,000 member months)	High-Utilizers	8.3	11.5	15.8	91%
		Low-Utilizers	S	S	S	S
2-25	Number of members with admission to an institution from the community, per 1,000 member months					
	Short-term	High-Utilizers	146.7	175.4	182.9	25%
		Low-Utilizers	77.5	80.3	112.9	46%
	Medium-term	High-Utilizers	14.5	18.7	27.7	91%
		Low-Utilizers	7.8	7.8	15.0	92%
	Long-term	High-Utilizers	S	S	S	S
		Low-Utilizers	S	S	S	S
2-27	Percentage of adult IP discharges with an unplanned readmission within 30 days	High-Utilizers	13.9%	25.2%	27.9%	100%
		Low-Utilizers	16.7%	20.4%	20.4%	22%

Note: ED: emergency department; H2O: Housing and Health Opportunities; IP: inpatient; pp: percentage points; PQI: Prevention Quality Indicator.
Data Source: PMMIS and H2O-PA data were used in the analysis of RQ 2.4.1
Baseline Period: 10/01/2021–09/30/2024.

Research Question 2.4.2: Do any groups experience increasing use of hospital and institutional care compared to the baseline with the implementation of the HRSN demonstration?

Data following H2O implementation in FFY 2025 were not available to assess Research Questions 2.4.2 in this Interim Evaluation Report as rates of hospital and institutional care during the evaluation period were not available due to the implementation of H2O beginning in FFY 2025. The Summative Evaluation Report will include an assessment of hospital utilization during the evaluation period and identify changes among demographic groups.

Hypothesis 3: By meeting or reducing HRSN, the demonstration will improve physical and mental health outcomes among members overall and among subpopulations who experience disparities in physical and mental health outcomes.

Hypothesis 3 assessed whether H2O improved physical and mental health outcomes among participating members. PMMIS, H2O-PA, AHP waitlist, vital records, key informant interviews, and survey data were used to address seven research questions. Eleven key informant interviews conducted in October and November 2025 examined the experiences of case managers and community-based organizations (CBOs).

As H2O was not implemented until October 2024, before and after comparisons cannot be made in this Interim Evaluation Report. Instead, H2O and AHP waitlist member physical and mental health outcomes are compared during the baseline period among measures that rely on PMMIS data. Surveys were conducted in FFY 2025, with results reflective of member responses during the evaluation period.

Research Question 3.1: How does the H2O demonstration impact members' physical and mental health outcomes?

Table 9-20 utilized beneficiary surveys to assess H2O's impact on members' physical and mental health outcomes. Measure 3-5, *Percentage of births with low birth weight*, utilized member enrollment, H2O-PA, AHP waitlist, and vital records data to retrospectively assess the rate of live births with low birth weight in the baseline period among members who enrolled in H2O in FFY 2025 and those who remained on the AHP waitlist; however, the results were suppressed because the counts met suppression criteria.[114]

Key Findings:

Evaluation Period:

- The *Percentage of members who reported a rating of overall health as very good or excellent* and the *Percentage of members who reported a rating of overall mental or emotional health as very good or excellent* could not be reported due to suppression criteria.
- The *Percentage of members who reported a rating of life satisfaction as "Satisfied" or "Very Satisfied"* was 11.0 percentage points higher for members who ultimately enrolled in H2O at a later time compared to those on the AHP waitlist; however, this difference was not statistically significant (p=0.221). Although the difference in the rates was not statistically significant, the difference suggests a moderate and positive effect, with an effect size of 0.22.
- The *Percentage of members who reported "Always" or "Usually" feeling stressed or anxious* was 10.0 percentage points lower for H2O members compared to those on the AHP waitlist; however, this difference was not statistically significant (p=0.257). Although the difference in the rates was not statistically significant, the difference suggests a moderate and positive effect, with an effect size of 0.20.

H2O members had higher rates of satisfaction and lower rates of stress or anxiety compared to those on the AHP waitlist; however, these differences were not statistically significant, likely due to small sample sizes. Although the differences were not statistically significant, the effect sizes relating to life satisfaction and stress and anxiety highlight a potentially clinically meaningful, and positive outcome among H2O members.

[114] Suppression criteria follow the CMS Cell Size Suppression Policy and rates with denominators less than 30 are not reported. Available at: https://resdac.org/articles/cms-cell-size-suppression-policy. Accessed on: Mar 12, 2026.

Table 9-20—Research Question 3.1, Measures 3-1 through 3-4

How does the H2O demonstration impact members' physical and mental health outcomes?				
		Evaluation Period Weighted Rate[1]		
		H2O	AHP Waitlist	Difference in Rates (*p*-value)
3-1	Percentage of members who reported a rating of overall health as very good or excellent	S N=47	20.9% N=168	S
3-2	Percentage of members who reported a rating of overall mental or emotional health as very good or excellent	S N=46	12.8% N=166	S
3-3	Percentage of members who reported a rating of life satisfaction as "Satisfied" or "Very Satisfied"	57.2% N=45	46.2% N=164	11.0pp (0.221)
3-4	Percentage of members who reported "Always" or "Usually" feeling stressed or anxious (lower is better)	46.4% N=47	56.4% N=167	-10.0pp (0.257)

*p <0.1, **p <0.05, ***p <0.001

Note: N represents the number of survey responses. S refers to rates involving numerators between 0 and 10 members or denominators smaller than 30 members, which are suppressed due to potentially unreliable statistical testing and rate calculation and to ensure anonymity. Surveys were administered in calendar year (CY) 2025. AHP: AHCCCS Housing Program; H2O: Housing and Health Opportunities; pp: percentage point.

Data Source: Beneficiary surveys were used in the analysis of RQ 3.1.

[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP Code.

Research Question 3.2: How does the H2O demonstration impact members' management of chronic conditions?

Table 9-21 utilized PMMIS, H2O-PA, and AHP waitlist data to identify changes in chronic condition management in the three years prior to H2O implementation among members who ultimately enrolled in H2O at a later time and members on the AHP waitlist. As H2O was not implemented until October 2024, before and after comparisons cannot be made in this Interim Evaluation Report. Instead, H2O and AHP waitlist member management of chronic conditions are compared during the baseline period, prior to the implementation of H2O.

Key Findings:

Baseline Period:

- In FFYs 2022 and 2024, the *Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent* was lower among members who ultimately enrolled in H2O at a later time relative to members on the AHP waitlist by 5.08 and 11.92 percentage points, respectively; however, these results were not statistically significant (p=0.681, p=0.418)
- Prior to enrollment in H2O, the percentage of members who ultimately enrolled in H2O at a later time with cardiovascular disease dispensed at least one statin medication improved by 15.3 percentage points between FFYs 2023 and 2024, surpassing the AHP waitlist rate by 13.83 percentage points in FFY 2024; however, the difference was not statistically significant (p=0.170).

In the baseline period, chronic condition management among members who ultimately enrolled in H2O at a later time was mixed. While statin use among members with cardiovascular disease improved modestly, rates of asthma medication management declined. Differences between baseline rates among H2O and AHP waitlist members were generally not significant.

Table 9-21—Research Question 3.2, Measures 3-6 through 3-8

How does the H2O demonstration impact members' management of chronic conditions?			Baseline Period					
			2022	Difference in Rates (*p*-value)	2023	Difference in Rates (*p*-value)	2024	Difference in Rates (*p*-value)
3-6	Percentage of members with diabetes with poor hemoglobin control							
	Percentage of members with HbA1c control (<8.0 percent)	H2O	--	--	--	--	--	--
		AHP Waitlist	--		--		--	
	Percentage of members with HbA1c poor control (>9.0 percent)	H2O	--	--	--	--	--	--
		AHP Waitlist	--		--		--	
3-7	Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent	H2O	47.6%	-5.1pp (0.681)	S	S	40.0%	-11.9pp (0.418)
		AHP Waitlist	52.7%		63.8%		51.9%	
3-8	Percentage of members with clinical atherosclerotic cardiovascular disease who received and adhered to statin therapy							
	Percentage of members who were dispended at least one high-intensity or moderate-intensity statin medication	H2O	S	S	40.0%	-3.3pp (0.763)	55.3%	13.8pp (0.170)
		AHP Waitlist	40.4%		43.3%		41.4%	
	Percentage of members who remained on a high-intensity or moderate-intensity statin medication for at least 80 percent of the treatment period	H2O	S	S	S	S	S	S
		AHP Waitlist	60.9%		S		69.0%	

*p <0.1, **p <0.05, ***p <0.001
Note: -- indicates that results for Measure 3-6 are not presented due to insufficient data and calculated rates that are unreliable from using administrative data only.
S refers to rates involving numerators between 0 and 10 members or denominators smaller than 30 members, which are suppressed due to potentially unreliable statistical testing and rate calculation and to ensure anonymity. AHP: AHCCCS Housing Program; H2O: Housing Health Opportunities; HbA1c: hemoglobin A1c; pp: percentage points.
Data Source: PMMIS, H2O-PA, and AHP Waitlist data were used in the analysis of RQ 3.2.
Baseline Period: 10/01/2021–09/30/2024.

Research Question 3.3: How does the H2O demonstration impact rates of mortality?

Table 9-22 utilized member enrollment, PMMIS, H2O-PA, AHP waitlist, and vital records data to assess maternal mortality among AHP waitlist members in the baseline period. Results for Measures 3-9 and 3-10 are omitted for the H2O population in this Interim Report.

Key Findings:

Baseline Period:

- The rate of all-cause mortality ranged between 0.3 and 1.0 percent among members on the AHP waitlist during the baseline period. These rates were calculated with state administrative data, which may under-report the number of deaths that occurred.
- The rate of maternal mortality was consistently 0 percent among members on the AHP waitlist during the baseline period.

Table 9-22—Research Question 3.3, Measures 3-9 and 3-10

How does the H2O demonstration impact rates of mortality?			Baseline Period			Baseline Average
			2022	2023	2024	
3-9	All-cause mortality rate	H2O	NR	NR	NR	NR
		AHP Waitlist	0.3%	0.5%	1.0%	0.6%
3-10	Maternal mortality rate	H2O	NR	NR	NR	NR
		AHP Waitlist	0.0%	0.0%	0.0%	0.0%

Note: NR indicates that these results were not reported in the baseline period for the H2O population. AHP: AHCCCS Housing Program; H2O: Housing and Health Opportunities.
Data Source: PMMIS, H2O-PA data, H2O Waitlist data, and vital records were used in the analysis of RQ 3.3.
Baseline Period: 10/01/2021–09/30/2024.

Research Question 3.4: How does the H2O demonstration impact the quality and effectiveness of downstream services?

Case coordinators/managers and CBOs described positive and negative impacts of H2O on downstream services. Across interviews, downstream services were defined broadly and included a range of services, from emergency shelters to BH. Case coordinators and CBOs worked together to provide services to and monitor members throughout service delivery. Key themes included the following:

- **Pre-tenancy and tenancy sustaining services**: Case coordinators assisted members with locating housing and provided services such as move-in assistance. Pre-tenancy services supported members in navigating the housing process, connecting to resources, and establishing long-term connections to support systems. Case coordinators also assisted members with completing applications and securing transportation. One case manager described accompanying members during housing applications, ensuring they understood their rights, and following up to support successful placement.
- **Physical health (PH) and BH services**: Case coordinators described providing case management to members with serious mental illness (SMI) to connect them to PH and BH services. CBOs described monitoring changes in members' PH and BH status over time. CBOs shared that once members obtained housing, they were better able to focus on their BH needs and more likely to seek BH services.
- **Support for members**: CBOs identified rental assistance, eviction prevention, housing education, transitional housing placement, and housing subsidies as key downstream services that supported members' stability and ongoing engagement in care.

Research Question 3.5: How does the H2O demonstration impact disparities in health outcomes?

Research Question 3.5.1 assesses physical and mental health outcomes by key subpopulations, which largely relies on beneficiary survey data (i.e., measures associated with Research Question 3.1). Due to small sample sizes among the H2O and AHP waitlist respondents, subgroup analyses could not be reported. Each subgroup had a denominator with less than 30 members, which did not meet reporting standards. The small respondent pool is reflective of the small sample size available for the H2O population at the time of survey administration (415 members). The survey results for the Summative Evaluation Report are expected to reflect a larger cohort of H2O members, thereby supporting stratification of survey results by demographic subgroups.

At the time of this Interim Evaluation Report, PMMIS data were not available to identify rates during the evaluation period; therefore, H2O impacts on health disparities could not be assessed. The Summative Evaluation Report will evaluate H2O through FFY 2027, which will support the assessment of H2O impacts on health disparities.

Research Question 3.5.1: Does the H2O demonstration improve the physical and mental health outcomes of groups who had poor health outcomes at baseline?

Research Question 3.5.1 assesses physical and mental health outcomes by key subpopulations, which largely relies on beneficiary survey data (i.e., measures associated with Research Question 3.1). Due to small sample sizes among the H2O and AHP waitlist respondents, accurate and reportable subgroup analyses could not be reported. Each subgroup had a denominator of less than 30 members, which did not meet reporting standards. The small respondent pool is reflective of the small sample size available for the H2O population at the time of survey administration (415 members). The survey results for the Summative Evaluation Report are expected to reflect a larger cohort of H2O members, thereby supporting stratification of survey results by demographic subgroups.

Similarly, other measures included in Hypothesis 3 either have reported rates of 0 percent (Measure 3-10), could not be reported with administrative data reliably (Measure 3-6), or do not have sufficient sample sizes to support further stratification by demographic groups (Measures 3-7, 3-8, and 3-9).

At the time of this Interim Evaluation Report, PMMIS data were not available to identify rates during the evaluation period; therefore, H2O impacts on health disparities could not be assessed. The Summative Evaluation Report will evaluate H2O through FFY 2027, which will support the assessment of H2O impacts on health disparities.

Research Question 3.5.2: Do any groups experience worsening physical and mental health outcomes compared to the baseline with the implementation of the H2O demonstration?

Research Question 3.5.2 assesses physical and mental health outcomes by key subpopulations, which largely relies on beneficiary survey data (i.e., measures associated with Research Question 3.1). Due to small sample sizes among the H2O and AHP waitlist respondents, subgroup analyses could not be reported. Each subgroup had a denominator of less than 30 members, which did not meet reporting standards. The small respondent pool is reflective of the small sample size available for the H2O population at the time of survey administration (415 members). The survey results for the Summative Evaluation Report are expected to reflect a larger cohort of H2O members, thereby supporting stratification of survey results by demographic subgroups.

Similarly, other measures included in Hypothesis 3 either have reported rates of 0 percent (Measure 3-10), could not be reported with administrative data reliably (Measure 3-6), or do not have sufficient sample sizes to support further stratification by demographic groups (Measures 3-7, 3-8, and 3-9).

At the time of this Interim Evaluation Report, PMMIS data were not available to identify rates during the evaluation period; therefore, the impact of the H2O demonstration on health disparities could not be assessed. The Summative Evaluation Report will evaluate H2O through FFY 2027, which will support the assessment of H2O impacts on health disparities.

Hypothesis 4: The H2O demonstration will reduce cost of care for members who utilize H2O services.

Because H2O was not implemented until October 2024, before and after comparisons cannot be made in this Interim Evaluation Report. Instead, H2O and AHP waitlist member cost of care trends are compared during the baseline period. Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars.

Research Question 4.1: How does the H2O demonstration impact the total cost of care among H2O members compared to members who are eligible but not participating in the H2O demonstration?

Table 9-23 and Figure 9-1 utilized PMMIS data and a linear trend analysis to examine the trend in per-member per-month (PMPM) costs among members who were ultimately enrolled in H2O at a later time and those on the AHP waitlist prior to implementation in October 2024. As the H2O program was not implemented until October 2024, before and after comparisons cannot be made in this Interim Evaluation Report, therefore results presented reflect baseline trends and do not directly answer the Research Question. Instead, the costs in the baseline period are presented.

Average PMPM costs were approximately $1,963 at the beginning of the baseline period for AHP waitlist members and were an average of $854 PMPM higher among members who ultimately enrolled in H2O at a later

time. The trend among both groups increased throughout the baseline period, with the H2O baseline member trend increasing at a significantly faster rate.

There may be systematic differences among members who were placed in H2O compared to those who remained on the AHP waitlist. These results suggest that members who ultimately enrolled in H2O at a later time were those with high costs/high needs and significantly more utilization of intensive care settings, such as IP and ED.

Table 9-23 and Figure 9-2 utilized PMMIS data to assess the differences in aggregated costs during the baseline period among members who ultimately enrolled in H2O at a later time and AHP waitlist members. The different H2O and AHP waitlist population sizes influenced the aggregated costs; therefore, caution should be used when making comparisons. AHP waitlist members' total cost of care averaged approximately $8,952.2 thousand in the first month of the baseline period and increased by an average of $153.6 thousand per month. H2O baseline members' aggregated costs averaged $5,597.0 thousand less than AHP waitlist members in the first month of the baseline period. Members who ultimately enrolled in H2O at a later time exhibited a lower trend relative to AHP waitlist members during the baseline period.

Key Findings:

Baseline Period:

- **PMPM costs**
  - Total PMPM costs averaged $1,962.57 at the beginning of the baseline period among AHP waitlist members, which increased by $33.14 per month. Total PMPM costs among members who ultimately enrolled in H2O at a later time were $854.23 higher than AHP waitlist members at the start of the baseline period, during which costs increased by an average of $50.30 per month more than AHP waitlist members ($p<0.001$).
  - The primary PMPM cost drivers were professional and IP, with professional costs averaging $859.68 PMPM among AHP waitlist members at the beginning of the baseline period and members who ultimately enrolled in H2O at a later time, averaging $195.36 PMPM higher. IP costs averaged $468.52 among AHP waitlist members, while H2O members averaged $474.30 PMPM higher. Additionally, professional and IP PMPM cost trends were $25.73 PMPM and $22.71 PMPM higher among H2O members than AHP waitlist members during the baseline period ($\boldsymbol{p}<0.001$ for both).
  - Average OP ED PMPM costs were approximately $96.61 higher among members who ultimately enrolled in H2O at a later time than AHP waitlist members at the start of the baseline period. This suggests that the total ED costs for H2O members averaged approximately $159.63, or more than 2.5 times that of AHP waitlist members.
- **Aggregate costs**
  - AHP waitlist members' total costs averaged $8,952.2 thousand at the beginning of the baseline period and increased by an average of $153.6 thousand per month ($p<0.001$) during the baseline period.
  - Total costs among members who ultimately enrolled in H2O at a later time averaged $5,597.0 thousand less than AHP waitlist members, for an overall total cost of $3,355.2 thousand. Additionally, there was a difference in trend among H2O baseline members relative to the AHP waitlist group of -$29.2 thousand per month ($p=0.034$).
  - The primary drivers of total costs were professional and IP, which averaged $3,986.3 thousand and $2,083.2 thousand among AHP waitlist members at the beginning of the baseline period, respectively. Members who ultimately enrolled in H2O at a later time exhibited professional and IP costs averaging $2,773.6 thousand and $943.4 thousand lower than the AHP waitlist group, which amounted to $1,212.7 thousand and $1,139.8 thousand, respectively, in total for H2O baseline members.

During the baseline period, members who ultimately enrolled in H2O at a later date had significantly higher PMPM costs than AHP waitlist members, and costs increased at a faster pace than AHP waitlist members. This increase was evident across most categories of service, primarily professional and IP.

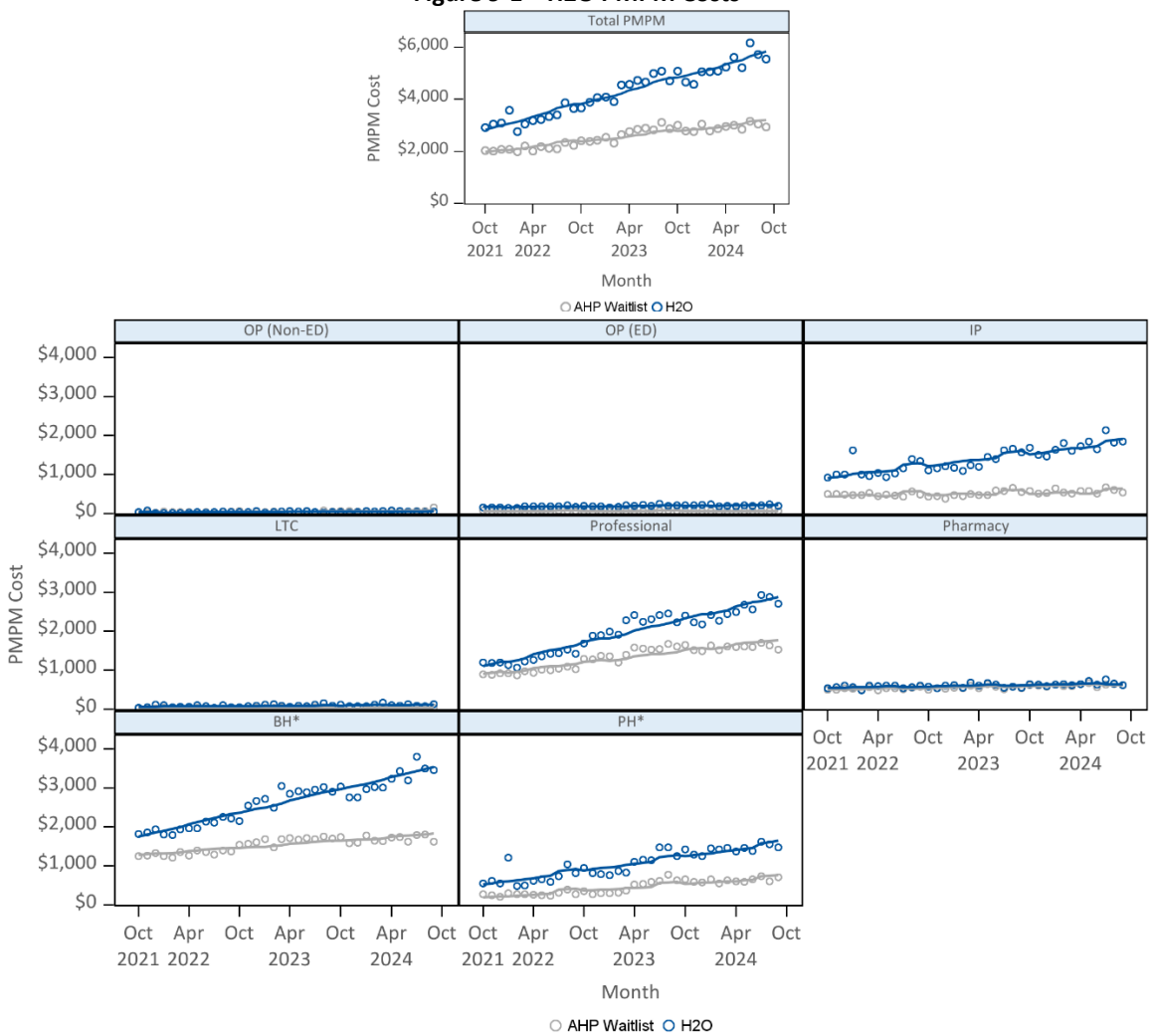
Table 9-23—H2O PMPM Costs

Variable	Estimate (*p*-value)								
	Total	Professional	IP	LTC	OP ED	OP Non-ED	Pharmacy	PH	BH
Intercept	$1,962.57 *** (<0.001)	$859.68 *** (<0.001)	$468.52 *** (<0.001)	$39.66 *** (<0.001)	$63.02 *** (<0.001)	$25.72 *** (<0.001)	$505.98 *** (<0.001)	$184.32 *** (<0.001)	$1,272.27 *** (<0.001)
Monthly baseline trend for AHP waitlist members	$33.14 *** (<0.001)	$25.45 *** (<0.001)	$2.74 (0.165)	$0.05 (0.880)	$-0.12 (0.606)	$1.34 *** (<0.001)	$3.67 *** (<0.001)	$14.46 *** (<0.001)	$15.00 *** (<0.001)
Difference in intercept between H2O and AHP waitlist members	$854.23 *** (<0.001)	$195.36 ** (0.005)	$474.30 *** (<0.001)	$35.31 *** (<0.001)	$96.61 *** (<0.001)	$2.53 (0.751)	$50.11 ** (0.005)	$330.62 *** (<0.001)	$473.50 *** (<0.001)
Difference in baseline trend between H2O and AHP waitlist members	$50.30 *** (<0.001)	$25.73 *** (<0.001)	$22.71 *** (<0.001)	$1.29 ** (0.007)	$1.68 *** (<0.001)	$-0.57 (0.148)	$-0.54 (0.527)	$15.59 *** (<0.001)	$35.26 *** (<0.001)

*p <0.1, **p <0.05, ***p <0.001

Note: Full model results are presented in Appendix A, Attachments. Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. AHP: AHCCCS Housing Program; BH: behavioral health; ED: emergency department; H2O: Housing to Health Opportunities; IP: inpatient; LTC: long-term care; OP: outpatient; PH: physical health.
Data Source: PMMIS data were used in the analysis of RQ 4.1.

Figure 9-1—H2O PMPM Costs



Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. AHP: AHCCCS Housing Program; BH: behavioral health; ED: emergency department; H2O: Housing and Health Opportunities; IP: inpatient; LTC: long-term care; OP: outpatient; PH: physical health; PMPM: per-member per-month.
*BH and PH costs are inclusive of all other categories of service except pharmacy.

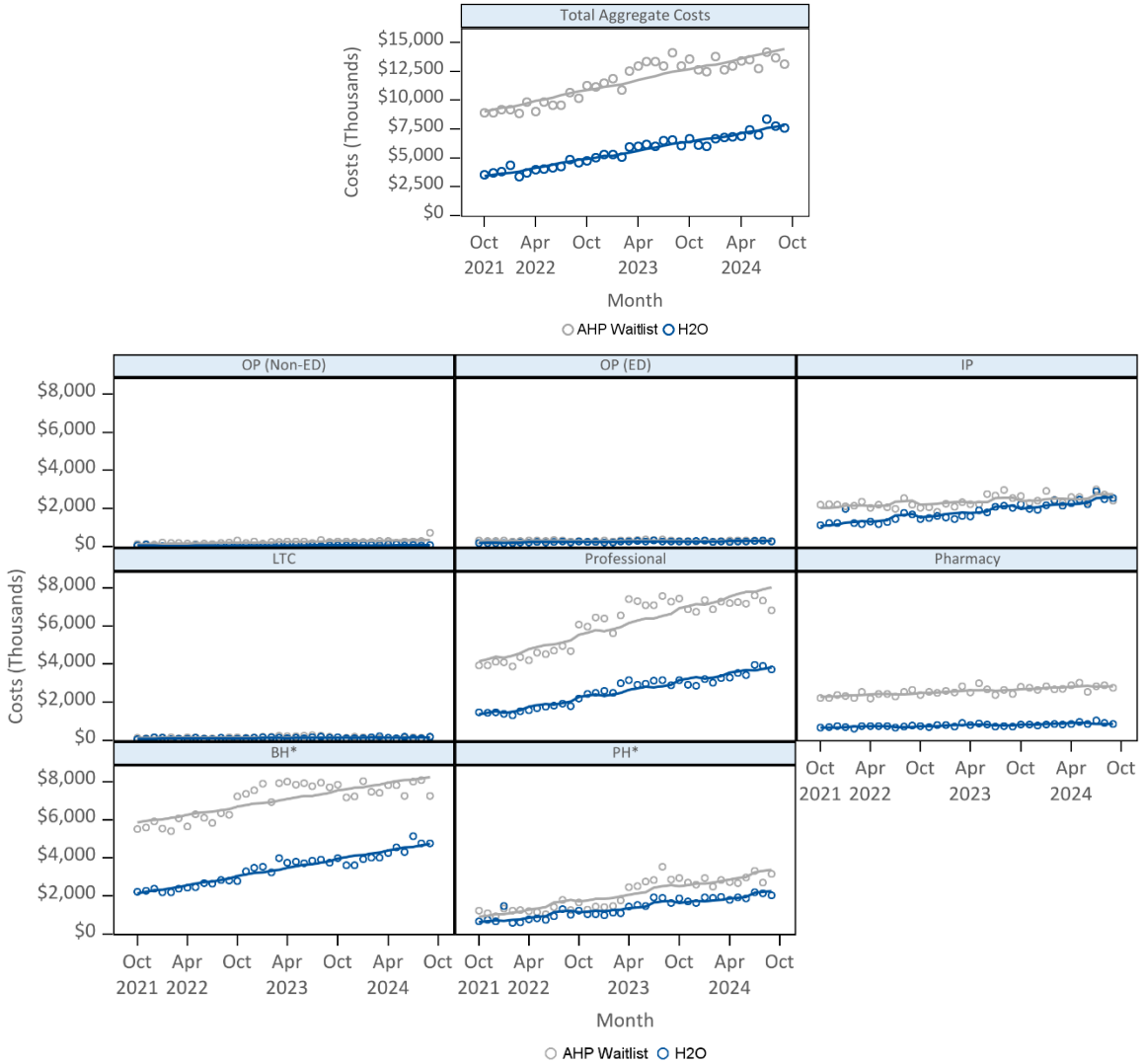
Table 9-24—H2O Total Aggregate Costs (in Thousands)

Variable	Estimate in Thousands (p-value)								
	Total	Professional	IP	LTC	OP ED	OP Non-ED	Pharmacy	PH	BH
Intercept	$8,952.2 *** (<0.001)	$3,986.3 *** (<0.001)	$2,083.2 *** (<0.001)	$161.7 *** (<0.001)	$297.2 *** (<0.001)	$128.3 *** (<0.001)	$2,295.5 *** (<0.001)	$846.3 *** (<0.001)	$5,810.4 *** (<0.001)
Monthly baseline trend for AHP waitlist members	$153.6 *** (<0.001)	$115.4 *** (<0.001)	$15.2 *** (<0.001)	$0.2 (0.743)	$-0.3 (0.511)	$6.0 *** (<0.001)	$17.0 *** (<0.001)	$66.5 *** (<0.001)	$70.1 *** (<0.001)
Difference in intercept between H2O and AHP waitlist members	$-5,597.0 *** (<0.001)	$-2,773.6 *** (<0.001)	$-943.4 *** (<0.001)	$-69.3 *** (<0.001)	$-106.5 *** (<0.001)	$-95.5 ** (0.001)	$-1,608.5 *** (<0.001)	$-271.9 * (0.050)	$-3,716.5 *** (<0.001)
Difference in baseline trend between H2O and AHP waitlist members	$-29.2 ** (0.034)	$-40.9 *** (<0.001)	$22.4 *** (<0.001)	$1.8 ** (0.049)	$2.9 *** (<0.001)	$-4.9 *** (<0.001)	$-10.4 *** (<0.001)	$-24.5 *** (<0.001)	$5.7 (0.560)

*p <0.1, **p <0.05, ***p <0.001

Note: Full model results are presented in Appendix A, Attachments. Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. AHP: AHCCCS Housing Program; BH: behavioral health; ED: emergency department; H2O: Housing to Health Opportunities; IP: inpatient; LTC: long-term care; OP: outpatient; PH: physical health.
Data Source: PMMIS data were used in the analysis of RQ 4.1.

Figure 9-2—H2O Total Aggregate Costs (in Thousands)



Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. AHP: AHCCCS Housing Program; BH: behavioral health; ED: emergency department; H2O: Housing and Health Opportunities; IP: inpatient; LTC: long-term care; OP: outpatient; PH: physical health.
*BH and PH costs are inclusive of all other categories of service except pharmacy.

10. KidsCare Eligibility Expansion

The following chapter describes the quantitative and qualitative results for the evaluation of the KidsCare Eligibility Expansion Program. A complete list of measures and their specifications is available in Evaluation Designs linked in the Appendix.

Results Summary

Table 10-1 displays the number of measures by research question that showed improvement, worsened, did not change significantly, or were not applicable.

Table 10-1—KidsCare Eligibility Expansion Quantitative Measure Results

Research Questions	Number of Measures			
	Worsening	No Significant Change	Improving	N/A[1]
RQ 1.1: Did expanding KidsCare eligibility increase the number of members enrolled in KidsCare?	0	0	0	1
RQ 1.2: Did expanding KidsCare eligibility reduce the number of uninsured children?	1	0	0	0
RQ 1.3: Does the KidsCare program promote continuity of care for its members?	0	2	3	0
RQ 2.1: Did expanding KidsCare eligibility improve access to health care for CHIP members?	0	0	1	0
RQ 2.2: Did expanding KidsCare eligibility maintain or increase the utilization of primary care and preventative health services?	0	5	1	3
RQ 2.3: Did expanding KidsCare eligibility improve access to dental care for CHIP members?	0	0	2	0
RQ 3.1: Did expanding KidsCare eligibility improve member satisfaction with the care received?	0	0	2	0
RQ 4.1: Did expanding KidsCare eligibility improve the management of BH conditions?	0	4	0	1
RQ 4.2: Did expanding KidsCare eligibility impact hospital utilization?	0	1	0	2
RQ 4.3: Did expanding KidsCare eligibility maintain or improve the management of chronic conditions for members?	0	2	0	0
RQ 4.4: Did expanding KidsCare eligibility improve parental understanding of their child's care?	0	0	1	0
RQ 5.1: Did expanding KidsCare improve member perception of health outcomes?	0	0	2	0
RQ 6.1: Did the KidsCare program provide cost-effective care for members?	1	0	0	1
Total	**2**	**14**	**12**	**8**

Note: BH: behavioral health; CHIP: Children's Health Insurance Program; N/A: not applicable.
The determination of support is based on performance relative to the comparison group.
[1] Measures did not have a desired directionality or require additional context to describe the outcome.

KidsCare Eligibility Expansion Program Results

State enrollment data were used to identify members enrolled in the KidsCare program; however, distinguishing between KidsCare standard enrollment and KidsCare expansion enrollment was limited to identifying members who were enrolled based on a supplemental file, which identified if members were eligible for KidsCare expansion during federal fiscal year (FFY) 2024. As such, measures that differentiate between KidsCare non-expansion and KidsCare expansion members cannot identify the duration of enrollment spans in the respective groups but can identify exposure to the expansion group.

Hypothesis 1: Expanding KidsCare eligibility will increase the number of members eligible for and enrolled in KidsCare and reduce the number of children losing eligibility for procedural reasons.

Hypothesis 1 identifies if the KidsCare expansion increased the number of members eligible for and enrolled in KidsCare. State enrollment data, KidsCare Expansion Identification, Arizona Health Care Cost Containment System (AHCCCS) population reports, and Integrated Public Use such Microdata Series (IPUMS) American Community Survey (ACS) data were used to assess three research questions.

Due to limitations and discrepancies across data sources, one measure could not be calculated and deviated from the Evaluation Design.

- Measure 1-2: *Percentage of KidsCare members out of estimated children eligible for KidsCare* relies on IPUMS ACS data to estimate the number of children eligible for KidsCare. Data from calendar year (CY) 2024 were not integrated into IPUMS at the time of writing this report. Results for each evaluation year will be included in the upcoming Summative Evaluation Report.

Research Question 1.1: Did expanding KidsCare eligibility increase the number of members enrolled in KidsCare?

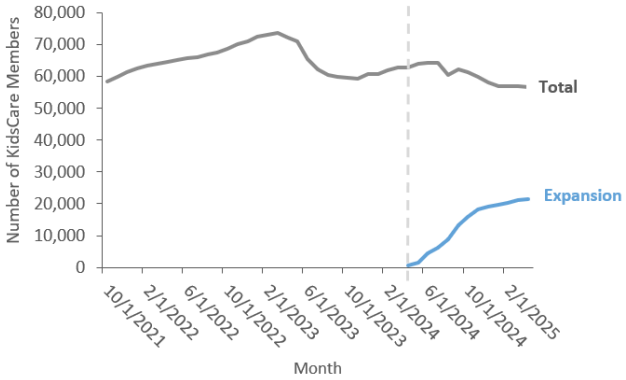
Figure 10-1 utilized member enrollment and KidsCare expansion enrollment data to identify the number of children enrolled in KidsCare.

Key Findings:

- KidsCare enrollment declined from a peak of 73,737 members in March 2023 to 56,725 members in April 2025. Notably, the declines in enrollment coincided with the unwinding of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) continuous enrollment provision.
- Enrollment in KidsCare Expansion began in April 2024, with enrollment in the expansion population increasing steadily to 21,460 members enrolled in April 2025. Although the KidsCare expansion population increased beginning in April 2024, the number of KidsCare members overall remained relatively stable after expansion implementation, likely due to the COVID-19 PHE continuous enrollment provision unwinding.

Enrollment in KidsCare declined due to the unwinding of the COVID-19 PHE continuous enrollment provision; however, the expansion of eligibility contributed to an influx of newly eligible members. Among the total KidsCare population, member enrollment remained relatively stable beginning in June 2023 through April 2025, with an average of 60,813 members enrolled each month.

Figure 10-1—Research Question 1.1, Measure 1-1



The grey dashed line represents the expansion implementation date.
The "Total" KidsCare count includes the count of "Expansion" members.
Data Source: AHCCCS Population Reports were used in the analysis of RQ 1.1.

Research Question 1.2: Did expanding KidsCare eligibility reduce the number of uninsured children?

Table 10-2 utilized ACS data to identify changes in the uninsured rate among children in Arizona during the baseline and evaluation periods and compared to trends among states with similar Children's Health Insurance Program (CHIP) requirements.[115]

Key Findings:

- The *Number of uninsured children in Arizona* increased by 0.3 percentage points ($p<0.001$) more than the increase among comparison states during the same time period. The rate among comparison states increased by approximately 0.4 percentage points, while the rate in Arizona increased by approximately 0.8 percentage points.

The rate of uninsured children increased both in Arizona and among the comparison states between the baseline and evaluation periods, with Arizona experiencing a relatively greater increase in the rate of uninsured children.

Table 10-2—Research Question 1.2, Measure 1-3

Did expanding KidsCare eligibility reduce the number of uninsured children?					
			Baseline Average	Evaluation Rate	2023/2024 DiD (p-value)
1-3	Number of uninsured children in Arizona	Arizona	8.5%	9.3%	0.3pp *** (<0.001)
		Comparison[1]	6.0%	6.4%	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: The change in rate displayed may not equal the difference between the baseline (CY 2021–CY 2023) and evaluation (CY 2024) averages due to rounding. pp: percentage point.

Data Source: United States Census, American Community Survey data were used in the analysis of RQ 1.2.

[1]The comparison group is comprised of states with similar federal poverty line (FPL) limits for the Children's Health Insurance Program (CHIP), including, Idaho, Nevada, Utah, Virginia, and Wyoming.

115 The states selected for comparison included Idaho, Nevada, Utah, Virginia, and Wyoming. These states were selected due to the CHIP federal poverty line (FPL) eligibility being at or below that of Arizona and not fluctuating during the evaluation period. Additionally, these states were primarily located in the Mountain West region, neighboring Arizona.

Research Question 1.3: Does the KidsCare program promote continuity of care for its members?

Table 10-3 utilized member enrollment and KidsCare expansion enrollment data to determine the average number of months that KidsCare members were enrolled in the program, the percentage of KidsCare members who re-enrolled after a gap of up to six months, the average number of enrollment gaps, and the average number of days per enrollment gap. Due to limitations in the KidsCare expansion enrollment data, the results presented below display enrollment continuity among all KidsCare members and are not separated out by expansion and non-expansion members.

Table 10-4 utilized member enrollment and KidsCare expansion enrollment data to identify the percentage of members who were eligible for renewal and remained enrolled after their renewal date. Due to limitations in data availability, continued enrollment after the renewal date was used as a proxy to identify completed renewals.[116]

Key Findings:

- The *Average number of months enrolled* per year among all KidsCare members increased by 0.38 months between the baseline and evaluation periods ($p<0.001$).
- The *Percentage of KidsCare members who re-enroll after a gap of up to six months* among all KidsCare members increased by 7.81 percentage points between the baseline and evaluation periods ($p<0.001$).
- The *Average number of gaps in Medicaid coverage for KidsCare members who re-enrolled after a gap of up to six months* among all KidsCare members remained consistent throughout the baseline and evaluation periods, but the *Average number of days per gap in Medicaid coverage* decreased by 17.55 days ($p<0.001$).
- The *Percentage of KidsCare members due for renewal who completed the renewal process* among all KidsCare members was similar during the baseline and evaluation periods, with a difference of 0.2 percentage points ($p=0.380$).

Compared to the baseline period, enrollment continuity among all KidsCare members improved during the evaluation period. The average number of months members were enrolled in KidsCare each year increased. Among members with gaps in coverage, a larger percentage re-enrolled after a gap of up to six months, and the number of days per gap in coverage decreased substantially.

Table 10-3—Research Question 1.3, Measures 1-4 through 1-7

Does the KidsCare program promote continuity of care for its members?				
		Baseline Average	Evaluation Average	Pre/Post Change in Rate[1]
1-4	Average number of months enrolled	6.53	6.91	0.38 *** (<0.001)
1-5	Percentage of KidsCare members who re-enroll after a gap of up to six months	10.3%	18.1%	7.81pp *** (<0.001)
1-6	Average number of gaps in Medicaid coverage for KidsCare members who re-enroll after a gap of up to six months	1.02	1.02	0.00 (0.900)
1-7	Average number of days per gap in Medicaid coverage for KidsCare members who re-enroll after a gap of up to six months	70.06	52.52	-17.55 *** (<0.001)

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: pp: percentage point.

Data Source: KidsCare expansion enrollment data were used in the analysis of RQ 1.3. Due to the availability of member enrollment data through May 2025, Measures 1-4 through 1-7 include a full baseline year and a full evaluation year.

[1]Change in Rate compares the rate or number in the baseline period (04/01/2023–03/31/2024) to the average rate or number in the evaluation period (04/01/2024–03/31/2025) using a pre/post model.

116 A full year of evaluation period data were not available for calculation of Measure 1-8: *Percentage of KidsCare members due for renewal who complete the renewal process*.

Table 10-4—Research Question 1.3, Measure 1-8

Does the KidsCare program promote continuity of care for its members?				
		Baseline Average	Evaluation Average	Pre/Post Change in Rate[1]
1-8	Percentage of KidsCare members due for renewal who complete the renewal process	76.1%	75.9%	-0.2pp (0.380)

Note: pp: percentage point
Data Source: Member enrollment data were used in the analysis of RQ 1.3.
[1]Change in Rate compares the rate or number in the baseline period (10/01/2022–09/30/2023) to the average rate or number in the evaluation period (10/01/2023–09/30/2024) using a pre/post model.

Hypothesis 2: Expanding KidsCare eligibility will improve access to care and increase primary care service utilization for Children's Health Insurance Program (CHIP) members.

Hypothesis 2 assesses if there are differences in access to care among KidsCare non-expansion and KidsCare expansion members. KidsCare Expansion Identification, State enrollment, Prepaid Medical Management Information System (PMMIS), and National Survey of Children's Health (NSCH) data were used to assess four research questions.

Given that members eligible for KidsCare expansion were not eligible for KidsCare prior to expansion, rates among KidsCare expansion members prior to FFY 2024 cannot be estimated. Therefore, the results for this hypothesis primarily examine the differences between the two groups during the first year after the KidsCare expansion was implemented.

Research Question 2.1: Did expanding KidsCare eligibility improve access to health care for CHIP members?

Table 10-5 utilized PMMIS and KidsCare expansion enrollment data to determine the percentage of KidsCare non-expansion and KidsCare expansion members meeting time/distance standards by provider type in quarter (Q) 4 of FFY 2024.[117]

Key Findings:

- In Q4 of FFY 2024, the *Percentage of members within time/distance standards* was at least 98 percent among all provider types for the KidsCare non-expansion and KidsCare expansion populations, with the exception of behavioral health residential facilities (BHRFs) for both populations.
  - The percentage of members meeting time/distance standards was nearly identical among all provider types; however, the differences were statistically significant among behavioral health (BH) outpatient (OP), BHRFs, dentists, and primary care providers (PCPs) ($p<0.05$). Additionally, KidsCare non-expansion and expansion members had nearly 100 percent of members meeting time/distance standards for cardiologist networks.

Among all provider types included in the analysis, both the KidsCare non-expansion and KidsCare expansion populations had rates of members meeting time/distance standards exceeding 97 percent. The percentage of members who met time/distance standards were generally equivalent among KidsCare non-expansion and KidsCare expansion members.

[117] Additional details on time/distance measure calculations and standards can be found in Appendix A, Attachments.

Table 10-5—Research Question 2.1, Measure 2-3

Did expanding KidsCare eligibility improve access to healthcare for CHIP members?				
		KidsCare Non-Expansion Rates	KidsCare Expansion Rates	Difference in Rates[1] (*p*-value)
2-1	Percentage of members meeting minimum time/distance network standards			
	BH Outpatient, Adult	98.9%	99.6%	0.7pp (0.274)
	BH Outpatient, Pediatric	99.0%	99.3%	0.3pp ** (0.005)
	BH Residential Facility	97.2%	97.6%	0.4pp ** (0.043)
	Cardiologist, Pediatric	100.0%	100.0%	0.0pp (0.960)
	Dentist, Pediatric	99.1%	99.5%	0.4pp *** (<0.001)
	Hospital	99.8%	99.9%	0.0pp (0.699)
	OB/GYN	99.9%	99.8%	-0.1pp (0.415)
	PCP, Pediatric	99.7%	99.8%	0.2pp ** (0.004)
	Pharmacy	98.9%	99.1%	0.2pp * (0.054)

*p <0.1, **p <0.05, ***p <0.001

Note: The differences in the rate may not equal the differences between the KidsCare non-expansion and KidsCare expansion group rates due to rounding. BH: behavioral health; CHIP: Children's Health Insurance Program; OB/GYN: obstetrician gynecologist; PCP: primary care provider; pp: percentage point.

Data Source: PMMIS data and KidsCare expansion enrollment data were used in the analysis of RQ 2.1.

[1]Difference in Rates compares the rate among KidsCare non-expansion members to KidsCare expansion members in the evaluation period (07/01/2024–09/30/2024).

Research Question 2.2: Did expanding KidsCare eligibility maintain or increase the utilization of primary care and preventative health services?

Table 10-6, Table 10-7, Table 10-8, and Table 10-9 utilized PMMIS, KidsCare expansion enrollment data, and data from the NSCH to identify changes in utilization of primary care and preventive health services among KidsCare members.

Key Findings:

- *The Percentage of children 2 years of age with appropriate immunization status* for the Combination 3 indicator was lower by 3.3 percentage points among KidsCare expansion members compared to non-expansion members (p=0.171). Conversely, the rates of measles, mumps, and rubella (MMR), varicella zoster virus (VZV), hepatitis A, and rotavirus vaccines were over 7 percentage points higher among KidsCare expansion members compared to KidsCare non-expansion members during the evaluation period (p<0.05 for all).
- The *Percentage of adolescents 13 years of age with appropriate immunizations* was slightly higher for the Combination 1 indicator among KidsCare expansion members by 3.7 percentage points; however, this difference was not statistically significant (p=0.150).
  - Rates of meningococcal vaccine and tetanus, diphtheria, pertussis (Tdap) vaccinations were higher by 4.9 and 5.7 percentage points, respectively, among KidsCare expansion members compared to KidsCare non-expansion members during the

evaluation period (p=0.055 and p=0.020, respectively). No other differences in immunization rates between the two groups were statistically significant.

- The *Percentage of children with well-child visits in the first 30 months of life* was higher among the KidsCare expansion population for both the *2 or more well child visits before the 15-month birthday* and *6 or more well child visits between the child's 15-month* and *30-month birthday* indicators, by 5.9 and 3.8 percentage points, respectively (p=0.054 and p=0.353).
- The *Percentage of members 3–21 years of age who had a well-care visit with a PCP or obstetrician gynecologist (OB/GYN)* was higher by 6.1 percentage points for the KidsCare expansion population compared to the KidsCare non-expansion population (p<0.001).
- The *Percentage of children who received any medical care in the past 12 months* increased by 2.5 percentage points between survey years 2021/2022 and 2022/2023 for Arizona children. Conversely, the *Percentage of children who did not receive needed health care in the past 12 months* increased by 1 percent for Arizona children.
- The *Percentage of children screened for risk of developmental, behavioral, and social delays in the 12 months prior to their third birthday* and the *Percentage of children who had an OP visit with a PCP who received a weight assessment or nutrition counseling* were similar among KidsCare expansion and non-expansion members; with differences that were not statistically significant.

KidsCare non-expansion and KidsCare expansion members accessed screenings at a similar rate; however, rates of well-care visits and immunizations were generally higher among KidsCare expansion members.

Table 10-6—Research Question 2.2, Measures 2-2 and 2-3

Did expanding KidsCare eligibility maintain or increase the utilization of primary care and preventative health services?		KidsCare Non-Expansion Rates[1]	KidsCare Expansion Rates[1]	Difference in Rates[2] (*p*-value)
2-2	Percentage of children two years of age with appropriate immunization			
	DTaP	38.5%	41.6%	3.1pp (0.376)
	IPV	50.9%	56.7%	5.9pp (0.105)
	MMR	74.8%	82.7%	8.0pp ** (0.010)
	HiB	55.4%	61.3%	5.9pp (0.101)
	Hepatitis B	23.6%	20.9%	-2.8pp (0.364)
	VZV	73.2%	81.6%	8.3pp ** (0.009)
	Pneumococcal Conjugate	38.8%	44.4%	5.6pp (0.113)
	Hepatitis A	77.5%	84.8%	7.3pp ** (0.015)
	Rotavirus	46.8%	54.6%	7.9pp ** (0.030)
	Influenza	24.9%	27.3%	2.4pp (0.449)
	Combination 3	**13.5%**	**10.1%**	-3.3pp (0.171)
	Combination 7	12.4%	8.8%	-3.6pp (0.123)
	Combination 10	5.3%	3.7%	-1.5pp (0.337)
2-3	Percentage of adolescents 13 years of age with appropriate immunizations			
	Meningococcal	58.4%	63.3%	4.9pp * (0.055)
	Tdap	66.4%	72.1%	5.7pp ** (0.020)
	HPV	29.0%	32.3%	3.3pp (0.170)
	Combination 1 (Meningococcal, Tdap)	**56.9%**	**60.6%**	3.7pp (0.150)
	Combination 2 (Meningococcal, Tdap, HPV)	25.2%	27.1%	1.9pp (0.405)

*p <0.1, **p <0.05, ***p <0.001

Note: DTaP: diphtheria, tetanus, pertussis; HiB: haemophilus influenzae type b; HPV: human papillomavirus; IPV: inactivated poliovirus vaccine; MMR: measles, mumps, and rubella; pp: percentage point; Tdap: tetanus, diphtheria, pertussis; VZV: varicella zoster virus.

Indicators in bold denote inclusion for evaluation in summary table.

Data Source: PMMIS data and KidsCare expansion enrollment data were used in the analysis of RQ 2.2.

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

[2]Difference in Rates compares the rate among KidsCare non-expansion members to KidsCare expansion members in the evaluation period (10/1/2023–09/30/2024).

Table 10-7—Research Question 2.2, Measures 2-4 and 2-5

Did expanding KidsCare eligibility maintain or increase the utilization of primary care and preventative health services?				
		KidsCare Non-Expansion Rates[1]	KidsCare Expansion Rates[1]	Difference in Rates[3] (*p*-value)
2-4	Percentage of members with well-child visits in the first 30 months of life			
	2 or more well child visits before the 15-month birthday	72.9%	78.8%	5.9pp * (0.054)
	6 or more well child visits between the child's 15-month and 30-month birthday	68.9%	72.7%	3.8pp (0.353)
2-5	Percentage of members 3-21 years of age who had a well-care visit with a PCP or OB/GYN	55.9%	61.9%	6.1pp *** (<0.001)

*p <0.1, **p <0.05, ***p <0.001

Note: OB/GYN: obstetrician gynecologist; PCP: primary care provider; pp: percentage point.

Data Source: PMMIS data and KidsCare expansion enrollment data were used in the analysis of RQ 2.2.

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

[2]Difference in Rates compares the rate among KidsCare non-expansion members to KidsCare expansion members in the evaluation period (10/1/2023–09/30/2024).

Table 10-8—Research Question 2.2, Measures 2-6 through 2-8

Did expanding KidsCare eligibility maintain or increase the utilization of primary care and preventative health services?				
			Baseline Period Weighted Rates[1]	
			2021-2022	2022-2023
2-6	Percentage of children who received any medical care in the past 12 months	Arizona	76.8% (CI = 73.7–79.6) N=1,677	79.3% (CI = 76.2–82.1) N=1,611
		National	80.9% (CI = 80.3–81.5) N=104,787	82.7% (CI = 82.2–83.2) N=109,080
2-7	Percentage of children who did not receive needed medical care in the past 12 months	Arizona	95.3% (CI = 93.6–96.5) N=1,677	96.3% (CI = 94.8–97.4) N=1,606
		National	96.6% (CI = 96.4–96.8) N=104,544	96.6% (CI = 96.4–96.8) N=108,753
2-8	Percentage of children who did not receive needed medical care due to cost in the past 12 months	Arizona	54.2% (CI = 39.1–68.5) N=73	— —
		National	43.3% (CI = 39.9–46.8) N=3,589	— —

Note: — indicates this question was not asked in that survey year. CI: 95% Confidence Interval. N represents the denominator count.

Data Source: National Survey of Children's Health (NSCH) was used in the analysis of RQ 2.2.

Baseline period: CY 2021–2022 and CY 2022–2023. Data for the evaluation period were not available.

[1]Percentages are based on weighted rates as reported by the NSCH.

Table 10-9—Research Question 2.2, Measures 2-9 and 2-10

Did expanding KidsCare eligibility maintain or increase the utilization of primary care and preventative health services?				
		KidsCare Non-Expansion Rates[1]	KidsCare Expansion Rates[1]	Difference in Rates[2] (*p*-value)
2-9	Percentage of children screened for risk of developmental, behavioral, and social delays in the 12 months prior to third birthday	49.1%	50.0%	0.9pp (0.686)
2-10	Percentage of children who had an outpatient visit with a PCP who received a weight assessment or nutrition counseling			
	BMI percentile documentation	28.0%	28.3%	0.3pp (0.635)
	Counseling for nutrition	18.9%	19.0%	0.1pp (0.882)
	Counseling for physical activity	13.5%	14.4%	0.8pp (0.110)

Note: BMI: body mass index; OB/GYN: obstetrician gynecologist; PCP: primary care provider; pp: percentage point.
Data Source: PMMIS data and KidsCare expansion enrollment data were used in the analysis of RQ 2.2.
[1]Rates are weighted by duration of enrollment in KidsCare.
[2]Difference in Rates compares the rate among KidsCare non-expansion members to KidsCare expansion members in the evaluation period (10/1/2023–09/30/2024).

Research Question 2.3: Did expanding KidsCare eligibility improve access to dental care for CHIP members?

Table 10-10 utilized PMMIS and KidsCare expansion enrollment data to determine changes in access to dental care among KidsCare members.

Key Findings:

- The *Percentage of members under 21 who received a comprehensive or periodic oral evaluation* was 9.9 percentage points ($p<0.001$) higher for KidsCare expansion members compared to non-expansion KidsCare members during the evaluation period.
- The *Percentage of members under 21 who received a topical fluoride application* was 5.9 percentage points ($p<0.001$) higher for KidsCare expansion members compared to non-expansion KidsCare members during the evaluation period.

The KidsCare expansion population accessed dental care at a significantly higher rate than non-expansion members.

Table 10-10—Research Question 2.3, Measures 2-11 and 2-12

Did expanding KidsCare eligibility maintain or increase the utilization of primary care and preventative health services?				
		KidsCare Non-Expansion Rates[1]	KidsCare Expansion Rates[1]	Difference in Rates[2] (*p*-value)
2-11	Percentage of members under 21 who received a comprehensive or periodic oral evaluation	53.1%	63.1%	9.9pp *** (<0.001)
2-12	Percentage of members under 21 who received a topical fluoride application	27.2%	33.1%	5.9pp *** (<0.001)

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Data Source: PMMIS data and KidsCare expansion enrollment data were used in the analysis of RQ.2.1.
[1]Rates are weighted by duration of enrollment in KidsCare.
[2]Difference in Rates compares the rate among KidsCare non-expansion members to KidsCare expansion members in the evaluation period (10/1/2023–09/30/2024).

Hypothesis 3: Expanding KidsCare eligibility will improve member care satisfaction.

Research Question 3.1: Did expanding KidsCare eligibility improve member satisfaction with the care received?

Table 10-11 utilized beneficiary surveys to assess members' satisfaction with the care they received. Survey responses may have been reported by parents or guardians of members.

Key Findings:

- The percentage of members with a high rating of their personal doctor was 6.0 percentage points higher for KidsCare expansion members compared to KidsCare non-expansion members during the evaluation period (p<0.001).
- The *Percentage of members who reported they were able to schedule an appointment for a checkup or routine care at a doctor's office or clinic as soon as they needed* was 7.4 percentage points higher for KidsCare expansion members compared to KidsCare non-expansion members during the evaluation period (p<0.001).

KidsCare expansion members had higher ratings of satisfaction with the care they received compared to KidsCare non-expansion members.

Table 10-11—Research Question 3.1, Measures 3-1 through 3-3

Did expanding KidsCare eligibility improve member satisfaction with the care received?				
		Evaluation Period Weighted Rate[1]		
		KidsCare Non-Expansion	KidsCare Expansion	Difference in Rates (p-value)
3-1	Member rating of personal doctor	84.0% N=110	90.0% N=95	6.0pp *** (<0.001)
3-2	Percentage of members who reported they received care as soon as they needed	S N=29	S N=26	S
3-3	Percentage of members who reported they were able to schedule an appointment for a checkup or routine care at a doctor's office	70.4% N=91	77.8% N=78	7.4pp *** (<0.001)

*p <0.1, **p <0.05, ***p <0.001

Note: S refers to rates involving numerators smaller than 11 members or denominators smaller than 30 members, which are suppressed due to potentially unreliable statistical testing and rate calculation and to ensure anonymity. N represents the number of survey responses. Surveys were administered in calendar year (CY) 2025. pp: percentage point.
Data Source: Beneficiary surveys were used in the analysis of RQ 3.1.

[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP Code.

Hypothesis 4: Expanding KidsCare eligibility will improve quality of care for members.

Hypothesis 4 identifies if there are differences in the quality of care among KidsCare non-expansion and KidsCare expansion members. State enrollment data, KidsCare Expansion Identification and PMMIS were used to assess four research questions.

Given that members eligible for KidsCare expansion were not eligible for KidsCare prior to the expansion, rates among KidsCare expansion members prior to FFY 2024 cannot be estimated. Therefore, the results for this hypothesis primarily examine the differences between the two groups during the first year after the KidsCare expansion was implemented.

Research Question 4.1: Did expanding KidsCare eligibility improve the management of behavioral health (BH) conditions?

Table 10-12 utilized PMMIS and KidsCare expansion enrollment data to assess management of BH conditions among KidsCare non-expansion and KidsCare expansion members.

Key Findings:

- The *Percentage of children and adolescents on antipsychotics with metabolic monitoring* was 4.6 percentage points higher for KidsCare expansion members compared to KidsCare non-expansion members during the evaluation period; however, this difference was not statistically significant (p=0.496).
- The *Percentage of children on Attention Deficit/Hyperactivity Disorder (ADHD) medication with a follow up during the 30-day initiation and the 210-day continuation phase* was lower by 5.4 and 16.8 percentage points, respectively, for KidsCare expansion members compared to KidsCare non-expansion members during the evaluation period. These differences were not statistically significant (p=0.372 and p=0.119).
- *Follow-up after hospitalization for mental illness* and *Follow-up after ED visit for mental illness* were 8.9 and 23.3 percentage points higher for KidsCare expansion members compared to KidsCare non-expansion members, respectively; however, these differences were not statistically significant (p=0.248 and p=0.236).
- The percentage of KidsCare expansion members *Diagnosed with mental health disorders* was 1.5 percentage points (p=0.002) higher compared to KidsCare non-expansion members during the evaluation period.

The KidsCare expansion population had lower follow up rates after being prescribed an ADHD medication but had higher follow-up rates after hospitalizations and emergency department (ED) visits for mental illness; however, these results were not statistically significant.

Table 10-12—Research Question 4.1, Measures 4-1 through 4-6

Did expanding KidsCare eligibility improve the management of BH conditions?				
		KidsCare Non-Expansion Rates[1]	KidsCare Expansion Rates[1]	Difference in Rates[2] (*p*-value)
4-1	Percentage of children and adolescents on antipsychotics with metabolic monitoring	36.4%	40.9%	4.6pp (0.496)
4-2	Percentage of children on ADHD medication with a follow up during the 30-day initiation phase and the 210-day continuation phase			
	30-day initiation	63.7%	58.3%	-5.4pp (0.372)
	210-day continuation	69.9%	53.1%	-16.8pp (0.119)
4-3	Follow up after ED visit for substance use	16.9%	S	S
4-4	Follow up after hospitalization for mental illness	58.2%	67.1%	8.9pp (0.248)
4-5	Follow up after ED visit for mental illness	64.1%	87.4%	23.3pp (0.236)
4-6	Diagnosed mental health disorders	18.5%	20.1%	1.5pp ** (0.002)

*p <0.1, **p <0.05, ***p <0.001

Note: S refers to rates involving denominators or numerators smaller than 11 members, which are suppressed due to potentially unreliable statistical testing and rate calculation and to ensure anonymity. ADHD: attention deficit/hyperactivity disorder; BH: behavioral health; ED: emergency department; OB/GYN: obstetrician gynecologist; PCP: primary care provider; pp: percentage point.

Data Source: PMMIS data and KidsCare expansion enrollment data were used in the analysis of RQ.4.1.

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

[2]Difference in Rates compares the rate among KidsCare non-expansion members to KidsCare expansion members in the evaluation period (10/1/2023–09/30/2024).

Research Question 4.2: Did expanding KidsCare eligibility impact hospital utilization?

Table 10-13 utilized PMMIS and KidsCare enrollment data to assess changes in ED and inpatient (IP) utilization.

Key Findings:

- The *Number of emergent ED visits* for KidsCare expansion members was 2.12 visits per 1,000 member months higher than KidsCare non-expansion members (p=0.004).
- The *Number of non-emergent ED visits* per 1,000 member months and the *Number of IP stays* per 1,000 member months for KidsCare expansion members were nearly identical to KidsCare non-expansion members; any differences were not statistically significant.

The rate of emergent ED visits was higher for KidsCare expansion members, while the rates of non-emergent visits and IP stays were nearly identical between the two groups.

Table 10-13—Research Question 4.2, Measures 4-7 through 4-9

Did expanding KidsCare eligibility impact hospital utilization?				
		KidsCare Non-Expansion Rates	KidsCare Expansion Rates	Difference in Rates[1] (*p*-value)
4-7	Number of emergent ED visits per 1,000 member months	27.39	29.51	2.12 ** (0.004)
4-8	Number of non-emergent ED visits per 1,000 member months	1.40	1.39	-0.01 (0.950)
4-9	Number of IP stays per 1,000 member months	0.89	0.92	0.03 (0.837)

*p <0.1, **p <0.05, ***p <0.001
Note: ED: emergency department; IP: inpatient.
Data Source: PMMIS data and KidsCare expansion enrollment data were used in the analysis of RQ.4.2.
[1]Difference in Rates compares the rate among KidsCare non-expansion members to KidsCare expansion members in the evaluation period (10/1/2023–09/30/2024).

Research Question 4.3: Did expanding KidsCare eligibility maintain or improve the management of chronic conditions for members?

Table 10-14 utilized PMMIS and KidsCare enrollment data to measure the management of chronic conditions among KidsCare non-expansion and KidsCare expansion members.

Key Findings:

- The *Percentage of members ages 5 to 18 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year* was 5.1 percentage points lower (approximately an 8 percent relative difference [(59.4 percent / 64.5 percent]-1) for KidsCare expansion members compared to KidsCare non-expansion members during the evaluation period, although this difference was not statistically significant (p=0.407).
- There were no differences in the percentage of children diagnosed with diabetes between KidsCare expansion members and KidsCare non-expansion members during the evaluation period (p=0.786).

KidsCare non-expansion and KidsCare expansion members had similar management of chronic diseases with differences that were not statistically significant; however, appropriate asthma control was approximately 8 percent lower among KidsCare expansion members, which roughly represents the difference between the 33rd national percentile (for KidsCare expansion members) and the 50th percentile (for KidsCare non-expansion members) among Medicaid members nationally.

Table 10-14—Research Question 4.3, Measures 4-10 through 4-14

Did expanding KidsCare eligibility maintain or improve the management of chronic conditions for members?				
		KidsCare Non-Expansion Rates[1]	KidsCare Expansion Rates[1]	Difference in Rates[2] (*p*-value)
4-10	Percentage of members ages 5 to 18 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year	64.5%	59.4%	-5.1% (0.407)
4-11	Number of children hospitalized for asthma conditions	42.7	S	S
4-12	Number of children diagnosed with diabetes	0.4%	0.4%	0.00 (0.796)
4-13	Number of hospitalizations or ED visits for diabetes	17.7	S	S
4-14	Percentage of children with diabetes whose lab tests indicate control of their conditions	—	—	—

Note: — indicates that laboratory data were not available at the time of the evaluation. S refers to rates involving denominators or numerators smaller than 11 members, which are suppressed due to potentially unreliable statistical testing and rate calculation and to ensure anonymity. ED: emergency department.
Data Source: PMMIS data and KidsCare expansion enrollment data were used in the analysis of RQ 4.3.
[1]Rates are weighted by duration of enrollment in KidsCare.
[2]Difference in Rates compares the rate among KidsCare non-expansion members to KidsCare expansion members in the evaluation period (10/1/2023–09/30/2024).

Research Question 4.4: Did expanding KidsCare eligibility improve parental understanding of their child's care?

Table 10-15 utilized beneficiary surveys to assess parental understanding of their child's care. Survey responses may have been reported by parents or guardians of members.

Key Findings:

- *Parent understanding of their child's care needs* was 2.9 percentage points higher for KidsCare expansion members compared to KidsCare non-expansion members during the evaluation period ($p<0.001$).

Those in the KidsCare expansion population reported higher ratings of parental understanding of their child's care needs compared to those in the non-expansion KidsCare population.

Table 10-15—Research Question 4.4, Measures 4-15 through 4-17

Did expanding KidsCare eligibility improve parental understanding of their child's care?		Evaluation Period Weighted Rate[1]		
		KidsCare Non-Expansion	KidsCare Expansion	Difference in Rates (*p*-value)
4-15	Parent understanding of their child's health			
	Child has a medical, behavioral, or other health condition	S N=17	S N=13	S
	The condition is expected to last for at least 12 months	S N=15	S N=9	S
4-16	Parent understanding of their child's care needs	16.5% N=133	19.4% N=106	2.9pp *** (<0.001)
4-17	Parent knowledge of when to seek care for their child	S N=29	S N=26	S

*p <0.1, **p <0.05, ***p <0.001

Note: S refers to rates involving numerators smaller than 11 members or denominators smaller than 30 members, which are suppressed due to potentially unreliable statistical testing and rate calculation and to ensure anonymity. N represents the number of survey responses. Surveys were administered in calendar year (CY) 2025. pp: percentage point.

Data Source: Beneficiary surveys were used in the analysis of RQ 4.4.

[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP Code.

Hypothesis 5: Expanding KidsCare will improve self-assessed health outcomes.

Research Question 5.1: Did expanding KidsCare improve member perception of health outcomes?

Table 10-16 utilized beneficiary surveys to assess members' perception of their health outcomes. Survey responses may have been reported by parents or guardians of members.

Key Findings:

- The *Percentage of members who reported a rating of overall health as very good or excellent* was 4.1 percentage points higher for KidsCare expansion members compared to KidsCare non-expansion members during the evaluation period (p<0.001).
- The *Percentage of members who reported a rating of overall mental or emotional health as very good or excellent* was 2.3 percentage points higher for KidsCare expansion members compared to KidsCare non-expansion members during the evaluation period (*p*<0.001).

KidsCare expansion members reported higher ratings of overall health and overall mental or emotional health compared to KidsCare non-expansion members.

Table 10-16—Research Question 5.1, Measures 5-1 and 5-2

Did expanding KidsCare improve member perception of health outcomes?				
		Evaluation Period Weighted Rate[1]		
		KidsCare Non-Expansion	KidsCare Expansion	Difference in Rates (*p*-value)
5-1	Percentage of members who reported a rating of overall health as very good or excellent	72.1% N=132	76.2% N=107	4.1pp *** (<0.001)
5-2	Percentage of members who reported a rating of overall mental or emotional health as very good or excellent	72.6% N=132	74.8% N=107	2.3pp *** (<0.001)

*p <0.1, **p <0.05, ***p <0.001

Note: S refers to rates involving numerators smaller than 11 members or denominators smaller than 30 members, which are suppressed due to potentially unreliable statistical testing and rate calculation and to ensure anonymity. N represents the number of survey responses. Surveys were administered in calendar year (CY) 2025. pp: percentage point.

Data Source: Beneficiary surveys were used in the analysis of RQ 5.1.

[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP Code.

Hypothesis 6: Expanding KidsCare will yield cost-effective care for members.

Because costs among all KidsCare expansion members could not be identified prior to implementation, before and after comparisons cannot be made. Instead, the average cost of care during the evaluation period is compared between KidsCare expansion and non-expansion members. Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars.

Research Question 6.1: Did the KidsCare program provide cost-effective care for members?

Table 10-17 and Figure 10-2 utilized PMMIS data to examine the difference in average per-member per-month (PMPM) costs through a t-test between KidsCare expansion and non-expansion members during the evaluation period. Average PMPM costs were approximately $163.77 among non-expansion members and were $13.35 higher among the expansion group.

Table 10-18 and Figure 10-3 utilized PMMIS data to assess the differences in aggregated costs between KidsCare expansion and non-expansion members during the evaluation period. It is important to note that the differing sizes of the KidsCare expansion and non-expansion populations influenced the aggregated costs. Therefore, caution should be used when comparing aggregate costs between the two groups. Total cost of care averaged $8,167.7 thousand among the KidsCare non-expansion group, and was $6,553.9 thousand less among the expansion group, or $1,613.8 overall.

Table 10-19 utilized beneficiary surveys to assess reported medical debt. Given the findings presented in this Interim Evaluation Report reflect results from a single round of surveys, changes over time cannot be examined in this report. However, a subsequent round of surveys will be included in conjunction with the Summative Evaluation Report to further assess medical debt.

Key Findings:

- **PMPM Costs**
  - Total PMPM costs averaged $163.77 throughout the evaluation period for KidsCare non-expansion members and were an average of $13.35 higher ($p$=0.081) for KidsCare expansion members than non-expansion members.
  - The primary driver of PMPM costs were professional, averaging $94.24 among the non-expansion group, and were an average of $10.23 PMPM higher among the expansion group (p=0.002).

- KidsCare expansion members also had average PMPM pharmacy costs that were $6.01 higher than the non-expansion group (*p*=0.002).

- **Aggregate Costs**
  - Total costs among non-expansion members averaged $8,167.7 thousand throughout the evaluation period. The primary driver of aggregate costs were professional, averaging $4,699.2 thousand.
  - Among KidsCare expansion members, total costs averaged $6,553.9 thousand less than the non-expansion group, or $1,613.8 overall throughout the evaluation period. Similar to non-expansion members, the primary driver of costs were professional, which were an average of $3,747.1 thousand less than the non-expansion group, equating to $952.1 thousand total.
  - The incidence of medical debt was higher among KidsCare expansion members by 1.6 percentage points compared to KidsCare non-expansion members during the evaluation period (*p*<0.001). Among those who responded to a supplemental medical debt question, the median debt among KidsCare non-expansion members was higher than the debt reported among KidsCare expansion members.

Table 10-17—KidsCare PMPM Costs

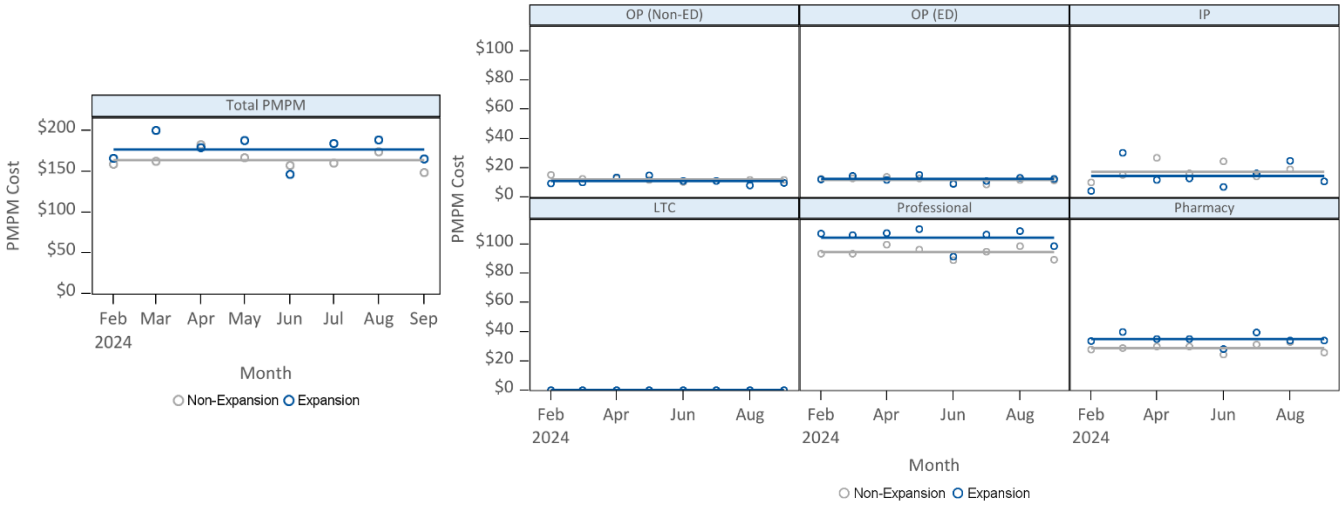
Variable	Estimate (*p*-value)						
	Total	Professional	IP	LTC	OP ED	OP Non-ED	Pharmacy
Intercept	$163.77 *** (<0.001)	$94.24 *** (<0.001)	$16.99 *** (<0.001)	<$0.01 (0.179)	$11.55 *** (<0.001)	$12.08 *** (<0.001)	$28.90 *** (<0.001)
Average difference between expansion and non-expansion	$13.35 * (0.081)	$10.23 ** (0.002)	$-2.42 (0.532)	>-$0.01 (0.334)	$0.75 (0.441)	$-1.22 (0.219)	$6.01 ** (0.002)

*p <0.1, **p <0.05, ***p <0.001

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

Data Source: PMMIS data were used in the analysis of RQ 6.1.

Figure 10-2—KidsCare PMPM Costs



Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient; PMPM: per-member per-month.

Table 10-18—KidsCare Total Aggregate Costs (in Thousands)

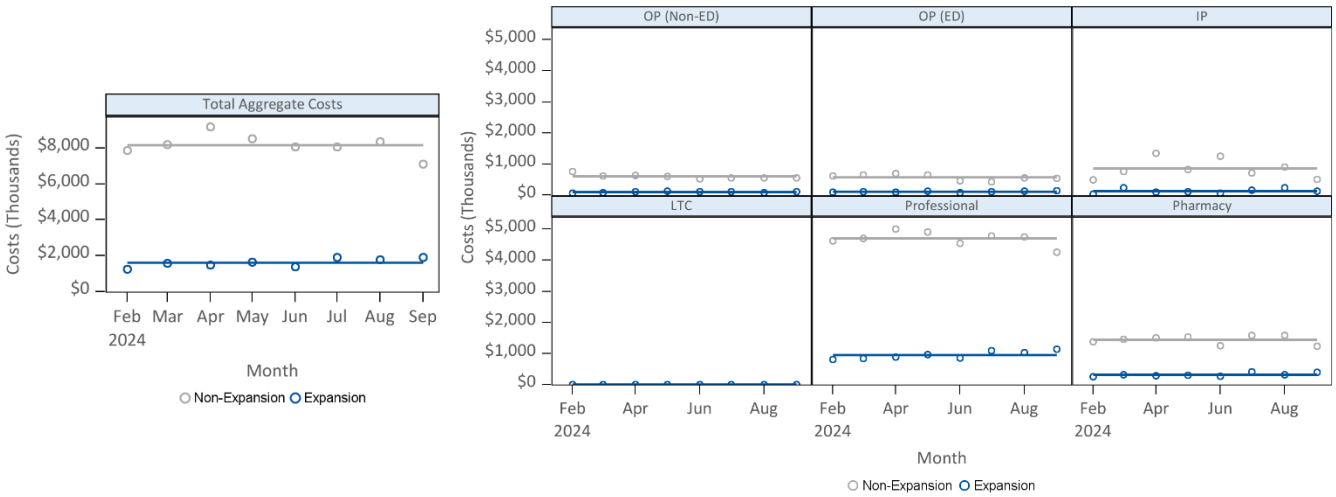
Variable	Estimate in Thousands (*p*-value)						
	Total	Professional	IP	LTC	OP ED	OP Non-ED	Pharmacy
Intercept	$8,167.7 *** (<0.001)	$4,699.2 *** (<0.001)	$850.0 *** (<0.001)	$0.1 (0.179)	$575.8 *** (<0.001)	$602.1 *** (<0.001)	$1,440.5 *** (<0.001)
Average difference between expansion and non-expansion	$-6,553.9 *** (<0.001)	$-3,747.1 *** (<0.001)	$-717.7 *** (<0.001)	$-0.1 (0.334)	$-463.9 *** (<0.001)	$-503.3 *** (<0.001)	$-1,121.8 *** (<0.001)

*p <0.1, **p <0.05, ***p <0.001

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

Data Source: PMMIS data were used in the analysis of RQ 6.1.

Figure 10-3—KidsCare Total Aggregate Costs (in Thousands)



Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

Table 10-19—Research Question 6.1, Measure 6-2

Did the KidsCare program provide cost-effective care for members?				
		Evaluation Period Weighted Rate[1]		
		KidsCare Non-Expansion	KidsCare Expansion	Difference in Rates (*p*-value)
6-2	Change in reported medical debt	5.5% N=122	7.1% N=104	1.6pp *** (<0.001)

*p <0.1, **p <0.05, ***p <0.001

Note: N represents the number of survey responses. Surveys were administered in calendar year (CY) 2025. pp: percentage point.

Data Source: Beneficiary surveys were used in the analysis of RQ 6.1.

[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP Code.

11. PQC Results

The following chapter describes the quantitative and qualitative results for the evaluation of the Prior Quarter Coverage (PQC) waiver. A complete list of measures and their specifications is available in Evaluation Designs linked in the Appendix.

Results Summary

Table 11-1 displays the number of measures by research question that showed improvement, worsened, did not change significantly, or were not applicable.

Table 11-1—PQC Quantitative Measure Results

Research Questions	Number of Measures			
	Worsening	No Significant Change	Improving	N/A[1]
RQ 1.1: Do eligible people without PQC enroll in Medicaid at the same rates as other eligible people with PQC?	2	0	0	2
RQ 1.2: What is the likelihood of enrollment continuity for those without PQC compared to other Medicaid members with PQC?	0	0	2	0
RQ 1.3: Do members without PQC who disenroll from Medicaid have shorter enrollment gaps than other members with PQC?	2	0	2	0
RQ 5.1: Do members without PQC have the same or higher rates of office visits compared to members with PQC?	0	2	0	0
RQ 5.2: Do members without PQC have the same or higher rates of service and facility utilization compared to rates prior to waiver renewal with PQC?	1	0	0	0
RQ 7.3: Do costs to non-AHCCCS entities stay the same or decrease after implementation of the waiver compared to before?	1	0	0	0
Total	**6**	**2**	**4**	**2**

Note: AHCCCS: Arizona Health Care Cost Containment System; N/A: not applicable; PQC: prior quarter coverage; RQ: research question.
[1] Measures did not have a desired directionality or require additional context to describe the outcome.

PQC Program Results

Hypothesis 1: Eliminating PQC will increase the likelihood and continuity of enrollment.

Research Question 1.1: Do eligible people without PQC enroll in Medicaid at the same rates as other eligible people with PQC?

Research Question 1.1 results identify the proportion of enrolled Medicaid members by eligibility group and the number of members who enrolled in Medicaid each month. A combination of pre-test/post-test analyses and interrupted time series (ITS) analyses assessed this research question.

Measure 1-1 (*Percentage of Medicaid enrollees per month by eligibility group out of estimated eligible Medicaid recipients*) and Measure 1-2 (*Percentage of new Medicaid enrollees per month by eligibility group, as identified by those without a recent spell of Medicaid coverage out of estimated eligible Medicaid recipients*) include non-inferiority results assessing whether the proportion of existing and new Medicaid members out of estimated eligible members has meaningfully changed following the implementation of the Waiver. Data to identify the estimated eligible Medicaid members by eligibility group originate from the American Community Survey (ACS) data from Integrated Public Use Microdata Series (IPUMS) and the number of newly enrolled members is derived from the Prepaid Medical Management Information System (PMMIS).

Key Findings:

- The percentage of estimated eligible existing and new Medicaid members declined between the baseline and evaluation periods and was statistically significant ($p<0.001$).
  - The Parent eligibility group had the largest decline in Medicaid enrollment among the estimated eligible Medicaid recipients, while retaining the highest proportion of estimated eligible members enrolled among all eligibility groups.
  - The Disabled (Freedom to Work [FTW]) and Supplemental Security Income (SSI)-Aged groups had the lowest proportion of estimated eligible members enrolled.
- All eligibility groups except the Parent group had a significant decline in the percentage of estimated eligible Medicaid members who were newly enrolled ($p<0.001$). The SSI-Aged group had the largest decline of 2.8 percentage points.

Table 11-2 presents results identifying the change in the percentage of estimated eligible Medicaid recipients enrolled and newly enrolled.

Table 11-2—Research Question 1.1, Measures 1-1 and 1-2

Do eligible people without PQC enroll in Medicaid at the same rates as other eligible people with PQC?				
		Baseline Average	Evaluation Average	Pre/Post Change in Rate[3]
1-1	Percentage of estimated eligible Medicaid recipients enrolled, by eligibility group[1]			
	Eligible - Total	**39.0%**	**38.6%**	-0.4pp *** (<0.001)
	Eligible - Adult	36.3%	37.6%	1.3pp *** (<0.001)
	Eligible - Disabled (FTW)	27.9%	27.5%	-0.4pp *** (<0.001)
	Eligible - Parent	56.3%	52.6%	-3.8pp *** (<0.001)
	Eligible - Senior (DIS)	43.6%	44.8%	1.2pp *** (<0.001)
	Eligible - SSI Aged	27.0%	27.8%	0.8pp *** (<0.001)
1-2	Percentage of estimated eligible Medicaid recipients newly enrolled, by eligibility group[2]			
	Eligible - Total	**11.2%**	**10.1%**	-1.1pp *** (<0.001)
	Eligible - Adult	11.5%	10.8%	-0.7pp *** (<0.001)
	Eligible - Disabled (FTW)	0.4%	0.3%	-0.2pp *** (<0.001)
	Eligible - Parent	17.0%	17.5%	0.5pp *** (<0.001)
	Eligible - Senior (DIS)	0.9%	0.7%	-0.2pp *** (<0.001)
	Eligible - SSI Aged	12.4%	9.6%	-2.8pp *** (<0.001)

Note: Indicators in bold denote inclusion for evaluation in summary table. The pre/post change in rate may not align with the reported baseline and evaluation averages, due to rounding. DIS: disabled; FTW: Freedom to Work; SSI: Supplemental Security Income.
Baseline period: January 1, 2018–December 31, 2019; Evaluation period: January 1, 2020–December 31, 2024
Data Source: PMMIS and IPUMS ACS data were used in the analysis of RQ 1.1
[1]Rates are based on calendar years due to IPUMS annual reporting periods.
[2]Newly enrolled beneficiaries are those who did not have Medicaid enrollment in the six months prior to joining.
[3]Change in Rate compares the rate in the evaluation period to the average rate in the baseline period using a pre/post model.

Measure 1-3 (*Number of Medicaid enrollees per month by eligibility group and/or per-capita of State*) and Measure 1-4 (*Number of new Medicaid enrollees per month by eligibility group, as identified by those without a recent spell of Medicaid coverage*) include ITS results comparing trends projected from baseline rates to trends in the evaluation period for the number of Medicaid members enrolling each month among those renewing their coverage after a gap in enrollment and those without a recent spell of Medicaid coverage. In Figure 11-1, the blue line represents the model-based average rates for each month, and the dashed grey line represents the counterfactual projection of the baseline period trend in the post-policy period before the coronavirus disease 2019 (COVID-19) public health emergency (PHE)-affected months. The continuous enrollment requirement established under the Families First Coronavirus Response Act allowed most members who would otherwise have been disenrolled to remain on Medicaid during the COVID-19 PHE. The Arizona Health Care Cost Containment System (AHCCCS) returned to the regular renewal process on April 1, 2023. The ITS model intends to capture the post-implementation and COVID-19 PHE periods separately to isolate the impact of the elimination of the PQC waiver.

Key Findings:

- The number of Medicaid members increased upon implementation of the PQC waiver. This increase was statistically significant for the Adult and Disabled FTW groups. Prior to the COVID-19 PHE, the post-implementation trend increased relative to the projected baseline trend among all eligibility groups, with statistically significant changes reported for the Parent and SSI-Aged groups.
  - The COVID-19 PHE continuous eligibility provision impacted the results, as the number of Adult and Parent members increased substantially in March 2020. Throughout the remainder of the COVID-19 PHE, the number of new members generally decreased month over month, as members who otherwise may have been disenrolled were authorized to retain coverage throughout the COVID-19 PHE.

The COVID-19 PHE had a profound impact on Medicaid enrollment during the evaluation period. Although the rate and number of estimated eligible Medicaid members generally declined between the baseline and evaluation periods, more members obtained enrollment at the start of the COVID-19 PHE compared to months prior and retained their enrollment throughout the COVID-19 PHE.

Figure 11-1 and Table 11-3 display the ITS results identifying the number of members beginning enrollment in Medicaid each month, among those renewing their coverage. Figure 11-2 and Table 11-4 display the ITS results identifying the number of members beginning enrollment in Medicaid each month, among members who did not have Medicaid coverage in the six months prior.

Figure 11-1—Research Question 1.1, Measure 1-3

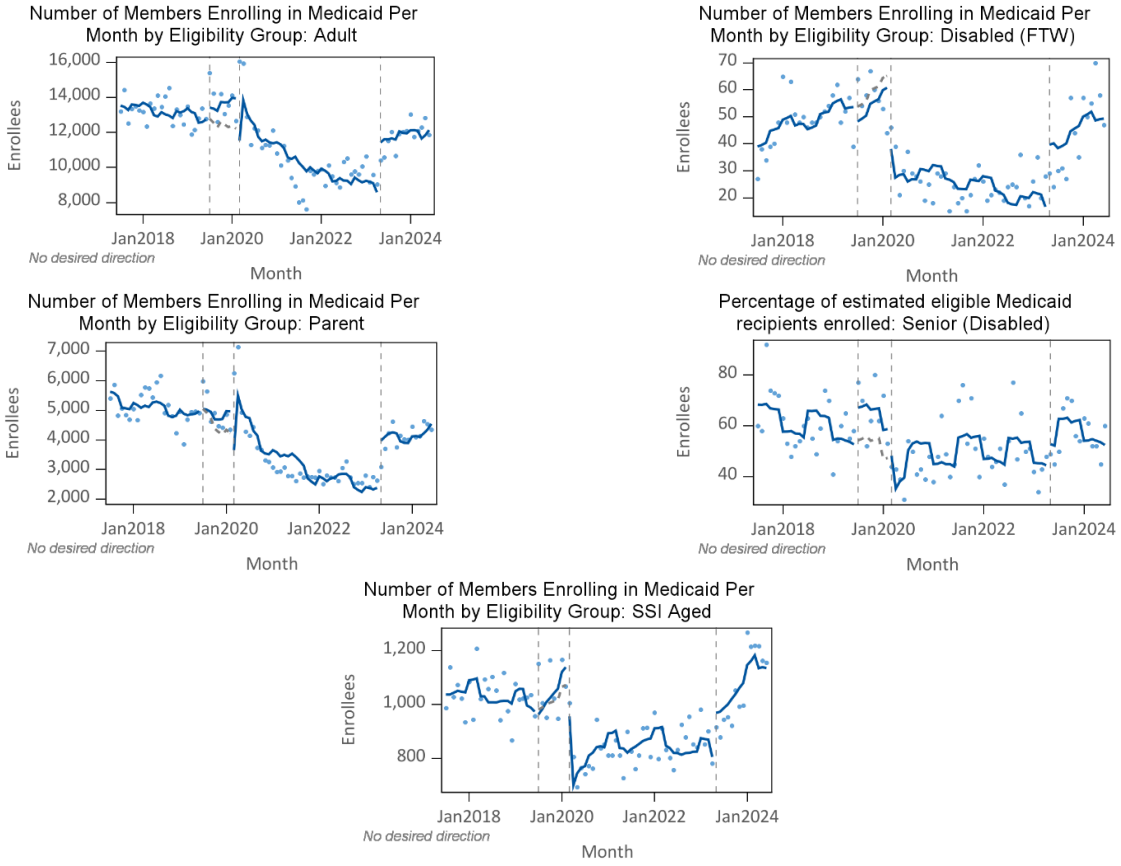


Table 11-3—Research Question 1.1, Measure 1-3

Variable	Adult	Disabled (FTW)	Parent	Senior (DIS)	SSI-Aged
Intercept	11,991.2 *** (<0.001)	48.5 *** (<0.001)	4,080.9 *** (<0.001)	72.1 *** (<0.001)	1,139.1 *** (<0.001)
Baseline monthly trend	-51.2 ** (0.007)	-0.3 ** (0.033)	-26.9 ** (0.008)	-0.3 (0.116)	-4.8 *** (<0.001)
Level change at implementation	940.5 * (0.087)	8.5 * (0.077)	32.1 (0.912)	4.5 (0.363)	16.0 (0.675)
Change in monthly trend	107.7 (0.138)	0.9 (0.173)	71.5 * (0.066)	0.6 (0.379)	21.8 *** (<0.001)
Level change at beginning COVID-19 PHE	-3,039.5 *** (<0.001)	-30.4 *** (<0.001)	-1,595.7 *** (<0.001)	-14.3 ** (0.029)	-244.6 *** (<0.001)
Change in monthly trend during COVID-PHE	18.1 (0.560)	0.3 (0.265)	6.5 (0.696)	0.3 (0.332)	4.2 * (0.059)

*p<0.1, **p<0.05, ***p<0.001

Note: Full model results are presented in Appendix A. p value is presented in parentheses. COVID-19: coronavirus disease 2019; DIS: disabled; FTW: Freedom to Work; PHE: public health emergency.

The results include rates from the baseline period (FFY 2018–FFY 2019) and the evaluation period (FFY 2020–FFY 2024).

Data Source: PMMIS data were used in the analysis of RQ 1.1.

Figure 11-2—Research Question 1.1, Measure 1-4

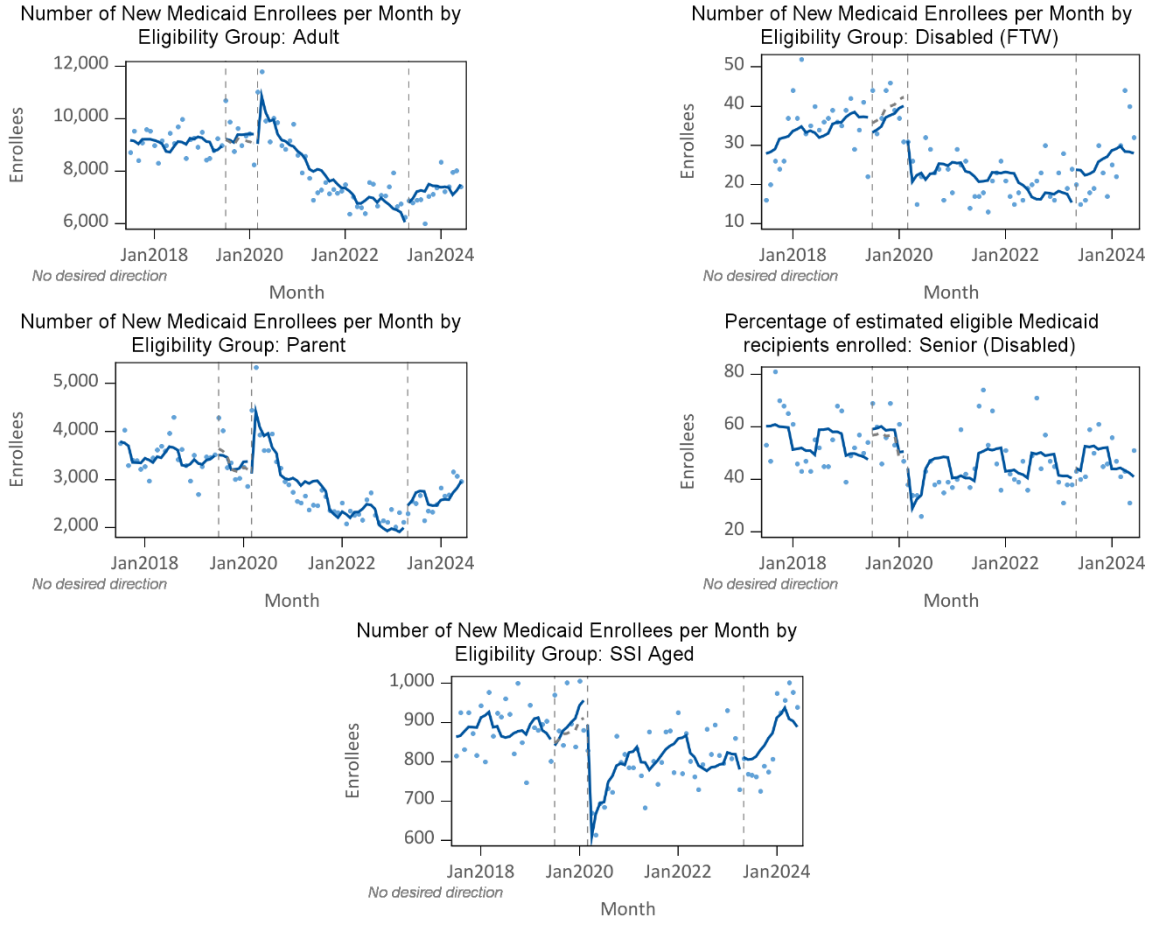


Table 11-4—Research Question 1.1, Measure 1-4

Variable	Adult	Disabled (FTW)	Parent	Senior (DIS)	SSI-Aged
Intercept	8,236.9 ***	36.3 ***	2,763.5 ***	67.5 ***	1016.8 ***
	(<0.001)	*(<0.001)*	*(<0.001)*	*(<0.001)*	*(<0.001)*
Baseline monthly trend	-41.2 ***	-0.3 **	-20.7 **	-0.2	-4.0 ***
	(<0.001)	*(0.011)*	*(0.001)*	*(0.185)*	*(<0.001)*
Level change at implementation	613.3 *	6.4 *	73.5	3.2	36.5
	(0.073)	*(0.093)*	*(0.689)*	*(0.511)*	*(0.274)*
Change in monthly trend	50.9	0.6	45.6 *	0.2	12.5 **
	(0.257)	*(0.267)*	*(0.063)*	*(0.803)*	*(0.006)*
Level change at beginning COVID-19 PHE	-564.4	-15.2 **	-399.8 *	-8.1	-110.2 **
	(0.200)	*(0.002)*	*(0.096)*	*(0.202)*	*(0.012)*
Change in monthly trend during COVID-PHE	-6.4	0.3	-0.1	0.2	3.5 *
	(0.740)	*(0.199)*	*(0.993)*	*(0.550)*	*(0.072)*

*p<0.1, **p<0.05, ***p<0.001

Note: Full model results are presented in Appendix A. p value is presented in parentheses. COVID-19: coronavirus disease 2019; DIS: disabled; FTW: Freedom to Work; PHE: public health emergency; SSI: Supplemental Security Income.
The results include rates from the baseline period (FFY 2018–FFY 2019) and the evaluation period (FFY 2020–FFY 2024).
Data Source: PMMIS data were used in the analysis of RQ 1.1.

Research Question 1.2: What is the likelihood of enrollment continuity for those without PQC compared to other Medicaid members with PQC?

Figure 11-3 and Table 11-5 display the ITS results comparing trends projected from baseline rates to trends in the evaluation period for the percentage of Medicaid members due for renewal who completed the renewal process.[118] The blue line represents the model-based average rates for each month. The dashed grey line represents the counterfactual projection of the baseline period trend in the post-policy period before the COVID-19 PHE-affected months. Table 11-6 displays the average number of months with Medicaid coverage per year.

Key Findings:

- Upon elimination of PQC, there was an average increase of 50.99 percentage points each month of Medicaid members due for renewal who completed the renewal process compared to the projected baseline trend. Although the COVID-19 PHE continuous eligibility provision initially improved rates of renewals, the monthly trend during the COVID-19 PHE declined by 0.26 percentage points compared to the trend in the implementation period. Immediately after the COVID-19 PHE concluded, renewals decreased to their lowest point before recovering in 2024.
- The average number of months with Medicaid coverage within each federal fiscal year (FFY) increased slightly between the baseline period and FFY 2024. Due to the impact of the continuous enrollment provision authorized during the COVID-19 PHE, FFY 2020 through FFY 2023 experienced an increase in enrollment continuity. To better estimate the impact of the PQC waiver, the analysis for Measure 1-6 (Average number of months with Medicaid coverage) does not include COVID-19 PHE-impacted years.

The COVID-19 PHE had a clear impact on enrollment continuity. Following the start of the COVID-19 PHE, members both completed renewals at a higher rate and had longer coverage periods due to the continuous enrollment provision. Prior to the COVID-19 PHE, positive impacts from the Waiver can be seen, as the monthly trend in completed renewals increased compared to the baseline and members had longer enrollment coverage in 2024 compared to baseline rates.

[118] Data for this measure were provided by AHCCCS, which identified the number of members due for enrollment who complete the renewal process. In November 2023, the data were provided in a different format, which may contribute to changes in the rates.

Figure 11-3—Research Question 1.2, Measure 1-5

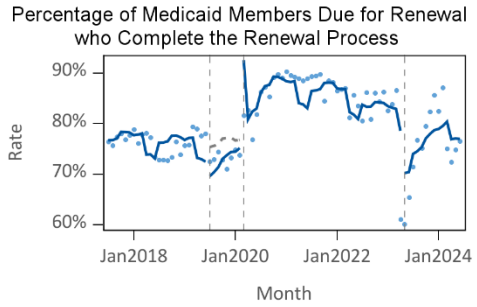


Table 11-5—Research Question 1.2, Measure 1-5

Variable	Estimate
Intercept	82.77% *** *(<0.001)*
Baseline monthly trend	-0.05pp *(0.447)*
Level change at implementation	-5.79pp ** *(0.008)*
Change in monthly trend	0.59pp ** *(0.038)*
Level change at beginning COVID-19 PHE	18.18pp *** *(<0.001)*
Change in monthly trend during COVID-PHE	-0.26pp ** *(0.034)*

*p<0.1, **p<0.05, ***p<0.001
p value is presented in parentheses.
Note: Full model results are presented in Appendix A. COVID-19: coronavirus disease 2019; PHE: public health emergency
Baseline period: July 1, 2016–June 30, 2021; Evaluation period: July 1, 2019–September 30, 2024.
The results include rates from the baseline period (FFY 2018–FFY 2019) and the evaluation period (FFY 2020–FFY 2024).
Data Source: PMMIS data were used in the analysis of RQ 1.2.

Table 11-6—Research Question 1.2, Measure 1-6

What is the likelihood of enrollment continuity for those without PQC compared to other Medicaid beneficiaries with PQC?				
		Baseline Average	Evaluation Average (Excluding CEP)	Pre/Post Change in Rate[1]
1-6	Average number of months with Medicaid coverage	9.82	10.09	0.27 (<0.001)

Note: CEP: continuous eligibility provision
Given the impact of the continuous enrollment provision on enrollment-based measures, statistical testing excluded results from FFY 2020–FFY 2023. The full results are available in Appendix A.
Baseline period: July 1, 2016–June 30, 2021; Evaluation period: July 1, 2019–September 30, 2024
Data source: PMMIS data were used in the analysis of RQ 1.2.
[1]Change in Rate compares the rate in the evaluation period (FFY 2024) to the average rate in the baseline period (FFY 2018–FFY 2019) using a pre/post model.

Research Question 1.3: Do members without PQC who disenroll from Medicaid have shorter enrollment gaps than other members with PQC?

Table 11-7 displays the results utilizing PMMIS data to identify the percentage of Medicaid members who re-enrolled after a gap in Medicaid coverage of up to six months, the average number of months without Medicaid coverage following a gap in coverage, average number of gaps, and average days per gap.

Key Findings:

- The percentage of Medicaid members who re-enrolled after a gap of up to six months declined between the baseline period and FFY 2024, with notable increases during the COVID-19 PHE. Additionally, the average number of days without Medicaid coverage for members who re-enrolled after a gap of up to six months decreased by 5.06 days, and the average number of months without Medicaid coverage decreased by 0.15 months between the baseline and evaluation periods. Each of these results were statistically significant.
- The average number of gaps in Medicaid coverage for members who re-enrolled after a gap of up to six months increased by 0.03 gaps between the baseline and evaluation periods, a statistically significant increase.
- Due to the impact of the continuous enrollment provision authorized during the COVID-19 PHE, FFY 2020 through FFY 2023 experienced an increase in enrollment continuity. To better estimate the impact of PQC, analyses for Measure 1-7 through Measure 1-10 do not include COVID-19 PHE-impacted years.

Compared to the baseline period, members were less likely to re-enroll after a gap of up to six months, had fewer days per gap in Medicaid coverage, and had fewer months without Medicaid coverage during the evaluation period. Among those who re-enrolled, the average number of gaps in coverage increased, indicating that although the average days per gap decreased, the number of gaps per member increased slightly. Increases in the number of members who re-enrolled after a gap of up to six months and the subsequent reduction in days/months without coverage in FFY 2024 highlights the changes in enrollment patterns following the elimination of the PQC waiver.

Table 11-7—Research Question 1.3, Measures 1-7 through 1-10

Do beneficiaries without PQC who disenroll from Medicaid have shorter enrollment gaps than other beneficiaries with PQC?				
		Baseline Average	Evaluation Average (Excluding CEP)	Pre/Post Change in Rate[1]
1-7	Percentage of Medicaid beneficiaries who re-enroll after a gap of up to six months	24.5%	20.3%	-4.2pp (<0.001)
1-8	Average number of months without Medicaid coverage for beneficiaries who re-enroll after a gap of up to six months	2.27	2.13	-0.15 (<0.001)
1-9	Average number of gaps in Medicaid coverage for beneficiaries who re-enroll after a gap of up to six months	1.20	1.23	0.03 (<0.001)
1-10	Average number of days per gap in Medicaid coverage for beneficiaries who re-enroll after a gap of up to six months	56.82	51.76	-5.06 (<0.001)

Note: CEP: continuous eligibility provision, pp: percentage point
Given the impact of the continuous enrollment provision on enrollment-based measures, statistical testing excluded results from FFY 2020–FFY 2023. The full results are available in Appendix A.
Baseline period: July 1, 2016–June 30, 2021; Evaluation period: July 1, 2019–September 30, 2024
Data Source: PMMIS data were used in the analysis of RQ 1.3.
[1]Change in Rate compares the rate or number in the evaluation period (FFY 2024) to the average rate or number in the baseline period (FFY 2018–FFY 2019) using a pre/post model.

Hypothesis 2: Eliminating PQC will increase enrollment of eligible people when they are healthy.

Beneficiary surveys were used to assess changes in new members' reported health status in 2021 and 2025. However, the 2021 and 2025 surveys employed different sampling strategies and therefore captured slightly different populations.[119] In 2021, new members were defined as PQC-waiver eligible Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[120] survey respondents with an enrollment start date between July 1, 2019, and March 31, 2020, and no enrollment in the six months prior. In 2025, new members were defined as PQC-waiver eligible members with an enrollment start date between December 28, 2024, and June 27, 2025 (i.e., six months prior to the survey), and no enrollment in the six months prior. This change allowed for a more representative sample of the PQC-eligible population. As a result, the experiences reported by newly enrolled members in 2025 reflect more recent enrollment compared to those captured in 2021.

Research Question 2.1: Do newly enrolled members without PQC have higher self-assessed health status?

Table 11-8 displays newly enrolled members' self-assessed health status. These findings cannot be used to draw causal conclusions due to absence of pre-PQC baseline rates and differences in survey time frames and populations between PQC and national benchmarks. However, differences between the 2021 and 2025 survey rates may indicate changes in health status among newly enrolled members following the start of the PQC waiver.

Key Findings:

- The percentage of excellent or very good *Member reported rating of overall health* increased by 1.8 percentage points to 30.6 percent between the 2021 and 2025 surveys, a change that was not statistically significant (p=0.796).
- The percentage of excellent or very good *Member reported rating of overall mental or emotional health* decreased by 2.6 percentage points to 41.7 percent in the 2025 survey, a change that was not statistically significant (p=0.716).
- The *Percentage of members who reported an emergency department (ED) visit in prior 6 months* increased by 6.3 percentage points to 31.9 percent in 2025. Although this change was not statistically significant (p=0.291), it represented a nearly 25 percent ([31.9 percent / 25.6 percent]-1) relative increase from 2021.
- The *Percentage of members who reported a hospital admission in prior 6 months* decreased by 0.8 percentage points to 9.1 percent in 2025; however, this change was not statistically significant (p=0.816).
- The *Percentage of members who reported getting health care three or more times for the same condition or problem* decreased 5.6 percentage points to 27.6 percent in the 2025 survey, a change that was not statistically significant (p=0.354) but represented a decline of nearly 17 percent ([27.6 percent / 33.2 percent] - 1) relative to 2021.

Changes in newly enrolled member-assessed health status were mixed; however, changes were not statistically significant.

[119] To streamline data collection in 2021, survey questions pertaining to the PQC waiver were included in a broader AHCCCS-wide survey effort, which consisted of seven AHCCCS Complete Care (ACC) and three Regional Behavioral Health Agreement (RBHA) plans. Therefore, questions were not administered to members immediately enrolled in Medicaid.

[120] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Table 11-8—Research Question 2.1, Measures 2-1 through 2-5

		Weighted Rate[1]		Change in Rate
		2021 Survey	2025 Survey	(*p*-value)
2-1	Member reported rating of overall health	28.8% N=282	30.6% N=134	1.8pp (0.796)
2-2	Member reported rating of overall mental or emotional health	44.3% N=281	41.7% N=133	-2.6pp (0.716)
2-3	Percentage of members who reported ED visit in prior six months	25.6% N=283	31.9% N=135	6.3pp (0.291)
2-4	Percentage of members who reported hospital admission in prior six months	9.9% N=282	9.1% N=136	-0.8pp (0.816)
2-5	Percentage of members who reported getting health care three or more times for the same condition or problem	33.2% N=283	27.6% N=132	-5.6pp (0.354)

*p <0.1, **p <0.05, ***p <0.001

Note: N represents the number of survey responses. Surveys were administered in calendar years (CYs) 2021 and 2025. ED: emergency department; pp: percentage point.

Data Source: Beneficiary surveys were used in the analysis of RQ 2.1.

[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP Code.

Hypothesis 3: Health outcomes will be better for those without PQC compared to Medicaid members with PQC.

Research Question 3.1: Do members without PQC have better health outcomes when compared to outcomes prior to the renewal period rates and out-of-state outcomes for those with PQC?

The elimination of PQC aimed to encourage healthy members to maintain enrollment, which could have shifted the existing member population toward a higher proportion of members reporting high ratings of overall and mental or emotional health. Because the 2021 survey was conducted after PQC elimination, these findings cannot be used to draw causal conclusions. However, the analysis suggests that health status among continuously enrolled members was at least maintained, if not improved, between 2021 and 2025.

Table 11-9 displays newly enrolled and existing members' self-assessed health status. These findings cannot be used to draw causal conclusions due to absence of pre-PQC baseline rates and differences in survey time frames and populations between PQC and national benchmarks. However, differences between the 2021 and 2025 survey rates may indicate changes in health status among newly enrolled members following the start of the PQC waiver.

Key Findings:

- The percentage of newly enrolled members with a high rating (excellent or very good) of overall health increased by 1.8 percentage points to 30.6 percent, and the percentage of members with a high rating of their overall mental or emotional health decreased by 2.6 percentage points to 41.7 percent; however, neither change was statistically significant (p=0.796 and p=0.716, respectively).
- The percentage of existing members with a high rating (excellent of very good) of their overall health and mental or emotional health increased by 11.2 and 3.3 percentage points respectively to nearly 36 percent; however, the change was only statistically significant for *Member reported rating of overall health* (p=0.042 and p=0.561, respectively).

The elimination of PQC aimed to encourage healthy members to maintain enrollment, which could have shifted the existing member population toward a higher proportion of members reporting high ratings of overall and mental or emotional health. Because the 2021 survey was conducted after PQC elimination, these findings cannot

be used to draw causal conclusions. However, the analysis suggests that health status among continuously enrolled members was at least maintained, if not improved, between 2021 and 2025.

Table 11-9—Research Question 3.1, Measures 3-1 and 3-2

		Weighted Rate[1] 2021 Survey	Weighted Rate[1] 2025 Survey	Change in Rate (*p*-value)
3-1	Member reported rating of overall health for all members			
	New Enrollees	28.8% N=282	30.6% N=134	1.8pp (0.796)
	Existing Enrollees	25.7% N=2,859	36.9% N=173	11.2pp ** (0.042)
3-2	Member reported rating of overall mental or emotional health for all members			
	New Enrollees	44.3% N=281	41.7% N=133	-2.6pp (0.716)
	Existing Enrollees	33.1% N=2,867	36.3% N=173	3.3pp (0.561)

*p <0.1, **p <0.05, ***p<0.001

Note: N represents the number of survey responses. Surveys were administered in calendar years (CYs) 2021 and 2025. pp: percentage point.

Data Source: Beneficiary surveys were used in the analysis of RQ 3.1.

[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP Code.

Hypothesis 4: Eliminating PQC will not have adverse financial impacts on consumers.

Research Question 4.1: Does the PQC waiver lead to changes in the incidence of member medical debt?

Table 11-10 displays self-reported medical debt among newly enrolled and existing members. The findings cannot be used to draw causal conclusions due to absence of pre-PQC baseline rates and differences in survey time frames and populations between PQC and national benchmarks. Differences between 2021 and 2025 survey rates may indicate changes among newly enrolled members following the start of the PQC waiver.

Key Findings:

- The *Percentage of members who reported medical debt* increased for new enrollees by 4.3 percentage points. Although this change was not statistically significant (p=0.465), it represented an increase of approximately 22 percent ([23.8 percent / 19.5 percent]-1) relative to 2021. Among existing members, the rate increased by 0.7 percentage points; however, this change was not statistically significant (p=0.834).

The incidence of member-reported medical debt increased between the 2021 and 2025 surveys by statistically insignificant margins; however, the incidence of reported medical debt among newly enrolled members increased from approximately one in five members to nearly one in four members.

Table 11-10—Research Question 4.1, Measure 4-1

		Weighted Rate[1] 2021 Survey	Weighted Rate[1] 2025 Survey	Change in Rate (*p*-value)
4-1	Percentage of members who reported medical debt			
	New Enrollees	19.5% N=240	23.8% N=115	4.3pp (0.465)
	Existing Enrollees	10.6% N=2,537	11.3% N=156	0.7pp (0.834)

*p <0.1, **p <0.05, ***p <0.001

Note: N represents the number of survey responses. Surveys were administered in calendar years (CYs) 2021 and 2025. pp: percentage point.

Data Source: Beneficiary surveys were used in the analysis of RQ 4.1.

[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP Code.

Hypothesis 5: Eliminating PQC will not adversely affect access to appropriate care for routine medical conditions.

Research Question 5.1: Do members without PQC have the same or higher rates of office visits compared to members with PQC?

Table 11-11 displays member-reported access to care among newly enrolled and existing members. The findings cannot be used to draw causal conclusions due to absence of pre-PQC baseline rates and differences in survey time frames and populations between PQC and national benchmarks. Differences between 2021 and 2025 survey rates may indicate changes among newly enrolled members following the start of the PQC waiver.

Key Findings:

- *Member response to getting needed care right away* that was "Always" or "Usually" varied for newly enrolled and existing members. The rate for both groups was near 80 percent in 2021; however, new enrollee rates decreased by 9.0 percentage points to 72.3 percent (p=0.320) while existing member rates increased by 11.0 percentage points to 90.1 percent (p=0.048). The change was statistically significant for existing members.
- *Member response to getting an appointment for a check-up or routine care at a doctor's office or clinic* that was "Always" or "Usually" decreased for both newly enrolled and existing members by 4.6 and 1.9 percentage points, respectively. These changes were not statistically significant (p=0.564 and p=0.712, respectively). Compared to national averages, new enrollee rates fell between the 10th and 25th percentiles and the 33rd to 50th percentiles among existing members.

While existing members reported high levels of receiving needed care right away in 2025, above the 90th percentile nationally, new enrollees reported low rates of being able to get needed care, below the 5th percentile nationally. Some of this disparity may be due to the differences in survey sampling strategies, as new enrollees were more recently enrolled at the time of the 2025 survey compared to the 2021 survey. Additionally, the elimination of PQC may have encouraged existing members to remain enrolled for longer, thereby making it easier for them to get care when needed.

Table 11-11—Research Question 5.1, Measures 5-1 and 5-2

		Weighted Rate[1] 2021 Survey	Weighted Rate[1] 2025 Survey	2025 Rate Compared to National Percentile[2]	Change in Rate (*p*-value)
5-1	Member response to getting needed care right away				
	New Enrollees	81.3% N=100	72.3% N=48	Below 5th	-9.0pp (0.320)
	Existing Enrollees	79.1% N=953	90.1% N=59	90th–95th	11.0pp ** (0.048)
5-2	Member response to getting an appointment for a check-up or routine care at a doctor's office or clinic				
	New Enrollees	78.1% N=164	73.5% N=72	10th–25th	-4.6pp (0.564)
	Existing Enrollees	78.9% N=1,722	77.0% N=114	25th–33rd	-1.9pp (0.712)

*p <0.1, **p <0.05, ***p <0.001
Note: N represents the number of survey responses. Surveys were administered in calendar years (CYs) 2021 and 2025. pp: percentage point.
Data Source: Beneficiary surveys were used in the analysis of RQ 5.1.
[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP Code.
[2]Rates from the 2025 Survey are compared to NCQA Quality Compass Benchmarks for the Medicaid Population in measurement year (MY) 2024.

Research Question 5.2: Do members without PQC have the same or higher rates of service and facility utilization compared to rates prior to waiver renewal with PQC?

Table 11-12 utilized PMMIS data to identify the change in the percentage of members with a visit to a specialist.

Key Findings:

- The average *Percentage of members with a visit to a specialist* increased by 3.2 percentage points during the evaluation period (p<0.001).

The annual rate of members with a visit to a specialist declined throughout the evaluation period.

Table 11-12—Research Question 5.2, Measure 5-3

Do members without PQC have the same or higher rates of service and facility utilization compared to rates prior to waiver renewal with PQC?				
		Baseline Average	Evaluation Average	Pre/Post Change in Rate[1]
5-3	Percentage of members with a visit to a specialist (e.g., eye doctor, otolaryngologist [ENT], cardiologist)	41.8%	38.6%	-3.2pp *** (<0.001)

*p <0.1, **p <0.05, ***p <0.001
Note: ENT: ear, nose, and throat; pp: percentage point.
Baseline period: July 1, 2017–June 30, 2019; Evaluation period: July 1, 2019–September 30, 2024.
Data Source: PMMIS data were used in the analysis of RQ 5.2.
[1]Change in Rate compares the rate in the evaluation period to the average rate in the baseline period using a pre/post model.

Hypothesis 6: Eliminating PQC will not result in reduced member satisfaction.

Research Question 6.1: Do members without PQC have the same or higher satisfaction with their health care compared to prior to waiver renewal with PQC?

Table 11-13 displays members' rating of overall health care among newly enrolled and existing members. The findings cannot be used to draw causal conclusions due to absence of pre-PQC baseline rates and differences in

survey time frames and populations between PQC and national benchmarks. Differences between 2021 and 2025 survey rates may indicate changes among newly enrolled members following the start of the PQC waiver.

Key Findings:

- The percentage of members with a favorable rating of their overall health care decreased by 5.6 percentage points among new enrollees and increased by 6.1 percentage points among existing members; however, neither change was statistically significant (p=0.402 and p=0.196, respectively).
- Compared to national averages, 2025 existing member rates fell between the 50th and 67th percentile.

While no baseline data were available to assess changes in satisfaction following the implementation of the PQC waiver, member satisfaction with their health care decreased for new enrollees and increased for existing members between 2021 and 2025.

Table 11-13—Research Question 6.1, Measure 6-1

		Weighted Rate[1] 2021 Survey	Weighted Rate[1] 2025 Survey	2025 Rate Compared to National Percentile[2]	Change in Rate (p-value)
6-1	Member rating of overall health care				
	New Enrollees	76.0% N=181	70.4% N=132	5th–10th	-5.6pp (0.402)
	Existing Enrollees	70.9% N=1,831	77.0% N=171	50th–67th	6.1pp (0.196)

*p <0.1, **p <0.05, ***p <0.001

Note: N represents the number of survey responses. Surveys were administered in calendar years (CYs) 2021 and 2025. pp: percentage point.

Data Source: Beneficiary surveys were used in the analysis of RQ 6.1.

[1]Rates are weighted through a raking algorithm to be representative of the general Medicaid population by demographic variables including age, health plan, gender, and 3-digit ZIP Code.

[2]Rates from the 2025 Survey are compared to NCQA Quality Compass Benchmarks for the Medicaid Population in measurement year (MY) 2024.

Hypothesis 7: Eliminating PQC will generate cost savings over the term of the waiver.

There are no specific measures associated with Hypothesis 7. To assess the cost-effectiveness of care provided, an ITS analysis was conducted to analyze the differences between actual and projected costs during the evaluation period, which is intended to address Research Questions 6.1 and 6.2. Separate analyses are conducted at the per-member per-month (PMPM) level and at the total aggregated cost level. Costs were adjusted for medical inflation and are presented in terms of September 2024 dollars.

The cost analyses do not refer to or attempt to replicate the formal Budget Neutrality test required for Section 1115 Waiver Demonstrations.[121] Additionally, the cost-effectiveness analysis does not involve a direct comparison of costs and savings, as program benefits may be non-pecuniary in nature, such as provision of new services that previously were unavailable, increased employment opportunities leading to improved financial well-being, lower mortality rates and improved health outcomes overall. Some outcomes may manifest over an extended period and may not be measurable at the time of the evaluation.

[121] Centers for Medicare & Medicaid Services. Budget Neutrality SMDL for Section 1115(a) Medicaid Demonstration Project. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd24003.pdf. Accessed on: Mar 12, 2026.

Research Question 7.1: What are the costs associated with eliminating PQC?

Table 11-14 and Figure 11-4 assessed PMMIS data through an ITS analysis to examine PMPM cost changes among members who met the eligibility criteria for the PQC waiver following the elimination of PQC in July 2019. Members who met the eligibility criteria for the PQC waiver during each fiscal year (FY) were considered in the analysis. Average PMPM costs were approximately $672.38 at the beginning of the baseline period, and the inflation-adjusted trend in costs increased slightly during the baseline period. Following the implementation of the PQC waiver, the increasing trend slowed; however, this change was not statistically significant.

Table 11-15 and Figure 11-5 utilized PMMIS data to assess the changes in aggregated costs among members who met the eligibility criteria for the PQC waiver through an ITS analysis. Total cost of care among this population was approximately $561.3 million in the first month of the baseline period and continued to increase by an average of approximately $1.9 million per month; however, this increase was not statistically significant. Following the implementation of the PQC waiver, the trend continued to increase by an average of approximately $4.6 million per month relative to the baseline trend. Notably, non-emergency department (ED) outpatient (OP) increased by $0.8 million per month relative to baseline projections.

Key Findings:

- **PMPM Costs**
  - Total PMPM costs among PQC-eligible members averaged $672.38 at the beginning of the baseline period and increased by $3.37 per month ($p$=0.058) during the baseline. Following the implementation of the PQC waiver, average PMPM costs declined slightly by $70.40 ($p$=0.032) and the trend in costs declined slightly by $2.05 per month ($p$=0.256) relative to the baseline trend; however, this change was not statistically significant.
  - Professional costs were the primary costs driver, with an average of $317.75 at the beginning of the baseline period and an increasing trend of $2.38 per month ($p$=0.054) during the baseline. Although professional costs declined slightly following implementation of the PQC waiver relative to the baseline trend, these changes were not statistically significant.
- **Aggregate Costs**
  - Total costs among PQC-eligible members averaged $561,268.1 thousand (or approximately $561.3 million) at the beginning of the baseline period, in which costs were increasing by $1,873.8 thousand per month (p=0.413). Following implementation of the PQC waiver, average costs declined by $28,835.8 thousand ($p$=0.493) while the trend increased by $4,636.2 thousand per month (p=0.050).

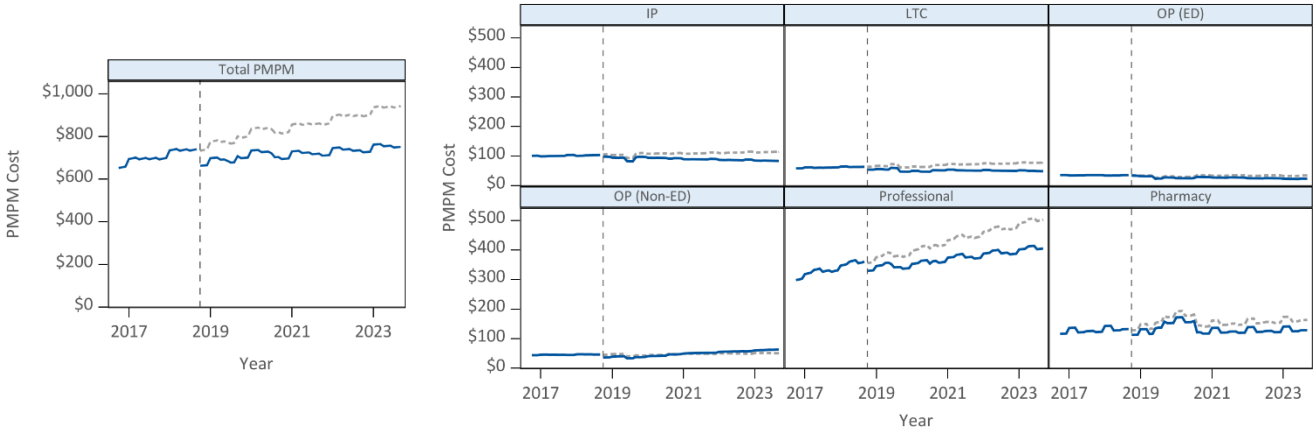
Table 11-14—PQC PMPM Costs

	Estimate (p-value)						
Variable	Total	Professional	IP	LTC	OP (ED)	OP (Non-ED)	Pharmacy
Intercept	$672.38 *** (<0.001)	$317.75 *** (<0.001)	$98.59 *** (<0.001)	$58.54 *** (<0.001)	$34.32 *** (<0.001)	$45.27 *** (<0.001)	$117.90 *** (<0.001)
Baseline monthly trend	$3.37 * (0.058)	$2.38 * (0.054)	$0.19 (0.332)	$0.23 (0.167)	$-0.02 (0.765)	$0.07 (0.740)	$0.51 (0.451)
Level change at implementation	$-70.40 ** (0.032)	$-25.97 (0.249)	$-7.34 ** (0.040)	$-9.66 ** (0.002)	$-1.69 (0.160)	$-9.89 ** (0.014)	$-15.85 (0.208)
Change in monthly trend	$-2.05 (0.256)	$-1.22 (0.330)	$-0.40 ** (0.043)	$-0.33 * (0.059)	$-0.16 ** (0.017)	$0.38 * (0.086)	$-0.32 (0.645)

*p <0.1, **p <0.05, ***p <0.001

Note: Full model results are presented in Appendix A, Attachments. Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.
Data Source: PMMIS data were used in the analysis of RQ 7.1 and 7.2.

Figure 11-4—PQC PMPM Costs



Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. This figure presents the model-based average rate in each month (blue line), and the projected rates had the baseline trend continued (grey dashed line). The grey vertical dashed line indicates the PQC implementation date (July 1, 2019). ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient; PMPM: per-member per-month.

Table 11-15—PQC Total Aggregate Costs (in Thousands)

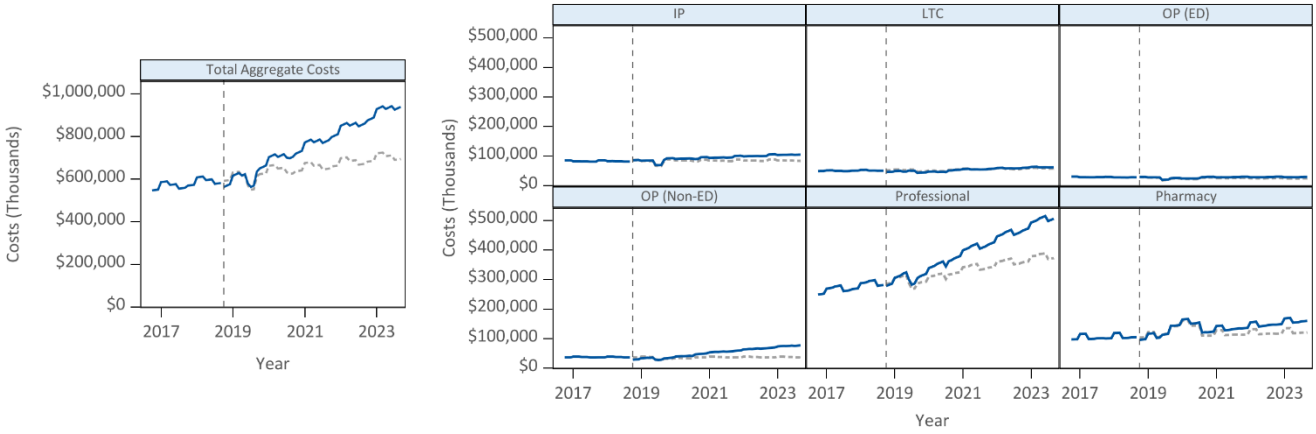
Variable	Estimate in Thousands (*p*-value)						
	Total	Professional	IP	LTC	OP (ED)	OP (Non-ED)	Pharmacy
Intercept	$561,268.1 *** (<0.001)	$267,564.0 *** (<0.001)	$81,690.5 *** (<0.001)	$48,487.7 *** (<0.001)	$28,406.3 *** (<0.001)	$37,873.0 *** (<0.001)	$97,246.5 *** (<0.001)
Baseline monthly trend	$1,873.8 (0.413)	$1,514.1 (0.408)	$38.1 (0.840)	$116.9 (0.317)	-$64.6 (0.256)	$0.9 (0.997)	$268.4 (0.661)
Level change at implementation	-$28,835.8 (0.493)	-$7,157.7 (0.831)	-$464.2 (0.894)	-$6,003.4 ** (0.006)	$644.8 (0.537)	-$7,989.8 * (0.083)	-$7,865.5 (0.485)
Change in monthly trend	$4,636.2 ** (0.050)	$2,378.0 (0.205)	$367.5 * (0.060)	$180.7 (0.132)	$77.3 (0.185)	$829.3 ** (0.002)	$803.4 (0.201)

*p <0.1, **p <0.05, ***p <0.001

Note: Full model results are presented in Appendix A, Attachments. Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

Data Source: PMMIS data were used in the analysis of RQ 7.1 and 7.2.

Figure 11-5—PQC Total Aggregate Costs (in Thousands)



Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. This figure presents the model-based average rate in each month (blue line), and the projected rates had the baseline trend continued (grey dashed line). The grey vertical dashed line indicates the PQC implementation date (July 1, 2019). ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

Research Question 7.2: What are the benefits/savings associated with eliminating PQC?

Table 11-16 and Table 11-17 display the historical and projected costs of PQC. The projected savings data indicate that PQC anticipated saving 327 million dollars between state fiscal year (SFY) 2018 and SFY 2026. These data were provided by AHCCCS and could not be compared to publicly available budget neutrality reports; therefore, the results presented could not be independently validated.

Key Findings:

- Historical costs generally increased during the baseline period, while the annual projected savings were predicted to increase between 33,000 to 44,000 dollars during the evaluation period.

Table 11-16—Research Question 7.2

SFY	Historical PQC Costs
2014	$19,809
2015	$15,743,139
2016	$21,708,207
2017	$21,347,704
2018*	$11,136,736
Total	**$69,955,595**

*SFY 2018 includes PQC expenditures from July 1, 2017, to November 30, 2017.
Note: PQC: prior quarter coverage; SFY: state fiscal year

Table 11-17—Research Question 7.2

SFY	Projected PQC Savings
2018*	$9,857,750
2019	$39,431,100
2020	$41,828,500
2021	$44,388,610
2022	$33,541,995
2023	$35,755,767
2024	$37,936,868
2025	$40,630,386
2026	$43,840,187
Total	**$327,211,163**

*SFY 2018 includes PQC expenditures from December 1, 2017, to June 30, 2018.
Note: PQC: prior quarter coverage; SFY: state fiscal year

Research Question 7.3: Do costs to non-AHCCCS entities stay the same or decrease after implementation of the waiver compared to before?

Table 11-18 and Figure 11-6 display the changes in costs for uninsured or likely eligible Medicaid members using a pre/post model using data collected through the Healthcare Cost Report Information System (HCRIS).[122] The cost of uninsured charity care in Arizona increased year over year between SFY 2017 and SFY 2023, while the national average cost rose at a slower pace, before decreasing. Although the increase among Arizona hospitals cannot be attributed specifically to the elimination of the PQC waiver, there is some evidence to support that the PQC impacted uncompensated care costs.

Key Findings:

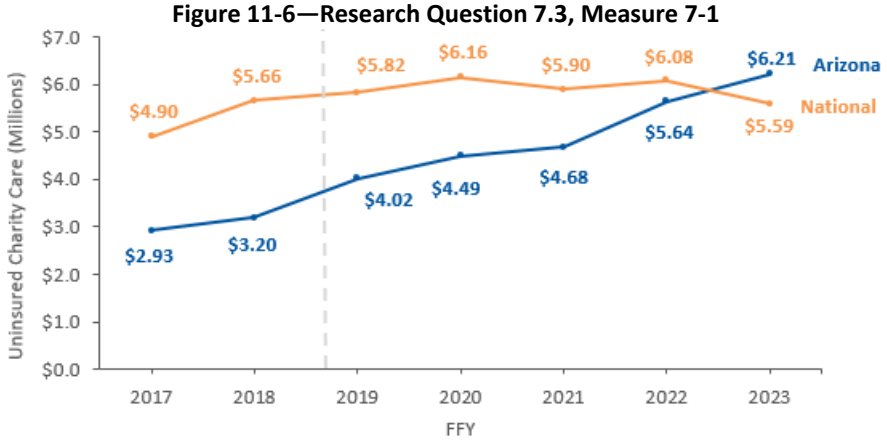
- When adjusting for inflation, the average costs of charity care among reporting Arizona hospitals increased by $1.84 million between the baseline and evaluation periods.
- The average Arizona uninsured charity care costs among reporting hospitals exceeded the national average in FFY 2023.

Table 11-18—Research Question 7.3, Measure 7-1

Do costs to non-AHCCCS entities stay the same or decrease after implementation of the waiver compared to before?				
		Baseline Average	Evaluation Average	Pre/Post Change in Rate[1]
7-1	Reported costs for uninsured and/or likely eligible Medicaid recipients among potentially impacted providers and/or provider networks	$3,376,673	$5,213,113	$1.84*** (<0.001)

Totals shown are reported in the millions and were adjusted for inflation in 2023 dollars.
Baseline period: July 1, 2016–June 30, 2021; Evaluation period: July 1, 2019–September 30, 2024
Data Source: HCRIS data were utilized in the analysis of RQ 7.3.
[1]Change in Rate compares the rate in the evaluation period to the average rate in the baseline period using a pre/post model.

Figure 11-6—Research Question 7.3, Measure 7-1



Note: Totals shown are reported in the millions and were adjusted for inflation in 2023 dollars. The dashed line represents the implementation of the PQC program. FFY: federal fiscal year
Data Source: HCRIS data were utilized in the analysis of RQ 7.3.

[122] The statistical model controlled for Medicaid patient days as a percentage of total patient days, total number of beds, type of control (government, for-profit, and nonprofit), urbanicity, and the COVID-19 PHE.

12. Tribal Dental Authority Results

The following chapter describes the quantitative and qualitative results for the evaluation of the Tribal Dental Authority program. A complete list of measures and their specifications is available in Evaluation Designs linked in the Appendix.

The evaluation of the Tribal Dental Authority program was limited to two years of post-implementation evaluation data only. As such, the results for this program are largely descriptive and definitive conclusions cannot be drawn without additional years of evaluation period data.

Tribal Dental Authority Program Results

Hypothesis 1: Member access to appropriate, routine dental care will be maintained or improved during the renewal period.

Research Question 1.1: Did the waiver result in an increased number of dental providers practicing in IHS and 638 facilities?

Table 12-1 and Table 12-2 utilized Prepaid Medical Management Information System (PMMIS) data to assess if the Tribal Dental Authority increased the percentage of members within time/distance standards of a dental provider and whether the number of dental providers practicing in Indian Health Service (IHS) and Tribal 638 facilities increased. Key informant interviews were used to assess changes in the number of dental providers practicing in IHS and Tribal 638 facilities.

Key Findings:

- The *Percentage of members meeting minimum time/distance standards* for dental providers remained between 85.98 percent and 87.15 percent during state fiscal year (SFY) 2023 and SFY 2024.
- The *Number of dental providers practicing in IHS facilities* decreased by six dental providers between SFY 2023 and SFY 2024.
- IHS and Tribal 638 facilities reported that increased revenue associated with the Tribal Dental Authority enabled facilities to recruit additional dentists and increase pay.

Due to the lack of pre-implementation data and viable comparison group, there is insufficient data to attribute any changes directly to the Tribal Dental Authority.

Table 12-1—Research Question 1.1, Measure 1-1

Did the waiver result in an increased number of dental providers practicing in IHS and 638 facilities?		Evaluation Period			
		2023		2024	
		Q2	Q4	Q2	Q4
1-1	Percentage of members meeting minimum time/distance network standards	87.15%	86.99%	85.98%	86.08%

Note: IHS: Indian Health Services; Q: quarter.
Data Source: PMMIS were used in the analysis of RQ 1.1.

Table 12-2—Research Question 1.1, Measure 1-2

Did the waiver result in an increased number of dental providers practicing in IHS and 638 facilities?		Evaluation Period	
		2023	2024
1-2	Number of dental providers practicing in IHS facilities	61	55

Note: IHS: Indian Health Services.
Data source: PMMIS data were used in the analysis of RQ 1.1.

Most IHS and Tribal 638 facilities reported increases in the number of dental providers since the implementation of the Tribal Dental Authority. Facilities emphasized that the importance of the increase in revenue resulting from adult dental benefit reimbursements was a key factor in hiring additional providers and expanding service availability. Key themes included:

- Increased revenue: Increased revenue due to the Tribal Dental Authority enabled facilities to recruit more dentists and increase pay. In addition to hiring more general dentists, facilities hired specialists as a direct result of the increased revenue received from billing for adult services.
- Technological advancements: Facilities updated technology, including digital scanners and CEREC machines for same-day crowns. Updated technology reduced the number of visits required by a patient, allowing facilities to service more patients.
- Increased utilization: Facilities experienced steady growth in patient populations receiving care after the implementation of the Tribal Dental Authority.

Research Question 1.2: Do members have the same or better access to routine, preventive dental services compared to prior to the demonstration?

Table 12-3 utilized PMMIS data to assess whether the Tribal Dental Authority improved member access to dental services.

Key Findings:

- The *Percentage of adult members who received a comprehensive or periodic oral evaluation* averaged approximately 2.25 percent during the evaluation period. The *Number of adult members who received any covered dental service* averaged approximately 12.65 percent during the evaluation period.

Rates of access to routine and preventive dental services remained stable in the evaluation period. Due to the lack of pre-implementation data available to identify the eligible population and viable comparison group, there is insufficient data to attribute any changes directly to the Tribal Dental Authority.

Table 12-3—Research Question 1.2, Measures 1-6 and 1-7

Do members have the same or better access to routine, preventative dental services compared to prior to the demonstration?		Evaluation Period	
		2023	2024
1-6	Percentage of adult members who received a comprehensive or periodic oral evaluation	2.28%	2.23%
1-7	Number of adult members receiving any covered service in the plan year	12.59%	12.71%

Data Source: PMMIS were used in the analysis of RQ 1.2.

Hypothesis 2: Quality of care will be maintained or improved during the integration period.

Research Question 2.1: Do members have the same or better management of chronic dental conditions compared to prior to the demonstration?

Table 12-4 utilized PMMIS data to assess changes in the management of chronic dental conditions, specifically examining rates of preventive checkups and care for dental conditions among eligible members.

Key Findings:

- The *Percentage of adult members with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation* remained relatively stable under 2 percent during the evaluation period.
- The *Percentage of enrolled adults ages 30 years and older with a history of periodontitis who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation* decreased from 17.17 percent to 14.89 percent during the evaluation period.
- Treatment among members with elevated risk factors remained relatively stable during the evaluation period, decreasing slightly from 38.70 percent to 37.32 percent for members with a history of periodontitis, and from 8.4 percent to 8.25 percent among members with an elevated caries risk between SFY 2023 and SFY 2024.

Rates of oral exams among members with diabetes and preventive care remained stable in the evaluation period; however, the rates among members with a history of periodontitis decreased between SFY 2023 and SFY 2024. Due to the lack of pre-implementation data available to identify the eligible population and viable comparison group, there is insufficient data to attribute any changes to the Tribal Dental Authority.

Table 12-4—Research Question 2.1, Measures 2-1, 2-2, 2-3, and 2-4

Do members have the same or better management of chronic dental conditions compared to prior to the		Evaluation Period	
		2023	2024
2-1	Percentage of adult members with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year	1.93%	1.83%
2-2	Percentage of enrolled adults ages 30 years and older with a history of periodontitis who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year	17.17%	14.89%
2-3	Percentage of enrolled adults ages 30 years and older with a history of periodontitis who received an oral prophylaxis or scaling/root planing or periodontal maintenance visit at least two times within the reporting year	38.70%	37.32%
2-4	Percentage of enrolled adults ages 18 years and older who are at "elevated" caries risk (i.e., "moderate" or "high") and received at least two topical fluoride applications within the reporting year	8.40%	8.25%

Data Source: PMMIS data were used in the analysis of RQ 2.1.

Research Question 2.2: Do members have equal or lower emergency department (ED) or hospital utilization compared to prior to the demonstration?

Table 12-5 utilized PMMIS data to identify rates of ED utilization and follow-up care after an ED visit and to assess changes in ED utilization patterns.

Key Findings:

- The *Number of ED visits for ambulatory care sensitive dental conditions* among eligible members increased from 86.24 visits per 100,000 member months to 88.45 visits per 100,000 member months during the evaluation period.
- The *Percentage of ambulatory care sensitive dental condition ED visits among adults who visited a dentist after an ED visit* increased from 86.24 visits per 100,000 member months to 88.45 visits per 100,000 member months during the evaluation period.

Rates of ED visits for dental conditions increased slightly during the evaluation period between SFY 2023 and SFY 2024; however, follow-up care within 30 days for these visits increased slightly between SFY 2023 and SFY 2024. Due to the lack of pre-implementation data and viable comparison group, there is insufficient data to attribute any changes to the Tribal Dental Authority.

Table 12-5—Research Question 2.2, Measure 2-5 and 2-6

Do members have equal or lower ED or hospital utilization compared to prior to the demonstration?		Evaluation Period	
		2023	2024
2-5	Number of ED visits for ambulatory care sensitive dental conditions, per 100,000 member months	86.24	88.45
2-6	Percentage of ambulatory care sensitive dental condition ED visits among adults who visited a dentist after an ED visit		
	7-Day Indicator	2.34%	1.94%
	30-Day Indicator	3.40%	4.14%

Note: ED: emergency department.
Data Source: PMMIS data were used in the analysis of RQ 2.2.

Hypothesis 3: Member oral health outcomes will be maintained or improved during the renewal period.

Research Question 3.1: Do members have the same or better oral health outcomes compared to prior to the demonstration?

Table 12-6 and Figure 12-1 utilized data from the Behavioral Risk Factor Surveillance System (BRFSS) survey to identify rates of permanent tooth loss and assess changes over time. Table 12-7 also utilized fee-for-service (FFS) claims data to identify changes in oral health outcomes among members eligible for services provided through the Tribal Dental Authority.

Key Findings:

- The percentage of Arizona American Indian/Alaska Native (AI/AN) respondents who indicated at least one permanent tooth removal due to tooth decay or gum disease declined statewide by 6.00 percentage points between the baseline and evaluation periods; however, this difference was not statistically significant (p=0.256).

- The *Percentage of members who were at risk of dental caries* and the *Percentage of members with periodontitis* increased slightly during the evaluation period from SFY 2023 to SFY 2024.
- The *Percentage of members with oral cancer* remained stable during the evaluation period, with a rate of 0.05 percent.

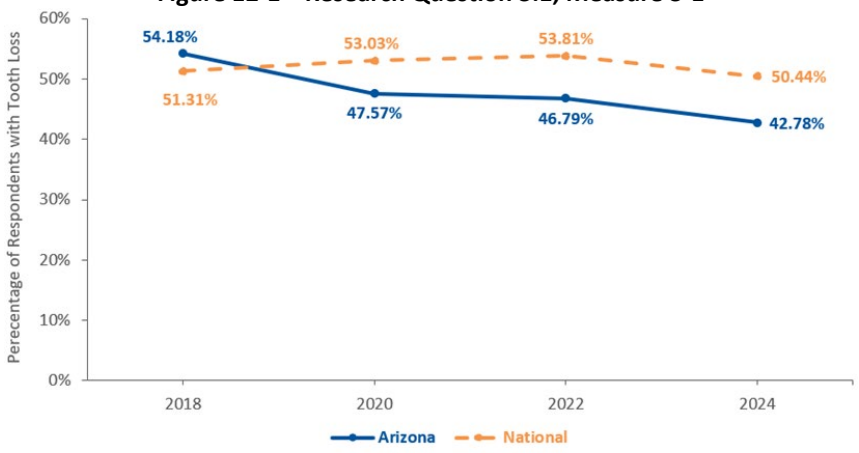
Among Arizona AI/AN respondents, rates of permanent tooth loss have declined consistently since 2018, with respondents indicating fewer teeth lost compared to the national average beginning in 2020. Additionally, although rates of some dental conditions increased during the evaluation period, due to the lack of pre-implementation data and viable comparison group, there is insufficient data to attribute the changes in prevalence of dental conditions directly to the Tribal Dental Authority.

Table 12-6—Research Question 3.1, Measure 3-1

Do members have the same or better oral health outcomes compared to prior to the demonstration?		Regression-Adjusted			Trend Model	
		Baseline Period Weighted Average	Evaluation Period Weighted Average	Pre/Post Change in Rate[1] (*p*-value)	Difference Between Actual and Projected (*p*-value) 2022	2024
3-1	Percentage of members with permanent tooth loss	50.88%	43.78%	-6.09pp (0.256)	-6.00pp (0.495)	-8.00pp (0.540)

*p<0.1, **p<0.05, ***p<0.001
Note: Results are weighted using BRFSS survey weights. pp: percentage point
Data Source: Statewide BRFSS data were used in the analysis of RQ 3.1.
[1]Change in Rate compares the average rate in the baseline period (2018, 2020) to the evaluation period (2022, 2024) using a pre/post model.

Figure 12-1—Research Question 3.1, Measure 3-1



Data Source: BRFSS data were used in the analysis of RQ 3.1.

Table 12-7—Research Question 3.1, Measures 3-2, 3-3, and 3-4

Do members have the same or better oral health outcomes compared to prior to the demonstration?		Evaluation Period 2023	2024
3-2	Percentage of members with risk of dental caries	1.39%	1.66%
3-3	Percentage of members with periodontitis	0.78%	0.99%
3-4	Percentage of members with oral cancer	0.05%	0.05%

Data Source: PMMIS data were used in the analysis of RQ 3.1.

Research Question 3.2: Has the rate of emergency dental services decreased following implementation of the waiver?

Table 12-8 leveraged PMMIS data to determine the percentage of members who utilized an emergency dental service.[123]

Key Findings:

- The *Percentage of members that utilized an emergency dental service* decreased by approximately 0.17 percentage points during the evaluation period between SFY 2023 and SFY 2024.

The percentage of members utilizing an emergency dental service remained below one percent throughout the evaluation period following the implementation of the Tribal Dental Authority. Due to the lack of pre-implementation data and viable comparison group, there is insufficient data to attribute any changes directly to the Tribal Dental Authority.

Table 12-8—Research Question 3.2, Measure 3-5

Has the rate of emergency dental services decreased following implementation of the waiver?		Evaluation Period	
		2023	2024
3-5	Percentage/number of members that utilized an emergency dental service	0.25%	0.08%

Data Source: PMMIS data were used in the analysis of RQ 3.2.

Hypothesis 4: The Tribal Dental program provides cost-effective care.

Due to the lack of pre-implementation data, before and after comparisons cannot be made in this Interim Evaluation Report. Instead, trends in cost of care are examined during the evaluation period. Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Although the Waiver's scope was limited to allowing coverage of additional adult dental services, costs across all categories of service were assessed. This includes behavioral health (BH) claims for AI/AN members that were associated with a Medicaid fraud scheme first announced in May 2023, when provider suspensions began. Although not related to the Tribal Dental Authority, the fraud has cost Arizona an estimated $218 million between January 2019 and August 2023.[124, 125] Because falsified billing practices among the impacted BH services and non-tribal providers continued through approximately April 2023, the evaluation of the Tribal Dental Authority does not purport to examine or quantify the extent of fraudulent billing. Therefore, results should be interpreted with caution for total and professional costs, which are skewed by falsified billing practices in the first several months of the evaluation period. Supplemental results from an alternate model that controls for this time period are also presented. These results confirm that dental services were not impacted by the fraud scheme.

123 Emergency dental services were identified based on claims containing revenue codes of 045x and 0512.

124 Arizona Health Care Cost Containment System. Findings and Recommendation Report (FARR) For AHCCCS. Available at: https://www.azahcccs.gov/Fraud/Downloads/ForensicAudit-FindingsandRecommendationsReport_FARR.pdf. Accessed on: Jun 23, 2026.

125 Arizona Health Care Cost Containment System. Protecting Program Integrity. Available at: https://www.azahcccs.gov/Fraud/programintegrity.html. Accessed on: Jun 16, 2026.

Research Question 4.1: What are the costs associated with providing care under the Tribal Dental Authority?

The results for Research Questions 4.1 and 4.2 assessing the costs, benefits, and savings associated with the Tribal Dental Authority during the evaluation period are addressed jointly in Research Question 4.2 below.

Research Question 4.2: What are the benefits/savings associated with providing care under the Tribal Dental Authority?

Table 12-9 and Figure 12-2 utilized PMMIS data to examine the changes in per-member per-month (PMPM) costs after Waiver implementation among members eligible for the Tribal Dental Authority through a post-implementation trend analysis. Average PMPM costs were approximately $2,346.49 at the beginning of the evaluation period and declined significantly by $51.23 per month. Dental costs overall remained low, at $1.03 PMPM at the beginning of the evaluation period and remained stable. After controlling for the initial portion of the evaluation period that was most heavily impacted by falsified billing practices among professional services, analysis shows that the average PMPM costs across all services at the beginning of the evaluation period were $1,375.83. There is no evidence that the falsified billing practices relates to services rendered under the Tribal Dental Authority.

Table 12-10 and Figure 12-3 utilized PMMIS data to examine the changes in aggregated costs after Waiver implementation among members eligible for the Tribal Dental Authority through a post-implementation trend analysis.

Key Findings:

- **PMPM Costs**
  - Total PMPM costs averaged $2,346.49 at the beginning of the evaluation period in October 2022. PMPM costs declined significantly throughout the evaluation period by an average of $51.23 per month ($p<0.001$). This was largely driven by professional claims, which was comprised in part by the suspension of providers submitting fraudulent claims.
  - Dental costs remained low overall, at $1.03 PMPM at the beginning of the evaluation period with an effectively flat trend, declining by $0.01 (p=0.135).
  - Professional costs were the primary driver of total PMPM costs, averaging $1,892.59 at the beginning of the evaluation period and declined by an average of $73.87 per month ($p<0.001$).
  - Supplemental results from an alternate model that include a control variable for months primarily impacted by falsified billing practices show that Total PMPM costs averaged $1,375.83 at the beginning of the evaluation period and remained effectively unchanged, declining by just $3.25 per month ($p=0.651$), which was not statistically significant.
- **Aggregate Costs**
  - Total costs among the Tribal Dental population averaged approximately $320,615.1 thousand in the first month of the evaluation period, but decreased by an average of $8,255.8 thousand per month thereafter ($p<0.001$).
  - Total dental costs averaged approximately $140.2 thousand in the first month of the evaluation period and declined slightly by $1.7 thousand per month (p=0.002).
  - Similar to PMPM costs, this was primarily driven by professional costs, which averaged $256,046.2 thousand in the first month of the evaluation period and declined by $10,334.4 per month thereafter ($p<0.001$).
  - Supplemental results from an alternate model suggest that the total costs among the Tribal Dental population averaged $185,646.6 thousand in the first month of the evaluation period after controlling for the average cost between October 2022 and April 2023. Total costs declined during the evaluation period by $1,585.0 thousand per month ($p=0.144$), which was not statistically significant.

Table 12-9—Tribal Dental Authority PMPM Costs

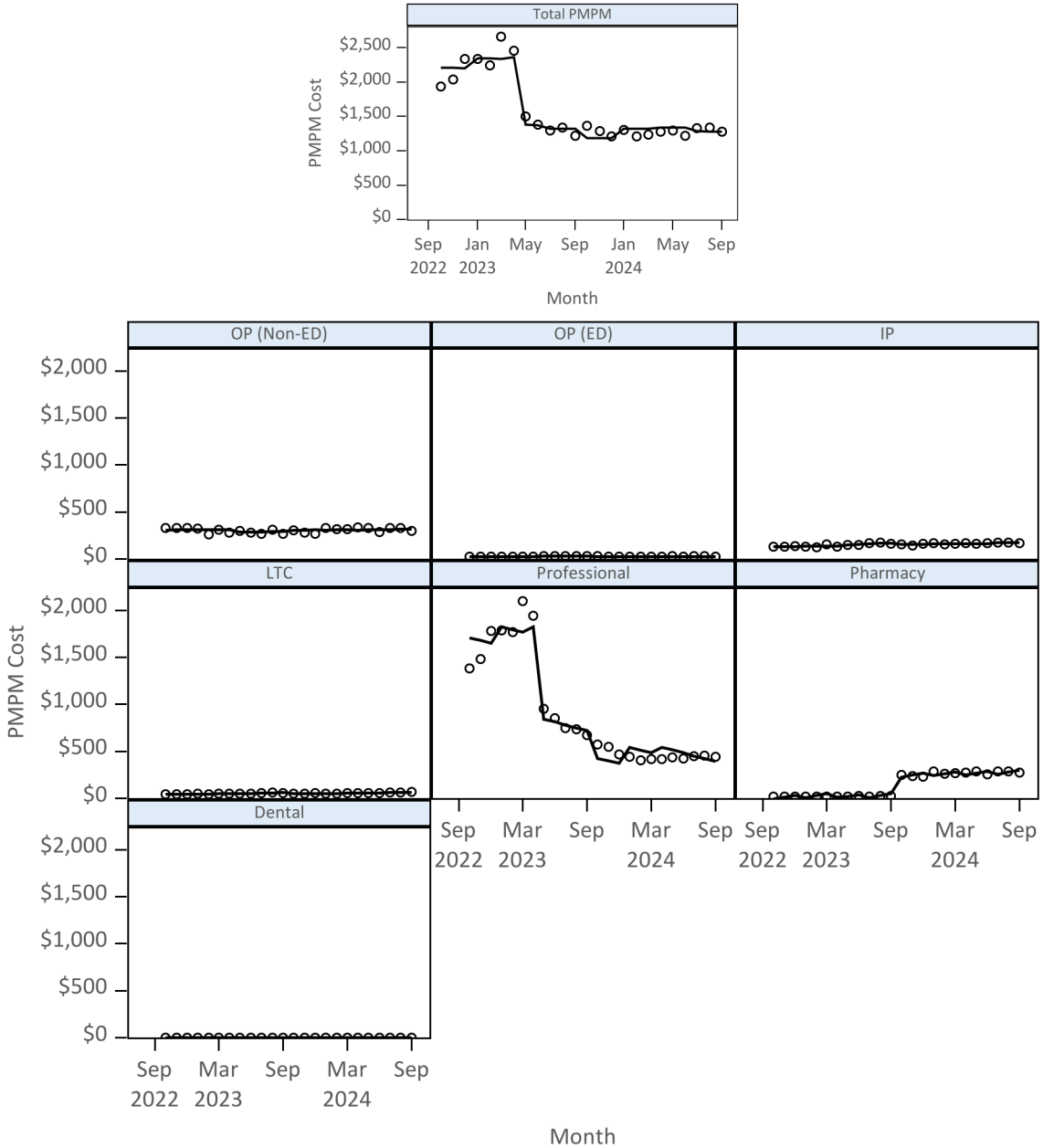
Variable	Estimate (*p*-value)							
	Total	Professional	IP	LTC	OP (ED)	OP (Non-ED)	Dental	Pharmacy
Intercept	$2,346.49 *** (<0.001)	$1,892.59 *** (<0.001)	$133.48 *** (<0.001)	$44.83 *** (<0.001)	$26.87 *** (<0.001)	$302.29 *** (<0.001)	$1.03 *** (<0.001)	$-54.59 *** (<0.001)
Post-implementation trend	$-51.23 *** (<0.001)	$-73.87 *** (<0.001)	$1.49 *** (<0.001)	$0.48 *** (<0.001)	$-0.08 (0.139)	$0.75 (0.416)	$-0.01 (0.135)	$20.01 *** (<0.001)
Alternate Model								
Intercept	$1,375.83 *** (<0.001)	$948.15 *** (<0.001)	$146.51 *** (<0.001)	$45.42 *** (<0.001)	$30.10 *** (<0.001)	$274.97 *** (<0.001)	$1.20 *** (<0.001)	$-70.53 ** (0.006)
Post-implementation trend	$-3.25 (0.651)	$-27.19 ** (0.002)	$0.85 ** (0.046)	$0.45 *** (<0.001)	$-0.24 *** (<0.001)	$2.10 (0.127)	$-0.01 ** (0.015)	$20.79 *** (<0.001)
Oct 2022–April 2023	$981.82 *** (<0.001)	$955.29 *** (<0.001)	$-13.19 ** (0.041)	$-0.60 (0.651)	$-3.27 ** (0.001)	$27.63 (0.182)	$-0.17 * (0.052)	$16.12 (0.400)

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Full model results are presented in Appendix A, Attachments. Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

Data Source: PMMIS data were used in the analysis of RQ 6.1.

Figure 12-2—Tribal Dental Authority PMPM Costs



Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient; PMPM: per-member per-month.

Table 12-10—Tribal Dental Authority Total Aggregate Costs (in Thousands)

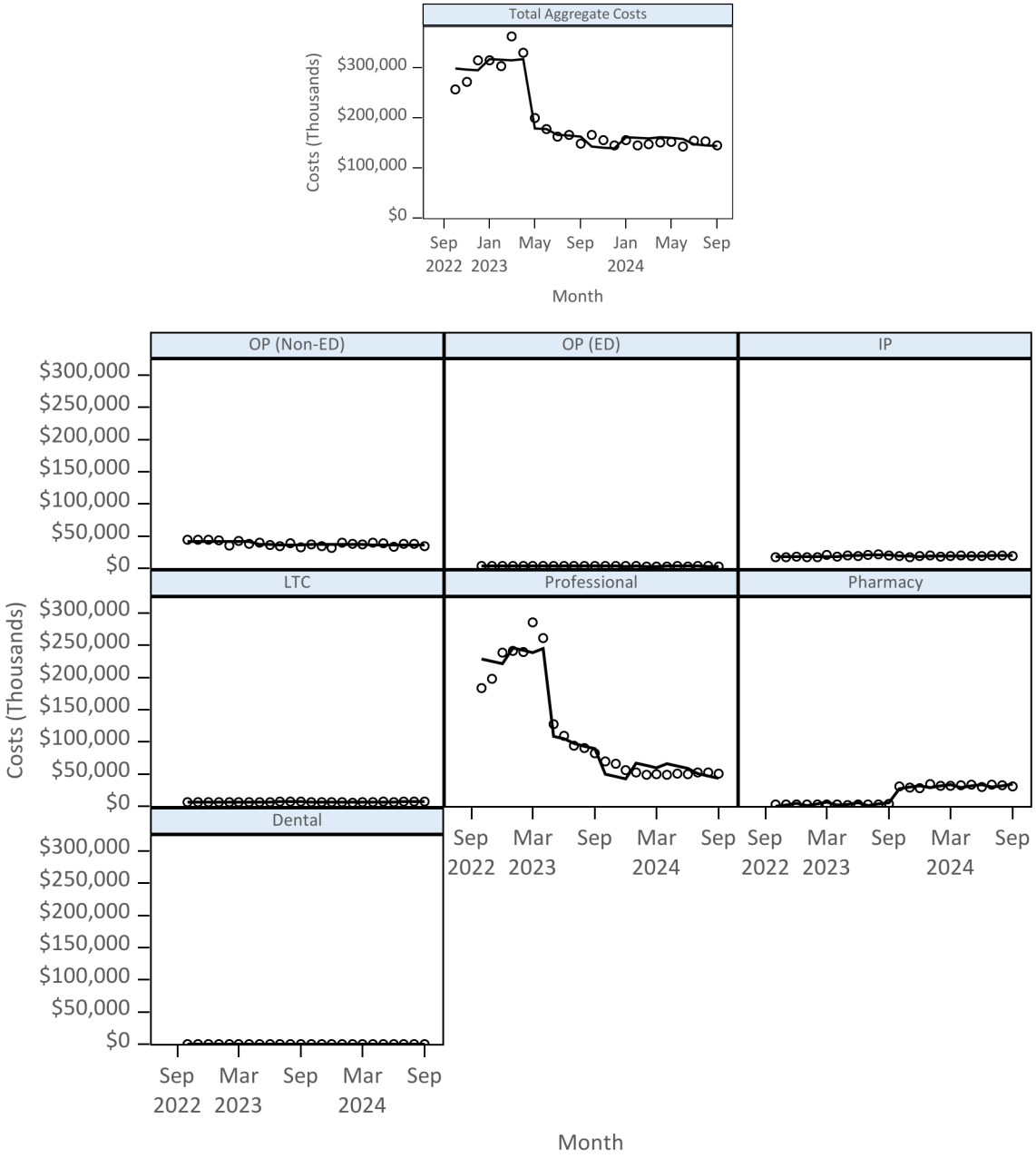
	Estimate in Thousands (*p*-value)							
Variable	**Total**	**Professional**	**IP**	**LTC**	**OP (ED)**	**OP (Non-ED)**	**Dental**	**Pharmacy**
Intercept	$320,615.1 *** (<0.001)	$256,046.2 *** (<0.001)	$18,556.6 *** (<0.001)	$6,265.2 *** (<0.001)	$3,706.1 *** (<0.001)	$41,728.2 *** (<0.001)	$140.2 *** (<0.001)	$-5,827.5 ** (0.001)
Post-implementation trend	$-8,255.8 *** (<0.001)	$-10,334.4 *** (<0.001)	$23.1 (0.539)	$2.5 (0.738)	$-38.4 *** (<0.001)	$-240.3 ** (0.049)	$-1.7 ** (0.002)	$2,333.4 *** (<0.001)
Alternate Model								
Intercept	$185,646.6 *** (<0.001)	$124,854.8 *** (<0.001)	$19,906.0 *** (<0.001)	$6,273.4 *** (<0.001)	$4,030.1 *** (<0.001)	$37,312.1 *** (<0.001)	$156.1 *** (<0.001)	$-6,885.9 ** (0.021)
Post-implementation trend	$-1,585.0 (0.144)	$-3,850.2 ** (0.002)	$-43.6 (0.414)	$2.1 (0.855)	$-54.4 *** (<0.001)	$-22.0 (0.892)	$-2.5 ** (0.001)	$2,385.7 *** (<0.001)
Oct 2022–April 2023	$136,519.8 *** (<0.001)	$132,699.4 *** (<0.001)	$-1,365.0 (0.101)	$-8.3 (0.961)	$-327.7 ** (0.010)	$4,466.9 * (0.082)	$-16.1 (0.120)	$1,070.6 (0.639)

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Full model results are presented in Appendix A, Attachments. Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

Data Source: PMMIS data were used in the analysis of RQ 6.1.

Figure 12-3—Tribal Dental Authority Total Aggregate Costs (in Thousands)

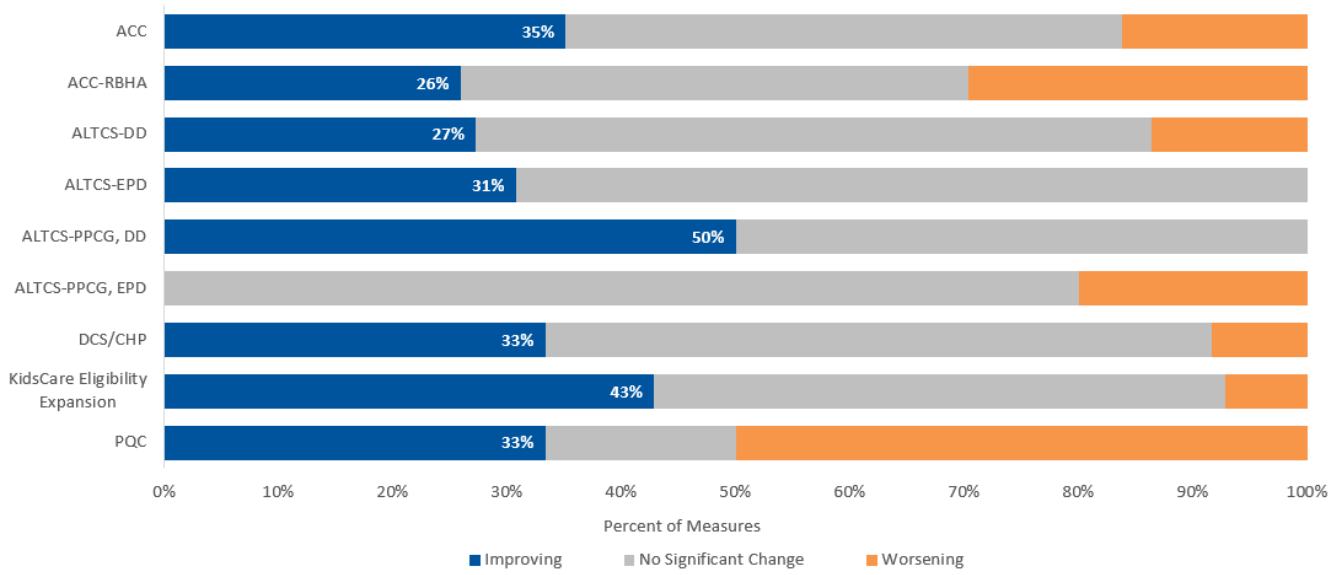


Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. ED: emergency department; IP: inpatient; LTC: long-term care; OP: outpatient.

13. Conclusions

The evaluation of the Arizona Health Care Cost Containment System (AHCCCS) Demonstration Waiver (the Waiver) analyzed a range of programs and populations to identify successes, challenges, and opportunities for future improvement. Results from this Interim Evaluation Report indicate that a majority of measures supported their respective hypotheses or did not exhibit significant changes between the baseline and evaluation periods. Of the 168 measures evaluated with a defined desired direction, 33 percent of measures supported the hypothesis. An additional 69 percent of measures exhibited no statistically significant change, while 16 percent of measures across the evaluated programs worsened. The AHCCCS programs evaluated demonstrated substantial variability in the results. Figure 13-1 illustrates the percentage of measures consistent with their hypothesis across each Waiver program.

Figure 13-1—Percentage of Measures Consistent with Research Hypotheses



ACC

Results for the AHCCCS Complete Care (ACC) program showed that more than 80 percent of the measures either supported their respective hypothesis or showed no significant change between the baseline and evaluation periods. Measures demonstrating improvement were primarily related to substance use disorder (SUD) treatment, management of opioid prescriptions, and management of chronic conditions. However, access to care for adult members may have worsened, as indicated by a decrease in the proportion of members who had a preventive care visit. Regarding member perceptions of care, ACC-Adult members reported higher ratings of their health plan but lower ratings of being able to access care as soon as they needed compared to baseline survey results.

Children enrolled in an ACC plan demonstrated improved access to appropriate care, reflected in increases in routine well-child and dental care visits. Similar to ACC-Adult members' perceptions, ACC-Child members reported lower rates of timely access to care compared to the baseline period. Additionally, ACC-Child members reported lower ratings of overall health and mental or emotional health relative to the baseline period.

Increases in per-member per-month (PMPM) costs for ACC-Adult members were primarily driven by professional and pharmacy costs. Total aggregate costs decreased during the renewal period across all service categories, with a notable decline in professional costs. PMPM costs for children enrolled in an ACC plan increased during the renewal period, also driven by professional and pharmacy costs. At the same time, total aggregate costs were increasing during the baseline period before slowing in the renewal period. It is important to note that increases in costs may be attributable to changes in available services, benefit packages, or an increase in the number of covered prescription medications during the evaluation period.

During key informant interviews, ACC plans described care coordination strategies implemented between physical health (PH) and behavioral health (BH) providers. Plans strengthened coordination by leveraging data, dedicated care management teams, and collaboration with external partners to support members' health and improve integration. Despite these advances, plans continued to face barriers, including workforce shortages, data sharing challenges, and administrative policy constraints. ACC providers similarly implemented strategies to enhance PH and BH care coordination during the renewal period, relying on dedicated care coordination staff, use of member data, and cross-system collaboration. Providers reported improvements in coordination over time but continued to experience challenges such as data delays and inaccuracies, preauthorization challenges, workforce shortages, coordination difficulties with external stakeholders, and evolving policy changes.

ACC-RBHA

Among the 27 measures with a desired direction evaluated for the ACC-Regional Behavioral Health Agreement (RBHA) program, nearly 75 percent supported the hypothesis or did not significantly change between the baseline and evaluation periods. Members enrolled in an ACC-RBHA plan had higher rates of engagement with and adherence to SUD and mental health treatment, as well as opioid prescription management during the renewal period compared to the baseline period. Although members had better access to SUD and mental health treatment, management of these conditions highlights an area of opportunity, as rates worsened among certain follow-up metrics. Members enrolled in an ACC-RBHA plan had lower ratings of their overall health and mental or emotional health, and generally rated their health plan lower than observed in the baseline period. PMPM and total aggregate costs increased during the renewal period relative to the baseline trend, driven by professional and inpatient (IP) costs. At the same time, both PMPM and total aggregate costs declined among long-term care (LTC) costs.

During key informant interviews, ACC-RBHA plans reported that integrating PH and BH services improved care coordination among members with a serious mental illness (SMI). Care coordination efforts included collaboration with external stakeholders, such as community-based organizations (CBOs), health homes (HHs), justice agencies, providers, and first responders, to ensure coordinated services. Internally, plans developed strategies to strengthen and enhance care coordination among members. AHCCCS strengthened the ACC-RBHA and BH system by supporting care coordination for members with SMI. AHCCCS efforts focused on targeted populations, coordination for general SMI ACC-RBHA members, and monitoring and supporting members in HHs. ACC-RBHA providers enhanced care coordination by leveraging dedicated staff and technology. Providers relied on case managers, peer support workers, and recovery coaches to help members access integrated PH and BH services.

ALTCS

Of the measures calculated for the ALTCS-DD population with a desired direction, 86 percent either supported the hypothesis or did not demonstrate a significant change between the baseline and evaluation periods. Adult and

minor members demonstrated higher rates of preventive and well-child visits during the evaluation period compared with the baseline period. All measures with a desired direction for the ALTCS-EPD population either improved or showed no significant change between the baseline and evaluation periods. Increased rates were seen for access to preventive care, rates of members residing in their own home, and follow-ups after emergency department (ED) visits, representing improvements across health care access, quality of life, and care coordination efforts.

PMPM and total aggregate costs for the ALTCS-DD population increased relative to the baseline trends, particularly among professional costs. PMPM and total aggregate costs also increased for the ALTCS-EPD population, particularly among professional and long-term care (LTC) costs.

The Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD) and Arizona Long Term Care System (ALTCS) plans experienced multiple barriers to care coordination during the Waiver renewal period. DES/DDD experienced barriers related to educating other stakeholders on the needs of its member population and challenges related to engaging foster youth. ALTCS-EPD plans encountered several barriers to care coordination, including member engagement challenges, difficulty obtaining accurate contact information, workforce shortages, challenges with care team communication, and member transitions related to policy changes that disrupted care teams and contributed to inconsistencies in member relationships. To address these challenges, both DES/DDD and ALTCS implemented a variety of strategies to enhance care coordination, including holding care coordination meetings to address member needs and collaborating with stakeholders to support members.

AHCCCS identified additional barriers during the Waiver renewal period, including challenges related to caring for an aging population, an increase in individuals with developmental disabilities (DDs), and workforce shortages. ALTCS providers also experienced several barriers, including unreliable transportation, challenges associated with the ALTCS application process, authorization requirements, reimbursement challenges, funding limitations, and difficulties communicating with AHCCCS.

ALTCS-PPCG

During the first year of the evaluation, 50 percent of Parents as Paid Caregivers (PPCG) measures with available data and a desired direction showed improvement, and no measures worsened. Results suggest that the PPCG service model contributed to increased access to care and care stability. Utilization of services through the PPCG service model increased, and the average number of direct care workers (DCWs) per member per year declined. Guardians or caregivers of members in the ALTCS-PPCG DD population were surveyed to assess how the PPCG model affected perceptions of health outcomes and family unit stability. Compared with ALTCS-DD minors living at home who did not receive PPCG services, members receiving services through the PPCG model reported higher rates of community integration and overall mental or emotional health. In contrast, parents providing services through the PPCG model reported higher rates of burnout compared with guardians or caregivers of members enrolled in ALTCS-DD who lived at home but did not receive services from the PPCG service model.

During key informant interviews, ALTCS providers reported that the PPCG service model was valued because it expanded caregiver options and improved continuity of care. Data completeness and availability limited the ability to assess changes following implementation of the PPCG service model for the ALTCS-EPD population. Among measures where performance could be compared with a comparison group (i.e., ALTCS-EPD minors living at home who did not receive services from the PPCG service model), no significant differences were identified.

Professional costs among the ALTCS-DD PPCG population increased throughout the baseline period and continued to increase following implementation of the PPCG service model in federal fiscal year (FFY) 2024. Total PMPM costs among the ALTCS-DD PPCG population also increased relative to ALTCS-DD minors living at home who did not receive PPCG services. PMPM costs among the ALTCS-PPCG EPD population decreased relative to ALTCS-EPD minors living at home who did not receive PPCG services, with notable lower costs among IP and pharmacy settings.

ALTCS-EFSS

The Extended Family Support Services (EFSS) initiative was not operationalized at the time this Interim Evaluation Report was developed. However, the National Core Indicators (NCI) survey data were used to assess rates of community integration among adults in Arizona with developmental disabilities in the baseline period. Prior to implementation, rates of community integration increased among Arizona respondents compared to those nationally.

DCS CHP

Nearly all measures with a desired direction evaluated for the Department of Child Safety Comprehensive Health Plan (DCS CHP) improved or did not demonstrate a significant change between the baseline and evaluation periods. Results related to DCS CHP renewal indicated that 33 percent of measures supported their respective hypotheses. Access to care, measured by the number of members meeting time and distance network standards and the rate of children accessing preventive care visits, improved relative to baseline rates. Conversely, rates of asthma medication management declined significantly between the baseline and evaluation periods.

PMPM costs among the DCS CHP population increased during the evaluation period relative to the baseline trends, primarily among professional and pharmacy service categories. In contrast, the total aggregate costs declined during the evaluation period.

In key informant interviews, DCS CHP described several strategies implemented to support members' PH and BH and strengthen care coordination. Strategies included proactive care coordination assignment, consistent internal coordination and collaboration, and collaboration with Mercy Care and other AHCCCS plans. Identified barriers included limited integration between PH and BH providers, ongoing shortages in the BH workforce, and challenges associated with the unique DCS CHP member population.

H2O

Although causality and program impacts cannot be assessed based on pre-implementation data alone, the results presented in this Interim Evaluation Report identify the baseline trends among the populations of interest. A majority of measures calculated for the Housing and Health Opportunities (H2O) program were based on data from the three years prior to implementation. Members who ultimately enrolled in H2O were identified as the intervention group, and members who remained on the AHCCCS housing program (AHP) waitlist served as the comparison group.

H2O members had higher rates of IP stays and both emergent and non-emergent ED visits compared to AHP waitlist members. This may be attributed to the fact that enrollment into the H2O program is primarily driven by the prevalence of PH chronic conditions, and members with chronic conditions are more likely to utilize high-acuity settings at a higher rate. During the baseline period, costs among H2O members were higher than those among AHP waitlist members, which may also reflect differences in member characteristics.

Measures relying on Closed-Loop Referral System (CLRS) data were available for the first year of evaluation period (FFY 2025) and identified screening rates among the H2O-enrolled members. Among H2O members, 32 percent received a screening using an appropriate screening tool, and 83 percent of those screened had a health-related social needs (HRSN) identified. These findings may indicate a need for increased HRSN screening to better connect members with needed services. Where demographic stratifications were possible, Black and American Indian/Alaska Native (AI/AN) H2O members had lower rates of HRSN screenings compared to White H2O members during the evaluation period.

Results from beneficiary surveys indicated that H2O members reported lower reported rates of inability to pay mortgage, rent, or utility bills compared to AHP waitlist members. Additionally, H2O members reported substantially higher levels of life satisfaction and lower levels of stress and anxiety; however, these differences were not statistically significant.

During key informant interviews, AHCCCS reported that housing investments evolved as a result of the H2O program. These changes included using H2O funding to support hiring incentives for providers and integrating existing long-term housing supports with H2O services. Case coordinators/managers and CBOs described both positive and negative impacts of H2O on downstream services. Across interviews, downstream services were broadly defined and included services ranging from emergency shelters to BH services. Case coordinators and CBOs collaborated to provide services and monitor members throughout service delivery.

KidsCare Eligibility Expansion

The expansion of KidsCare eligibility to household incomes between 200 and 225 percent of the federal poverty level (FPL) resulted in increased enrollment continuity demonstrated by an increase in the number of months members were enrolled during the first year of the expansion, an increase in the percentage of members who re-enrolled after a gap of up to six months, and a decrease in the number of days per gap in Medicaid coverage. Where pre-intervention data were not available, results among members in the KidsCare expansion population were compared with results among the KidsCare non-expansion population. The expansion population had higher rates of well-child visits and dental care. Results from beneficiary surveys indicated higher perceived access to health care, as well as higher ratings of overall health and mental health, among expansion members compared with non-expansion members. PMPM costs were higher among the KidsCare expansion population across professional, outpatient (OP), ED, and pharmacy settings.

PQC

The implementation of PQC limited retroactive coverage among eligible populations, with the goal of improving enrollment continuity among members. When examining enrollment trends, the number of members eligible for Medicaid enrollment decreased compared to the pre-implementation period. Additionally, members who disenrolled from Medicaid were less likely to reenroll compared to baseline rates, and among members who reenrolled there was an increase in the number of enrollment gaps. However, other elements of enrollment continuity improved, as demonstrated by an increase in the percentage of members completing the renewal process, an increase in the number of months with Medicaid coverage, and a decrease in the length of gaps between periods of coverage.

Beneficiary surveys provided insight into members' perceptions of their health, health care quality, and medical debt. Compared to surveys conducted during the baseline period, members who were newly enrolled in Medicaid (i.e., those without Medicaid enrollment in the past six months) reported lower rates of positive mental or

emotional health and timely access medical care and reported higher frequencies of medical debt; however, these results were not statistically significant.

Although total aggregate costs increased across all service types for Prior Quarter Coverage (PQC)-eligible members during the evaluation period, PMPM costs decreased across nearly all service types, excluding non-ED OP services.

Tribal Dental Authority

Due to unavailable fee-for-service (FFS) enrollment data in FFY 2022, baseline data for the Tribal Dental Authority were not included in the report. As such, statistical testing could not be conducted for the majority of measures evaluated as part of the Tribal Dental Authority. However, assessment of post-implementation trends indicated that the percentage of members with effective management of chronic conditions decreased slightly during the evaluation period while ED utilization increased slightly. PMPM costs among members eligible for the Tribal Dental Authority decreased steadily throughout the evaluation period.

During key informant interviews, Indian Health Service (IHS) and Tribal 638 facilities reported increases in dental provider capacity following the implementation of the Tribal Dental Authority. Facilities emphasized that increased revenue resulting from adult dental benefit reimbursements was a key factor in hiring additional providers and expanding service availability.

14. Lessons Learned and Policy Implications

Previous chapters in this Interim Evaluation Report provide background on the Arizona Health Care Cost Containment System (AHCCCS) Section 1115 Waiver programs, including a description of the evaluation research questions, hypotheses, measures, and data sources; methodology; results; and conclusions. This chapter presents lessons learned from the implementation of new programs and the renewal of existing programs and discusses policy implications and recommendations for future improvements for both Arizona and other states considering similar programs.

Across AHCCCS Complete Care (ACC), ACC-Regional Behavioral Health Agreement (RBHA), the Department of Child Safety Comprehensive Health Plan (DCS CHP), and Arizona Long Term Care System (ALTCS), stakeholders reported meaningful gains in care integration through proactive care coordination, internal case conferencing, and cross-system collaboration. Although improvements in these key areas were observed, constraints remain, including workforce shortages, barriers to member engagement and contact, and challenges related to data-sharing and interoperability.

While this chapter is intended to reflect lessons learned across all demonstrations, additional findings may be included in the Summative Evaluation Report for the KidsCare Eligibility Expansion, Tribal Dental Authority, ALTCS-Parents as Paid Caregivers (PPCG), and Housing and Health Opportunities (H2O) programs as additional data become available. It is also important to note that this Interim Evaluation Report generally examines the first two years of the renewal period. Therefore, findings do not necessarily represent the full impact of the demonstration, as findings may change as additional data are collected throughout the remainder of the renewal period. Specifically, H2O was not operationalized until October 1, 2024, which resulted in only a single year of post-implementation data available for this Interim Report (FFY 2025). Furthermore, the first year of implementation included provider onboarding and training, which may impact the effectiveness of the program during the initial transition period.

Lessons Learned

The following section presents cross-program lessons identified through the interim evaluation of the Waiver, drawing on both quantitative performance measure findings and qualitative feedback from stakeholders.

Integration of physical health (PH) and behavioral health (BH) has improved care delivery, but challenges persist for high-acuity members. Results indicate improvements in member care and outcomes associated with the integration of PH and BH care. For example, ACC and ACC-RBHA plans reported improved care delivery through targeted coordination efforts for at-risk populations, including justice-involved members, members experiencing BH crises, and individuals with high needs identified through social determinants of health (SDOH) assessments. However, members with more complex needs continue to experience fragmentation in care coordination. In particular, individuals enrolled in ALTCS long-term services and supports (LTSS) programs and members transitioning across service systems remain challenging to coordinate across providers and plans.

Workforce constraints consistently create barriers. Workforce shortages were a consistent challenge reported across programs. High caseloads, staff turnover, and provider shortages, particularly among BH specialists, limited the ability to effectively coordinate care and reduced access to services for members, especially in rural areas. Specifically, ALTCS stakeholders reported a lack of gerontologists in the State, with demand for these specialists anticipated to grow as the ALTCS population continues to age. The ALTCS-PPCG program may

alleviate some of the workforce challenges in certain areas of the ALTCS program, particularly among the DD population. Additionally, DCS CHP faced challenges finding providers willing to work with the program's uniquely complex member population.

Effective member engagement is dependent on reliable contact information. Challenges with outdated telephone numbers and address data, combined with housing instability among members, reduced the ability to effectively outreach to and follow up with members. Having up-to-date contact information, particularly for members with complex health needs, is critical to effective care coordination.

Access to needed data is critical to effective care coordination. Stakeholders reported that interoperability gaps, substance use disorder (SUD)-related data restrictions, and limited discharge data hindered care coordination activities. Care coordination improved when Admission, Discharge, Transfer (ADT) alerts and Closed-Loop Referral Systems (CLRSs) were available. ACC plans reported success utilizing health information exchanges (HIEs) to ensure stakeholders had access to up-to-date member information and to identify community resources to address member needs. Conversely, ACC-RBHA plans reported barriers such as federal restrictions on SUD-related data sharing and limitations within health exchange platforms, both of which hindered access to essential information and contributed to challenges in accessing and sharing data.

Proactive coordination practices lead to positive member outcomes. When members are proactively assigned to care coordination staff, such as in the DCS CHP program, risks and potential interventions could be identified in a timelier manner, resulting in more effective and efficient care delivery. Collaboration across teams and organizations also supported improved care coordination efforts. To better anticipate member needs, ACC and ACC-RBHA plans implemented support strategies for specific high-needs member groups to help ensure their needs were adequately addressed.

Administrative burdens delay care for members. Issues with authorization requirements, renewals, and complex applications processes, particularly for ALTCS, created delays in members receiving needed care and increased staff burden. These issues disproportionately affected high-acuity members, who were often required to navigate these challenges to receive care. ACC plans noted that policy and requirement changes following integration of PH and BH were often unclear, which increased administrative burden for contracted providers.

Transportation remains a critical barrier to accessing care. Challenges with the reliability and capacity of non-emergency medical transportation (NEMT) created barriers for members accessing care. This especially impacted members in rural areas and those requiring complex and specialty care, such as the aging ALTCS population.

Policy Implications

Taking these lessons learned into consideration, the following policy recommendations should be considered to support continued improvement of the Waiver programs.

Workforce and Provider Network Improvement Strategies. To address workforce shortages, AHCCCS should consider a comprehensive approach to improving provider capacity and retention, particularly in rural areas. Potential strategies include rate adjustments tied to retention, incentives for providers practicing in rural areas, targeted onboarding of long-term support services and BH providers serving the pediatric population, and continued expansion of reimbursable provider roles.

Data Sharing and Interoperability. Improvements to care coordination could be supported through stronger data sharing and interoperability standards. Ensuring the availability of transition data, such as admission, discharge, and transfer alerts and discharge summaries, may improve care coordination across providers. In addition, promoting the use of CLRS where not already implemented could strengthen transitions for specialty care among vulnerable populations. For DCS CHP specifically, establishing clearer guidance regarding what health information may be shared and with which stakeholders may improve operational efficiency.

Risk-Tiered Care Coordination as a Standard Approach. Although plans reported targeting care coordination to high-risk populations, implementing a standardized risk-tiered care coordination framework across all AHCCCS programs could help ensure members receive appropriate and timely care. Leveraging available electronic health record (EHR) data to identify member needs and utilization patterns may help direct care coordination resources to members with the greatest needs.

Member Data Infrastructure. Outdated, incomplete, and/or missing member contact information created challenges for outreach and coordination. To mitigate these barriers, AHCCCS could implement periodic contact verification processes and support cross-system updates to member contact information when feasible. ACC-RBHA plans reported distributing cell phones to members to help maintain reliable contact information. Similar approaches could be considered for other member populations to improve outreach.

Transportation Reliability. Addressing NEMT challenges could improve timely access to care, particularly for members with complex needs. Potential strategies include updating NEMT rates and strengthening ride-share programs with appropriate clinical safeguards. Additional efforts to strengthen rural NEMT capacity through targeted incentive programs may further improve access to care for members struggling to meet appointments.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Arizona's Medicaid Section 1115 Waiver Evaluation

Interim Evaluation Report, Appendix

July 2026

HSAG HEALTH SERVICES ADVISORY GROUP

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Appendix A. Attachments

Evaluation Design

The current Evaluation Design for the Arizona Section 1115 Demonstration Waiver (the Waiver) was approved by the Centers for Medicare & Medicaid Services (CMS) on September 17, 2024. The current CMS-approved Evaluation Design can be found at the following link: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-cms-aprvd-amndmnd-evlutn-dsgn.pdf. The CMS-approved Evaluation Design for the Housing and Health Opportunities (H2O) program can be found at the following link: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hcccs-appvd-h2o-eval-des-08302024.pdf. Detailed measure specifications can be found in the Evaluation Designs.

Supplemental Results

This section provides additional and/or supplemental results of the summative evaluation, including expanded qualitative results.

ACC

This section provides the supplemental quantitative and qualitative results for Arizona Health Care Cost Containment System (AHCCCS) Complete Care (ACC).

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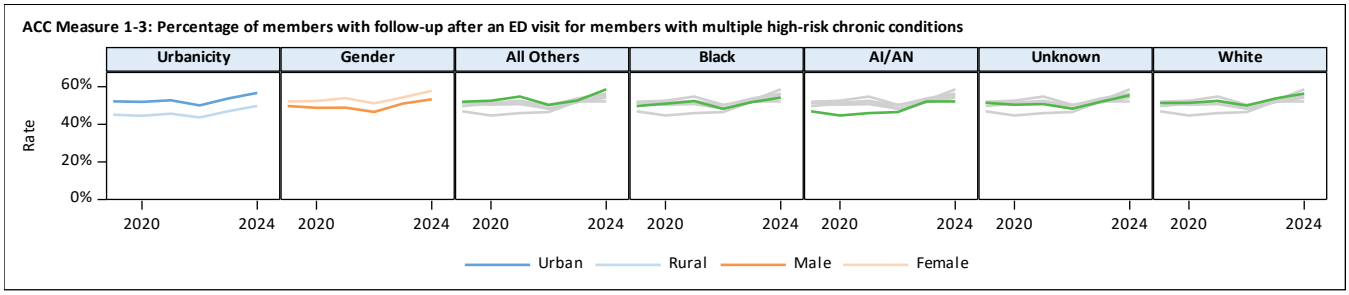
Quantitative

Table A-1—ACC Supplemental Results

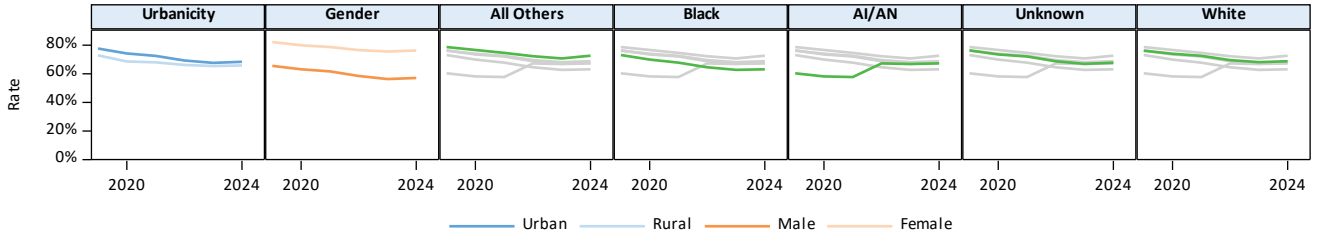
Time	BH OP, Adult	BH Residential Facility	BH OP, Pediatric	Cardiologist, Adult	Cardiologist, Pediatric	Dentist, Pediatric	Hospital	OB/GYN	PCP, Adult	PCP, Pediatric	Pharmacy
Q1 2019	97.1% N=795,671	97.0% N=1,118,717	97.2% N=681,638	99.8% N=718,421	100.0% N=758,888	98.8% N=758,888	99.8% N=1,477,309	99.9% N=349,865	99.7% N=718,421	99.6% N=758,888	98.5% N=1,477,309
Q2 2019	98.2% N=809,256	97.7% N=1,131,538	98.3% N=684,136	99.9% N=729,540	100.0% N=763,852	98.4% N=763,852	99.9% N=1,493,392	99.9% N=355,629	99.7% N=729,540	99.6% N=763,852	98.1% N=1,493,392
Q3 2019	98.3% N=793,674	97.7% N=1,109,165	98.3% N=672,155	99.8% N=716,466	100.0% N=749,363	98.9% N=749,363	99.8% N=1,465,829	99.9% N=348,234	99.7% N=716,466	99.6% N=749,363	98.7% N=1,465,829
Q4 2019	98.3% N=913,451	97.7% N=1,208,853	98.3% N=767,771	99.7% N=824,300	100.0% N=856,922	98.6% N=856,922	99.9% N=1,681,222	99.9% N=400,727	99.7% N=824,300	99.5% N=856,922	98.7% N=1,681,222
Q1 2020	98.4% N=903,544	97.1% N=1,191,052	98.5% N=753,917	99.7% N=815,768	100.0% N=841,693	98.7% N=841,693	99.8% N=1,657,461	99.9% N=393,950	99.6% N=815,768	99.6% N=841,693	98.7% N=1,657,461
Q2 2020	97.0% N=820,567	95.7% N=1,134,869	97.5% N=678,663	99.7% N=740,388	100.0% N=758,842	98.9% N=758,842	97.2% N=1,499,230	99.9% N=358,566	99.6% N=740,388	99.5% N=758,842	98.9% N=1,499,230
Q3 2020	97.1% N=883,022	95.8% N=1,207,151	97.6% N=706,424	99.7% N=796,166	100.0% N=793,280	86.5% N=793,280	97.2% N=1,589,446	99.9% N=386,227	99.6% N=796,166	99.6% N=793,280	98.9% N=1,589,446
Q2 2021	98.6% N=1,005,704	97.8% N=1,338,494	98.6% N=752,730	99.7% N=904,701	100.0% N=853,733	98.9% N=853,733	99.8% N=1,758,434	99.9% N=437,123	99.6% N=904,701	99.6% N=853,733	98.8% N=1,758,434
Q4 2021	98.6% N=1,065,130	97.7% N=1,399,433	98.6% N=772,268	99.7% N=957,818	100.0% N=879,580	98.7% N=879,580	99.8% N=1,837,398	99.9% N=461,757	99.6% N=957,818	99.6% N=879,580	97.0% N=1,837,398
Q2 2022	98.7% N=1,123,322	97.7% N=1,456,133	98.7% N=789,391	99.7% N=1,010,850	100.0% N=901,863	91.1% N=901,863	99.8% N=1,912,713	99.9% N=484,453	99.7% N=1,010,850	99.6% N=901,863	97.3% N=1,912,713
Q4 2022	98.5% N=1,045,098	97.7% N=1,328,907	98.6% N=702,697	99.8% N=941,029	100.0% N=806,766	96.5% N=806,766	99.8% N=1,747,795	99.9% N=450,968	99.7% N=941,029	99.6% N=806,766	98.8% N=1,747,795
Q2 2023	98.3% N=1,227,481	97.6% N=1,551,230	98.2% N=814,180	99.8% N=1,106,440	100.0% N=935,221	98.8% N=935,221	99.8% N=2,041,661	100.0% N=524,490	99.7% N=1,106,440	99.7% N=935,221	98.9% N=2,041,661
Q4 2023	98.9% N=1,075,242	97.8% N=1,369,960	98.9% N=733,372	99.8% N=970,629	100.0% N=837,985	98.6% N=837,985	99.8% N=1,808,614	99.9% N=460,343	99.7% N=970,629	99.6% N=837,985	98.9% N=1,808,614
Q2 2024	97.3% N=1,053,447	94.3% N=1,345,783	97.6% N=723,666	99.8% N=951,285	100.0% N=825,828	98.9% N=825,828	99.8% N=1,777,113	99.9% N=452,117	99.7% N=951,285	99.6% N=825,828	98.9% N=1,777,113
Q4 2024	98.8% N=1,007,109	97.1% N=1,289,871	98.9% N=715,634	99.8% N=909,303	100.0% N=813,440	98.9% N=813,440	99.8% N=1,722,743	99.9% N=433,161	99.7% N=909,303	99.6% N=813,440	98.9% N=1,722,743

Note: BH: behavioral health; OB/GYN: obstetrics and gynecology; OP: outpatient; PCP: primary care provider; Q: quarter.

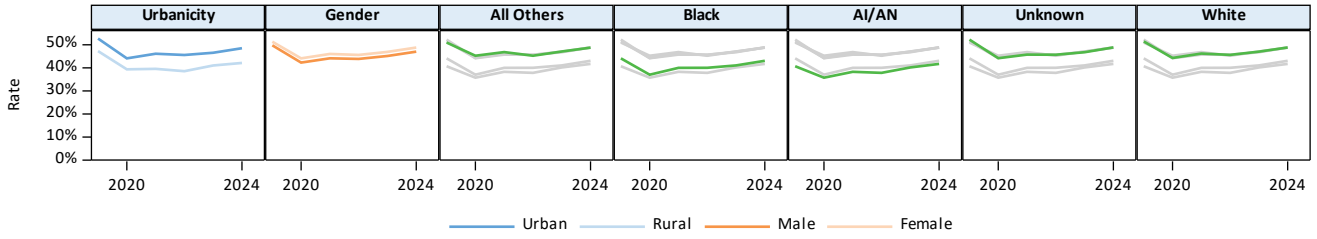
Table A-2—ACC Demographics



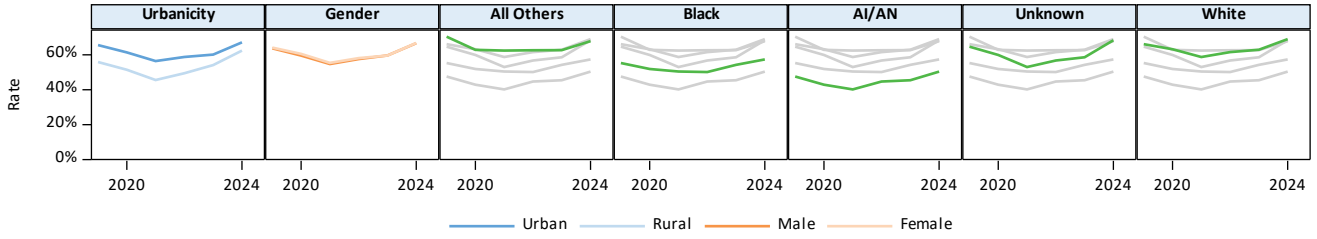
ACC Measure 2-2: Percentage of adults who accessed preventive/ambulatory health services



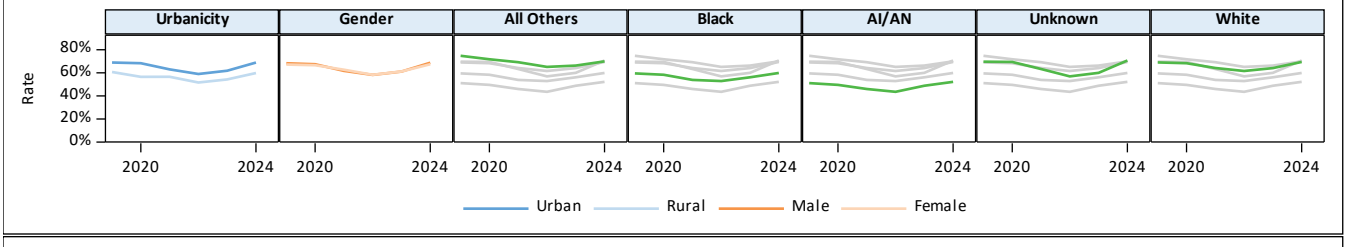
ACC Measure 2-3: Percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation



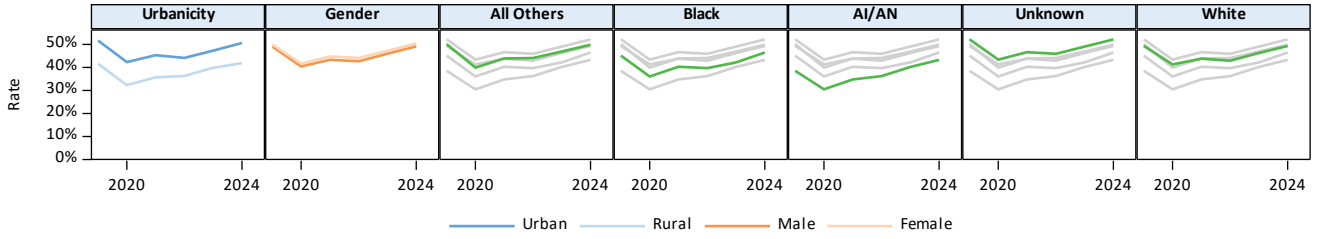
ACC Measure 2-4: Percentage of members who had a well-child visit in the first 30 months of life (six or more well-child visits before the 15-month birthday)

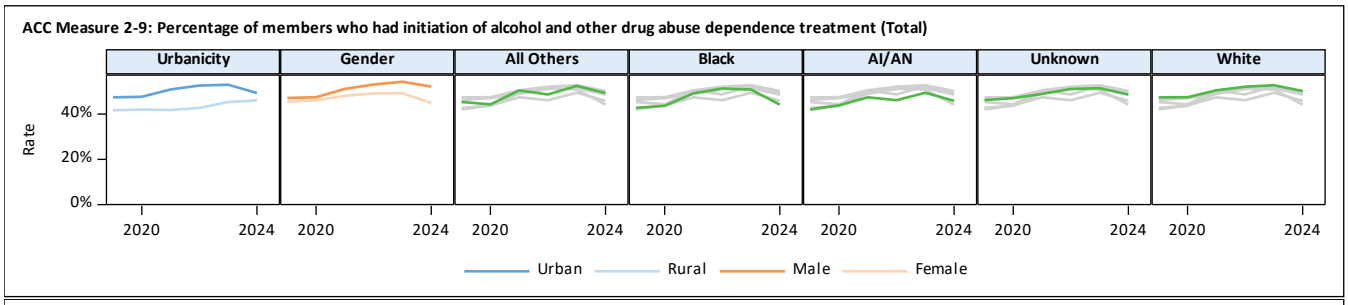


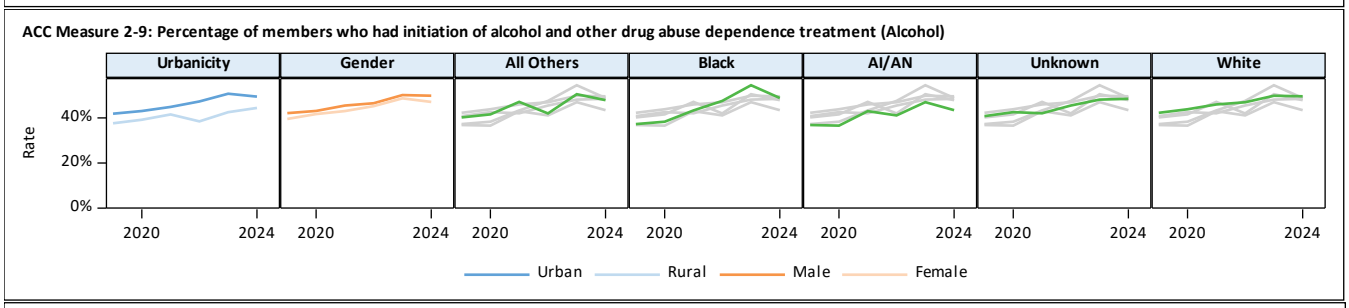
ACC Measure 2-4: Percentage of members who had a well-child visit in the first 30 months of life (two or more well-child visits between the child's 15-month and 30-month birthday)

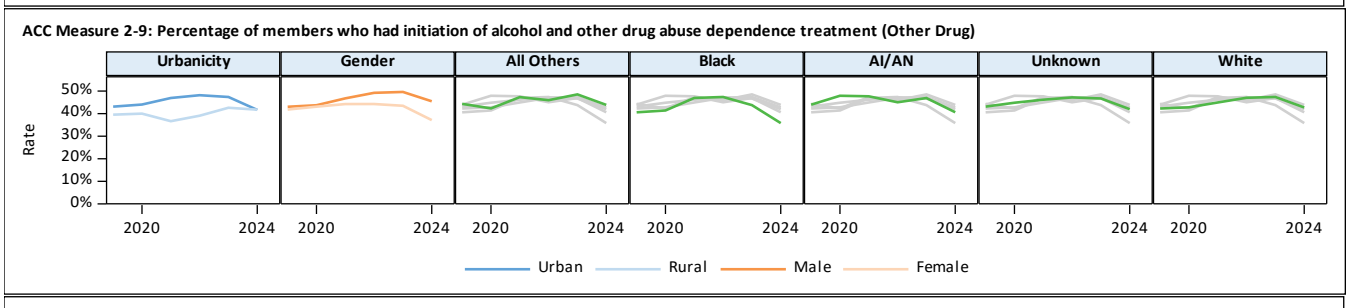


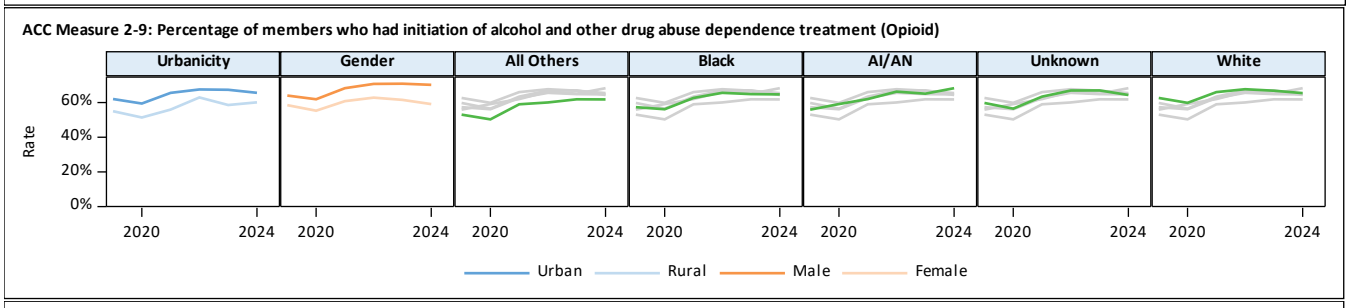
ACC Measure 2-5: Percentage of members 3–21 years of age who had a well-care visit with a PCP or OB/GYN

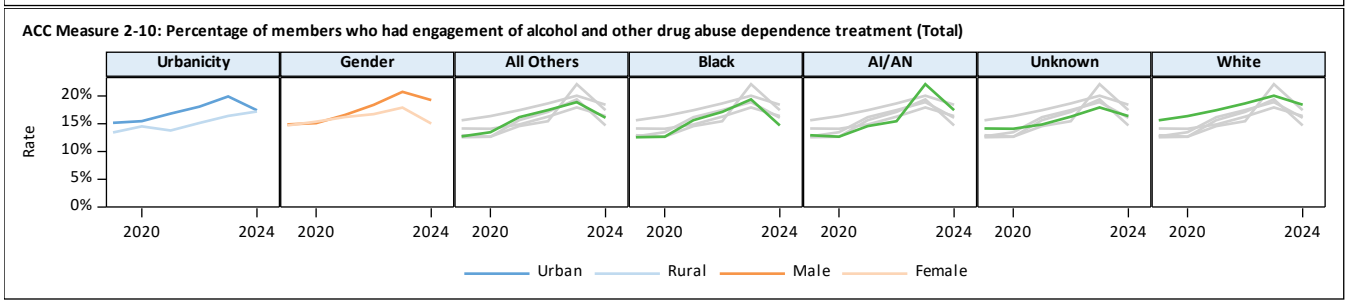



ACC Measure 2-9: Percentage of members who had initiation of alcohol and other drug abuse dependence treatment (Total)
Urbanicity
Gender
All Others
Black
AI/AN
Unknown
White
Rate
40%
20%
0%
2020
2024
Urban
Rural
Male
Female

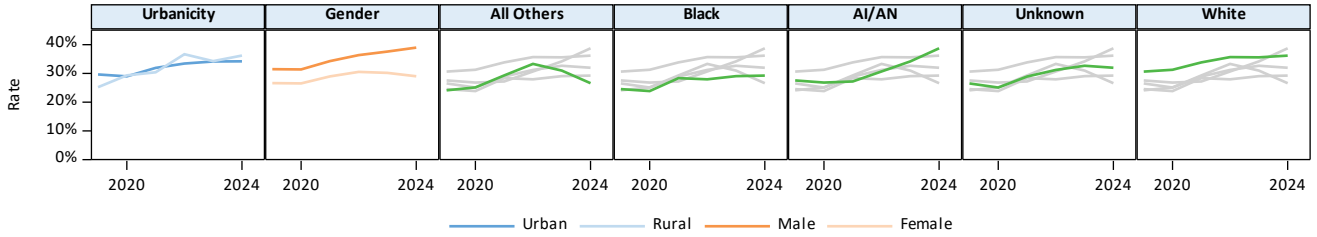

ACC Measure 2-9: Percentage of members who had initiation of alcohol and other drug abuse dependence treatment (Alcohol)
Urbanicity
Gender
All Others
Black
AI/AN
Unknown
White
Rate
40%
20%
0%
2020
2024
Urban
Rural
Male
Female


ACC Measure 2-9: Percentage of members who had initiation of alcohol and other drug abuse dependence treatment (Other Drug)
Urbanicity
Gender
All Others
Black
AI/AN
Unknown
White
Rate
50%
40%
30%
20%
10%
0%
2020
2024
Urban
Rural
Male
Female

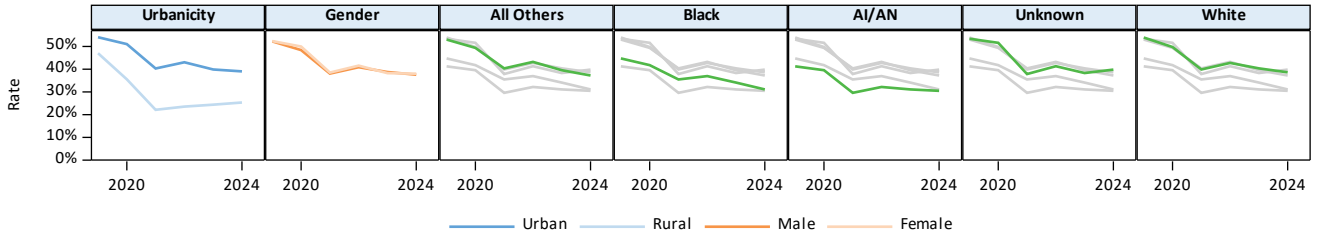

ACC Measure 2-9: Percentage of members who had initiation of alcohol and other drug abuse dependence treatment (Opioid)
Urbanicity
Gender
All Others
Black
AI/AN
Unknown
White
Rate
60%
40%
20%
0%
2020
2024
Urban
Rural
Male
Female


ACC Measure 2-10: Percentage of members who had engagement of alcohol and other drug abuse dependence treatment (Total)
Urbanicity
Gender
All Others
Black
AI/AN
Unknown
White
Rate
20%
15%
10%
5%
0%
2020
2024
Urban
Rural
Male
Female

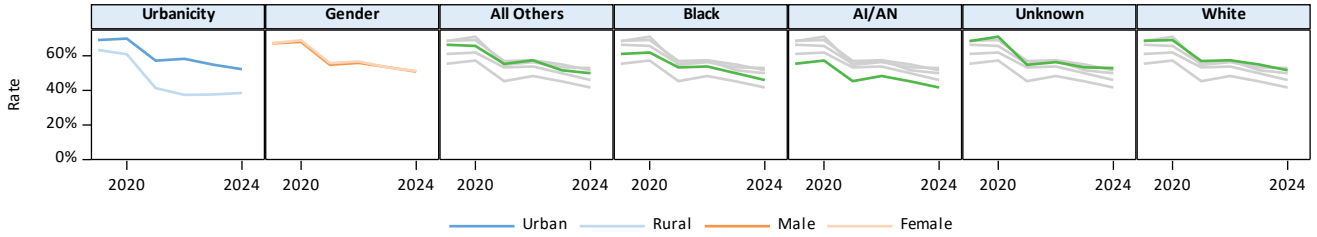
ACC Measure 2-10: Percentage of members who had engagement of alcohol and other drug abuse dependence treatment (Opioid)



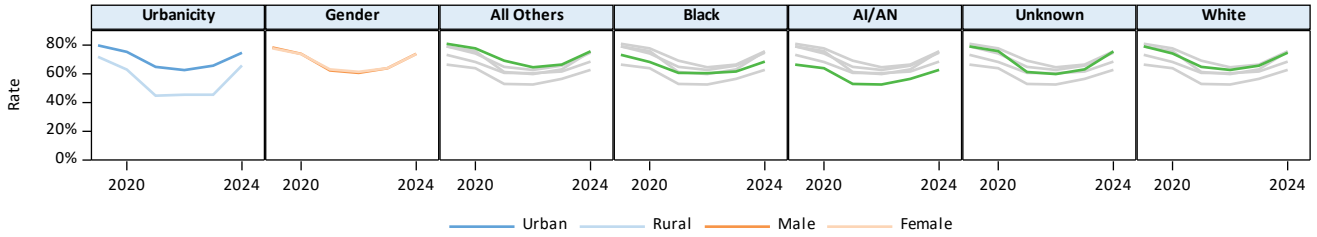
ACC Measure 3-1: Percentage of children 2 years of age with appropriate immunization status (DTaP)



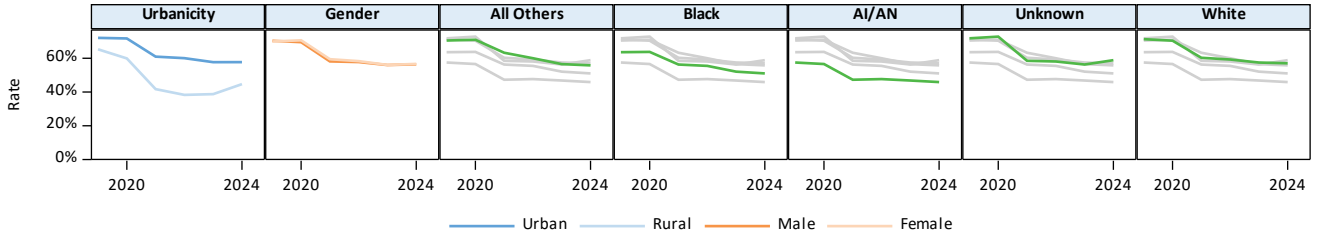
ACC Measure 3-1: Percentage of children 2 years of age with appropriate immunization status (IPV)



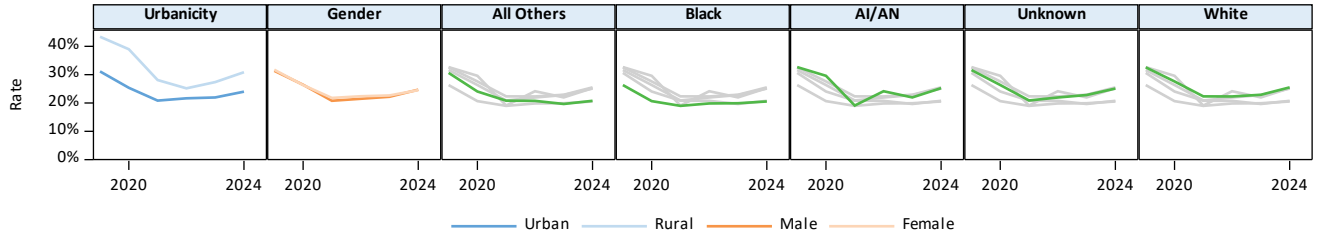
ACC Measure 3-1: Percentage of children 2 years of age with appropriate immunization status (MMR)



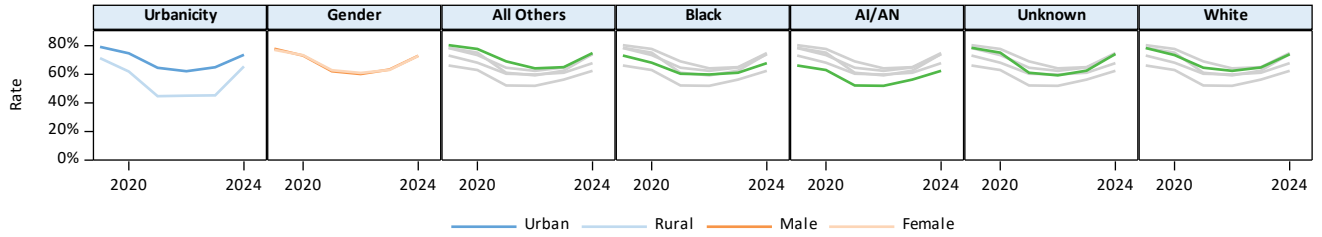
ACC Measure 3-1: Percentage of children 2 years of age with appropriate immunization status (HiB)



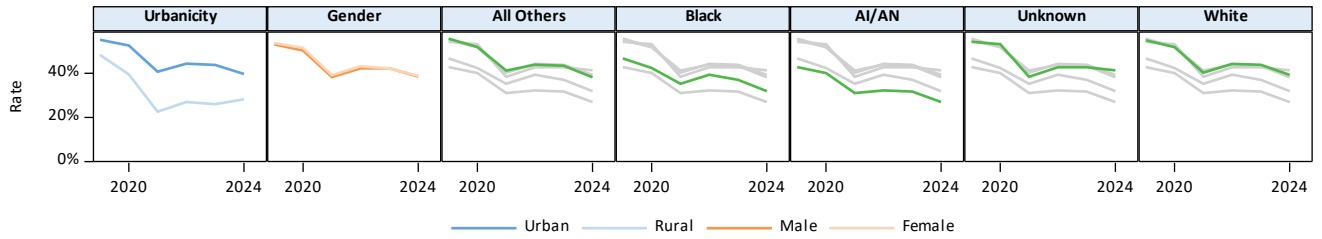
ACC Measure 3-1: Percentage of children 2 years of age with appropriate immunization status (Hepatitis B)



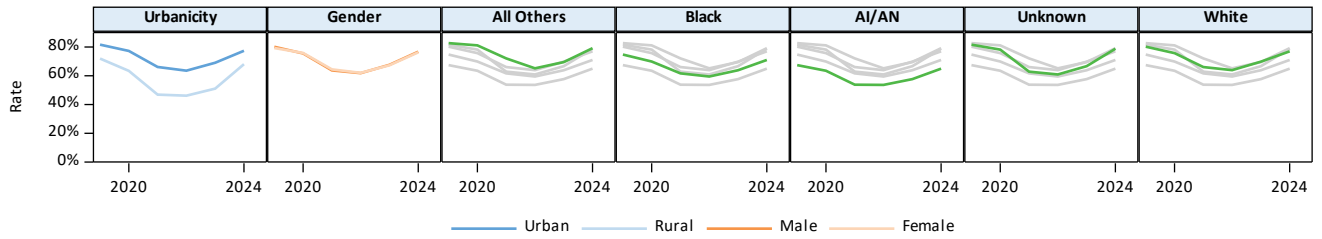
ACC Measure 3-1: Percentage of children 2 years of age with appropriate immunization status (VZV)



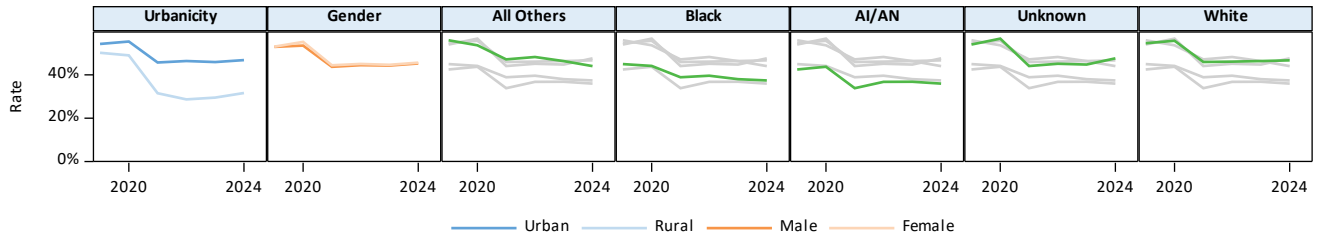
ACC Measure 3-1: Percentage of children 2 years of age with appropriate immunization status (Pneumococcal Conjugate)



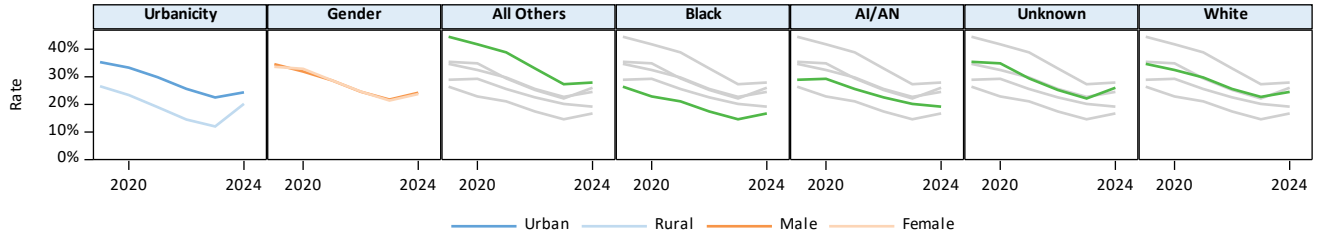
ACC Measure 3-1: Percentage of children 2 years of age with appropriate immunization status (Hepatitis A)



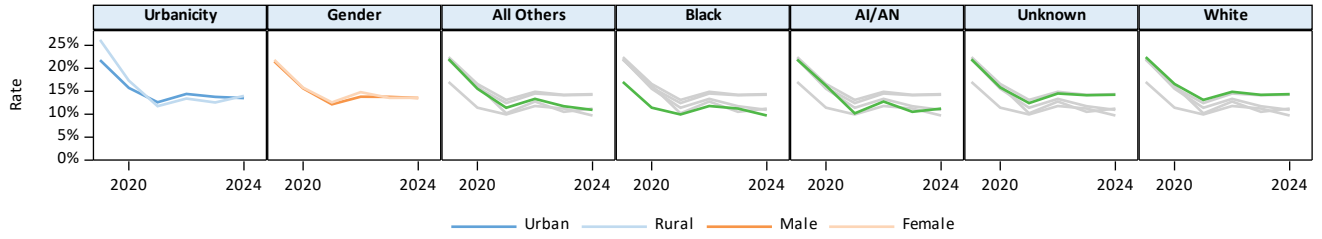
ACC Measure 3-1: Percentage of children 2 years of age with appropriate immunization status (Rotavirus)



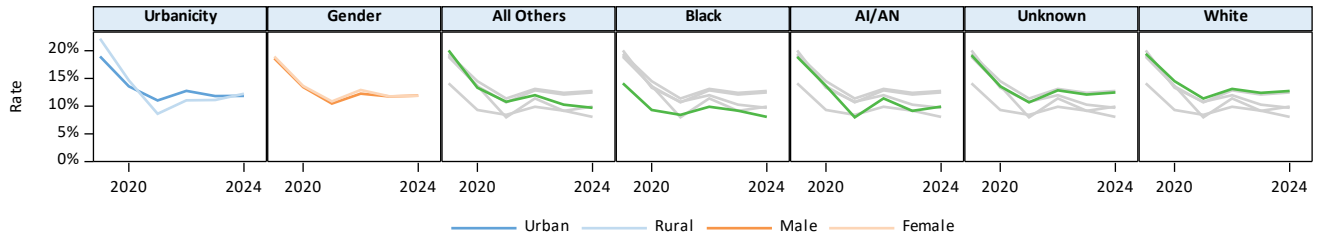
ACC Measure 3-1: Percentage of children 2 years of age with appropriate immunization status (Influenza)



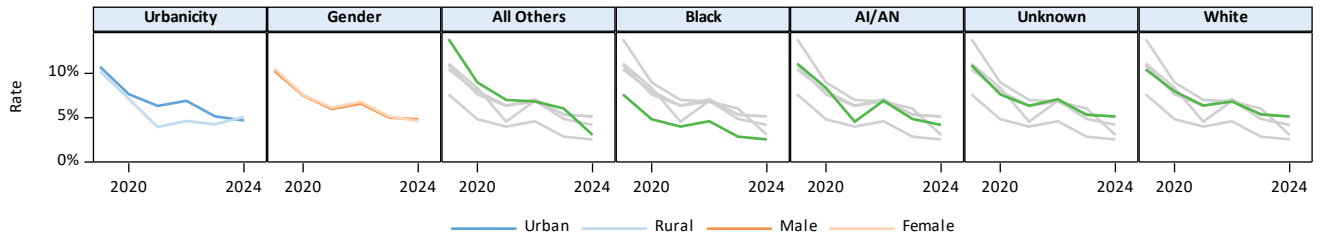
ACC Measure 3-1: Percentage of children 2 years of age with appropriate immunization status (Combination 3)



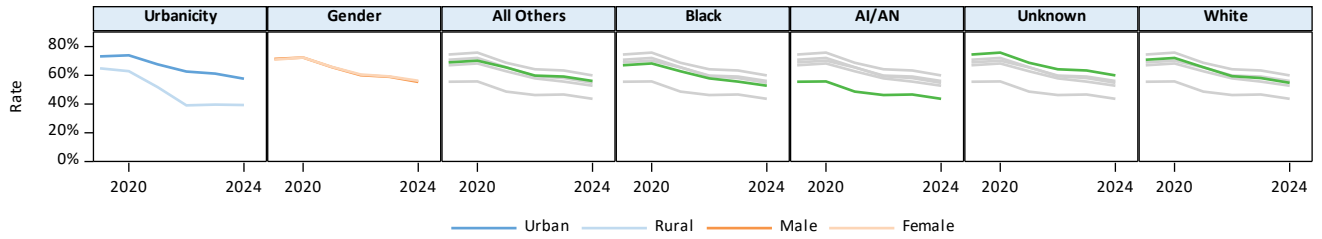
ACC Measure 3-1: Percentage of children 2 years of age with appropriate immunization status (Combination 7)



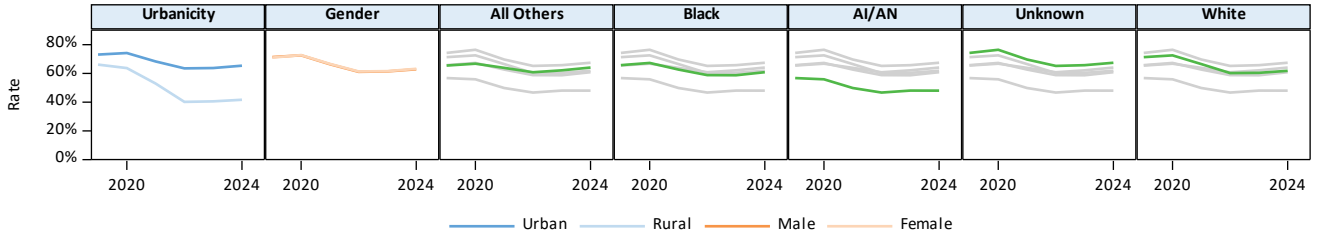
ACC Measure 3-1: Percentage of children 2 years of age with appropriate immunization status (Combination 10)



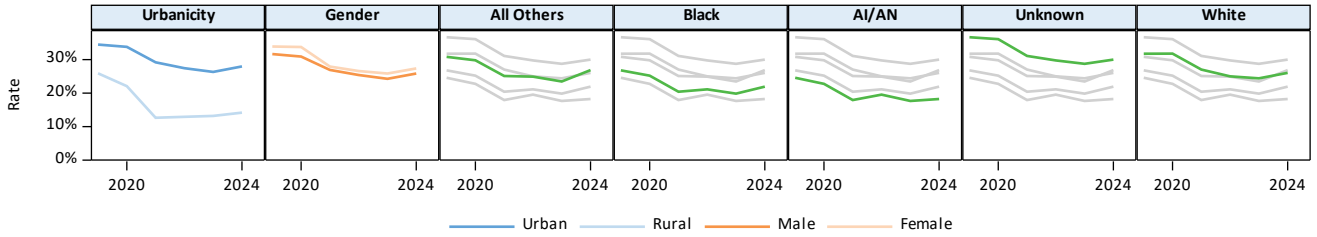
ACC Measure 3-2: Percentage of adolescents 13 years of age with appropriate immunizations (Meningococcal)



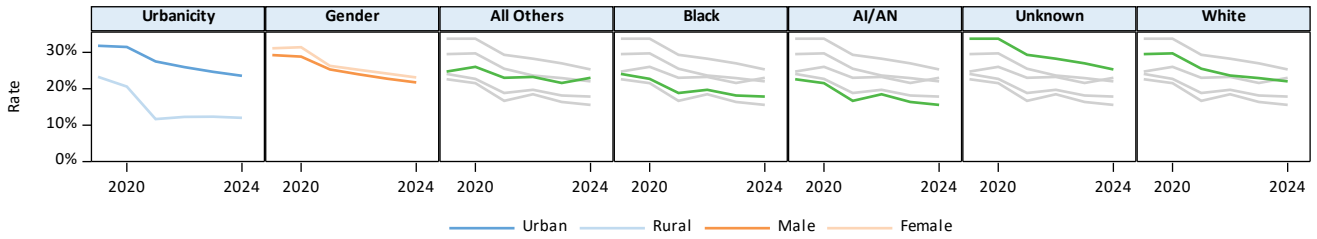
ACC Measure 3-2: Percentage of adolescents 13 years of age with appropriate immunizations (Tdap)



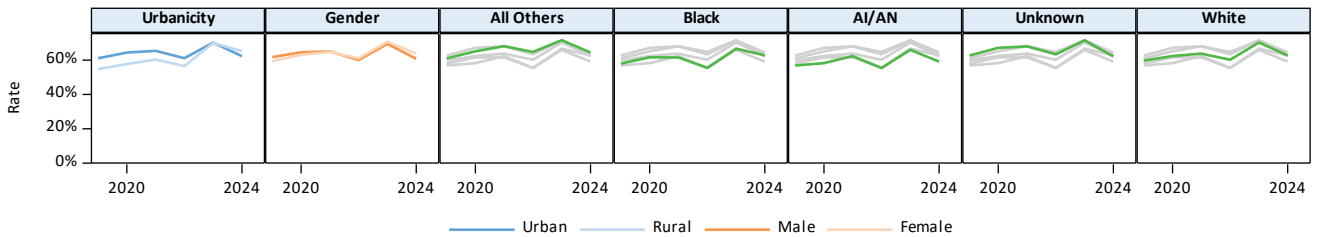
ACC Measure 3-2: Percentage of adolescents 13 years of age with appropriate immunizations (HPV)



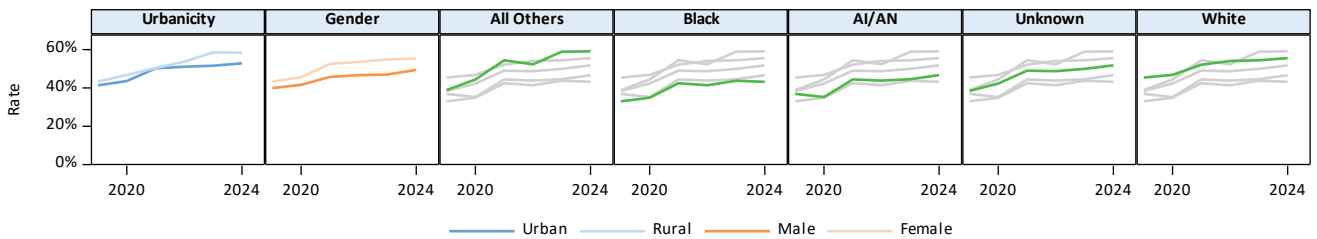
ACC Measure 3-2: Percentage of adolescents 13 years of age with appropriate immunizations (Combination 2: Meningococcal, Tdap, HPV)



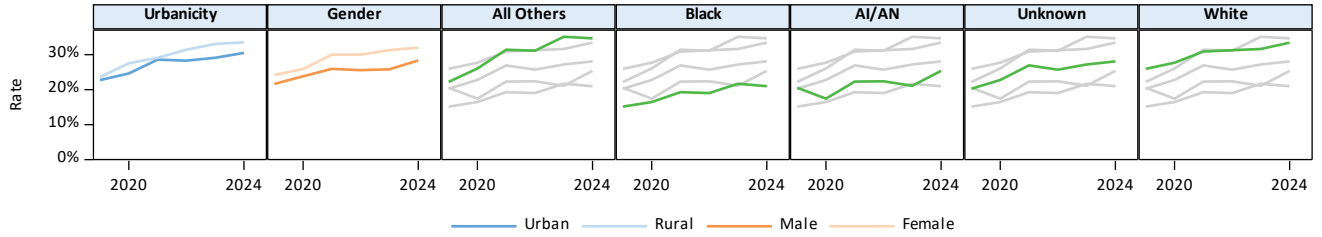
ACC Measure 3-4: Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent



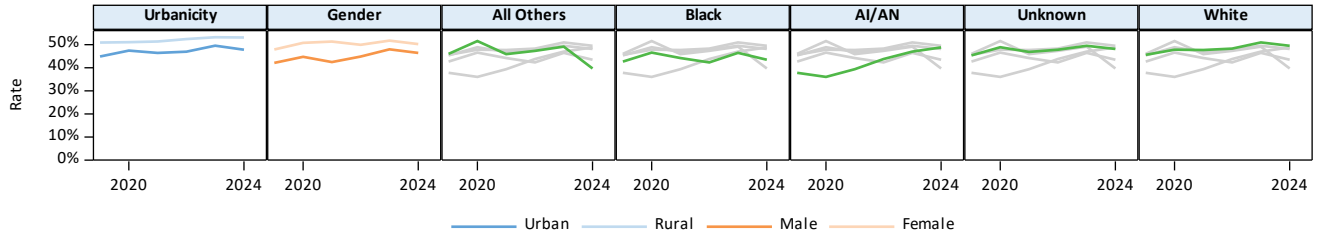
ACC Measure 3-5: Percentage of adult members who remained on an antidepressant medication treatment (84 days)



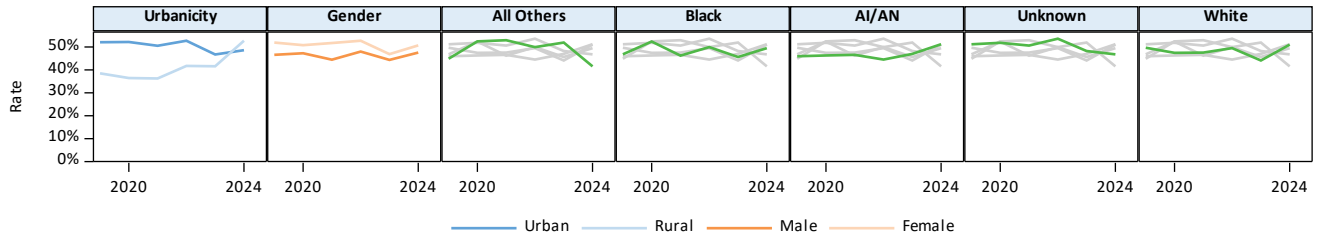
ACC Measure 3-5: Percentage of adult members who remained on an antidepressant medication treatment (180 days)



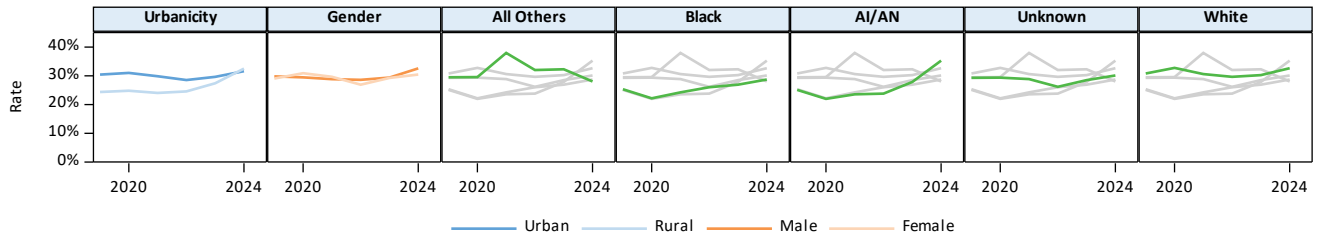
ACC Measure 3-6: Percentage of members with a follow-up visit within 7 days after hospitalization for mental illness



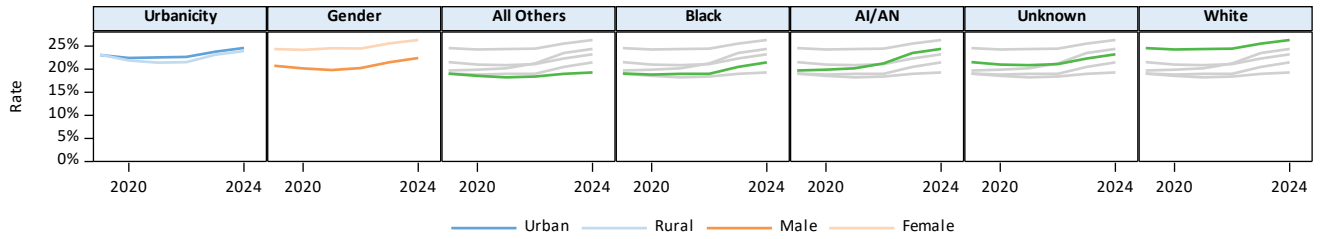
ACC Measure 3-7: Percentage of members with a follow-up visit within 7 days after an ED visit for mental illness



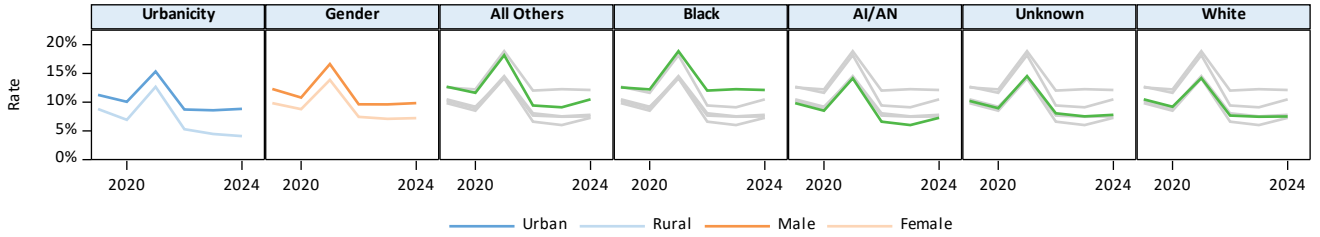
ACC Measure 3-8: Percentage of members with follow-up within 7 days after an ED visit for SUD



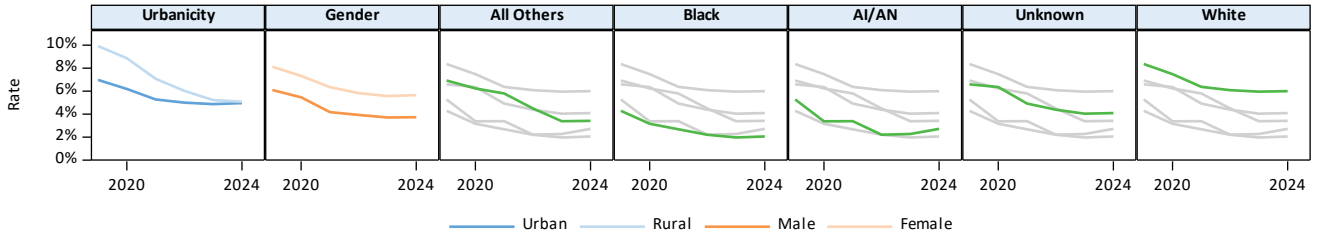
ACC Measure 3-9: Percentage of members diagnosed with a mental health disorder



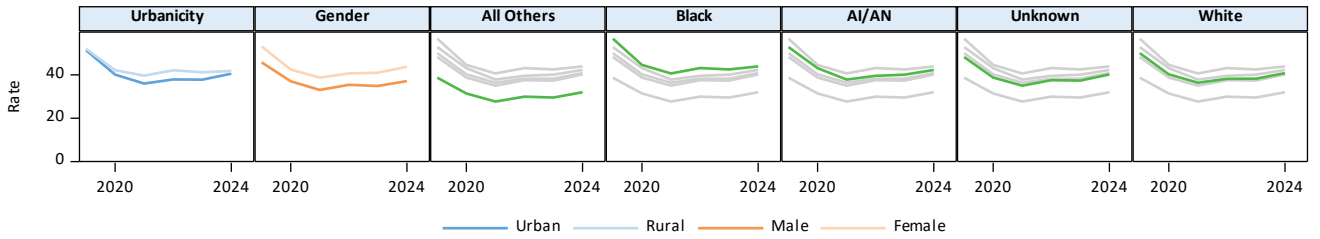
ACC Measure 3-10: Percentage of adult members who have prescriptions for opioids at a high dosage



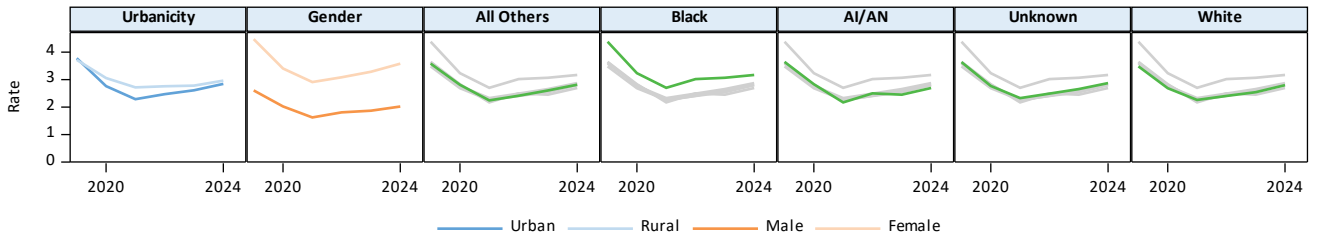
ACC Measure 3-11: Percentage of adult members with concurrent use of opioids and benzodiazepines



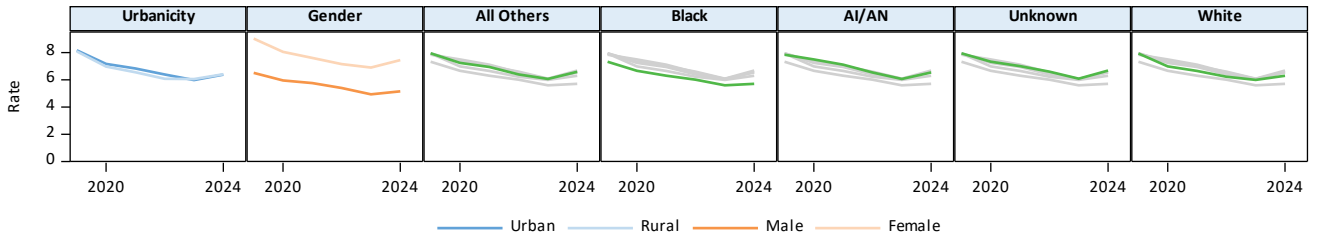
ACC Measure 3-12: Number of emergent ED visits per 1,000 member months



ACC Measure 3-13: Number of non-emergent ED visits per 1,000 member months



ACC Measure 3-14: Number of IP stays per 1,000 member months



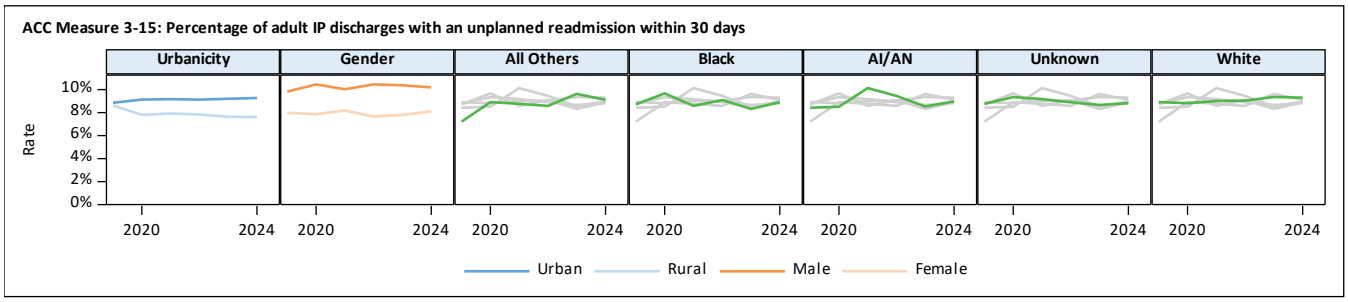


Table A-3—ACC-Adult Per-Member Per-Month (PMPM) Costs (Total)

Variable	Estimate	*p*-value
Intercept	$472.71 ***	<0.001
	(10.404)	
Baseline monthly trend	-$1.34 ***	<0.001
	(0.308)	
Level change at implementation	-$15.59	0.306
	(15.096)	
Change in monthly trend	$3.96 ***	<0.001
	(0.918)	
COVID-19 Lockdown (Q2 2020)	-$39.99 **	0.029
	(17.855)	
COVID-19 (June 2020 - April 2021)	$30.34 **	0.003
	(9.979)	
Seasonality: Q2	-$0.84	0.931
	(9.701)	
Seasonality: Q3	$2.88	0.771
	(9.854)	
Seasonality: Q4	$12.65	0.196
	(9.690)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-4—ACC-Adult PMPM Costs (Professional)

Variable	Estimate	*p*-value
Intercept	$190.96 ***	<0.001
	(3.580)	
Baseline monthly trend	-$0.34 **	0.002
	(0.106)	
Level change at implementation	$2.04	0.696
	(5.194)	
Change in monthly trend	$1.00 **	0.002
	(0.316)	
COVID-19 Lockdown (Q2 2020)	-$20.66 **	0.001
	(6.143)	
COVID-19 (June 2020 - April 2021)	$7.08 **	0.043
	(3.433)	
Seasonality: Q2	-$1.99	0.552
	(3.338)	
Seasonality: Q3	-$0.92	0.788
	(3.390)	
Seasonality: Q4	-$5.36	0.113
	(3.334)	

*p<0.1, **p <0.05, ***p <0.001
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-5—ACC-Adult PMPM Costs (Inpatient [IP])

Variable	Estimate	*p*-value
Intercept	$96.55 ***	<0.001
	(1.766)	
Baseline monthly trend	-$0.45 ***	<0.001
	(0.052)	
Level change at implementation	-$8.85 ***	<0.001
	(2.562)	
Change in monthly trend	$0.86 ***	<0.001
	(0.156)	
COVID-19 Lockdown (Q2 2020)	-$12.48 ***	<0.001
	(3.031)	
COVID-19 (June 2020 - April 2021)	$0.71	0.674
	(1.694)	
Seasonality: Q2	-$1.55	0.351
	(1.647)	
Seasonality: Q3	$2.64	0.119
	(1.673)	
Seasonality: Q4	$1.03	0.534
	(1.645)	

*p<0.1, **p <0.05, ***p <0.001
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-6—ACC-Adult PMPM Costs (Long-Term Care [LTC])

Variable	Estimate	*p*-value
Intercept	$5.56 ***	<0.001
	(0.149)	
Baseline monthly trend	-$0.02 ***	<0.001
	(0.004)	
Level change at implementation	$0.10	0.650
	(0.217)	
Change in monthly trend	$0.04 **	0.006
	(0.013)	
COVID-19 Lockdown (Q2 2020)	-$0.81 **	0.002
	(0.256)	
COVID-19 (June 2020 - April 2021)	-$0.54 ***	<0.001
	(0.143)	
Seasonality: Q2	-$0.33 **	0.020
	(0.139)	
Seasonality: Q3	-$0.12	0.387
	(0.141)	
Seasonality: Q4	-$0.01	0.948
	(0.139)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-7—ACC-Adult PMPM Costs (Outpatient [OP] Emergency Department [ED])

Variable	Estimate	*p*-value
Intercept	$35.83 ***	<0.001
	(0.631)	
Baseline monthly trend	-$0.28 ***	<0.001
	(0.019)	
Level change at implementation	<$0.01	0.997
	(0.915)	
Change in monthly trend	$0.35 ***	<0.001
	(0.056)	
COVID-19 Lockdown (Q2 2020)	-$7.99 ***	<0.001
	(1.082)	
COVID-19 (June 2020 - April 2021)	-$3.91 ***	<0.001
	(0.605)	
Seasonality: Q2	$0.82	0.170
	(0.588)	
Seasonality: Q3	$1.28 **	0.037
	(0.597)	
Seasonality: Q4	-$0.17	0.779
	(0.587)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-8—ACC-Adult PMPM Costs (OP Non-ED)

Variable	Estimate	*p*-value
Intercept	$43.91 ***	<0.001
	(1.014)	
Baseline monthly trend	-$0.14 ***	<0.001
	(0.030)	
Level change at implementation	-$1.92	0.197
	(1.471)	
Change in monthly trend	$0.37 ***	<0.001
	(0.089)	
COVID-19 Lockdown (Q2 2020)	-$10.29 ***	<0.001
	(1.740)	
COVID-19 (June 2020 - April 2021)	-$2.16 **	0.030
	(0.972)	
Seasonality: Q2	$0.56	0.558
	(0.945)	
Seasonality: Q3	-$0.05	0.959
	(0.960)	
Seasonality: Q4	-$0.50	0.601
	(0.944)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-9—ACC-Adult PMPM Costs (Pharmacy)

Variable	Estimate	*p*-value
Intercept	$99.89 ***	<0.001
	(6.456)	
Baseline monthly trend	-$0.12	0.545
	(0.191)	
Level change at implementation	-$6.96	0.460
	(9.367)	
Change in monthly trend	$1.33 **	0.023
	(0.569)	
COVID-19 Lockdown (Q2 2020)	$12.22	0.274
	(11.079)	
COVID-19 (June 2020 - April 2021)	$29.16 ***	<0.001
	(6.192)	
Seasonality: Q2	$1.66	0.783
	(6.020)	
Seasonality: Q3	$0.05	0.994
	(6.115)	
Seasonality: Q4	$17.65 **	0.005
	(6.013)	

*p<0.1, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-10—ACC-Adult Aggregate Costs (Total, in Thousands)

Variable	Estimate	*p*-value
Intercept	$362,666.70 *** *(10930.526)*	<0.001
Baseline monthly trend	$2,565.70 *** *(323.597)*	<0.001
Level change at implementation	-$2,231.60 *(15860.008)*	0.889
Change in monthly trend	-$3,891.90 *** *(964.061)*	<0.001
COVID-19 Lockdown (Q2 2020)	-$62,045.00 ** *(18758.469)*	0.002
COVID-19 (June 2020 - April 2021)	$23,934.20 ** *(10483.789)*	0.026
Seasonality: Q2	$1,038.30 *(10191.982)*	0.919
Seasonality: Q3	-$164.80 *(10352.606)*	0.987
Seasonality: Q4	$8,601.80 *(10180.489)*	0.401

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-11—ACC-Adult Aggregate Costs (Professional, in Thousands)

Variable	Estimate	*p*-value
Intercept	$146,958.30 *** *(3909.579)*	<0.001
Baseline monthly trend	$1,235.60 *** *(115.743)*	<0.001
Level change at implementation	$9,642.70 * *(5672.733)*	0.094
Change in monthly trend	-$2,296.40 *** *(344.821)*	<0.001
COVID-19 Lockdown (Q2 2020)	-$29,691.90 *** *(6709.441)*	<0.001
COVID-19 (June 2020 - April 2021)	$4,294.20 *(3749.793)*	0.256
Seasonality: Q2	-$1,222.60 *(3645.421)*	0.738
Seasonality: Q3	-$2,160.40 *(3702.872)*	0.562
Seasonality: Q4	-$6,758.80 * *(3641.310)*	0.068

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-12—ACC-Adult Aggregate Costs (IP, in Thousands)

Variable	Estimate	*p*-value
Intercept	$74,706.40 ***	<0.001
	(1991.650)	
Baseline monthly trend	$308.30 ***	<0.001
	(58.963)	
Level change at implementation	-$8,637.10 **	0.004
	(2889.850)	
Change in monthly trend	-$536.60 **	0.003
	(175.661)	
COVID-19 Lockdown (Q2 2020)	-$15,582.80 ***	<0.001
	(3417.979)	
COVID-19 (June 2020 - April 2021)	-$0.50	1.000
	(1910.250)	
Seasonality: Q2	-$1,338.90	0.474
	(1857.080)	
Seasonality: Q3	$2,051.30	0.281
	(1886.347)	
Seasonality: Q4	$534.60	0.774
	(1854.986)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-13—ACC-Adult Aggregate Costs (LTC, in Thousands)

Variable	Estimate	*p*-value
Intercept	$4,309.30 ***	<0.001
	(159.750)	
Baseline monthly trend	$27.00 ***	<0.001
	(4.729)	
Level change at implementation	$311.80	0.183
	(231.795)	
Change in monthly trend	-$52.90 ***	<0.001
	(14.090)	
COVID-19 Lockdown (Q2 2020)	-$1,000.80 ***	<0.001
	(274.156)	
COVID-19 (June 2020 - April 2021)	-$561.90 ***	<0.001
	(153.221)	
Seasonality: Q2	-$294.90 *	0.052
	(148.956)	
Seasonality: Q3	-$133.30	0.382
	(151.304)	
Seasonality: Q4	-$37.40	0.802
	(148.788)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-14—ACC-Adult Aggregate Costs (OP ED, in Thousands)

Variable	Estimate	*p*-value
Intercept	$27,841.40 ***	<0.001
	(605.717)	
Baseline monthly trend	-$10.00	0.579
	(17.932)	
Level change at implementation	$262.40	0.766
	(878.885)	
Change in monthly trend	-$132.50 **	0.016
	(53.424)	
COVID-19 Lockdown (Q2 2020)	-$8,423.50 ***	<0.001
	(1039.504)	
COVID-19 (June 2020 - April 2021)	-$3,668.00 ***	<0.001
	(580.961)	
Seasonality: Q2	$1,044.10 *	0.069
	(564.790)	
Seasonality: Q3	$1,192.80 **	0.042
	(573.691)	
Seasonality: Q4	-$225.50	0.691
	(564.154)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-15—ACC-Adult Aggregate Costs (OP Non-ED, in Thousands)

Variable	Estimate	*p*-value
Intercept	$33,827.10 ***	<0.001
	(1029.742)	
Baseline monthly trend	$221.50 ***	<0.001
	(30.485)	
Level change at implementation	-$1,027.10	0.494
	(1494.137)	
Change in monthly trend	-$338.90 ***	<0.001
	(90.822)	
COVID-19 Lockdown (Q2 2020)	-$11,415.80 ***	<0.001
	(1767.195)	
COVID-19 (June 2020 - April 2021)	-$2,507.50 **	0.014
	(987.655)	
Seasonality: Q2	$675.80	0.484
	(960.165)	
Seasonality: Q3	-$434.70	0.657
	(975.297)	
Seasonality: Q4	-$934.20	0.334
	(959.082)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-16—ACC-Adult Aggregate Costs (Pharmacy, in Thousands)

Variable	Estimate	*p*-value
Intercept	$75,024.20 ***	<0.001
	(6320.055)	
Baseline monthly trend	$783.30 ***	<0.001
	(187.105)	
Level change at implementation	-$2,784.30	0.762
	(9170.293)	
Change in monthly trend	-$534.50	0.341
	(557.422)	
COVID-19 Lockdown (Q2 2020)	$4,069.80	0.709
	(10846.189)	
COVID-19 (June 2020 - April 2021)	$26,378.00 ***	<0.001
	(6061.751)	
Seasonality: Q2	$2,174.70	0.713
	(5893.028)	
Seasonality: Q3	-$680.60	0.910
	(5985.901)	
Seasonality: Q4	$16,023.10 **	0.008
	(5886.382)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-17—ACC-Child PMPM Costs (Total)

Variable	Estimate	*p*-value
Intercept	$210.56 ***	<0.001
	(4.560)	
Baseline monthly trend	-$0.28 **	0.043
	(0.135)	
Level change at implementation	$6.40	0.337
	(6.617)	
Change in monthly trend	$1.64 ***	<0.001
	(0.402)	
COVID-19 Lockdown (Q2 2020)	-$44.12 ***	<0.001
	(7.826)	
COVID-19 (June 2020 - April 2021)	-$19.97 ***	<0.001
	(4.374)	
Seasonality: Q2	-$15.66 ***	<0.001
	(4.252)	
Seasonality: Q3	-$15.36 ***	<0.001
	(4.319)	
Seasonality: Q4	-$2.84	0.506
	(4.247)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-18—ACC-Child PMPM Costs (Professional)

Variable	Estimate	*p*-value
Intercept	$100.62 ***	<0.001
	(2.206)	
Baseline monthly trend	<$0.01	0.951
	(0.065)	
Level change at implementation	$4.62	0.154
	(3.201)	
Change in monthly trend	$0.79 ***	<0.001
	(0.195)	
COVID-19 Lockdown (Q2 2020)	-$24.89 ***	<0.001
	(3.786)	
COVID-19 (June 2020 - April 2021)	-$8.24 ***	<0.001
	(2.116)	
Seasonality: Q2	-$6.37 **	0.003
	(2.057)	
Seasonality: Q3	-$5.39 **	0.012
	(2.089)	
Seasonality: Q4	-$3.75 *	0.073
	(2.054)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-19—ACC-Child PMPM Costs (IP)

Variable	Estimate	*p*-value
Intercept	$50.33 ***	<0.001
	(1.587)	
Baseline monthly trend	-$0.19 ***	<0.001
	(0.047)	
Level change at implementation	$3.13	0.179
	(2.302)	
Change in monthly trend	$0.26 *	0.070
	(0.140)	
COVID-19 Lockdown (Q2 2020)	-$7.31 **	0.009
	(2.723)	
COVID-19 (June 2020 - April 2021)	-$7.87 ***	<0.001
	(1.522)	
Seasonality: Q2	-$5.82 ***	<0.001
	(1.479)	
Seasonality: Q3	-$4.99 **	0.002
	(1.503)	
Seasonality: Q4	-$1.81	0.226
	(1.478)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-20—ACC-Child PMPM Costs (LTC)

Variable	Estimate	*p*-value
Intercept	$0.01	0.426
	(0.018)	
Baseline monthly trend	>-$0.01	0.549
	(0.001)	
Level change at implementation	$0.04	0.178
	(0.026)	
Change in monthly trend	>-$0.01	0.441
	(0.002)	
COVID-19 Lockdown (Q2 2020)	-$0.01	0.748
	(0.031)	
COVID-19 (June 2020 - April 2021)	-$0.01	0.496
	(0.017)	
Seasonality: Q2	$0.02	0.225
	(0.017)	
Seasonality: Q3	$0.01	0.674
	(0.017)	
Seasonality: Q4	>-$0.01	0.952
	(0.017)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-21—ACC-Child PMPM Costs (OP ED)

Variable	Estimate	*p*-value
Intercept	$16.83 ***	<0.001
	(0.664)	
Baseline monthly trend	-$0.07 ***	<0.001
	(0.020)	
Level change at implementation	$0.50	0.609
	(0.963)	
Change in monthly trend	$0.16 **	0.009
	(0.059)	
COVID-19 Lockdown (Q2 2020)	-$6.58 ***	<0.001
	(1.139)	
COVID-19 (June 2020 - April 2021)	-$5.33 ***	<0.001
	(0.637)	
Seasonality: Q2	-$1.59 **	0.013
	(0.619)	
Seasonality: Q3	-$2.20 ***	<0.001
	(0.629)	
Seasonality: Q4	$0.01	0.993
	(0.618)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-22—ACC-Child PMPM Costs (OP Non-ED)

Variable	Estimate	*p*-value
Intercept	$14.97 ***	<0.001
	(0.529)	
Baseline monthly trend	-$0.01	0.435
	(0.016)	
Level change at implementation	$1.90 **	0.016
	(0.768)	
Change in monthly trend	$0.04	0.409
	(0.047)	
COVID-19 Lockdown (Q2 2020)	-$6.01 ***	<0.001
	(0.908)	
COVID-19 (June 2020 - April 2021)	-$2.33 ***	<0.001
	(0.507)	
Seasonality: Q2	-$0.37	0.455
	(0.493)	
Seasonality: Q3	-$1.14 **	0.027
	(0.501)	
Seasonality: Q4	-$1.65 **	0.001
	(0.493)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-23—ACC-Child PMPM Costs (Pharmacy)

Variable	Estimate	*p*-value
Intercept	$27.79 ***	<0.001
	(1.683)	
Baseline monthly trend	-$0.01	0.794
	(0.050)	
Level change at implementation	-$3.78	0.127
	(2.443)	
Change in monthly trend	$0.40 **	0.010
	(0.148)	
COVID-19 Lockdown (Q2 2020)	$0.67	0.816
	(2.889)	
COVID-19 (June 2020 - April 2021)	$3.81 **	0.022
	(1.615)	
Seasonality: Q2	-$1.53	0.334
	(1.570)	
Seasonality: Q3	-$1.66	0.302
	(1.594)	
Seasonality: Q4	$4.36 **	0.007
	(1.568)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-24—ACC-Child Aggregate Costs (Total, in Thousands)

Variable	Estimate	*p*-value
Intercept	$135,271.80 ***	<0.001
	(3245.246)	
Baseline monthly trend	$227.70 **	0.021
	(96.075)	
Level change at implementation	$5,946.70	0.211
	(4708.797)	
Change in monthly trend	-$264.10	0.360
	(286.227)	
COVID-19 Lockdown (Q2 2020)	-$33,818.00 ***	<0.001
	(5569.343)	
COVID-19 (June 2020 - April 2021)	-$13,782.20 ***	<0.001
	(3112.611)	
Seasonality: Q2	-$9,756.80 **	0.002
	(3025.974)	
Seasonality: Q3	-$9,776.70 **	0.002
	(3073.663)	
Seasonality: Q4	-$1,966.40	0.518
	(3022.562)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-25—ACC-Child Aggregate Costs (Professional, in Thousands)

Variable	Estimate	*p*-value
Intercept	$64,646.80 ***	<0.001
	(1603.953)	
Baseline monthly trend	$210.90 ***	<0.001
	(47.485)	
Level change at implementation	$4,080.30 *	0.084
	(2327.309)	
Change in monthly trend	-$168.20	0.239
	(141.467)	
COVID-19 Lockdown (Q2 2020)	-$18,858.60 ***	<0.001
	(2752.631)	
COVID-19 (June 2020 - April 2021)	-$5,784.20 ***	<0.001
	(1538.399)	
Seasonality: Q2	-$3,934.80 **	0.011
	(1495.579)	
Seasonality: Q3	-$3,413.90 **	0.028
	(1519.149)	
Seasonality: Q4	-$2,720.70 *	0.073
	(1493.892)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-26—ACC-Child Aggregate Costs (IP, in Thousands)

Variable	Estimate	*p*-value
Intercept	$32,408.30 ***	<0.001
	(1098.784)	
Baseline monthly trend	-$38.30	0.244
	(32.529)	
Level change at implementation	$2,466.10	0.127
	(1594.316)	
Change in monthly trend	-$114.40	0.242
	(96.912)	
COVID-19 Lockdown (Q2 2020)	-$5,763.60 **	0.003
	(1885.682)	
COVID-19 (June 2020 - April 2021)	-$5,364.80 ***	<0.001
	(1053.876)	
Seasonality: Q2	-$3,759.10 ***	<0.001
	(1024.542)	
Seasonality: Q3	-$3,158.20 **	0.003
	(1040.689)	
Seasonality: Q4	-$1,138.10	0.270
	(1023.387)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-27—ACC-Child Aggregate Costs (LTC, in Thousands)

Variable	Estimate	*p*-value
Intercept	$9.00	0.496
	(13.108)	
Baseline monthly trend	-$0.20	0.598
	(0.388)	
Level change at implementation	$26.10	0.176
	(19.020)	
Change in monthly trend	-$1.00	0.410
	(1.156)	
COVID-19 Lockdown (Q2 2020)	-$7.50	0.739
	(22.495)	
COVID-19 (June 2020 - April 2021)	-$7.90	0.530
	(12.572)	
Seasonality: Q2	$15.50	0.209
	(12.222)	
Seasonality: Q3	$5.20	0.674
	(12.415)	
Seasonality: Q4	-$0.60	0.962
	(12.209)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-28—ACC-Child Aggregate Costs (OP ED, in Thousands)

Variable	Estimate	*p*-value
Intercept	$10,836.10 ***	<0.001
	(454.797)	
Baseline monthly trend	-$17.40	0.201
	(13.464)	
Level change at implementation	$462.50	0.486
	(659.903)	
Change in monthly trend	$11.20	0.782
	(40.113)	
COVID-19 Lockdown (Q2 2020)	-$4,650.00 ***	<0.001
	(780.502)	
COVID-19 (June 2020 - April 2021)	-$3,651.00 ***	<0.001
	(436.209)	
Seasonality: Q2	-$985.60 **	0.023
	(424.068)	
Seasonality: Q3	-$1,407.80 **	0.002
	(430.751)	
Seasonality: Q4	$25.50	0.952
	(423.590)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-29—ACC-Child Aggregate Costs (OP Non-ED, in Thousands)

Variable	Estimate	*p*-value
Intercept	$9,622.10 ***	<0.001
	(360.718)	
Baseline monthly trend	$22.00 **	0.044
	(10.679)	
Level change at implementation	$1,448.30 **	0.007
	(523.395)	
Change in monthly trend	-$76.60 **	0.019
	(31.815)	
COVID-19 Lockdown (Q2 2020)	-$4,325.90 ***	<0.001
	(619.047)	
COVID-19 (June 2020 - April 2021)	-$1,623.00 ***	<0.001
	(345.975)	
Seasonality: Q2	-$193.70	0.567
	(336.345)	
Seasonality: Q3	-$745.00 **	0.033
	(341.646)	
Seasonality: Q4	-$1,159.10 **	0.001
	(335.966)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-30—ACC-Child Aggregate Costs (Pharmacy, in Thousands)

Variable	Estimate	*p*-value
Intercept	$17,749.50 ***	<0.001
	(1175.751)	
Baseline monthly trend	$50.70	0.150
	(34.808)	
Level change at implementation	-$2,536.60	0.142
	(1705.994)	
Change in monthly trend	$85.00	0.416
	(103.700)	
COVID-19 Lockdown (Q2 2020)	-$212.40	0.917
	(2017.769)	
COVID-19 (June 2020 - April 2021)	$2,648.70 **	0.022
	(1127.697)	
Seasonality: Q2	-$899.10	0.415
	(1096.309)	
Seasonality: Q3	-$1,057.10	0.346
	(1113.586)	
Seasonality: Q4	$3,026.60 **	0.007
	(1095.072)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Qualitative Results

Plans

Four ACC plans shared robust care coordination and management programs to support members' health and well-being and promote the integration of physical health (PH) and behavioral health (BH) care. Plans wholistically assessed members and worked with care management staff to ensure that member needs were met. Care managers evaluated members' health status, assessed health-related social needs (HRSN) and social determinants of health (SDOH), assisted with scheduling appointments, coordinated among providers, set goals and intervention plans, referred members to community-based organizations (CBOs), provided education, and coordinated transitions of care. In addition to care coordination initiatives available to the general ACC population, plans implemented strategies targeted at specific groups, such as members who were:

- American Indian/Alaska Native (AI/AN)
- Receiving BH services or had BH conditions, including serious mental illness (SMI) or substance use disorder (SUD)
- Justice-involved
- Between settings of care
- Veterans
- Pregnant or postpartum
- High-need, high-use

Plans reported that data use was essential for successful care coordination, as it allowed plans to identify members who required additional support. Plans' use of data in care coordination processes included:

- Providing member enrollment and transition information for transfers between plans.
  - One plan shared that it automated incoming forms to identify health risks and ensure needs were addressed.
- Utilizing the health information exchange (HIE) to ensure stakeholders had access to up-to-date member information and to identify community resources to address member needs.
- Receiving real-time data from providers to identify members in crisis.

Plans shared that collaboration with external stakeholders was instrumental in operating successful care coordination activities, as it decreased fragmentation and enhanced Arizona's integrated system of care. Collaboration efforts described by plans are described in Table A-31.

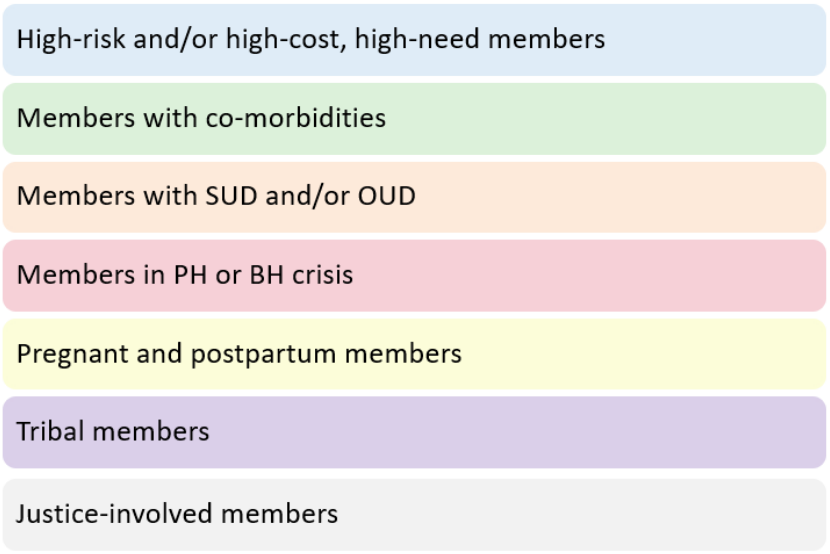
Table A-31—Collaboration with External Stakeholders

Organization Type	Stakeholder Description
CBOs	• To effectively coordinate members' care, plans collaborated with CBOs including: – Non-profit and/or religious organizations. – Organizations that assisted in member outreach and engagement efforts. – Organizations targeted at specific populations, including members with SUD or complex wounds. – Organizations targeted at HRSNs to ensure whole-person care, including family support, food support, housing assistance, veteran assistance, and organizations support education and workforce participation.
Providers	• Plans met with providers to discuss specific members, leveraging provider relationships to enhance coordination efforts. • Plans incentivized providers to engage hard-to-reach members through value-based programs. • Plans shared data with provider organizations to ensure all stakeholders had access to updated member information.
Government departments	• Plans collaborated with government entities, including: – AHCCCS to solve challenges, support continued learning and development, and improve quality of care. – ADHS to improve data sharing and baseline MOUD treatment. – The justice and court system to coordinate care for members reentering the community.
Other plans	• One plan reported Health Plan Association meetings, where senior plan staff met, brainstormed problem solving, and shared ideas. • Plans attended AHCCCS-led MCO meetings to ensure cross-plan collaboration.

Note: ADHS: Arizona Department of Health Services; AHCCCS: Arizona Health Care Cost Containment System; CBO: community-based organization; HRSN: health-related social needs; MCO: managed care organization; MOUD: medications for opioid use disorder; SUD: substance use disorder

The member populations reported by plans to benefit most from care coordination strategies are presented in Figure A-1. These benefits were largely attributed to care coordination efforts and initiatives targeted at these specific populations.

Figure A-1—Member Populations



Note: BH: behavioral health; OUD: opioid use disorder; PH: physical health; SUD: substance use disorder.

Plans shared a variety of barriers to successful care coordination. Multiple plans noted that the geographic diversity of Arizona posed a challenge, as members in rural areas faced unique barriers to accessing care. To address this, one plan hosted a Network Advisory Committee and invited provider groups from different regions to share region-specific feedback. Another plan developed initiatives to improve care for members in primary care deserts, such as expanding telehealth, contracting with in-home services, improving non-emergency medical transportation (NEMT), and establishing physical clinics.

Workforce shortages led to some provider organizations lacking sufficient resources and staffing to focus on member engagement and coordination. Additionally, plans reported difficulty obtaining and maintaining accurate member contact information needed for outreach and engagement. To address this, plans implemented innovative strategies to gather contact information, such as using pharmacy data, reaching out to providers, and engaging directly with members in the community. Outreach efforts were further complicated by government restrictions in 2022, including the Telephone Consumer Protection Act, that limited the frequency and methods of outreach, as well as new mobile phone blocking technologies that prevented calls from reaching members.[1]

Additional barriers described by plans included:

- BH and PH care integration hindered effective care coordination. One plan noted that some BH health homes (HHs) struggled to provide PH services, and that members encountered difficulties coordinating between PH and BH providers.
- Changes in policy and requirements following integration were often unclear and/or added administrative burden for providers.
- Social barriers, including health literacy, member priorities, and cultural factors, impacted member engagement.

[1] Federal Communications Commission. Telephone Consumer Protection Act 47 U.S.C. § 227. Available at: https://www.fcc.gov/sites/default/files/tcpa-rules.pdf. Accessed on: Mar 27, 2026.

Plans continued to welcome feedback and recommendations from members and providers. One plan highlighting its annual population assessment, which identified characteristics and needs of its member population, as a successful strategy to drive decision-making and improve care coordination.

Providers

Five ACC providers reported their care coordination strategies to manage ACC members' PH and BH care. According to providers, members with SUD, pregnant and postpartum members, and adults with BH challenges benefited the most from the additional resources available through care coordination, such as:

- Coordination between members, plans, family support, and other providers, including scheduling appointments; managing intake and referrals; conducting home visits; providing SDOH, BH, and/or needs assessments; connecting members to primary care; educating members to reduce hospitalization and ED utilization; addressing SDOH needs; and training internal staff on care coordination.
- Support staff dedicated to care coordination, such as care managers, recovery coaches, population health managers, integrated health coordinators, and engagement specialists.
- Contracts with the Department of Child Safety (DCS) to engage with and coordinate care for DCS-involved families with suspected SUD.
- PH and BH services in one location and the use of BH assessments during primary care appointments to promote integrated care.

Providers leveraged data and technology to enhance care coordination. One provider developed an algorithm to identify gaps in care, while another utilized member data to determine where and when members were seen. Other providers employed patient portals that allowed members to communicate with providers, ask questions, and receive updates about their care. Providers also used text messaging, email, and in-office advertisements to share information about vaccinations, wellness reminders, and integrated care.

Barriers to successful care coordination cited by providers included:

- Challenges with timely and accurate exchange of member data, complicated by an inefficient HIE and the need to access multiple sources (e.g., several portals) to gather complete member information.
- Plan preauthorization requirements that hindered timely access to the appropriate levels of care. Providers reported expending internal resources to appeal denials.
- Workforce shortages that created difficulties meeting caseload ratios and peer support mandates.
- Challenges with coordinating with external stakeholders.
  - ACC care coordination requirements were not as strong as ACC-Regional Behavioral Health Agreement (ACC-RBHA) requirements. As a result, providers did not receive sufficient notification about changes in ACC members' care to effectively coordinate care.
    - One provider noted that the availability of care coordination for ACC members improved during the Waiver, despite the lack of contractual obligations to do so.
  - Inefficient hospital discharges coordination, with members sometimes leaving the hospital without discharge instructions when the provider organizations were closed and unable to assist in care transitions.
- Billing changes implemented in October 2024 that prevented providers from billing case management services lasting less than eight minutes and limited outreach billing to once per day for care coordination. Providers reported these changes negatively impacted their workflow, billing, and training processes.

ACC-RBHA

This section provides the supplemental quantitative and qualitative results for ACC-RBHA.

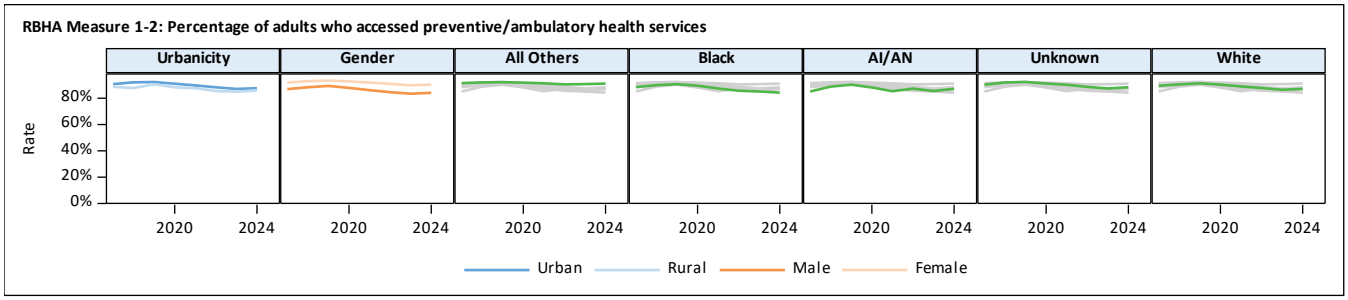
Quantitative

Table A-32—ACC-RBHA Supplemental Results

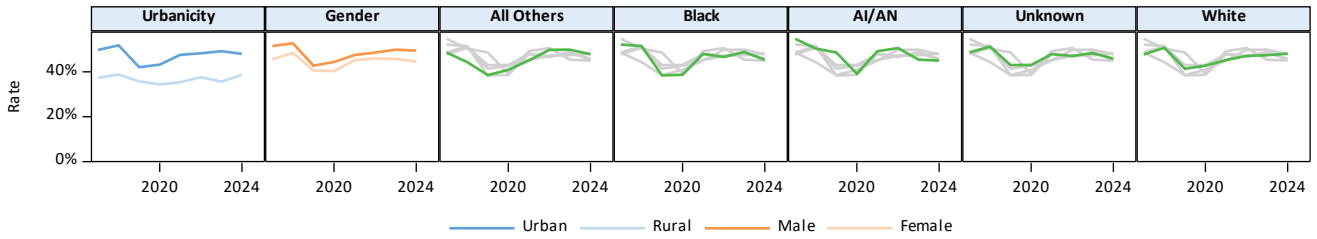
Time	BH OP, Adult	BH Residential Facility	Cardiologist, Adult	Cardiologist, Pediatric	Crisis Stabilization Facility	Dentist, Pediatric	Hospital	OB/GYN	PCP, Adult	PCP, Pediatric	Pharmacy
Q1 2019	97.7% N=41,677	97.3% N=32,490	99.8% N=40,899	100.0% N=782	98.3% N=41,681	99.0% N=782	99.8% N=41,681	99.8% N=10,252	99.8% N=40,899	100.0% N=782	99.0% N=41,681
Q2 2019	98.4% N=42,031	97.8% N=32,760	99.9% N=41,247	100.0% N=788	98.7% N=42,035	99.4% N=788	99.9% N=42,035	99.9% N=10,337	99.8% N=41,247	100.0% N=788	99.0% N=42,035
Q3 2019	98.6% N=41,871	97.8% N=32,556	99.8% N=41,070	100.0% N=804	99.0% N=41,874	97.8% N=804	99.9% N=41,874	99.9% N=10,204	99.9% N=41,070	100.0% N=804	99.2% N=41,874
Q4 2019	98.5% N=47,686	97.9% N=32,458	99.8% N=46,809	100.0% N=880	99.0% N=47,689	97.5% N=880	99.9% N=47,689	99.9% N=11,496	99.9% N=46,809	100.0% N=880	99.2% N=47,689
Q1 2020	98.8% N=47,778	97.9% N=32,595	99.8% N=46,919	100.0% N=860	99.3% N=47,779	96.5% N=860	99.9% N=47,779	99.9% N=11,414	99.8% N=46,919	99.9% N=860	99.2% N=47,779
Q2 2020	98.9% N=42,771	98.0% N=33,297	99.8% N=41,963	99.9% N=808	99.4% N=42,771	96.7% N=808	99.9% N=42,771	99.9% N=10,334	99.8% N=41,963	99.9% N=808	99.3% N=42,771
Q3 2020	98.8% N=44,110	98.1% N=34,439	99.8% N=43,260	99.9% N=850	99.3% N=44,110	96.6% N=850	99.9% N=44,110	99.9% N=10,682	99.8% N=43,260	99.9% N=850	99.3% N=44,110
Q2 2021	98.8% N=46,521	98.3% N=36,468	99.8% N=45,617	100.0% N=905	99.1% N=46,522	97.3% N=905	99.9% N=46,522	99.9% N=11,289	99.7% N=45,617	99.8% N=905	99.2% N=46,522
Q4 2021	98.9% N=47,689	98.4% N=37,515	99.8% N=46,773	99.9% N=916	99.2% N=47,689	97.2% N=916	99.9% N=47,689	99.9% N=11,539	99.7% N=46,773	99.8% N=916	99.2% N=47,689
Q2 2022	99.0% N=48,460	98.3% N=38,127	99.8% N=47,557	100.0% N=903	99.2% N=48,460	97.1% N=903	99.9% N=48,460	99.9% N=11,648	99.8% N=47,557	99.8% N=903	99.2% N=48,460
Q4 2022	99.0% N=43,589	98.3% N=34,407	99.8% N=42,778	99.9% N=812	99.2% N=43,590	98.4% N=812	99.9% N=43,590	100.0% N=10,489	99.8% N=42,778	99.9% N=812	99.2% N=43,590
Q2 2023	99.0% N=49,788	98.3% N=39,272	99.8% N=48,911	99.9% N=882	99.1% N=49,793	97.6% N=882	99.9% N=49,793	99.9% N=11,775	99.7% N=48,911	99.7% N=882	99.1% N=49,793
Q4 2023	99.4% N=46,580	98.5% N=36,798	99.8% N=45,760	100.0% N=820	99.4% N=46,580	99.1% N=820	99.9% N=46,580	99.9% N=10,965	99.8% N=45,760	99.8% N=820	99.2% N=46,580
Q2 2024	99.6% N=45,772	98.4% N=36,203	99.8% N=44,933	100.0% N=839	99.4% N=45,772	99.5% N=839	99.9% N=45,772	99.9% N=10,790	99.8% N=44,933	99.8% N=839	99.2% N=45,772
Q4 2024	99.2% N=45,690	98.1% N=35,936	99.7% N=44,798	100.0% N=892	99.0% N=45,690	99.3% N=892	99.9% N=45,690	99.9% N=10,814	99.8% N=44,798	99.8% N=892	99.3% N=45,690

Note: BH: behavioral health; OB/GYN: obstetrics and gynecology; OP: outpatient; PCP: primary care provider; Q: quarter.

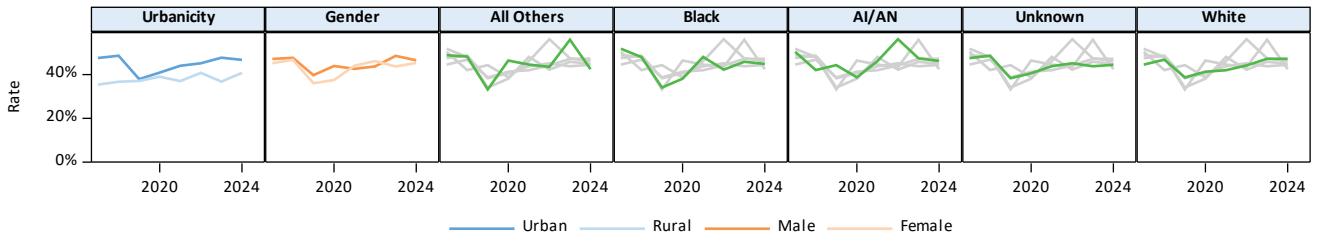
Table A-33—ACC-RBHA Demographics



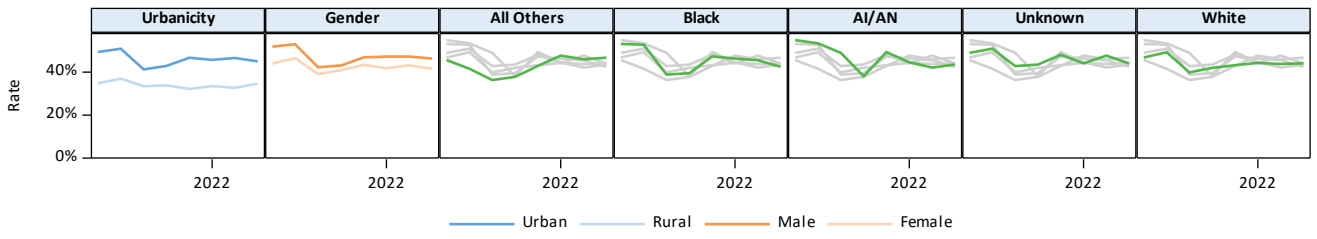
RBHA Measure 1-6: Percentage of members who had initiation of alcohol and other drug abuse dependence treatment (Total)



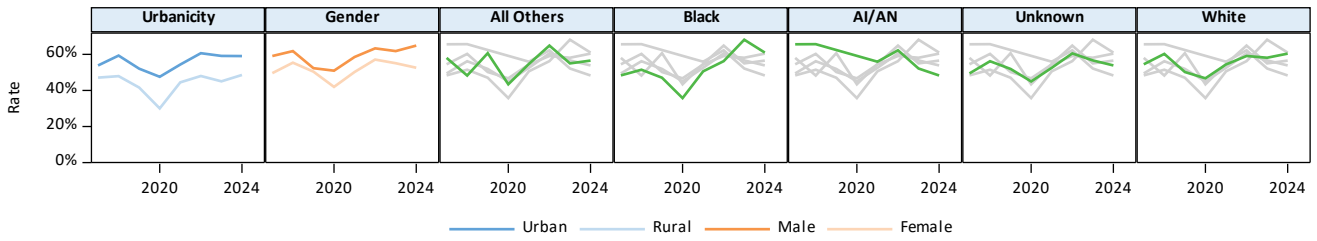
RBHA Measure 1-6: Percentage of members who had initiation of alcohol and other drug abuse dependence treatment (Alcohol)



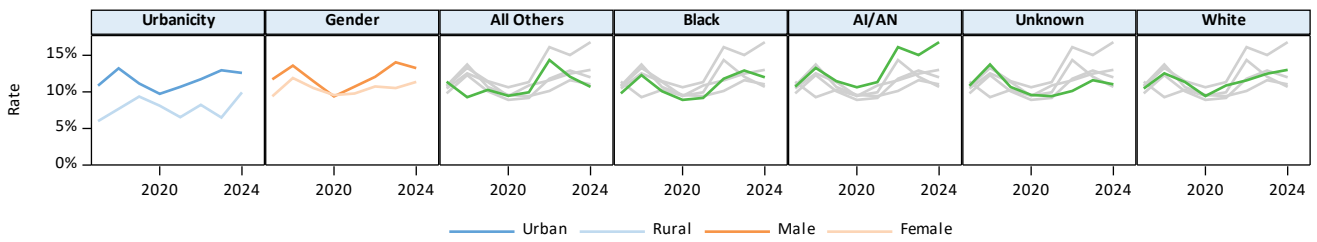
RBHA Measure 1-6: Percentage of members who had initiation of alcohol and other drug abuse dependence treatment (Other Drug)



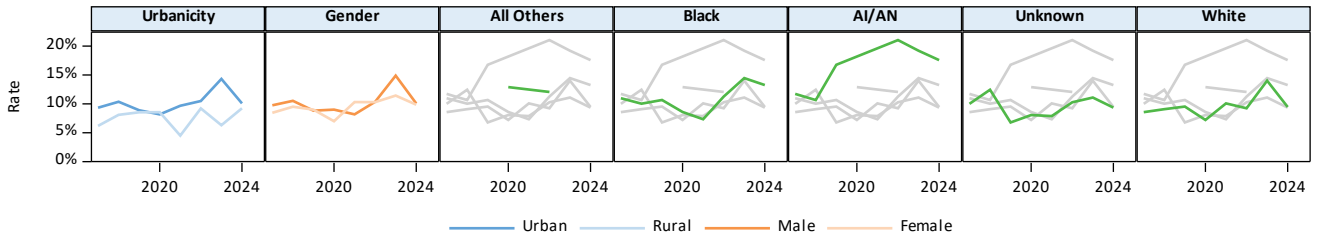
RBHA Measure 1-6: Percentage of members who had initiation of alcohol and other drug abuse dependence treatment (Opioid)



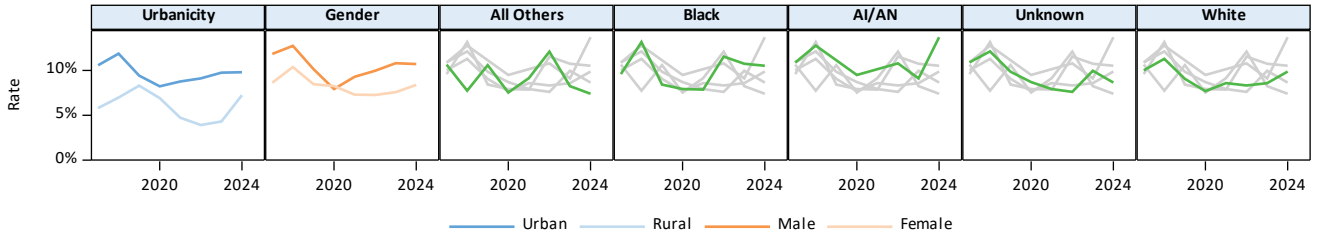
RBHA Measure 1-7: Percentage of members who had engagement of alcohol and other drug abuse dependence treatment (Total)



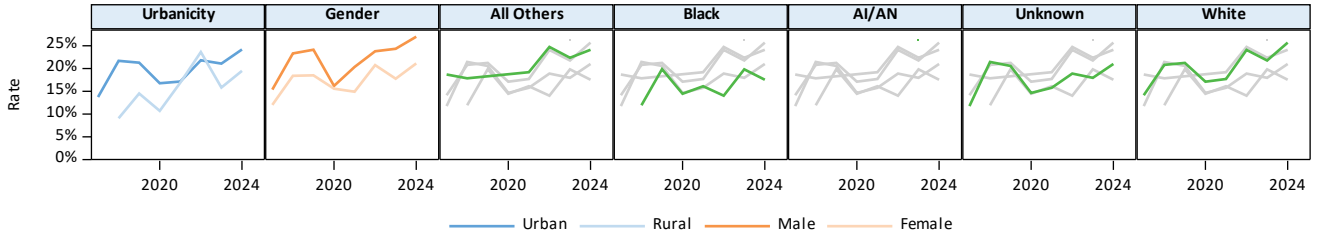
RBHA Measure 1-7: Percentage of members who had engagement of alcohol and other drug abuse dependence treatment (Alcohol)



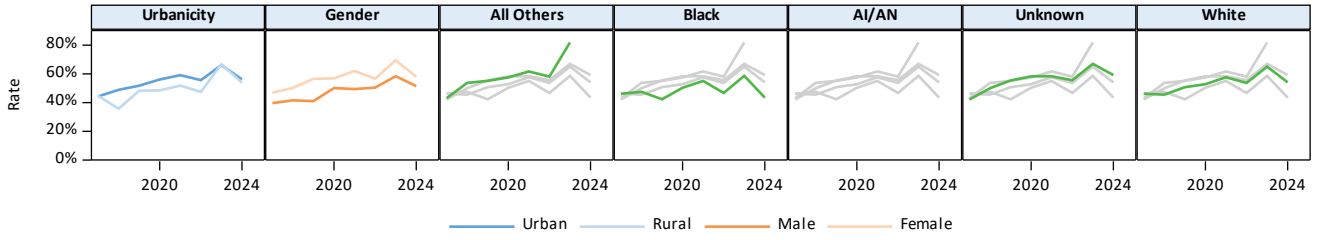
RBHA Measure 1-7: Percentage of members who had engagement of alcohol and other drug abuse dependence treatment (Other Drug)



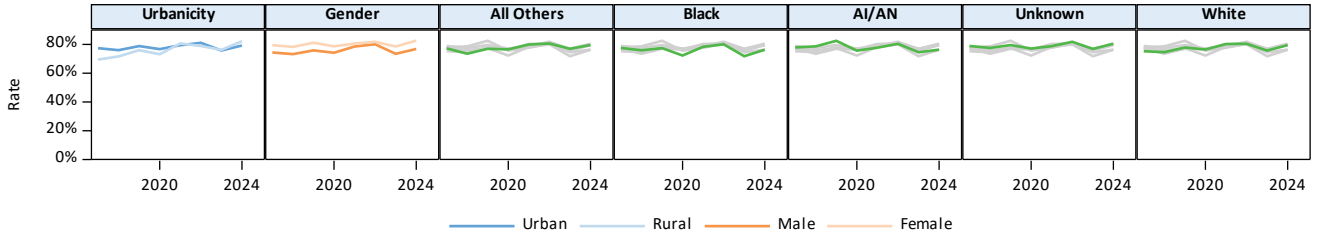
RBHA Measure 1-7: Percentage of members who had engagement of alcohol and other drug abuse dependence treatment (Opioid)



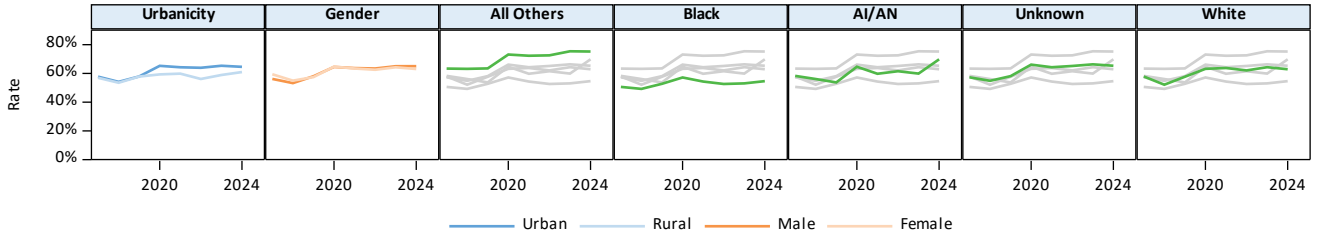
RBHA Measure 2-2: Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent



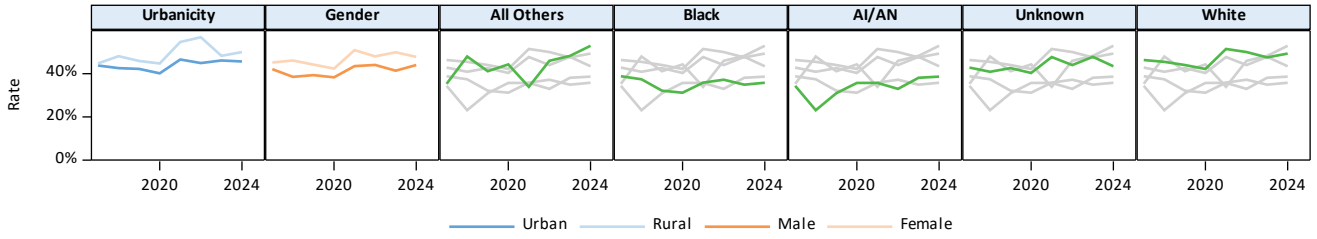
RBHA Measure 2-3: Percentage of members with schizophrenia or bipolar disorder using antipsychotic medications who had a diabetes screening test



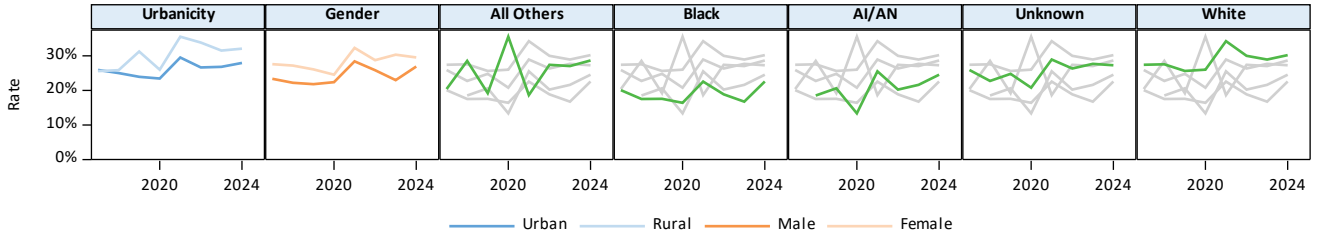
RBHA Measure 2-4: Percentage of members with schizophrenia who adhered to antipsychotic medications



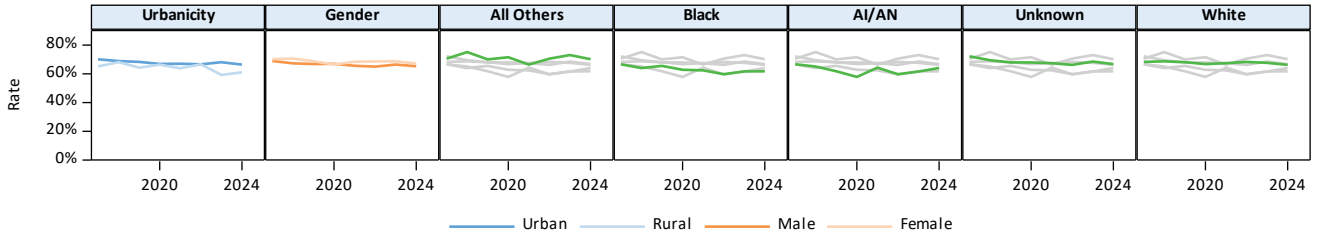
RBHA Measure 2-5: Percentage of adult members who remained on an antidepressant medication treatment (84 days)



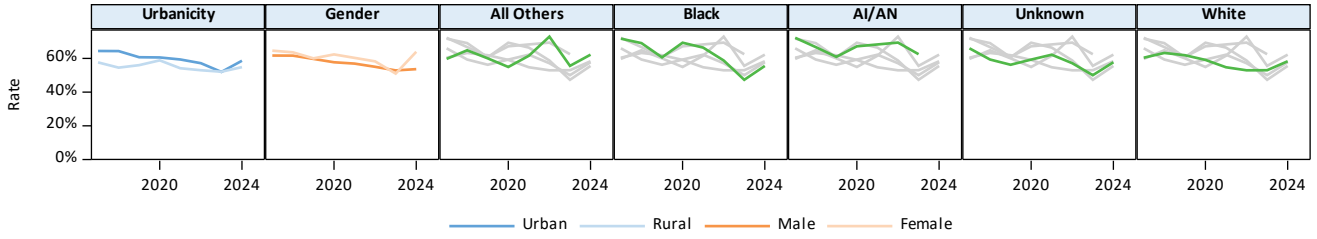
RBHA Measure 2-5: Percentage of adult members who remained on an antidepressant medication treatment (180 days)



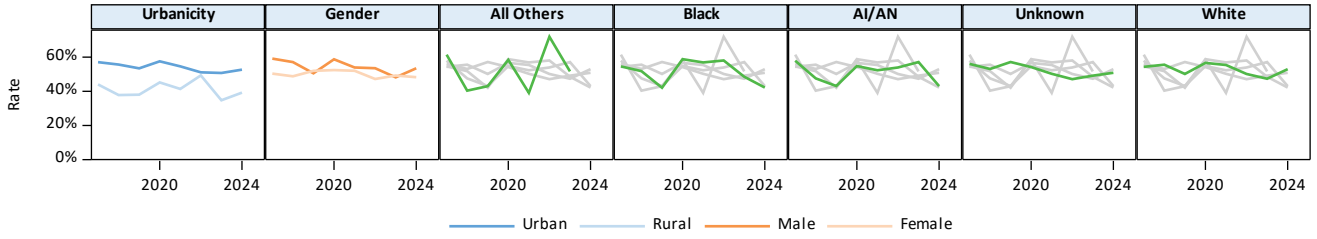
RBHA Measure 2-6: Percentage of members with a follow-up visit within 7 days after hospitalization for mental illness



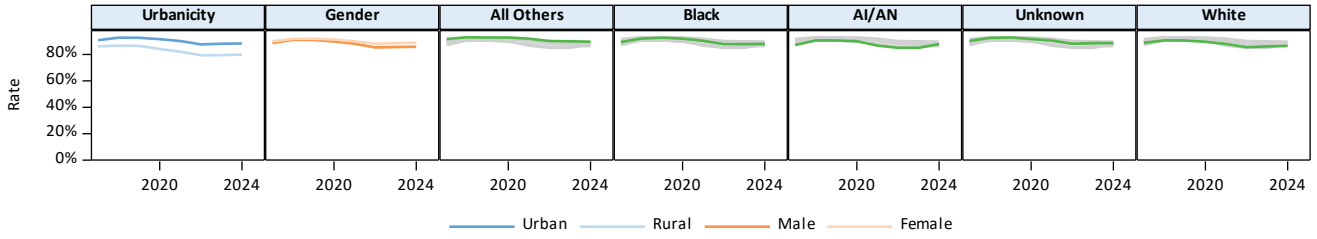
RBHA Measure 2-7: Percentage of members with a follow-up visit within 7 days after an ED visit for mental illness



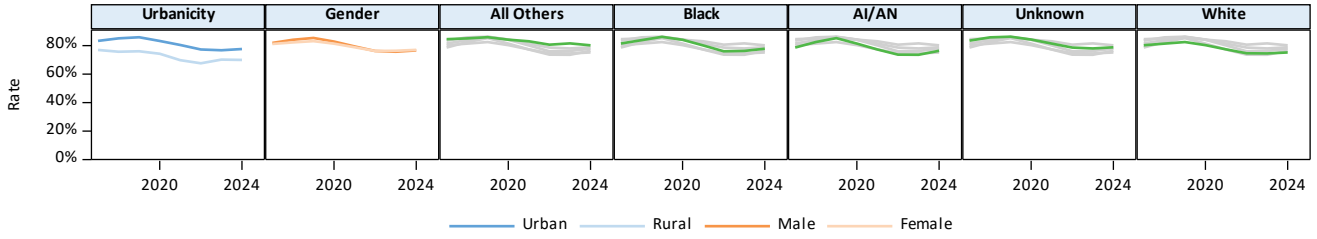
RBHA Measure 2-8: Percentage of members with follow-up visit within 7 days after an ED visit for SUD



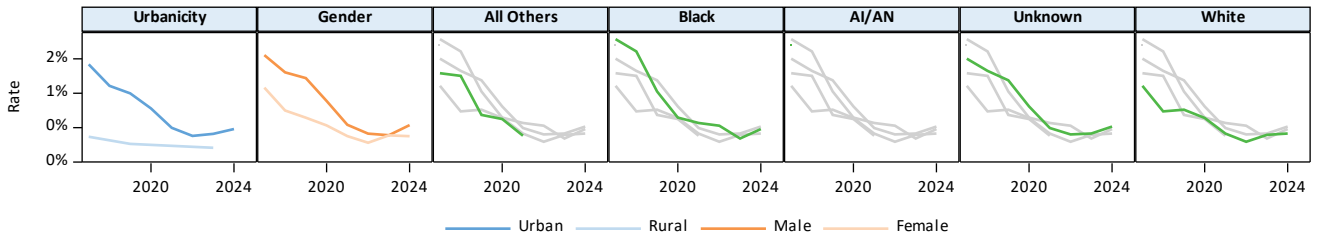
RBHA Measure 2-9: Percentage of members diagnosed with a mental health disorder



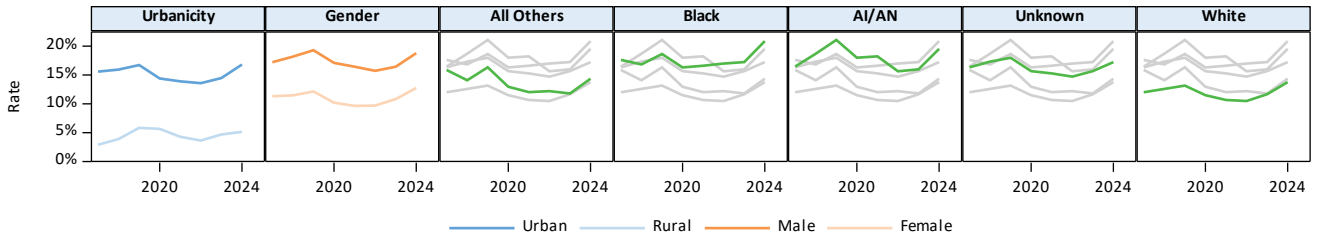
RBHA Measure 2-10: Percentage of members receiving mental health services (Any)



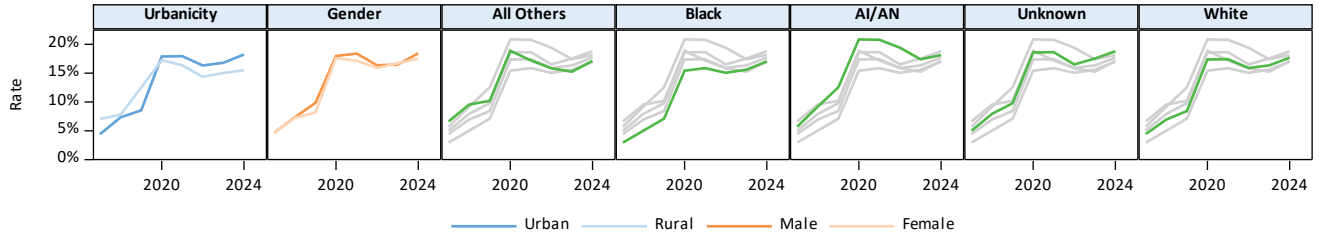
RBHA Measure 2-10: Percentage of members receiving mental health services (ED)



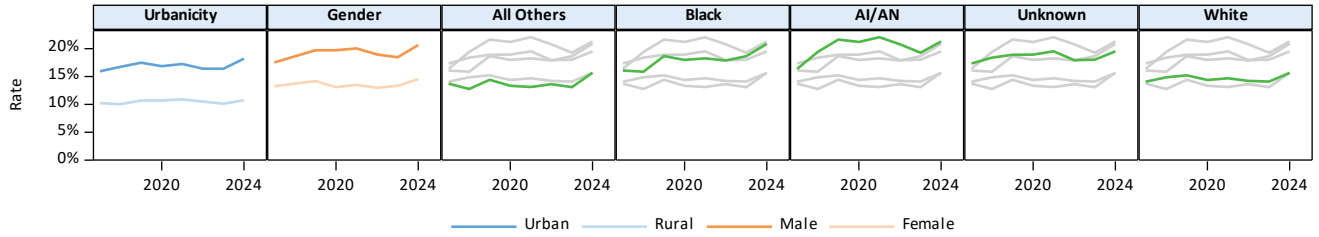
RBHA Measure 2-10: Percentage of members receiving mental health services (Intensive outpatient or partial hospitalization)



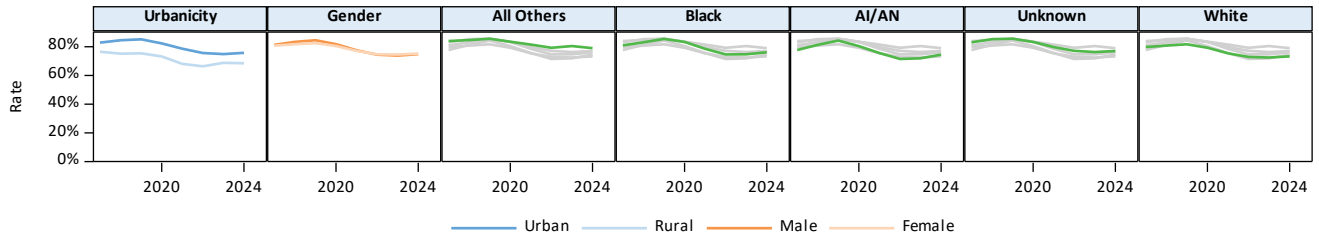
RBHA Measure 2-10: Percentage of members receiving mental health services (Telehealth)



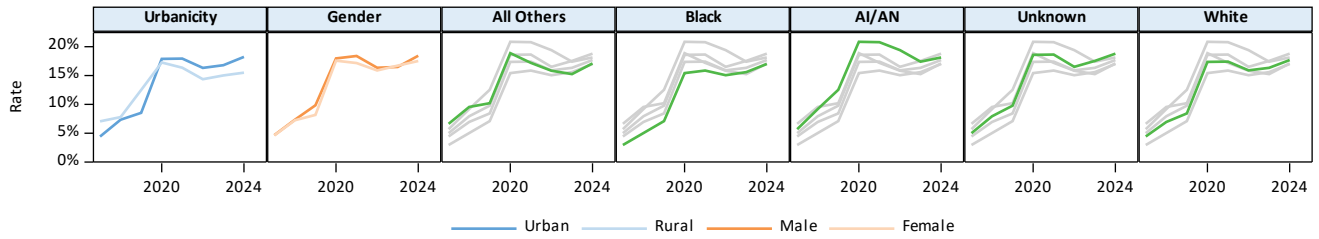
RBHA Measure 2-10: Percentage of members receiving mental health services (Inpatient)



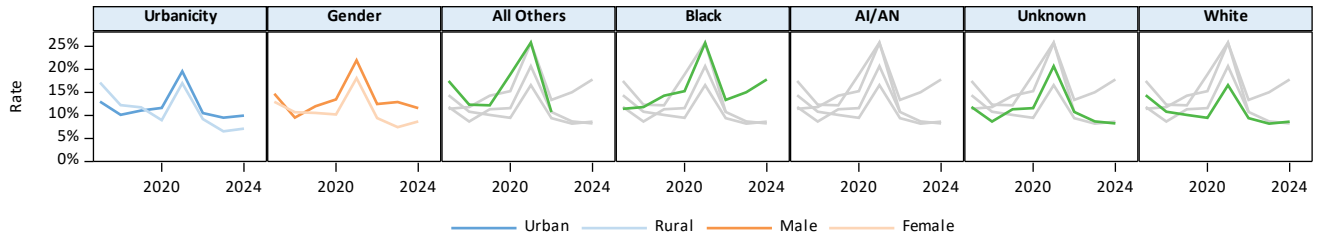
RBHA Measure 2-10: Percentage of members receiving mental health services (Outpatient)



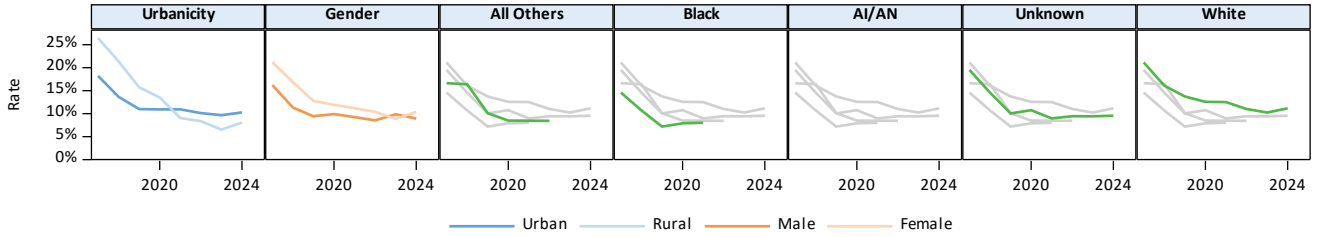
RBHA Measure 2-10: Percentage of members receiving mental health services (Telehealth)



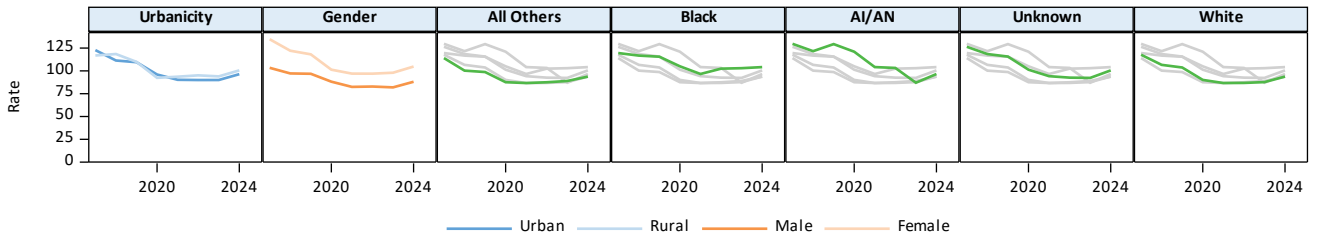
RBHA Measure 2-11: Percentage of members who have prescriptions for opioids at a high dosage



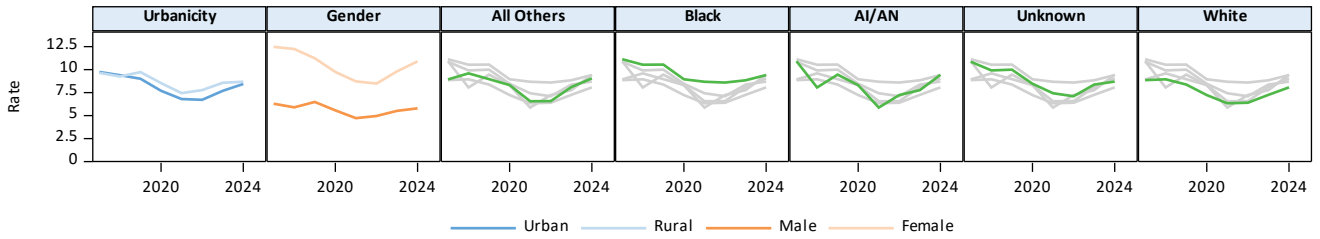
RBHA Measure 2-12: Percentage of members with concurrent use of opioids and benzodiazepines



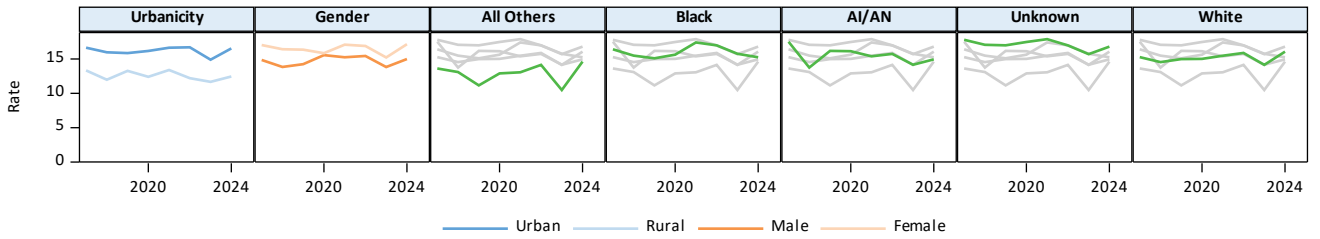
RBHA Measure 2-14: Number of emergent ED visits per 1,000 member months



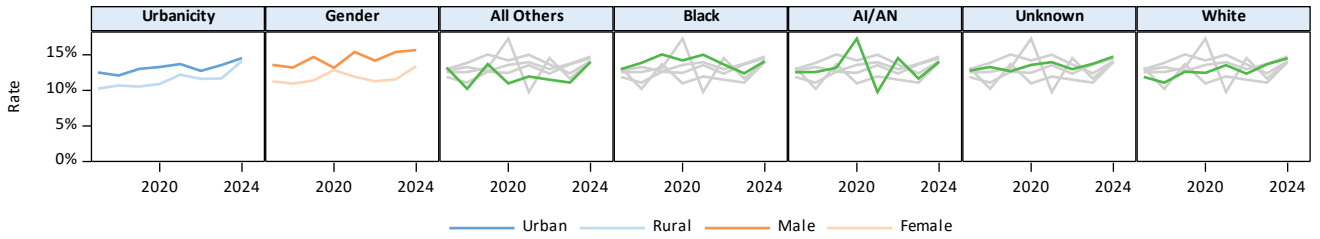
RBHA Measure 2-15: Number of non-emergent ED visits per 1,000 member months



RBHA Measure 2-16: Number of IP stays per 1,000 member months



RBHA Measure 2-17: Percentage of IP discharges with an unplanned readmission within 30 days



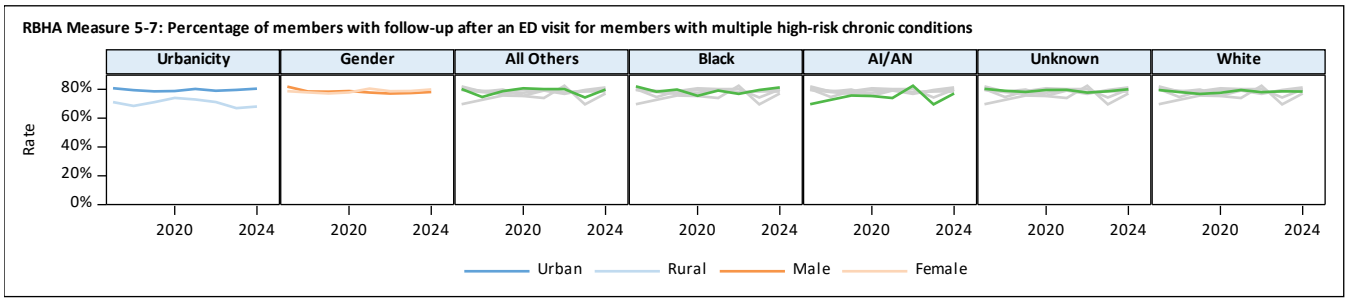


Table A-34—ACC-RBHA PMPM Costs (Total)

Variable	Estimate	*p*-value
Intercept	$1,241.95 *** *(31.295)*	<0.001
Baseline monthly trend	$4.09 *** *(0.646)*	<0.001
Level change at implementation	$78.78 *(53.171)*	0.142
Change in monthly trend	$16.72 *** *(3.318)*	<0.001
COVID-19 Lockdown (Q2 2020)	-$6.21 *(65.361)*	0.924
COVID-19 (June 2020 - April 2021)	$88.28 ** *(37.059)*	0.019
Seasonality: Q2	$13.45 *(31.410)*	0.669
Seasonality: Q3	$21.72 *(31.796)*	0.496
Seasonality: Q4	$28.14 *(31.364)*	0.372

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses.

COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-35—ACC-RBHA PMPM Costs (Professional)

Variable	Estimate	*p*-value
Intercept	$470.40 ***	<0.001
	(16.379)	
Baseline monthly trend	$2.71 ***	<0.001
	(0.338)	
Level change at implementation	$112.50 ***	<0.001
	(27.828)	
Change in monthly trend	$11.51 ***	<0.001
	(1.737)	
COVID-19 Lockdown (Q2 2020)	$24.95	0.468
	(34.207)	
COVID-19 (June 2020 - April 2021)	$1.10	0.955
	(19.395)	
Seasonality: Q2	$5.14	0.755
	(16.439)	
Seasonality: Q3	$4.00	0.811
	(16.641)	
Seasonality: Q4	-$17.17	0.298
	(16.415)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses.
COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-36—ACC-RBHA PMPM Costs (IP)

Variable	Estimate	*p*-value
Intercept	$304.92 ***	<0.001
	(7.221)	
Baseline monthly trend	$0.35 **	0.020
	(0.149)	
Level change at implementation	-$20.57 *	0.097
	(12.269)	
Change in monthly trend	$2.87 ***	<0.001
	(0.766)	
COVID-19 Lockdown (Q2 2020)	-$9.56	0.528
	(15.081)	
COVID-19 (June 2020 - April 2021)	-$3.75	0.662
	(8.551)	
Seasonality: Q2	$2.17	0.765
	(7.248)	
Seasonality: Q3	$15.93 **	0.033
	(7.337)	
Seasonality: Q4	-$0.35	0.961
	(7.237)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses.
COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-37—ACC- RBHA PMPM Costs (LTC)

Variable	Estimate	*p*-value
Intercept	$4.98 ***	<0.001
	(0.842)	
Baseline monthly trend	$0.32 ***	<0.001
	(0.017)	
Level change at implementation	$7.98 ***	<0.001
	(1.430)	
Change in monthly trend	-$1.18 ***	<0.001
	(0.089)	
COVID-19 Lockdown (Q2 2020)	-$6.51 ***	<0.001
	(1.758)	
COVID-19 (June 2020 - April 2021)	-$3.88 ***	<0.001
	(0.997)	
Seasonality: Q2	-$0.50	0.556
	(0.845)	
Seasonality: Q3	$0.32	0.712
	(0.855)	
Seasonality: Q4	-$0.19	0.822
	(0.844)	

*p<0.1, **p <0.05, ***p <0.001
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses.
COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-38—ACC-RBHA PMPM Costs (OP ED)

Variable	Estimate	*p*-value
Intercept	$65.65 ***	<0.001
	(1.329)	
Baseline monthly trend	-$0.26 ***	<0.001
	(0.027)	
Level change at implementation	-$0.85	0.707
	(2.257)	
Change in monthly trend	$0.44 **	0.002
	(0.141)	
COVID-19 Lockdown (Q2 2020)	-$15.19 ***	<0.001
	(2.775)	
COVID-19 (June 2020 - April 2021)	-$8.04 ***	<0.001
	(1.573)	
Seasonality: Q2	$2.73 **	0.043
	(1.334)	
Seasonality: Q3	$4.11 **	0.003
	(1.350)	
Seasonality: Q4	-$0.42	0.755
	(1.332)	

*p<0.1, **p <0.05, ***p <0.001
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses.
COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-39—ACC-RBHA PMPM Costs (OP Non-ED)

Variable	Estimate	*p*-value
Intercept	$47.78 ***	<0.001
	(1.155)	
Baseline monthly trend	-$0.13 ***	<0.001
	(0.024)	
Level change at implementation	$2.02	0.306
	(1.962)	
Change in monthly trend	$0.28 **	0.024
	(0.122)	
COVID-19 Lockdown (Q2 2020)	-$15.64 ***	<0.001
	(2.412)	
COVID-19 (June 2020 - April 2021)	-$4.22 **	0.003
	(1.368)	
Seasonality: Q2	<$0.01	0.999
	(1.159)	
Seasonality: Q3	-$0.92	0.437
	(1.173)	
Seasonality: Q4	-$2.31 **	0.049
	(1.158)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses.
COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-40—ACC-RBHA PMPM Costs (Pharmacy)

Variable	Estimate	*p*-value
Intercept	$348.23 ***	<0.001
	(18.631)	
Baseline monthly trend	$1.10 **	0.005
	(0.385)	
Level change at implementation	-$22.30	0.483
	(31.654)	
Change in monthly trend	$2.79	0.161
	(1.976)	
COVID-19 Lockdown (Q2 2020)	$15.74	0.687
	(38.911)	
COVID-19 (June 2020 - April 2021)	$107.07 ***	<0.001
	(22.062)	
Seasonality: Q2	$3.91	0.835
	(18.700)	
Seasonality: Q3	-$1.73	0.928
	(18.929)	
Seasonality: Q4	$48.58 **	0.011
	(18.672)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses.
COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-41—ACC-RBHA Aggregate Costs (Total, in Thousands)

Variable	Estimate	*p*-value
Intercept	$50,247.60 ***	<0.001
	(1306.444)	
Baseline monthly trend	$325.50 ***	<0.001
	(26.985)	
Level change at implementation	$6,534.30 **	0.004
	(2219.658)	
Change in monthly trend	$257.80 *	0.066
	(138.526)	
COVID-19 Lockdown (Q2 2020)	-$3,223.30	0.241
	(2728.529)	
COVID-19 (June 2020 - April 2021)	$3,249.20 **	0.039
	(1547.031)	
Seasonality: Q2	$991.20	0.452
	(1311.246)	
Seasonality: Q3	$1,134.70	0.395
	(1327.342)	
Seasonality: Q4	$945.20	0.472
	(1309.302)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-42—ACC-RBHA Aggregate Costs (Professional, in Thousands)

Variable	Estimate	*p*-value
Intercept	$18,912.00 ***	<0.001
	(641.332)	
Baseline monthly trend	$178.40 ***	<0.001
	(13.247)	
Level change at implementation	$6,802.10 ***	<0.001
	(1089.629)	
Change in monthly trend	$296.20 ***	<0.001
	(68.002)	
COVID-19 Lockdown (Q2 2020)	-$195.70	0.884
	(1339.433)	
COVID-19 (June 2020 - April 2021)	-$288.00	0.705
	(759.437)	
Seasonality: Q2	$477.90	0.460
	(643.690)	
Seasonality: Q3	$322.60	0.622
	(651.591)	
Seasonality: Q4	-$914.80	0.158
	(642.736)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-43—ACC-RBHA Aggregate Costs (IP, in Thousands)

Variable	Estimate	*p*-value
Intercept	$12,430.70 ***	<0.001
	(318.411)	
Baseline monthly trend	$48.00 ***	<0.001
	(6.577)	
Level change at implementation	-$511.10	0.347
	(540.982)	
Change in monthly trend	$30.10	0.375
	(33.762)	
COVID-19 Lockdown (Q2 2020)	-$1,035.00	0.123
	(665.006)	
COVID-19 (June 2020 - April 2021)	-$321.20	0.397
	(377.047)	
Seasonality: Q2	$134.00	0.676
	(319.581)	
Seasonality: Q3	$734.30 **	0.026
	(323.504)	
Seasonality: Q4	-$80.60	0.801
	(319.107)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-44—ACC-RBHA Aggregate Costs (LTC, in Thousands)

Variable	Estimate	*p*-value
Intercept	$166.40 ***	<0.001
	(43.252)	
Baseline monthly trend	$16.40 ***	<0.001
	(0.893)	
Level change at implementation	$425.20 ***	<0.001
	(73.485)	
Change in monthly trend	-$63.00 ***	<0.001
	(4.586)	
COVID-19 Lockdown (Q2 2020)	-$340.90 ***	<0.001
	(90.332)	
COVID-19 (June 2020 - April 2021)	-$205.10 ***	<0.001
	(51.217)	
Seasonality: Q2	-$19.10	0.661
	(43.411)	
Seasonality: Q3	$14.40	0.744
	(43.943)	
Seasonality: Q4	-$14.30	0.742
	(43.346)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-45—ACC-RBHA Aggregate Costs (OP ED, in Thousands)

Variable	Estimate	*p*-value
Intercept	$2,709.40 ***	<0.001
	(56.919)	
Baseline monthly trend	-$5.80 ***	<0.001
	(1.176)	
Level change at implementation	$12.50	0.897
	(96.705)	
Change in monthly trend	$4.30	0.478
	(6.035)	
COVID-19 Lockdown (Q2 2020)	-$753.50 ***	<0.001
	(118.875)	
COVID-19 (June 2020 - April 2021)	-$371.50 ***	<0.001
	(67.400)	
Seasonality: Q2	$132.60 **	0.023
	(57.128)	
Seasonality: Q3	$182.70 **	0.002
	(57.829)	
Seasonality: Q4	-$29.30	0.608
	(57.043)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-46—ACC-RBHA Aggregate Costs (OP Non-ED, in Thousands)

Variable	Estimate	*p*-value
Intercept	$1,973.70 ***	<0.001
	(54.772)	
Baseline monthly trend	-$1.70	0.141
	(1.131)	
Level change at implementation	$145.10	0.123
	(93.058)	
Change in monthly trend	-$0.20	0.974
	(5.808)	
COVID-19 Lockdown (Q2 2020)	-$753.50 ***	<0.001
	(114.392)	
COVID-19 (June 2020 - April 2021)	-$201.40 **	0.003
	(64.859)	
Seasonality: Q2	$4.50	0.934
	(54.973)	
Seasonality: Q3	-$42.00	0.453
	(55.648)	
Seasonality: Q4	-$114.50 **	0.040
	(54.892)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-47—ACC-RBHA Aggregate Costs (Pharmacy, in Thousands)

Variable	Estimate	*p*-value
Intercept	$14,055.30 ***	<0.001
	(843.642)	
Baseline monthly trend	$90.30 ***	<0.001
	(17.425)	
Level change at implementation	-$339.50	0.813
	(1433.354)	
Change in monthly trend	-$9.70	0.914
	(89.454)	
COVID-19 Lockdown (Q2 2020)	-$144.80	0.935
	(1761.959)	
COVID-19 (June 2020 - April 2021)	$4,636.50 ***	<0.001
	(999.002)	
Seasonality: Q2	$261.20	0.758
	(846.743)	
Seasonality: Q3	-$77.30	0.928
	(857.137)	
Seasonality: Q4	$2,098.80 **	0.015
	(845.488)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Qualitative

AHCCCS Staff

AHCCCS supported the ACC-RHBA and BH system of care by prioritizing care coordination for ACC-RHBA members. Care coordination activities identified by AHCCCS are outlined in Table A-48.

Table A-48—AHCCCS ACC-RHBA Care Coordination Activities

Target Population	Description
Justice-involved members	AHCCCS, along with ACC-RHBA plans and carceral facilities, coordinated care for members prior to release to support continuity of care and a successful reentry. AHCCCS worked with over 100 facility types across the carceral system, each with its own funding streams, policies, and contracts. Some facilities also allowed coordinators and peer support staff to meet members on-site.
Members in BH crisis	AHCCCS coordinated with ACC and ACC-RHBA plans to ensure members entering the crisis continuum of care received coordinated services.
General SMI members	SMI members were assigned to HHs for services, treatment, assessment, and referral. Members who met needs criteria based on diagnoses and functional status were assigned ACT teams for more intensive support and treatment.

Note: AHCCCS: Arizona Health Care Cost Containment System; ACC: AHCCCS Complete Care; ACC-RHBA: ACC–Regional Behavioral Health Agreement; ACT: assertive community treatment; BH: behavioral health; HH: Health Home; SMI: serious mental illness

Challenges to effective care coordination reported by AHCCCS staff included:

- Ensuring that HHs involved the necessary family and other stakeholders in care coordination. This often required educating HHs on patient privacy to support the inclusion of member support teams in care discussions.
- Workforce shortages in the BH system of care. There was a statewide effort to grow the workforce, which remained ongoing in fall 2025.
  - Arizona's legislature appropriated care management workforce funding, which was distributed to providers through ACC-RHBA direct payments to supporting hiring providers and staff.
  - ACC-RHBAs also utilized community reinvestment and other resources to bolster the workforce.
- Medicaid funding did not increase in alignment with the State's population growth or the desired expansion of the continuum of services. Providers struggled financially and were forced to close lines of business or reduce staff.

AHCCCS actively worked to mitigate these challenges and support the BH system of care. The State regularly met with providers to discuss administrative and uncompensated burdens and to reduce spending not covered by Medicaid. The State also met frequently with plans to address concerns and financial needs, as well as with the Governor's office and legislators to discuss ongoing challenges.

Plans

Two ACC-RHBA plans reported robust care coordination strategies to manage ACC-RHBA members' PH and BH care. A significant driver of successful care coordination was partnerships with external stakeholders, outlined in Table A-49.

Table A-49—Collaboration with External Stakeholders

Justice Partners	CBOs	HHs
• Held MOUs with the DOC, jails, and county sheriffs. Staff in jails and courts to coordinate care upon intake. • Informed care management teams when members were incarcerated. • Assigned members to forensic ACT teams prior to release to begin engagement and release coordination. • Shared data to create diversion systems and reduce recidivism.	• Utilized the CLRS to connect members with HRSN to CBOs, allowing plan staff to coordinate and validate the progress and the outcome of the referral. • Provided funding for care coordination positions at CBOs. • Supported CBOs dedicated to members experiencing homelessness, providing guidance and coordination.	• Partnered with large HHs and created value-based contracting and protocols. • Partnered with specialty HHs to engage members with specific conditions. • Embedded care managers in HHs to support engagement in meetings, support discharge planning, and provide long-term support.
Providers	**Business Partners**	**First Responders**
• Partnered with mobile provider organizations. • Leveraged peer support services to enhance engagement and connection. • Encouraged collaboration and integration across provider coordination and referral systems. • Partnered to enhance data sharing across provider organizations.	• Contracted with a partner to support complex, difficult to engage members. The partner employed nurse practitioners, counselors, care coordinators, and care managers to address gaps in care and connect members to BH and PH services.	• Collaborated with 911 centers to divert crisis calls to care coordination.

Note: ACT: assertive community treatment; BH: behavioral health; CBO: community-based organization; CLRS: closed-loop referral system; DOC: Department of Corrections, Rehabilitation & Reentry; HH: health home; HRSN: health-related social needs; MOU: memorandum of understanding; PH: physical health; SMI: serious mental illness

Internally, plans employed dedicated care coordination and care management teams that carried out a range of care coordination activities. These included:

- Monitoring members for elevated risk to ensure coordinated care for at-risk individuals.
- Holding weekly interdisciplinary meetings to review high-needs, complex, and SMI cases and resolve members' challenges.
- Coordinating across staff and following up on prior interventions.
- Developing individualized care plans with members to ensure members' priorities and needs are met.
- Assessing members for SDOH needs to support holistic care.
- Coordinating hospital discharge.
- Proactively identifying members to referral to assertive community treatment (ACT) teams or permanent supportive housing (PSH).
- Conducting outreach to SMI members following crisis to support follow-up, connection, and stability.
- Operating targeted care management programs for specific populations, such as members experiencing a first episode of psychosis, justice-involved members, individuals with SMI, or members with SUD.
- Incorporating peer supports to engage SMI members and build trust in the health care system.

Plans reported improved member outcomes because care coordination and the expansion of integrated care helped ensure members access to PH and BH services. However, barriers to successful care coordination continued during the Waiver. ACC-RHBA plans reported BH provider workforce shortages that affected care coordination across the State. As a result, providers closed locations and reduced service arrays, including high-needs case management. High caseload ratios and staff turnover further strained provider networks and care coordination services. Plans actively partnered with stakeholders to address shortages by:

- Supporting health care students, including collaborating with the Arizona State College of Nursing, partnering with Phoenix Bioscience Core to coordinate placements for Arizona medical students, and partnering with ElevateEdAZ to support student placement and development.
- Utilizing PipelineAZ, an Arizona-specific career website, to connect with active providers.
- Partnering with the Phoenix Chamber of Commerce to support rural workforce development, including funding a development coordinator in Northern Arizona.
- Allocating AHCCCS-provided funding to support SMI case manager referral and retention incentives for providers.
- Collaborating across six plans to administer the Arizona Healthcare Workforce Goals and Metrics Assessment Survey to collect statewide workforce data in 2022, 2024, and 2025, reducing burden on individual plans to track workforce data.

Plan-level staffing challenges were also reported, as shortages and turnover created a need for frequent staff training. Another barrier to care coordination was data limitations. Federal regulations restricted plans' abilities to share SUD data with providers. In addition, electronic medical records (EMRs), and health exchange platforms limitations, along with general fragmentation of health care data systems, hindered access to information needed to effectively coordinate care, such as hospital discharge records. To improve data integration, one plan developed its own dashboard and worked with providers and community-based organizations (CBOs) to promote the use of the closed-loop referral system (CLRS).

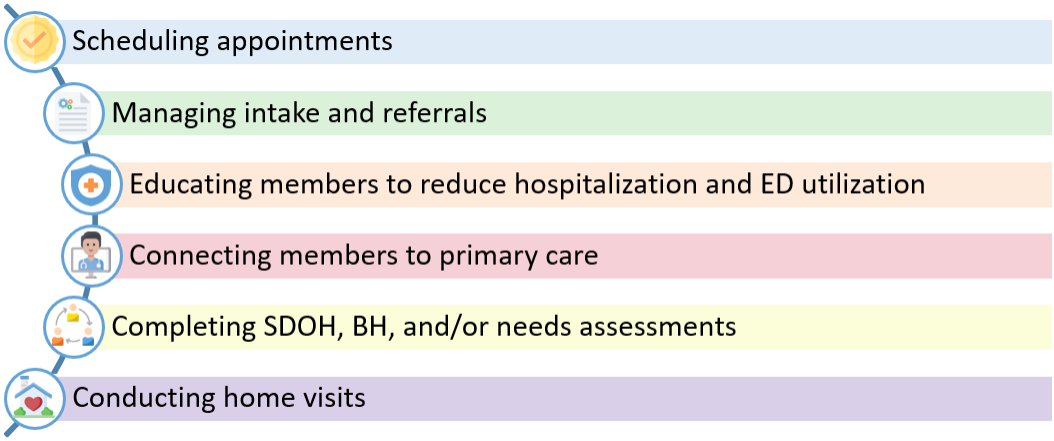
To address challenges with member outreach, one plan reported a 65 percent success rate in care management outreach. A significant barrier was inaccurate member contact information, which one plan addressed by

distributing cell phones to ensure accurate member telephone numbers. Plans also employed technology for outreach through a mass text messaging platform and text messaging campaigns. To ensure members did not receive a burdensome volume of communication, plans collaborated with stakeholders to send messaging from a single source. Plans further relied on providers, peer support staff, ACT teams, and care management staff to maintain connection with vulnerable members.

Providers

Five ACC-RHBA providers reported care coordination strategies to manage members' PH and BH care. Providers used dedicated staff (e.g., case managers, peer support workers, and recovery coaches) to help members stay connected to integrated PH and BH services. This included coordination with health plans, family supports, and other providers. Figure A-2 outlines the care coordination activities conducted by staff.

Figure A-2—Provider Care Coordination



Note: BH: behavioral health; ED: emergency department; SDOH: social determinants of health.

Providers continued to evolve their care coordination strategies by increasing the use of technology. Providers received plan reimbursements to purchase tablets for members to promote virtual communication, use social media to spread awareness of events, developed algorithms to identify gaps in care and support data-based decision making, and used telehealth to connect with members. One provider noted that the effectiveness of technology in care coordination depended on a member's ability to use the platforms. As a result, providers also focused on in-person interaction with the ACC-RHBA population, conducting home visits, transporting members to appointments, and teaching life skills to support education, employment, and activities of daily living.

Providers found challenges navigating between ACC and ACC-RHBA plans, each with varying deliverables, prior authorization requirements, and portals. Prior authorizations were further complicated by the fraud, waste, and abuse challenges faced by the State, which contributed to delays in members receiving approvals for SUD care. In general, plan preauthorization requirements hindered timely access to appropriate levels of care, and providers expended internal resources appealing denials. Additional challenges cited by providers related to care coordination for ACC-RHBA members included:

- Challenges with timely and accurate transportation of members to care by transportation vendors.
- Challenges with timely and accurate member data exchange due to inefficient health information exchange (HIE) and the need to access multiple sources (i.e., several portals) to obtain complete member information.
- Difficulty coordinating with external stakeholders.

- Hospital discharges were not coordinated effectively (i.e., members leaving the hospital without discharge instructions when provider organizations were closed and unable to assist with care transitions). Discharge concerns were exacerbated by workforce shortages that disrupted efforts to ensure discharge plans were in place.
- Challenges working across varying policies and processes across health plans.

- Beginning in October 2024, providers could not bill for case management services lasting less than eight minutes, and outreach billing could only be used once per day for care coordination. These changes reportedly negatively affected workflow, billing, and training.
- Workforce shortages created barriers to meeting caseload ratio requirements and peer support mandates, worsened by low reimbursement rates and time spent on unbillable coordination tasks.
- Difficulty ensuring ACC-RHBA members understood and utilized the integrated PH and BH care.

ALTCS

This section provides the supplemental quantitative and qualitative results for Arizona Long Term Care System (ALTCS).

Quantitative

Table A-50—ALTCS-DD Supplemental Results

Time	BH OP, Adult	BH Residential Facility	BH OP, Pediatric	Cardiologist, Adult	Cardiologist, Pediatric	Crisis Stabilization Facility	Dentist, Pediatric	Hospital	OB/GYN	PCP, Adult	PCP, Pediatric	Pharmacy
Q1 2020	97.6% N=16,483	98.1% N=28,379	97.7% N=17,822	99.9% N=13,797	100.0% N=20,508	98.5% N=34,305	98.8% N=20,508	99.9% N=34,305	100.0% N=6,048	99.6% N=13,797	99.7% N=20,508	99.1% N=34,305
Q2 2020	97.7% N=16,703	98.1% N=28,708	97.7% N=17,983	99.9% N=13,974	100.0% N=20,712	98.6% N=34,686	98.9% N=20,712	99.9% N=34,686	100.0% N=6,107	99.7% N=13,974	99.7% N=20,712	99.1% N=34,686
Q3 2020	98.1% N=16,934	98.0% N=29,088	97.9% N=18,196	99.7% N=14,147	99.9% N=20,983	98.7% N=35,130	98.8% N=20,983	99.9% N=35,130	100.0% N=6,162	99.7% N=14,147	99.7% N=20,983	99.1% N=35,130
Q2 2021	98.2% N=17,591	97.9% N=29,429	98.2% N=18,418	99.7% N=14,611	99.9% N=21,398	98.9% N=36,009	99.4% N=21,398	99.8% N=36,009	99.9% N=6,356	99.6% N=14,611	99.6% N=21,398	99.0% N=36,009
Q4 2021	98.2% N=18,078	98.0% N=29,956	98.2% N=18,561	99.7% N=14,940	99.9% N=21,699	99.1% N=36,639	99.5% N=21,699	99.9% N=36,639	100.0% N=6,474	99.6% N=14,940	99.7% N=21,699	99.0% N=36,639
Q2 2022	98.3% N=18,508	98.0% N=30,491	98.3% N=18,802	99.7% N=15,261	99.9% N=22,049	99.2% N=37,310	99.3% N=22,049	99.9% N=37,310	100.0% N=6,612	99.6% N=15,261	99.6% N=22,049	99.1% N=37,310
Q4 2022	98.0% N=16,792	97.6% N=27,537	98.0% N=16,922	99.8% N=13,815	99.9% N=19,899	99.1% N=33,714	99.2% N=19,899	99.9% N=33,714	100.0% N=6,156	99.7% N=13,815	99.7% N=19,899	99.1% N=33,714
Q2 2023	97.7% N=19,489	97.8% N=32,069	97.8% N=19,842	99.7% N=16,062	99.9% N=23,269	100.0% N=202	99.3% N=23,269	99.9% N=39,331	99.9% N=6,952	99.7% N=16,062	99.7% N=23,269	99.1% N=39,331
Q4 2023	98.0% N=19,930	97.3% N=33,001	98.1% N=20,564	99.7% N=16,440	99.9% N=24,054	100.0% N=209	99.1% N=24,054	99.8% N=40,494	100.0% N=7,059	99.7% N=16,440	99.7% N=24,054	99.2% N=40,494
Q2 2024	98.4% N=20,259	97.1% N=34,095	98.7% N=21,577	99.7% N=16,697	99.9% N=25,139	100.0% N=217	99.1% N=25,139	99.9% N=41,836	99.9% N=7,187	99.5% N=16,697	99.7% N=25,139	99.1% N=41,836
Q4 2024	98.3% N=20,723	97.2% N=35,480	98.5% N=22,759	99.7% N=17,157	99.9% N=26,325	100.0% N=212	99.1% N=26,325	99.9% N=43,482	99.9% N=7,320	99.6% N=17,157	99.7% N=26,325	99.1% N=43,482

Note: BH: behavioral health; OB/GYN: obstetrics and gynecology; OP: outpatient; PCP: primary care provider; Q: quarter.

Table A-51—ALTCS-EPD Supplemental Results

Time	BH OP, Adult	BH Residential Facility	BH OP, Pediatric	Cardiologist, Adult	Cardiologist, Pediatric	Dentist, Pediatric	Hospital	Nursing Facility	OB/GYN	PCP, Adult	PCP, Pediatric	Pharmacy
Q1 2019	97.9% N=27,807	98.6% N=22,223	97.2% N=390	99.9% N=27,674	100.0% N=523	99.0% N=523	99.9% N=28,197	99.8% N=13,495	100.0% N=923	99.9% N=27,674	100.0% N=523	99.5% N=28,197
Q2 2019	99.0% N=28,044	98.6% N=22,428	98.1% N=376	99.9% N=27,903	100.0% N=517	99.4% N=517	99.9% N=28,420	99.8% N=14,322	100.0% N=913	99.9% 27,903	100.0% 517	99.5% 28,420
Q3 2019	98.9% N=28,437	98.5% N=22,823	97.7% N=399	99.9% N=28,290	100.0% N=546	99.1% N=546	99.8% N=28,836	99.8% N=14,522	100.0% N=932	99.9% N=28,290	100.0% N=546	99.5% N=28,836
Q4 2019	99.0% N=28,758	98.6% N=23,134	97.8% N=401	100.0% N=28,620	100.0% N=539	99.1% N=539	99.9% N=29,159	99.7% N=14,676	99.9% N=932	99.9% N=28,620	100.0% N=539	99.6% N=29,159
Q1 2020	99.2% N=28,837	98.6% N=23,245	97.8% N=411	100.0% N=28,696	100.0% N=552	99.5% N=552	99.9% N=29,248	99.7% N=14,787	99.9% N=937	99.9% N=28,696	100.0% N=552	99.6% N=29,248
Q2 2020	96.4% N=28,726	93.9% N=23,125	94.0% N=433	100.0% N=28,587	100.0% N=572	99.5% N=572	96.5% N=29,159	88.6% N=14,628	99.9% N=955	99.9% N=28,587	100.0% N=572	99.7% N=29,159
Q3 2020	97.1% N=28,041	95.5% N=22,610	95.9% N=435	100.0% N=27,909	100.0% N=567	80.4% N=567	96.5% N=28,476	88.4% N=14,784	99.9% N=940	99.9% N=27,909	99.8% N=567	99.6% N=28,476
Q2 2021	99.3% N=25,766	98.6% N=20,669	98.0% N=406	100.0% N=25,626	100.0% N=546	99.8% N=546	99.8% N=26,172	99.7% N=13,701	99.9% N=928	99.9% N=25,626	100.0% N=546	99.6% N=26,172
Q4 2021	99.2% N=25,642	98.5% N=20,485	98.3% N=402	99.9% N=25,486	100.0% N=558	100.0% N=558	99.8% N=26,044	99.7% N=13,231	99.9% N=949	99.9% N=25,486	100.0% N=558	99.5% N=26,044
Q2 2022	99.4% N=25,272	98.5% N=20,233	98.7% N=394	99.9% N=25,115	100.0% N=551	90.4% N=551	99.9% N=25,666	98.3% N=12,795	99.9% N=937	99.9% N=25,115	100.0% N=551	97.3% N=25,666
Q4 2022	99.0% N=22,451	98.3% N=17,938	97.4% N=340	99.8% N=22,313	100.0% N=478	97.1% N=478	99.9% N=22,791	99.6% N=11,646	100.0% N=841	99.9% N=22,313	99.6% N=478	99.5% N=22,791
Q2 2023	98.9% N=25,428	98.3% N=20,441	97.1% N=412	99.8% N=25,285	100.0% N=555	99.5% N=555	99.9% N=25,840	99.6% N=13,507	100.0% N=947	99.9% N=25,285	99.8% 555	99.5% 25,840
Q4 2023	98.9% N=25,637	98.4% N=20,604	97.6% N=413	99.9% N=25,497	100.0% N=553	98.9% N=553	99.9% N=26,050	99.7% N=14,324	99.9% N=944	99.9% N=25,497	99.8% 553	99.6% 26,050
Q2 2024	99.1% N=25,421	97.3% N=20,491	97.6% N=409	99.8% N=25,286	100.0% N=544	98.7% N=544	99.9% N=25,830	99.6% N=14,234	100.0% N=936	99.9% N=25,286	99.8% N=544	99.5% N=25,830
Q4 2024	98.9% N=25,523	97.6% N=20,586	96.8% N=412	99.9% N=25,400	100.0% N=535	98.9% N=535	99.9% N=25,935	99.7% N=14,318	99.8% N=938	99.9% N=25,400	99.6% N=535	99.5% N=25,935

Note: BH: behavioral health; OB/GYN: obstetrics and gynecology; OP: outpatient; PCP: primary care provider; Q: quarter.

Table A-52—Research Question 9.1, Measure 9-1 Supplemental Results

Did the PPCG service model improve or maintain care stability for ALTCS minors?						
			Ramp-Up Period			Evaluation Period
			2021	2022	2023	2024
ALTCS-DD Population						
9-1	Average number of DCWs per member per year	Habilitation Care	1.51	1.50	1.48	1.40
		Attendant Care	1.69	1.72	1.70	1.56
ALTCS-EPD Population						
9-1	Average number of DCWs per member per year	Habilitation Care	S	S	S	S
		Attendant Care	1.39	1.36	1.38	1.47

Note: S refers to rates involving denominators or numerators smaller than 11 members, which are suppressed due to potentially unreliable statistical testing and rate calculation and to ensure anonymity. ALTCS: Arizona Long Term Care System; DCW: direct care worker; DD: developmental disabilities; EPD: elderly or physically disabled; PPCG: Parents as Paid Caregivers.
Data Source: DCW data were used in the analysis of RQ 9.1.
ALTCS-DD: Ramp-up period (CYs 2021, 2022, 2023) and evaluation period (01/01/2024–10/31/2024).
ALTCS-EPD: Ramp-up period (CYs 2021, 2022, 2023) and evaluation period (CY 2024).
Results are limited to members who were enrolled in and receiving services from the PPCG service model at any point between CY 2023–2024.

Table A-53—Research Question 11.1, Measure 11-6 Supplemental Results

Do members receiving services through the PPCG service model and EFSS have the same or lower rates of social isolation?				
			Ramp-Up Period	Evaluation Period
			2023	2024
ALTCS-DD Population				
11-6	Percentage of members engaging with day program services	PPCG service model	9.1%	7.4%
		PPCG comparison	9.3%	8.2%
ALTCS-EPD Population				
11-6	Percentage of members engaging with day program services	PPCG service model	N/A	S
		PPCG comparison	N/A	S

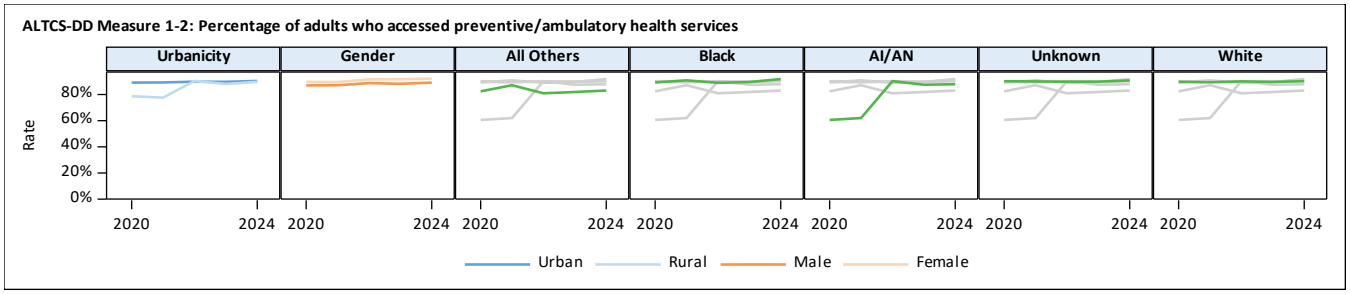
Note: S refers to rates involving denominators or numerators smaller than 11 members, which are suppressed due to potentially unreliable statistical testing and rate calculation and to ensure anonymity. ALTCS: Arizona Long Term Care System; DD: developmental disabilities; EFFS: Extended Family Support services; EPD: elderly and physically disabled; HCBS: home and community-based services; N/A: not available; PPCG: Parents as Paid Caregivers.
Data Source: PMMIS and PPCG Utilization data were used in the analysis of RQ 11.2.
ALTCS-DD: Ramp-up period (10/01/2022–09/30/2023) and evaluation period (10/01/2023–09/30/2024).
ALTCS-EPD: Evaluation period (01/01/2024–10/31/2024).
The PPCG service model was first approved through Appendix K authority in March 2020. On Feburary 16, 2024, CMS approved the PPCG service model under Waiver authority. Programmatic changes based on Waiver requirements were not implemented until June 2025.

Table A-54—Research Question 11.2, Measure 11-11 Supplemental Results

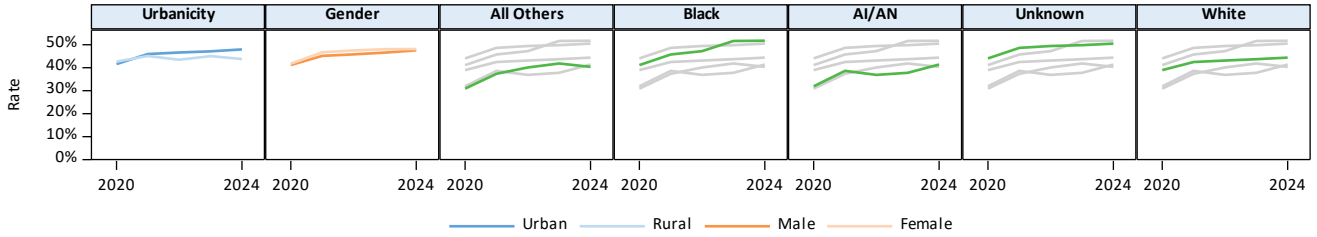
Do members receiving services through the PPCG service model have the same or lower rates of reported cases of					
					Evaluation Period
		2021	2022	2023	2024
ALTCS-DD					
11-11	Number of members with substantiated cases of abuse or neglect	297	254	496	360
ALTCS-EPD					
11-11	Number of members with substantiated cases of abuse or neglect	13	S	S	S

Note: S refers to rates involving denominators or numerators smaller than 11 members, which are suppressed due to potentially unreliable statistical testing and rate calculation and to ensure anonymity. ALTCS: Arizona Long Term Care System; DD: developmental disabilities; EPD: elderly and physically disabled; PPCG: Parents as Paid Caregivers.
Data Source: AHCCCS Quality of Care data were used in the analysis of RQ 11.2.
ALTCS-DD and ALTCS-EPD: Ramp-up period (01/01/2021–12/31/2023) and evaluation period (01/01/2024–12/31/2024).

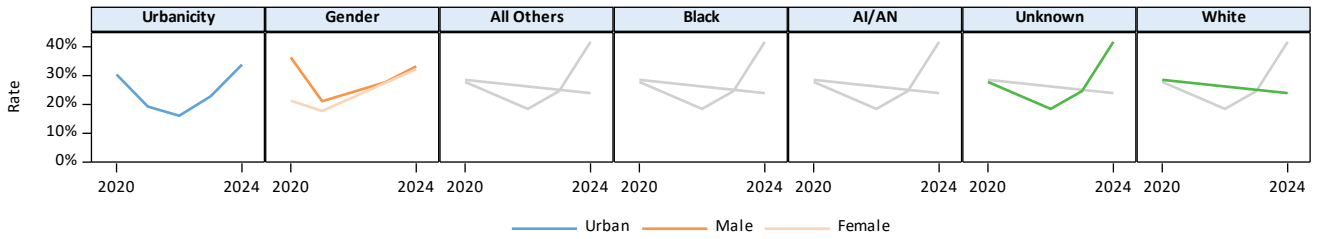
Table A-55—ALTCS-Developmental Disabilities (DD) Demographics



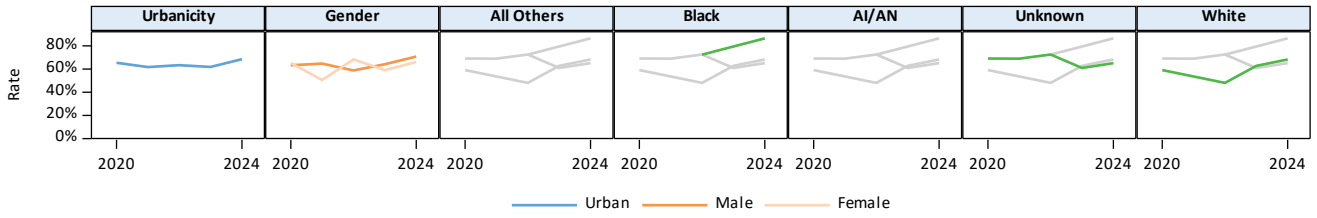
ALTCS-DD Measure 1-3: Percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation



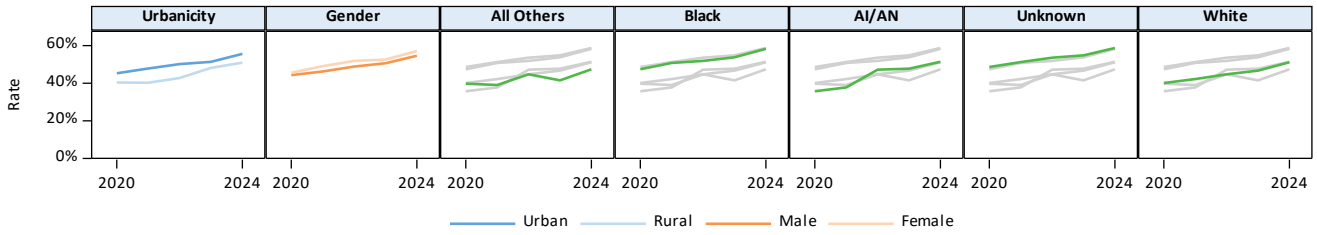
ALTCS-DD Measure 1-4: Percentage of members who had a well-child visit in the first 30 months of life (six or more well-child visits before the 15-month birthday)



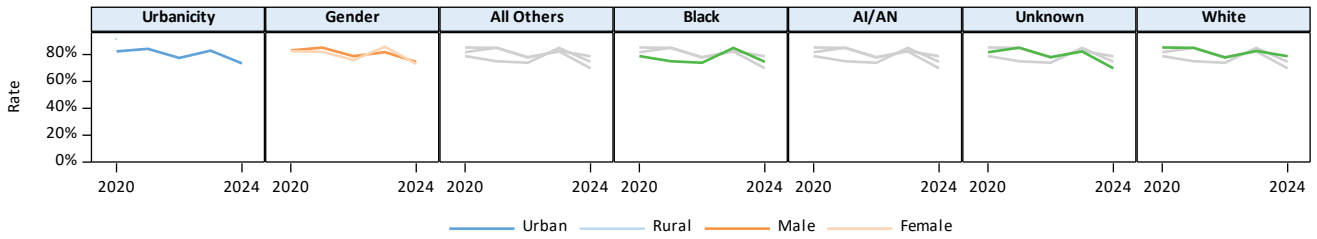
ALTCS-DD Measure 1-4: Percentage of members who had a well-child visit in the first 30 months of life (two or more well-child visits between the child's 15-month and 30-month birthday)



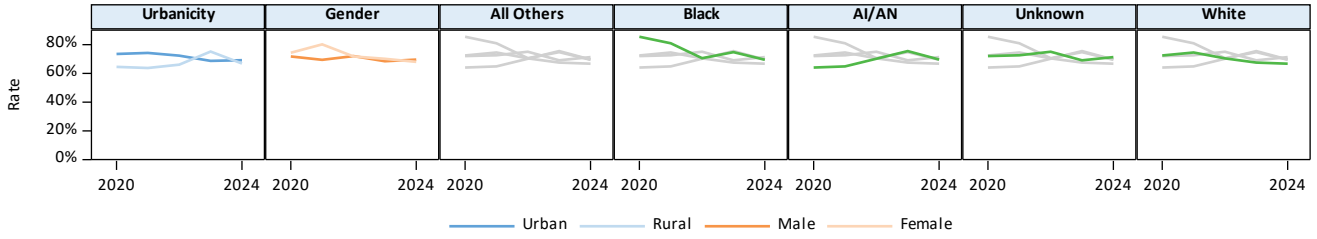
ALTCS-DD Measure 1-5: Percentage of members 3–21 years of age who had a well-care visit with a PCP or OB/GYN



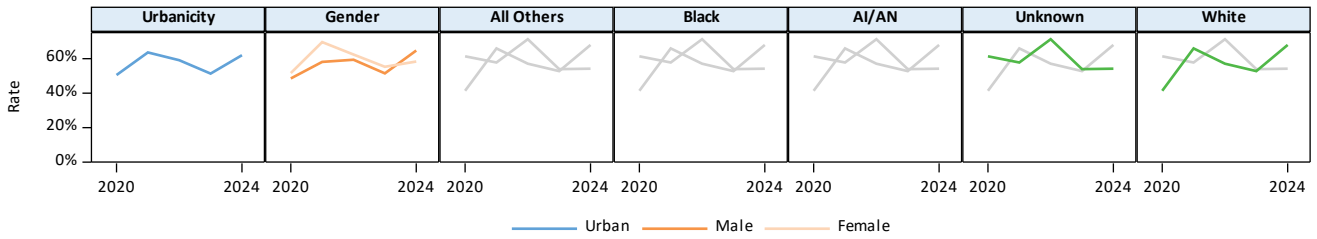
ALTCS-DD Measure 2-1: Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent



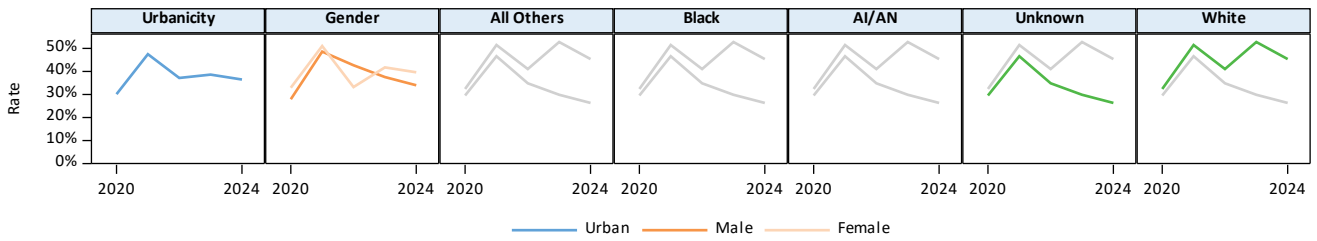
ALTCS-DD Measure 2-2: Percentage of members with a follow-up visit after hospitalization for mental illness



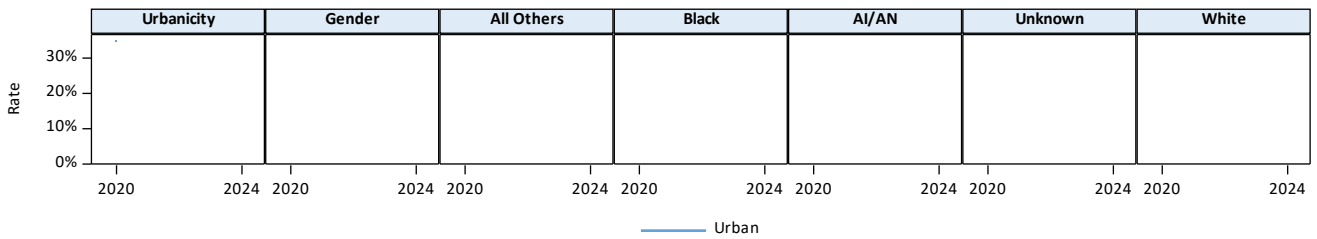
ALTCS-DD Measure 2-3: Percentage of adult members who remained on an antidepressant medication treatment (84 days)



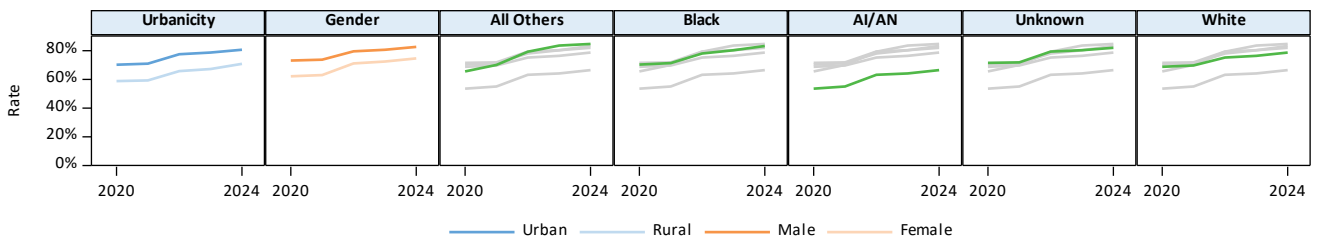
ALTCS-DD Measure 2-3: Percentage of adult members who remained on an antidepressant medication treatment (180 days)



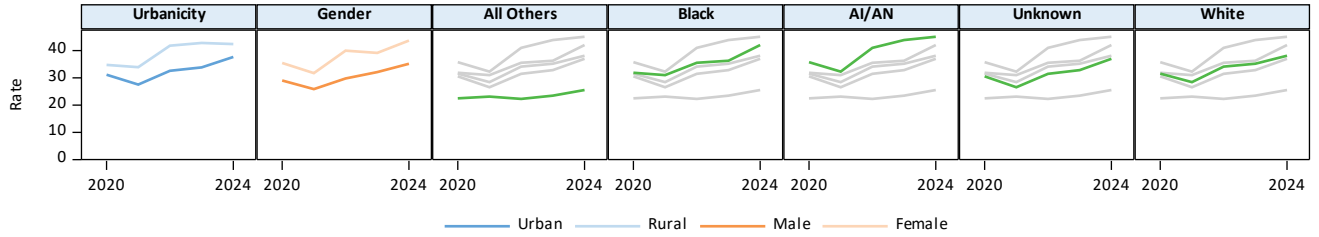
ALTCS-DD Measure 2-4: Percentage of members with follow-up after an ED visit for SUD



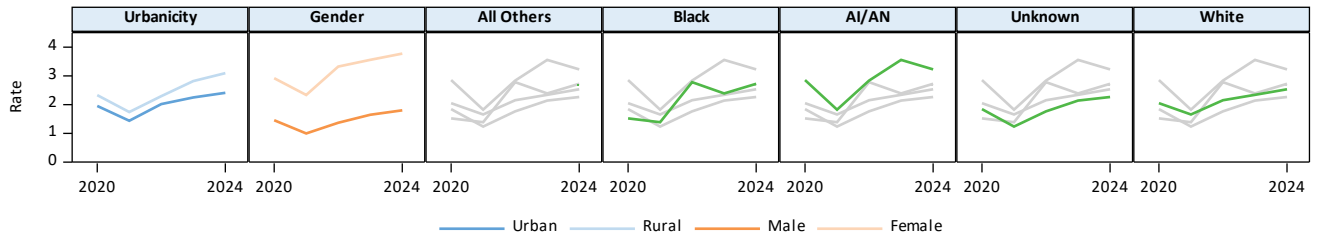
ALTCS-DD Measure 2-5: Percentage of members diagnosed with a mental health disorder



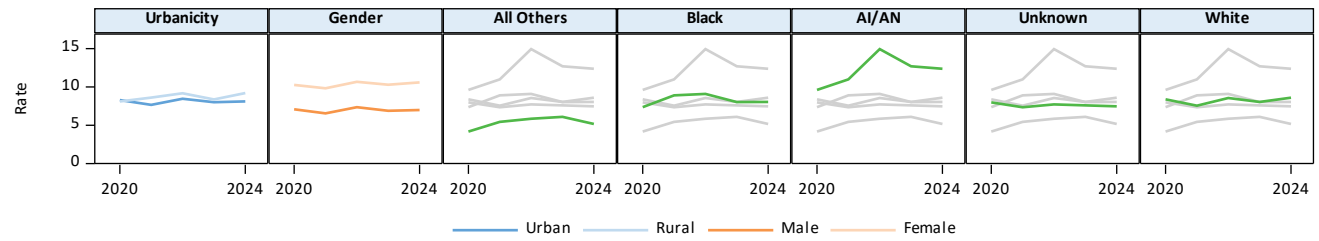
ALTCS-DD Measure 2-8: Number of emergent ED visits per 1,000 member months



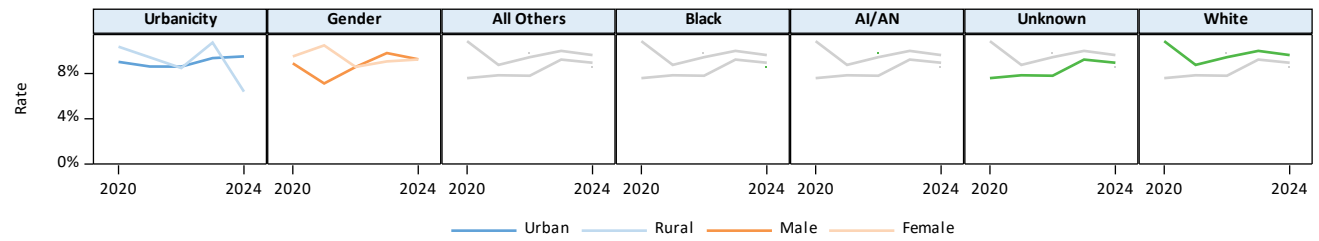
ALTCS-DD Measure 2-9: Number of non-emergent ED visits per 1,000 member months



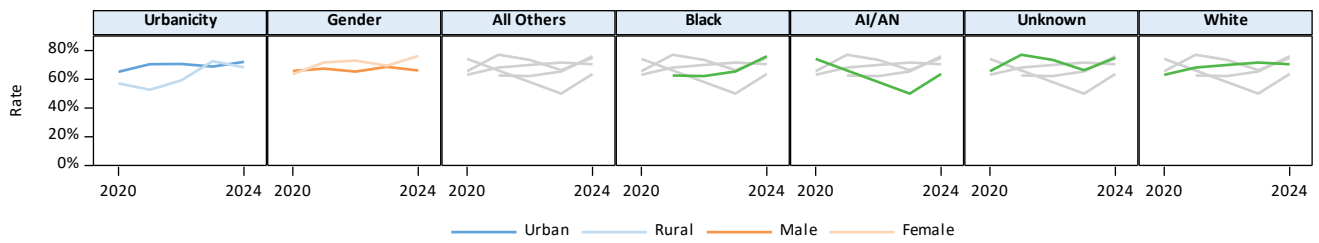
ALTCS-DD Measure 2-10: Number of IP stays per 1,000 member months



ALTCS-DD Measure 2-11: Percentage of adult IP discharges with an unplanned readmission within 30 days



ALTCS-DD Measure 4-9: Percentage of members with multiple high-risk chronic conditions who had follow-up after an ED visit



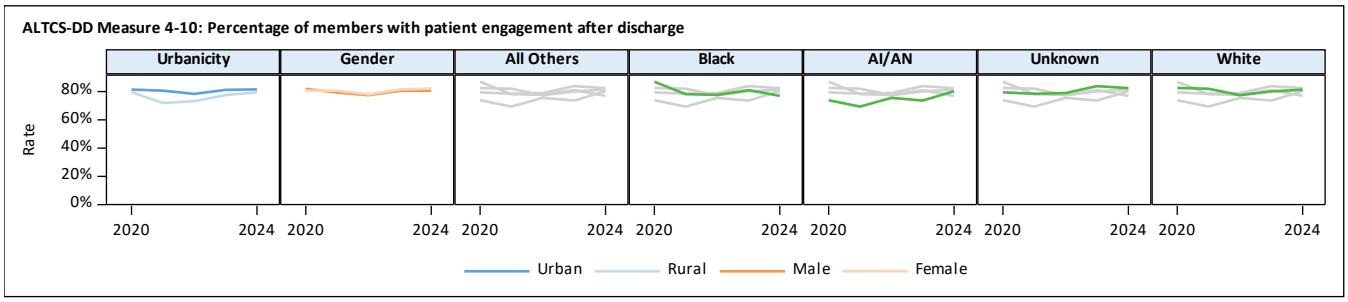
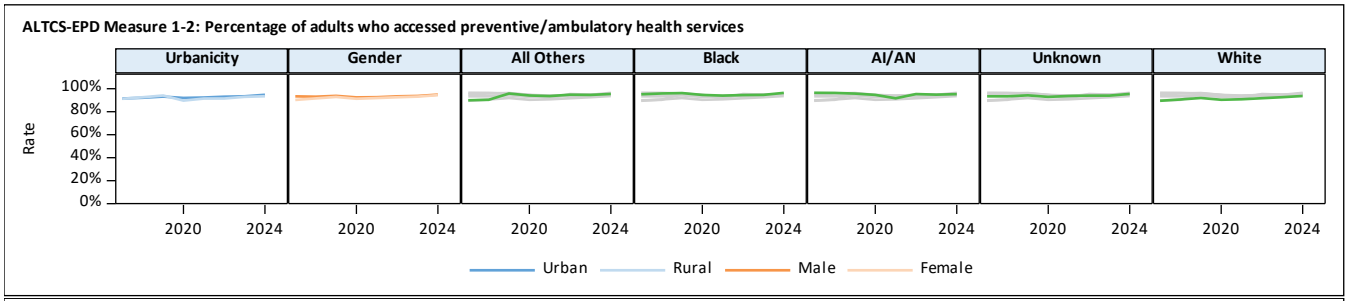
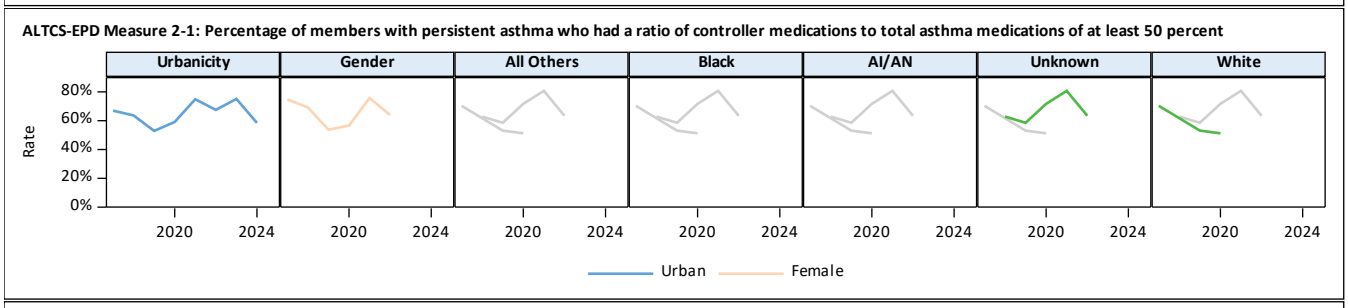
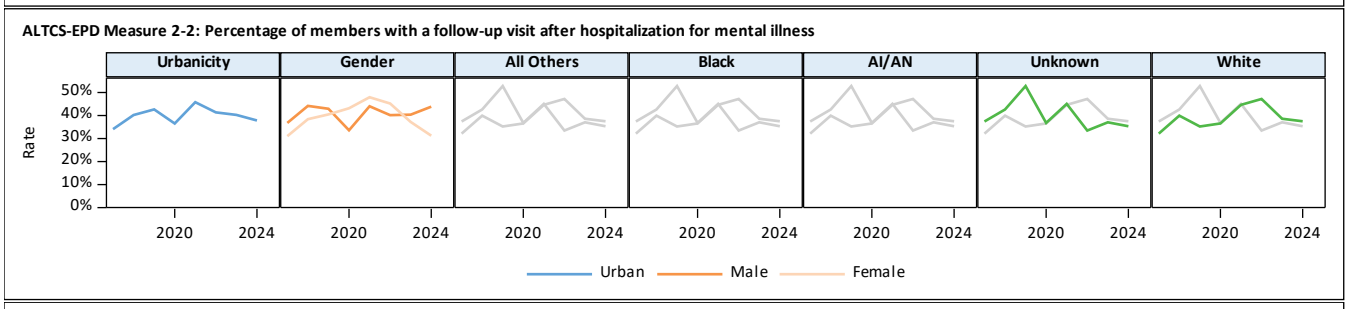
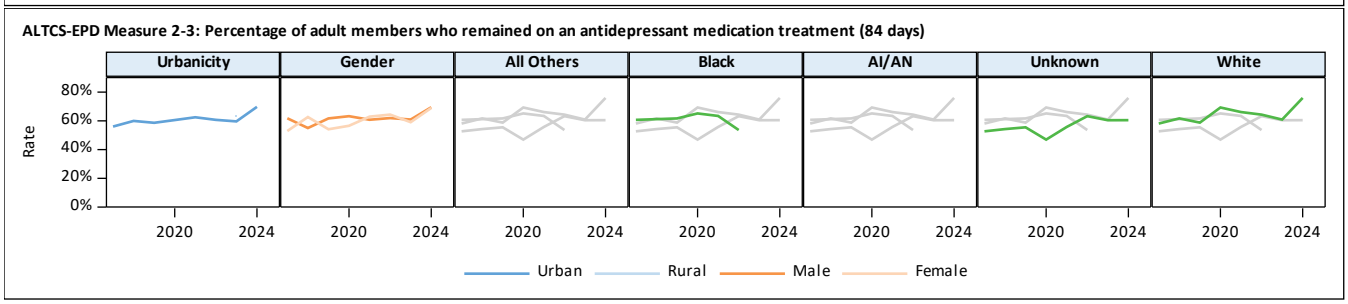


Table A-56—ALTCS-Elderly and/or have Physical Disabilities (EPD) Demographics

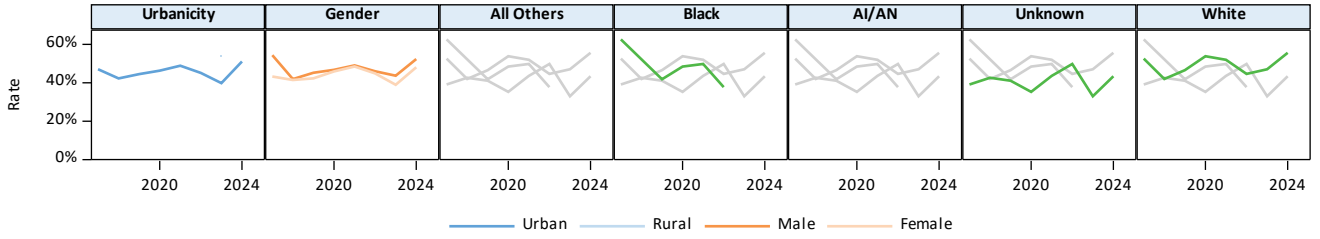




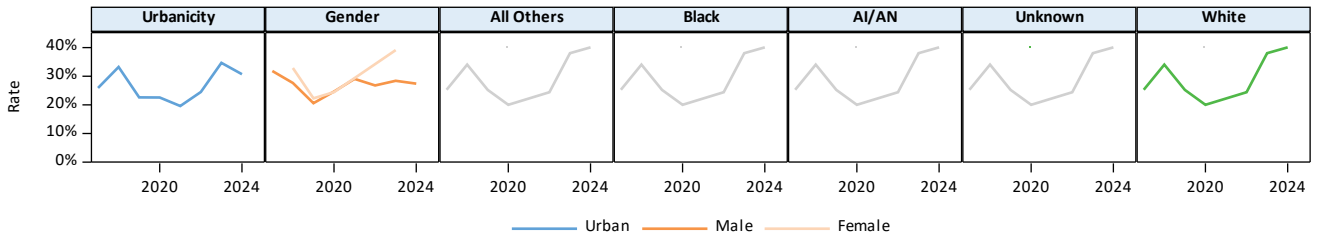




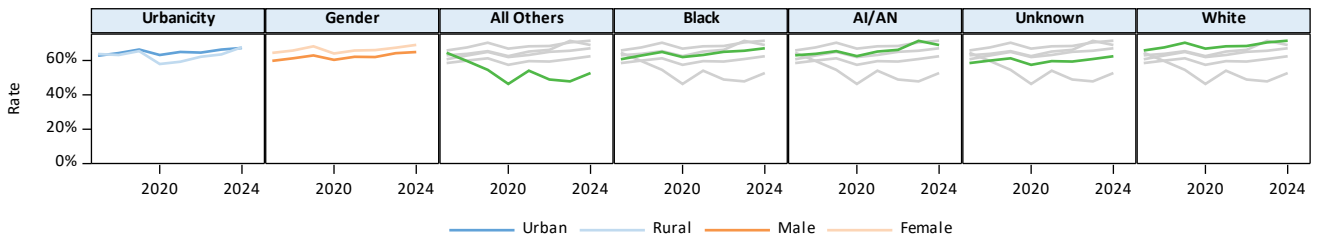
ALTCS-EPD Measure 2-3: Percentage of adult members who remained on an antidepressant medication treatment (180 days)



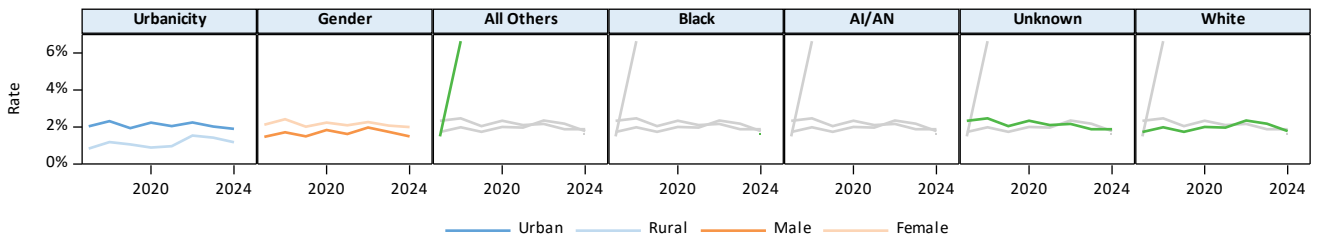
ALTCS-EPD Measure 2-4: Percentage of members with follow-up after an ED visit for SUD



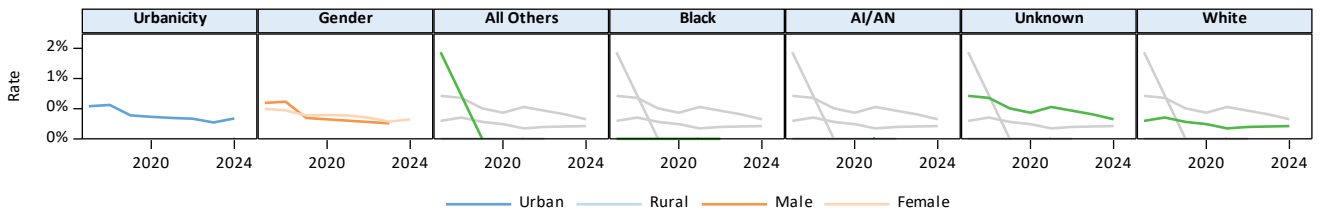
ALTCS-EPD Measure 2-5: Percentage of members diagnosed with a mental health disorder



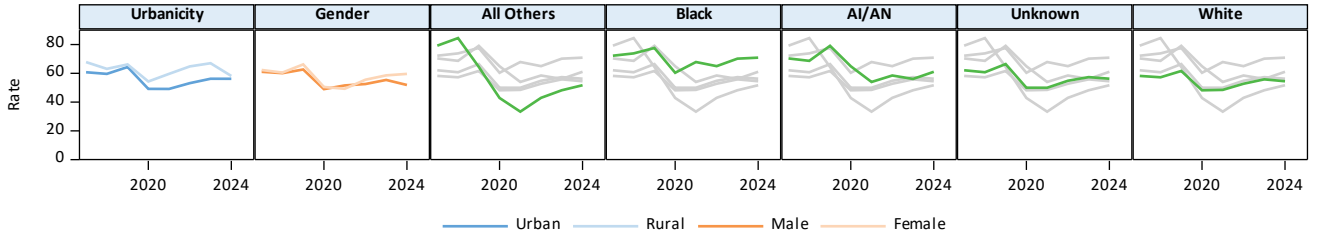
ALTCS-EPD Measure 2-6: Percentage of members aged 67 years or older who received at least two dispensing events for high-risk medications from the same drug class



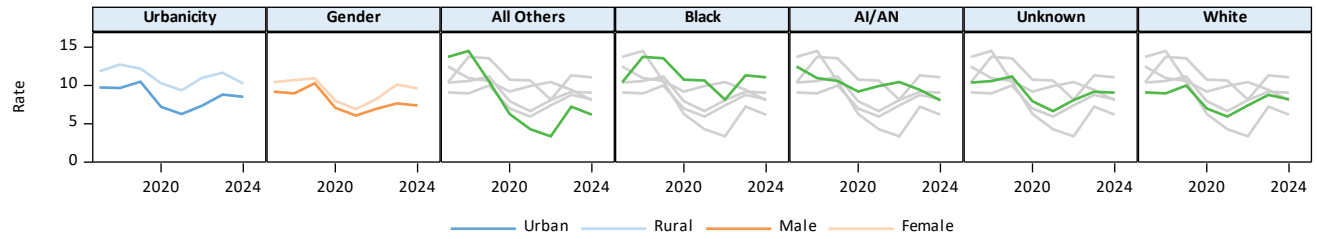
ALTCS-EPD Measure 2-6: Percentage of members aged 67 years or older who received at least two dispensing events for high-risk medications from the same drug class except for appropriate diagnosis



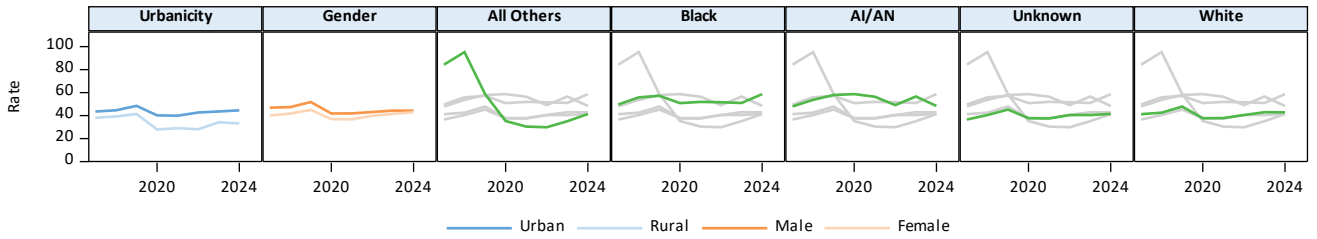
ALTCS-EPD Measure 2-8: Number of emergent ED visits per 1,000 member months



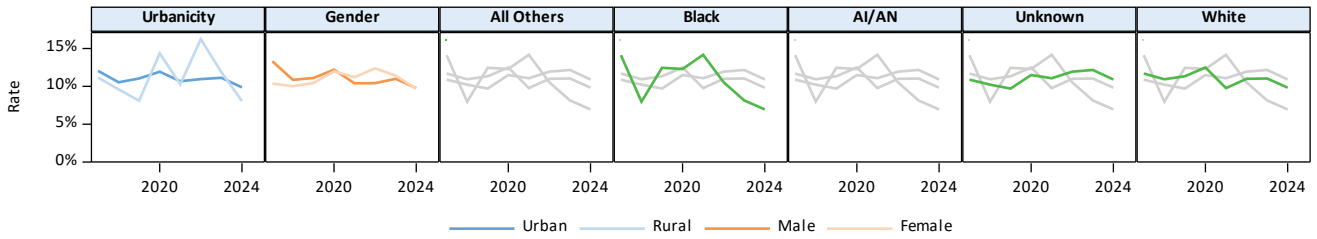
ALTCS-EPD Measure 2-9: Number of non-emergent ED visits per 1,000 member months



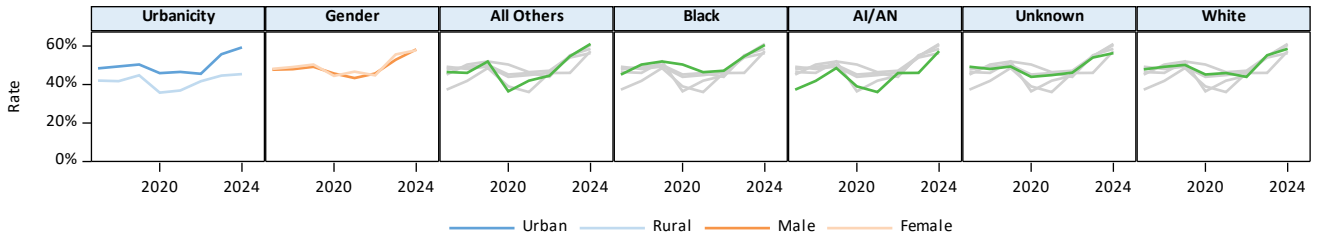
ALTCS-EPD Measure 2-10: Number of IP stays per 1,000 member months



ALTCS-EPD Measure 2-11: Percentage of adult IP discharges with an unplanned readmission within 30 days



ALTCS-EPD Measure 4-9: Percentage of members with multiple high-risk chronic conditions who had follow-up after an ED visit



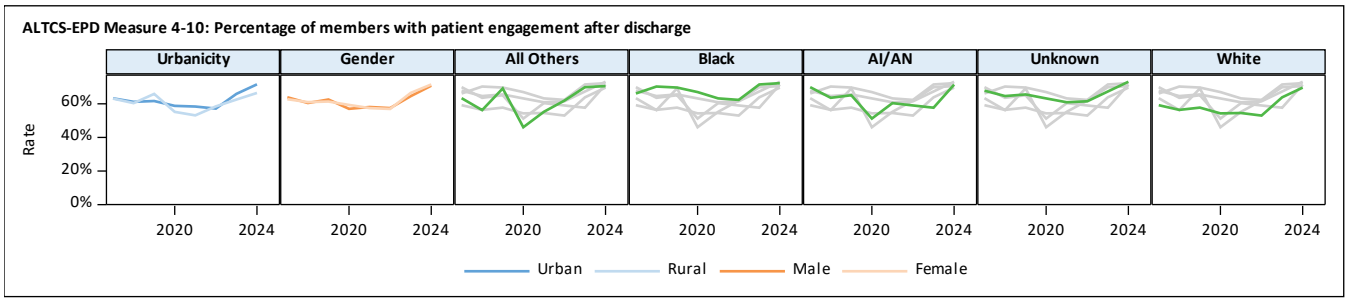


Table A-57—ALTCS-DD PMPM Costs (Total)

Variable	Estimate	*p*-value
Intercept	$4,128.35 ***	<0.001
	(93.384)	
Baseline monthly trend	$8.41 **	0.021
	(3.545)	
Level change at implementation	$227.75 **	0.031
	(102.455)	
Change in monthly trend	$41.34 ***	<0.001
	(6.375)	
COVID-19 Lockdown (Q2 2020)	$7.59	0.954
	(129.598)	
COVID-19 (June 2020 - April 2021)	$255.49 **	0.001
	(73.276)	
Seasonality: Q2	$9.15	0.893
	(67.890)	
Seasonality: Q3	$16.67	0.810
	(68.985)	
Seasonality: Q4	$0.82	0.990
	(68.121)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-58—ALTCS-DD PMPM Costs (Professional)

Variable	Estimate	*p*-value
Intercept	$3,643.14 ***	<0.001
	(89.323)	
Baseline monthly trend	$8.25 **	0.019
	(3.391)	
Level change at implementation	$273.38 **	0.007
	(97.999)	
Change in monthly trend	$36.91 ***	<0.001
	(6.098)	
COVID-19 Lockdown (Q2 2020)	$2.54	0.984
	(123.962)	
COVID-19 (June 2020 - April 2021)	$190.07 **	0.009
	(70.089)	
Seasonality: Q2	$23.59	0.718
	(64.937)	
Seasonality: Q3	$50.71	0.446
	(65.984)	
Seasonality: Q4	-$15.64	0.811
	(65.158)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-59— ALTCS-DD PMPM Costs (IP)

Variable	Estimate	*p*-value
Intercept	$162.63 ***	<0.001
	(18.147)	
Baseline monthly trend	-$0.42	0.540
	(0.689)	
Level change at implementation	-$14.94	0.456
	(19.909)	
Change in monthly trend	$0.81	0.515
	(1.239)	
COVID-19 Lockdown (Q2 2020)	-$6.15	0.808
	(25.184)	
COVID-19 (June 2020 - April 2021)	$11.36	0.429
	(14.239)	
Seasonality: Q2	$2.68	0.840
	(13.192)	
Seasonality: Q3	-$6.53	0.628
	(13.405)	
Seasonality: Q4	-$9.74	0.465
	(13.237)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-60—ALTCS-DD PMPM Costs (LTC)

Variable	Estimate	*p*-value
Intercept	$45.57 ***	<0.001
	(3.154)	
Baseline monthly trend	-$0.30 **	0.015
	(0.120)	
Level change at implementation	$0.21	0.951
	(3.460)	
Change in monthly trend	$0.65 **	0.004
	(0.215)	
COVID-19 Lockdown (Q2 2020)	$4.50	0.309
	(4.377)	
COVID-19 (June 2020 - April 2021)	-$0.64	0.797
	(2.475)	
Seasonality: Q2	-$4.75 **	0.043
	(2.293)	
Seasonality: Q3	-$0.90	0.701
	(2.330)	
Seasonality: Q4	$1.70	0.463
	(2.301)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-61—ACC ALTCS-DD PMPM Costs (OP ED)

Variable	Estimate	*p*-value
Intercept	$17.03 ***	<0.001
	(0.752)	
Baseline monthly trend	-$0.07 **	0.026
	(0.029)	
Level change at implementation	$0.61	0.462
	(0.825)	
Change in monthly trend	$0.13 **	0.012
	(0.051)	
COVID-19 Lockdown (Q2 2020)	-$4.10 ***	<0.001
	(1.044)	
COVID-19 (June 2020 - April 2021)	-$3.67 ***	<0.001
	(0.590)	
Seasonality: Q2	-$1.52 **	0.007
	(0.547)	
Seasonality: Q3	-$2.01 ***	<0.001
	(0.556)	
Seasonality: Q4	-$0.60	0.278
	(0.549)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-62—ALTCS-DD PMPM Costs (OP Non-ED)

Variable	Estimate	*p*-value
Intercept	$46.89 ***	<0.001
	(3.710)	
Baseline monthly trend	$0.23	0.109
	(0.141)	
Level change at implementation	$1.72	0.675
	(4.071)	
Change in monthly trend	-$0.13	0.597
	(0.253)	
COVID-19 Lockdown (Q2 2020)	-$20.77 ***	<0.001
	(5.149)	
COVID-19 (June 2020 - April 2021)	-$4.99 *	0.093
	(2.911)	
Seasonality: Q2	-$5.59 **	0.043
	(2.697)	
Seasonality: Q3	-$8.15 **	0.005
	(2.741)	
Seasonality: Q4	-$9.43 **	0.001
	(2.706)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-63—ALTCS-DD PMPM Costs (Pharmacy)

Variable	Estimate	*p*-value
Intercept	$213.08 ***	<0.001
	(22.273)	
Baseline monthly trend	$0.72	0.396
	(0.846)	
Level change at implementation	-$33.23	0.180
	(24.436)	
Change in monthly trend	$2.96 *	0.057
	(1.520)	
COVID-19 Lockdown (Q2 2020)	$31.56	0.312
	(30.910)	
COVID-19 (June 2020 - April 2021)	$63.36 ***	<0.001
	(17.477)	
Seasonality: Q2	-$5.25	0.747
	(16.192)	
Seasonality: Q3	-$16.46	0.322
	(16.453)	
Seasonality: Q4	$34.53 **	0.038
	(16.247)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-64—ALTCS-DD Aggregate Costs (Total, in Thousands)

Variable	Estimate	*p*-value
Intercept	$142,976.80 ***	<0.001
	(3598.276)	
Baseline monthly trend	$794.90 ***	<0.001
	(136.614)	
Level change at implementation	$8,096.30 **	0.045
	(3947.792)	
Change in monthly trend	$2,431.20 ***	<0.001
	(245.639)	
COVID-19 Lockdown (Q2 2020)	$809.90	0.872
	(4993.654)	
COVID-19 (June 2020 - April 2021)	$9,142.50 **	0.002
	(2823.470)	
Seasonality: Q2	$443.20	0.866
	(2615.925)	
Seasonality: Q3	$1,566.30	0.558
	(2658.112)	
Seasonality: Q4	$552.10	0.834
	(2624.824)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-65—ALTCS-DD Aggregate Costs (Professional, in Thousands)

Variable	Estimate	*p*-value
Intercept	$126,172.10 ***	<0.001
	(3405.426)	
Baseline monthly trend	$733.00 ***	<0.001
	(129.292)	
Level change at implementation	$9,883.00 **	0.011
	(3736.210)	
Change in monthly trend	$2,202.50 ***	<0.001
	(232.474)	
COVID-19 Lockdown (Q2 2020)	$562.50	0.906
	(4726.018)	
COVID-19 (June 2020 - April 2021)	$6,744.30 **	0.015
	(2672.146)	
Seasonality: Q2	$940.20	0.706
	(2475.724)	
Seasonality: Q3	$2,735.90	0.282
	(2515.650)	
Seasonality: Q4	-$78.60	0.975
	(2484.146)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-66—ALTCS-DD Aggregate Costs (IP, in Thousands)

Variable	Estimate	*p*-value
Intercept	$5,624.60 ***	<0.001
	(691.145)	
Baseline monthly trend	$2.50	0.925
	(26.240)	
Level change at implementation	-$598.30	0.434
	(758.279)	
Change in monthly trend	$42.10	0.376
	(47.181)	
COVID-19 Lockdown (Q2 2020)	-$196.20	0.839
	(959.165)	
COVID-19 (June 2020 - April 2021)	$423.40	0.439
	(542.323)	
Seasonality: Q2	$124.30	0.806
	(502.458)	
Seasonality: Q3	-$196.70	0.702
	(510.561)	
Seasonality: Q4	-$315.20	0.535
	(504.168)	

*p<0.1, **p <0.05, ***p <0.001
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-67—ALTCS-DD Aggregate Costs (LTC, in Thousands)

Variable	Estimate	*p*-value
Intercept	$1,586.70 ***	<0.001
	(126.018)	
Baseline monthly trend	-$6.40	0.185
	(4.784)	
Level change at implementation	-$4.80	0.972
	(138.258)	
Change in monthly trend	$29.00 **	0.001
	(8.603)	
COVID-19 Lockdown (Q2 2020)	$179.10	0.311
	(174.886)	
COVID-19 (June 2020 - April 2021)	-$17.00	0.864
	(98.883)	
Seasonality: Q2	-$189.60 **	0.044
	(91.614)	
Seasonality: Q3	-$26.40	0.778
	(93.091)	
Seasonality: Q4	$68.30	0.461
	(91.926)	

*p<0.1, **p <0.05, ***p <0.001
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-68—ALTCS-DD Aggregate Costs (OP ED, in Thousands)

Variable	Estimate	*p*-value
Intercept	$592.20 ***	<0.001
	(28.550)	
Baseline monthly trend	-$0.60	0.576
	(1.084)	
Level change at implementation	$22.30	0.479
	(31.323)	
Change in monthly trend	$6.50 **	0.002
	(1.949)	
COVID-19 Lockdown (Q2 2020)	-$143.00 ***	<0.001
	(39.621)	
COVID-19 (June 2020 - April 2021)	-$130.20 ***	<0.001
	(22.402)	
Seasonality: Q2	-$55.70 **	0.010
	(20.755)	
Seasonality: Q3	-$74.30 ***	<0.001
	(21.090)	
Seasonality: Q4	-$21.60	0.305
	(20.826)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-69—ALTCS-DD Aggregate Costs (OP Non-ED, in Thousands)

Variable	Estimate	*p*-value
Intercept	$1,637.80 ***	<0.001
	(143.194)	
Baseline monthly trend	$13.90 **	0.013
	(5.437)	
Level change at implementation	$65.20	0.680
	(157.103)	
Change in monthly trend	$1.50	0.877
	(9.775)	
COVID-19 Lockdown (Q2 2020)	-$734.90 ***	<0.001
	(198.723)	
COVID-19 (June 2020 - April 2021)	-$181.50	0.112
	(112.360)	
Seasonality: Q2	-$214.60 **	0.044
	(104.101)	
Seasonality: Q3	-$304.60 **	0.006
	(105.780)	
Seasonality: Q4	-$360.90 **	0.001
	(104.455)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-70—ALTCS-DD Aggregate Costs (Pharmacy, in Thousands)

Variable	Estimate	*p*-value
Intercept	$7,363.50 ***	<0.001
	(827.359)	
Baseline monthly trend	$52.50	0.101
	(31.412)	
Level change at implementation	-$1,271.00	0.168
	(907.725)	
Change in monthly trend	$149.60 **	0.011
	(56.480)	
COVID-19 Lockdown (Q2 2020)	$1,142.40	0.324
	(1148.202)	
COVID-19 (June 2020 - April 2021)	$2,303.50 ***	<0.001
	(649.207)	
Seasonality: Q2	-$161.40	0.790
	(601.485)	
Seasonality: Q3	-$567.60	0.357
	(611.185)	
Seasonality: Q4	$1,260.00 **	0.042
	(603.532)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-71—ALTCS-EPD PMPM Costs (Total)

Variable	Estimate	*p*-value
Intercept	$3,676.45 ***	<0.001
	(44.374)	
Baseline monthly trend	$8.82 ***	<0.001
	(0.917)	
Level change at implementation	$358.94 ***	<0.001
	(75.391)	
Change in monthly trend	$11.84 **	0.014
	(4.705)	
COVID-19 Lockdown (Q2 2020)	-$75.74	0.416
	(92.675)	
COVID-19 (June 2020 - April 2021)	-$84.24	0.113
	(52.545)	
Seasonality: Q2	-$37.75	0.399
	(44.537)	
Seasonality: Q3	-$72.00	0.114
	(45.083)	
Seasonality: Q4	$52.82	0.238
	(44.471)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-72—ALTCS-EPD PMPM Costs (Professional)

Variable	Estimate	*p*-value
Intercept	$1,773.17 ***	<0.001
	(21.530)	
Baseline monthly trend	$6.24 ***	<0.001
	(0.445)	
Level change at implementation	$173.72 ***	<0.001
	(36.579)	
Change in monthly trend	$4.09 *	0.077
	(2.283)	
COVID-19 Lockdown (Q2 2020)	$1.08	0.981
	(44.965)	
COVID-19 (June 2020 - April 2021)	$14.21	0.579
	(25.495)	
Seasonality: Q2	-$32.14	0.141
	(21.609)	
Seasonality: Q3	-$47.80 **	0.032
	(21.874)	
Seasonality: Q4	$7.30	0.736
	(21.577)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-73—ALTCS-EPD PMPM Costs (IP)

Variable	Estimate	*p*-value
Intercept	$170.80 ***	<0.001
	(9.938)	
Baseline monthly trend	$0.49 **	0.020
	(0.205)	
Level change at implementation	$0.82	0.962
	(16.884)	
Change in monthly trend	-$1.93 *	0.070
	(1.054)	
COVID-19 Lockdown (Q2 2020)	-$50.37 **	0.017
	(20.755)	
COVID-19 (June 2020 - April 2021)	-$14.51	0.221
	(11.768)	
Seasonality: Q2	-$13.39	0.183
	(9.974)	
Seasonality: Q3	-$25.93 **	0.012
	(10.097)	
Seasonality: Q4	-$8.86	0.376
	(9.959)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-74—ALTCS-EPD PMPM Costs (LTC)

Variable	Estimate	*p*-value
Intercept	$1,506.78 ***	<0.001
	(17.670)	
Baseline monthly trend	$0.88 **	0.018
	(0.365)	
Level change at implementation	$201.26 ***	<0.001
	(30.021)	
Change in monthly trend	$8.26 ***	<0.001
	(1.874)	
COVID-19 Lockdown (Q2 2020)	-$20.02	0.589
	(36.904)	
COVID-19 (June 2020 - April 2021)	-$134.71 ***	<0.001
	(20.924)	
Seasonality: Q2	$5.88	0.741
	(17.735)	
Seasonality: Q3	$6.59	0.714
	(17.953)	
Seasonality: Q4	$42.77 **	0.018
	(17.709)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-75—ALTCS-EPD PMPM Costs (OP ED)

Variable	Estimate	*p*-value
Intercept	$19.70 ***	<0.001
	(0.572)	
Baseline monthly trend	>-$0.01	0.757
	(0.012)	
Level change at implementation	$0.76	0.439
	(0.972)	
Change in monthly trend	-$0.08	0.172
	(0.061)	
COVID-19 Lockdown (Q2 2020)	-$8.05 ***	<0.001
	(1.195)	
COVID-19 (June 2020 - April 2021)	-$3.95 ***	<0.001
	(0.677)	
Seasonality: Q2	$0.51	0.375
	(0.574)	
Seasonality: Q3	-$0.89	0.129
	(0.581)	
Seasonality: Q4	-$0.73	0.209
	(0.573)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-76—ALTCS-EPD PMPM Costs (OP Non-ED)

Variable	Estimate	*p*-value
Intercept	$83.80 ***	<0.001
	(1.838)	
Baseline monthly trend	-$0.06 *	0.099
	(0.038)	
Level change at implementation	-$4.69	0.137
	(3.124)	
Change in monthly trend	$0.40 **	0.045
	(0.195)	
COVID-19 Lockdown (Q2 2020)	-$14.72 ***	<0.001
	(3.840)	
COVID-19 (June 2020 - April 2021)	-$1.64	0.454
	(2.177)	
Seasonality: Q2	$1.25	0.501
	(1.845)	
Seasonality: Q3	-$5.59 **	0.004
	(1.868)	
Seasonality: Q4	-$4.39 **	0.019
	(1.843)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-77—ALTCS-EPD PMPM Costs (Pharmacy)

Variable	Estimate	*p*-value
Intercept	$122.19 ***	<0.001
	(10.016)	
Baseline monthly trend	$1.28 ***	<0.001
	(0.207)	
Level change at implementation	-$12.93	0.450
	(17.018)	
Change in monthly trend	$1.11	0.300
	(1.062)	
COVID-19 Lockdown (Q2 2020)	$16.35	0.437
	(20.919)	
COVID-19 (June 2020 - April 2021)	$56.35 ***	<0.001
	(11.861)	
Seasonality: Q2	$0.13	0.989
	(10.053)	
Seasonality: Q3	$1.62	0.874
	(10.177)	
Seasonality: Q4	$16.73 *	0.099
	(10.038)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-78—ALTCS-EPD Aggregate Costs (Total, in Thousands)

Variable	Estimate	*p* -value
Intercept	$103,857.20 ***	<0.001
	(1548.254)	
Baseline monthly trend	$163.20 ***	<0.001
	(31.979)	
Level change at implementation	$6,668.60 **	0.013
	(2630.495)	
Change in monthly trend	$389.40 **	0.020
	(164.166)	
COVID-19 Lockdown (Q2 2020)	$5,657.00 *	0.084
	(3233.553)	
COVID-19 (June 2020 - April 2021)	-$2,153.40	0.243
	(1833.372)	
Seasonality: Q2	-$941.80	0.546
	(1553.945)	
Seasonality: Q3	-$270.80	0.864
	(1573.020)	
Seasonality: Q4	$2,501.80	0.110
	(1551.642)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-79— ALTCS-EPD Aggregate Costs (Professional, in Thousands)

Variable	Estimate	*p* -value
Intercept	$50,141.00 ***	<0.001
	(771.547)	
Baseline monthly trend	$131.20 ***	<0.001
	(15.936)	
Level change at implementation	$3,160.10 **	0.018
	(1310.864)	
Change in monthly trend	$145.30 *	0.079
	(81.809)	
COVID-19 Lockdown (Q2 2020)	$4,002.90 **	0.015
	(1611.389)	
COVID-19 (June 2020 - April 2021)	$485.90	0.596
	(913.631)	
Seasonality: Q2	-$839.40	0.281
	(774.383)	
Seasonality: Q3	-$449.80	0.568
	(783.889)	
Seasonality: Q4	$734.40	0.345
	(773.235)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-80—ALTCS-EPD Aggregate Costs (IP, in Thousands)

Variable	Estimate	*p*-value
Intercept	$4,809.10 ***	<0.001
	(268.904)	
Baseline monthly trend	$9.70 *	0.083
	(5.554)	
Level change at implementation	-$100.50	0.826
	(456.870)	
Change in monthly trend	-$47.40 *	0.100
	(28.513)	
COVID-19 Lockdown (Q2 2020)	-$1,115.30 *	0.050
	(561.610)	
COVID-19 (June 2020 - April 2021)	-$389.00	0.225
	(318.424)	
Seasonality: Q2	-$346.40	0.203
	(269.892)	
Seasonality: Q3	-$622.40 **	0.025
	(273.205)	
Seasonality: Q4	-$181.20	0.503
	(269.492)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-81—ALTCS-EPD Aggregate Costs (LTC, in Thousands)

Variable	Estimate	*p*-value
Intercept	$42,512.10 ***	<0.001
	(601.360)	
Baseline monthly trend	-$5.40	0.665
	(12.421)	
Level change at implementation	$4,247.20 ***	<0.001
	(1021.716)	
Change in monthly trend	$249.00 ***	<0.001
	(63.764)	
COVID-19 Lockdown (Q2 2020)	$2,406.10 *	0.059
	(1255.951)	
COVID-19 (June 2020 - April 2021)	-$3,670.60 ***	<0.001
	(712.104)	
Seasonality: Q2	$175.40	0.772
	(603.571)	
Seasonality: Q3	$809.70	0.189
	(610.980)	
Seasonality: Q4	$1,549.50 **	0.012
	(602.676)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-82—ALTCS-EPD Aggregate Costs (OP ED, in Thousands)

Variable	Estimate	*p*-value
Intercept	$555.30 ***	<0.001
	(18.520)	
Baseline monthly trend	-$0.40	0.254
	(0.383)	
Level change at implementation	$5.00	0.873
	(31.466)	
Change in monthly trend	-$1.80	0.354
	(1.964)	
COVID-19 Lockdown (Q2 2020)	-$199.00 ***	<0.001
	(38.679)	
COVID-19 (June 2020 - April 2021)	-$111.50 ***	<0.001
	(21.931)	
Seasonality: Q2	$14.20	0.448
	(18.588)	
Seasonality: Q3	-$16.20	0.390
	(18.816)	
Seasonality: Q4	-$14.30	0.444
	(18.561)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-83—ALTCS-EPD Aggregate Costs (OP Non-ED, in Thousands)

Variable	Estimate	*p*-value
Intercept	$2,360.40 ***	<0.001
	(61.737)	
Baseline monthly trend	-$3.10 **	0.016
	(1.275)	
Level change at implementation	-$179.60 *	0.090
	(104.892)	
Change in monthly trend	$11.90 *	0.072
	(6.546)	
COVID-19 Lockdown (Q2 2020)	-$278.60 **	0.033
	(128.939)	
COVID-19 (June 2020 - April 2021)	-$52.60	0.474
	(73.106)	
Seasonality: Q2	$34.00	0.585
	(61.964)	
Seasonality: Q3	-$120.10 *	0.059
	(62.725)	
Seasonality: Q4	-$102.70	0.100
	(61.872)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-84—ALTCS-EPD Aggregate Costs (Pharmacy, in Thousands)

Variable	Estimate	*p*-value
Intercept	$3,479.30 *** *(273.594)*	<0.001
Baseline monthly trend	$31.20 *** *(5.651)*	<0.001
Level change at implementation	-$463.60 *(464.838)*	0.321
Change in monthly trend	$32.40 *(29.010)*	0.268
COVID-19 Lockdown (Q2 2020)	$840.90 *(571.405)*	0.145
COVID-19 (June 2020 - April 2021)	$1,584.40 *** *(323.977)*	<0.001
Seasonality: Q2	$20.50 *(274.599)*	0.941
Seasonality: Q3	$128.10 *(277.970)*	0.646
Seasonality: Q4	$516.00 * *(274.192)*	0.063

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-85—ALTCS-Parents as Paid Caregivers (PPCG) (DD) PMPM Costs (Total)

Variable	Estimate	*p*-value
Intercept	$2,698.0 *** *(74.239)*	<0.001
Baseline monthly trend for Comparison	$24.4 *** *(5.531)*	<0.001
Level change at implementation for Comparison	$34.8 *(144.582)*	0.811
Change in monthly trend for Comparison	$51.7 * *(29.465)*	0.085
Difference in intercept for PPCG Group	$343.2 ** *(104.990)*	0.002
Difference in baseline monthly trend for PPCG Group	$51.2 *** *(7.822)*	<0.001
Difference in level change at implementation for PPCG Group	-$18.4 *(204.469)*	0.929
Difference in change in the monthly trend at implementation for PPCG Group	$59.5 *(41.670)*	0.159

*$p < 0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-86—ALTCS-PPCG (DD) PMPM Costs (Professional)

Variable	Estimate	*p*-value
Intercept	$2,191.8 ***	<0.001
	(49.095)	
Baseline monthly trend for Comparison	$24.3 ***	<0.001
	(3.658)	
Level change at implementation for Comparison	$36.1	0.707
	(95.613)	
Change in monthly trend for Comparison	$40.2 **	0.044
	(19.486)	
Difference in intercept for PPCG Group	$467.8 ***	<0.001
	(69.431)	
Difference in baseline monthly trend for PPCG Group	$48.0 ***	<0.001
	(5.173)	
Difference in level change at implementation for PPCG Group	-$38.0	0.780
	(135.217)	
Difference in change in the monthly trend at implementation for PPCG Group	$49.0 *	0.081
	(27.557)	

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-87—ALTCS-PPCG (DD) PMPM Costs (IP)

Variable	Estimate	*p*-value
Intercept	$178.6 ***	<0.001
	(24.187)	
Baseline monthly trend for Comparison	$0.7	0.713
	(1.802)	
Level change at implementation for Comparison	-$23.8	0.616
	(47.104)	
Change in monthly trend for Comparison	$14.2	0.144
	(9.600)	
Difference in intercept for PPCG Group	-$57.2	0.100
	(34.205)	
Difference in baseline monthly trend for PPCG Group	-$0.2	0.948
	(2.548)	
Difference in level change at implementation for PPCG Group	-$20.9	0.754
	(66.615)	
Difference in change in the monthly trend at implementation for PPCG Group	-$15.3	0.266
	(13.576)	

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-88—ALTCS-PPCG (DD) PMPM Costs (LTC)

Variable	Estimate	*p*-value
Intercept	-$0.9 ** *(0.303)*	0.005
Baseline monthly trend for Comparison	$0.1 *** *(0.023)*	<0.001
Level change at implementation for Comparison	-$1.7 ** *(0.589)*	0.005
Change in monthly trend for Comparison	$0.4 ** *(0.120)*	0.006
Difference in intercept for PPCG Group	$0.9 ** *(0.428)*	0.043
Difference in baseline monthly trend for PPCG Group	-$0.1 *** *(0.032)*	<0.001
Difference in level change at implementation for PPCG Group	$1.7 ** *(0.833)*	0.044
Difference in change in the monthly trend at implementation for PPCG Group	-$0.4 ** *(0.170)*	0.046

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-89—ALTCS-PPCG (DD) PMPM Costs (OP ED)

Variable	Estimate	*p*-value
Intercept	$15.1 *** *(0.987)*	<0.001
Baseline monthly trend for Comparison	$0.2 ** *(0.074)*	0.034
Level change at implementation for Comparison	$1.5 *(1.922)*	0.444
Change in monthly trend for Comparison	-$0.8 * *(0.392)*	0.053
Difference in intercept for PPCG Group	-$0.3 *(1.396)*	0.843
Difference in baseline monthly trend for PPCG Group	$0.0 *(0.104)*	0.858
Difference in level change at implementation for PPCG Group	-$0.4 *(2.718)*	0.881
Difference in change in the monthly trend at implementation for PPCG Group	-$0.3 *(0.554)*	0.599

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-90—ALTCS-PPCG (DD) PMPM Costs (OP Non-ED)

Variable	Estimate	*p*-value
Intercept	$76.2 *** *(7.320)*	<0.001
Baseline monthly trend for Comparison	-$0.4 *(0.545)*	0.441
Level change at implementation for Comparison	$4.5 *(14.256)*	0.752
Change in monthly trend for Comparison	$1.7 *(2.905)*	0.566
Difference in intercept for PPCG Group	-$11.1 *(10.352)*	0.287
Difference in baseline monthly trend for PPCG Group	$0.1 *(0.771)*	0.872
Difference in level change at implementation for PPCG Group	$10.8 *(20.162)*	0.596
Difference in change in the monthly trend at implementation for PPCG Group	-$2.8 *(4.109)*	0.492

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-91—ALTCS-PPCG (DD) PMPM Costs (Pharmacy)

Variable	Estimate	*p*-value
Intercept	$237.2 *** *(32.613)*	<0.001
Baseline monthly trend for Comparison	-$0.5 *(2.430)*	0.855
Level change at implementation for Comparison	$18.1 *(63.514)*	0.776
Change in monthly trend for Comparison	-$3.9 *(12.944)*	0.762
Difference in intercept for PPCG Group	-$57.0 *(46.121)*	0.222
Difference in baseline monthly trend for PPCG Group	$3.4 *(3.436)*	0.332
Difference in level change at implementation for PPCG Group	$28.4 *(89.822)*	0.753
Difference in change in the monthly trend at implementation for PPCG Group	$29.2 *(18.305)*	0.116

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-92—ALTCS-PPCG (DD) Total Costs (Total, in Thousands)

Variable	Estimate	*p*-value
Intercept	$24,866.8 *** *(708.587)*	<0.001
Baseline monthly trend for Comparison	$690.2 *** *(52.791)*	<0.001
Level change at implementation for Comparison	$1,860.4 *(1379.978)*	0.183
Change in monthly trend for Comparison	$875.0 ** *(281.235)*	0.003
Difference in intercept for PPCG Group	-$13,643.0 *** *(1002.093)*	<0.001
Difference in baseline monthly trend for PPCG Group	$9.5 *(74.657)*	0.899
Difference in level change at implementation for PPCG Group	-$652.9 *(1951.584)*	0.739
Difference in change in the monthly trend at implementation for PPCG Group	-$38.7 *(397.726)*	0.923

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-93—ALTCS-PPCG (DD) Total Costs (Professional, in Thousands)

Variable	Estimate	*p*-value
Intercept	$20,133.6 *** *(470.080)*	<0.001
Baseline monthly trend for Comparison	$618.5 *** *(35.021)*	<0.001
Level change at implementation for Comparison	$1,692.2 * *(915.485)*	0.070
Change in monthly trend for Comparison	$709.7 *** *(186.573)*	<0.001
Difference in intercept for PPCG Group	-$10,358.7 *** *(664.794)*	<0.001
Difference in baseline monthly trend for PPCG Group	$29.2 *(49.528)*	0.558
Difference in level change at implementation for PPCG Group	-$677.4 *(1294.691)*	0.603
Difference in change in the monthly trend at implementation for PPCG Group	-$11.6 *(263.854)*	0.965

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-94—ALTCS-PPCG (DD) Total Costs (IP, in Thousands)

Variable	Estimate	*p*-value
Intercept	$1,658.7 *** *(268.925)*	<0.001
Baseline monthly trend for Comparison	$33.7 * *(20.035)*	0.099
Level change at implementation for Comparison	-$237.8 *(523.734)*	0.651
Change in monthly trend for Comparison	$198.9 * *(106.735)*	0.068
Difference in intercept for PPCG Group	-$1,191.8 ** *(380.318)*	0.003
Difference in baseline monthly trend for PPCG Group	-$20.4 *(28.334)*	0.474
Difference in level change at implementation for PPCG Group	-$11.2 *(740.672)*	0.988
Difference in change in the monthly trend at implementation for PPCG Group	-$210.0 *(150.947)*	0.170

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-95—ALTCS-PPCG (DD) Total Costs (LTC, in Thousands)

Variable	Estimate	*p*-value
Intercept	-$11.1 ** *(3.822)*	0.005
Baseline monthly trend for Comparison	$1.7 *** *(0.285)*	<0.001
Level change at implementation for Comparison	-$21.4 ** *(7.444)*	0.006
Change in monthly trend for Comparison	$5.1 ** *(1.517)*	0.001
Difference in intercept for PPCG Group	$11.1 ** *(5.406)*	0.044
Difference in baseline monthly trend for PPCG Group	-$1.7 *** *(0.403)*	<0.001
Difference in level change at implementation for PPCG Group	$21.4 ** *(10.528)*	0.047
Difference in change in the monthly trend at implementation for PPCG Group	-$5.1 ** *(2.146)*	0.020

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-96—ALTCS-PPCG (DD) Total Costs (OP ED, in Thousands)

Variable	Estimate	*p*-value
Intercept	$137.9 ***	<0.001
	(9.126)	
Baseline monthly trend for Comparison	$4.2 ***	<0.001
	(0.680)	
Level change at implementation for Comparison	$27.9	0.122
	(17.772)	
Change in monthly trend for Comparison	-$9.7 **	0.009
	(3.622)	
Difference in intercept for PPCG Group	-$81.2 ***	<0.001
	(12.906)	
Difference in baseline monthly trend for PPCG Group	-$2.0 **	0.045
	(0.961)	
Difference in level change at implementation for PPCG Group	-$16.8	0.507
	(25.134)	
Difference in change in the monthly trend at implementation for PPCG Group	$3.2	0.536
	(5.122)	

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-97—ALTCS-PPCG (DD) Total Costs (OP Non-ED, in Thousands)

Variable	Estimate	*p*-value
Intercept	$723.0 ***	<0.001
	(70.304)	
Baseline monthly trend for Comparison	$4.8	0.359
	(5.238)	
Level change at implementation for Comparison	$81.6	0.554
	(136.917)	
Change in monthly trend for Comparison	$23.6	0.402
	(27.903)	
Difference in intercept for PPCG Group	-$470.9 ***	<0.001
	(99.425)	
Difference in baseline monthly trend for PPCG Group	-$0.8	0.912
	(7.407)	
Difference in level change at implementation for PPCG Group	$10.3	0.958
	(193.630)	
Difference in change in the monthly trend at implementation for PPCG Group	-$32.0	0.422
	(39.461)	

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-98—ALTCS-PPCG (DD) Total Costs (Pharmacy, in Thousands)

Variable	Estimate	*p*-value
Intercept	$2,224.7 *** *(208.954)*	<0.001
Baseline monthly trend for Comparison	$27.4 * *(15.567)*	0.084
Level change at implementation for Comparison	$317.9 *(406.939)*	0.438
Change in monthly trend for Comparison	-$52.6 *(82.933)*	0.528
Difference in intercept for PPCG Group	-$1,551.5 *** *(295.505)*	<0.001
Difference in baseline monthly trend for PPCG Group	$5.2 *(22.015)*	0.813
Difference in level change at implementation for PPCG Group	$20.7 *(575.498)*	0.971
Difference in change in the monthly trend at implementation for PPCG Group	$216.8 * *(117.285)*	0.070

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-99—ALTCS-PPCG (EPD) PMPM Costs (Total)

Variable	Estimate	*p*-value
Intercept	$8,086.6 *** *(1899.970)*	<0.001
Baseline monthly trend for Comparison	$79.4 *(141.550)*	0.577
Level change at implementation for Comparison	$1,812.6 *(3700.206)*	0.626
Change in monthly trend for Comparison	-$628.2 *(754.090)*	0.408
Difference in intercept for PPCG Group	$5,618.5 ** *(2686.964)*	0.041
Difference in baseline monthly trend for PPCG Group	-$97.3 *(200.182)*	0.629
Difference in level change at implementation for PPCG Group	-$2,143.8 *(5232.881)*	0.684
Difference in change in the monthly trend at implementation for PPCG Group	$548.9 *(1066.444)*	0.609

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-100—ALTCS-PPCG (EPD) PMPM Costs (Professional)

Variable	Estimate	*p*-value
Intercept	$2,950.9 *** *(112.396)*	<0.001
Baseline monthly trend for Comparison	$36.1 *** *(8.374)*	<0.001
Level change at implementation for Comparison	-$411.7 * *(218.893)*	0.065
Change in monthly trend for Comparison	$19.5 *(44.610)*	0.664
Difference in intercept for PPCG Group	$594.8 *** *(158.953)*	<0.001
Difference in baseline monthly trend for PPCG Group	$19.3 *(11.842)*	0.109
Difference in level change at implementation for PPCG Group	$256.6 *(309.561)*	0.411
Difference in change in the monthly trend at implementation for PPCG Group	-$17.7 *(63.088)*	0.780

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-101—ALTCS-PPCG (EPD) PMPM Costs (IP)

Variable	Estimate	*p*-value
Intercept	$953.5 *(1053.915)*	0.370
Baseline monthly trend for Comparison	$26.4 *(78.518)*	0.738
Level change at implementation for Comparison	$1,702.2 *(2052.507)*	0.410
Change in monthly trend for Comparison	-$406.4 *(418.294)*	0.336
Difference in intercept for PPCG Group	$1,440.9 *(1490.461)*	0.338
Difference in baseline monthly trend for PPCG Group	-$3.4 *(111.041)*	0.976
Difference in level change at implementation for PPCG Group	-$1,890.5 *(2902.683)*	0.518
Difference in change in the monthly trend at implementation for PPCG Group	$176.0 *(591.557)*	0.767

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-102—ALTCS-PPCG (EPD) PMPM Costs (LTC)

Variable	Estimate	*p*-value
Intercept	<$0.01 *(1.144)*	1.000
Baseline monthly trend for Comparison	$0.0 *(0.085)*	1.000
Level change at implementation for Comparison	$1.6 *(2.228)*	0.488
Change in monthly trend for Comparison	$0.9 * *(0.454)*	0.064
Difference in intercept for PPCG Group	>-$0.01 *(1.618)*	1.000
Difference in baseline monthly trend for PPCG Group	$0.0 *(0.121)*	1.000
Difference in level change at implementation for PPCG Group	-$1.6 *(3.151)*	0.623
Difference in change in the monthly trend at implementation for PPCG Group	-$0.9 *(0.642)*	0.187

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-103—ALTCS-PPCG (EPD) PMPM Costs (OP ED)

Variable	Estimate	*p*-value
Intercept	$58.2 *** *(10.377)*	<0.001
Baseline monthly trend for Comparison	-$0.1 *(0.773)*	0.886
Level change at implementation for Comparison	-$22.6 *(20.210)*	0.269
Change in monthly trend for Comparison	$3.1 *(4.119)*	0.460
Difference in intercept for PPCG Group	-$23.0 *(14.676)*	0.122
Difference in baseline monthly trend for PPCG Group	$2.2 ** *(1.093)*	0.047
Difference in level change at implementation for PPCG Group	-$0.9 *(28.581)*	0.975
Difference in change in the monthly trend at implementation for PPCG Group	-$1.2 *(5.825)*	0.843

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-104—ALTCS-PPCG (EPD) PMPM Costs (OP Non-ED)

Variable	Estimate	*p*-value
Intercept	$312.8 *** *(55.331)*	<0.001
Baseline monthly trend for Comparison	-$1.6 *(4.122)*	0.709
Level change at implementation for Comparison	$11.4 *(107.757)*	0.916
Change in monthly trend for Comparison	-$11.6 *(21.961)*	0.598
Difference in intercept for PPCG Group	$216.5 ** *(78.250)*	0.008
Difference in baseline monthly trend for PPCG Group	$9.4 *(5.830)*	0.114
Difference in level change at implementation for PPCG Group	$416.4 ** *(152.392)*	0.008
Difference in change in the monthly trend at implementation for PPCG Group	-$87.0 ** *(31.057)*	0.007

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-105—ALTCS-PPCG (EPD) PMPM Costs (Pharmacy)

Variable	Estimate	*p*-value
Intercept	$3,811.2 ** *(1540.073)*	0.016
Baseline monthly trend for Comparison	$18.6 *(114.737)*	0.872
Level change at implementation for Comparison	$531.7 *(2999.304)*	0.860
Change in monthly trend for Comparison	-$233.6 *(611.248)*	0.704
Difference in intercept for PPCG Group	$3,389.3 *(2177.992)*	0.125
Difference in baseline monthly trend for PPCG Group	-$124.7 *(162.263)*	0.445
Difference in level change at implementation for PPCG Group	-$923.8 *(4241.656)*	0.828
Difference in change in the monthly trend at implementation for PPCG Group	$479.7 *(864.436)*	0.581

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-106—ALTCS-PPCG (EPD) Total Costs (Total, in Thousands)

Variable	Estimate	*p*-value
Intercept	$1,203.4 ***	<0.001
	(275.206)	
Baseline monthly trend for Comparison	$25.5	0.219
	(20.503)	
Level change at implementation for Comparison	$388.7	0.471
	(535.966)	
Change in monthly trend for Comparison	-$108.8	0.324
	(109.228)	
Difference in intercept for PPCG Group	$312.1	0.426
	(389.200)	
Difference in baseline monthly trend for PPCG Group	$15.2	0.603
	(28.996)	
Difference in level change at implementation for PPCG Group	-$326.4	0.668
	(757.970)	
Difference in change in the monthly trend at implementation for PPCG Group	$56.8	0.714
	(154.472)	

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-107—ALTCS-PPCG (EPD) Total Costs (Professional, in Thousands)

Variable	Estimate	*p*-value
Intercept	$437.6 ***	<0.001
	(18.047)	
Baseline monthly trend for Comparison	$10.7 ***	<0.001
	(1.345)	
Level change at implementation for Comparison	-$60.3 *	0.092
	(35.146)	
Change in monthly trend for Comparison	$8.3	0.253
	(7.163)	
Difference in intercept for PPCG Group	-$58.1 **	0.027
	(25.522)	
Difference in baseline monthly trend for PPCG Group	$10.5 ***	<0.001
	(1.901)	
Difference in level change at implementation for PPCG Group	$99.9 **	0.049
	(49.705)	
Difference in change in the monthly trend at implementation for PPCG Group	-$14.5	0.159
	(10.130)	

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-108—ALTCS-PPCG (EPD) Total Costs (IP, in Thousands)

Variable	Estimate	*p* -value
Intercept	$139.3 *(172.749)*	0.423
Baseline monthly trend for Comparison	$6.1 *(12.870)*	0.635
Level change at implementation for Comparison	$334.9 *(336.431)*	0.324
Change in monthly trend for Comparison	-$76.2 *(68.563)*	0.271
Difference in intercept for PPCG Group	$149.3 *(244.304)*	0.544
Difference in baseline monthly trend for PPCG Group	$2.8 *(18.201)*	0.876
Difference in level change at implementation for PPCG Group	-$290.3 *(475.785)*	0.544
Difference in change in the monthly trend at implementation for PPCG Group	$26.4 *(96.963)*	0.787

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-109—ALTCS-PPCG (EPD) Total Costs (LTC, in Thousands)

Variable	Estimate	*p* -value
Intercept	>-$0.1 *(0.228)*	1.000
Baseline monthly trend for Comparison	$0.0 *(0.017)*	1.000
Level change at implementation for Comparison	$0.3 *(0.443)*	0.490
Change in monthly trend for Comparison	$0.2 * *(0.090)*	0.064
Difference in intercept for PPCG Group	<$0.1 *(0.322)*	1.000
Difference in baseline monthly trend for PPCG Group	$0.0 *(0.024)*	1.000
Difference in level change at implementation for PPCG Group	-$0.3 *(0.627)*	0.625
Difference in change in the monthly trend at implementation for PPCG Group	-$0.2 *(0.128)*	0.186

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-110—ALTCS-PPCG (EPD) Total Costs (OP ED, in Thousands)

Variable	Estimate	*p*-value
Intercept	$8.7 ***	<0.001
	(1.771)	
Baseline monthly trend for Comparison	$0.1	0.632
	(0.132)	
Level change at implementation for Comparison	-$4.1	0.245
	(3.450)	
Change in monthly trend for Comparison	$0.6	0.403
	(0.703)	
Difference in intercept for PPCG Group	-$5.4 **	0.036
	(2.505)	
Difference in baseline monthly trend for PPCG Group	$0.4 **	0.024
	(0.187)	
Difference in level change at implementation for PPCG Group	$1.0	0.841
	(4.879)	
Difference in change in the monthly trend at implementation for PPCG Group	-$0.2	0.821
	(0.994)	

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-111—ALTCS-PPCG (EPD) Total Costs (OP Non-ED, in Thousands)

Variable	Estimate	*p*-value
Intercept	$47.0 ***	<0.001
	(8.609)	
Baseline monthly trend for Comparison	$0.1	0.816
	(0.641)	
Level change at implementation for Comparison	$3.3	0.845
	(16.766)	
Change in monthly trend for Comparison	-$2.2	0.517
	(3.417)	
Difference in intercept for PPCG Group	$8.5	0.487
	(12.175)	
Difference in baseline monthly trend for PPCG Group	$3.1 **	0.001
	(0.907)	
Difference in level change at implementation for PPCG Group	$89.3 ***	<0.001
	(23.711)	
Difference in change in the monthly trend at implementation for PPCG Group	-$18.3 ***	<0.001
	(4.832)	

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table A-112—ALTCS-PPCG (EPD) Total Costs (Pharmacy, in Thousands)

Variable	Estimate	*p*-value
Intercept	$570.8 ** *(209.321)*	0.009
Baseline monthly trend for Comparison	$8.5 *(15.595)*	0.589
Level change at implementation for Comparison	$114.5 *(407.654)*	0.780
Change in monthly trend for Comparison	-$39.3 *(83.079)*	0.638
Difference in intercept for PPCG Group	$217.7 *(296.025)*	0.465
Difference in baseline monthly trend for PPCG Group	-$1.7 *(22.054)*	0.938
Difference in level change at implementation for PPCG Group	-$225.9 *(576.510)*	0.697
Difference in change in the monthly trend at implementation for PPCG Group	$63.7 *(117.491)*	0.590

*$p < 0.1$, **$p < 0.05$, ***$p < 0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. PPCG: Parents as Paid Caregivers.

Table 113—NCI Survey Measure Crosswalk Hypotheses 1 and 2

Measure		Survey	Interim Report Measure Nane	Survey Question 2018-2019	2020-2021	2021-2022	2022-2023	2023-2024	Numerator Criteria
1-6	Percentage of members who have a primary care doctor or practitioner	NCI-IDD AFS	Can your family member see a primary care provider (doctor, registered nurse, etc.) when needed?	N/A	N/A	Can your family member see a primary care provider when needed?	N/A	Can your family member see a primary care provider when needed?	Respondent answered "Usually" or "Always"
1-6	Percentage of members who have a primary care doctor or practitioner	NCI-IDD FGS	Can your family member see a primary care provider (doctor, registered nurse, etc.) when needed?	N/A	N/A	Can your family member see a primary care provider (doctor, registered nurse, etc.) when needed?	Same as previous years	Same as previous years	Respondent answered "Usually" or "Always"
1-7	Percentage of members who had a complete physical exam in the past year	NCI-AD	Had a physical exam or wellness visit in the past 12 months	N/A	N/A	N/A	N/A	Had a physical exam or wellness visit in the past 12 months	Respondent answered "Yes"
1-8	Percentage of members who had a dental exam in the past year	NCI-IDD AFS	Can your family member go to the dentist when needed?	Does your family member go to the dentist when needed?	Same as previous years	Can your family member go to the dentist when needed?	N/A	Can your family member go to the dentist when needed?	Respondent answered "Usually" or "Always"
1-8	Percentage of members who had a dental exam in the past year	NCI-IDD FGS	Can your family member go to the dentist when needed?	Does your family member go to the dentist when needed?	Same as previous years	Can your family member go to the dentist when needed?	Same as previous years	Same as previous years	Respondent answered "Usually" or "Always"
1-8	Percentage of members who had a dental exam in the past year	NCI-AD	Percentage of members who had a dental exam in the past year	N/A	N/A	N/A	N/A	Had a dental visit in the past 12 months	Respondent answered "Yes"
1-9	Percentage of members who had an eye exam in the past year	NCI-AD	Had a vision exam in the past year	N/A	N/A	N/A	N/A	Had a vision exam in the past year	Respondent answered "Yes"
1-10	Percentage of members who had an influenza vaccine in the past year	NCI-AD	Had a flu shot in the past 12 months	N/A	N/A	N/A	N/A	Had a flu shot in the past 12 months	Respondent answered "Yes"
2-7	Percentage of members who know what prescription medications are for	NCI-IDD AFS	If your family member takes prescription medications, do you know what they're for?	N/A	N/A	If your family member takes prescription medications, do you know what they're for?	N/A	If your family member takes prescription medications, do you know what they're for?	Respondent answered "Usually" or "Always"
2-7	Percentage of members who know what prescription medications are for	NCI IDD-FGS	If your family member takes prescription medications, do you know what they're for?	N/A	N/A	If your family member takes prescription medications, do you know what they're for?	Same as previous years	Same as previous years	Respondent answered "Usually" or "Always"
2-7	Percentage of members who know what prescription medications	NCI-AD	Knows what prescription medications are for	N/A	N/A	N/A	N/A	Knows what prescription medications are for	Respondent answered "Yes"

Note: AFS: Adult Family Survey; AD: Aging and Disabilities; FGS: Family Guardian Survey; NCI: National Core Indicators; N/A: not applicable.

Table 114—NCI Survey Measure Crosswalk Hypothesis 3

Measure		Survey	Interim Report Measure Nane	Survey Question 2018-2019	2020-2021	2021-2022	2022-2023	2023-2024	Numerator Criteria
3-2	Type of residence for adult members with DD	NCI-IDD FGS	Family Member's Residence	Residence (Specialized Facility for People with Intellectual Disabilities / Group Home or Agency-Operated Apartment /Independent Home or Apartment /Adult Foster Care or Host Family Home / Nursing Home / Homeless / Other)	Same as previous years	Same as previous years	Same as previous years	Same as previous years	Respondent indicates "Independent Home or Apartment"
3-2	Type of residence for adult members with DD	NCI-AD	Type of Residence	N/A	N/A	N/A	N/A	Options are (Own or Family House or Apartment / Senior Living Apartment or Complex / Group Home, Adult Family Home, Foster Home, Host Home / Assisted Living Facility, Residential Care Facility / Nursing Facility, Nursing Home / Homeless or Temporary Shelter / Other / Don't Know or Unclear)	"Own or Family House or Apartment"
3-3	Percentage of members who want to live somewhere else	NCI-AD	Wants to live somewhere else	N/A	N/A	N/A	N/A	Wants to live somewhere else	Respondent answered "Yes"
3-4	Percentage of members who believe services and supports help them live a good life	NCI-IDD AFS	Are services and supports helping your family member to live a good life?	Are services and supports helping your family member to live a good life?	Same as previous years	Same as previous years	N/A	Same as previous years	Respondent answered "Yes"
3-4	Percentage of members who believe services and supports help them live a good life	NCI-IDD FGS	Are services and supports helping your family member to live a good life?	Are services and supports helping your family member to live a good life?	Same as previous years	Same as previous years	Same as previous years	Same as previous years	Respondent answered "Yes"
3-4	Percentage of members who believe services and supports help them live a good life	NCI-AD	Services and supports help them live the life they want	N/A	N/A	N/A	N/A	Services and supports help them live the life they want	Respondent answered "Yes"
3-5	Percentage of members able to go out and do things they like to do in the community	NCI-IDD AFS	Does your family member do things in the community?	Does your family member take part in activities in the community?	Same as previous years	Same as previous years	N/A	Does your family member do things in the community?	Respondent answered "Yes"
3-5	Percentage of members able to go out and do things they like to do in the community	NCI-IDD FGS	Does your family member do things in the community?	Does your family member take part in activities in the community?	Same as previous years	Same as previous years	Same as previous years	Same as previous years	Respondent answered "Yes"
3-5	Percentage of members able to go out and do things they like to do in the community	NCI-AD	Gets to do things outside of their home as much as they want to	N/A	N/A	N/A	N/A	Gets to do things outside of the home as mush as they want to	Respondent answered "Yes"
3-6	Percentage of members who have friends who are not staff or family members	NCI-IDD AFS	Does your family member have friends other than paid support workers or family?	Does your family member have friends other than paid support workers or family?	Same as previous years	Same as previous years	N/A	Does your family member have friends other than paid support workers or family?	Respondent answered "Yes"
3-6	Percentage of members who have friends who are not staff or family members	NCI-IDD FGS	Does your family member have friends other than paid support workers or family?	Does your family member have friends other than paid support workers or family?	Same as previous years	Same as previous years	Same as previous years	Same as previous years	Respondent answered "Yes"
3-6	Percentage of members who have friends who are not staff or family members	NCI-AD	Has friends or family they do not live with who are a part of their life	N/A	N/A	N/A	N/A	Has friends or family they do not live with who are a part of their life	Respondent answered "Yes"
3-8	Percentage of members who usually like how they spend their time during the day	NCI-AD	Usually likes how they spend their time during the day	N/A	N/A	N/A	N/A	Usually like how they spend their time during the day	Respondent answered "Yes," "Always," or "Almost Always"

Note: AFS: Adult Family Survey; AD: Aging and Disabilities; FGS: Family Guardian Survey; NCI: National Core Indicators; N/A: not applicable.

Table 115—NCI Survey Measure Crosswalk Hypothesis 11

Measure		Survey	Interim Report Measure Nane	Survey Question 2018-2019	2020-2021	2021-2022	2022-2023	2023-2024	Numerator Criteria
11-7	The percentage of respondents who report having friendships with people other than staff or family members	NCI-FGS	Does your family member have friends other than paid support workers or family?	NR	NR	NR	NR	Does your family member have friends other than paid support workers or family?	Respondent answered "Yes"
11-9	The percentage of respondents who report often feeling lonely	NCI-AD	Often feels lonely	NR	NR	NR	NR	Often feels lonely	Respondent answered "Yes" or "Often"
11-10	Community inclusion scale	NCI-FGS	Does your family member do things in the community?	NR	NR	NR	NR	Does your family member do things in the community?	Respondent answered "Yes"

Note: AD: Aging and Disabilities; FGS: Family Guardian Survey; NCI: National Core Indicators; NR: not reported for this measure.

Qualitative

Plans

Three ALTCS-EPD plans described successful strategies for providing care coordination. These strategies included:

- Providing person-centered care plans tailored to members to identify gaps in care.
- Inviting family members, friends, and providers to participate in care planning meetings to ensure clear communication and support member engagement.
- Connecting members with community resources and agencies to ensure access to local resources.
- Integrating PH and BH into a comprehensive care plan to support coordination and ease of communication across teams.
- Obtaining a holistic picture of the member through assessments and screenings that capture SDOH, HRSN, and potential overmedication.
- Providing support for family caregivers or other informal caregivers.
- Monitoring success through member satisfaction surveys and Healthcare Effectiveness Data and Information Set (HEDIS)® measure performances.[2]

Plans cited the expansion of telemedicine and technology initiatives as major facilitators of care coordination and member engagement. Plans reported providing tablets or smartphones to members to support making appointments, contacting case managers and clinicians, requesting medication refills, and ordering medical equipment. Plans also offered digital literacy education resources to members, families, and caregivers. Case managers assisted members via telephone or computer, which was especially helpful for members in rural areas or those who had difficulty traveling to medical offices.

Despite these strategies, plans identified member engagement as a barrier to successful care coordination. Accurate contact information was difficult to obtain and was often missing or outdated. Contacting members was especially challenging when members lived at home rather than an assisted living or other residential facility. Additional barriers included inaccurate or incomplete demographic data, challenges with provider reimbursement, limited time to prepare for policy changes, gaps in care team communication, administrative burden at intake, and increased workload.

Plans pointed out that many ALTCS members experience challenges during care transitions, especially when they have good relationships with their teams. Plans emphasized that policy changes or other factors that change these relationships can have a profound impact on members and their care, indicating the importance of consistency.

Plans also described workforce stability challenges, outlined in Table A-116.

[2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Table A-116—Challenges With and Strategies to Address Workforce Stability

Topic	Description
Concerns	• A lack of skilled workers such as DCWs, licensed professionals, and SNF staff, particularly in rural areas, despite an increase in the member population. • Lingering effects of the COVID-19 PHE, such as fewer people in the workforce and/or willing to work in person or in-home settings. • A lack of competition, and therefore competitive rates, in rural areas.
Strategies to improve workforce stability	• Matching members with DCWs based on location, hours needed, and other preferences. • Creating dedicated positions, such as a workforce development administrator, to address issues and provide solutions. • Waiving some educational requirements for case managers. • Expanding recruitment efforts by working with high schools and colleges, attending community events, and outreaching potential candidates, including family members who may want to become formal or informal caregivers. • Supporting candidates' training and certification. • Providing more competitive pay, benefits, and job flexibility. • Using technology to track the workforce to receive notice of staffing needs. • Using technology such as telehealth to provide services to areas with a smaller workforce or fewer resources. • Providing opportunities for growth within the organization.

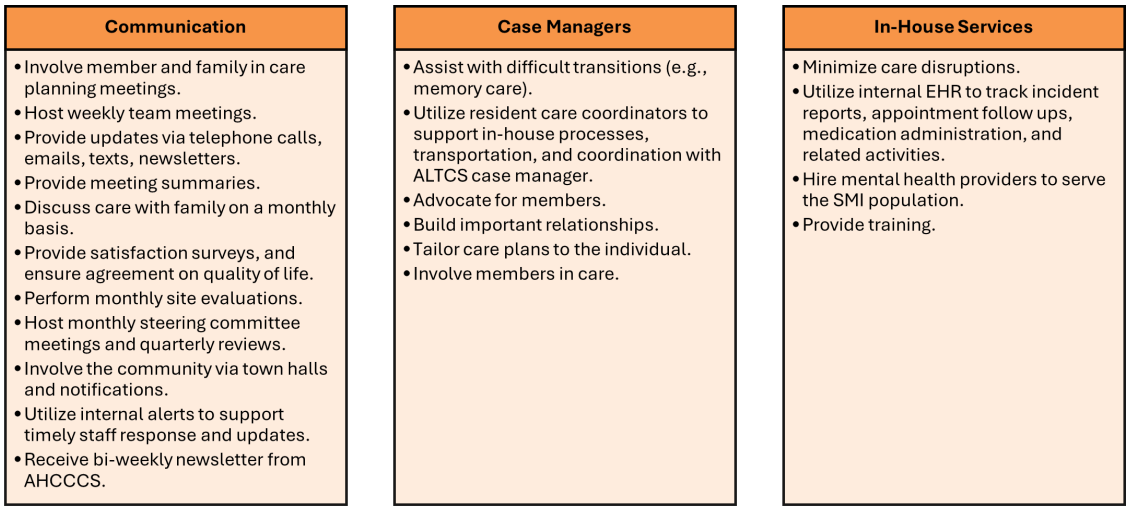
Note: COVID-19: coronavirus disease 2019; DCW: direct care worker; PHE: public health emergency; SNF: skilled nursing facility

Providers

Seven provider organizations were interviewed about ALTCS. Providers emphasized the importance of good communication, the role of case managers, and delivering services in-house when performing care coordination.

Figure A-3 describes the importance of these aspects in more detail.

Figure A-3—Benefits of Communication, Case Managers, and In-House Services



Note: AHCCCS: Arizona Health Care Cost Containment System; ALTCS: Arizona Long Term Care System; EHR: electronic health record; SMI: severe mental illness.

The Parents as Paid Caregivers (PPCG) model was appreciated by some providers, including one organization that accepted referrals for children it otherwise would have declined due to the availability of PPCG. Providers welcomed the stability the PPCG model provided, noting lower turnover among parent caregivers compared to agency caregivers, which supported improved continuity of care. However, providers highlighted challenges related to the weekly 40-hour limit for parent caregivers, which often required families to hire agency caregivers or identify other family members to cover additional hours needed.

Table A-117 lists the barriers to care and care coordination described by providers.

Table A-117—Provider Barriers

Barrier	Issues Encountered
Transportation	• Transportation did not always arrive to take members to or from appointments, causing member frustration and requiring providers to file grievances. • Transportation was difficult to arrange. • Providers reported a lack of financial support to offer transportation services in house.
ALTCS Application Process	• Eligibility evaluations and applications required significant set-up and/or processing time. • The application process increased provider workload due to required member assistance. • Eligibility criteria was unclear and difficult to find. • Providers suggested that AHCCCS hire staff dedicated to assisting members with ALTCS applications and provide application materials to improve efficiency.
Authorizations	• Authorization delays postponed treatment for members. • Prior authorizations took anywhere from 24 hours to three months, during which providers could not bill for services. • Authorizations were denied and required appeals.
Reimbursement/Lack of Funding	• Providers reported a gap between provider costs and reimbursement rates. • Providers experienced increased costs without corresponding rate increases. • Providers reported difficulty getting CHW contracts. • MCOs did not utilize CHW services effectively. • Providers expressed concerns about the Waiver's sustainability, noting that AHCCCS predicted a budget shortfall in 2025.
Communication with AHCCCS	• Providers often did not receive timely responses from AHCCCS. • AHCCCS did not clearly communicate policy changes to members. • Providers reported insufficient training, guidance, and limited time to adjust to new policies.

Note: AHCCCS: Arizona Health Care Cost Containment System; ALTCS: Arizona Long Term Care System; CHW: community health worker; MCO: managed care organization.

Providers shared several suggestions for improvements to ALTCS, including improved member communication from AHCCCS and plans to help members better understand their benefits. Suggested actions included:

- Conducting a new member orientation call from the Medicaid case manager.
- Holding meetings for members when regulations and/or policy changes affects their care.
- Establishing a call center and after-hours line for members and providers to access individualized information.

Providers also emphasized the need for more opportunities for communication between AHCCCS and providers, especially when policy changes are introduced. Providers recommended developing a repository of documents for

all organizations (including providers, AHCCCS, Division of Developmental Disabilities [DDD], etc.) to improve ease of access and reduce administrative burden.

Some providers expressed dissatisfaction with pressure to discharge members with SMI to a lower level of care, noting that this may be cost effective for the State but did not necessarily improve members' quality of care. One provider shared an example in which a member was discharged with nowhere to go, so they ended up in the hospital. Following a 72-hour hold at the hospital, the member was discharged to the street, which providers noted was both costly and disruptive to care.

Providers also reported persistent workforce challenges, including:

- The need to increase compensation without corresponding increases in reimbursement rates.
- High turnover among case managers and care coordinators, affecting continuity of care.
- Difficulty recruiting candidates with the right credentials, especially entry level direct care workers (DCW) and skilled staff for assisted living settings.
- Significant overtime, leading to burnout and reduced quality of care.
- Challenges recruiting in rural areas.

One provider described DCWs as a "revolving door" due to low pay and the difficult work. The provider noted operating with minimal staffing and considering closing some locations because of the lack of staffing and funding.

Strategies that helped address workforce challenges included offering competitive pay, building a positive and supportive company culture to attract and retain candidates, focusing on character and ensuring the candidate was a good fit for the team in addition to ensuring they had the skills needed for the position, and providing sign on and referral bonuses to enhance compensation.

DES/DDD

The Department of Economic Security/DDD (DES/DDD) shared several care coordination strategies to support ALTCS members' health. Care coordination meetings were identified as an important strategy, including meetings with case managers to determine member needs or discharge planning meetings aimed at reducing hospital readmissions. DES/DDD strives to keep members in their homes and out of institutional settings by working closely with programs, families, and community organizations.

DES/DDD established behavioral support group homes to support members with complex conditions while remaining in community-based settings. DES/DDD also collaborated with the DCS to support children entering care and developed a program for children who may be covered by ALTCS. In addition, DES/DDD provided incentive funding and collaborated with health plans to improve responsiveness of provider networks. DES/DDD was also the first State agency to obtain a National Committee for Quality Assurance (NCQA) accreditation.

Due to DES/DDD's role as a State agency, it is subject to regulations that managed care organizations (MCOs) are not, which created barriers to care coordination. These barriers included educating other stakeholders on ALTCS members' needs, coordinating safe discharges, engaging foster youth, and determining which organization was responsible for specific services (e.g., a plan or a school).

DES/DDD implemented several trainings to support education and outreach for direct support professionals (DSPs), members' families, health plans, and staff. DES/DDD also experienced issues with workforce shortages, particularly in rural areas where it was difficult to recruit qualified employees. To address these shortages,

DES/DDD collaborated with AHCCCS to develop the PH and BH workforce and improve access to resources and health care careers.

The PPCG service model expanded during the renewal period, leading DES/DDD to collaborate with AHCCCS to update PPCG policies, guardrails, and tools.

AHCCCS

AHCCCS described its efforts to improve care coordination, including providing person-centered care, incorporating additional mental health and SDOH screenings to better assess member needs, considering the needs and well-being of caregivers providing for members, and having a closed loop system for referrals. Table A-118 provides examples of these efforts.

Table A-118—AHCCCS Strategies to Improve Care Coordination

Strategies	Examples
Person-centered care	• Focused on assessing member needs and developing individualized care plans.
Screenings	• Incorporated mental health and SDOH screenings to more accurately assess members' needs, providing better insight into needs beyond medical care.
Assessing caregiver needs	• Offered resources to caregivers to better address their needs, allowing caregivers to provide a higher quality of care to members. • Facilitated provider visits in member's home, when possible, to reduce the burden of transportation and scheduling for caregiver.
Closed loop system	• Implemented a State mandated referral system, Community Cares, to support plans and case managers in tracking member care and needs.

Note: SDOH: social determinants of health

AHCCCS also described serving an aging population with increasingly complex medical diagnoses, which made care coordination more challenging. One interviewee reported that the number of members requiring LTC with more significant needs doubled in 2025 compared to previous years. Additional barriers to successful care coordination included encouraging collaboration among care teams during care planning meetings, provider understanding of administrative oversight requirements, a perceived increase in individuals with developmental disorders requiring LTC, and providers receiving adequate payment to support the workload they manage.

"That's kind of what keeps us up at night...think[ing] about not only meeting the current need, but what's coming." — AHCCCS staff

AHCCCS staff expressed concern about the workforce capacity and its effect on ALTCS' ability to provide quality care. Staff cited a lack of gerontologists in the State, noting that demand for these providers is expected to grow as the population continues to age. AHCCCS staff also reported that family support for members has decreased as developmental disorders became more prominent, leading to increased pressure on the workforce and decreased advocacy for members' care. Additional workforce challenges included limited financial and holistic support for DCWs, shortages of licensed professionals, and a lack of services and infrastructure in rural communities. Table A-119 provides some solutions that were proposed to address these challenges.

Table A-119—Proposed Solutions to Workforce Challenges

Challenge	Proposed Solution
Lack of support for DCWs	• Increase wages to support DCWs. • Provide benefits such as childcare and transportation assistance. • Introduce policies that allow DCWs who are ACC members to work additional hours without losing Medicaid benefits.
Lack of licensed professionals	• Provide financial support for education, such as tuition reimbursement and educational loan forgiveness.
Lack of services in rural communities	• Pay workers who commute to rural communities for drive time. • Promote development of medical services and infrastructure in rural area.

Note: ACC: AHCCCS Complete Care; DCW: direct care worker

DCS CHP

This section provides the supplemental quantitative and qualitative results for the Department of Child Safety (DCS) Comprehensive Health Plan (CHP).

Quantitative

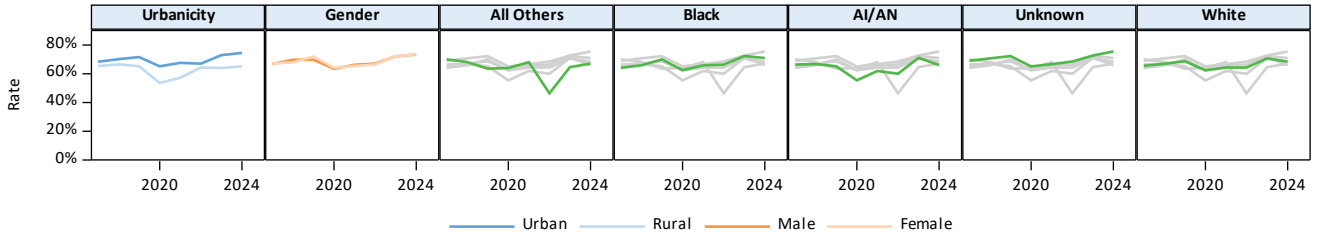
Table A-120—DCS CHP Supplemental Results

Time	BH Residential Facility	BH OP, Pediatric	Cardiologist, Pediatric	Dentist, Pediatric	Hospital	OB/GYN	PCP, Pediatric	Pharmacy
Q4 2019	91.0% N=10,025	93.9% N=12,643	98.2% N=12,644	97.6% N=12,644	99.8% N=12,645	99.3% N=1,071	99.5% N=12,644	99.0% N=12,645
Q4 2020	90.8% N=10,318	95.1% N=13,031	98.9% N=13,033	97.4% N=13,033	99.7% N=13,035	99.5% N=1,062	99.1% N=13,033	99.1% N=13,035
Q4 2021	97.7% N=10,798	97.0% N=13,064	100.0% N=13,171	99.3% N=13,171	99.8% N=13,171	100.0% N=1,144	99.5% N=13,171	98.9% N=13,171
Q2 2022	97.3% N=9,565	97.4% N=11,589	100.0% N=11,730	99.1% N=11,730	99.9% N=11,730	100.0% N=1,337	99.4% N=11,730	98.9% N=11,730
Q4 2022	97.5% N=8,657	97.1% N=10,309	100.0% N=10,455	99.2% N=10,455	99.9% N=10,455	100.0% N=1,181	99.6% N=10,455	98.9% N=10,455
Q2 2023	97.1% N=6,731	97.0% N=8,199	99.9% N=8,355	98.9% N=8,355	99.8% N=8,355	100.0% N=1,115	99.4% N=8,355	98.8% N=8,355
Q4 2023	96.1% N=8,077	97.3% N=9,956	99.9% N=10,110	98.1% N=10,110	99.9% N=10,110	99.9% N=1,122	99.4% N=10,110	98.7% N=10,110
Q2 2024	96.0% N=7,032	98.9% N=8,739	99.9% N=8,743	99.1% N=8,743	100.0% N=8,743	100.0% N=1,014	99.5% N=8,743	98.7% N=8,743
Q4 2024	96.9% N=6,673	98.4% N=8,156	99.9% N=8,316	99.3% N=8,316	99.9% N=8,316	100.0% N=994	99.5% N=8,316	98.7% N=8,316

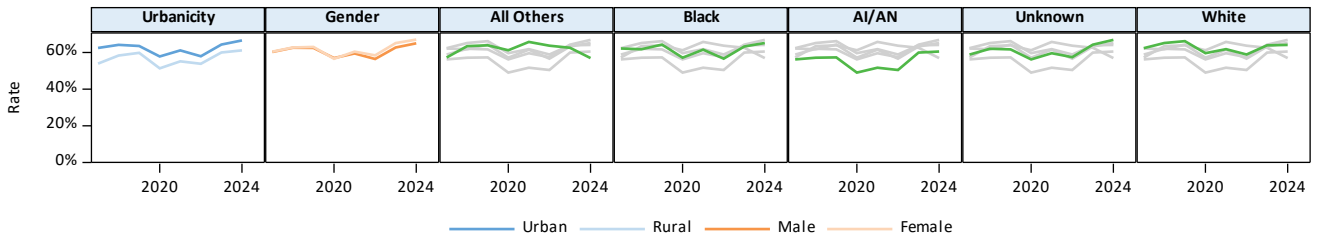
Note: BH: behavioral health; OB/GYN: obstetrics and gynecology; OP: outpatient; PCP: primary care provider; Q: quarter.

Table A-121—DCS CHP Demographics

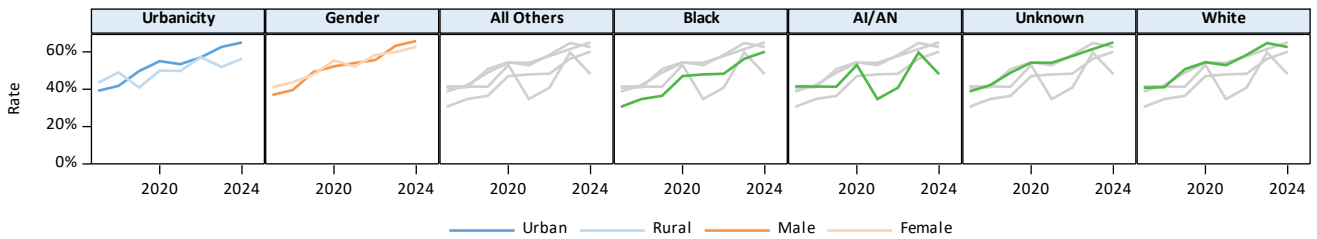
DCS/CHP Measure 1-2: Percentage of members 3–21 years of age who had a well-care visit with a PCP or OB/GYN



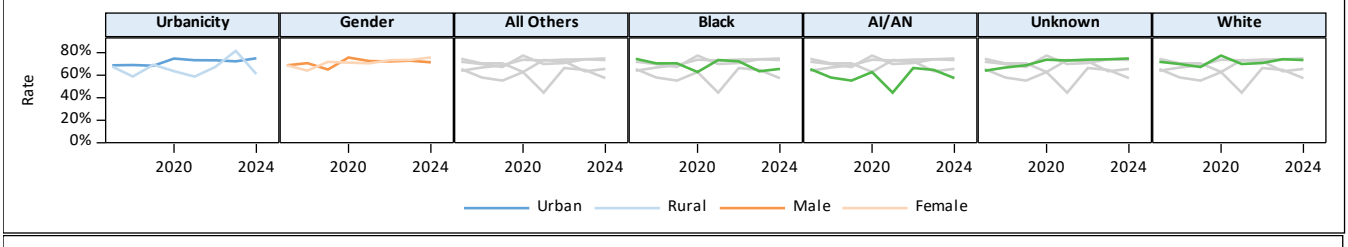
DCS/CHP Measure 1-3: Percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation



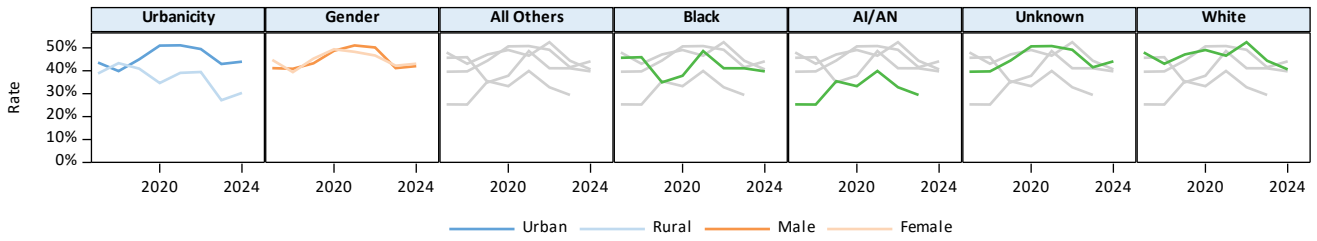
DCS/CHP Measure 1-4: Percentage of members who had a well-child visit in the first 30 months of life (six or more well-child visits before the 15-month birthday)



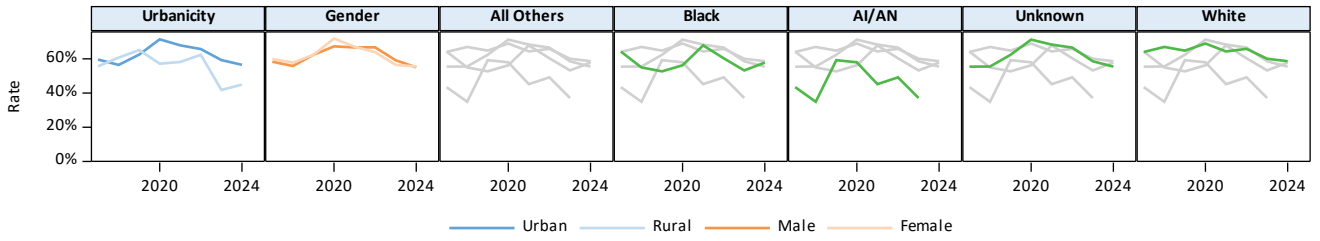
DCS/CHP Measure 1-4: Percentage of members who had a well-child visit in the first 30 months of life (two or more well-child visits between the child's 15-month and 30-month birthday)



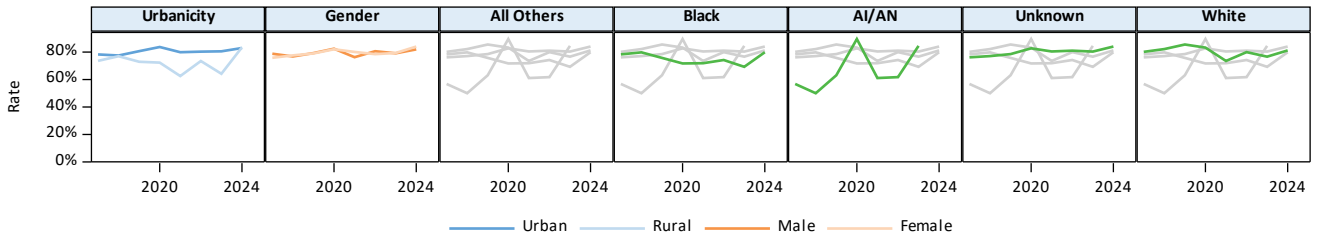
DCS/CHP Measure 2-1: Percentage of children 2 years of age with appropriate immunization status (DTaP)



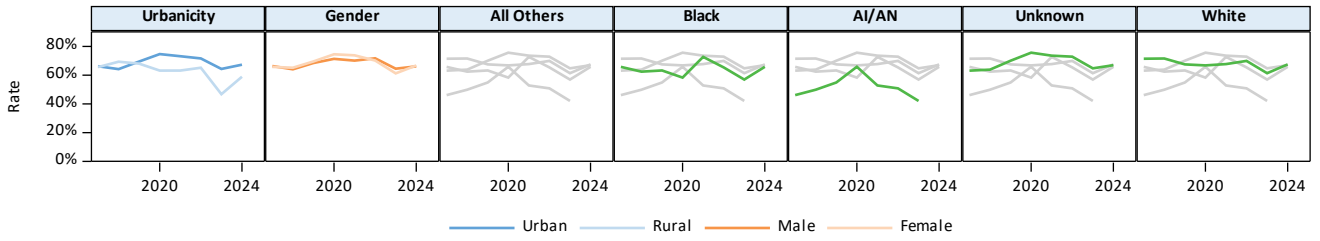
DCS/CHP Measure 2-1: Percentage of children 2 years of age with appropriate immunization status (IPV)



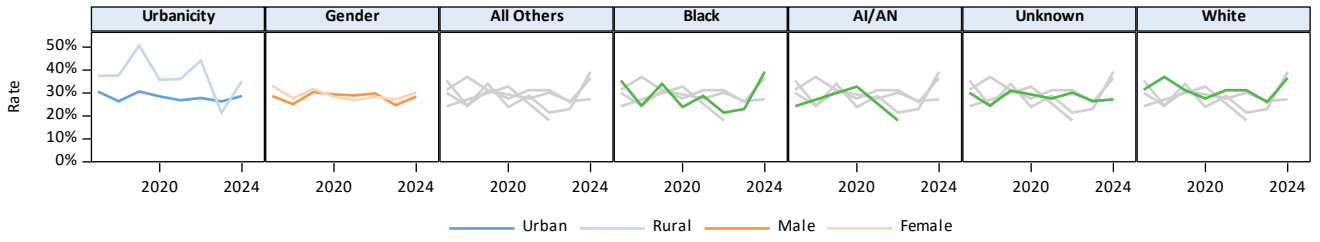
DCS/CHP Measure 2-1: Percentage of children 2 years of age with appropriate immunization status (MMR)



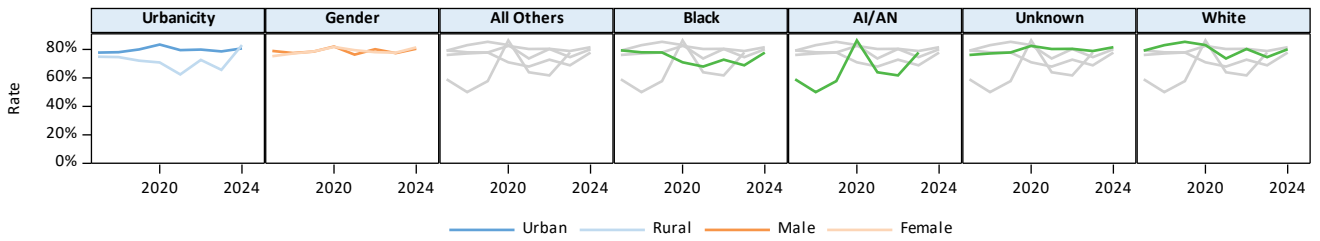
DCS/CHP Measure 2-1: Percentage of children 2 years of age with appropriate immunization status (HiB)

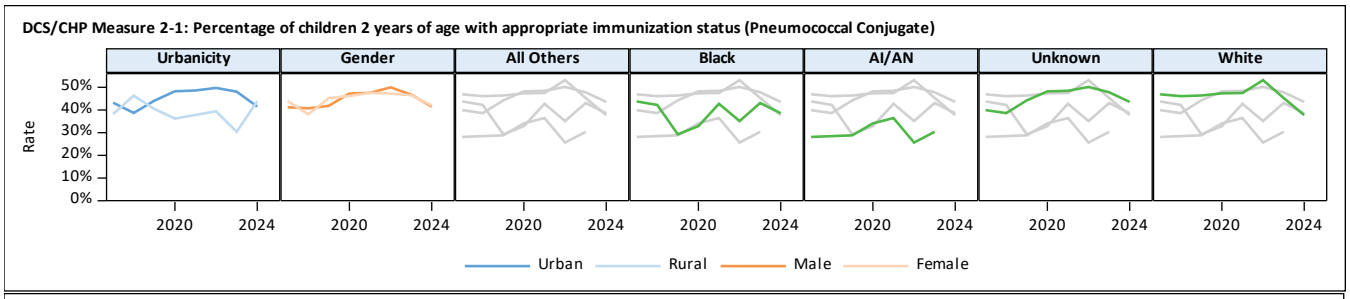


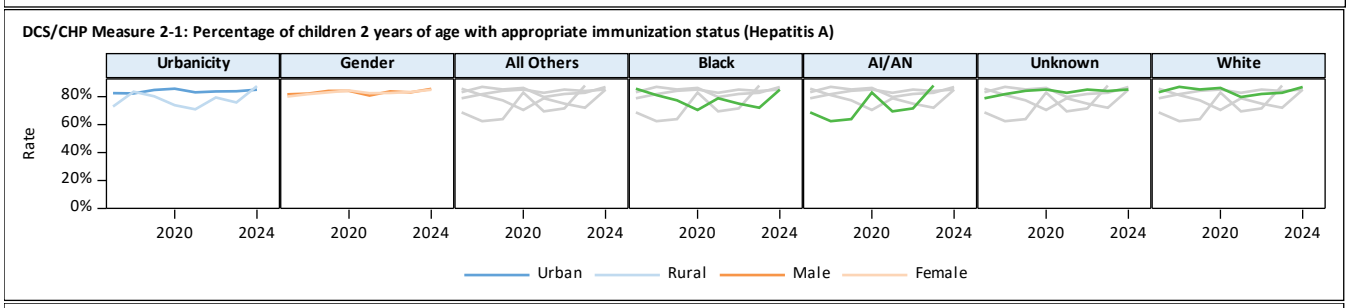
DCS/CHP Measure 2-1: Percentage of children 2 years of age with appropriate immunization status (Hepatitis B)

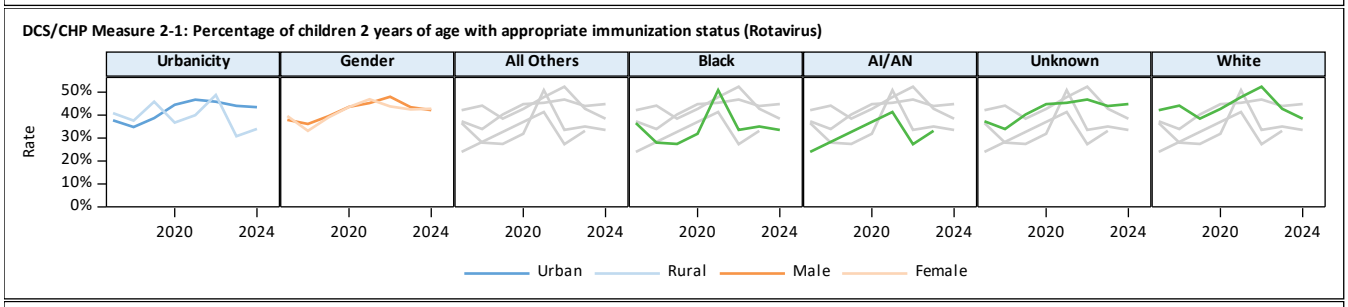


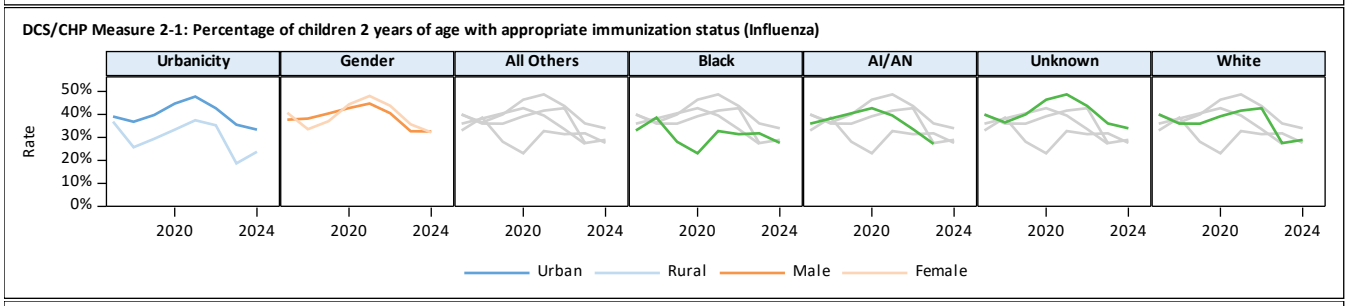
DCS/CHP Measure 2-1: Percentage of children 2 years of age with appropriate immunization status (VZV)

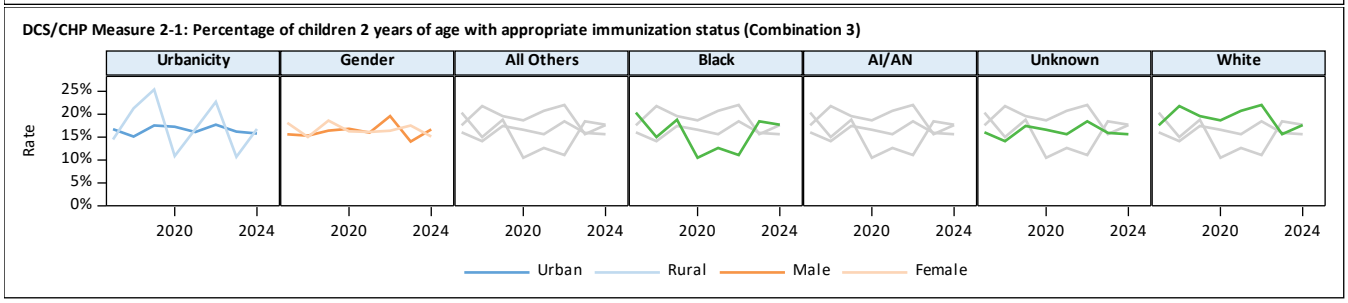



DCS/CHP Measure 2-1: Percentage of children 2 years of age with appropriate immunization status (Pneumococcal Conjugate)
Urbanicity
Gender
All Others
Black
AI/AN
Unknown
White
Rate
50%
40%
30%
20%
10%
0%
2020
2024
Urban
Rural
Male
Female

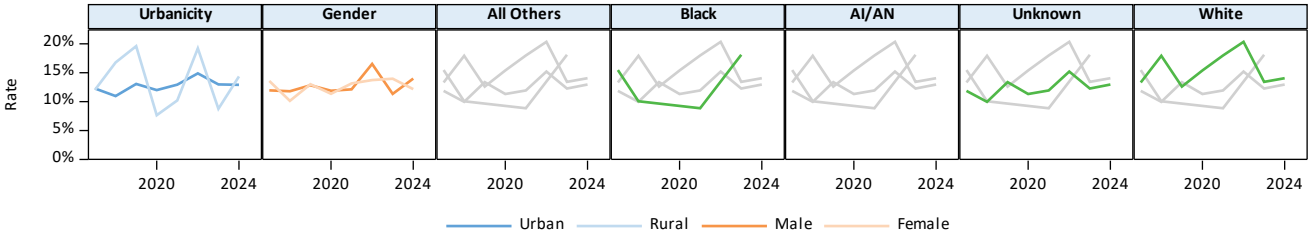

DCS/CHP Measure 2-1: Percentage of children 2 years of age with appropriate immunization status (Hepatitis A)
Urbanicity
Gender
All Others
Black
AI/AN
Unknown
White
Rate
80%
60%
40%
20%
0%
2020
2024
Urban
Rural
Male
Female


DCS/CHP Measure 2-1: Percentage of children 2 years of age with appropriate immunization status (Rotavirus)
Urbanicity
Gender
All Others
Black
AI/AN
Unknown
White
Rate
50%
40%
30%
20%
10%
0%
2020
2024
Urban
Rural
Male
Female

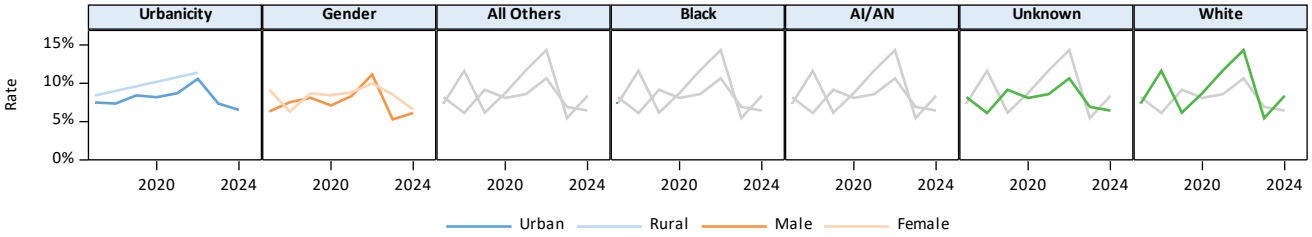

DCS/CHP Measure 2-1: Percentage of children 2 years of age with appropriate immunization status (Influenza)
Urbanicity
Gender
All Others
Black
AI/AN
Unknown
White
Rate
50%
40%
30%
20%
10%
0%
2020
2024
Urban
Rural
Male
Female


DCS/CHP Measure 2-1: Percentage of children 2 years of age with appropriate immunization status (Combination 3)
Urbanicity
Gender
All Others
Black
AI/AN
Unknown
White
Rate
25%
20%
15%
10%
5%
0%
2020
2024
Urban
Rural
Male
Female

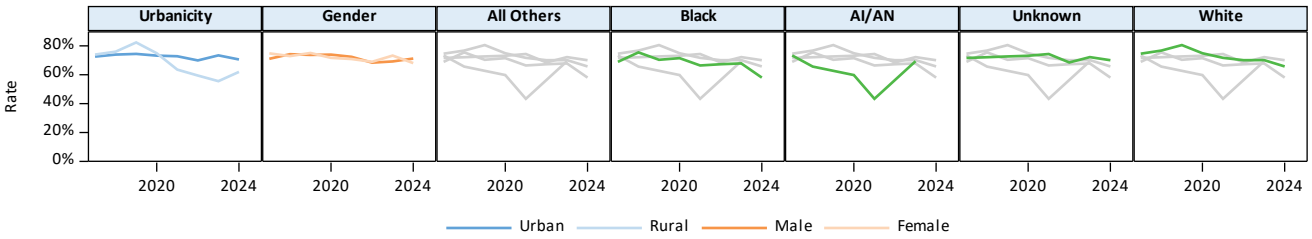
DCS/CHP Measure 2-1: Percentage of children 2 years of age with appropriate immunization status (Combination 7)



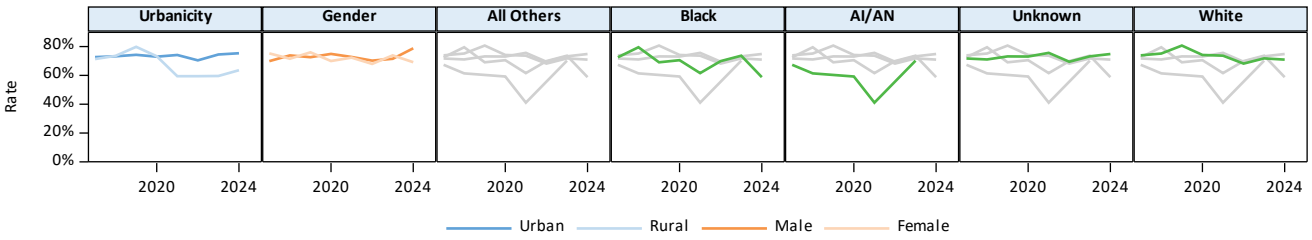
DCS/CHP Measure 2-1: Percentage of children 2 years of age with appropriate immunization status (Combination 10)



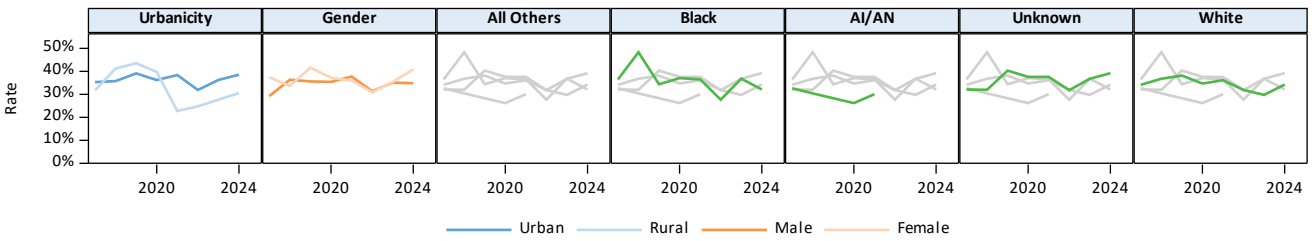
DCS/CHP Measure 2-2: Percentage of adolescents 13 years of age with appropriate immunizations (Meningococcal)



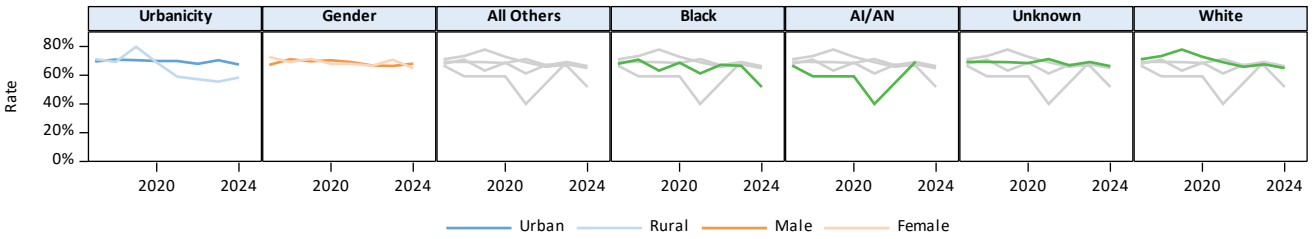
DCS/CHP Measure 2-2: Percentage of adolescents 13 years of age with appropriate immunizations (Tdap)



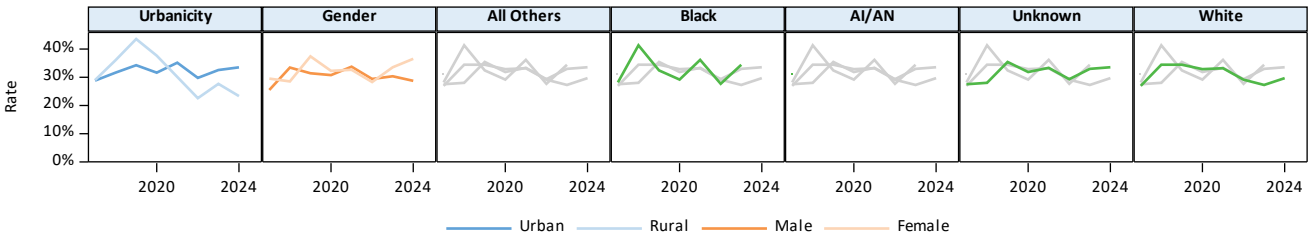
DCS/CHP Measure 2-2: Percentage of adolescents 13 years of age with appropriate immunizations (HPV)



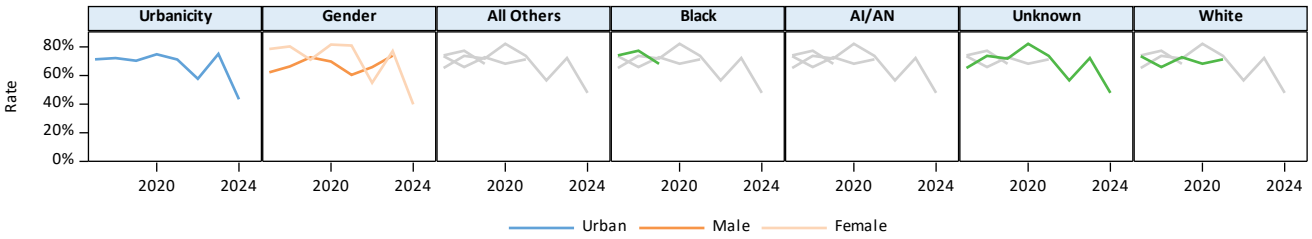
DCS/CHP Measure 2-2: Percentage of adolescents 13 years of age with appropriate immunizations (Combination 1: Meningococcal, Tdap)



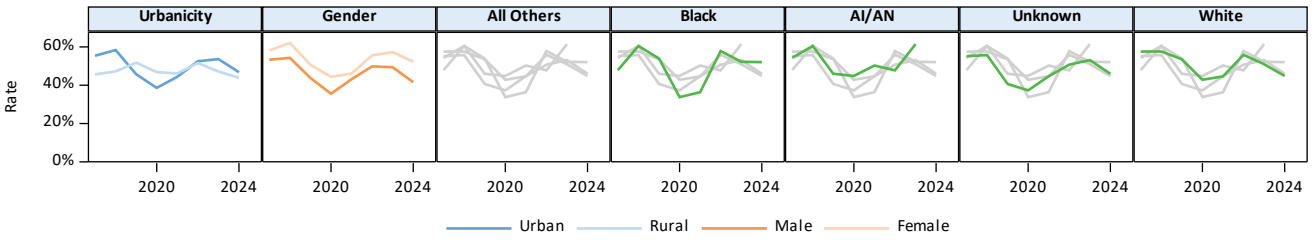
DCS/CHP Measure 2-2: Percentage of adolescents 13 years of age with appropriate immunizations (Combination 2: Meningococcal, Tdap, HPV)



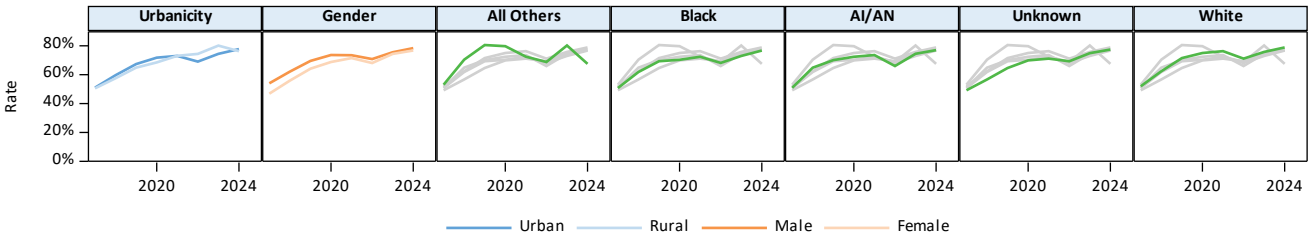
DCS/CHP Measure 2-3: Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent



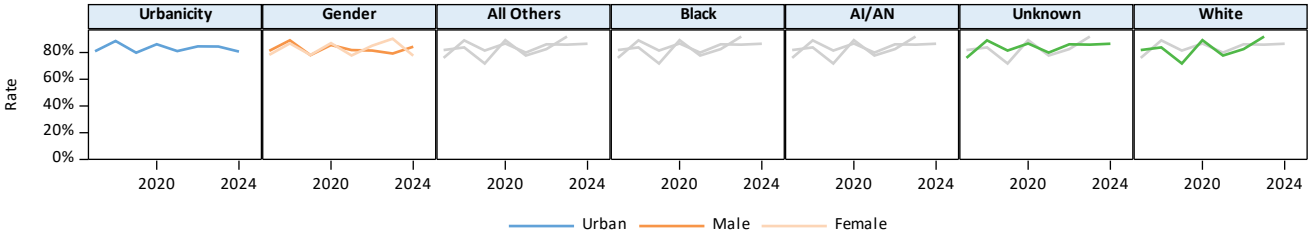
DCS/CHP Measure 2-4: Percentage of children and adolescents on antipsychotics with metabolic monitoring



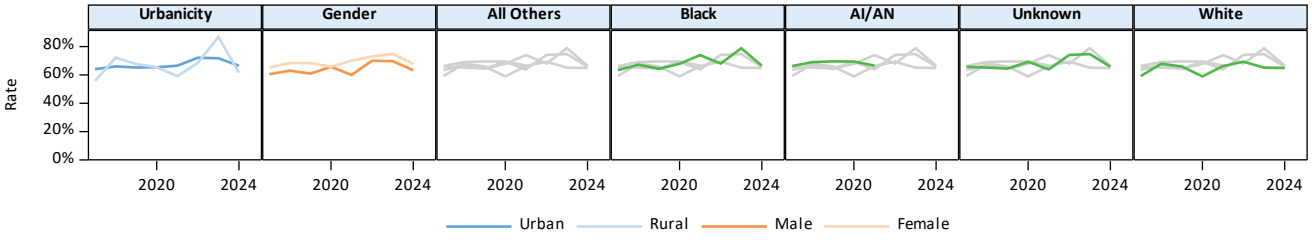
DCS/CHP Measure 2-5: Percentage of members diagnosed with a mental health disorder



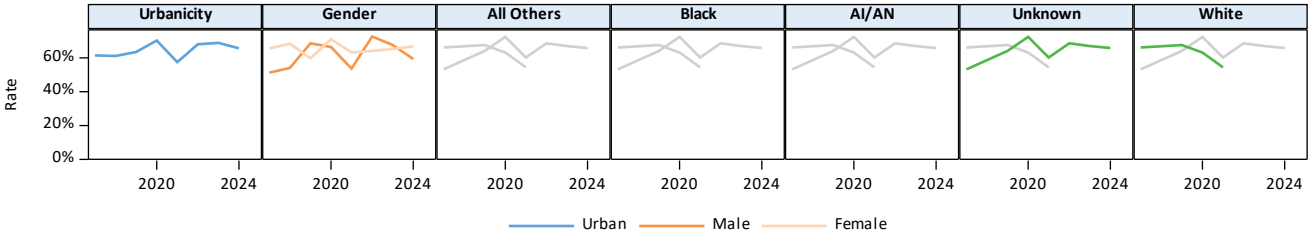
DCS/CHP Measure 2-6: Percentage of members with a follow-up visit within 7 days after an ED visit for mental illness



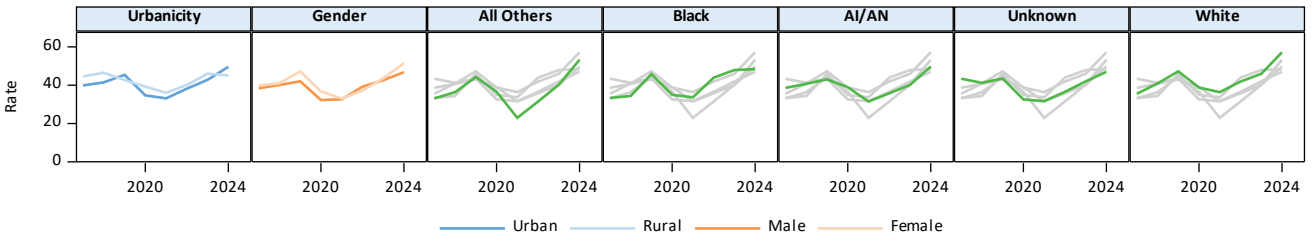
DCS/CHP Measure 2-7: Percentage of members with a follow-up visit within 7 days after a hospitalization for mental illness



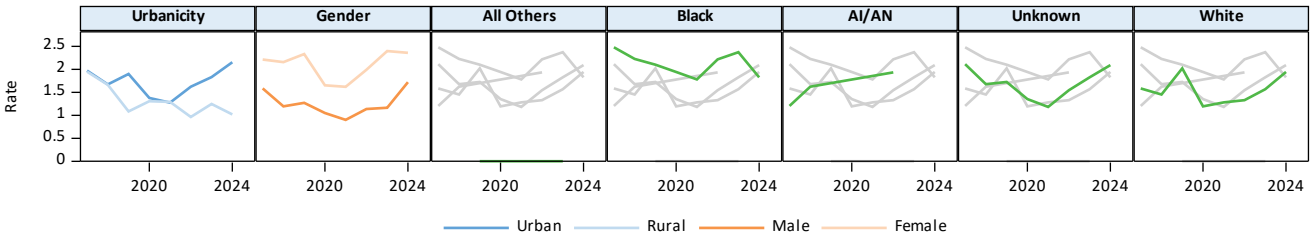
DCS/CHP Measure 2-8: Percentage of members with follow-up within 7 days after an ED visit for SUD



DCS/CHP Measure 2-9: Number of emergent ED visits per 1,000 member months



DCS/CHP Measure 2-10: Number of non-emergent ED visits per 1,000 member months



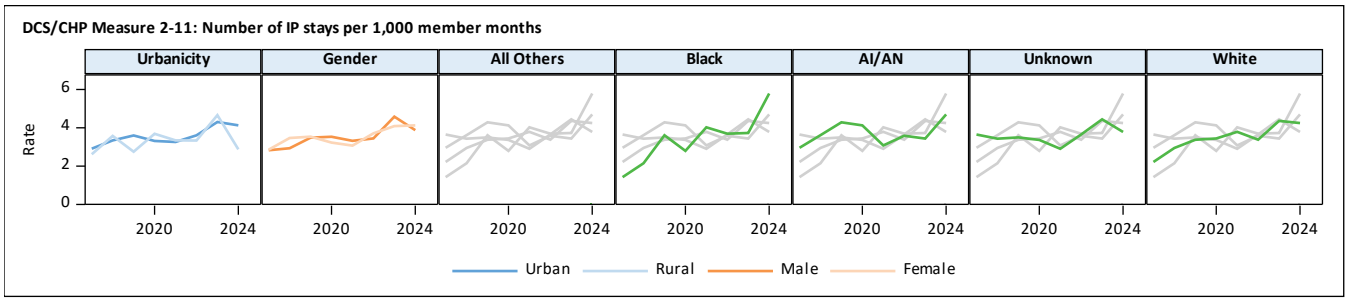


Table A-122—DCS CHP PMPM Costs (Total)

Variable	Estimate	*p*-value
Intercept	$525.12 ***	<0.001
	(25.494)	
Baseline monthly trend	$10.26 ***	<0.001
	(0.904)	
Level change at implementation	-$173.64 ***	<0.001
	(37.428)	
Change in monthly trend	$2.00	0.140
	(1.345)	
COVID-19 Lockdown (Q2 2020)	-$100.60 **	0.041
	(48.526)	
COVID-19 (June 2020 - April 2021)	-$129.74 ***	<0.001
	(33.433)	
Seasonality: Q2	-$2.80	0.895
	(21.214)	
Seasonality: Q3	-$41.44 *	0.052
	(21.034)	
Seasonality: Q4	-$36.50 *	0.086
	(21.014)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses.
COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-123—DCS CHP PMPM Costs (Professional)

Variable	Estimate	*p*-value
Intercept	$289.84 ***	<0.001
	(14.266)	
Baseline monthly trend	$5.63 ***	<0.001
	(0.506)	
Level change at implementation	-$17.06	0.418
	(20.944)	
Change in monthly trend	-$0.37	0.621
	(0.752)	
COVID-19 Lockdown (Q2 2020)	-$44.71	0.103
	(27.154)	
COVID-19 (June 2020 - April 2021)	-$34.18 *	0.071
	(18.708)	
Seasonality: Q2	$9.63	0.419
	(11.871)	
Seasonality: Q3	-$8.03	0.497
	(11.770)	
Seasonality: Q4	-$20.95 *	0.078
	(11.759)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses.
COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-124—DCS CHP PMPM Costs (IP)

Variable	Estimate	*p*-value
Intercept	$147.15 ***	<0.001
	(16.416)	
Baseline monthly trend	$4.17 ***	<0.001
	(0.582)	
Level change at implementation	-$153.08 ***	<0.001
	(24.100)	
Change in monthly trend	$1.43	0.102
	(0.866)	
COVID-19 Lockdown (Q2 2020)	-$50.13	0.112
	(31.246)	
COVID-19 (June 2020 - April 2021)	-$85.02 ***	<0.001
	(21.527)	
Seasonality: Q2	$5.01	0.715
	(13.659)	
Seasonality: Q3	-$9.02	0.507
	(13.544)	
Seasonality: Q4	-$9.04	0.506
	(13.531)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses.
COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-125—DCS CHP PMPM Costs (OP ED)

Variable	Estimate	*p*-value
Intercept	$10.44 ***	<0.001
	(1.220)	
Baseline monthly trend	$0.31 ***	<0.001
	(0.043)	
Level change at implementation	-$6.22 ***	<0.001
	(1.792)	
Change in monthly trend	-$0.14 **	0.030
	(0.064)	
COVID-19 Lockdown (Q2 2020)	-$9.29 ***	<0.001
	(2.323)	
COVID-19 (June 2020 - April 2021)	-$14.67 ***	<0.001
	(1.600)	
Seasonality: Q2	-$2.12 **	0.040
	(1.015)	
Seasonality: Q3	-$1.66	0.102
	(1.007)	
Seasonality: Q4	$0.19	0.848
	(1.006)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses.
COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-126—DCS CHP PMPM Costs (OP Non-ED)

Variable	Estimate	*p*-value
Intercept	$9.12 ***	<0.001
	(2.023)	
Baseline monthly trend	$0.42 ***	<0.001
	(0.072)	
Level change at implementation	$2.85	0.340
	(2.970)	
Change in monthly trend	-$0.42 ***	<0.001
	(0.107)	
COVID-19 Lockdown (Q2 2020)	-$8.18 **	0.036
	(3.850)	
COVID-19 (June 2020 - April 2021)	-$10.77 ***	<0.001
	(2.653)	
Seasonality: Q2	-$0.51	0.761
	(1.683)	
Seasonality: Q3	-$4.09 **	0.016
	(1.669)	
Seasonality: Q4	-$0.75	0.654
	(1.667)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses.
COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-127—DCS CHP PMPM Costs (Pharmacy)

Variable	Estimate	*p*-value
Intercept	$68.57 ***	<0.001
	(9.884)	
Baseline monthly trend	-$0.27	0.441
	(0.350)	
Level change at implementation	-$0.14	0.993
	(14.510)	
Change in monthly trend	$1.51 **	0.005
	(0.521)	
COVID-19 Lockdown (Q2 2020)	$11.71	0.535
	(18.812)	
COVID-19 (June 2020 - April 2021)	$14.89	0.254
	(12.961)	
Seasonality: Q2	-$14.81 *	0.075
	(8.224)	
Seasonality: Q3	-$18.64 **	0.025
	(8.154)	
Seasonality: Q4	-$5.96	0.466
	(8.147)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-128—DCS CHP Aggregate Costs (Total, in Thousands)

Variable	Estimate	*p*-value
Intercept	$8,614.00 ***	<0.001
	(287.879)	
Baseline monthly trend	$86.90 ***	<0.001
	(10.203)	
Level change at implementation	$760.30 *	0.075
	(422.641)	
Change in monthly trend	-$140.90 ***	<0.001
	(15.183)	
COVID-19 Lockdown (Q2 2020)	-$517.30	0.348
	(547.952)	
COVID-19 (June 2020 - April 2021)	-$993.80 **	0.010
	(377.526)	
Seasonality: Q2	-$274.80	0.254
	(239.546)	
Seasonality: Q3	-$450.70 *	0.061
	(237.517)	
Seasonality: Q4	-$412.40 *	0.086
	(237.290)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-129—DCS CHP Aggregate Costs (Professional, in Thousands)

Variable	Estimate	*p*-value
Intercept	$4,793.20 ***	<0.001
	(177.611)	
Baseline monthly trend	$46.60 ***	<0.001
	(6.295)	
Level change at implementation	$1,570.10 ***	<0.001
	(260.754)	
Change in monthly trend	-$103.00 ***	<0.001
	(9.367)	
COVID-19 Lockdown (Q2 2020)	-$112.00	0.741
	(338.066)	
COVID-19 (June 2020 - April 2021)	-$27.30	0.907
	(232.919)	
Seasonality: Q2	-$40.80	0.783
	(147.791)	
Seasonality: Q3	-$65.40	0.657
	(146.539)	
Seasonality: Q4	-$247.00 *	0.095
	(146.399)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-130—DCS CHP Aggregate Costs (IP, in Thousands)

Variable	Estimate	*p*-value
Intercept	$2,438.20 ***	<0.001
	(205.791)	
Baseline monthly trend	$41.70 ***	<0.001
	(7.294)	
Level change at implementation	-$1,129.40 ***	<0.001
	(302.125)	
Change in monthly trend	-$34.80 **	0.002
	(10.854)	
COVID-19 Lockdown (Q2 2020)	-$445.60	0.258
	(391.704)	
COVID-19 (June 2020 - April 2021)	-$941.20 ***	<0.001
	(269.874)	
Seasonality: Q2	-$14.80	0.931
	(171.240)	
Seasonality: Q3	-$118.30	0.488
	(169.789)	
Seasonality: Q4	-$127.70	0.454
	(169.627)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-131—DCS CHP Aggregate Costs (OP ED, in Thousands)

Variable	Estimate	*p*-value
Intercept	$172.80 ***	<0.001
	(14.659)	
Baseline monthly trend	$3.10 ***	<0.001
	(0.520)	
Level change at implementation	-$17.20	0.427
	(21.521)	
Change in monthly trend	-$5.20 ***	<0.001
	(0.773)	
COVID-19 Lockdown (Q2 2020)	-$108.20 ***	<0.001
	(27.901)	
COVID-19 (June 2020 - April 2021)	-$180.30 ***	<0.001
	(19.223)	
Seasonality: Q2	-$30.60 **	0.014
	(12.198)	
Seasonality: Q3	-$19.30	0.113
	(12.094)	
Seasonality: Q4	$2.40	0.844
	(12.083)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-132—DCS CHP Aggregate Costs (OP Non-ED, in Thousands)

Variable	Estimate	*p*-value
Intercept	$151.50 ***	<0.001
	(26.606)	
Baseline monthly trend	$4.60 ***	<0.001
	(0.943)	
Level change at implementation	$100.10 **	0.012
	(39.060)	
Change in monthly trend	-$9.70 ***	<0.001
	(1.403)	
COVID-19 Lockdown (Q2 2020)	-$90.70 *	0.077
	(50.641)	
COVID-19 (June 2020 - April 2021)	-$127.60 ***	<0.001
	(34.891)	
Seasonality: Q2	-$9.90	0.657
	(22.139)	
Seasonality: Q3	-$49.10 **	0.028
	(21.951)	
Seasonality: Q4	-$5.80	0.793
	(21.930)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-133—DCS CHP Aggregate Costs (Pharmacy, in Thousands)

Variable	Estimate	*p*-value
Intercept	$1,058.20 ***	<0.001
	(94.867)	
Baseline monthly trend	-$9.00 **	0.009
	(3.362)	
Level change at implementation	$236.70 *	0.093
	(139.276)	
Change in monthly trend	$11.80 **	0.021
	(5.003)	
COVID-19 Lockdown (Q2 2020)	$239.10	0.189
	(180.571)	
COVID-19 (June 2020 - April 2021)	$282.60 **	0.026
	(124.409)	
Seasonality: Q2	-$178.70 **	0.026
	(78.939)	
Seasonality: Q3	-$198.60 **	0.013
	(78.271)	
Seasonality: Q4	-$34.30	0.662
	(78.196)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Qualitative

The DCS CHP staff shared robust care coordination and management strategies to support members' health and well-being and promote the integration of PH and BH care, outlined in Table A-134.

Table A-134—Successful Care Coordination and Integration Strategies

Strategy	Description
Automatic Care Coordination Assignments	• All members were assigned to participate in care coordination. Members in target populations, including those who were pregnant or transition-age youth in BH levels of care, received higher levels of care coordination.
Resource Coordination Unit	• The unit proactively contacted caregivers to inform them of changes in members' care or the health care system. • The unit reported caregiver concerns to DCS CHP clinical staff to ensure timely support. • The unit assisted unlicensed kinship caregivers by helping them understand members' care requirements and connecting them with care coordination.
Internal Coordination	• DCS CHP held regular meetings to discuss challenging cases, events, and actions plans, promoting collective problem solving and cross-team awareness. • DCS CHP reported having sufficient internal staffing to meet operational needs, with a focus on integrated BH and PH staff.
DCS CHP Collaboration	• DCS CHP met weekly to discuss members being discharged or awaiting alternative level of care placements. • The agencies met monthly to discuss target populations, including transition-age youth, children's rehabilitative services, and maternity. • DCS CHP staff received continuing education on health care topics.

Strategy	Description
	• The subcontracted health plan proved a capable partner to DCS CHP in operating the plan, tailoring its workforce to the population, consistently communicating, and leveraging strong provider relationships.
Welcome Centers	• Welcome centers for members entering care provided integrated rapid response, including PH and BH screening and assessment, along with care coordination upon intake.
Collaboration With Other Plans	• Collaboration between DCS CHP and other AHCCCS plans supported successful transitions for members who were adopted and moved to another plan. • DCS CHP communicated with other AHCCCS plans to offer solutions for situations involving children, helping ensure members remained with their legal guardians rather than returning to DCS care.

Note: AHCCCS: Arizona Health Care Cost Containment System; BH: behavioral health; CHP: Comprehensive Health Plan; DCS: Department of Child Safety; PH: physical health.

Despite the successes highlighted above, DCS CHP reported barriers related to care coordination and integration. These barriers included:

- Members exhibited increasing BH and PH acuity, leading to overall greater health care needs.
- The BH provider workforce experienced shortages. DCS CHP initiated workforce development efforts, including partnerships with local colleges and universities and online training opportunities for existing providers.
  - DCS CHP reported a future intent to focus recruitment efforts on individuals with lived experiences like plan members, encouraging them to enter the BH field.
- DCS CHP faced challenges ensuring temporary placements and transitional settings aligned with members' appropriate level of care. For example, supporting members who required residential or inpatient (IP) care while in transition was difficult, as those members were not always suited for temporary placements or kinship caregiving.
- DCS served both the custodial agent and plan, which created challenges determining which stakeholders could legally receive health information. DCS utilized specialists regarding guardians as case managers to approve information sharing and ensure compliance with laws and regulations.
- DCS CHP operated differently from the typical care coordination model, which typically relies on members' guardians to confirm care plans and histories. Rather, DCS CHP was often more informed on members' medical histories and conditions than caregivers.
- DCS CHP identified room for growth in providers' BH and PH integration. For example, the Child Family Teams primarily discussed BH needs, with no formal mechanism to involve PH providers. DCS CHP continued to work toward better provider integration, particularly at higher levels of care.

H2O

This section provides the supplemental quantitative and qualitative results for H2O during the baseline period.

Quantitative

Table A-135—Baseline H2O PMPM Costs (Total)

Variable	Estimate	*p*-value
Intercept	$1,962.57 *** *(80.057)*	<0.001
Baseline monthly trend for AHP waitlist members	$33.14 *** *(3.462)*	<0.001
Difference in intercept between H2O and AHP waitlist members	$854.23 *** *(96.864)*	<0.001
Difference in baseline trend between H2O and AHP waitlist members	$50.30 *** *(4.760)*	<0.001
Seasonality: Q2	$34.09 *(70.331)*	0.630
Seasonality: Q3	$99.33 *(71.535)*	0.170
Seasonality: Q4	$21.89 *(70.331)*	0.757

*p <0.1, **p <0.05, ***p <0.001

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. AHP: AHCCCS Housing Program; H2O: Housing and Health Opportunities; Q: Quarter.

Table A-136—Baseline H2O PMPM Costs (Professional)

Variable	Estimate	*p*-value
Intercept	$859.68 *** *(55.652)*	<0.001
Baseline monthly trend for AHP waitlist members	$25.45 *** *(2.407)*	<0.001
Difference in intercept between H2O and AHP waitlist members	$195.36 ** *(67.336)*	0.005
Difference in baseline trend between H2O and AHP waitlist members	$25.73 *** *(3.309)*	<0.001
Seasonality: Q2	$47.90 *(48.891)*	0.331
Seasonality: Q3	$24.67 *(49.728)*	0.621
Seasonality: Q4	$55.79 *(48.891)*	0.258

*p <0.1, **p <0.05, ***p <0.001

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. AHP: AHCCCS Housing Program; H2O: Housing and Health Opportunities; Q: Quarter.

Table A-137—Baseline H2O PMPM Costs (IP)

Variable	Estimate	*p*-value
Intercept	$468.52 ***	<0.001
	(45.134)	
Baseline monthly trend for AHP waitlist members	$2.74	0.165
	(1.952)	
Difference in intercept between H2O and AHP waitlist members	$474.30 ***	<0.001
	(54.609)	
Difference in baseline trend between H2O and AHP waitlist members	$22.71 ***	<0.001
	(2.683)	
Seasonality: Q2	-$32.29	0.418
	(39.651)	
Seasonality: Q3	$76.41 *	0.063
	(40.329)	
Seasonality: Q4	-$29.27	0.463
	(39.651)	

*p <0.1, **p <0.05, ***p <0.001

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. AHP: AHCCCS Housing Program; H2O: Housing and Health Opportunities; Q: Quarter.

Table A-138—Baseline H2O PMPM Costs (LTC)

Variable	Estimate	*p*-value
Intercept	$39.66 ***	<0.001
	(7.865)	
Baseline monthly trend for AHP waitlist members	$0.05	0.880
	(0.340)	
Difference in intercept between H2O and AHP waitlist members	$35.31 ***	<0.001
	(9.516)	
Difference in baseline trend between H2O and AHP waitlist members	$1.29 **	0.007
	(0.468)	
Seasonality: Q2	-$7.68	0.271
	(6.910)	
Seasonality: Q3	-$5.40	0.445
	(7.028)	
Seasonality: Q4	-$9.45	0.176
	(6.910)	

*p <0.1, **p <0.05, ***p <0.001

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. AHP: AHCCCS Housing Program; H2O: Housing and Health Opportunities; Q: Quarter.

Table A-139—Baseline H2O PMPM Costs (OP ED)

Variable	Estimate	*p*-value
Intercept	$63.02 ***	<0.001
	(5.195)	
Baseline monthly trend for AHP waitlist members	-$0.12	0.606
	(0.225)	
Difference in intercept between H2O and AHP waitlist members	$96.61 ***	<0.001
	(6.286)	
Difference in baseline trend between H2O and AHP waitlist members	$1.68 ***	<0.001
	(0.309)	
Seasonality: Q2	$8.70 *	0.061
	(4.564)	
Seasonality: Q3	$12.48 **	0.009
	(4.642)	
Seasonality: Q4	$5.75	0.212
	(4.564)	

*p <0.1, **p <0.05, ***p <0.001

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. AHP: AHCCCS Housing Program; H2O: Housing and Health Opportunities; Q: Quarter.

Table A-140—Baseline H2O PMPM Costs (OP Non-ED)

Variable	Estimate	*p*-value
Intercept	$25.72 ***	<0.001
	(6.580)	
Baseline monthly trend for AHP waitlist members	$1.34 ***	<0.001
	(0.285)	
Difference in intercept between H2O and AHP waitlist members	$2.53	0.751
	(7.962)	
Difference in baseline trend between H2O and AHP waitlist members	-$0.57	0.148
	(0.391)	
Seasonality: Q2	$4.99	0.391
	(5.781)	
Seasonality: Q3	$4.41	0.456
	(5.880)	
Seasonality: Q4	$5.46	0.348
	(5.781)	

*p <0.1, **p <0.05, ***p <0.001

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. AHP: AHCCCS Housing Program; H2O: Housing and Health Opportunities; Q: Quarter.

Table A-141—Baseline H2O PMPM Costs (Pharmacy)

Variable	Estimate	*p*-value
Intercept	$505.98 *** *(14.243)*	<0.001
Baseline monthly trend for AHP waitlist members	$3.67 *** *(0.616)*	<0.001
Difference in intercept between H2O and AHP waitlist members	$50.11 ** *(17.234)*	0.005
Difference in baseline trend between H2O and AHP waitlist members	-$0.54 *(0.847)*	0.527
Seasonality: Q2	$12.47 *(12.513)*	0.323
Seasonality: Q3	-$13.25 *(12.727)*	0.302
Seasonality: Q4	-$6.40 *(12.513)*	0.611

*p <0.1, **p <0.05, ***p <0.001

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. AHP: AHCCCS Housing Program; H2O: Housing and Health Opportunities; Q: Quarter.

Table A-142—Baseline H2O PMPM Costs (PH)

Variable	Estimate	*p*-value
Intercept	$184.32 *** *(49.385)*	<0.001
Baseline monthly trend for AHP waitlist members	$14.46 *** *(2.136)*	<0.001
Difference in intercept between H2O and AHP waitlist members	$330.62 *** *(59.754)*	<0.001
Difference in baseline trend between H2O and AHP waitlist members	$15.59 *** *(2.936)*	<0.001
Seasonality: Q2	-$5.65 *(43.386)*	0.897
Seasonality: Q3	$80.16 * *(44.128)*	0.074
Seasonality: Q4	$14.53 *(43.386)*	0.739

*p <0.1, **p <0.05, ***p <0.001

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. AHP: AHCCCS Housing Program; H2O: Housing and Health Opportunities; Q: Quarter.

Table A-143—Baseline H2O PMPM Costs (BH)

Variable	Estimate	*p*-value
Intercept	$1,272.27 ***	<0.001
	(54.714)	
Baseline monthly trend for AHP waitlist members	$15.00 ***	<0.001
	(2.366)	
Difference in intercept between H2O and AHP waitlist members	$473.50 ***	<0.001
	(66.201)	
Difference in baseline trend between H2O and AHP waitlist members	$35.26 ***	<0.001
	(3.253)	
Seasonality: Q2	$27.27	0.572
	(48.067)	
Seasonality: Q3	$32.42	0.510
	(48.889)	
Seasonality: Q4	$13.75	0.776
	(48.067)	

*p <0.1, **p <0.05, ***p <0.001
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. AHP: AHCCCS Housing Program; H2O: Housing and Health Opportunities; Q: Quarter.

Table A-144—Baseline H2O Total Costs (Total, in Thousands)

Variable	Estimate	*p*-value
Intercept	$8,952.2 ***	<0.001
	(225.808)	
Baseline monthly trend for AHP waitlist members	$153.6 ***	<0.001
	(9.765)	
Difference in intercept between H2O and AHP waitlist members	-$5,597.0 ***	<0.001
	(273.215)	
Difference in baseline trend between H2O and AHP waitlist members	-$29.2 **	0.034
	(13.425)	
Seasonality: Q2	$67.0	0.737
	(198.376)	
Seasonality: Q3	$126.4	0.533
	(201.770)	
Seasonality: Q4	$76.6	0.701
	(198.376)	

*p <0.1, **p <0.05, ***p <0.001
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. AHP: AHCCCS Housing Program; H2O: Housing and Health Opportunities; Q: Quarter.

Table A-145—Baseline H2O Total Costs (Professional, in Thousands)

Variable	Estimate	*p*-value
Intercept	$3,986.3 ***	<0.001
	(173.263)	
Baseline monthly trend for AHP waitlist members	$115.4 ***	<0.001
	(7.493)	
Difference in intercept between H2O and AHP waitlist members	-$2,773.6 ***	<0.001
	(209.638)	
Difference in baseline trend between H2O and AHP waitlist members	-$40.9 ***	<0.001
	(10.301)	
Seasonality: Q2	$98.7	0.519
	(152.214)	
Seasonality: Q3	-$7.9	0.960
	(154.818)	
Seasonality: Q4	$160.0	0.297
	(152.214)	

*p <0.1, **p <0.05, ***p <0.001

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. AHP: AHCCCS Housing Program; H2O: Housing and Health Opportunities; Q: Quarter.

Table A-146—Baseline H2O Total Costs (IP, in Thousands)

Variable	Estimate	*p*-value
Intercept	$2,083.2 ***	<0.001
	(78.705)	
Baseline monthly trend for AHP waitlist members	$15.2 ***	<0.001
	(3.404)	
Difference in intercept between H2O and AHP waitlist members	-$943.4 ***	<0.001
	(95.228)	
Difference in baseline trend between H2O and AHP waitlist members	$22.4 ***	<0.001
	(4.679)	
Seasonality: Q2	-$58.1	0.403
	(69.143)	
Seasonality: Q3	$144.9 **	0.043
	(70.326)	
Seasonality: Q4	-$62.2	0.371
	(69.143)	

*p <0.1, **p <0.05, ***p <0.001

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. AHP: AHCCCS Housing Program; H2O: Housing and Health Opportunities; Q: Quarter.

Table A-147—Baseline H2O Total Costs (LTC, in Thousands)

Variable	Estimate	*p*-value
Intercept	$161.7 ***	<0.001
	(14.841)	
Baseline monthly trend for AHP waitlist members	$0.2	0.743
	(0.642)	
Difference in intercept between H2O and AHP waitlist members	-$69.3 ***	<0.001
	(17.956)	
Difference in baseline trend between H2O and AHP waitlist members	$1.8 **	0.049
	(0.882)	
Seasonality: Q2	-$8.8	0.502
	(13.038)	
Seasonality: Q3	-$2.0	0.880
	(13.261)	
Seasonality: Q4	-$16.1	0.221
	(13.038)	

*p <0.1, **p <0.05, ***p <0.001

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. AHP: AHCCCS Housing Program; H2O: Housing and Health Opportunities; Q: Quarter.

Table A-148—Baseline H2O Total Costs (OP ED, in Thousands)

Variable	Estimate	*p*-value
Intercept	$297.2 ***	<0.001
	(8.962)	
Baseline monthly trend for AHP waitlist members	-$0.3	0.511
	(0.388)	
Difference in intercept between H2O and AHP waitlist members	-$106.5 ***	<0.001
	(10.843)	
Difference in baseline trend between H2O and AHP waitlist members	$2.9 ***	<0.001
	(0.533)	
Seasonality: Q2	$22.3 **	0.006
	(7.873)	
Seasonality: Q3	$25.3 **	0.002
	(8.008)	
Seasonality: Q4	$9.2	0.248
	(7.873)	

*p <0.1, **p <0.05, ***p <0.001

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. AHP: AHCCCS Housing Program; H2O: Housing and Health Opportunities; Q: Quarter.

Table A-149—Baseline H2O Total Costs (OP Non-ED, in Thousands)

Variable	Estimate	*p*-value
Intercept	$128.3 ***	<0.001
	(23.084)	
Baseline monthly trend for AHP waitlist members	$6.0 ***	<0.001
	(0.998)	
Difference in intercept between H2O and AHP waitlist members	-$95.5 **	0.001
	(27.930)	
Difference in baseline trend between H2O and AHP waitlist members	-$4.9 ***	<0.001
	(1.372)	
Seasonality: Q2	$0.5	0.982
	(20.279)	
Seasonality: Q3	$17.1	0.411
	(20.626)	
Seasonality: Q4	$10.2	0.616
	(20.279)	

*p <0.1, **p <0.05, ***p <0.001

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. AHP: AHCCCS Housing Program; H2O: Housing and Health Opportunities; Q: Quarter.

Table A-150—Baseline H2O Total Costs (Pharmacy, in Thousands)

Variable	Estimate	*p*-value
Intercept	$2,295.5 ***	<0.001
	(42.427)	
Baseline monthly trend for AHP waitlist members	$17.0 ***	<0.001
	(1.835)	
Difference in intercept between H2O and AHP waitlist members	-$1,608.5 ***	<0.001
	(51.334)	
Difference in baseline trend between H2O and AHP waitlist members	-$10.4 ***	<0.001
	(2.522)	
Seasonality: Q2	$12.5	0.739
	(37.273)	
Seasonality: Q3	-$51.1	0.183
	(37.910)	
Seasonality: Q4	-$24.5	0.513
	(37.273)	

*p <0.1, **p <0.05, ***p <0.001

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. AHP: AHCCCS Housing Program; H2O: Housing and Health Opportunities; Q: Quarter.

Table A-151—Baseline H2O Total Costs (PH, in Thousands)

Variable	Estimate	*p*-value
Intercept	$846.3 ***	<0.001
	(112.631)	
Baseline monthly trend for AHP waitlist members	$66.5 ***	<0.001
	(4.871)	
Difference in intercept between H2O and AHP waitlist members	-$271.9 *	0.050
	(136.277)	
Difference in baseline trend between H2O and AHP waitlist members	-$24.5 ***	<0.001
	(6.696)	
Seasonality: Q2	$28.4	0.775
	(98.948)	
Seasonality: Q3	$203.3 **	0.048
	(100.641)	
Seasonality: Q4	$58.2	0.558
	(98.948)	

*p <0.1, **p <0.05, ***p <0.001

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. AHP: AHCCCS Housing Program; H2O: Housing and Health Opportunities; Q: Quarter.

Table A-152—Baseline H2O Total Costs (BH, in Thousands)

Variable	Estimate	*p*-value
Intercept	$5,810.4 ***	<0.001
	(163.372)	
Baseline monthly trend for AHP waitlist members	$70.1 ***	<0.001
	(7.065)	
Difference in intercept between H2O and AHP waitlist members	-$3,716.5 ***	<0.001
	(197.671)	
Difference in baseline trend between H2O and AHP waitlist members	$5.7	0.560
	(9.713)	
Seasonality: Q2	$26.2	0.856
	(143.525)	
Seasonality: Q3	-$25.8	0.860
	(145.981)	
Seasonality: Q4	$42.9	0.766
	(143.525)	

*p <0.1, **p <0.05, ***p <0.001

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. AHP: AHCCCS Housing Program; H2O: Housing and Health Opportunities; Q: Quarter.

Qualitative

AHCCCS

AHCCCS discussed challenges and experiences related to H2O implementation, including the relationship between H2O and members' HRSN. AHCCCS reported that H2O development, implementation, and maintenance involved close collaboration with external stakeholders, such as the H2O Program Administrator (H2O-PA), health plans, subcontractors, and providers to support program success.

AHCCCS cited collaboration as key to the integration of services and success of H2O. Frequent collaboration between the H2O-PA, providers, and plans supported continuity of care and service integration.

Administrative Processes and Care Coordination: The H2O-PA streamlined administrative processes by converting provider invoices into Medicaid-billable claims, reducing burden for providers new to Medicaid billing. AHCCCS, the H2O-PA, and subcontractors worked together to ensure the accuracy and completeness of these claims.

In addition, the H2O-PA managed eligibility verification and coordinated member referrals to HHs, where members were linked to pre-tenancy services.

Data-Driven Identification and Data Sharing: AHCCCS used a data driven approach to identify members who met clinical and social risk factors for HSRN services. This approach included the use of Z codes and other indicators to identify members experiencing homelessness or at risk of experiencing homelessness.

AHCCCS required data sharing agreements (DSAs) between the health plans and the H2O-PA to support communication related to care coordination and the H2O evaluation. AHCCCS also worked with health plans to ensure availability of plan-level data, specifically for utilization of BH residential facilities (BHRFs) and Flex Care services. Flex Care is a short-term program combining housing and BH treatment within an apartment setting.

Leveraging Existing Infrastructure and Housing Resources: AHCCCS emphasized the importance of leveraging existing infrastructure for the delivery and billing of HSRN services to promote continuity of care and reduce duplicative efforts. Because enhanced shelter services or short-term rental assistance end at the six-month mark for members, AHCCCS noted the importance of integrating H2O participants with existing federal and State housing subsidies.

AHCCCS emphasized stable housing as a cornerstone for improving health outcomes and addressing SDOH.

Implementation Barriers and Mitigation Strategies: AHCCCS anticipated and addressed several barriers before and during implementation, including difficulty hiring and onboarding staff and the lack of existing documentation to support ongoing maintenance and evaluation of H2O. Specifically:

- AHCCCS used Waiver funds to offer incentive payments to providers to hire staff dedicated to H2O. Providers received the incentive if hired staff completed H2O training and accepted a member onto their case load.
- AHCCCS developed a new Medicaid provider type and onboarded providers in stages, including existing Medicaid providers, providers in the community familiar with federal and State funding, and the broader community of housing providers.
- H2O was a novel program developed without an existing model or implementation framework. Given no prior documentation was available to support program maintenance and evaluation, AHCCCS collaborated with stakeholders to establish guidance for documenting contact attempts, billing activities, and other operational processes needed for ongoing program monitoring and evaluation.

H2O-PA

The H2O-PA oversaw AHCCCS' vision for H2O, managed eligibility, supported provider network development, and provided technical assistance to providers to support accurate and timely invoice submission. Specifically, the work to increase provider enrollment, verify member eligibility, coordinate H2O services with health plans and care coordination teams, develop a process for H2O providers to submit reimbursable claims, monitor and track service utilization, and serve as the single source of contact for health plans and care coordination teams. Responsibilities of organizations that worked with H2O-PA included:

- **AHCCCS.** Set H2O goals, identified program objectives, and ensured compliance. AHCCCS also supported the H2O-PA in overcoming implementation barriers and maintaining provider agreements for care coordination.
- **Subcontractor.** Managed quality assurance activities, fraud/waste/abuse prevention, and claims logistics.

Data Use and Referral Coordination: The H2O-PA used data, including claims, Z codes, and Homeless Management Information System (HMIS) data to identify members with social risk factors and refer members for services. Providers also leveraged the CLRS to refer members to existing providers for a variety of HRSN services outside of H2O.

In addition, the H2O-PA worked with CLRS and HIE administrators to integrate systems and support member alerts.

Leveraging and Enhancing Existing Infrastructure: The H2O-PA reported investing in existing infrastructure to support H2O, including:

- **HMIS.** Enhanced data entry, workflows, and reporting capabilities.
- **CLRS.** Enabled claims-based reimbursement for H2O services.
- **Learning Management System.** Developed State-funded training modules for providers.

In addition to leveraging existing infrastructure, the H2O-PA developed an Application Programming Interface (API) connection between the Statewide Housing Administrator (SHA) and HMIS to improve communication and data sharing entities.

Case Management and Member Transitions: The H2O-PA described case management activities for members participating in H2O. HRSN case management was primarily conducted through pre-tenancy and tenancy services. The H2O-PA coordinated with SMI care teams and followed Substance Abuse and Mental Health Administration (SAMHSA) best practices.

Case management goals initially focused on addressing members' housing needs and expanded as appropriate. Following participation in H2O, members transitioned to long-term care or RBHA-based permanent supportive housing. Outcomes were tracked through public dashboards to support transparency and private dashboards to inform internal program insights.

Implementation Barriers and Program Challenges: The H2O-PA reported multiple barriers encountered during and following implementation, including funding uncertainty, limited housing voucher availability due to federal cuts and changing United States Department of Housing and Urban Development (HUD) priorities, and the discontinuation of emergency vouchers. To address these challenges, the H2O-PA established partnerships with organizations providing housing vouchers.

Additional barriers included:

- A six-month cap on Medicaid-funded enhanced shelter services or short-term rental assistance.
- The loss of coronavirus disease 2019 (COVID-19) and American Rescue Plan Act of 2021 (ARPA) funding.
- Technical difficulties integrating BH and PH systems with HMIS and Health Insurance Portability and Accountability Act (HIPAA)-compliant environments.

The H2O-PA responded to these challenges by investing in infrastructure and system improvements. The novelty of the program also contributed to unclear expectations, training gaps, and delays in onboarding new Medicaid providers, which slowed service delivery despite technical assistance efforts.

The H2O-PA reported that members experienced challenges accessing shelters, understanding program processes, and meeting narrow eligibility criteria. Historically, members relied on Health Homes (HHs); however, members increasingly sought provider support for a broader range of SDOHs, including meals, employment, and income assistance.

Facilitators of Success and Opportunities for Improvement: Facilitators of program success included strong partnerships with health plans and HHs, regular collaboration with the SHA to update policies and provider manuals, and external partnerships to offset reduction in social services resulting from federal changes and government shutdowns that affected Supplemental Nutrition Assistance Program (SNAP) and Medicaid.

To improve H2O, the H2O-PA recommended leveraging existing resources, including enhanced shelters. Enhanced shelter services were reserved for a small subset of H2O members with permanent housing vouchers; however, the H2O-PA noted that this resource could be further utilized. The H2O-PA also recommended working with providers to identify housing opportunities beyond vouchers due to ongoing voucher scarcity.

Health Plans

Health plans managed communication with HHs related to care coordination and member assistance. Plans collaborated with key entities, including contracting with AHCCCS to provide services, serving as liaison between the H2O-PA and HHs, and maintaining regular meetings with HHs to ensure program understanding. In addition, Plans reported working with the H2O-PA to educate and support providers.

Data Sharing and Member Identification: Plans promoted data sharing through participation in CLRS, which enabled referrals for HRSN services and tracking of service utilization. Plans used criteria established by the H2O-PA and internal guidelines to identify members with social risk factors. HHs screened for these factors during intake, and AHCCCS provided a portal to flag member eligibility, improving coordination among plans, the H2O-PA, and HHs. Screening results were shared through monthly reports and dashboards.

Some plans built new infrastructure to support H2O, while others adapted existing systems through updated policies and procedures.

Member Experience and Engagement Challenges: Plans described mixed findings related to member experiences. One plan reported challenges with member participation and awareness, while another reported no complaints, potentially due to limited member engagement. Plans identified several potential barriers to member engagement, including confusion related to eligibility, limited housing resources, halted funding, and delays caused by complex eligibility processes.

Strategies to address these included adding program details to member handbooks and websites and creating a data match program to identify unengaged members.

Implementation Challenges and Facilitators: Additional challenges included evolving provider roles, system integration issues (such as HMIS licensing), and concerns that H2O diverted resources from existing housing programs. Facilitators of success included access to the H2O-PA for questions and ongoing support.

Suggested Improvements: Plans suggested improvements focused on ongoing training and communication to address staff turnover, role-specific training, streamlining data sharing among stakeholders, and leveraging existing housing assistance processes to avoid duplication, such as using enhanced shelters for hard-to-reach members.

SHA

The SHA developed policies related to housing processes, managed payments, lease and income verification documentation, and housing subsidy provisions. The SHA collaborated with several key entities to support the H2O implementation, including:

- **AHCCCS.** Provided compliance protocols and guidance, and valued SHA's expertise in developing effective housing processes. Guidance included allowable activities under H2O, rental assistance limitations, vendor verification requirements, and funding parameters.
- **Subcontractors.** The SHA partnered with subcontractors to submit claims for processing.
- **Pre-Tenancy Providers.** The SHA partnered with pre-tenancy providers to identify members and connect them with housing resources.
- **H2O-PA.** The SHA worked closely with the H2O-PA and contracted providers to identify members eligible for housing vouchers and review policies.

Communication, Integration, and Technical Infrastructure: H2O enhanced communication across entities and supported technical integration, including API connectivity between the SHA's software and a statewide data warehouse. The SHA reported that the roles of key entities evolved post-implementation, with increased collaboration to address BH needs for members experiencing housing instability. Regular meetings with health plans supported care coordination.

The SHA emphasized the importance of integrating technical systems and building staffing capacity to manage H2O processes. Although the SHA did not directly provide HRSN services, it implemented a pre-tenancy checklist requiring housing care plans to incorporate HRSN requirements. The SHA emphasized that housing itself is a critical HRSN service, noting that other social needs cannot be addressed without stable housing.

Enrollment Processes and Member Interaction: To streamline enrollment, the SHA used a housing provider matching form, adopted processes from the Public Housing Authority's (PHA's) administrative plan, and leveraged its Section 8 program. The matching form also served as a pre-application to reduce member burden.

The SHA primarily served an administrative role and reported limited direct interaction with members. However, the SHA noted that involvement from multiple entities, such as HHs, pre-tenancy service providers, the H2O-PA, and the subcontractors, could be confusing for members. The SHA shared that members identified the housing search as a key area of importance and that housing location support was provided through software used in partnership with the pre-tenancy supports providers.

Barriers and Facilitators: The SHA identified limited housing and voucher availability as a key barrier to H2O implementation and ongoing operation. AHCCCS and the H2O-PA worked to secure long-term subsidies for members receiving short-term rental assistance, which created challenges in ensuring sufficient voucher availability. The SHA addressed these challenges by leveraging its subsidy program under AHCCCS as a permanent solution and partnering with local PHAs.

Facilitators of success included AHCCCS's collaboration with the United States Interagency Council on Homelessness (USICH), the availability of pre-tenancy services, and strong partnerships among entities.[3,4] However, the SHA noted that key resources, including housing vouchers and ARPA funding, have decreased over time.

CBOs

H2O assisted CBOs in connecting members to resources and assessing member needs. CBOs provided members with rental assistance, eviction prevention services, transitional housing placement, and housing subsidies. In addition, CBOs provided housing peer support, assisted members with transportation, and conducted regular check-ins following housing placement. CBOs worked with case managers to review charts and track member status, PH, and BH.

CBOs discussed positive impacts of H2O, including:

- **Quality and effectiveness of downstream services.** H2O improved follow-up with members at risk for homelessness by providing day-to-day support and strengthening connections to downstream services.
- **Improving member outcomes.** Member PH and BH improved due to access to additional resources.

In addition to successes, CBOs shared challenges encountered during implementation and operation of H2O, including:

- **Member outreach and engagement.** Member engagement varied by individual. Some members perceived outreach as invasion of privacy and were skeptical of the program. However, many members expressed appreciation for the program once enrolled.
- **Communication gaps.** Lapses in communications between HHs, CBOs, and case managers led to delays in care. One CBO shared that after a member was placed in a HH, communication with HHs did not continue, limiting the ability to track member progress.
- **HH collaboration issues.** CBOs expressed frustration that some HHs were nonresponsive and did not understand the H2O program, leading to gaps in continuity of care and increased burden on CBOs to educate HHs and providers.

CBOs had several recommendations for improving H2O, including:

- Leveraging HMIS to locate members and assess program eligibility.
- Increasing providers and health plan collaboration to better leverage covered benefits.
- Increasing member outreach and engagement to spread awareness about the program.

Case Coordinators/Managers

Enhanced shelter and pre-tenancy services were cited by case managers as key services provided by H2O. Case coordinators assisted members with securing housing and provided services such as move-in and pre-tenancy assistance. Pre-tenancy services supported members in navigating housing processes, connecting them to

[3] Although the SHA specifically mentioned AHCCCS collaboration with USICH for H2O, it is important to note that AHCCCS participated in the Housing Services Partnership Accelerator (HSPA).

[4] HUD Exchange. HUD and HHS Announce Housing and Services Partnership Accelerator. Available at: https://www.hudexchange.info/news/hud-and-hhs-announce-housing-and-services-partnership-accelerator/. Accessed on: July 7, 2026.

resources, and establishing long-term connections to support systems. Facilitators of success shared by case managers included maintaining continuous contact with members to build rapport, developing housing plans, assisting with housing applications and vouchers, and supporting the development of independent living skills. One case manager described accompanying members during the housing application process, ensuring members understood their rights, and conducting follow-up to support successful placement.

Following housing placement, case managers assist with life skills development, lease comprehension, and addressing barriers to housing stability. Case managers noted that the long-term goal, beyond housing placement itself, was ensuring members received BH and PH services to address HRSN. At the time of the interviews, H2O had been operational for less than a year; therefore, long-term impacts could not be assessed. Case managers reported that connections to housing resources increased following H2O implementation, as entities collaborated to better support members. An additional facilitator of success included the responsiveness and availability of the H2O-PA.

Case managers also identified areas for potential improvement, including:

- **Gaps in Access.** Members without a housing voucher were unable to access enhanced housing services, creating barriers to continuous care.
- **Member Outreach Inefficiencies.** Outreach often occurred after the H2O-PA sent referrals to case managers, resulting in delays and difficulties contacting members. If a member could not be reached, the referral was passed to another outreach service. If that service later located the member, the referral was sent back to the case manager, resulting in duplicated efforts. One case manager recommended conducting outreach before referrals to reduce inefficiencies and improve member contact.
- **Administrative Burden.** H2O guidelines resulted in high upfront costs due to required, program-specific training. One case manager shared they needed to train and onboard staff quickly, but there was lag in receiving referrals, which delayed payment for services and made it difficult to cover training and hiring costs. Additionally, the H2O-required contact quotas for member outreach were not always feasible for case managers to meet.

KidsCare Eligibility Expansion

This section provides the supplemental results for the KidsCare Eligibility Expansion.

Table A-153—Research Question 1.2, Measure 1-3 Supplemental Results

Did expanding KidsCare eligibility reduce the number of uninsured children?						
			Baseline Period			Evaluation Period
			2021	2022	2023	2024
1-3	Number of uninsured children in Arizona	Arizona	8.5%	8.4%	8.6%	9.3%
		Comparison[1]	6.4%	5.6%	5.9%	6.4%

*p<0.1, **p<0.05, ***p<0.001

Data Source: United States Census, American Community Survey data were used in the analysis of RQ 1.2.

[1]The comparison group is comprised of states with similar federal poverty line (FPL) limits for the Children's Health Insurance Program (CHIP), including, Idaho, Nevada, Utah, Virginia, and Wyoming.

PQC

This section provides the supplemental results for Prior Quarter Coverage (PQC).

Table A-154—Research Question 1.1, Measures 1-1 and 1-2 Supplemental Results

Do eligible people without PQC enroll in Medicaid at the same rates as other eligible people with PQC?

		Baseline Period		Evaluation Period				
		SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
1-1	Percentage of estimated eligible Medicaid recipients enrolled, by eligibility group[1]							
	Eligible - Total	**38.9%**	**39.1%**	**38.3%**	**36.5%**	**39.8%**	**39.4%**	**38.8%**
	Eligible - Adult	36.3%	36.3%	36.9%	34.3%	39.3%	38.5%	39.4%
	Eligible - Disabled (FTW)	25.5%	30.2%	25.2%	26.8%	25.7%	31.6%	27.6%
	Eligible - Parent	57.6%	55.1%	51.0%	52.1%	54.7%	53.8%	51.4%
	Eligible - Senior (DIS)	43.2%	43.9%	47.7%	48.8%	43.0%	43.7%	41.4%
	Eligible - SSI Aged	25.1%	28.9%	29.3%	25.8%	28.7%	29.3%	26.0%
1-2	Percentage of estimated eligible Medicaid recipients newly enrolled, by eligibility group[2]							
	Eligible - Total	**11.1%**	**11.3%**	**12.1%**	**10.6%**	**9.1%**	**9.0%**	**9.6%**
	Eligible - Adult	11.3%	11.7%	12.6%	11.2%	9.7%	9.8%	10.5%
	Eligible - Disabled (FTW)	0.4%	0.4%	0.4%	0.3%	0.2%	0.2%	0.2%
	Eligible - Parent	17.0%	17.0%	20.7%	17.9%	14.7%	15.6%	18.0%
	Eligible - Senior (DIS)	0.9%	0.8%	0.7%	0.6%	0.7%	0.6%	0.6%
	Eligible - SSI Aged	12.1%	12.6%	10.7%	10.1%	9.8%	8.9%	8.8%

Note: Indicators in bold denote inclusion for evaluation in summary table. DIS: disabled; FTW: Freedom To Work: PQC: Prior Quarter Coverage; SFY: state fiscal year; SSI: Supplemental Security Income.

[1]Rates are based on calendar years due to IPUMS annual reporting periods.

[2]Newly enrolled beneficiaries are those who did not have Medicaid enrollment in the six months prior to joining.

Table A-155—Research Question 1.2, Measure 1-6 Supplemental Results

What is the likelihood of enrollment continuity for those without PQC compared to other Medicaid beneficiaries with PQC?		Baseline Period		Evaluation Period				
		SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
1-6	Average number of months with Medicaid coverage	9.76	9.89	9.94	10.91	11.07	10.95	10.09

Note: PQC: Prior Quarter Coverage; SFY: state fiscal year.

Table A-156—Research Question 1.3, Measures 1-7 through 1-10 Supplemental Results

Do beneficiaries without PQC who disenroll from Medicaid have shorter enrollment gaps than other beneficiaries with PQC?		Baseline Period		Evaluation Period				
		SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
1-7	Percentage of Medicaid beneficiaries who re-enroll after a gap of up to six months	24.8%	24.1%	25.8%	34.9%	27.2%	32.5%	20.3%
1-8	Average number of months without Medicaid coverage for beneficiaries who re-enroll after a gap of up to six months	2.28	2.27	2.15	1.44	1.70	1.50	2.13
1-9	Average number of gaps in Medicaid coverage for beneficiaries who re-enroll after a gap of up to six months	1.20	1.20	1.22	1.45	1.35	1.46	1.23
1-10	Average number of days per gap in Medicaid coverage for beneficiaries who re-enroll after a gap of up to six months	57.06	56.54	52.85	29.64	37.71	30.77	51.76

Note: PQC: Prior Quarter Coverage; SFY: state fiscal year.

Table A-157—Research Question 7.1, Measure 7-1 Supplemental Results

Do costs to non-AHCCCS entities stay the same or decrease after implementation of the waiver compared to before?			Baseline Average		Evaluation Average				
			CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
7-1	Reported costs for uninsured and/or likely eligible Medicaid recipients among potentially impacted providers and/or provider networks	Arizona	$ 2.93	$ 3.20	$ 4.02	$ 4.49	$ 4.68	$ 5.64	$ 6.21
		National	$ 4.90	$ 5.66	$ 5.82	$ 6.16	$ 5.90	$ 6.08	$ 5.59

Note: Totals shown are reported in the millions and were adjusted for inflation in 2023 dollars. AHCCCS: Arizona Health Care Cost Containment System; CY: calendar year.

Table A-158—Additional PQC Supplemental Results

Measure		SFY 2018		SFY 2019		SFY 2020		SFY 2021		SFY 2022		SFY 2023		SFY 2024	
		Denominator	Rate	Denominator	Rate	Denominator	Rate	Denominator	Rate	Denominator	Rate	Denominator	Rate	Denominator	Rate
1-1	**Percentage of estimated eligible Medicaid recipients enrolled, by eligibility group**														
	Eligible - Total	1,459,810	38.9%	1,435,146	39.1%	1,425,829	38.3%	1,401,602	36.5%	1,352,249	39.8%	1,368,611	39.4%	1,358,225	38.8%
	Eligible - Adult	961,150	36.3%	928,879	36.3%	929,467	36.9%	927,727	34.3%	864,570	39.3%	866,094	38.5%	834,060	39.4%
	Eligible - Disabled (FTW)	93,825	25.5%	100,584	30.2%	104,928	25.2%	104,393	26.8%	113,423	25.7%	127,845	31.6%	130,868	27.6%
	Eligible - Parent	244,852	57.6%	244,616	55.1%	214,771	51.0%	197,730	52.1%	194,573	54.7%	176,844	53.8%	176,538	51.4%
	Eligible - Senior (DIS)	72,468	43.2%	76,979	43.9%	81,731	47.7%	79,419	48.8%	80,849	43.0%	86,825	43.7%	98,204	41.4%
	Eligible - SSI Aged	87,515	25.1%	84,088	28.9%	94,932	29.3%	92,333	25.8%	98,834	28.7%	111,003	29.3%	118,555	26.0%
1-2	**Percentage of estimated eligible Medicaid recipients newly enrolled, by eligibility group**														
	Eligible - Total	1,459,810	11.1%	1,435,146	11.3%	1,425,829	12.1%	1,401,602	10.6%	1,352,249	9.1%	1,368,611	9.0%	1,358,225	9.6%
	Eligible - Adult	961,150	11.3%	928,879	11.7%	929,467	12.6%	927,727	11.2%	864,570	9.7%	866,094	9.8%	834,060	10.5%
	Eligible - Disabled (FTW)	93,825	0.4%	100,584	0.4%	104,928	0.4%	104,393	0.3%	113,423	0.2%	127,845	0.2%	130,868	0.2%
	Eligible - Parent	244,852	17.0%	244,616	17.0%	214,771	20.7%	197,730	17.9%	194,573	14.7%	176,844	15.6%	176,538	18.0%
	Eligible - Senior (DIS)	72,468	0.9%	76,979	0.8%	81,731	0.7%	79,419	0.6%	80,849	0.7%	86,825	0.6%	98,204	0.6%
	Eligible - SSI Aged	87,515	12.1%	84,088	12.6%	94,932	10.7%	92,333	10.1%	98,834	9.8%	111,003	8.9%	118,555	8.8%
1-6	Average number of months with Medicaid coverage	1,011,142	9.76	979,288	9.89	1,004,234	9.94	1,064,778	10.91	1,183,669	11.07	1,284,990	10.95	1,248,803	10.09
1-7	Percentage of Medicaid beneficiaries who re-enroll after a gap of up to six months	140,529	24.8%	124,361	24.1%	128,825	25.8%	39,863	34.9%	45,608	27.2%	52,720	32.5%	173,180	20.3%
1-8	Average number of months without Medicaid coverage for beneficiaries who re-enroll after a gap of up to six months	34,878	2.28	29,988	2.27	33,213	2.15	13,924	1.44	12,407	1.70	17,143	1.50	35,163	2.13
1-9	Average number of gaps in Medicaid coverage for beneficiaries who re-enroll after a gap of up to six months	34,878	1.20	29,988	1.20	33,213	1.22	13,924	1.45	12,407	1.35	17,143	1.46	35,163	1.23
1-10	Average number of days per gap in Medicaid coverage for beneficiaries who re-enroll after a gap of up to six months	41,775	57.06	36,123	56.54	40,486	52.85	20,228	29.64	16,748	37.71	25,031	30.77	43,362	51.76
5-3	Percentage of beneficiaries with a visit to a specialist	1,011,461	41.5%	979,546	42.2%	1,004,617	40.7%	1,065,439	41.4%	1,188,332	39.5%	1,376,716	37.0%	1,341,424	35.6%

Note: Year 1 of PQC baseline period exends from July 1, 2017, through June 30, 2018. Year 2 extends from July 1, 2018, through June 30, 2019. Data from IPUMS used in Measures 1-1, and 1-2 utilize 2017 and 2018 data, for years 1 and 2, respectively. FTW: Freedom to Work; DIS: disabled; SFY: state fiscal year.

Table A-159—PQC PMPM Costs (Total)

Variable	Estimate	*p*-value
Intercept	$672.38 ***	<0.001
	(26.314)	
Baseline monthly trend	$3.37 *	0.058
	(1.750)	
Level change at implementation	-$70.40 **	0.032
	(32.189)	
Change in monthly trend	-$2.05	0.256
	(1.788)	
COVID-19 Lockdown (Q2 2020)	-$7.62	0.841
	(37.755)	
COVID-19 (June 2020 - April 2021)	$19.87	0.351
	(21.169)	
Seasonality: Q2	-$9.64	0.591
	(17.846)	
Seasonality: Q3	-$20.45	0.265
	(18.225)	
Seasonality: Q4	$11.45	0.524
	(17.870)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses.
COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-160—PQC PMPM Costs (Professional)

Variable	Estimate	*p*-value
Intercept	$317.75 ***	<0.001
	(18.272)	
Baseline monthly trend	$2.38 *	0.054
	(1.215)	
Level change at implementation	-$25.97	0.249
	(22.352)	
Change in monthly trend	-$1.22	0.330
	(1.241)	
COVID-19 Lockdown (Q2 2020)	-$5.66	0.830
	(26.217)	
COVID-19 (June 2020 - April 2021)	-$6.68	0.651
	(14.700)	
Seasonality: Q2	-$12.80	0.305
	(12.392)	
Seasonality: Q3	-$19.91	0.120
	(12.655)	
Seasonality: Q4	-$6.59	0.597
	(12.409)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses.
COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-161—PQC PMPM Costs (IP)

Variable	Estimate	*p*-value
Intercept	$98.59 ***	<0.001
	(2.865)	
Baseline monthly trend	$0.19	0.332
	(0.191)	
Level change at implementation	-$7.34 **	0.040
	(3.504)	
Change in monthly trend	-$0.40 **	0.043
	(0.195)	
COVID-19 Lockdown (Q2 2020)	-$11.35 **	0.007
	(4.110)	
COVID-19 (June 2020 - April 2021)	$2.21	0.341
	(2.305)	
Seasonality: Q2	$0.08	0.967
	(1.943)	
Seasonality: Q3	$2.28	0.253
	(1.984)	
Seasonality: Q4	-$0.65	0.739
	(1.945)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses.
COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-162—PQC PMPM Costs (LTC)

Variable	Estimate	*p*-value
Intercept	$58.54 ***	<0.001
	(2.508)	
Baseline monthly trend	$0.23	0.167
	(0.167)	
Level change at implementation	-$9.66 **	0.002
	(3.068)	
Change in monthly trend	-$0.33 *	0.059
	(0.170)	
COVID-19 Lockdown (Q2 2020)	$6.31 *	0.084
	(3.599)	
COVID-19 (June 2020 - April 2021)	-$5.50 **	0.008
	(2.018)	
Seasonality: Q2	-$0.44	0.797
	(1.701)	
Seasonality: Q3	-$0.65	0.709
	(1.737)	
Seasonality: Q4	$1.90	0.268
	(1.703)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses.
COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-163— PQC PMPM Costs (OP ED)

Variable	Estimate	*p*-value
Intercept	$34.32 ***	<0.001
	(0.972)	
Baseline monthly trend	-$0.02	0.765
	(0.065)	
Level change at implementation	-$1.69	0.160
	(1.189)	
Change in monthly trend	-$0.16 **	0.017
	(0.066)	
COVID-19 Lockdown (Q2 2020)	-$8.06 ***	<0.001
	(1.395)	
COVID-19 (June 2020 - April 2021)	-$4.14 ***	<0.001
	(0.782)	
Seasonality: Q2	$1.30 *	0.052
	(0.659)	
Seasonality: Q3	$1.37 **	0.045
	(0.673)	
Seasonality: Q4	-$0.26	0.698
	(0.660)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses.
COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-164—PQC PMPM Costs (OP Non-ED)

Variable	Estimate	*p*-value
Intercept	$45.27 ***	<0.001
	(3.196)	
Baseline monthly trend	$0.07	0.740
	(0.213)	
Level change at implementation	-$9.89 **	0.014
	(3.909)	
Change in monthly trend	$0.38 *	0.086
	(0.217)	
COVID-19 Lockdown (Q2 2020)	-$7.18	0.121
	(4.585)	
COVID-19 (June 2020 - April 2021)	-$3.81	0.143
	(2.571)	
Seasonality: Q2	-$0.62	0.775
	(2.167)	
Seasonality: Q3	-$1.56	0.482
	(2.213)	
Seasonality: Q4	$0.40	0.853
	(2.170)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses.
COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-165—PQC PMPM Costs (Pharmacy)

Variable	Estimate	*p*-value
Intercept	$117.90 ***	<0.001
	(10.202)	
Baseline monthly trend	$0.51	0.451
	(0.679)	
Level change at implementation	-$15.85	0.208
	(12.480)	
Change in monthly trend	-$0.32	0.645
	(0.693)	
COVID-19 Lockdown (Q2 2020)	$18.33	0.214
	(14.638)	
COVID-19 (June 2020 - April 2021)	$37.78 ***	<0.001
	(8.207)	
Seasonality: Q2	$2.84	0.683
	(6.919)	
Seasonality: Q3	-$1.98	0.780
	(7.066)	
Seasonality: Q4	$16.64 **	0.019
	(6.928)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-166—PQC Aggregate Costs (Total, in Thousands)

Variable	Estimate	*p*-value
Intercept	$561,268.10 ***	<0.001
	(34245.606)	
Baseline monthly trend	$1,873.80	0.413
	(2277.956)	
Level change at implementation	-$28,835.80	0.493
	(41892.377)	
Change in monthly trend	$4,636.20 **	0.050
	(2326.504)	
COVID-19 Lockdown (Q2 2020)	-$49,965.50	0.312
	(49135.949)	
COVID-19 (June 2020 - April 2021)	$9,228.60	0.739
	(27550.221)	
Seasonality: Q2	-$22,999.80	0.325
	(23225.923)	
Seasonality: Q3	-$14,525.90	0.542
	(23718.888)	
Seasonality: Q4	$18,716.40	0.424
	(23257.157)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-167—PQC Aggregate Costs (Professional, in Thousands)

Variable	Estimate	*p*-value
Intercept	$267,564.00 ***	<0.001
	(27370.864)	
Baseline monthly trend	$1,514.10	0.408
	(1820.660)	
Level change at implementation	-$7,157.70	0.831
	(33482.560)	
Change in monthly trend	$2,378.00	0.205
	(1859.463)	
COVID-19 Lockdown (Q2 2020)	-$28,283.80	0.474
	(39271.999)	
COVID-19 (June 2020 - April 2021)	-$13,598.30	0.539
	(22019.565)	
Seasonality: Q2	-$20,933.30	0.263
	(18563.362)	
Seasonality: Q3	-$18,678.80	0.328
	(18957.365)	
Seasonality: Q4	-$2,973.80	0.873
	(18588.326)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-168—PQC Aggregate Costs (IP, in Thousands)

Variable	Estimate	*p*-value
Intercept	$81,690.50 ***	<0.001
	(2835.352)	
Baseline monthly trend	$38.10	0.840
	(188.602)	
Level change at implementation	-$464.20	0.894
	(3468.464)	
Change in monthly trend	$367.50 *	0.060
	(192.622)	
COVID-19 Lockdown (Q2 2020)	-$15,737.10 ***	<0.001
	(4068.193)	
COVID-19 (June 2020 - April 2021)	$1,298.00	0.571
	(2281.011)	
Seasonality: Q2	-$1,333.10	0.490
	(1922.982)	
Seasonality: Q3	$3,645.80 *	0.067
	(1963.797)	
Seasonality: Q4	$440.20	0.820
	(1925.568)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-169—PQC Aggregate Costs (LTC, in Thousands)

Variable	Estimate	*p*-value
Intercept	$48,487.70 ***	<0.001
	(1744.583)	
Baseline monthly trend	$116.90	0.317
	(116.046)	
Level change at implementation	-$6,003.40 **	0.006
	(2134.134)	
Change in monthly trend	$180.70	0.132
	(118.520)	
COVID-19 Lockdown (Q2 2020)	$2,757.50	0.274
	(2503.145)	
COVID-19 (June 2020 - April 2021)	-$5,091.30 ***	<0.001
	(1403.498)	
Seasonality: Q2	-$1,097.60	0.357
	(1183.204)	
Seasonality: Q3	$272.10	0.822
	(1208.317)	
Seasonality: Q4	$2,592.40 **	0.032
	(1184.795)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-170—PQC Aggregate Costs (OP ED, in Thousands)

Variable	Estimate	*p*-value
Intercept	$28,406.30 ***	<0.001
	(849.490)	
Baseline monthly trend	-$64.60	0.256
	(56.507)	
Level change at implementation	$644.80	0.537
	(1039.175)	
Change in monthly trend	$77.30	0.185
	(57.711)	
COVID-19 Lockdown (Q2 2020)	-$8,741.90 ***	<0.001
	(1218.857)	
COVID-19 (June 2020 - April 2021)	-$3,885.70 ***	<0.001
	(683.406)	
Seasonality: Q2	$1,030.30 *	0.078
	(576.138)	
Seasonality: Q3	$1,850.00 **	0.002
	(588.366)	
Seasonality: Q4	$151.10	0.794
	(576.913)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-171—PQC Aggregate Costs (OP Non-ED, in Thousands)

Variable	Estimate	*p* -value
Intercept	$37,873.00 ***	<0.001
	(3722.611)	
Baseline monthly trend	$0.90	0.997
	(247.621)	
Level change at implementation	-$7,989.80 *	0.083
	(4553.840)	
Change in monthly trend	$829.30 **	0.002
	(252.899)	
COVID-19 Lockdown (Q2 2020)	-$8,091.00	0.134
	(5341.240)	
COVID-19 (June 2020 - April 2021)	-$4,505.60	0.137
	(2994.800)	
Seasonality: Q2	-$1,759.00	0.488
	(2524.735)	
Seasonality: Q3	-$1,437.90	0.579
	(2578.322)	
Seasonality: Q4	$1,092.60	0.667
	(2528.130)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Table A-172—PQC Aggregate Costs (Pharmacy, in Thousands)

Variable	Estimate	*p* -value
Intercept	$97,246.50 ***	<0.001
	(9157.086)	
Baseline monthly trend	$268.40	0.661
	(609.113)	
Level change at implementation	-$7,865.50	0.485
	(11201.790)	
Change in monthly trend	$803.40	0.201
	(622.094)	
COVID-19 Lockdown (Q2 2020)	$8,130.70	0.538
	(13138.681)	
COVID-19 (June 2020 - April 2021)	$35,011.50 ***	<0.001
	(7366.777)	
Seasonality: Q2	$1,093.00	0.861
	(6210.483)	
Seasonality: Q3	-$177.10	0.978
	(6342.300)	
Seasonality: Q4	$17,413.80 **	0.006
	(6218.835)	

*$p<0.1$, **$p<0.05$, ***$p<0.001$

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors are presented in parentheses. COVID-19: coronavirus disease 2019; Q: Quarter.

Tribal Dental Authority

This section provides the supplemental quantitative and qualitative results for the Tribal Dental Authority.

Quantitative

Table A-173—Tribal Dental Authority Supplemental Results

Time	Dentist, Pediatric
Q2 2022	71.5% N=37,039
Q4 2022	71.2% N=33,990
Q2 2023	87.2% N=135,666
Q4 2023	87.0% N=124,852
Q2 2024	86.0% N=122,292
Q4 2024	86.1% N=119,492

Note: Q: quarter

Table A-174—Tribal Dental Authority PMPM Costs (Total)

Variable	Estimate	*p*-value
Intercept	$2,346.49 ***	<0.001
	(172.975)	
Post-implementation trend	-$51.23 ***	<0.001
	(11.014)	
Seasonality: Q2	-$156.27	0.425
	(191.501)	
Seasonality: Q3	-$223.34	0.278
	(199.870)	
Seasonality: Q4	-$290.64	0.146
	(191.501)	
Alternate Model		
Intercept	$1,375.83 ***	<0.001
	(129.663)	
Post-implementation trend	-$3.25	0.651
	(7.075)	
Seasonality: Q2	$27.08	0.754
	(85.088)	
Seasonality: Q3	-$20.28	0.823
	(89.115)	
Seasonality: Q4	-$146.71 *	0.098
	(84.179)	
Oct 2022–April 2023	$981.82 ***	<0.001
	(107.202)	

*p <0.1, **p <0.05, ***p <0.001

Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. Q: Quarter.

Table A-175—Tribal Dental Authority PMPM Costs (Professional)

Variable	Estimate	*p*-value
Intercept	$1,892.59 ***	<0.001
	(171.626)	
Post-implementation trend	-$73.87 ***	<0.001
	(10.928)	
Seasonality: Q2	-$93.97	0.627
	(190.008)	
Seasonality: Q3	-$125.28	0.535
	(198.311)	
Seasonality: Q4	-$335.76 *	0.093
	(190.008)	
Alternate Model		
Intercept	$948.15 ***	<0.001
	(139.680)	
Post-implementation trend	-$27.19 **	0.002
	(7.622)	
Seasonality: Q2	$84.42	0.369
	(91.661)	
Seasonality: Q3	$72.29	0.461
	(96.000)	
Seasonality: Q4	-$195.72 **	0.045
	(90.682)	
Oct 2022–April 2023	$955.29 ***	<0.001
	(115.484)	

*p <0.1, **p <0.05, ***p <0.001
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. Q: Quarter.

Table A-176—Tribal Dental Authority PMPM Costs (IP)

Variable	Estimate	*p*-value
Intercept	$133.48 ***	<0.001
	(4.582)	
Post-implementation trend	$1.49 ***	<0.001
	(0.292)	
Seasonality: Q2	$2.51	0.627
	(5.073)	
Seasonality: Q3	$13.05 **	0.023
	(5.295)	
Seasonality: Q4	-$0.81	0.876
	(5.073)	
Alternate Model		
Intercept	$146.51 ***	<0.001
	(7.255)	
Post-implementation trend	$0.85 **	0.046
	(0.396)	
Seasonality: Q2	$0.04	0.993
	(4.761)	
Seasonality: Q3	$10.33 *	0.053
	(4.986)	
Seasonality: Q4	-$2.74	0.568
	(4.710)	
Oct 2022–April 2023	-$13.19 **	0.041
	(5.998)	

*p <0.1, **p <0.05, ***p <0.001
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. Q: Quarter.

Table A-177—Tribal Dental Authority PMPM Costs (LTC)

Variable	Estimate	*p*-value
Intercept	$44.83 ***	<0.001
	(0.883)	
Post-implementation trend	$0.48 ***	<0.001
	(0.056)	
Seasonality: Q2	$2.25 **	0.033
	(0.977)	
Seasonality: Q3	$9.21 ***	<0.001
	(1.020)	
Seasonality: Q4	$0.62	0.534
	(0.977)	
Alternate Model		
Intercept	$45.42 ***	<0.001
	(1.565)	
Post-implementation trend	$0.45 ***	<0.001
	(0.085)	
Seasonality: Q2	$2.14 *	0.052
	(1.027)	
Seasonality: Q3	$9.09 ***	<0.001
	(1.076)	
Seasonality: Q4	$0.53	0.607
	(1.016)	
Oct 2022–April 2023	-$0.60	0.651
	(1.294)	

*p <0.1, **p <0.05, ***p <0.001
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. Q: Quarter.

Table A-178—Tribal Dental Authority PMPM Costs (OP ED)

Variable	Estimate	*p*-value
Intercept	$26.87 ***	<0.001
	(0.773)	
Post-implementation trend	-$0.08	0.139
	(0.049)	
Seasonality: Q2	$2.18 **	0.020
	(0.855)	
Seasonality: Q3	$3.50 ***	<0.001
	(0.893)	
Seasonality: Q4	$0.09	0.920
	(0.855)	
Alternate Model		
Intercept	$30.10 ***	<0.001
	(1.015)	
Post-implementation trend	-$0.24 ***	<0.001
	(0.055)	
Seasonality: Q2	$1.57 **	0.030
	(0.666)	
Seasonality: Q3	$2.83 ***	<0.001
	(0.698)	
Seasonality: Q4	-$0.39	0.560
	(0.659)	
Oct 2022–April 2023	-$3.27 **	0.001
	(0.839)	

*p <0.1, **p <0.05, ***p <0.001
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. Q: Quarter.

Table A-179—Tribal Dental Authority PMPM Costs (OP Non-ED)

Variable	Estimate	*p*-value
Intercept	$302.29 ***	<0.001
	(14.215)	
Post-implementation trend	$0.75	0.416
	(0.905)	
Seasonality: Q2	-$10.17	0.526
	(15.737)	
Seasonality: Q3	-$11.32	0.499
	(16.425)	
Seasonality: Q4	$0.95	0.953
	(15.737)	
Alternate Model		
Intercept	$274.97 ***	<0.001
	(24.094)	
Post-implementation trend	$2.10	0.127
	(1.315)	
Seasonality: Q2	-$5.01	0.755
	(15.811)	
Seasonality: Q3	-$5.60	0.739
	(16.560)	
Seasonality: Q4	$5.00	0.753
	(15.642)	
Oct 2022–April 2023	$27.63	0.182
	(19.921)	

*p <0.1, **p <0.05, ***p <0.001
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. Q: Quarter.

Table A-180—Tribal Dental Authority PMPM Costs (Pharmacy)

Variable	Estimate	*p*-value
Intercept	-$54.59 ***	<0.001
	(12.948)	
Post-implementation trend	$20.01 ***	<0.001
	(0.824)	
Seasonality: Q2	-$58.96 ***	<0.001
	(14.335)	
Seasonality: Q3	-$112.32 ***	<0.001
	(14.961)	
Seasonality: Q4	$44.35 **	0.006
	(14.335)	
Alternate Model		
Intercept	-$70.53 **	0.006
	(22.629)	
Post-implementation trend	$20.79 ***	<0.001
	(1.235)	
Seasonality: Q2	-$55.95 **	0.001
	(14.850)	
Seasonality: Q3	-$108.99 ***	<0.001
	(15.553)	
Seasonality: Q4	$46.71 **	0.005
	(14.691)	
Oct 2022–April 2023	$16.12	0.400
	(18.709)	

*p <0.1, **p <0.05, ***p <0.001
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. Q: Quarter.

Table A-181—Tribal Dental Authority PMPM Costs (Dental)

Variable	Estimate	*p*-value
Intercept	$1.03 ***	<0.001
	(0.063)	
Post-implementation trend	-$0.01	0.135
	(0.004)	
Seasonality: Q2	-$0.10	0.149
	(0.069)	
Seasonality: Q3	-$0.19 **	0.019
	(0.072)	
Seasonality: Q4	-$0.08	0.279
	(0.069)	
Alternate Model		
Intercept	$1.20 ***	<0.001
	(0.100)	
Post-implementation trend	-$0.01 **	0.015
	(0.005)	
Seasonality: Q2	-$0.14 *	0.053
	(0.066)	
Seasonality: Q3	-$0.22 **	0.005
	(0.069)	
Seasonality: Q4	-$0.10	0.132
	(0.065)	
Oct 2022–April 2023	-$0.17 *	0.052
	(0.083)	

*p <0.1, **p <0.05, ***p <0.001
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. Q: Quarter.

Table A-182—Tribal Dental Authority Total Costs (Total, in Thousands)

Variable	Estimate	*p*-value
Intercept	$320,615.10 ***	<0.001
	(24283.317)	
Post-implementation trend	-$8,255.80 ***	<0.001
	(1546.154)	
Seasonality: Q2	-$21,401.00	0.436
	(26884.118)	
Seasonality: Q3	-$33,513.30	0.247
	(28058.899)	
Seasonality: Q4	-$44,383.50	0.115
	(26884.118)	
Alternate Model		
Intercept	$185,646.60 ***	<0.001
	(18990.925)	
Post-implementation trend	-$1,585.00	0.144
	(1036.286)	
Seasonality: Q2	$4,093.00	0.746
	(12462.309)	
Seasonality: Q3	-$5,278.50	0.691
	(13052.170)	
Seasonality: Q4	-$24,371.00 *	0.064
	(12329.219)	
Oct 2022–April 2023	$136,519.80 ***	<0.001
	(15701.190)	

*p <0.1, **p <0.05, ***p <0.001
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. Q: Quarter.

Table A-183—Tribal Dental Authority Total Costs (Professional, in Thousands)

Variable	Estimate	*p*-value
Intercept	$256,046.20 ***	<0.001
	(23881.629)	
Post-implementation trend	-$10,334.40 ***	<0.001
	(1520.578)	
Seasonality: Q2	-$13,971.40	0.603
	(26439.409)	
Seasonality: Q3	-$20,441.30	0.468
	(27594.756)	
Seasonality: Q4	-$48,260.30 *	0.084
	(26439.409)	
Alternate Model		
Intercept	$124,854.80 ***	<0.001
	(19563.157)	
Post-implementation trend	-$3,850.20 **	0.002
	(1067.511)	
Seasonality: Q2	$10,809.20	0.411
	(12837.821)	
Seasonality: Q3	$7,003.30	0.609
	(13445.456)	
Seasonality: Q4	-$28,807.80 **	0.036
	(12700.722)	
Oct 2022–April 2023	$132,699.40 ***	<0.001
	(16174.296)	

*p <0.1, **p <0.05, ***p <0.001
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. Q: Quarter.

Table A-184—Tribal Dental Authority Total Costs (IP, in Thousands)

Variable	Estimate	*p*-value
Intercept	$18,556.60 ***	<0.001
	(578.924)	
Post-implementation trend	$23.10	0.539
	(36.861)	
Seasonality: Q2	$375.00	0.565
	(640.928)	
Seasonality: Q3	$1,331.80 *	0.061
	(668.935)	
Seasonality: Q4	-$581.70	0.375
	(640.928)	
Alternate Model		
Intercept	$19,906.00 ***	<0.001
	(956.294)	
Post-implementation trend	-$43.60	0.414
	(52.182)	
Seasonality: Q2	$120.10	0.850
	(627.543)	
Seasonality: Q3	$1,049.50	0.128
	(657.246)	
Seasonality: Q4	-$781.80	0.224
	(620.842)	
Oct 2022–April 2023	-$1,365.00	0.101
	(790.638)	

*p <0.1, **p <0.05, ***p <0.001
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. Q: Quarter.

Table A-185—Tribal Dental Authority Total Costs (LTC, in Thousands)

Variable	Estimate	*p*-value
Intercept	$6,265.20 ***	<0.001
	(114.466)	
Post-implementation trend	$2.50	0.738
	(7.288)	
Seasonality: Q2	$298.70 **	0.029
	(126.726)	
Seasonality: Q3	$1,017.20 ***	<0.001
	(132.264)	
Seasonality: Q4	-$98.70	0.446
	(126.726)	
Alternate Model		
Intercept	$6,273.40 ***	<0.001
	(204.122)	
Post-implementation trend	$2.10	0.855
	(11.138)	
Seasonality: Q2	$297.10 **	0.040
	(133.950)	
Seasonality: Q3	$1,015.50 ***	<0.001
	(140.290)	
Seasonality: Q4	-$99.90	0.461
	(132.519)	
Oct 2022–April 2023	-$8.30	0.961
	(168.763)	

*p <0.1, **p <0.05, ***p <0.001
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. Q: Quarter.

Table A-186—Tribal Dental Authority Total Costs (OP ED, in Thousands)

Variable	Estimate	*p*-value
Intercept	$3,706.10 ***	<0.001
	(93.758)	
Post-implementation trend	-$38.40 ***	<0.001
	(5.970)	
Seasonality: Q2	$288.30 **	0.012
	(103.800)	
Seasonality: Q3	$383.00 **	0.002
	(108.336)	
Seasonality: Q4	-$82.50	0.437
	(103.800)	
Alternate Model		
Intercept	$4,030.10 ***	<0.001
	(138.666)	
Post-implementation trend	-$54.40 ***	<0.001
	(7.567)	
Seasonality: Q2	$227.10 **	0.023
	(90.996)	
Seasonality: Q3	$315.20 **	0.004
	(95.303)	
Seasonality: Q4	-$130.50	0.164
	(90.024)	
Oct 2022–April 2023	-$327.70 **	0.010
	(114.645)	

*p <0.1, **p <0.05, ***p <0.001
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. Q: Quarter.

Table A-187—Tribal Dental Authority Total Costs (OP Non-ED, in Thousands)

Variable	Estimate	*p*-value
Intercept	$41,728.20 ***	<0.001
	(1791.512)	
Post-implementation trend	-$240.30 **	0.049
	(114.068)	
Seasonality: Q2	-$1,169.30	0.562
	(1983.388)	
Seasonality: Q3	-$1,919.10	0.366
	(2070.057)	
Seasonality: Q4	-$665.30	0.741
	(1983.388)	
Alternate Model		
Intercept	$37,312.10 ***	<0.001
	(2930.165)	
Post-implementation trend	-$22.00	0.892
	(159.892)	
Seasonality: Q2	-$335.20	0.864
	(1922.846)	
Seasonality: Q3	-$995.20	0.627
	(2013.857)	
Seasonality: Q4	-$10.50	0.996
	(1902.311)	
Oct 2022–April 2023	$4,466.90 *	0.082
	(2422.582)	

*p <0.1, **p <0.05, ***p <0.001
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. Q: Quarter.

Table A-188—Tribal Dental Authority Total Costs (Pharmacy, in Thousands)

Variable	Estimate	*p*-value
Intercept	-$5,827.50 **	0.001
	(1531.458)	
Post-implementation trend	$2,333.40 ***	<0.001
	(97.510)	
Seasonality: Q2	-$7,209.50 ***	<0.001
	(1695.480)	
Seasonality: Q3	-$13,860.90 ***	<0.001
	(1769.569)	
Seasonality: Q4	$5,317.50 **	0.005
	(1695.480)	
Alternate Model		
Intercept	-$6,885.90 **	0.021
	(2714.047)	
Post-implementation trend	$2,385.70 ***	<0.001
	(148.099)	
Seasonality: Q2	-$7,009.60 ***	<0.001
	(1781.024)	
Seasonality: Q3	-$13,639.50 ***	<0.001
	(1865.323)	
Seasonality: Q4	$5,474.40 **	0.006
	(1762.004)	
Oct 2022–April 2023	$1,070.60	0.639
	(2243.902)	

*p <0.1, **p <0.05, ***p <0.001
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. Q: Quarter.

Table A-189—Tribal Dental Authority Total Costs (Dental, in Thousands)

Variable	Estimate	*p*-value
Intercept	$140.20 ***	<0.001
	(7.161)	
Post-implementation trend	-$1.70 **	0.002
	(0.456)	
Seasonality: Q2	-$12.70	0.124
	(7.927)	
Seasonality: Q3	-$23.90 **	0.009
	(8.274)	
Seasonality: Q4	-$12.60	0.128
	(7.927)	
Alternate Model		
Intercept	$156.10 ***	<0.001
	(11.920)	
Post-implementation trend	-$2.50 **	0.001
	(0.650)	
Seasonality: Q2	-$15.70 *	0.059
	(7.822)	
Seasonality: Q3	-$27.30 **	0.004
	(8.192)	
Seasonality: Q4	-$15.00 *	0.069
	(7.738)	
Oct 2022–April 2023	-$16.10	0.120
	(9.855)	

*p <0.1, **p <0.05, ***p <0.001
Note: Costs are adjusted for medical inflation and are presented in terms of September 2024 dollars. Standard errors in parentheses. Q: Quarter.

Qualitative

Indian Health Service (IHS) and Tribal 638 facilities described several successes due to the Tribal Dental Authority, outlined in Table A-190.

Table A-190—Tribal Dental Authority Successes

Area of Success	Description
Increased capacity	• Facilities increased provider workforce and operational capacity and efficiency due to the additional revenue received from dental benefit reimbursements. The Tribal Dental Authority allowed facilities to offer additional services, increasing access to coordinated care. • Facilities onboarded specialists, such as periodontists and oral surgeons, to expand capacity and service arrays. • Prior to the Tribal Dental Authority, facilities treated emergency walk ins and did not limit treatment despite low reimbursement. Following implementation of the benefit, facilities reported high reimbursement rates. Facilities noted that higher reimbursements offset costs associated with other specialty services, resulting in more comprehensive care at no cost to members.
Technological advancements	• Facilities updated technology, including digital scanners and CEREC machines for same-day crowns. Updated technology reduced the number of visits required by a patient, allowing facilities to service more patients.
Increased utilization	• Since 2022, facilities have experienced steady growth in patient populations receiving care. One facility reported an increase from 11,000 patients in 2022 to over 12,000 patients in 2024.

Area of Success	Description
Ease in transition	• Facilities did not report challenges transitioning to Medicaid billing. Facilities collaborated between themselves and AHCCCS regarding billing and coding claims. AHCCCS was quick to respond when issues or questions arose.

Note: AHCCCS: Arizona Health Care Cost Containment System; CEREC: Chairside Economical Restoration of Esthetic Ceramics

In addition to reported successes, IHS and Tribal 638 facilities shared challenges experienced while operating under the Tribal Dental Authority, including:

- Long waitlists for care due to significant patient volume.
- Challenges recruiting providers, largely due to the rural locations of facilities despite the demand.
  - Potential providers faced housing barriers and were unwilling to commute from more urban areas.
- Some facilities continued to expand the continuum of care despite workforce shortages, while others were unable to offer specialized services.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

APPENDIX B:

CYE 2025 EXTERNAL QUALITY REVIEW ANNUAL REPORT

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Contract Year Ending 2025 External Quality Review Annual Technical Report

April 2026

HSAG HEALTH SERVICES ADVISORY GROUP

1. Executive Summary

Background

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, required states that contract with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) for administering Medicaid and Children's Health Insurance Program (CHIP) programs to contract with a qualified external quality review organization (EQRO) to provide an independent external quality review (EQR) of the domains of Quality, Timeliness, and Access to services provided by the contracted MCOs (also referred to as Contractors in this report). Revisions to the regulations originally articulated in the BBA were released in the May 2016 Medicaid and CHIP Managed Care Regulations,[1] with further revisions released in November 2020 [2] and May 2024.[3] The final rule is provided in Title 42 of the Code of Federal Regulations (CFR) Part 438 and cross-referenced in the CHIP regulations at 42 CFR Part 457. To comply with 42 CFR 438.358, the Arizona Health Care Cost Containment System (AHCCCS) has contracted with Health Services Advisory Group, Inc. (HSAG), a qualified EQRO. This technical report is intended to help AHCCCS:

- Identify areas for quality improvement (QI).
- Ensure alignment among the Contractors' Quality Management/Performance Improvement (QM/PI) Program Plan requirements, the State's Quality Strategy, and the annual EQR activities.
- Provide high-value care.
- Enhance performance of its healthcare delivery system for Medicaid and CHIP members.
- Improve AHCCCS' ability to oversee and manage its Contractors.
- Assist Contactors with improving their performance with respect to the quality, timeliness, and accessibility of care.

[1] Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: Feb 18, 2026.

[2] Centers for Medicare & Medicaid Services. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care. Available at: https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care. Accessed on: Feb 18, 2026.

[3] Centers for Medicare & Medicaid Services. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality. Available at: https://www.federalregister.gov/documents/2024/05/10/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance. Accessed on: Feb 18, 2026.

Contractors Reviewed

AHCCCS maintains managed care agreements with several Contractors to administer its Medicaid Managed Care program. A general description of each AHCCCS program and the associated Contractors reviewed are included below. No Contractors were exempt from EQR in contract year ending (CYE) 2025.

AHCCCS Complete Care (ACC) Program

The **ACC Program** provides integrated care addressing the physical and behavioral health needs for the majority of Medicaid (Title XIX) eligible children and adults as well as addressing the physical and behavioral health needs for the majority of CHIP KidsCare (Title XXI) eligible children (under age 19 years). Seven ACC Contractors were responsible for providing services under the ACC Program. Three of the ACC Contractors were also responsible for providing services for the Serious Mental Illness (SMI)-Designated population. These Contractors are referred to as ACC-Regional Behavioral Health Agreement (ACC-RBHA) Contractors. Throughout this report, ACC Program discussions are limited to the ACC and ACC-RBHA Contractors' Non-SMI-Designated population.

Table 1-1—ACC Program Contracted MCOs

ACC Program Contractors	
Contractor Name	**Contractor Abbreviation**
Arizona Complete Health – Complete Care Plan	AzCH-CCP ACC-RBHA*
Banner-University Family Care	BUFC ACC
Care1st Health Plan	Care1st ACC-RBHA[1]*
Health Choice Arizona	HCA ACC
Mercy Care	Mercy Care ACC-RBHA*
Molina Healthcare	Molina ACC
UnitedHealthcare Community Plan	UHCCP ACC

* Contractor serves both the ACC and the ACC-RBHA SMI-Designated populations. Throughout this report, ACC Program discussions are limited to the ACC-RBHA Contractors' Non-SMI-Designated population.

ACC-Regional Behavioral Health Agreement (ACC-RBHA) Serious Mental Illness (SMI)-Designated Program

The **ACC-RBHA Program** provides integrated physical and behavioral health services to eligible Medicaid (Title XIX) and CHIP KidsCare (Title XXI) covered members determined to have a SMI designation. ACC-RBHA Contractors are also responsible for providing crisis services to all individuals, including but not limited to crisis telephone services, community-based mobile crisis teams, and facility-

based crisis stabilization services. Additionally, ACC-RBHA Contractors are responsible for providing services to the ACC Non-SMI-Designated population.

Table 1-2—ACC-RBHA SMI-Designated Program Contracted MCOs

ACC-RBHA SMI-Designated Program Contractors*	
Contractor Name	**Contractor Abbreviation**
Arizona Complete Health – Complete Care Plan	AzCH-CCP ACC-RBHA
Care1st Health Plan	Care1st ACC-RBHA[1]
Mercy Care	Mercy Care ACC-RBHA

*The ACC-RBHA Contractors serve both the SMI-Designated population (under the ACC-RBHA program) and the Non-SMI-Designated population (under the ACC program).

Arizona Department of Child Safety Comprehensive Health Plan (DCS CHP) Program

The **DCS CHP Program** provides physical, dental, and behavioral health services for children and youth in foster care throughout the State of Arizona.

Table 1-3—DCS CHP Program Contracted MCO

DCS CHP Program Contractor	
Contractor Name	**Contractor Abbreviation**
Arizona Department of Child Safety Comprehensive Health Plan	DCS CHP*

*DCS CHP provides services through a subcontracted MCO, Mercy Care Department of Child Safety Comprehensive Health Plan (Mercy Care DCS CHP). This report uses DCS CHP when referring to activities conducted by the DCS CHP Program and Mercy Care DCS CHP when referring to activities conducted by the DCS CHP subcontracted health plan (Mercy Care).

Arizona Long Term Care System Elderly and Physically Disabled (ALTCS-EPD) Program

The **ALTCS-EPD Program** provides long-term services and supports (LTSS) as well as integrated physical and behavioral health services to eligible members who are elderly and/or have a physical disability.

Table 1-4—ALTCS-EPD Program Contracted MCOs

ALTCS-EPD Program Contractors	
Contractor Name	**Contractor Abbreviation**
Banner-University Family Care	BUFC LTC
Mercy Care	Mercy Care LTC
UnitedHealthcare Community Plan	UHCCP LTC

ALTCS Developmental Disabilities (ALTCS-DD) Program

The **ALTCS-DD Program** provides LTSS as well as integrated physical and behavioral health services to eligible members who have an intellectual/developmental disability (IDD) as outlined under Arizona State law.

Table 1-5—ALTCS-DD Program Contracted MCO

ALTCS-DD Program Contractor	
Contractor Name	**Contractor Abbreviation**
Arizona Department of Economic Security, Division of Developmental Disabilities	DES/DDD*

*DES/DDD provides services through two subcontracted health plans, Mercy Care and UnitedHealthcare Community Plan (UHCCP). The report uses DES/DDD when referring to the DES/DDD Contractor, and Mercy Care DD or UHCCP DD when referring to activities conducted by the DES/DDD subcontracted health plans.

Program-Level Summary of Findings and Assessment

In this section, HSAG presents program-level strengths, weaknesses (referred to in this report as opportunities for improvement), and recommendations. Each strength, opportunity for improvement, and recommendation is derived from HSAG's review of the EQR activity results. Table 1-6 below provides a timeline for conducting each of the EQR activities. For additional information related to key milestones and associated dates, please refer to Appendix A. Methodology for each activity.

Table 1-6—Timeline for EQR Activities

Activity	Start Date	End Date	Measurement/Lookback Period
Performance Measure Validation (PMV)	06/11/2025	04/01/2026	01/01/2024–12/31/2024
Performance Improvement Projects (PIPs)	08/29/2025	03/31/2026	01/01/2024–12/31/2024
Compliance Review	12/09/2024	12/01/2025	10/01/2024–03/31/2025
Network Adequacy Validation (NAV)	10/01/2024	12/19/2025	07/01/2024–09/30/2024
Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[4]	10/01/2024	11/10/2025	07/01/2025–12/31/2025

[4] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

ACC Program

Table 1-7 presents program-level strengths, opportunities for improvement, and recommendations for the ACC Program based on all EQR activities conducted. For additional information about ACC Program-level strengths, opportunities for improvement, and recommendations, see Section 4. ACC Program-Level Comparative Results.

Table 1-7—ACC Program Strengths, Opportunities for Improvement, and Recommendations

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths related to performance measure validation (PMV): • The rates for all seven ACC Program Contractors and the ACC Program Aggregate rate met or exceeded the National Committee for Quality Assurance (NCQA) Quality Compass® [5]national Medicaid health maintenance organization (HMO) mean for Healthcare Effectiveness Data and Information Set (HEDIS®)[6] measurement year (MY) 2024 for these measures: – *Follow-Up After Emergency Department (ED) Visit for Substance Use—7-Day Follow-Up—Total (13+ Years)* and *30-Day Follow-Up—Total (13+ Years)* measure rates **[Quality, Timeliness, Access]** – *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase (6–12 Years)* and *Continuation and Maintenance Phase (6–12 Years)* measure rates **[Quality, Timeliness, Access]** – *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years)* **[Quality, Timeliness, Access]** • The rates for six of seven ACC Program Contractors and the ACC Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 for these measures: – *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* **[Quality, Timeliness, Access]** – *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* **[Quality, Timeliness, Access]** – *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* and *Engagement of SUD Treatment—Total—Total (13+ Years)* measure rate **[Quality, Timeliness, Access]** – *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)* **[Quality]** – *Well-Child Visits in the First 30 Months of Life—First 15 Months—Six or More Well-Child Visits* **[Quality]**

[5] Quality Compass® is a registered trademark of NCQA.
[6] HEDIS® is a registered trademark of NCQA.

Strengths, Opportunities for Improvement, and Recommendations

- *Oral Evaluation, Dental Services—Total (0–20 Years)* **[Access]**

HSAG identified the following strengths related to the validation of performance improvement projects (PIPs):

- For the *Back to Basics* PIP, five ACC Program Contractors were able to achieve statistically significant improvement for both performance indicators when comparing baseline rates to Remeasurement 3 rates. Additionally, another ACC Program contractor had statistically significant improvement for one of the two performance indicators. At Remeasurement 3, two ACC Program Contractors sustained the statistically significant improvement they achieved previously for both performance indicators. **[Quality, Access]**

HSAG identified the following strengths related to compliance reviews:

- All four ACC Program Contractors that underwent compliance reviews in CYE 2025 scored at or above 95 percent in the following standards:
  - Assurances of Adequate Capacity and Services **[Timeliness, Access]**
  - Coordination and Continuity of Care **[Quality, Timeliness, Access]**
  - Confidentiality **[Quality]**
  - Practice Guidelines **[Quality]**
  - Program Integrity **[Quality]**

HSAG identified the following strengths related to network adequacy validation (NAV):

- The ACC Program Contractors received *High Confidence* for both appointment availability and time/distance indicators. **[Access]**
- The applicable ACC Program Contractors met all minimum time/distance network standards in Cochise, Graham, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties. **[Access]**
- The ACC Program Contractors consistently met Behavioral Health Residential Facility (BHRF); Cardiologist, Adult and Pediatric; Hospital; Obstetrician/Gynecologist (OB/GYN); and Primary Care Provider (PCP), Adult and Pediatric standards. **[Access]**

HSAG identified the following strengths related to the CAHPS results for the ACC Program's adult Medicaid population:

- The ACC Program's member experience ratings for *Rating of Personal Doctor, Rating of Specialist Seen Most Often,* and *Customer Service* were at or above the 90th percentile for the adult Medicaid population. **[Quality]**
- The ACC Program's member experience rating for *Getting Needed Care* was between the 75th and 89th percentiles for the adult Medicaid population. **[Quality, Access]**

Strengths, Opportunities for Improvement, and Recommendations
• The ACC Program's member experience rating for *Rating of Personal Doctor* was statistically significantly higher than the NCQA national average for the adult Medicaid population. **[Quality]** • The ACC Program's 2025 score for *Getting Needed Care* was statistically significantly higher than the 2024 score for the adult Medicaid population. **[Quality, Access]** HSAG identified the following strengths related to the CAHPS results for the ACC Program's child Medicaid population: • The ACC Program's member experience ratings for *Customer Service, Coordination of Care for Children with Chronic Conditions,* and *Access to Prescription Medicines* were at or above the 90th percentile for the CCC population. **[Quality, Access]** • The ACC Program's member experience ratings for *Rating of All Health Care, Rating of Personal Doctor, Getting Needed Care,* and *Getting Care Quickly* were at or between the 75th and 89th percentiles for the general child population. **[Quality, Timeliness]** • The ACC Program's 2025 score for *Getting Care Quickly* was statistically significantly higher than the NCQA national average for the general child population. **[Quality, Timeliness]** • The ACC Program's 2025 score for *Coordination of Care for Children with Chronic Conditions* was statistically significantly higher than the NCQA national averages for the CCC population. **[Quality]** • The ACC Program's 2025 score for *Customer Service* was statistically significantly higher than the 2024 score for the CCC population. **[Quality]** HSAG identified the following strengths related to the CAHPS results for KidsCare: • The KidsCare member experience rating for *How Well Doctors Communicate* was at or above the 90th percentile for the general child population. **[Quality]** • The KidsCare member experience rating for *Access to Prescription Medicines* was at or above the 90th percentile for the CCC population. **[Quality, Access]** • The KidsCare member experience ratings for *Rating of All Health Care* and *Rating of Personal Doctor* were at or between the 75th and 89th percentiles for the general child population. **[Quality]** • The KidsCare member experience rating for *Rating of All Health Care* was at or between the 75th and 89th percentile for the CCC population. **[Quality]** • The KidsCare 2025 score for *How Well Doctors Communicate* was statistically significantly higher than the NCQA national average for the general child population. **[Quality]**
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement related to PMV:

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- The rates for all seven ACC Program Contractors and the ACC Program Aggregate rate fell below the NCQA Quality Compass national Medicaid HMO mean for MY 2024 and fell below the 25th percentile for the following measure:
  - *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—18+ Years* **[Quality]**
  - *Prenatal and Postpartum Care—Postpartum Care* **[Quality, Timeliness, Access]**

  Recommendations:

  - Regarding the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—18+ Years* measure, HSAG recommends that the ACC Program Contractors consider implementing one or more of the interventions that have been associated with increased medication adherence for members with schizophrenia. In a systematic review of medication adherence studies, several interventions that worked in studies were motivational interviewing, daily texts to individuals with schizophrenia, and other medication reminders. Other effective studies utilized Meds-Help, a pharmacy-based intervention, environmental support through home visits and reminders to adhere to medication, a psychoeducational program (Family Schizophrenia Psychoeducation Program [FSPP]), an intervention called Supervised Treatment in Outpatients for Schizophrenia (STOPS) that focuses on the importance of the supervisor's role for patients during treatment, and an individualized occupational therapy (IOT) program.[7] In addition, HSAG recommends that ACC Program Contractors consider utilizing financial incentives offered to patients with severe mental illness to improve treatment adherence.
  - Regarding the *Prenatal and Postpartum Care—Postpartum Care* measure, ACC Program Contractors are currently conducting the *Prenatal and Postpartum Care* PIP, which includes a root cause analysis and interventions to address this measure. HSAG recommends that the ACC Program Contractors continue monitoring the success of the interventions and submit the PIP results as required by AHCCCS.

HSAG identified no opportunities for improvement related to the *Back to Basics* PIP.

Recommendations: HSAG recommends that the Contractors consider the following for the future PIPs:

- Apply lessons learned from the *Back to Basics* PIP.

[7] Cahaya N, Kristina SA, Widayanti AW, et al. Interventions to Improve Medication Adherence in People with Schizophrenia: A Systematic Review. Patient preference and adherence vol. 16 2431-2449. 1 Sep. 2022, doi:10.2147/PPA.S378951. Available at: https://pubmed.ncbi.nlm.nih.gov/36072918/. Accessed on: Feb 11, 2026.

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- Seek technical assistance from HSAG to understand the CMS EQR Protocol 1 requirements.
- Implement interventions with clearly defined intervention effectiveness measures.

HSAG identified the following opportunities for improvement related to compliance reviews:

- All four ACC Program Contractors that underwent compliance reviews in CYE 2025 scored below 95 percent in the following standards:
  - Disenrollment: Requirements and Limitations **[Quality]**
  - Coverage and Authorization of Services **[Quality, Timeliness, Access]**

  Recommendations: HSAG recommends that the ACC Program Contractors address the elements scored as *Not Met* through the CAP process during CYE 2026.

HSAG identified the following opportunities for improvement related to NAV:

- Based on the NAV results, more than one ACC Program Contractor did not meet the standards for Dentist, Pediatric; and Pharmacy. **[Access]**

  Recommendations: HSAG recommends that AHCCCS support each ACC Program Contractor in continuing to monitor and maintain its existing provider network coverage as of CYE 2024 Semiannual Review 2 (S2), with specific attention to ensuring the availability of the following provider categories for which more than one ACC Program Contractor did not meet the network requirement:
  - Dentist, Pediatric in Apache, Greenlee, and La Paz counties
  - Pharmacy in La Paz County

HSAG identified the following opportunities for improvement related to CAHPS results for the ACC Program's adult Medicaid population:

- The ACC Program's member experience ratings for *Advising Smokers and Tobacco Users to Quit, Discussing Cessation Medications,* and *Discussing Cessation Strategies* were below the 25th percentiles for the adult Medicaid population. **[Quality]**
- The ACC Program's member experience rating for *Coordination of Care* was at or between the 25th and 49th percentiles for the adult Medicaid population. **[Quality]**

  Recommendations: HSAG recommends that the ACC Program Contractors explore what may be driving lower experience scores and develop initiatives designed to improve the quality of care, including a focus on improving adult members' overall experiences with their care coordination and medical assistance with quitting smoking and tobacco use.

HSAG identified the following opportunities for improvement related to CAHPS results for the ACC Program's child Medicaid population:

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- The ACC Program's member experience rating for *FCC: Personal Doctor Who Knows Child* was below the 25th percentile for the CCC population. **[Quality]**
- The ACC Program's member experience ratings for *Rating of Specialist Seen Most Often* and *Coordination of Care* were between the 25th and 49th percentiles for the general child population. **[Quality]**
- The ACC Program's member experience ratings for Rating of All Health Care, Rating of Specialist Seen Most Often, Access to Specialized Services, and FCC: Getting Needed Information were between the 25th and 49th percentiles for the CCC population. **[Quality, Access]**
- The ACC Program's 2025 scores for *Rating of All Health Care* and *Access to Prescription Medicines* were statistically significantly lower than the 2024 scores for the CCC population. **[Quality, Access]**

  Recommendations: HSAG recommends that the ACC Program Contractors explore what may be driving lower experience scores and develop initiatives designed to improve the quality of and access to care, including a focus on improving parents'/caretakers' overall experiences with their child's health care, child's specialist seen most often, personal doctor who knows child, coordination of care, getting needed information, and access to specialized services for child members.

HSAG identified the following opportunities for improvement related to CAHPS results for KidsCare:

- The KidsCare member experience ratings for *Rating of Specialist Seen Most Often* and *Customer Service* were below the 25th percentiles for the general child population. **[Quality]**
- The KidsCare member experience ratings for *Getting Care Quickly* and *FCC: Personal Doctor Who Knows Child* were below the 25th percentiles for the CCC population. **[Quality, Timeliness]**
- The KidsCare member experience ratings for *Getting Care Quickly* and *Coordination of Care* were between the 25th and 49th percentiles for the general child population. **[Quality, Timeliness]**
- The KidsCare member experience ratings for *Rating of Specialist Seen Most Often*, *Getting Needed Care, Customer Service*, and *Coordination of Care for Children with Chronic Conditions* were between the 25th and 49th percentiles for the CCC population. **[Quality, Access]**
- The KidsCare 2025 score for *Rating of Specialist Seen Most Often* was statistically significantly higher than the NCQA national average for the general child population. **[Quality]**

  Recommendations: HSAG recommends that the KidsCare Contractors explore what may be driving lower experience scores and develop initiatives designed to improve the quality of, access to, and timeliness of care, including a focus on improving parents'/caretakers' overall experiences

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with the specialist their child sees the most, their child's personal doctor knowing the child, coordination of care, customer service, and getting needed care in a timely manner.

ACC-RBHA SMI-Designated Program

Table 1-8 presents program-level strengths, opportunities for improvement, and recommendations for the ACC-RBHA SMI-Designated Program based on all EQR activities conducted. For additional information about ACC-RBHA SMI-Designated Program-level strengths, opportunities for improvement, and recommendations, see Section 6—ACC-RBHA SMI-Designated Program-Level Comparative Results.

Table 1-8—ACC-RBHA Program Strengths and Opportunities for Improvement

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths related to PMV: • Rates for all of the ACC-RBHA Contractors and the ACC-RBHA SMI-Designated Program Aggregate rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 for these measures: – *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years* **[Quality]** – *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* **[Quality, Timeliness, Access]** – *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years)* and *30-Day Follow-Up—Total (13+ Years)* – *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* **[Quality, Timeliness, Access]** HSAG identified the following strengths related to PIP validation: • For the *Preventive Screening* PIP, both ACC-RBHA Contractors adhered to acceptable methodology through all phases of the PIP and were able to measure the effectiveness of interventions and perform accurate statistical testing between the baseline rate and the Remeasurement 3 rate. One ACC-RBHA Contractor was able to achieve statistically significant improvement for both performance indicators at Remeasurement 3. The second Contractor achieved statistically significant improvement for Performance Indicator 1 (*Breast Cancer Screening [BCS]*) when comparing the baseline rate to the Remeasurement 3 rate. **[Quality, Access]**

Strengths, Opportunities for Improvement, and Recommendations
HSAG did not identify any ACC-RBHA SMI-Designated Program strengths related to compliance reviews. HSAG identified the following strengths related to NAV: • The ACC-RBHA Program Contractors received *High Confidence* for both appointment availability and time/distance indicators. **[Access]** • The applicable ACC-RBHA Program Contractors met all minimum time/distance network standards in Apache, Coconino, Gila, Graham, Greenlee, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties. **[Access]** • The ACC-RBHA Program Contractors' performance consistently met the BHRF; Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult and Pediatric; Hospital; OB/GYN; and PCP, Adult and Pediatric standards. **[Access]** HSAG identified the following strengths related to the CAHPS results for the ACC-RBHA SMI-Designated Program's adult Medicaid population: • The ACC-RBHA SMI-Designated Program's member experience ratings for *Advising Smokers and Tobacco Users to Quit, Discussing Cessation Medications,* and *Discussing Cessation Strategies* were at or between the 75th and 89th percentiles for the adult Medicaid population. **[Quality]**
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement related to PMV: • None of the ACC-RBHA Contractors' rates nor the ACC-RBHA SMI-Designated Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024, and all rates fell below the 25th percentile for these measures: – *Breast Cancer Screening (ECDS)—Total (50–74 Years)* **[Quality]** – *Cervical Cancer Screening—21–64 Years* **[Quality]** – *Cervical Cancer Screening (ECDS)—21–64 Years* **[Quality]** – *Plan All-Cause Readmissions—O/E Ratio—Total—18–64 Years* **[Quality]** • The rates for two of the ACC-RBHA Contractors and the ACC-RBHA SMI-Designated Program Aggregate rate did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and fell below the 25th percentile for Use *of Opioids at High Dosage—18+ Years.* **[Quality]** • The rates for two of the ACC-RBHA Contractors and the ACC-RBHA SMI-Designated Program Aggregate rate did not meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and fell below the 25th percentile for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care.* **[Quality, Timeliness]**

Strengths, Opportunities for Improvement, and Recommendations
Recommendations: • Regarding the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measures, HSAG recommends that these Contractors continue to implement appropriate interventions to improve performance relative to prenatal and postpartum care. HSAG also recommends that the Contractors continue to monitor and expand on interventions currently in place to improve performance related to the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measures. In addition, HSAG recommends that Contractors consider whether there are disparities/social determinants of health (SDOH) within their populations that contributed to lower access to care. A few strategies could include providing expanded access appointments outside of business hours to accommodate work schedules or childcare needs. Further, HSAG recommends that Contractors identify payment structure types that will incentivize quality care. Bundling payments may cause disincentives for postpartum care, as providers might receive the same payment regardless of whether the member attends the postpartum visit.[8] • Regarding the *Use of Opioids at High Dosage—18+ Years* measure, HSAG recommends that these Contractors continue to implement appropriate interventions to help reduce the proportion of members who may be considered at high risk for opioid overuse and misuse. HSAG also recommends that the ACC-RBHA Contractors monitor and expand on interventions currently in place to improve performance related to the *Use of Opioids at High Dosage—18+ Years* measure. • Regarding the *Plan All-Cause Readmissions—O/E Ratio—Total—18–64 Years* measure, HSAG recommends that these Contractors continue to follow through on performance improvement strategies to increase provider and member outreach and improve follow-up care after discharge from an acute inpatient admission or observation. HSAG recommends that Contractors consider reviewing the Re-Engineered Discharge (RED), which has been shown to reduce readmissions and posthospital ED visits.[9] Other interventions that might be effective include technology platforms, including artificial intelligence (AI) or machine learning, that can assist the plans in identifying members more at risk of readmission. HSAG recommends that Contractors utilize case management strategies which focus on person-centered techniques, addressing barriers and/or SDOH as needed. • Regarding the *Cervical Cancer Screening—21–64 Years* and *Breast Cancer Screening (ECDS)—Total (50–74 Years)* measures, HSAG recommends that the ACC-RBHA Contractors leverage interventions and root cause analyses identified through the *Preventive Screening* PIP to improve performance related to preventive screenings. HSAG recommends that the Contractors monitor and expand on interventions currently in place to improve

[8] Centers for Medicare & Medicaid Services. Lessons Learned about Payment Strategies to Improve Postpartum Care in Medicaid and CHIP. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/postpartum-payment-strategies.pdf. Accessed on: Feb 11, 2026.

[9] Agency for Healthcare Research and Quality. Re-Engineered Discharge (RED) Toolkit. Available at: https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool1.html. Accessed on: Feb 11, 2026.

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performance related to these measures. HSAG recommends that Contractors consider utilizing one-on-one interactions with healthcare professionals, such as CHWs, which have been shown to improve screening rates. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness.

- Starting as part of MY 2022 performance measure reporting, race and ethnicity stratifications (RES) were required based on NCQA HEDIS specifications. While HSAG did not identify Contractor-specific opportunities to improve RES, all ACC-RBHA Contractors could benefit from continuing to focus on refining RES reporting when required in keeping with measure specifications. **[Quality]**

  Recommendation: HSAG recommends that the ACC-RBHA Contractors explore data sources for the capture of race and ethnicity data to support future performance measure reporting that may require stratifications related to RES. The Contractors should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information.

HSAG identified the following opportunities for improvement related to PIP validation:

- One ACC-RBHA Contractor's Performance Indicator 2 (*Cervical Cancer Screening [CCS]*) rate remained below the baseline rate at Remeasurement 3 for the *Preventive Screening* PIP. **[Quality, Access]**

  Recommendations: HSAG recommends that the Contractors consider the following for the future PIPs:

  - Apply lessons learned from the *Preventive Screening* PIP.
  - Seek technical assistance from HSAG to understand the CMS EQR Protocol 1 requirements.
  - Implement interventions with clearly defined intervention effectiveness measures.

HSAG identified no program-level opportunities for improvement related to compliance reviews.

HSAG identified the following opportunities for improvement related to NAV:

- Based on the NAV results, one ACC-RBHA SMI-Designated Program Contractor did not meet the standard for Dentist, Pediatric in more than one county. **[Access]**

  Recommendations: HSAG recommends that AHCCCS support the ACC-RBHA SMI-Designated Program Contractor in continuing to monitor and maintain its existing provider network coverage as of CYE 2024 S2, with specific attention to ensuring the availability of the following provider

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category for which one ACC-RBHA SMI-Designated Program Contractor did not meet the network requirement in more than one county: • Dentist, Pediatric in Cochise and La Paz counties. HSAG identified the following opportunities for improvement related to CAHPS results for the ACC-RBHA SMI-Designated Program's adult Medicaid population: • The ACC-RBHA SMI-Designated Program's member experience ratings for *Rating of Health Plan, Rating of All Health Care, Rating of Specialist Seen Most Often, How Well Doctors Communicate, Customer Service,* and *Coordination of Care* were below the 25th percentiles for the adult Medicaid population. **[Quality]** • The ACC-RBHA SMI-Designated Program's member experience ratings for *Rating of Personal Doctor*, *Getting Needed Care*, and *Getting Care Quickly* were at or between the 25th and 49th percentiles for the adult Medicaid population. **[Quality, Timeliness, Access]** Recommendations: HSAG recommends that the ACC-RBHA SMI-Designated Program Contractors explore what may be driving lower experience scores and develop initiatives designed to improve the quality of and access to care, including a focus on improving adult members' overall experiences with their health plan, overall health care, the specialist they see most often, their doctor's ability to communicate, coordination of care, customer service, and getting needed care in a timely manner.

DCS CHP Program

Table 1-9 presents program-level strengths, opportunities for improvement, and recommendations for the DCS CHP Program based on all EQR activities conducted. DCS CHP strengths, opportunities for improvement, and recommendations by EQR activity are provided in Section 8. DCS CHP Program Results.

Table 1-9—DCS CHP Program Strengths, Opportunities for Improvement, and Recommendations

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths related to PMV: • DCS CHP met or exceeded the NCQA Quality Compass national Medicaid HMO mean and was at or above the 90th percentile for HEDIS MY 2024 for these measures: – *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* **[Quality, Timeliness, Access]**

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- *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total (13+ Years)* and *30-Day Follow-Up—Total (13+ Years)* **[Quality, Timeliness, Access]**
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* **[Quality, Timeliness, Access]**
- *Follow-Up Care for Children Prescribed ADHD Medication (ECDS)—Initiation Phase (6–12 Years)* and *Continuation and Maintenance Phase (6–12 Years)* **[Quality, Timeliness, Access]**
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years)* **[Quality, Timeliness, Access]**
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)* **[Quality]**
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* **[Quality]**
- *Immunizations for Adolescents (ECDS)—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* **[Quality]**
- *Child and Adolescent Well-Care Visits—Total (3–21 Years)* **[Quality, Timeliness]**
- *Oral Evaluation, Dental Services—Total (0–20 Years)* **[Access]**

HSAG identified the following strengths related to PIP validation:

- DCS CHP adhered to acceptable methodology through all phases of the *Back to Basics* PIP. The Contractor achieved statistically significant improvement between the baseline rate and the Remeasurement 2 rate and sustained that statistically significant improvement at Remeasurement 3 for the *Child and Adolescent Well-Care Visits (WCV)* performance indicator. **[Quality, Access]**

HSAG identified the following strengths related to compliance reviews:

- DCS CHP successfully closed CAPs in the following focus areas:
  - Delivery Systems (DS) **[Timeliness, Access]**
  - Adult, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), and Maternal Child Health (MCH) **[Quality, Timeliness, Access]**
  - Quality Management (QM) **[Quality]**
  - Quality Improvement (QI) **[Quality, Access]**

HSAG identified the following strengths related to NAV:

- The DCS CHP subcontracted health plan received *High Confidence* for both appointment availability and time/distance indicators. **[Access]**
- The DCS CHP subcontracted health plan met all minimum network requirements for all assigned counties except Apache, Coconino, Greenlee, La Paz, and Pima counties. **[Access]**

Strengths, Opportunities for Improvement, and Recommendations
• The DCS CHP subcontracted health plan consistently met the Behavioral Health Outpatient and Integrated Clinic, Pediatric; Cardiologist, Pediatric; Hospital; OB/GYN; and PCP, Pediatric standards. **[Access]** HSAG identified the following strengths related to the CAHPS results for DCS CHP**:** • DCS CHP's member experience ratings for *Rating of All Health Care*, *Getting Care Quickly*, and *Customer Service* were at or above the 90th percentiles for the general child population. **[Quality, Timeliness]** • DCS CHP's member experience ratings for *Getting Care Quickly* and *Access to Specialized Services* were at or above the 90th percentiles for the CCC population. **[Quality, Timeliness, Access]** • DCS CHP's member experience ratings for *Rating of Personal Doctor*, *Getting Needed Care*, and *How Well Doctors Communicate* were at or between the 75th and 89th percentiles for the general child population. **[Quality, Access]** • DCS CHP's member experience rating for *Customer Service* was at or between the 75th and 89th percentiles for the CCC population. **[Quality]** • DCS CHP's 2025 scores for *Getting Care Quickly* and *Customer Service* were statistically significantly higher than the NCQA national averages for the general child population. **[Quality, Timeliness]** • DCS CHP's 2025 scores for *Getting Care Quickly* and *Access to Specialized Services* were statistically significantly higher than the NCQA national averages for the CCC population. **[Quality, Timeliness, Access]** • DCS CHP's 2025 score for *Getting Care Quickly* was statistically significantly higher than the 2024 score for the general child population. **[Quality, Timeliness]** • DCS CHP's 2025 scores for *Getting Care Quickly, Access to Specialized Services, FCC: Personal Doctor Who Knows Child,* and *Access to Prescription Medicines* were statistically significantly higher than the 2024 scores for the CCC population. **[Quality, Timeliness, Access]**
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement related to PMV: • DCS CHP's performance measure rate for *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* remained below the 25th percentile, indicating that not all members were following the engagement period for SUD treatments. **[Quality, Timeliness, Access]** Recommendation: HSAG recommends that DCS CHP continue all efforts being made to conduct a root cause analysis or focus study to determine why some members were not accessing SUD services or medication-assisted treatment (MAT) following their initiation visit. HSAG recommends that DCS CHP review patient data for any patterns present by ZIP Code and other

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demographics for case management prioritization. One study suggests that male members who have a schizophrenia spectrum disorder diagnosis are less likely to initiate treatment, while current drug dependence and recent arrest were associated with lowered odds of engaging in treatment. Current drug dependence is associated with factors that make scheduling and attending treatment appointments difficult, such as severe symptoms, chaotic living situations, and self-care and life functioning issues.[10]

- While DCS CHP was successful in reporting valid rates for all AHCCCS-required performance measures for its DCH CHP population, the audit identified the following recommendations for future years' reporting **[Quality]**:

  Recommendation: HSAG recommends that DCS CHP/Mercy Care continue to ensure compliance with AHCCCS requirements for continuous enrollment criteria for AHCCCS PMV reporting. This includes AHCCCS requirements for members for whom DCS CHP does not hold the primary insurance contract. In addition, HSAG recommends that DCS CHP continue to work with AHCCCS to explore additional data sources and other strategies for the capture of race/ethnicity data to support performance measure reporting that requires stratification related to RES.

HSAG identified no opportunities for improvement related to the *Back to Basics* PIP.

Recommendation: Although there were no opportunities for improvement identified, HSAG recommends that the Contractor consider the following for future PIPs:

- Apply lessons learned from the *Back to Basics* PIP.
- Seek technical assistance from HSAG to understand the CMS EQR Protocol 1 requirements.
- Implement interventions with clearly defined intervention effectiveness measures.

HSAG identified no program-level opportunities for improvement related to compliance reviews.

HSAG identified the following opportunities for improvement related to NAV:

- The DCS CHP subcontracted health plan did not meet standards for more than one county for Dentist, Pediatric and Pharmacy. **[Access]**

  Recommendation: HSAG recommends that AHCCCS support the DCS CHP subcontracted health plan in continuing to monitor and maintain its existing provider network coverage as of CYE 2024 S2, with specific attention to ensuring the availability of the following provider category for which

[10] National Committee for Quality Assurance. Initiation and Engagement of Substance Use Disorder (IET). Available at: https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/initiation-and-engagement-of-substance-use-disorder-treatment-iet/. Accessed on: Feb 11, 2026.

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the DCS CHP subcontracted health plan did not meet the network requirement in more than one county: • Dentist, Pediatric in Apache, Greenlee, and La Paz counties. • Pharmacy in Coconino and La Paz counties. HSAG identified the following opportunities for improvement related to the CAHPS results for DCS CHP: • DCS CHP's member experience ratings for *Coordination of Care, FCC: Personal Doctor Who Knows Child*, and *Coordination of Care for Children with Chronic Conditions* were below the 25th percentiles for the CCC population. **[Quality]** • DCS CHP's member experience ratings for *Rating of Health Plan, Rating of Specialist Seen Most Often*, and *Coordination of Care* were at or between the 25th and 49th percentiles for the general child population. **[Quality]** • DCS CHP's member experience ratings for *Rating of Health Plan* and *Rating of Personal Doctor* were at or between the 25th and 49th percentiles for the CCC population. **[Quality]** Recommendations: HSAG recommends that DCS CHP explore what may be driving lower experience scores and develop initiatives designed to improve the quality of care, including a focus on improving parents'/caretakers' overall experiences with the health plan, the specialist their child sees most often, access to care in a timely manner, and coordination of care for child members.

ALTCS-EPD Program

Table 1-10 presents program-level strengths, opportunities for improvement, and recommendations (as applicable) for the ALTCS-EPD Program based on all EQR activities conducted. For additional information about ALTCS-EPD Program-level results, see Section 9. ALTCS-EPD Program-Level Comparative Results.

Table 1-10—ALTCS-EPD Program Strengths, Opportunities for Improvement, and Recommendations

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths related to PMV: • All three ALTCS-EPD Program Contractors as well as the ALTCS-EPD Program Aggregate rate met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 for these measures:

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- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—18+ Years* **[Quality]**
- *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* and *Effective Continuation Phase Treatment—Total (18+ Years)* **[Quality]**
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years* **[Quality]**
- *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total (18–75 Years)* **[Quality]**
- *Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total (18–64 Years)* **[Quality]**

HSAG identified the following strengths related to PIP validation:

- All ALTCS-EPD Contractors adhered to acceptable methodology through all phases of the *Breast Cancer Screening* PIP and were able to achieve statistically significant improvement when comparing the baseline rate to the Remeasurement 3 rate. Additionally, two Contractors achieved sustained statistically significant improvement at Remeasurement 3. **[Quality, Access]**

HSAG identified the following strengths related to compliance reviews:

- The two ALTCS-EPD Program Contractors that underwent reviews in CYE 2025 scored at or above 95 percent in the following standards:
  - Assurances of Adequate Capacity and Services **[Timeliness, Access]**
  - Availability of Services **[Timeliness, Access]**
  - Confidentiality **[Quality]**
  - Coordination and Continuity of Care **[Quality, Timeliness, Access]**
  - Practice Guidelines **[Quality]**
  - Program Integrity **[Quality]**

HSAG identified the following strengths related to NAV:

- The ALTCS-EPD Program Contractors received *High Confidence* for both appointment availability and time/distance indicators. **[Access]**
- All the applicable ALTCS-EPD Program Contractors met all minimum time/distance network standards in Apache, Cochise, Coconino, Gila, Graham, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties. **[Access]**
- The ALTCS-EPD Program Contractors' performance consistently met the Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric; BHRF; Cardiologist, Adult and Pediatric; Dentist, Pediatric; Hospital; Nursing Facility; OB/GYN; and PCP, Adult and Pediatric standards. **[Access]**

Strengths, Opportunities for Improvement, and Recommendations
Opportunities for Improvement and Recommendations

HSAG identified the following opportunities for improvement related to PMV:

- All three ALTCS-EPD Program Contractors' rates and the ALTCS-EPD Program Aggregate rate failed to meet or exceed the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and fell below the 25th percentile for these measures:
  - *Initiation and Engagement of Substance Abuse Disorder Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* **[Quality, Timeliness, Access]**
  - *Breast Cancer Screening (ECDS)—Total (50–74 Years)* **[Quality]**
  - *Cervical Cancer Screening—21–64 Years* **[Quality]**
  - *Cervical Cancer Screening (ECDS)—21–64 Years* **[Quality]**
  - *Use of Opioids at High Dosage—18+ Years* **[Quality]**

Recommendations:

- For the *Initiation and Engagement of Substance Abuse Disorder Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* measure, HSAG recommends that the ALTCS-EPD Program Contractors continue all efforts to conduct a root cause analysis or focus study to determine why some members are not accessing SUD services or MAT following their initiation visit. HSAG recommends that the ALTCS-EPD Program Contractors review patient data for any patterns present by ZIP Code and other demographics for case management prioritization. One study suggests that male members who have a schizophrenia spectrum disorder diagnosis are less likely to initiate treatment, while current drug dependence and recent arrest were associated with lowered odds of engaging in treatment. Current drug dependence is associated with factors that make scheduling and attending treatment appointments difficult, such as severe symptoms, chaotic living situations, and self-care and life functioning issues.[11]
- Regarding the *Use of Opioids at High Dosage—18+ Years* measure, HSAG recommends that the ALTCS-EPD Program Contractors continue to evaluate their opioid prescription monitoring efforts to identify opportunities to enhance oversight of prescription opioids at a high dosage. Through this process, each ALTCS-EPD Program Contractor should determine if it is necessary to deploy additional mechanisms to identify members who may be at high risk for opioid overuse and misuse, as literature suggests there is a correlation between high dosages of prescription opioids and the risk of both fatal and nonfatal overdoses.[12] Each ALTCS-EPD Program Contractor should continue to report any completed prescription opioid monitoring effort enhancements to AHCCCS. HSAG also recommends that ALTCS-EPD

[11] National Committee for Quality Assurance. Use of Opioids at High Dosage. Available at: https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/use-of-opioids-at-high-dosage-hdo/. Accessed on: Feb 11, 2026.
[12] Brown CH, Bennett ME, Li L, Bellack AS. Predictors of initiation and engagement in substance abuse treatment among individuals with co-occurring serious mental illness and substance use disorders. *Addictive Behaviors.* 2010;36(5):439-47.

Strengths, Opportunities for Improvement, and Recommendations

Program Contractors identify provider-specific trends in opioid prescription to see if certain providers are prescribing opioids at higher rates and/or amounts.

- Regarding the *Breast Cancer Screening (ECDS)—Total (50–74 Years)* measure, ALTCS-EPD Program Contractors are currently conducting the *Breast Cancer Screening* PIP, which includes a root cause analysis and interventions to address this measure; therefore, HSAG recommends that the ALTCS-EPD Program Contractors continue all efforts to conduct a root cause analysis or focus study to determine why some female members are not receiving timely screenings for breast cancer.
- Regarding the *Cervical Cancer Screening—21–64 Years* and *Cervical Cancer Screening (ECDS)—21–64 Years* measures, HSAG recommends that ALTCS-EPD Program Contractors consider utilizing one-on-one interactions with healthcare professionals, such as CHWs, which have been shown to improve cervical cancer screening rates. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that ALTCS-EPD Program Contractors provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge.

- Starting with CY 2022 performance measure reporting, RES is required based on NCQA HEDIS specifications. While HSAG noted that two of the three ALTCS-EPD Contractors could benefit from improvement in performance measure reporting using RES, all ALTCS-EPD Contractors could benefit from continuing to focus on refining RES reporting when required in keeping with measure specifications. **[Quality]**

  Recommendation: HSAG recommends that the ALTCS-EPD Program Contractors continue to explore data sources for the capture of race and ethnicity data to support performance measure reporting that requires stratifications related to RES. The ALTCS-EPD Program Contractors should continue to work with AHCCCS on collaborative efforts to improve the completion and accuracy of race and ethnicity data and explore other methods to augment enrollment data information.

HSAG identified no program-level opportunities for improvement or recommendations related to the *Breast Cancer Screening* PIP.

Recommendation: Although there were no opportunities for improvement identified, HSAG recommends that the Contractors consider the following for future PIPs:

- Apply lessons learned from the *Breast Cancer Screening* PIP.
- Seek technical assistance from HSAG to understand the CMS EQR Protocol 1 requirements.
- Implement interventions with clearly defined intervention effectiveness measures.

Strengths, Opportunities for Improvement, and Recommendations
HSAG identified the following opportunities for improvement related to compliance reviews: • The two ALTCS-EPD Program Contractors that underwent compliance reviews in CYE 2025 scored below 95 percent in the following standards: – Coverage and Authorization of Services **[Quality, Timeliness, Access]** – Disenrollment: Requirements and Limitations **[Quality]** – Emergency and Poststabilization Services **[Quality, Timeliness, Access]** – Grievance and Appeal Systems **[Quality, Timeliness, Access]** – Quality Assessment and Performance Improvement Program **[Quality, Timeliness]** – Subcontractual Relationships and Delegation **[Quality]** Recommendations: HSAG recommends that the two ALTCS-EPD Program Contractors that underwent compliance reviews in CYE 2025 continue to work on any outstanding CAPs during CYE 2026. HSAG identified the following opportunities for improvement related to NAV: • Based on the NAV results, one ALTCS-EPD Program Contractor did not meet the standard for Pharmacy in more than one county. **[Access]** Recommendations: HSAG recommends that AHCCCS support the ALTCS-EPD Program Contractor in continuing to monitor and maintain its existing provider network coverage as of CYE 2024 S2, with specific attention to ensuring the availability of the following provider category for which one ALTCS-EPD Program Contractor did not meet the network requirement in more than one county: • Pharmacy in Greenlee and La Paz counties.

ALTCS-DD Program

Table 1-11 presents program-level strengths, opportunities for improvement, and recommendations for the ALTCS-DD Program based on all EQR activities conducted. ALTCS-DD strengths, opportunities for improvement, and recommendations by EQR activity are provided in Section 11. ALTCS-DD Program Results.

Table 1-11—ALTCS-DD Program Strengths, Opportunities for Improvement, and Recommendations

Strengths, Opportunities for Improvement, and Recommendations
Strengths
HSAG identified the following strengths related to PMV:

Strengths, Opportunities for Improvement, and Recommendations

- DES/DDD's performance measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and were at or above the 90th percentile for these measures:
  - *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—18+ Years* **[Quality]**
  - *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (18+ Years)* and *Effective Continuation Phase Treatment—Total (18+ Years)* measure rates **[Quality]**
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—18–64 Years* **[Quality]**
  - *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *30-Day Follow-Up—Total (6+ Years)* **[Quality, Timeliness, Access]**
  - *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total (6+ Years)* **[Quality, Timeliness, Access]**
- DES/DDD's performance measure rates met or exceeded the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and were at or between the 75th and 89th percentile for these measures:
  - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)* **[Quality]**
  - *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* **[Quality, Timeliness, Access]**
  - *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* **[Quality, Timeliness, Access]**
  - *Colorectal Cancer Screening (ECDS)—Total (45–75 Years)* **[Quality]**
  - *Oral Evaluation, Dental Services—Total (0–20 Years)* **[Access]**

HSAG identified the following strengths related to the *Back to Basics* PIP:

- The DES/DDD Contractor was able to achieve statistically significant improvement at Remeasurement 3 when compared to the baseline rate, sustaining the statistically significant improvement achieved at Remeasurement 2. **[Quality, Access]**

HSAG identified the following strengths related to compliance reviews:

- DES/DDD achieved full compliance in five of the 14 focus areas reviewed, demonstrating strengths and adherence to all requirements measured in the following areas:
  - Claims and Information Standards **[Access]**
  - Grievance Systems **[Quality, Timeliness, Access]**
  - Adult; EPSDT; and Maternal Child Health **[Timeliness, Access]**

Strengths, Opportunities for Improvement, and Recommendations
– Reinsurance **[Quality]** – Third-Party Liability **[Quality, Timeliness, Access]** HSAG identified the following strengths related to NAV: • The DES/DDD subcontracted health plans received *High Confidence* for both appointment availability and time/distance indicators. **[Access]** • The DES/DDD subcontracted health plans met all minimum time/distance network standards for Cochise, Coconino, Graham, Maricopa, Mohave, Navajo, Pinal, Santa Cruz, Yavapai, and Yuma counties. **[Access]** • The DES/DDD subcontracted health plans consistently met the Cardiologist, Pediatric; Hospital OB/GYN; and PCP, Adult and Pediatric standards. **[Access]**
Opportunities for Improvement and Recommendations
HSAG identified the following opportunities for improvement related to PMV: • DES/DDD performance measure rates fell below the NCQA Quality Compass national Medicaid HMO mean for HEDIS MY 2024 and the 25th percentile for these measures: – *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* **[Quality, Timeliness, Access]** – *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years)* **[Quality]** – *Childhood Immunization Status—Combination 7* and *Combination 10* **[Quality]** – *Childhood Immunization Status (ECDS)—Combination 7* and *Combination 10* **[Quality]** – *Breast Cancer Screening (ECDS)—50–74 Years* **[Quality]** – *Cervical Cancer Screening—21–64 Years* **[Quality]** – *Cervical Cancer Screening (ECDS)—21–64 Years* **[Quality]** Recommendations: • Regarding the *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)* measure, HSAG recommends that DES/DDD conduct a root cause analysis or focus study to determine why some members are not accessing SUD treatment services. HSAG recommends that DES/DDD review patient data for any patterns present by ZIP Code and other demographics for case management prioritization. One study suggests that male members who have a schizophrenia spectrum disorder diagnosis are less likely to initiate treatment, while current drug dependence and recent arrest were associated with lowered odds of engaging in treatment. Current drug dependence is associated with factors that make

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scheduling and attending treatment appointments difficult, such as severe symptoms, chaotic living situations, and self-care and life functioning issues.[13]

- Regarding the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years)* measure, HSAG recommends that DES/DDD identify providers who may be overprescribing antipsychotics to children and adolescents. DES/DDD can collaborate with its pharmacy benefits manager (PBM) in conducting drug utilization reviews and then educate providers to ensure that members are receiving timely psychosocial care which includes a comprehensive treatment plan and behavioral and psychological therapies, in addition to medication management.[14]
- Regarding the *Childhood Immunization Status* measures, HSAG continues to recommend that DES/DDD identify best practices to support children in receiving preventive vaccinations according to recommended schedules. HSAG recommends that DES/DDD provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.
- Regarding the preventive screening measures, HSAG recommends that DES/DDD consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended cancer screenings and make appropriate health decisions. HSAG recommends that DES/DDD consider utilizing one-on-one interactions with healthcare professionals, such as CHWs, which have been shown to improve cervical cancer screening rates. Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that DES/DDD provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge. In addition, HSAG recommends that DES/DDD work with its subcontracted health plans to analyze their data and consider whether there are disparities within DES/DDD's populations that contributed to lower screening rates.

- While DES/DDD was successful in reporting valid rates for all AHCCCS-required performance measures for its ALTCS-DD population, and HSAG did not identify specific opportunities for DES/DDD to improve RES, DES/DDD could benefit from continuing to focus on refining RES reporting when required in keeping with measure specifications. **[Quality]**

  Recommendations: HSAG recommends that DES DDD work with AHCCCS on collaborative efforts to improve the completion and accuracy of race/ethnicity data and explore other methods to

[13] National Committee for Quality Assurance. Initiation and Engagement of Substance Use Disorder (IET). Available at: https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/initiation-and-engagement-of-substance-use-disorder-treatment-iet/. Accessed on: Feb 11, 2026.

[14] Substance Abuse and Mental Health Services Administration (SAMHSA). Guidance on Strategies to Promote Best Practice in Antipsychotic Prescribing for Children and Adolescents. Available at: https://library.samhsa.gov/sites/default/files/promote-best-practice-pep19-antipsychotic-bp.pdf. Accessed on: Feb 18, 2026.

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augment enrollment data information. HSAG also recommends that DES DDD explore other potential data sources for the capture of race/ethnicity data to support future performance measure reporting that may require stratification related to RES. To ensure data reporting accuracy, HSAG recommends that DES DDD investigate conducting sample reviews on the subcontractor's reported rates prior to submission as a component of its ongoing quality review process, along with benchmark reviews of the individual subcontractor rates.

HSAG identified the following opportunities for improvement related to the *Back to Basics* PIP:

- The Contractor added a recalculated baseline rate in the narrative and used it for statistical testing between the baseline and Remeasurement 3 without explanation or updating the performance indicator data table. **[Quality]**
- Subcontractor statistical testing was conducted between the Intervention Year and Remeasurement 3 instead of between the baseline and Remeasurement 3 for Mercy Care. **[Quality]**
- The Contractor did not report intervention effectiveness data for ongoing Mercy Care interventions. **[Quality]**

Recommendations: HSAG recommends that for future selected PIPs, DES/DDD:

- Apply lessons learned from the *Back to Basics* PIP.
- Use the same baseline for all remeasurement period statistical testing.
- Implement interventions with clearly defined intervention effectiveness measures that are directly linked to the intervention to assess the effectiveness of each intervention**.**
- Track intervention effectiveness data for all subcontractor interventions.
- Seek technical assistance from HSAG to understand the CMS EQR Protocol 1 requirements.

HSAG identified the following opportunities for improvement related to compliance reviews:

- The areas with the greatest opportunity for improvement were related to the following, as these areas received performance scores under 95 percent:
  - Corporate Compliance **[Quality, Access]**
  - Case Management **[Quality, Access]**
  - General Administration **[Timeliness, Access]**
  - Medical Management **[Quality, Timeliness, Access]**
  - Member Information **[Quality]**
  - Quality Management **[Quality]**
  - Quality Improvement **[Quality, Access]**

Recommendation: HSAG recommends that DES/DDD continue to work with AHCCCS on closing remaining CAPs.

Strengths, Opportunities for Improvement, and Recommendations

HSAG identified the following opportunities for improvement related to NAV:

- Based on the NAV results, neither of the DES/DDD subcontracted health plans met the standards for Behavioral Health Outpatient and Integrated Clinic, Adult; Cardiologist, Adult; and Dentist, Pediatric. **[Access]**

  Recommendation: HSAG recommends that AHCCCS support each DES/DDD subcontracted health plan in continuing to monitor and maintain its existing provider network coverage as of CYE 2024 S2, with specific attention to ensuring the availability of the following provider categories for which neither DES/DDD subcontracted health plan met the network requirement:
  - Behavioral Health Outpatient and Integrated Clinic, Adult in Apache County.
  - Cardiologist, Adult in Apache County.
  - Dentist, Pediatric in Greenlee County.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

APPENDIX C:

BUDGET NEUTRALITY REPORT

Arizona Health Care Cost Containment System
Budget Neutrality Status by Federal Fiscal Year
Total Funds - All Populations
For the Period October 1, 2021 - September 30, 2026
Updated 9/20

Without Waiver Expenditure Limit Calculation	PMPM 2026 DY 15	PMPM 2027 DY 16	Weighted 80/20 2027 DY 16	Estimate 2028 DY 17	Estimate 2029 DY 18	Estimate 2030 DY 19	Estimate 2031 DY 20	Estimate 2032 DY 21	2028 - 2032 Total
Member Months									
TANF/SOBRA		11,580,018	11,580,018	11,811,618	12,047,851	12,288,808	12,534,584	12,785,276	61,468,136
SSI		2,540,121	2,540,121	2,590,923	2,642,742	2,695,597	2,749,509	2,804,499	13,483,269
ALTCS-EPD		603,600	603,600	615,672	627,985	640,545	653,356	666,423	3,203,982
ALTCS-DD		344,993	344,993	351,893	358,931	366,110	373,432	380,901	1,831,267
Newly Eligible Adults-Expansion State Adults		5,885,058	5,885,058	6,002,759	6,122,814	6,245,271	6,370,176	6,497,580	31,238,600
Combined		20,953,790	20,953,790	21,372,866	21,800,323	22,236,330	22,681,057	23,134,678	111,225,254
Without Waiver PMPM									
TANF/SOBRA	654.31	687.03	744.59	781.82	820.91	861.96	905.05	950.31	
SSI	1,428.27	1,495.40	1,613.22	1,689.05	1,768.43	1,851.55	1,938.57	2,029.68	
ALTCS-EPD	7,446.60	7,818.93	8,610.83	9,041.38	9,493.44	9,968.12	10,466.52	10,989.85	
ALTCS-DD	6,878.37	7,201.65	6,818.17	7,138.62	7,474.14	7,825.42	8,193.22	8,578.30	
Newly Eligible Adults-Expansion State Adults	1,012.67	1,068.37	1,138.55	1,201.17	1,267.23	1,336.93	1,410.46	1,488.03	
Weighted		1,204.83	1,287.13	1,352.16	1,420.49	1,492.28	1,567.72	1,646.97	
Without Waiver Expenditure Limit									
TANF/SOBRA		7,955,819,752	8,622,365,587	9,234,553,544	9,890,206,845	10,592,411,532	11,344,472,750	12,149,930,316	53,211,574,987
SSI		3,798,496,790	4,097,783,994	4,376,187,439	4,673,505,614	4,991,023,585	5,330,113,727	5,692,241,654	25,063,072,019
ALTCS-EPD		4,719,506,148	5,197,499,402	5,566,521,860	5,961,744,912	6,385,028,801	6,838,365,846	7,323,889,821	32,075,551,239
ALTCS-DD		2,484,521,970	2,352,223,888	2,512,033,979	2,682,701,568	2,864,964,312	3,059,609,987	3,267,479,890	14,386,789,736
Newly Eligible Adults-Expansion State Adults		6,287,419,415	6,700,409,246	7,210,310,389	7,759,015,010	8,349,476,052	8,984,871,180	9,668,619,876	41,972,292,507
Total		25,245,764,076	26,970,282,118	28,899,607,211	30,967,173,949	33,182,904,281	35,557,433,490	38,102,161,557	166,709,280,488
DSH Allotment		65,335,200	65,335,200	65,335,200	65,335,200	65,335,200	65,335,200	65,335,200	326,676,000
Total Without Waiver Expenditure Limit		25,311,099,276	27,035,617,318	28,964,942,411	31,032,509,149	33,248,239,481	35,622,768,690	38,167,496,757	167,035,956,488
With Waiver Expenditures									
TANF/SOBRA		8,789,002,897	8,789,002,897	9,323,373,370	9,890,234,471	10,491,560,727	11,129,447,619	11,806,118,035	52,640,734,222
SSI		4,172,598,317	4,172,598,317	4,426,300,228	4,695,419,282	4,980,900,774	5,283,739,541	5,604,990,905	24,991,350,730
ALTCS-EPD		5,317,000,000	5,317,000,000	5,640,271,177	5,983,199,665	6,346,978,204	6,732,874,479	7,142,233,247	31,845,556,773
ALTCS-DD		2,319,147,700	2,319,147,700	2,460,153,649	2,609,730,991	2,768,402,635	2,936,721,515	3,115,274,183	13,890,282,974
Newly Eligible Adults-Expansion State Adults		6,803,681,015	6,803,681,015	7,217,319,031	7,656,132,028	8,121,624,855	8,615,419,646	9,139,237,161	40,749,732,721
Targeted Investment		24,416,764	24,416,764	-	-	-	-	-	-
Re-Entry		31,865,169	31,865,169	33,139,776	34,465,367	35,843,982	37,277,741	38,768,850	179,495,716
Non-Medical Transportation		1,014,840	1,014,840	1,055,434	1,097,651	1,141,557	1,187,219	1,234,708	5,716,569
IHS Services		430,473	430,473	447,692	465,599	484,223	503,592	523,736	2,424,842
Re-Entry Non-Services		1,991,600	1,991,600	2,071,264	2,154,115	2,240,279	2,329,890	2,423,086	11,218,634
Housing Initiatives		160,583,333	160,583,333	96,350,000	96,350,000	96,350,000	96,350,000	96,350,000	481,750,000
Housing Initiatives Infrastructure		21,372,187	21,372,187	13,500,000	13,500,000	13,500,000	13,500,000	13,500,000	67,500,000
Enhanced Residential Treatment		7,812,000	7,812,000	8,124,480	8,449,459	8,787,438	9,138,935	9,504,492	44,004,804
Expenditure Subtotal		27,650,916,295	27,650,916,295	29,222,106,100	30,991,198,627	32,867,814,674	34,858,490,179	36,970,158,404	164,909,767,985
DSH		65,335,200	65,335,200	65,335,200	65,335,200	65,335,200	65,335,200	65,335,200	326,676,000
Total With Waiver Expenditures		27,716,251,495	27,716,251,495	29,287,441,300	31,056,533,827	32,933,149,874	34,923,825,379	37,035,493,604	165,236,443,985
With Waiver Expenditure PMPMs									
TANF/SOBRA		758.98	758.98	789.34	820.91	853.75	887.90	923.42	
SSI		1,642.68	1,642.68	1,708.39	1,776.72	1,847.79	1,921.70	1,998.57	
ALTCS-EPD		8,808.81	8,808.81	9,161.16	9,527.61	9,908.71	10,305.06	10,717.26	
ALTCS-DD		6,722.30	6,722.30	6,991.19	7,270.84	7,561.67	7,864.14	8,178.71	
Newly Eligible Adults-Expansion State Adults		1,156.09	1,156.09	1,202.33	1,250.43	1,300.44	1,352.46	1,406.56	
DY12-16 BN Carry-over			**2,897,592,700**						
DY17-DY21 BN Variance				(322,498,889)	(24,024,679)	315,089,607	698,943,312	1,132,003,152	
Cumulative DY1-DY20Variance				2,575,093,811	2,551,069,132	2,866,158,740	3,565,102,051	4,697,105,203	**4,697,105,203**
Variables									
Population		2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	
WOW PMPM Growth									
TANF/SOBRA		5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	
SSI		4.7%	4.7%	4.7%	4.7%	4.7%	4.7%	4.7%	
ALTCS-EPD		5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	
ALTCS-DD		4.7%	4.7%	4.7%	4.7%	4.7%	4.7%	4.7%	
Newly Eligible Adults-Expansion State Adults		5.5%	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%	
WW Expenditures		4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	