CENTERS FOR MEDICARE & MEDICAID SERVICES WAIVER LIST

NUMBERS: **11-W-00275/9 and 21-W-00074/9**

TITLE: **Arizona Medicaid Section 1115 Demonstration**

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

All Medicaid and Children's Health Insurance Program (CHIP) requirements expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in this list, shall apply to the demonstration project beginning October 14, 2022, through September 30, 2027, unless otherwise specified. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

1. Eligibility Based on Institutional Status **Section 1902(a)(10)(A)(ii)(V) (42 CFR 435.236)**

To the extent necessary to relieve the State of the obligation to make eligible individuals who meet the statutory definition of this eligibility group because they are in an acute care hospital for greater than 30 days.

2. Comparability; Amount, Duration, Scope of Services **Section 1902(a)(10)(B); 1902(a)(17) (42 CFR 440.240 and 440.230)**

To the extent necessary to enable the State to offer different or additional services to some categorically eligible individuals, than to other eligible individuals, based on differing care arrangements for eligible minor Arizona Long Term Care System (ALTCS) beneficiaries and their legally responsible parents and spouses in the Paid Caregivers Program.

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

3. Estate Recovery **Section 1902(a)(18) (42 CFR 433.36)**

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

4. Freedom of Choice **Section 1902(a)(23)(A) (42 CFR 431.51)**

To the extent necessary to enable the State to restrict freedom of choice of providers through mandatory enrollment of eligible individuals in managed care organizations that do not meet the requirements of section 1932 of the Act. No waiver of freedom of choice is authorized for family planning providers.

To the extent necessary to enable the State to impose a limitation on providers on charges associated with

non-covered activities.

5. Retroactive Eligibility **Section 1902(a)(10) and (a)(34) (42 CFR 435.915)**

To the extent necessary to enable the state to not provide medical assistance for any month prior to the month in which a beneficiary's Medicaid application is filed. The waiver of retroactive eligibility does not apply to applicants who would have been eligible at any point within the three-month period immediately preceding the month in which an application was received, as 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.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBERS: **11-W-00275/9 and 21-W-00074/9**

TITLE: **Arizona Medicaid Section 1115 Demonstration**

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

Medicaid Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below (which would not otherwise be included as matchable expenditures under section 1903 of the Act) shall, for the period beginning October 14, 2022, through September 30, 2027, unless otherwise specified, be regarded as matchable expenditures under the state's Medicaid state plan.

The following Title XIX expenditure authorities shall enable Arizona to implement the AHCCCS section 1115 demonstration:

1. Expenditures under contracts with managed care entities that do not meet the requirements in 1903(m)(2)(A) and 1932(a) of the Act in so far as they incorporate 42 CFR 438.52(a) to the extent necessary to allow the state to limit the choice of managed care plans:
   a. For AHCCCS Arizona Complete Care - Regional Behavioral Health Agreement (ACC-RBHA) beneficiaries with a serious mental illness to a single MCO in each GSA subject to STC 22. The designated MCOs, ACC-RBHA, contract with AHCCCS for the treatment of physical and behavioral health conditions for enrollees determined to have a SMI other than persons enrolled in ALTCS, foster care children enrolled in DCS/CHP, and American Indians receiving coverage through the American Indian Health Plan. In addition, the ACC-RBHA provides coverage for crisis services as defined in the MCO agreement, for all eligible persons in the GSA; and
   b. Outside of the Central Geographic Service Area (GSA), to permit the state to limit choice of managed care plans to a single MCO for individuals enrolled in the ALTCS program, so long as enrollees in such plans have a choice of at least two primary care providers, and may request change of primary care provider at least at the times described in 42 CFR 438.56(c). Notwithstanding this authority, the state must offer a choice of at least two MCOs to elderly and physically disabled individuals in the Central GSA. For individuals with intellectual or developmental disabilities who are institutionalized or at risk of institutionalization to the ALTCS managed care organization (MCO) administered by the Department of Economic Security/Division of Developmental Disabilities (DES/DDD); individuals enrolled in ALTCS/DDD have a choice of MCOs that subcontract with DES/DDD to provide coverage for physical health services (including Children's Rehabilitative Services), behavioral health services, and certain long term services and supports not otherwise covered by DES/DDD.
   c. For foster children enrolled in the Comprehensive Health Plan operated by the Arizona Department of Child Safety, so long as enrollees in such plans have a choice of at least two primary care providers, and may request change of primary care provider at least at the times described in 42 CFR 438.56(c).
   d. To the extent necessary to permit the state to restrict beneficiary disenrollment based on 42 CFR 438.56(d)(2)(v), which provides for disenrollment for causes including but not limited to, poor

quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.

2. Expenditures under contracts with managed care entities that do not meet the requirements in section 1903(m)(2)(A) of the Act specified below. AHCCCS's managed care plans participating in the demonstration will have to meet all the requirements of section 1903(m) except the section 1903(m)(2)(H) of the Act and 42 CFR 438.56(g), but only insofar as to allow the state to automatically reenroll an individual who loses Medicaid eligibility for a period of 90 days or less in the same managed care plan from which the individual was previously enrolled.

3. Expenditures for capitation payments made under contracts with managed care entities that do not comply with section 1932(h) of the Act and 42 CFR 438.14 to the extent those provisions require the managed care entities to include Indian Health Service (IHS), tribal, and Urban Indian Organization providers in the managed care entities' networks of contracted providers. Services provided by IHS, tribal, and Urban Indian Organization providers are excluded from the scope of the managed care contracts, and expenditures for services provided to managed care enrollees by these providers are covered through direct payments by the state to these providers.

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

5. Expenditures for items and services provided to AHCCCS fee-for-service beneficiaries that exceed the amounts allowable under section 1902(a)(30)(A) of the Act and the upper payment limitation and actual cost requirements of 42 CFR 447.250 through 447.280 (regarding payments for inpatient hospital and long-term care facility services), 447.300 through 447.321 (regarding payment methods for other institutional and non-institutional services), and 447.512 through 447.518(b) (regarding payment for drugs) so long as those expenditures are in accordance with Special Term and Condition (STC) 121 entitled "Applicability of Fee-for-Service Upper Payment Limit."

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

7. Expenditures related to:

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

(QMB), Special Low Income Beneficiary (SLMB), Qualified Individuals-1(QI-1), or Supplemental Security Income Medical Assistance Only (SSI MAO) beneficiaries based only on a disregard of in-kind support and maintenance (ISM).

e. Medical assistance furnished to individuals who are eligible based only on an alternate budget calculation for ALTCS and SSI-MAO income eligibility determinations when spousal impoverishment requirements of section 1924 of the Act do not apply or when the applicant/recipient is living with a minor dependent child.
f. Medical assistance furnished to individuals who are eligible only based on the disregard of interest and dividend from resources, and are in the following eligibility groups:
    i. The Pickle Amendment Group under 42 CFR 435.135;
    ii. The Disabled Adult Child under section 1634(c) of the Act;
    iii. Disabled Children under section 1902(a)(10)(A)(i)(II) of the Act; and
    iv. The Disabled Widow/Widower group under section 1634(d) of the Act.
g. Medical assistance furnished to ALTCS enrollees under the eligibility group described in section 1902(a)(10)(A)(ii)(V) of the Act that exceeds the amount that would be allowable except for a disregard of interest and dividend from the post-eligibility calculations.
h. Medical assistance provided to individuals who would be eligible but for excess resources under the "Pickle Amendment," section 503 of Public Law 94-566; section 1634(c) of the Act (disabled adult children); or section 1634(b) of the Act (disabled widows and widowers).
i. Medical assistance that would not be allowable but for the disregard of quarterly income totaling less than $20 from the post-eligibility determination.

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

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

10. Expenditures to extend ALTCS eligibility to individuals under the age of 65 who meet the applicable financial criteria but are not disabled, but who are found to be at risk of needing nursing facility services based on medical illness or intellectual disability on the preadmission screening instrument.

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

12. Expenditures for demonstration caregiver services, including personal care services, provided by spouses of eligible ALTCS beneficiaries, and personal care and habilitation services provided by legally responsible parents of eligible minor ALTCS beneficiaries in the Paid Caregivers Program that are inconsistent with the requirements of 42 CFR 440.167.

13. 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 ALTCS program, excluding beneficiaries who are American Indian/Alaskan Native (AI/AN) who are addressed in Expenditure 15.

14. Expenditures for all state plan and demonstration covered services for pregnant women during their hospital presumptive eligibility period.

15. Expenditures for any Medicaid coverable services that were eliminated from, reduced, or limited in the Arizona Medicaid State Plan on or after September 2010, including expenditures for medically necessary diagnostic, therapeutic, and preventative dental services. This expenditure authority applies only if the services are provided to American Indian/Alaskan Native (AI/AN) beneficiaries by participating IHS facilities and/or participating facilities operated by tribes under the Indian Self-Determination and Education Assistance Act (ISDEAA).

16. Targeted Investment (TI) 2.0 Program. Expenditures under contracts with managed care entities that pay incentive payments to providers that meet targets specified in the contract as described in the STCs. Total incentive payments will be limited to the amounts established in STC 53 and payments will be limited to those providers who participate in integrated care activities established under the Targeted Investments 2.0 Program.

17. Designated State Health Programs (DSHP). Expenditures for designated programs, described in these STCs, which are otherwise state-funded, and not otherwise eligible for Medicaid payment. These expenditures are subject to the terms and limitations and not to exceed specified amounts as set forth in these STCs. These expenditures are specifically contingent on compliance with Section X, as well as all other applicable STCs.

18. Health-Related Social Needs (HRSN) Services. Expenditures for approved evidence-based health-related social needs services not otherwise eligible for Medicaid payments furnished to individuals who meet the qualifying criteria as described in STC 31. These expenditures are specifically contingent on compliance with Section X, as well as all other applicable STCs.

19. Expenditures for Health-Related Social Needs Services Infrastructure. Expenditures for allowable administrative costs and infrastructure not otherwise eligible for Medicaid payments, to the extent such activities are authorized as part of the approved HRSN Infrastructure activities in STC 34. These expenditures are specifically contingent on compliance with Section X, as well as all other applicable STCs.

Title XIX requirements not applicable to these demonstration expenditures.

20. Comparability; Amount, Duration, Scope of Services **Section 1902(a)(10)(B)**
Section 1902(a)(17)

To the extent necessary to allow 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 as described in STC 30.

21. Comparability; Amount, Duration, Scope of Services; Freedom of Choice **Section 1902(a)(10)(B)**
Section 1902(a)(17)

To the extent necessary to allow the state to offer the coverage described in Expenditure Authority 15 only to American Indian/Alaskan Native (AI/AN) beneficiaries and only if the covered services are provided by participating IHS facilities and/or participating facilities operated by tribes under the Indian Self-Determination and Education Assistance Act (ISDEAA).

Title XXI Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act as incorporated into Title XXI by section 2107(e)(2)(A), state expenditures described below, shall, for the period of this demonstration, through September 30, 2027, and to the extent of the state's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the state's Title XXI plan. All requirements of Title XXI will be applicable to such expenditures for the beneficiaries described in the demonstration expenditure authority 22.

22. **Expenditures for KidsCare Expansion**. 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) as described in STC 6 and 19 who are not otherwise covered as of February 16, 2024, subject to approval by the state legislature.

SPECIAL TERMS AND CONDITIONS
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
MEDICAID SECTION 1115 DEMONSTRATION

NUMBERS: 11-W-00275/09 and 21-W-00074/9

TITLE: Arizona Medicaid Section 1115 Demonstration

AWARDEE: Arizona Health Care Cost Containment System (AHCCCS)

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the "Arizona Health Care Cost Containment System (AHCCCS)" section 1115(a) Medicaid and CHIP demonstration (hereinafter "demonstration") to enable Arizona (state) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted the state waivers of requirements under section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs that are not otherwise matchable, and which are separately enumerated. These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to this demonstration. The AHCCCS demonstration will be statewide, and is approved for a 5-year period, from October 14, 2022, through September 30, 2027.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Overview and Historical Context
III. General Program Requirements
IV. Eligibility
V. Demonstration Programs
VI. HCBS Quality Assurance and Reporting Requirements
VII. Housing and Health Opportunities
VIII. Targeted Investments 2.0 Program
IX. Designated State Health Programs
X. Provider Payment Rate Increase Requirements
XI. Payments under the Demonstration
XII. Delivery Systems
XIII. Monitoring and Reporting Requirements
XIV. Evaluation of the Demonstration
XV. General Financial Requirements
XVI. Monitoring Budget Neutrality
XVII. Monitoring Allotment Neutrality
XVIII. Schedule of Deliverables

Attachment A Developing the Evaluation Design
Attachment B Preparing the Interim and Summative Evaluation Report
Attachment C Reimbursement for Critical Access Hospitals

Attachment D	DSHP Claiming Protocol
Attachment E	Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications (reserved)
Attachment F	New Initiatives Implementation Plan
Attachment G	Monitoring Protocol (reserved)
Attachment H	Evaluation Design (reserved)
Attachment I	Targeted Investments 2.0 Incentivized Metrics and Funding Protocol (reserved)
Attachment J	HCBS Quality Assessment and Performance Improvement Plan
Attachment K	Approved Appendix K
Attachment L	ALTCS Service Definitions
Attachment M	DSHP Sustainability Plan (reserved)
Attachment N	Attestation Table
Attachment O	Approved Time-limited Expenditure Authority and Associated Requirements for the COVID-19 Public Health Emergency (PHE) Demonstration Amendment
Attachment P	Approved DSHP List

II. PROGRAM OVERVIEW AND HISTORICAL CONTEXT

Until 1982, Arizona was the only state that did not have a Medicaid program under title XIX of the Social Security Act. In October 1982, Arizona implemented the AHCCCS in the state's first section 1115 demonstration project. AHCCCS initially covered only acute care services, however, by 1989, the program was expanded to include the Arizona Long Term Care System (ALTCS), the state's capitated long-term care program for the elderly and physically disabled (EPD) and the developmentally disabled (DD) populations. In 2000, the state also expanded coverage to adults without dependent children with family income up to and including 100 percent of the federal poverty level (FPL) as well as established the Medical Expense Deduction (MED) program for adults with income in excess of 100 percent of the FPL who have qualifying healthcare costs that reduce their income at or below 40 percent of the FPL. On March 31, 2011, Arizona requested to eliminate the MED program and implement an enrollment freeze on the adults without dependent children population. On April 30, 2011, and July 1, 2011, CMS approved the state's required phase-out plans for the MED program and the adults without dependent children population, respectively. Arizona amended its State Plan, effective January 1, 2014, to provide coverage under section 1902(a)(10)(A)(i)(VIII) for certain persons with income not exceeding 133 percent of the FPL.

The demonstration provides health care services through a prepaid, capitated managed care delivery model that operates statewide for both Medicaid state plan groups as well as demonstration expansion groups. It affects coverage for certain specified mandatory state plan eligibles by requiring enrollment in coordinated, cost effective, health care delivery systems. In this way, the demonstration will test the use of managed care entities to provide cost effective care coordination, including the effect of integrating behavioral and physical health services for most AHCCCS beneficiaries. In addition, the demonstration will provide for payments to IHS and tribal 638 facilities to address the fiscal burden for certain services not covered under the state plan and provided in or by such facilities. This authority will enable the state to evaluate how this approach impacts the financial viability of IHS and 638 facilities and ensures the continued availability of a robust health care delivery network for current and future Medicaid beneficiaries. As part of the extension of the demonstration in 2016, based on CMS clarifying its policy for claiming 100 percent federal matching for services received through IHS and 638 facilities, the state can transition from the current uncompensated care reimbursement methodology to service-based claiming.

On January 18, 2017, an amendment was approved which established the "Targeted Investments Program." The state directs its managed care plans to make specific payments to certain providers pursuant to 42 CFR 438.6(c), with such payments incorporated into the actuarially sound capitation rates, to incentivize providers to improve performance. Specifically, providers are paid incentive payments for increasing physical and behavioral health care integration and coordination for individuals with behavioral health needs.

The Targeted Investments 1.0 Program was expected to:

a. Reduce fragmentation that occurs between acute care and behavioral health care,
b. Increase efficiencies in service delivery for beneficiaries with behavioral health needs, and
c. Improve health outcomes for the affected populations.

On January 18, 2019, CMS approved two amendments for AHCCCS. Under the first amendment, beginning no sooner than April 1, 2019, Arizona will not provide retroactive eligibility for beneficiaries enrolled in AHCCCS (with exceptions for pregnant women, women who are 60 days or less postpartum, infants under age 1, and children under age 19).

On September 30, 2021, CMS approved a temporary extension through September 30, 2022. This temporary extension included a temporary, one-year extension of the Targeted Investments program. The AHCCCS Choice Accountability Responsibility Engagement (CARE) program was not extended in the temporary extension, and the authority for that program has been removed from the STCs.

On October 14, 2022, CMS approved a five-year extension of the demonstration through September 30, 2027. This approval includes the extension of: 1) AHCCCS Complete Care (ACC), the statewide managed care system, which provides physical and behavioral health services to the majority of Arizona's Medicaid population; 2) the Arizona Long Term Care System (ALTCS), which provides physical, behavioral, long-term care services and supports, including home-and-community based services, to targeted populations; 3) the Comprehensive Health Plan (CHP) for children in foster care; and 4) the AHCCCS Complete Care - Regional Behavioral Health Agreement (ACC-RBHA), which provides integrated care for individuals with a serious mental illness (SMI). The extension approval will also continue the existing waiver of retroactive eligibility. This extension approval adds two new programs, 1) the Housing and Health Opportunities (H2O) program, which provides health-related social needs (HRSN) services including housing supports to targeted populations; and, 2) the Targeted Investment (TI) 2.0 program, which provides incentive payments to participating providers to improve health quality for targeted populations through addressing social determinants of health (SDOH).

The core goals of the demonstration program components include, but not limited to:

a. implementing best practices in care coordination and care management for physical and behavioral health care and proactively identifying beneficiaries for engagement in care management (ACC),
b. ensuring elderly and physically disabled (EPD) beneficiaries and beneficiaries with developmental disabilities (DD) are living in the most integrated settings and are actively engaged and participating in community life (ALTCS),
c. proactively responding to the unique health care needs of Arizona's children in foster care with high-quality, cost-effective care and continuity of care givers (CHP),
d. identifying high-risk beneficiaries with an SMI and transitioning them across levels of care and effectively providing beneficiaries with tools to self-manage care to promote health and wellness by improving the quality of care. (RBHA),

e. encouraging beneficiaries to apply for Medicaid without delays, promoting a continuity of eligibility and enrollment for improved health status (waiver of prior quarter coverage),
f. enhancing and expanding housing supports and housing-related interventions for AHCCCS beneficiaries who are homeless or at risk of becoming homeless (H2O), and
g. improving health by providing financial incentives to encourage the coordination and ultimately, the complete integration of care between primary care providers and behavioral health care providers (TI 2.0).

On February 16, 2024, CMS approved an amendment that allows Arizona to reimburse legally responsible parents for providing extraordinary care to minor children in the ALTCS program, initially approved through a COVID-19 Attachment K flexibility. The amendment also establishes a Family Support service as part of the home and community-based services (HCBS) benefit package. The Family Support service aims to support primary caregivers, including parents, and improve access to timely, effective care in the home and community. Additionally, on February 16, 2024, CMS approved expenditure authority to increase the CHIP eligibility threshold from 200 percent up to and including 225 percent of the FPL.

This amendment also provides Title XXI expenditure authority to increase the CHIP eligibility thresholds from 200 percent of the federal poverty level (FPL) up to and including 300 percent of the FPL, subject to approval by the state legislature, and as described in STC 6 and 19.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Laws.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557).

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

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or written policy affecting the Medicaid and/or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 calendar days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
    a. To the extent that a change in federal law, regulation, or written policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration,

the state must adopt, subject to CMS approval, a modified budget neutrality agreement and/or a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.

b. If mandated changes in the federal law, regulation, or policy require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under federal law, whichever is sooner.

5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances, the Medicaid and CHIP state plans govern.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements authorized through these STCs must be submitted to CMS as amendments to the demonstration. Changes that increase the eligibility threshold as described in Expenditure Authority 22 and STC 19 shall not require submission of an amendment but must comply with public notice processes as specified under 42 CFR 431.408. Documentation of the state's public notice processes and tribal consultation requirements outlined in STC 13 must be submitted to CMS at least 60 days in advance of implementation. Any reduction in the CHIP eligibility threshold below the most recently approved threshold will require submission of a formal amendment, as described in STC 7. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement or begin operational changes to these demonstration elements without prior approval. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or service-based expenditures, will be available for amendments to the demonstration that have not been approved through the amendment process set forth in STC 7 below, except as provided in STC 3 or otherwise specified in the STCs.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit reports and other deliverables according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

   a. An explanation of the public process used by the state, consistent with the requirements of STC 13. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;
   b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
   c. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total

computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment neutrality worksheet, if necessary;
e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

8. **Extension of the Demonstration.** States that intend to request an extension of the demonstration extension must submit an application to CMS from the Governor of the state in accordance with the requirements of 42 Code of Federal Regulations (CFR) 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit a phase-out plan consistent with the requirements of STC 9.

9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:
    a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 13, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.
    b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its transition and phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.
    c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must begin no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.
    d. Transition and Phase-out Procedures. The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different category prior to making a determination of ineligibility as required under 42 CFR 435.916(f)(1) or for children in CHIP consider eligibility for other insurance affordability programs under 42 CFR 457.350. For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable notice requirements for Medicaid

found in 42 CFR, part 431 subpart E, including sections 431.206 through 431.214 or for CHIP found at 42 CFR 457.340(e), including information about a right to a review consistent with 42 CFR 457.1180. In addition, the state must assure all applicable Medicaid appeal and hearing rights are afforded to Medicaid beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.

e. Exemption from Public Notice Procedures, 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers suspended by the state, FFP must be limited to normal closeout costs associated with termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling participants.

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

11. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX or title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

12. Adequacy of Infrastructure. The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

13. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved

Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers in accordance with 42 CFR §431.408(b)(2).

14. **Federal Financial Participation (FFP).** No federal matching for state expenditures under this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

15. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, managed care plans, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

16. **Common Rule Exemption**. The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid and CHIP benefits or services under those programs. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

IV. ELIGIBILITY

17. **Eligibility.** The demonstration affects all of the mandatory Medicaid eligibility groups set forth in Arizona's approved state plan and optional groups set forth in the state plan. Mandatory and optional state plan groups described below are subject to all applicable Medicaid laws and regulations except as expressly waived. Any Medicaid state plan amendments to the eligibility standards and methodologies for these eligibility groups apply to this demonstration. Expansion populations are defined as those groups made eligible by virtue of the expenditure authorities expressly granted in this demonstration and are subject to Medicaid and CHIP laws or regulations except as specified in the STCs and waiver and expenditure authorities for this demonstration. These cited documents generally provide that all requirements of Medicaid and CHIP laws and regulations do apply, except to the extent waived or specified as not applicable. The criteria for Arizona eligibility groups are as follows (Table 1):

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

Description	Program	Social Security Act Cite	42 CFR Cite
STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS **Families and Children**			

Low-income families under 1931 (Title IV A program that was in place in July 1996) including: • pregnant women with no other eligible children (coverage for third trimester) • relatives and their spouses living with and primary caretakers for children under age 18 or if age 18 is a full-time student	ACCP	1902(a)(10)(A)(i)(I) 1931(b) and (d)	435.110
Twelve months continued coverage (transitional medical assistance) for 1931 ineligible due to increase in income from employment.	ACCP	408(a)(11)(A) 1902(a)(52) 1902(e)(1) 1925 1931(c)(2)	
Four months continued coverage when spousal support collection results in 1931 ineligibility.	ACCP	408(a)(11)(B) 1931(c)(1)	435.115
STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS Pregnant Women, Children, and Newborns			
Pregnant Women Consolidated state plan group of mandatory and optional pregnant women's categories Includes postpartum coverage and continuous eligibility	ACCP	1902(a)(10)(A)(i)(III) and (IV) 1902(a)(10)(A)(ii)(I), (IV), and (IX) 1931(b) and (d) 1902(e)(5) and (6)	435.116 435.170
Children Consolidated state plan group of mandatory and optional infants and children under age 19 categories	ACCP ALTCS	1902(a)(10)(A)(i)(III), (IV), (VI) and (VII) 1902(a)(10)(A)(ii)(IV) and (IX) 1931(b) and (d)	435.118
Deemed Newborns Children born to a woman who was eligible and received Medicaid on the date of the child's birth, eligible for one year	ACCP	1902(e)(4)	435.117
STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS Aged, Blind, and Disabled			
All SSI cash recipients: aged, blind or disabled persons	ACCP	1902(a)(10)(A)(i)(II)	435.120
Qualified severely impaired working blind or disabled persons < 65 who were: a) receiving Title XIX, SSI or state supplement under 1619(a); or b) eligible for Medicaid under 1619(b) in 6/87	ACCP	1902(a)(10)(A)(i)(II) 1905(q)	435.120
"DAC" Disabled adult child (age 18+) who lost SSI by becoming Old Age, Survivor and Disability Insurance (OASDI) eligible (i.e., due to blindness or disability that began before age 22) or due to increase in amount of child's benefits.	ACCP	1634(c) 1939(a)(2)(D)	
SSI cash or state supplement ineligible for reasons prohibited by Title XIX.	ACCP		435.122
SSA Beneficiaries who lost SSI or state supplement cash benefits due to cost of living adjustment (COLA) increase in Title II benefits	ACCP	1939(a)(5)(E)	435.135

Disabled widow/widower who lost SSI or state supplement due to 1984 increase in OASDI caused by elimination of reduction factor in PL 98-21. (person must apply for this by 7/88)	ACCP	1634(b) 1939(a)(2)(C)	435.137
Disabled widow/widower (age 60-64 and ineligible for Medicare Part A) who lost SSI or state supplement due to early receipt of Social Security benefits.	ACCP	1634(d) 1939(a)(2)(E)	435.138
STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS Foster Care, Adoption Assistance and Former Foster Care Children			
Children in adoption subsidy/foster care under Title IV-E	ACCP ALTCS	473(b)(3) 1902(a)(10)(A)(i)(I)	435.145
Individuals under age 26 who aged out of foster care and were on Medicaid	ACCP	1902(a)(10)(A)(i)(IX)	435.150
STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS New Adult Group			
Individuals age 19 through 64 with incomes at or below 133% FPL	ACCP	1902(a)(10)(A)(i)(VIII)	435.119
STATE PLAN OPTIONAL TITLE XIX COVERAGE GROUPS			
"210 GROUP" Persons who meet AFDC, SSI or state supplement income & resource criteria.	ACCP ALTCS Case Management	1902(a)(10)(A)(ii)(I)	435.210
"211 GROUP" Persons who would be eligible for cash assistance except for their institutional status.	ALTCS	1902(a)(10)(A)(ii)(IV)	435.211
"GUARANTEED ENROLLMENT" Continuous coverage for persons enrolled in AHCCCS Health Plans who lose categorical eligibility prior to 6 months from enrollment. (5 full months plus month of enrollment)	ACCP	1902(e)(2)	435.212
"Independent Foster Care Adolescents" Individuals under age 21 who were in foster care upon turning age 18	ACCP	1902(a)(10)(A)(ii)(XVII)	435.226
"State Adoption Subsidy" Children under age 21 who receive a state adoption subsidy payment.	ACCP	1902(a)(10)(A)(ii)(VIII)	435.227
"236 GROUP" Persons in medical institutions for 30 consecutive days who meet state-set income level of < or equal to 300% of FBR.	ALTCS	1902(a)(10)(A)(ii)(V)	435.236
"Freedom to Work" Basic Coverage Group – individuals aged 16-64 with a disability who would be eligible, except for earnings, for SSI up to and including 250% of FPL.	ACCP ALTCS	1902(a)(10)(A)(ii)(XV)	
"Freedom to Work" Medical Improvement Group – employed individuals aged 16-64 with a medically improved disability up to and including 250% of FPL.	ACCP ALTCS	1902(a)(10)(A)(ii)(XVI)	
Uninsured individuals under 65 who need treatment for breast or cervical cancer	ACCP	1902(a)(10)(A)(ii)(XVIII)	435.213
TITLE XXI DEMONSTRATION GROUP			

KidsCare Expansion Group – individuals under age 19 with income above 200 up to and including 300 percent of the FPL who meet all other CHIP eligibility criteria.	CHIP	2110(b)	457.310

18. Waiver of Retroactive Eligibility. The state will not provide medical assistance for any month prior to the month in which a beneficiary's Medicaid application is filed, 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. The waiver of retroactive eligibility applies to all populations described in STC 17 who are not pregnant (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.

a. The state assures that, through various methods, it will provide outreach and education regarding how to apply for and receive Medicaid coverage to the public and to Medicaid providers, particularly those who serve populations that may be impacted by the retroactive eligibility waiver.

19. KidsCare Expansion Eligibility. On February 16, 2024, CMS approved expenditure authority to increase the CHIP eligibility threshold from 200 percent to 225 percent of the FPL. The KidsCare Expansion Group, beneficiaries described in expenditure authority 22 will include individuals under age 19 with incomes above 200 percent up to and including 300 percent of the federal poverty level (FPL) and who meet all other non-financial eligibility criteria for CHIP.

Subject to STC 6:

a. Beneficiaries with incomes above 200 percent up to and including 300 percent of the FPL, subject to approval by the state legislature, will receive all applicable CHIP state plan benefits through the delivery system described in the CHIP state plan. All other requirements of Title XXI apply.

V. DEMONSTRATION PROGRAMS

20. Mandatory Managed Care. With the exception of certain American Indian/Alaskan Native (AI/AN) beneficiaries identified below, enrollment in managed care is mandatory for all individuals determined eligible for full Medicaid benefits. Arizona has contracts separately for MCOs that provide services to beneficiaries needing LTSS, MCOs that provide behavioral health services to beneficiaries that meet the state definition of a person with a Serious Mental Illness (SMI), an MCO to provide services to children in foster care, and MCOs that provide services to all other Medicaid-eligible beneficiaries.

a. Enrollment. AHCCCS and the Arizona Department of Economic Security (DES), the state's IV-D agency, jointly determine eligibility for Medicaid. Applications are accepted in-person at offices operated by both agencies as well as by mail, phone, and online. The two agencies jointly operate an online application system that automatically adjudicates most applications without the need to request additional information. When intervention by an eligibility worker is requested, DES adjudicates applications that include individuals whose income eligibility is determined using MAGI standards. AHCCCS staff adjudicate applications for LTSS, the ALTCS program, as well as specialty groups such as DAC, DWW, Pickle, Breast and Cervical Cancer Treatment, and Freedom to Work. Eligibility workers from both agencies adjudicate SSI-MAO applications. In addition, when an application is received from a household with both MAGI and non-MAGI related individuals, the agencies share responsibility for determining eligibility. Applicants are asked to select a Medicaid MCO as part of the application process and have post-application choice of MCOs consistent with 42 CFR 438 subpart B, except as provided for in the list of waiver and expenditure authorities. Individuals who do not select an MCO are auto-assigned an MCO.

b. Benefits. Benefits consist of all benefits covered under the Medicaid state plan, unless otherwise noted within these STCs. The new adult group will receive benefits for ACC through the state's approved alternative benefit plan (ABP) state plan amendment (SPA).
c. Cost Sharing. Cost sharing shall be imposed as specified in the Medicaid state plan for all populations.

21. Children in Foster Care. Services for Arizona's children in foster care are provided through an MCO contract between AHCCCS and the Arizona Department of Child Safety (DCS) called the Comprehensive Health Plan (CHP). Children in foster care who receive acute care services will be enrolled in CHP instead of other Health Plans. Children in foster care who are eligible for or receive ALTCS will be enrolled or remain with the Program Contractor. Case Management services provided and reimbursed through this contractual relationship must be provided consistent with federal policy, regulations and law. Children in foster care receive integrated physical and behavioral health services through an MCO subcontracted with DCS/CHP.

22. Individuals with a Serious Mental Illness (SMI) designation. Individuals who are ACC beneficiaries and who are diagnosed with a SMI and designated as such will not have a choice of MCOs, but will receive integrated physical and behavioral health care services through the MCO in their GSA contracted with the state for that purpose.[1]

a. Transition Period. When individuals are determined to have an SMI designation and transition from an ACC to the RBHA for their integrated care, beneficiaries in active treatment (including but not limited to chemotherapy, pregnancy, drug regime or a scheduled procedure) with a provider not in the RBHA's network shall be allowed to continue receiving treatment from the out-of-network provider through the duration of their prescribed treatment ("Course of Care").
b. Choice of Primary Care Physician (PCP). The RBHA is required to assure that beneficiaries have a choice of PCPs. Specifically, enrollees will have a choice of at least two primary care providers and may request a change of primary care provider at least at the times described in 42 CFR 438.56(c). In addition, the RBHA will offer contracts to primary and specialist physicians who have established relationships with enrollees including specialists who may also serve as PCPs to encourage continuity of providers. For new enrollees who have an established relationship with a PCP that does not participate in the RBHA's provider network, the RBHA will provide, at a minimum, a 6-month transition period in which the enrollee may continue to seek care from their established PCP while the individual, the RBHA, and/or case manager finds an alternative PCP within the RBHA's provider network.
c. Opt-out for Cause. Individuals with an SMI designation will be allowed to opt-out of enrollment in the RBHA for physical healthcare services (but will remain enrolled with RBHA for behavioral health care) and the individual will be enrolled with an ACC plan for physical health care only under the following conditions:
    i. Either the enrollee, enrollee's guardian, or enrollee's physician successfully dispute the enrollee's diagnosis as SMI;

[1] Through September 30, 2022, the State will contract with a single MCO in each GSA, and under that contract all assigned enrollees are individuals living with a SMI designation. As of October 1, 2022, AHCCCS intends to amend the contracts of one ACC plan in each GSA and under that contract, the MCO will be responsible for providing integrated care to both individuals living with a SMI designation as well as enrollees with choice who do not live with a SMI designation. For purposes of these Special Terms and Conditions, the MCO responsible for covering care for individuals living with a SMI designation is referred to as a Regional Behavioral Health Agreement (RBHA) as designated in state law.

ii. The transfer is necessary due to the RBHA's network limitations and restrictions. This occurs when an enrollee does not have a choice for a Primary Care Physician (PCP) from at least two in-network PCPs, and has access to at least one specialty provider for each specialty area, to meet his/her medical needs;
iii. The transfer is necessary to continue or to fulfill a current physician's or provider's Course of Care recommendation;
iv. The beneficiary established that due to the enrollment and affiliation with the RBHA as a person designated with a SMI, and in contrast to persons enrolled with an acute care provider, there is demonstrable evidence to establish actual harm or the potential for discriminatory or disparate treatment in:
    a. The access to, continuity or availability of acute care covered services;
    b. Exercising client choice;
    c. Privacy rights;
    d. Quality of services provided; or
    e. Client rights under Arizona Administrative Code, Title 9, Chapter 21.

d. Under STC 22 subparagraph (c)(iv), an enrollee must either demonstrate that the discriminatory or disparate treatment has already occurred, or establish the plausible potential of such treatment. It is insufficient for a beneficiary to establish actual harm or the potential for discriminatory or disparate treatment solely on the basis that they are enrolled in the RBHA.
e. A transfer requested under STC 22 subparagraph (c)(iv) will be clearly documented in the enrollee handbook and any other relevant enrollee notices, and will be processed as follows:
    i. <u>The RBHA will</u>:
        a. Be responsible for reducing to writing the beneficiary's assertions of the actual or perceived disparate treatment of individuals as a result of their enrollment in the integrated plan.
        b. Be responsible for completing AHCCCS transfer of a RBHA beneficiary to an approved Acute Care Contractor Form.
        c. Confirm and document that the enrollee has been designated as a person with SMI and is enrolled in the SMI RBHA program.
        d. Provide documentation of efforts to investigate and resolve beneficiary's concern.
        e. Include in the enrollee's record any evidence provided by the beneficiary of actual or reasonable likelihood of discriminatory or disparate treatment.
        f. Make a recommendation to approve or decision to deny the request:
            i. If recommending approval, forward a completed packet to AHCCCS for a determination decision within 7 days of request.
            ii. If the decision is to deny the request, complete the packet and provide the enrollee with a written notice within 10 calendar days of request that includes the reasons for the denial and appeal and hearing rights.
            iii. If a hearing is requested, forward the request for hearing to the AHCCCS Administration.
    ii. <u>AHCCCS will:</u>
        a. Review the completed request packets and make a final decision to approve or deny the request.
        b. If AHCCCS rejects a RBHA recommendation to approve a transfer, AHCCCS will provide the enrollee written notice that includes the reasons for the denial and describes the enrollee's hearing rights. Notice will be provided within 10 days of

AHCCCS' receipt of the RBHA recommendation.

c. If a hearing is requested, schedule the matter for hearing.
d. Issue a written decision within 30 calendar days of receipt of the recommended decision of the administrative law judge conducting the hearing.

f. The state will track the Opt-out for Cause requests detailed in STC 22(c) including the number of each type of request; the county of each request; and the final result of the request. This information shall be provided to CMS in the quarterly reports.
g. Care Coordination for Integrated SMI Program. The State shall submit to CMS their procedures for ensuring that the RBHAs have sufficient resources and training to provide the full range of care coordination for individuals with disabilities, multiple and chronic conditions, and individuals who are aging. Persons providing care coordination should possess the knowledge and skills necessary to address the unique needs of individuals designated with an SMI. The needs may be identified through a risk assessment process. Care shall be coordinated across all settings including services outside the provider network.

23. Arizona Long Term Care System (ALTCS). The ALTCS program is for individuals who need ongoing nursing facility services, services provided by an intermediate care facility for individuals with developmental disabilities (ICF/IDD), or who are at immediate risk of needing those services. ALTCS enrollees have a choice of receiving care in an institutional setting or receiving home and community-based services (HCBS) in their homes or an alternative HCBS setting.

a. **ALTCS Eligibility Groups**. Individuals listed in Table 1 who need ongoing nursing facility services, services provided by an ICF/IID, or who are at immediate risk of needing those services.
b. **ALTCS Financial Eligibility**. To be financially eligible for ALTCS an individual must meet the income and resource requirements in the State Plan.
c. **Pre-Admission Screening (PAS).** A PAS will be conducted by a registered nurse or social worker to determine if the individual is at immediate risk of institutionalization in either a nursing facility or an ICF/IID. The PAS assesses the functional, medical, nursing, and social needs of the individual.
d. **Person-Centered Service Plan (PCSP)**. A written plan of care developed through an assessment of functional need that reflects the services and supports (paid and unpaid) that are important for and important to the beneficiary in meeting the identified needs and preferences for the delivery of such services and supports. The Person-Centered Service Plan (PCSP) shall also reflect the beneficiary's strengths and preferences that meet the beneficiary's social, cultural, and linguistic needs; individually identified goals and desired outcomes; and reflect risk factors (including risks to beneficiary rights) and measures in place to minimize them, including individualized back-up plans and other strategies as needed.
e. **FFP.** FFP will not be claimed for demonstration services furnished prior to the development of the plan of care. FFP will not be claimed for demonstration services, as described in STC 23(g)(iii) and (iv) which are not included in the individual written plan of care.
f. **ALTCS Safeguards.** AHCCCS will take the following necessary safeguards to protect the health and welfare of persons receiving HCBS services under the ALTCS program. Those safeguards include:
    i. Adequate standards for all types of providers that furnish services under the ALTCS program;
    ii. Assurance that the standards of any state licensure or certification requirements are met for services or for individuals furnishing services that are provided under the ALTCS program. The state assures that these requirements will be met on the date that the services are

furnished; and

iii. A formal quality control system which monitors the health and welfare of beneficiaries served in the ALTCS program.
    a. Monitoring will ensure that all provider standards and health and welfare assurances are continually met, and that plans of care are periodically reviewed to ensure that the services furnished are reasonably consistent with the identified needs of the individuals.
    b. The state further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

g. **ALTCS Benefits and Services**

i. **ALTCS Acute Care.** Enrollees receive the same acute services as defined in STC 20(b).

ii. **ALTCS Behavioral Health Care.** Enrollees receive behavioral health care services as defined in STC 20(b).

iii. **ALTCS Limited Adult Dental Benefits.** In addition to dental benefits covered under the State Plan, ALTCS participants aged 21 or older receive certain dental services up to $1,000 per person annually for therapeutic and preventative care, including but not limited to basic diagnostic services, preventative services, restorative services, periodontics, prosthetic services, and oral surgery.

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

    a. **Alternative HCBS Settings include:**

        1. A living arrangement where a beneficiary may reside and receive HCBS. The setting shall be approved by the director, and either (1) licensed or certified by a regulatory agency of the State or (2) operated by the IHS, and Indian tribe or tribal organization, or an Urban Indian Organization, and has met all the applicable standards for State licensure, regardless of whether it has actually obtained the license (A.A.C.R9-28-101). The possible types of settings include:
            a. For an individual with a developmental disability:
                i. Community residential settings,
                ii. Group homes,
                iii. State-operated group homes,
                iv. Group foster homes,
                v. Adult behavioral health therapeutic homes, and
                vi. Behavioral health respite homes.
            b. For an individual who is Elderly and Physically Disabled (E/PD):
                i. Adult foster care homes,
                ii. Assisted living homes or assisted living centers (units only),
                iii. Adult behavioral health therapeutics homes, and
                iv. Behavioral health respite homes.
        2. **HCBS.** Services provided to ALTCS enrollees are enumerated in Table 2 and described in Attachment L.

Table 2 – ALTCS HCBS not otherwise covered in the State Plan

Service	Title XIX	
	EPD	DD
Adult Day Health Services	X	N/A
Attendant Care	X	X
Community Transition Services*	X	X
Companion Care	X	X
Emergency Alert	X	X
Family Support Services	X	X
Habilitation	X	X
Home Delivered Meals	X	X
Home Modifications	X	X
Home Maker Services	X	X
Personal Care	X	X
Personal Care in Acute Care Hospitals	X	X
Private Duty Nursing	X	X
Respite Care (in home)	X	X
Respite Care (Institutional)	X	X

*As Defined in State Medicaid Director Letter #02-008

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

v. **Spouses of Beneficiaries and Legally Responsible Parents of Eligible Minor ALTCS Beneficiaries As Paid Caregivers.** Under this expenditure authority, AHCCCS may claim medical assistance expenditures for attendant care and similar services, including personal care, that constitute extraordinary care and that are provided to eligible ALTCS enrollees by their spouses[2] or by legally responsible parents[3] (when the beneficiary is a minor) who elect to provide these services. AHCCCS may also claim medical assistance expenditures for habilitation services provided to eligible minor ALTCS beneficiaries when the service is provided by legally responsible parents. Spouses of beneficiaries and legally responsible parents of minor ALTCS beneficiaries providing care to eligible beneficiaries will be employed/contracted by a provider in the beneficiary's MCO network or registered with AHCCCS as defined in agency policy. The services of a paid caregiver under this section must meet the following criteria and monitoring provisions.

a. Services provided by the spouse of a beneficiary as a Paid Caregiver are limited to personal care or similar services that constitute extraordinary care. Services provided by a legally responsible parent of a minor child serving as a Paid Caregiver may include personal care or similar services, as well as habilitation services, that constitute extraordinary care.

1. "Personal care or similar services" means assistance provided to enable the enrollee to perform Activities of Daily Living (ADL), or Instrumental Activities of Daily Living (IADL), that the beneficiary would normally perform for himself or herself if the beneficiary did not have a disability or

[2] Spouse is defined by Arizona Administrative Code R9-28-401. https://apps.azsos.gov/public_services/Title_09/9-28.pdf
[3] Legally responsible parent is defined by Arizona Revised Statute 25-401(4). https://www.azleg.gov/viewdocument/?docName=https://www.azleg.gov/ars/25/00401.htm

chronic illness. Assistance may involve performing a personal care task for the beneficiary or cuing the beneficiary so that the beneficiary performs the task for himself or herself.

2. "Habilitation services" means services as defined in Attachment L.
3. "Extraordinary care" means care that exceeds the range of activities that a spouse of a beneficiary or legally responsible parent of a minor child would ordinarily perform in the household on behalf of the recipient spouse or minor child, if he/she did not have a disability or chronic illness, and which are necessary to assure the health and welfare of the beneficiary, and avoid institutionalization.

b. The services of the spouse of a beneficiary or legally responsible parent of a minor child as a Paid Caregiver must be specified in a plan of care prepared by the enrollee's case manager.
c. The beneficiary who selects the spouse as a Paid Caregiver is not eligible to receive additional personal care and similar services from another attendant caregiver. The enrollee will remain eligible to receive other HCBS such as home modifications, respite care, and other services that are not within the scope of the personal care or similar services prescribed in the provider's plan of care.
d. The minor beneficiary who receives services from a legally responsible parent as a Paid Caregiver may be eligible to receive habilitation, personal care, and similar services (including other HCBS) beyond the established 40 hour limit described in subsection g from another caregiver, in accordance with the member's assessed need and the plan of care.
e. The spouse of a beneficiary or legally responsible parent of a minor beneficiary as a Paid Caregiver must meet the qualifications and training standards applicable to other providers of personal care or similar services. Spouses of beneficiaries as a Paid Caregiver are required to be co-employed by the beneficiary and DES/DDD under the Independent Provider Network model. Legally responsible parents of minor beneficiaries as a Paid Caregiver must be employed or contracted by an AHCCCS registered provider.
f. The spouse of a beneficiary or legally responsible parent of a minor beneficiary as a Paid Caregiver must be paid at a rate that does not exceed that which would otherwise be paid to a provider of personal care or similar services; and
g. The spouse of a beneficiary or legally responsible parent of a minor beneficiary as a Paid Caregiver will comply with the following conditions:
    1. A spouse of a beneficiary as a Paid Caregiver may not be paid for more than 40 hours of services in a 7-day period;
    2. The state shall implement a phased-in approach for a 40-hour weekly limit for a legally responsible parent of a minor beneficiary as a Paid Caregiver, which will be detailed in the quarterly monitoring reports. Additionally, services provided by a legally responsible parent of a minor beneficiary shall not exceed 16 hours in a 24 hour period. The spouse of a beneficiary or legally responsible parent of a minor beneficiary as a Paid Caregiver must meet conditions of employment related to claims submission and documentation;
    3. The ALTCS enrollee must be offered a choice of providers other than his/her spouse, if the beneficiary is a legally responsible parent, if the beneficiary is a

minor. The beneficiary's choice of a Paid Caregiver spouse or legally responsible parent as provider must be recorded in his/her plan of care at least annually.

h. AHCCCS and its ALTCS MCOs must comply with the following monitoring requirements:
    1. ALTCS MCO and FFS case managers must make an on-site case management visit at least every 90 days to reassess an enrollee's need for services and to assess the health, safety, and welfare status of the enrollee;

h. **Other ALTCS Requirements**
    i. The state of Arizona will continue to provide access to ALTCS services to American Indians on the reservation as it does to other citizens of the state.
    ii. AHCCCS will report annually on current placements and ongoing activities for expanding HCB services and settings. The report will be due by March 31 of each year.

24. ALTCS Transitional Program. The ALTCS Transitional Program is available for beneficiaries (both institutional and HCBS) who, at the time of medical reassessment, have improved either medically, functionally, or both to the extent that they no longer need institutional care, but who still need significant long-term services and support (LTSS).

a. An enrollee in the ALTCS transitional program is eligible to receive all services provided by an ACC/ALTCS MCO and may receive up to 90 consecutive days of nursing facility or ICF/IID services per year.
b. If the enrollee requires nursing facility or ICF/IID services for longer than 90 days, AHCCCS will conduct a reassessment of the need for institutional care.

25. Medicare Part B Premiums. The state of Arizona will continue to pay the Medicare Part B premiums on behalf of individuals enrolled in ALTCS with income up to 300 percent of the FBR who are also eligible for Medicare, but do not qualify as a QMB, SLMB or QI; eligible for Medicaid under a mandatory or optional Title XIX coverage group for the aged, blind, or disabled (SSI-MAO); eligible for continued coverage under 42 CFR 435.1003; or are in the guaranteed enrollment period described in 42 CFR 435.212 and the state was paying their Part B premium before eligibility terminated. Once the state has received the Medicare Part B premium invoice, it will automatically make an electronic payment on behalf of the beneficiary.

VI. HCBS QUALITY ASSURANCE AND REPORTING REQUIREMENTS

26. HCBS Electronic Visit Verification System. The state assures that it is in compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) as of January 1, 2021, and that it will demonstrate compliance with the EVV requirements for home health services by January 1, 2023, in accordance with section 12006 of the 21st Century CURES Act.

27. For LTSS: Quality Improvement Strategy for 1915(c) or 1915(i) approvable HCBS Services. For services that could have been authorized to individuals under a 1915(c) waiver or under a 1915(i) HCBS State plan, the state's Quality Assessment and Performance Improvement Plan, as described in Attachment J, encompassed LTSS specific measures set forth in the federal managed care rule at 42 CFR 438.330 and reflects how the state will assess and improve performance to demonstrate compliance with applicable federal waiver assurances set forth in 42 CFR 441.301 and 441.302 as follows:

a. **Administrative Authority**. A performance measure should be developed and tracked for any authority that the State Medicaid Agency (SMA) delegates to another agency, unless already captured in another performance measure.
b. **Level of Care or Eligibility based on 1115 Requirements**. Performance measures are required for the following: applicants with a reasonable likelihood of needing services receive a level of care determination or an evaluation for HCBS eligibility, and the processes for determining level of care or eligibility for HCBS are followed as documented. While a performance measure for annual levels of care/eligibility is not required to be reported, the state is expected to be sure that annual levels of care/eligibility are determined.
c. **Qualified Providers**. The state must have performance measures that track that providers meet licensure/certification standards, that non-certified providers are monitored to assure adherence to demonstration requirements, and that the state verifies that training is given to providers in accordance with the demonstration.
d. **Service Plan**. The state must demonstrate it has designed and implemented an effective system for reviewing the adequacy of service plans for HCBS participants. Performance measures are required for choice of waiver services and providers, service plans address all assessed needs and personal goals, and services are delivered in accordance with the service plan including the type, scope, amount, duration, and frequency specified in the service plan.
e. **Health and Welfare**. The state must demonstrate it has designed and implemented an effective system for assuring HCBS participants health and welfare. The state must have performance measures that track that on an ongoing basis it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death; that an incident management system is in place that effectively resolves incidents and prevents further singular incidents to the extent possible; that state policies and procedures for the use or prohibition of restrictive interventions are followed; and, that the state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved demonstration.
f. **Financial Accountability**. The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the HCBS program. The state must demonstrate actuarial soundness on an annual basis pursuant to 42 CFR 438.
g. **HCBS Settings Requirements**. The state must assure compliance with the characteristics of HCBS settings as described in the 1915(c) and 1915(i) regulations in accordance with implementation/effective dates as published in the Federal Register.

28. HCBS Reporting Requirements. The state will submit a report to CMS following receipt of an Evidence Request letter and report template from the Division of HCBS Operations and Oversight (DHCBSO) no later than 21 months prior to the end of the approved waiver demonstration period which includes evidence on the status of the HCBS quality assurances and measures that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers, as described in Attachment J. Following receipt of the state's evidence report, the DHCBSO will issue a draft report to the state and the state will have 90 days to respond. The DHCBSO will evaluate each evidentiary report to determine whether the assurances have been met and will issue a final report to the state 60 days following receipt of the state's response to the draft report.

The state must report annually the deficiencies found during the monitoring and evaluation of the HCBS demonstration assurances, an explanation of how these deficiencies have been or are being corrected, as

well as the steps that have been taken to ensure that these deficiencies do not reoccur. The state must also report on the number of substantiated instances of abuse, neglect, exploitation and/or death, the actions taken regarding the incidents and how they were resolved. Submission is due no later than 6 months following the end of the demonstration year. **NOTE:** This information could be included in the Annual Monitoring Reports detailed in STC 86.

29. HCBS Beneficiary Protections.

a. **Person-centered planning**. The state assures there is a person-centered service plan for each individual determined to be eligible for HCBS. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR 441.301(c)(1) (1915(c)) or 42 CFR 441.725(c) (1915(i)), and the written person-centered service plan meets federal requirements at 42 CFR 441.301(c)(2) (1915(c)) or 42 CFR 441.725(b) (1915(i)). The person-centered service plan is reviewed, and revised upon reassessment of functional need as required by 42 CFR 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

b. **Conflict of Interest**. The state agrees that the entity that authorizes the services is external to the agency or agencies that provide the HCB services. The state also agrees that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.

c. **Self-Direction.** Each beneficiary eligible for long term services and supports will have informed choice on their option to self-direct LTSS, have a designated representative direct LTSS on their behalf, or select traditional agency-based service delivery. Both level of care assessment and person-centered service planning personnel will receive training on these options (for use in MLTSS programs with self-direction).

d. **Community Participation.** The state, either directly or through its MCO contracts must ensure that participants' engagement and community participation is supported to the fullest extent desired by each participant.

e. Subject to Expenditure Authority 1, Beneficiaries may change managed care plans if their residential or employment support provider is no longer available through their current plan.

VII. HOUSING AND HEALTH OPPORTUNITIES

30. Housing and Health Opportunities (H2O) Overview. The state will provide an array allowable Health-Related Social Needs (HRSN) services consistent with STC 33 and STC 35 as Title XIX reimbursable services for populations that meet the eligibility criteria described in STC 31 and Attachment E. All H2O services will be implemented statewide subject to any service, population, and/or geographically based phase-in as approved by CMS.

31. Eligibility Criteria. Expenditures for HRSN services may be made for targeted populations specified below. Individuals in the targeted populations must have a documented medical need for the services and the services must be determined medically appropriate, as described in the H2O Services section in STC 32, for the documented need. Medical appropriateness must be based on clinical and social risk factors. This medical appropriateness determination must be documented in the beneficiary's medical record (e.g., housing assessment, individual service plan, etc.). To be eligible for HRSN services as set forth in this Section VII of the STCs, Medicaid eligible individuals must be assessed for a need for housing-related services and supports and have an identified need for a housing related goal included within their medical

record. Eligibility for these HRSN services shall be identified as having met one of each of the following criteria from the sections below:

a. Homelessness – beneficiaries must be experiencing homelessness or at risk of homelessness, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5; and
b. Clinical and social risk criteria – beneficiaries must have a health need as documented in their medical record, including but not limited to: a serious mental illness (SMI), high-cost high needs chronic health conditions or co-morbidities, or enrolled in ALTCS. Additional details establishing beneficiary eligibility and need will be documented in the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for H2O Services as described in STC 36.

32. H2O Services. The state may claim FFP for the specified evidence-based HRSN services identified in STC 33, subject to the restrictions described below and in STC 35. Expenditures for HRSN services are limited to costs not otherwise covered under Title XIX, including costs already covered under demonstration expenditures otherwise described in these STCs, but consistent with Medicaid demonstration objectives that enable the state to continue to improve health outcomes and increase the efficiency and quality of care. HRSN services must be clinically appropriate for the beneficiary and based on medical appropriateness using clinical and other health-related social needs criteria. The state is required to align clinical and social risk criteria across services and with other non-Medicaid social support agencies, to the extent possible. The HRSN services may not supplant any other available funding sources such as housing supports available to beneficiaries through local, state, or federal programs. The HRSN services will be the choice of the beneficiary; beneficiaries can opt out of HRSN services at any time; and HRSN services do not absolve the state or its managed care plans of their responsibilities to provide required coverage for other medically necessary services. Under no circumstances will the state be permitted to condition Medicaid coverage, or coverage of any benefit or service, on receipt of HRSN services. The state must submit additional details on covered services to CMS as outlined in STC 36 and Attachment E.

33. Allowable HRSN Services. The state may cover the following HRSN services as defined in this STC and in Attachment F:

a. Housing Supports, including:
    i. Rent/temporary housing for up to 6 months, specifically for individuals transitioning out of institutional care or congregate settings such as nursing facilities, large group homes, congregate residential settings, Institutions for Mental Diseases (IMDs), correctional facilities, and hospitals; individuals who are homeless, at risk of homelessness, or transitioning out of an emergency shelter as defined by 24 CFR 91.5; and individuals transitioning out of the child welfare system including foster care;
    ii. Utility costs including activation expenses and back payments to secure utilities, limited to individuals receiving rent/temporary housing as described in STC 33(a)(i);
    iii. Pre-tenancy and tenancy sustaining services, including tenant rights education and eviction prevention;
    iv. Housing transition navigation services;
    v. One-time transition and moving costs;
    vi. Housing deposits to secure housing, including application and inspection fees and fees to secure needed identification;
    vii. Medically necessary home accessibility modifications and remediation services.

b. Case management; outreach, and education including linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees.

34. HRSN Infrastructure.

a. The state may claim FFP in infrastructure investments in order to support the development and implementation of HRSN services, subject to Section X of these STCs. This FFP will be available for the following activities:
   i. Technology – e.g., electronic referral systems, shared data platforms, her modifications or integrations, screening tool and/or case management systems, databases/data warehouses, data analytics and reporting, data protections and privacy, accounting and billing systems;
   ii. Development of business or operational practices – e.g., procurement and planning, developing policies and workflows for referral management, privacy, quality improvement, trauma-informed practices, evaluation, and beneficiary navigation;
   iii. Workforce development – e.g., cultural competency training, trauma-informed training, traditional health worker certification, training staff on new policies and procedures; or
   iv. Outreach, education, and stakeholder convening – e.g., potential beneficiary engagement and coverage coordination, design and production of outreach and education materials, translation, obtaining community input, investments in stakeholder convening.

b. The state may claim FFP in HRSN infrastructure expenditures for no more than the annual amounts outlined in Table 3. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years for the activities described in this STC, not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 3 – Annual Limits of Total Computable Expenditures for HRSN Infrastructure

	DY12	DY13	DY14	DY15	DY16
Total Computable Expenditures	$13.5M	$13.5M	$13.5M	$13.5M	$13.5M

c. HRSN Infrastructure funding must be claimed at the applicable administrative match rate, and approved HRSN Infrastructure investments will be matched at the applicable administrative match for the expenditure.

d. This HRSN infrastructure funding is separate and distinct from the payment to the applicable managed care plans for delivery of HRSN services. The state must ensure that HRSN infrastructure expenditures for activities described in STC 34(a) are not factored into managed care capitation payments, and that there is no duplication of funds.

e. The state may not claim any FFP in HRSN infrastructure expenditures until the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN Services is approved, as described in STC 36. Once approved, the state can claim FFP in HRSN infrastructure expenditures retrospectively to the beginning of the demonstration approval date.

f. To the extent the state requests any additional HRSN infrastructure funding, or changes to the scope of HRSN infrastructure funding as described within this STC, it must submit an amendment to the demonstration for CMS's consideration.

35. Excluded HRSN services. Excluded items, services, and activities that are not covered as HRSN services include, but are not limited to:

a. Construction costs (bricks and mortar), except as needed for approved medically-necessary home modifications as described in STC 33(a)(viii);
b. Capital investments other than those as allowable as HRSN infrastructure as described in STC 34;
c. Room and board, except as described in STC 33;
d. Research grants and expenditures not related to monitoring and evaluation;
e. Costs for services in prisons, correctional facilities or services for people who are civilly committed and unable to leave an institutional setting;
f. Services provided to individuals who are not lawfully present in the United States or are undocumented;
g. Expenditures that supplant services and activities funded by other state and federal governmental entities;
h. School based programs for children that supplant Medicaid state plan programs, or that are funded under the Department of Education and/or state or the local education agency;
i. General workforce activities, not specifically linked to Medicaid or Medicaid beneficiaries; and
j. Any other projects or activities not specifically approved by CMS as qualifying for coverage as HRSN services under this demonstration.

36. Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for H2O Services. 180 days after approval, the state must submit a Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications to CMS (Protocol). The protocol/s must include, as appropriate, a list of the HRSN services and service descriptions, the criteria for defining a medically appropriate population for each service, the process by which that criteria will be applied including care plan requirements or other documented processes, proposed uses of HRSN infrastructure funds, and provider qualification criteria for each service. Each protocol may be submitted and approved separately. The state must resubmit an updated protocol, as required by CMS feedback on the initial submission. The protocol may be updated as details are changed or added. The state may not claim FFP in HRSN services or HRSN infrastructure expenditures until CMS approves the associated protocol, except as otherwise provided herein. Once the associated protocol is approved, the state can claim FFP in HRSN services and HRSN infrastructure expenditures retrospectively to the beginning of the demonstration approval date. The approved protocols will be appended to the STCs as Attachment E.

Specifically, the protocol must include the following information:

a. Proposed uses of HRSN infrastructure expenditures, including the type of entities to receive funding, the intended purpose of the funding, the projected expenditure amounts, and an implementation timeline
b. A list of the covered HRSN services (not to exceed those allowed under STC 33), with associated service descriptions and service-specific provider qualification requirements
c. A description of the process for identifying beneficiaries with health-related social needs, including outlining beneficiary eligibility, implementation settings, screening tool selection, and rescreening approach and frequency, as applicable
d. A description of the process by which clinical criteria will be applied, including a description of the documented process wherein a provider, using their professional judgment, may deem the service to be medically appropriate

i. Plan to identify medical appropriateness based on clinical and social risk factors
ii. Plan to publicly maintain these clinical/social risk criteria to ensure transparency for beneficiaries and stakeholders

e. A description of the process for developing care plans based on assessment of need
   i. Plan to initiate care plans and closed-loop referrals to social services and community providers based on the outcomes of screening
   ii. Description of how the state will ensure that HRSN screening and service delivery are provided to beneficiaries in ways that are culturally responsive and/or trauma-informed

37. Service Delivery.

a. Managed Care Service Delivery. Consistent with the managed care contract and guidance:
   i. HRSN services will be available from managed care plans.
   ii. Managed care plans must receive state approval and provide public notice of any availability of HRSN service including specifying such limitations in the enrollee handbook.
   iii. Any applicable HRSN services that are delivered by managed care plans need to be included in the managed care contracts and rates which are submitted to CMS for review and approval in accordance with 42 CFR 438.3(a) and 438.7(a).
   iv. The state will update the managed care plan contract language to require the managed care plans to provide HRSN services as described in STC 33 and Attachment F. HRSN services as described in STC 33 and Attachment F as demonstration services should be included in capitation rate setting and medical loss ratio (MLR) reporting as incurred claims. The state must develop a monitoring and oversight process specific to HRSN services no later than six (6) months after the extension approval. The process must specify how HRSN services will be identified for inclusion in capitation rate setting. The plan must also specify how expenditures for HRSN services will be identified for inclusion in the MLR numerator. The state's plan must indicate how expenditures for HRSN administrative costs and infrastructure will be identified and reported in the MLR as non-claims costs.
b. Fee-for-Service Delivery. HRSN services that are provided to fee-for-service beneficiaries are provided in accordance with the provisions of the demonstration, only to the mandatory and optional state plan eligibles. The services listed in STC 33 are excluded from the Standard benefit package, and are carved out of the managed care service delivery system for fee-for-service beneficiaries and shall instead be furnished as specified under the state plan.

38. Contracted Providers. Consistent with the managed care contract and applicable to all HRSN services.

a. Managed care plans will contract with HRSN service providers ("Contracted Providers") to deliver HRSN services authorized under the demonstration, as applicable.
b. Managed care plans must establish a network of providers and ensure the Contracted Providers have sufficient experience and training in the provision of the HRSN services being offered. Contracted Providers do not need to be licensed, however, staff offering services through Contracted Providers must be licensed when appropriate and applicable.
c. The managed care plan and Contracted Provider must agree to a rate for the provision of applicable HRSN services, consistent with state guidance for these services, and in compliance with all related federal requirements.
   i. Any state direction on the payment arrangement must abide by 42 CFR 438.6(c).

39. Provider Network Capacity. Managed care plans must ensure the HRSN services authorized under the

demonstration are provided to eligible beneficiaries in a timely manner, and shall develop policies and procedures outlining its approach to managing provider shortages or other barriers to timely provision of the HRSN services, in accordance with the managed care plan contracts and other state Medicaid/operating agency guidance.

40. Compliance with Federal Requirements. The state shall ensure HRSN services are delivered in accordance with all applicable federal statute, regulation or guidance.

41. HRSN Service Plan. The state shall ensure that there is a HRSN service plan for each individual determined to be eligible for HRSN services. The HRSN service plan must be person-centered, identify the individual's needs and individualized strategies and interventions for meeting those needs, and be developed in consultation with the individual and the individual's chosen support network as appropriate. The HRSN service plan will be reviewed and revised upon reassessment of need at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

42. Conflict of Interest. The state shall ensure appropriate protections against conflicts of interest in the service planning and delivery of HRSN services. The state agrees that appropriate separation of assessment, service planning and service provision functions are incorporated into state, CBOs, and other applicable vendors' conflict of interest policies.

43. CMS Approval of Managed Care Contracts. As part of the state's submission of associated Medicaid managed care plan contracts to implement HRSN services through managed care, the state must provide documentation including, but not limited to:

a. Beneficiary and plan protections, including but not limited to:
    i. HRSN services must not be used to reduce availability of, discourage, or jeopardize Medicaid beneficiaries' access to Medicaid state plan covered services.
    ii. Medicaid beneficiaries always retain their right to receive the Medicaid covered service on the same terms as would apply if HRSN services were not an option.
    iii. Medicaid beneficiaries always retain the right to file appeals and/or grievances pursuant to 42 CFR 438, if the requested HRSN services offered by their Medicaid managed care plan, but were not authorized to receive the requested HRSN services because of a determination that it was not medically appropriate.
    iv. Managed care plans are not permitted to deny a beneficiary a medically appropriate Medicaid covered service on the basis that they have requested, are currently receiving, or have previously received HRSN services.
    v. Managed care plans are prohibited from requiring a beneficiary to utilize HRSN services.
b. Managed care plans must timely submit data requested by the state or CMS, including, but not limited to:
    i. Data to evaluate the utilization and effectiveness of the covered HRSN services.
    ii. Any data necessary to monitor health outcomes and quality of care metrics at the individual and aggregate level through encounter data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status, and language spoken to inform health equity efforts and efforts to mitigate health disparities.
    iii. Any data necessary to monitor appeals and grievances for beneficiaries.
    iv. Documentation to ensure appropriate clinical support for the medical appropriateness of

HRSN services.

v. Any data determined necessary by the state or CMS to monitor and oversee the HRSN initiatives.

c. All data and related documentation necessary to monitor and evaluate the HRSN services initiatives, including cost assessment, to include but not limited to:

i. The managed care plans must submit timely and accurate encounter data to the state for beneficiaries eligible for HRSN services. The state must seek CMS approval on what is considered appropriate and reasonable timeframe for plan submission of encounter data. When possible, this encounter data must include data necessary for the state to stratify analyses by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status, and language spoken, to inform health equity efforts and efforts to mitigate health disparities undertaken by the state.

ii. Any additional information requested by CMS, the state or another legally authorized oversight body to aid in on-going evaluation of HRSN services or any independent assessment or analysis conducted by the state, CMS, or another legally authorized independent entity.

iii. Any additional information determined reasonable, appropriate and necessary by CMS.

44. Rate Methodologies. All rate and/or payment methodologies for authorized HRSN services outlined in these STCs must be submitted to CMS for review and approval prior to implementation, including but not limited to fee-for-service payment as well as non-risk payments and capitation rates in managed care delivery systems, as part of the New Initiatives Implementation Plan (see STC 84) and at least 60 days prior to implementation. States must submit all documentation requested by CMS, including but not limited to the payment rate methodology as well as other documentation and supporting information (e.g., state responses to Medicaid non-federal share financing questions). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting fee-for-service payment rates.

45. Maintenance of Effort (MOE). The state must maintain a baseline level of state funding for social services related to housing transition supports for the duration of the demonstration. Within 90 days of demonstration approval, the state will submit a plan to CMS as part of the New Initiatives Implementation Plan (see STC 84) that outlines how it will determine baseline spending on these services throughout the state. The annual MOE will be reported and monitored as part of the Annual Monitoring Report, described in STC 86 including any justifications necessary to describe the findings. A significant change in funding may trigger a need for notice to CMS and/or submission of an amendment, as outlined in these STCs. The agency will notify CMS of any update that will affect a change in funding and any potential impact to the H2O program or populations. CMS will determine based on the nature of the change whether an amendment is required.

46. Partnership with State and Local Entities. The state must have in place partnerships with other state and local entities (e.g., HUD Continuum of Care Program, local housing authority, SNAP state agency) to assist beneficiaries in obtaining non-Medicaid funded housing and other supports, if available, upon the conclusion of temporary Medicaid payment for such supports, in alignment with beneficiary needs identified in the medical record or HRSN service plans, as appropriate. The state will submit a plan to CMS as part of the New Initiatives Implementation Plan that outlines how it will coordinate the appropriate arrangements with other state and local entities and also work with those entities to assist beneficiaries in

obtaining available non-Medicaid funded housing and other supports upon conclusion of temporary Medicaid payment as stated above. The plan must provide a timeline for the activities outlined. As part of the Monitoring Reports described in STC 86, the state will provide the status of the state's fulfillment of its plan and progress relative to the timeline, and whether and to what extent the non-Medicaid funded supports are being accessed by beneficiaries as planned. Once the state's plan is fully implemented, the state may conclude its status updates in the Monitoring Reports.

VIII. TARGETED INVESTMENTS 2.0 PROGRAM

47. Description. Arizona created the Targeted Investments program to offer provider incentives via directed payments aligned with the state's capitation rates paid to managed care entities pursuant to 42 CFR 438.6(c). The initial TI program, TI 1.0, was active 2017 – 2021, with a one-year extension through 2022. TI 2.0 will build on TI 1.0 by creating a new five-year program that furthers point-of-care integration achievements of original TI 1.0 providers; rewards providers for establishing new and meaningful systems transformations; and, improves requirements to more comprehensively address quality and health equity by providing whole person care. TI 2.0 will direct managed care entities to use funding to make specific incentive payments to providers with the goal of improving quality and health equity for targeted populations through addressing HRSN. Each required performance target will have an incentive amount associated with it; providers will receive an incentive payment for each requirement that is met. Providers will also receive an incentive payment for completing the application process that includes new baseline deliverables and becoming approved for participation in TI 2.0.

48. Participating Providers. Provider participation is at the organization (Tax ID) level, rather than site or clinic specific, except for justice clinics which remain at the site level due to community collaboration requirements. A multi-site provider practice or organization can apply for all eligible ambulatory sites, earning incentives based on the organization's performance.

Provider participation is limited to the following specific provider types that are enrolled with AHCCCS:

a. Primary Care: includes pediatric, adult, and family practice MDs, DOs, nurse practitioners and physician assistants. Obstetrician and gynecologist practices will also be included in this category, as they often serve as de facto primary care providers, and encouraged to participate.
b. Behavioral Health: includes ambulatory behavioral health clinics and providers that serve children, adults, or both children and adults.
c. Integrated Clinics: provider organizations that provide both primary care and behavioral health care, are licensed by the Arizona Department of Health Services as integrated clinics, and registered with AHCCCS as an integrated clinic provider type.
d. Justice Clinics: licensed and registered integrated outpatient clinics (including ICs, Federally Qualified Health Centers and Rural Health Centers) with robust collaborative agreements with a justice partner, including but not limited to clinics co-located with or adjacent to probation and/or parole facilities, or probation and/or parole offices located with or adjacent to the integrated clinic. Providers will be incentivized to place an emphasis on justice-involved individuals (including AHCCCS beneficiaries adjudicated through diversion programs such as drug courts and veterans' courts) through additional incentives for addressing social risk factors most impactful for justice-involved individuals such as housing and employment instability and improving justice partner commitment to coordination and data sharing. Qualified clinics that best meet each community's needs will be selected from a pool or applicants that must:

i. Contract with all ACC plans and the RBHA service the site's GSA, and
ii. Submit a commitment letter from a justice partner or partners including at least one county probation department and/or the Arizona Department of Corrections Rehabilitation and Reentry that details plans for co-location or other novel approaches to collaboration, and, when feasible, with diversion-related court programs that specifies how the justice partner intends to collaborate with the clinic.

49. Provider Eligibility Requirements. Arizona's TI 2.0 program will continue the progress of providers from TI 1.0 while bringing in new providers and including an emphasis on improved consistency in health quality and delivery system reform through a lens of the HRSN. The state will require that all interested providers – both those who participated in TI 1.0 and new providers – complete an application that will include:

a. An attestation that all non-specialty outpatient clinics under the TIN utilize an EHR system capable of bidirectional data sharing with the Health Information Exchange (HIE).
b. An attestation that a certain minimum number of foundational prerequisites have been met by the end of Demonstration Year 1, in order to be successful in TI 2.0, including but not limited to:
    i. Procedures for screening all patients for social risks, coordinating referrals, and engaging other providers that serve that patient,
    ii. Procedures for identifying, tracking, and coordinating care for high-risk beneficiaries, and
    iii. Protocols for using beneficiary-centered, culturally sensitive, evidence-based practices in trauma-informed care.

If providers are approved to participate in TI 2.0, they will receive an incentive payment to create the infrastructure needed to meet the TI 2.0 metrics for the remaining demonstration years.

50. TI 2.0 Initiatives. Over the demonstration period, providers will be incentivized to implement certain processes and meet outcomes-based metrics. To meet these metrics providers will participate in the following activities, including but not limited to:

a. Implement national standards for Culturally and Linguistically Appropriate Services (CLAS).
b. Implement procedures to use a closed loop referral system to standardize referrals and coordination with community-based organizations.
c. Conduct population health analyses related to HRSN, identify populations with the greatest need for such services who are not getting them, and implement a plan to identify and address them.
d. Implement specialty-specific programs and processes such as postpartum depression screening in pediatric primary care programs, and tobacco cessation programs for patients transitioning from the criminal justice system.

51. Structure for Initiatives and Incentives.

a. Demonstration Year 1. Onboarding/application year – Providers apply and are accepted into TI 2.0. Incentive payments to support infrastructure and staff enhancements critical to developing and implementing future milestones.
b. Demonstration Year 2. Develop Processed and Performance Measurement – Providers develop processes and procedures related to TI 2.0 initiatives. Providers can receive additional incentives for meeting or exceeding performance measure targets.
c. Demonstration Year 3. Demonstrate Processes and Performance Measurement – Providers demonstrate through a self-audit that Demonstration Year 2 procedures and processes have been successfully implemented. Providers can receive additional incentives for meeting or exceeding

performance measure targets.

d. Demonstration Year 4. Performance Measurement – Providers can receive incentives for meeting or exceeding performance measure targets. These performance measures may vary from the prior two years.
e. Demonstration Year 5. Performance Measurement – Providers continue Demonstration Year 4 performance measures and incentive structure.

52. Targeted Investments 2.0 Incentivized Metrics and Funding Protocol. No later than 90 calendar days after the approval of the demonstration, the state will submit to CMS a TI 2.0 Incentivized Metrics and Funding Protocol outlining a set of metrics focused on access to, utilization of, and quality of care and/or health outcomes that the state will systematically calculate and report for the state's demonstration beneficiaries attributed to the TI 2.0 participating providers as well as for the state's overall Medicaid beneficiary population. The metrics will, to the extent possible, leverage the national established quality measures, including but not limited to, Medicaid Adult, Child, and Maternity Core Sets, and will in general be reported once annually. The state can also propose other nationally recognized measures or appropriate metrics that are aligned with its demonstration goals pertinent to the TI 2.0 program, and related health equity considerations.

The state will work collaboratively with CMS through iterations of the Metrics Protocol to finalize an approvable set of incentivized metrics and prioritize collection of data on beneficiary sex, age, race, ethnicity, English language proficiency, primary language, disability status, and geography, to the extent feasible, and will use the data to identify disparities in access, health outcomes and quality and experiences of care.

The TI 2.0 Incentivized Metrics and Funding Protocol will outline for each of the selected metrics the reporting timeline, which might be impacted by the state's data systems readiness, the baseline reporting period, and the reporting frequency. The state will report the progress and metrics data through its Quarterly and/or Annual Monitoring Reports, per the reporting schedule that will be established in the Metrics Protocol. To the extent the state will require ramp-up time to set up data systems to be able to begin reporting the various metrics data overall or for any of the key subpopulations of interest, the state should provide regular updates to CMS on progress with data systems readiness via the Monitoring Reports. Once approved, the Targeted Investments 2.0 Incentivized Metrics and Funding Protocol will be appended to these STCs as Attachment I.

Specifically, this Incentivized Metrics and Funding Protocol must provide details on the structures for initiatives and incentives outlined in STC 51 above. The protocol, for example, must outline the performance targets for each selected metric and the potential incentive amount associated with it that providers will receive if the performance target is met. As applicable, the protocol will establish the improvement targets for each of the selected metrics over the life-cycle of the demonstration approval period by each demonstration year. The state must provide information not already captured in the STCs about the funding available for incentive payments for each demonstration year. If providers take on risk under the arrangement, the state must describe the percentage and amount of funding that is at-risk. The protocol must also describe the state's carry-forward authority for any funds that are unused or unclaimed, including funds for incentive payments. Details must be included on what these funds will be used for, such as redistributing the funds to other initiatives or allowing participating providers to receive unearned funds in the next performance period.

53. Funding Limit. Pursuant to 42 CFR 438.6(c), AHCCCS may include in the actuarially sound capitation rates paid to managed care entities up to $250 million total for the period of October 14, 2022, through September 30, 2027, in directed incentive payments to providers at primary care clinics, behavioral health care clinics, integrated clinics, and justice clinics that identify and address social risk factors to mitigate health disparities that improve health outcomes for Medicaid beneficiaries, and achieve AHCCCS defined targets for performance improvement. In accordance with STC 80 the actual payment to the managed care entities may occur after September 30, 2027. The payments for the TI 2.0 Program will be paid annually to the managed care entities after the close of the contract period based on AHCCCS-determined target attainment of providers. AHCCSS will send contracted plans 1) plan-specific payment files delineating payment amount per provider, and 2) sufficient funds to cover the aggregate incentive amount. The contracted health plans will subsequently send the appropriate payments identified as TI 2.0 incentives to the contracted organization. The final amounts of the targeted payment amounts paid for the contract period must retrospectively be cost allocated across rate cells in an actuarially sound manner and in alignment with the described payment adjustment in the approved template for payments made under 438.6(c). Additionally, the total of all payments under the contract must be actuarially sound and in compliance with part 438. These capitation rates, which include amounts allocable to directed incentive payments and any associated taxes and managed care entity administration costs, are eligible for FFP at the state's FMAP for individual rate cells affected by the incentive payments.

Of the total $250 million, the state may expend up to $20 million to support the administration, including state level reporting and evaluation of the TI 2.0 Program. These administrative expenses will be eligible for FFP at the administrative match rate of 50 percent.

Table 4 – Estimated Annual Funding Distribution for the Targeted Investments 2.0 Program

Programs	DY12	DY13	DY14	DY15	DY16	Totals
Targeted Investments	$16.1 m.	$59.8m.	$62.1 m.	$50.6 m.	$41.4 m.	$230 m.
Administration	$3.298m	$4.078 m.	$4.412 m.	$3.925 m.	$4.287 m.	$20 m.
Totals	$19.398 m.	$63.878 m.	$66.512 m.	$54.5255 m.	$45.687 m.	$250 m.

54. Provider Payment Criteria. The state shall ensure that the contracts with managed care entities for provider performance payments adhere to the requirements in 42 CFR 438.6 (81 FR 27859-61) and sub-regulatory guidance unless otherwise explicitly modified by these STCs.

IX. DESIGNATED STATE HEALTH PROGRAMS (DSHP)

55. Designated State Health Programs (DSHP). The state may claim FFP for designated state health programs subject to the limits described below. This DSHP authority will allow the state to support the TI 2.0 Program and H2O Program and Infrastructure, as described in STC 30-54. This DSHP authority will be available from DY12-DY16.

a. The DSHP will have an established limit in the amount of $440,890,944 total computable expenditures, in aggregate, for DY12-DY16.

b. The state may claim FFP for DSHP up to the annual amounts outlined in Table 5, plus any unspent amounts from prior years. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed the demonstration period, and the state may claim the remaining amount in a subsequent demonstration year.

Table 5 – Annual Limits in Total Computable Expenditures for DSHP.

	DY12	DY13	DY14	DY15	DY16
Total Computable Expenditures	$88,178,188	$88,178,188	$88,178,188	$88,178,188	$88,178,188

c. The state must contribute $39,962,750 in original, non-freed up DSHP funds for the 5-year demonstration period towards its initiative described in STCs 29-53. These funds may only derive from other allowable sources of non-federal share, and must otherwise meet all applicable requirements of these STCs and the Medicaid statute and regulations.
d. The state attests, as a condition of receipt of FFP under the DSHP expenditure authority, that all non-federal share for the DSHP is allowable under all applicable statutory and regulatory requirements, including section 1903(w) of the Act and its implementing regulations. The state acknowledges that approval of the DSHP expenditure authority does not constitute approval of the underlying sources of non-federal share, which may be subject to CMS financial review.
e. As a post-approval protocol, the state shall submit an Approved DSHP List identifying the specific state programs for which FFP in expenditures can be claimed within 90 days of the demonstration approval date. The Approved DSHP List will be subject to CMS approval and will be limited to programs that are population- or public health-focused, aligned with the objectives of the Medicaid program with no likelihood that the program will frustrate or impede the primary objective of Medicaid to provide coverage of services for low-income and vulnerable populations, and serve a community largely made up of low-income individuals. Only after CMS approves the list and ensures that none of the requested state programs fall within the exclusions listed in STC 56 can the state begin claiming FFP for DSHP expenditures. The Approved DSHP List will be appended to the STCs as Attachment P.

56. Prohibited DSHP Expenditures.

a. Allowable DSHP expenditures do not include any expenditures that are funded by federal grants or other federal sources (for example, American Rescue Plan Act funding, grants from the Health Resources and Services Administration, the Centers for Disease Control and Prevention, etc.) or that are included as part of any maintenance of effort or non-federal share requirements of any federal grant.
b. Additionally, allowable DSHP expenditures do not include expenditures associated with the provision of non-emergency care to individuals who do not meet citizenship or immigration status requirements to be eligible for Medicaid. To implement this limitation, 3.9 percent of total provider expenditures or claims through DSHP identified as described in STC 55 will be treated as expended for non-emergency care to individuals who do not meet immigration status or citizenship requirements, and thus not matchable. This adjustment is reflected in the total computable amounts of DSHP described in STC 55.

c. The following types of expenditures are not permissible DSHP expenditures: expenditures that are already eligible for federal Medicaid matching funds or other sources of federal funding, that are generally part of normal operating costs that would be included in provider payment rates, that are not likely to promote the objectives of Medicaid, or otherwise prohibited by federal law. Exclusions that have historically fallen into these categories include, but are not limited to:
    i. Bricks and mortar;
    ii. Shelters, vaccines, and medications for animals;
    iii. Coverage/services specifically for individuals who are not lawfully present or are undocumented;
    iv. Revolving capital funds; and
    v. Non-specific projects for which CMS lacks sufficient information to ascertain the nature and character of the project and whether it is consistent with these STCs.

57. DSHP-Funded Initiatives.

a. **Definition.** DSHP-funded initiatives are Medicaid or CHIP section 1115 demonstration activities supported by DSHPs.
b. **Requirements.** Expenditures for DSHP-funded initiatives are limited to costs not otherwise matchable under the state plan. CMS will only approve those DSHP-funded initiatives that it determines to be consistent with the objectives of the Medicaid statute; specifically, to expand coverage (e.g., new eligibility groups or benefits), improve access to covered services including home- and community-based services and behavioral health services, improve quality by reducing health disparities, or increase the efficiency and quality of care. Funding for DSHP-funded initiatives will not be supplanting, nor merely supplementing existing services or programs. DSHP-funded initiatives must be new services or programs within the state. Funding for DSHP-funded initiatives specifically associated with infrastructure start-up costs for new initiatives is time limited to the current demonstration period and will not be renewed.
c. **Approve DSHP-Funded Initiatives.** The initiatives listed below are approved DSHP-funded initiatives for this demonstration. Any new DSHP-funded initiative requires approval from CMS via an amendment to the demonstration that meets the applicable transparency requirements.
    i. TI 2.0 Program
    ii. H2O (HRSN Services)
    iii. H2O Infrastructure (HRSN Infrastructure)

58. DSHP Claiming Protocol. The state will develop and submit to CMS within 150 calendar days of the approval of the AHCCCS demonstration extension, a DSHP Claiming Protocol subject to CMS approval with which the state will be required to comply in order to receive FFP in DSHP expenditures. State expenditures for the DSHP must be documented in accordance with the protocol. The state is not eligible to receive FFP until the protocol is approved by CMS. Once approved by CMS, the protocol becomes Attachment D to these STCs, and thereafter may be changed or updated only with CMS approval. Changes and updates are to be applied prospectively. In order to claim FFP for DSHP expenditures, the state will provide CMS a summary worksheet that identifies DSHP expenditures by program each quarter.

a. For all eligible DSHP expenditures, the state will maintain and make available to CMS upon request:
    i. Certification or attestation of expenditures.

ii. Actual expenditure data from state financial information system or state client sub-system. The Claiming Protocol will describe the procedures used that ensure that FFP is not claimed for the non-permissible expenditures listed in STC 56.

b. The state will claim FFP for DSHP quarterly based on actual expenditures.

59. DSHP Claiming Process. Documentation of all DSHP expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS. Federal funds must be claimed within two years after the calendar quarter in which the state disburses expenditures for the DSHPs.

a. Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. To the extent that DSHPs receive federal funds from any other federal programs, such funds shall not be used as a source of non-federal share to support expenditures for DSHPs or DSHP-funded initiatives under this demonstration.

b. The administrative costs associated with DSHPs (that are not generally part of normal operating costs for service delivery) shall not be included in any way as demonstration and/or other Medicaid expenditures.

c. DSHP will be claimed at administrative matching rate of 50 percent.

d. Expenditures will be claimed in accordance with the CMS-approved DSHP Claiming Protocol in Attachment D.

60. Sustainability Plan. The DSHP Sustainability Plan will describe the scope of DSHP-funded initiatives the state wants to maintain and the strategy to secure resources to maintain these initiatives beyond the current approval period. The state shall submit the DSHP Sustainability Plan to CMS no later than the end of September 30, 2025, after the approval of this authority. Upon CMS approval, the plan will become Attachment M to these STCs. Any future modifications for the DSHP Sustainability Plan will require CMS approval.

X. PROVIDER PAYMENT RATE INCREASE REQUIREMENT

61. The provider payment rate increase requirements, in Arizona, described hereafter are a condition for expenditure authorities as referenced in Expenditure Authority 16, 17, 18, and 19.

62. As a condition of approval and ongoing provision of FFP in DSHP and related expenditures over this demonstration period of performance, DY12 through DY16, the state will in accordance with these STCs increase and (at least) subsequently sustain, through DY16, Medicaid fee-for-service provider base rates, and require any relevant Medicaid managed care plan to increase for DY14 and (at least) subsequently sustain through DY16, network provider payment rates by at least two percentage points in the ratio of Medicaid to Medicare provider rates for each of the services that comprise the state’s definition of primary care, behavioral health care, or obstetric care, as relevant, if the average Medicaid to Medicare provider payment rate ratio, as determined by STC 68 for a representative sample of these services for any of these three categories of services is below 80 percent. If the average Medicaid to Medicare provider rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent for only the state’s Medicaid fee-for-service program or only Medicaid managed care, the state shall only be required to increase provider payments for the delivery system for which the ratio is below 80 percent.

63. State funds available as a result of receiving FFP in DSHP expenditures cannot be used to finance provider rate increases required under this section. Additionally, the state may not decrease provider payment rates

for other Medicaid- or demonstration-covered services for the purpose of making state funds available to finance provider rate increases required under this section (i.e., cost-shifting).

64. The state will, for the purposes of complying with these requirements to derive the Medicaid to Medicare provider payment rate ratio and to apply the rate increase as may be required under this section, identify the applicable service codes and provider types for each of the primary care, behavioral health, and obstetric care services, as relevant, in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition of behavioral health services.

65. By January 12, 2023, and if the state makes fee-for-service payments, the state must establish and report to CMS the state's average Medicaid to Medicare fee-for-service provider rate ratio for each of the three service categories – primary care, behavioral health and obstetric care, using either of the methodologies below:

a. Provide to CMS the average Medicaid to Medicare provider rate ratios if applicable for each of the three categories of services as these ratios are calculated for the state and service category as noted in the following sources:
    i. For primary care and obstetric care services, in Zuckerman, et al. 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." Health Affairs 40(2): 343–348 (Exhibit 3); and
    ii. For behavioral health services, the category called, 'Psychotherapy' in Clemans-Cope, et al. 2022. "Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021." Substance Abuse Treatment, Prevention, and Policy (2022) 17:49 (Table 3); OR
b. Provide to CMS for approval for any of the three service categories the average ratio, as well as the code sets, code level Medicaid utilization, Medicaid and Medicare rates, and other data used to calculate the ratio, and the methodology for the calculation of the ratio under this alternative approach as specified below:
    i. Service codes must be representative of each service category as defined in STC 64;
    ii. Medicaid and Medicare data must be from the same year and not older than 2019; and
    iii. The state's methodology for determining the year of data, the Medicaid code-level utilization, the service codes within the category, the geographic rate differentials for Medicaid and/or Medicare services and their incorporation into the determination of the category average rate, the selection of the same or similar Medicare service codes for comparison, and the timeframes of data and how alignment is ensured should be comprehensively discussed in the methodology as provided to CMS for approval.

66. To establish the state's ratio for each service category identified in STC 64 as it pertains to managed care plans' provider payment rates in the state, the state must provide to CMS either:

a. The average fee-for-service ratio as provided in STC 65(a), if the state and CMS determine it to be a reasonable and appropriate estimate of, or proxy for, the average provider rates paid by managed care plans (e.g., where managed care plans in the state pay providers based on state plan fee-for-service payment rate schedules); or
b. The data and methodology for any or all of the service categories as provided in STC 65(b) using Medicaid managed care provider payment rate and utilization data.

67. In determining the ratios required under STC 65(a) and (b), the state may not incorporate fee-for-service supplemental payments that the state made or plans to make to providers, or Medicaid managed care pass-through payments in accordance with 42 CFR 438.6(a), and 438.6(d).

68. If the state is required to increase provider payment rates for managed care plans per STC 62 and 66, the state must:

a. Comply with the requirements for state-directed payments in accordance with 42 CFR 438.6(c), as applicable; and
b. Ensure that the entirety of the percentage increase applied to the provider payment rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans.

69. For the entirety of DY14 through DY16, the provider payment rate increase for each service in a service category and delivery system for which the average ratio is less than 80 percent will be an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points over the highest rate for each service in DY12, and such rate will be in effect on the first day of DY14. A required payment rate increase for a delivery system shall apply to all services in a service category as defined under STC 64.

70. If the state uses a managed care delivery system for any of the service categories defined in STC 64, for the beginning of the first rating period as defined in 42 CFR 438.2(a) that starts in each demonstration year from DY14 through DY16, the managed care plans' provider payment rate increase for each service in the affected categories will be no lower than the highest rate in DY12 plus an amount necessary so that the Medicaid to Medicare ratio for that service increases by two percentage points. The payment rate increase shall apply to all services in a service category as defined under STC 64.

71. The state will provide the information to document the payment rate ratio required under STC 65 and 65, via submission to the Performance Metrics Database and Analytics (PMDA) portal for CMS review and approval.

72. For demonstration years following the first year of provider payment rate increases, the state will provide an annual attestation within the state's annual demonstration monitoring report that the provider payment rate increases subject to these STCs were at least sustained from, if not higher than, the previous year.

73. No later than January 12, 2023, the state will provide to CMS the following information and Attestation Table signed by the State Medicaid Director, or by the Director's Chief Financial Officer (or equivalent position), to PMDA, along with a description of the state's methodology and the state's supporting data for establishing ratios for each of the three service categories in accordance with STC 65 and 66 for CMS review and approval, at which time the Attestation Table will be appended to the STCs as Attachment N:

Arizona Provider Payment Rate Increase Assessment – Attestation Table		
The reported data and attestations pertain to provider payment rate increase requirements for the demonstration period of performance DY12 thru DY16		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-service Ratio**	**Medicaid Managed Care to Medicare Fee-for-service Ratio**

Primary Care Services	[*insert percent, or N/A if state does not make Medicaid fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories*]
	[*insert approach, either ratio derived under STC 65(a) or STC 65(b)*]	[*insert approach, either ratio derived under STC 66(a) or STC 66(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio*]
Obstetric Care Services	[*insert percent, or N/A if state does not make fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for providers for covered service categories*]
	[*insert approach, either ratio derived under STC 65(a) or STC 65(b)*]	[*insert approach, either ratio derived under STC 66(a) or STC 66(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio*]
Behavioral Health Services	[*insert percent, or N/A if state does not make fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]*
	[*insert approach, either ratio derived under STC 65(a) or STC 65(b)*]	[*insert approach, either ratio derived under STC 66(a) or STC 66(b); insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio*]
In accordance with STCs 60 through 71, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments or Medicaid managed care pass-through payments under 42 CFR 438.6(a) and 438.6(d), I attest that at least an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points will be applied to each of the services in each of the three categories with a ratio below 80 percent in both fee-for-service and managed care delivery systems as applicable to the state's Medicaid or demonstration service delivery model. Such provider payment rate increases for		

each service will be effective beginning on [*insert date*] and will not be lower than the highest rate for that service code in DY12 plus an amount necessary so that the Medicaid to Medicare ratio increases by two percentage point relative to the rate for the same or similar Medicare billing code through at least [*insert date*].

For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a fee-for-service delivery system or under a managed care delivery system, as applicable, the state agrees to define primary care, behavioral health and obstetric care, and to identify applicable service codes and provider types for each of these service categories in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition.

The services that comprise each service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services.

For provider payment rates paid under a managed care delivery system, the data and methodology for any one of the service categories as provided in STC 66(b) will be based on Medicaid managed care provider payment rate and utilization data.

[*Select the applicable effective date, must check either a. or b.*]
☐ a. The effective date of the rate increases is the first day of DY14 and will be at least sustained, if not higher, through DY16.
☐ b. Arizona has a biennial legislative session that requires provider payment rate approval and the timing of that session precludes the state from implementing the provider payment rate increase on the first day of DY14. Arizona will effectuate the rate increases no later than the CMS approved date of [*insert date*], and will sustain these rates, if not made higher, through DY16.

Arizona [*insert does or does not*] make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and / or obstetric care.

For any such payments, I agree to submit by no later than [*insert date*] for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than [*insert date*]

Arizona [*insert does or does not*] include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable

providers for at least some populations: primary care, behavioral health, and or obstetric care. For any such payments, I agree to submit the Medicaid managed care plans' provider payment rate increase methodology, including the information listed in STC 67 through the state-directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than *[insert date*].
If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 68, I attest that necessary arrangements will be made to assure that 100 percent of the amount necessary so that the Medicaid to Medicare ratio increases by two percentage points will be paid by managed care plans to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.
Arizona agrees not to use DSHP funding to finance any provider payment rate increase required under Section X, and will ensure that the entirety of a two percentage point increase applied to the provider payment rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans. Arizona further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under Section X.
I, *[insert name of SMD or CFO (or equivalent position*] [*insert title*], attest that the above information is complete and accurate. [*Provide signature*_____] [*Provide printed name of signatory* _____] [*Provide date*_____]

XI. PAYMENTS UNDER THE DEMONSTRATION.

74. Payments to IHS and Tribal Facilities. The state is authorized to make payments for Medicaid coverable services that were eliminated from, reduced, or limited in the Arizona Medicaid State Plan on or after September 2010, including payments for medically necessary diagnostic, therapeutic, and preventative dental services. This authority applies only if the services are provided to American Indian/Alaskan Native (AI/AN) beneficiaries by participating IHS facilities and/or participating facilities operated by tribes under the Indian Self-Determination and Education Assistance Act (ISDEAA).

XII. DELIVERY SYSTEMS

75. Arizona Complete Care (ACC). The ACC is a statewide, managed care system, which delivers health services through contracts with Managed Care Organizations (MCOs) that AHCCCS calls "Health Plans."

Enrollees, other than enrollees with a need for an institutional level of care, receive integrated physical and behavioral health care services through a single ACC Plan including services to individuals with a Children's Rehabilitative Service (CSR) qualifying condition. With the following exceptions, ACC enrollees have a choice of MCOs consistent with 42 CFR 438.52:

a. ACC enrollees determined to have a SMI are enrolled with and receive integrated physical and behavioral health services from the single health plan designated in each of the northern, central, or southern Geographic Service Areas (GSA), referred to as an ACC-RBHA. In addition, the ACC-RBHA provides coverage for crisis services, as defined in the MCO agreement, for all eligible persons in the GSA.

Children in foster care are enrolled with and receive physical and treatment for CRS conditions through an MCO, the Comprehensive Health Plan (CHP), operated by the Arizona Department of Child Safety.

76. Arizona Long Term Care System (ALTCS). ALTCS is administered through a statewide, managed care system which delivers physical, behavioral, long-term care services and supports (including home-and-community based services), and treatment for CRS conditions through contractors with MCOs that AHCCCS calls "Program Contractors." ALTCS beneficiaries in the Elderly and Physically Disabled (EPD) population, including those determined to have a SMI, receive integrated care through ALTCS/EPD Program Contractors. All ALTCS beneficiaries with a developmental disability (DD) and a need for an institutional level of care are enrolled with and receive services through an MCO operated by the Arizona Department of Economic Security (DES). DES provides LTSS to these enrollees and subcontracts with AHCCCS-contracted MCOs to provide physical, behavioral, and CRS services.

ALTCS/EPD contracts are awarded in the same geographic service areas as the ACC Plans. ALTCS/EPD enrollees in Maricopa, Gila, Pinal (outside the San Carlos Indian Reservation), and Pima Counties have a choice of Program Contractors, but ALTCS/EPD enrollees in the rest of the state enroll in the single Program Contractor for their GSA. The ALTCS contract with the Arizona DES/DDD provides coverage on a statewide basis of the full ALTCS benefit package to all eligible individuals with developmental disabilities. Under state law, A.R.S. 36-2940, AHCCCS is required to enter into an intergovernmental agreement (IGA) with DES/DDD to serve as the Program Contractor for individuals with developmental disabilities. The DES/DDD ALTCS contract is an at-risk MCO contract that complies with 42 C.F.R. Part 438 and as such is reviewed and approved by CMS. Payments to DES/DDD under the ALTCS contract shall not include any payments other than payments that meet the requirements of 42 CFR 438.3(c) and 438.4 through 438.8 including the requirement that all payments and risk-sharing mechanisms in the contract are actuarially sound. State law, A.R.S. 36-2953, requires DES/DDD to maintain a separate fund to account for all revenues and expenditures under the ALTCS contract and limits use of the fund for the administration of the ALTCS contract.

77. Children Rehabilitative Services (CRS). Historically, Arizona had a separate MCO to provide treatment services relating to children with certain chronic illnesses and disabilities. Coverage of those treatment services is now the responsibility of the beneficiary's ACC plan (including ACC-RBHA and the CHP plan) or ALTCS program contractor.

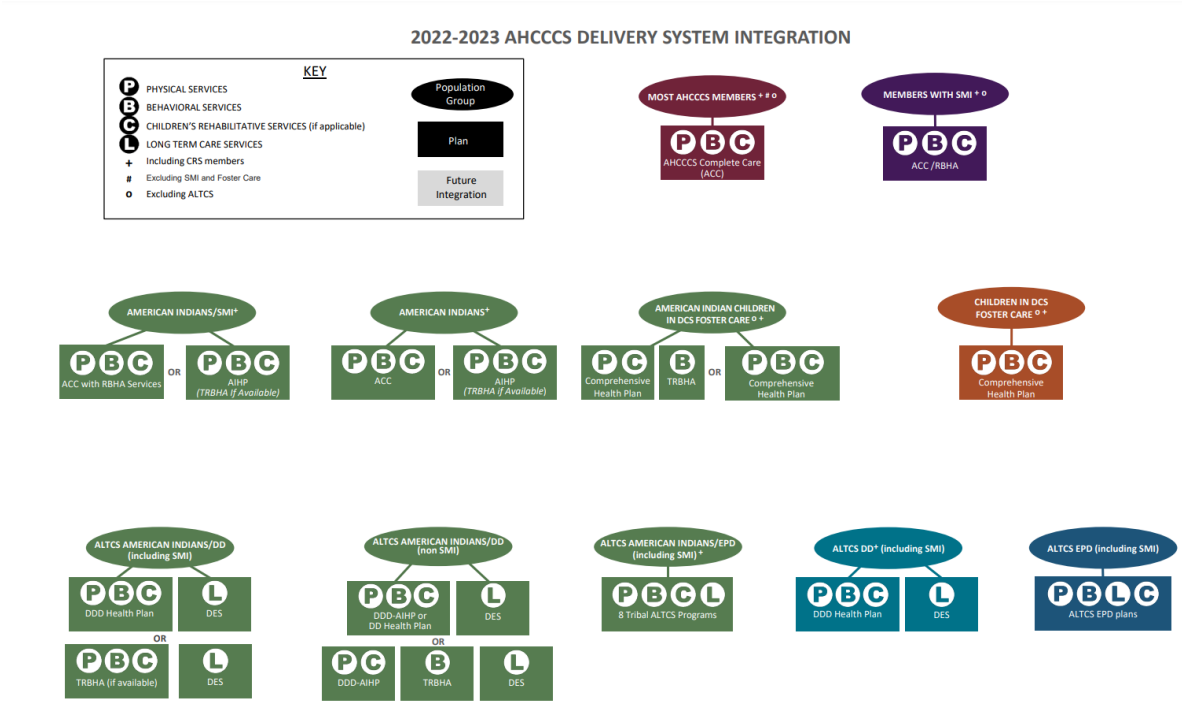
78. American Indians/Alaska Natives (AI/AN). Medicaid-eligible AI/AN may, but are not required to, participate in managed care with the following exceptions:

a. AI/AN children in foster care are enrolled with and receive physical and treatment for CRS

conditions through an MCO, the Comprehensive Health Plan (CHP), operated by the Arizona Department of Child Safety. These children have the option to receive behavioral health services through either the CHP or a Tribal Regional Behavioral Health Authority (TRBHA) with a TRBHA is available.

b. Medicaid-eligible AI/AN with a developmental disability and a need for an institutional level of care (i.e., are ALTCS/DD enrollees) are enrolled with and receive services through an MCO operated by the Arizona Department of Economic Security (DES) or on a Fee-for-Service basis if they chose to enroll with the Tribal Health Program (THP) option. DES provides LTSS to these enrollees and subcontracts with AHCCCS-contracts MCOs to provide physical, behavioral, and CRS services. THP also offers these same services. These AI/AN enrollees also have the option to receive behavioral and CRS services through a TRBHA when available. LTSS are provided on a managed care basis through DES.

c. Medicaid-eligible AI/AN with a need for an institutional level of care whose eligibility is based on age or a physical disability (i.e. are ALTCS/EPD enrollees) are enrolled with an receive physical, behavioral, CRS, and LTSS from one of eight Tribal ALTCS programs. AHCCCS enters into Intergovernmental Agreements with seven tribes and one contract to ensure coverage of all Arizona's twenty-two federally recognized tribes for ALTCS beneficiaries living on reservation.



79. Contracts. All contracts and modifications of existing contracts between the state and MCOs must be prior approved by CMS.

80. Compliance with Managed Care Regulations. The state, its MCOs and any subcontractor delegated to perform activities under the managed care contract, must comply with the managed care regulations published in 42 CFR part 438, except as expressly waived or specified as not applicable to an expenditure authority.

XIII. MONITORING AND REPORTING REQUIREMENTS

81. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singularly or collectively referred to as "deliverable(s)")) are not submitted timely to CMS or are found to be inconsistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

In the event that either (1) the state has not submitted a written request to CMS for approval of an extension, as described below, within 30 calendar days after a deliverable was due, or (2) the state has not submitted a revised submission or a plan for corrective action to CMS within 30 calendar days after CMS has notified the state in writing that a deliverable was not accepted for being inconsistent with the requirements of this agreement including the information needed to bring the deliverable into alignment with CMS requirements; the following process is triggered:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submission of required deliverable(s). For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided.
b. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.
c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action steps or still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.
d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.
e. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

82. Submission of Post-Approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

83. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional section 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
b. Ensure all section 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and
c. Submit deliverables to the appropriate system as directed by CMS.

84. New Initiatives Implementation Plan. The state is required to submit a New Initiatives Implementation Plan ("Implementation Plan") to cover certain key policies being tested under this demonstration, including those approved through any amendments. The Implementation Plan will contain applicable information for the following expenditure authorities: DSHP-funded initiatives, which includes HRSN Infrastructure, HRSN Services, and TI 2.0. The Implementation Plan, at a minimum, must provide a description of the state's strategic approach to implementing these demonstration policies, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation.

The state must submit the Maintenance of Effort information required by STC 45 for CMS approval no later than 90 calendar days after approval of this demonstration. All other Implementation Plan requirements outlined in this STC must be submitted for CMS approval no later than 9 months after the approval of this demonstration. The state must submit any required clarifications or revisions to their Implementation Plan submission within 60 calendar days after receipt of CMS feedback. Once approved, the finalized Implementation Plan will be incorporated into the STCs as Attachment F and may be further altered only with CMS approval.

In the Implementation Plan, the state is expected only to provide additional details regarding the implementation of the demonstration policies that are not already captured in the STCs or available elsewhere publicly. Furthermore, for the state's HRSN-related authorities, the Implementation Plan does not need to repeat any information submitted to CMS in the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for H2O Services (see STC 36); however, as applicable, the information provided in the two deliverables must be aligned and consistent with one another.

The Implementation Plan does not need to duplicate information that pertains to more than one initiative, assuming the information is the same. The Implementation Plan can be updated as necessary to align with state operations. CMS may provide the state with a template to support the state in developing and obtaining approval of the Implementation Plan.

The Implementation Plan must include information on, but not limited to, the following:

a. A plan for establishing and/or improving data sharing and partnerships with an array of health system and social services stakeholders to the extent those entities are vital to provide needed administrative and HRSN-related data on screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation
b. Information about key partnerships related to HRSN service delivery, including plans for capacity building for community partners and for soliciting and incorporating input from impacted groups (e.g., community partners, health care delivery system partners, and beneficiaries)
c. Plans for changes to information technology (IT) infrastructure that will support HRSN-related data exchange, including development and implementation of data systems necessary to support program

implementation, monitoring, and evaluation. These existing or new data systems should, at a minimum, collect data on beneficiary characteristics, eligibility and consent, screening, referrals, and service provision.

d. A plan for tracking and improving the share of Medicaid beneficiaries who are eligible and enrolled in the Supplemental Nutrition Assistance Program (SNAP), the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and federal and state housing assistance programs, relative to the number of total eligible beneficiaries, including establishing a timeline for reporting.
e. An implementation timeline and evaluation considerations impacted by the timeline, such as staged rollout that can facilitate robust evaluation designs if these implementation strategies are culturally appropriate
f. Information as required per STC 44 (HRSN Rate Methodologies)
g. Information as required per STC 45 (MOE)
h. Information as required per STC 46 (Partnerships with State and Local Entities)

Failure to submit the Implementation Plan will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the H2O Infrastructure, H2O Services, and/or DSHP-funded programs under this demonstration, as applicable.

85. Monitoring Protocol. The state must submit to CMS a Monitoring Protocol no later than 150 calendar days after the approval of the demonstration. The state must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS's comments. Once approved, the Monitoring Protocol will be incorporated in the STCs as Attachment G. In addition, the state must submit an updated or a separate Monitoring Protocol for any amendments to the demonstration no later than 150 calendar days after the approval of the amendment. Such amendment Monitoring Protocols are subject to the same requirement of revisions and CMS approval, as described above.

At a minimum, the Monitoring Protocol must affirm the state's commitment to conduct Quarterly and Annual Monitoring Reports in accordance with CMS's guidance and technical assistance and using CMS-provided reporting templates, if applicable. Any proposed deviations from CMS's guidance should be documented in the Monitoring Protocol. The Monitoring Protocol must describe the quantitative and qualitative elements on which the state will report through Quarterly and Annual Monitoring Reports. For the overall demonstration as well as specific policies where CMS provides states with a suite of quantitative monitoring metrics (e.g., the performance metrics described in STC 86), the state is required to calculate and report such metrics leveraging the technical specifications provided by CMS. The Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the demonstration's progress as part of the Quarterly and Annual Monitoring Reports. In alignment with CMS guidance, the Monitoring Protocol must additionally specify the state's plans and timeline on reporting metrics data stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography) and demonstration component.

For the HRSN services authorized through this demonstration, the Monitoring Protocol requires specifying a selection of quality of care and health outcomes metrics and population stratifications based on CMS's upcoming guidance on the Health Equity Measure Slate, and outlining the corresponding data sources and reporting timelines. This slate of measures represents a critical set of equity-focused metrics known to be

important for closing key equity gaps in Medicaid/CHIP (e.g. the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritizes key outcome measures and their clinical and non-clinical (i.e. social) drivers. The Monitoring Protocol must also outline the state's planned approaches and parameters to track performance relative to the goals and milestones, as provided in the implementation plan, for the HRSN infrastructure investments.

In addition, the state must describe in the Monitoring Protocol methods to collect and analyze non-Medicaid administrative data to help calculate applicable monitoring metrics. These sources may include, but are not limited to (1) community resource referral platforms, (2) records of social services receipt from other agencies (such as SNAP or TANF benefits, or HUD assistance), (3) other data from social services organizations linked to beneficiaries (such as, services rendered, resolution of identified need, etc., as applicable), and (4) social needs screening results from electronic health records, health plans, or other partner agencies. Across data sources, the state must make efforts and consult with relevant non-Medicaid social service agencies to collect data in ways that support analyses of data on beneficiary subgroups.

For the qualitative elements (e.g., operational updates as described in STC 86(a) below), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's Quarterly and Annual Monitoring Reports.

86. Monitoring Reports. The state must submit three Quarterly Monitoring Reports and one Annual Monitoring Report each DY. The fourth-quarter information that would ordinarily be provided in a separate Quarterly Monitoring Report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than 60 calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including the fourth-quarter information) is due no later than 90 calendar days following the end of the DY. The state must submit a revised Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Quarterly and Annual Monitoring Reports must follow the framework to be provided by CMS, which is subject to change as monitoring systems are developed/evolve, and must be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates. Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports must provide sufficient information to document key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. Monitoring Reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.
b. Performance Metrics. The performance metrics will provide data to demonstrate how the state is progressing towards meeting the goals and milestones—including relative to their projected timelines—of the demonstration's program and policy implementation and infrastructure investments, and must cover all key policies under this demonstration. Additionally, per 42 CFR

431.428, the Monitoring Reports must document the impact of the demonstration on beneficiaries' outcomes of care, quality and cost of care, and access to care. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals.

i. The demonstration's metrics reporting must cover categories to include, but not limited to: enrollment and renewal, access to providers, utilization of services, unpaid medical bills at application and quality of care and health outcomes. For the KidsCare expansion amendment, the state should also report the number of beneficiaries subject to premiums, enrollment by premium payment status, including the payment of premiums on time, and loss of benefits due to nonpayment of premiums. The state should also report payment-related and provider-level metrics, if applicable. The state must undertake robust reporting of quality of care and health outcomes metrics aligned with the demonstration's policy composition and objectives, to be reported for all demonstration populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography) and demonstration components. Subpopulation reporting will support identifying any existing disparities in quality of care and health outcomes, and help track whether the demonstration's initiatives help narrow certain inequities, while improving the outcomes for the state's overall Medicaid population. To that end, CMS underscores the importance of the state's reporting of quality of care and health outcomes metrics known to be important for closing key equity gaps in Medicaid/CHIP (e.g. the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritization of key outcome measures and their clinical and non-clinical (i.e. social) drivers of health. In coordination with CMS, the state is expected to select such measures for reporting in alignment with a critical set of equity-focused measures CMS is finalizing as part of its upcoming guidance on the Health Equity Measure Slate.

ii. For the H2O demonstration component, in addition to reporting on the metrics described above, the state must track beneficiary participation, screening, receipt of referrals and social services over time, as well as narratively report on the adoption of information technology infrastructure to support data sharing between the state or partner entities assisting in the administration of the demonstration and social services organizations. In alignment with STC 46, the state must additionally monitor and provide narrative updates on its progress in building and sustaining its partnership with existing housing agencies to leverage their expertise and existing housing resources instead of duplicating services. Furthermore, the state's enrollment and renewal metrics must also capture baseline data and track progress via Monitoring Reports for the percent of Medicaid renewals completed ex-parte (administratively), as well as the percentage of Medicaid beneficiaries enrolled in other public benefit programs (such as SNAP and WIC) for which they are eligible. The Monitoring Reports must also provide status updates in accordance with the Monitoring Protocol on the implementation of infrastructure investments tied to the HRSN initiatives.

iii. In order to ensure a link between DSHP-funded initiatives and improvements in health equity and beneficiary health outcomes, CMS and the state will coordinate to use the critical set of equity metrics outlined above, with applicable demographic stratification. In addition, the state must demonstrate through its annual monitoring reporting to CMS improvements in Medicaid fee-for-service base provider reimbursement rates and managed care reimbursement rates and that they are sustained, in accordance with the DSHP-related STCs (Section IX).

iv. As applicable, if the state, health plans, or health care providers will contract or partner with

organizations to implement the demonstration, the state must use monitoring metrics that track the number and characteristics of contracted or participating organizations in specific demonstration programs and corresponding payment-related metrics; these metrics are specifically relevant for the state's H2O and the DSHP-funded initiatives.

The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the CMS framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the CMS-64.
d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

87. Corrective Action Plan Related to Monitoring. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11. CMS will withdraw an authority, as described in STC 11, when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

88. Close-Out Report. Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The Close-Out Report must comply with the most current guidance from CMS.
b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in 101 and 102, respectively.
c. The state will present to and participate in a discussion with CMS on the Close-Out report.
d. The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.
e. A revised Close-Out Report is due to CMS no later than 30 days after receipt of CMS's comments.
f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 81.

89. Contractor Reviews. The state will forward summaries of the financial and operational reviews that:

a. The Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD) performs on its subcontracting MCOs.
b. The state will also forward summaries of the financial and operational reviews that AHCCCS completes on the Comprehensive Health Plan (CHP) at the Arizona DCS.

90. Contractor Quality. AHCCCS will require the same level of quality reporting for DCS/DDD and DCS/CHP as for Health Plans and Program Contractors, which include RBHAs, subject to the same time lines and penalties.

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

92. Monitoring Calls. CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to), any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, budget neutrality, and progress on evaluation activities.
b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.
c. The state and CMS will jointly develop the agenda for the calls.

93. Post Award Forum. Pursuant to 42 CFR 431.420(c), within 6 months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state must publish the date, time, and location of the forum in a prominent location on its website. The state must also post the most recent Annual Monitoring Report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the public comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Monitoring Report.

XIV. EVALUATION OF THE DEMONSTRATION

94. Cooperation with Federal Evaluators and Learning Collaboration. As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to: commenting on design and other federal evaluation documents; providing data and analytic files to CMS; entering into a data use agreement that explains how the data and data files will be exchanged; and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities that collect, produce, or maintain data and files for the demonstration, a requirement that they make data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. This may also include the state's participation—including representation from the state's contractors,

independent evaluators, and organizations associated with the demonstration operations, as applicable—in a federal learning collaborative aimed at cross-state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 81.

95. Independent Evaluator. The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party is to sign an agreement to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

96. Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be drafted in accordance with Attachment A (Developing the Evaluation Design) of these STCs, and any applicable CMS evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined culturally appropriate for the communities impacted by the demonstration, the state is encouraged to consider implementation approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic)—as these implementation strategies help create strong comparison groups and facilitate robust evaluation.

The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 99 and 100.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the Monitoring Reports. The amendment components of the Evaluation Design must also be reflected in the state's Interim and Summative Evaluation Reports, described below.

97. Evaluation Design Approval and Updates. The state must submit a revised Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon CMS approval of the draft Evaluation Design, the document will be included as Attachment H to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within 30 days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each of the Quarterly and Annual Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are

substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in Monitoring Reports.

98. Evaluation Questions and Hypotheses. Consistent with attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Report) of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as likelihood of enrollment and enrollment continuity, and measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, the Behavioral Risk Factor Surveillance System (BRFSS) survey, and/or measures endorsed by National Quality Forum (NQF).

Specifically, evaluation hypotheses for the H2O component of the demonstration must focus on assessing the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such assessment is expected to use applicable demonstration monitoring and other data on the prevalence and severity of beneficiaries' HRSNs and the provision of and beneficiary utilization of HRSN services. Furthermore, the HRSN evaluation must include analysis of how the initiatives affect utilization of preventive and routine care, utilization of and costs associated with potentially avoidable, high-acuity health care, and beneficiary physical and mental health outcomes. Hypotheses must be designed to help understand, in particular, the impacts of Arizona's housing support program on beneficiary health outcomes and experience. In alignment with the demonstration's objectives to improve outcomes for the state's overall beneficiary populations eligible for the HRSN initiatives, the state must also include research questions and hypotheses focused on understanding the impact of the HRSN initiatives on advancing health quality, including through the reduction of health disparities, for example, by assessing the effects of the initiatives in reducing disparities in health care access, quality of care, or health outcomes at the individual and/or community level.

The evaluation must also assess the effectiveness of the infrastructure investments authorized through the demonstration to support the development and implementation of the HRSN initiatives. The state must also examine whether and how state and local investments in housing supports change over time in concert with new Medicaid funding toward those HRSN services.

In addition, in light of how demonstration HRSN expenditures are being treated for budget neutrality, the evaluation of the HRSN initiative must include a cost analysis to support developing comprehensive and accurate cost estimates of providing such services. Evaluation of the H2O initiative is also required to include a robust assessment of potential improvements in the quality and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications.

The state's evaluation efforts must develop robust hypotheses and research questions to assess the effectiveness of the state's DSHP-funded initiatives in meeting the desired goals of such programs in advancing and complementing its broader HRSN and other applicable initiatives for its Medicaid beneficiaries and other low-income populations. The analysis must be designed to help demonstrate how these programs support, for example, expanding coverage, improving access, reducing health disparities, and/or enhancing home-and-community-based services or services to address HRSN or behavioral health. Furthermore, the state must develop hypotheses and research questions for its TI 2.0 program reduce health inequities related to utilization of preventative physical and behavioral health care services as well as high-cost utilization of inpatient and emergency department utilization, avoidance of inpatient and emergency department utilization, and efforts to improve quality and advance health equity.

The state must continue collecting necessary data to accommodate CMS's evaluation expectations to rigorously assess the effects of the waiver of prior quarter coverage on beneficiaries and providers. For example, hypotheses for the policy must relate to (but are not limited to) the following outcomes: likelihood of enrollment and enrollment continuity, enrollment when people are healthy, and health status (as a result of greater enrollment continuity) and financial status.

For the ACC, ALTCS, CHP, and RBHA components of the demonstration, the state must—as applicable—develop and test evaluation hypotheses and research questions in alignment with program goals. For the ACC component, hypotheses must assess (but not be limited to): care coordination, access to primary care and behavioral health services, rates of preventive and wellness services, and rates of emergency department (ED) visits (emergent and non-emergent) utilization. For the ALTCS component, hypotheses must address (but not be limited to): care coordination, access to primary, behavioral, and dental care services, rates of preventive care services, rates of hospitalization visits, rates of ED visits (emergent and non-emergent) utilization, and quality of life (e.g., living in own home). For the CHP component, hypotheses must address (but not be limited to): care coordination, access to primary, behavioral, and dental care services, rates of preventive and wellness services, rates of hospitalization visits, and rates of ED visits (emergent and non-emergent) utilization. For the RBHA component, hypotheses must address (but not be limited to): care coordination, access to primary and behavioral care services, rates of preventive and wellness services, rates of hospitalization visits, rates of ED visits (emergent and non-emergent), utilization management of behavioral health conditions, and utilization of different types of mental health services (e.g., outpatient, intensive outpatient, partial hospitalization, inpatient, ED, telehealth).

For the KidsCare eligibility expansion amendment, the state must develop hypotheses and research questions that assess the impact of expanding eligibility for the KidsCare program, including the premium requirement, on beneficiary enrollment, access, and health outcomes.

As part of its evaluation efforts, the state must also conduct a demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation, Medicaid health services expenditures, and provider uncompensated care costs. As noted above, the state must also analyze the budgetary effects of the HRSN services. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses together to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and experience with the various demonstration components, including but not limited to the HRSN and waiver of retroactive eligibility components, beneficiary experience with access to and quality of care, as well as changes in incidence of beneficiary medical debt. In addition, the state is strongly encouraged to evaluate the implementation of the demonstration programs in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of or barriers to successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Finally, the state must collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes, and help inform how the demonstration's various policies might support reducing such disparities.

99. Evaluation Budget. A budget for the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

100. Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Interim Evaluation Report should be posted to the state's website with the application for public comment.

a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.
b. For demonstration authority or any component within the demonstration that expires prior to the overall demonstration's expiration date, and depending on the timeline of the expiration/phase-out, the Interim Evaluation Report must include an evaluation of the authority, to be collaboratively determined by CMS and the state.
c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. If the state is not requesting an extension for a demonstration, an Interim Evaluation report is due one year prior to the end of the demonstration.
d. The state must submit a revised Interim Evaluation Report within 60 calendar days after receiving CMS's comments on the draft Interim Evaluation Report. Once approved by CMS, the state must post the final Evaluation Report to the state's Medicaid website within 30 calendar days.
e. The Interim Evaluation Report must comply with Attachment B (Preparing the Evaluation Report) of these STCs.

101. Summative Evaluation Report. The state must submit a draft Summative Evaluation Report for the

demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment B of these STCs, and in alignment with the approved Evaluation Design.

a. The state must submit a revised Summative Evaluation Report 60 calendar days after receiving CMS's comments on the draft.
b. Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid website within 30 calendar days.

102. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of a renewal process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

103. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report.

104. Public Access. The state shall post the final documents (e.g., Implementation Plan, Monitoring Protocol, Monitoring Reports, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

105. Additional Publications and Presentations. For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles, or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

XV. GENERAL FINANCIAL REQUIREMENTS

106. Allowable Expenditures. This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

107. Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

108. Sources of Non-Federal Share. As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.
b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.
c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

109. State Certification of Funding Conditions. As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.
b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The FFP paid to match CPEs may not be used as

the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

110. Financial Integrity for Managed Care Delivery Systems. As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

111. Requirements for Health Care-Related Taxes and Provider Donations. As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Act, 42 CFR 433.66, and 42 CFR 433.54.

112. State Monitoring of Non-Federal Share. If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the

demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 81. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state or other entities relating to each locality tax or payments received that are funded by the locality tax;
b. Number of providers in each locality of the taxing entities for each locality tax;
c. Whether or not all providers in the locality will be paying the assessment for each locality tax;
d. The assessment rate that the providers will be paying for each locality tax;
e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;
f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;
g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and
h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under Section 1903(w) of the Act.

113. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in section XVI:

a. Administrative costs, including those associated with the administration of the demonstration;
b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third-party liability.

114. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

115. Medicaid Expenditure Groups. Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 6: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
TANF/SOBRA	Main	X		X	Medicaid mandatory low-income families
SSI	Main	X		X	Aged, blind, and disabled
ALTCS-DD	Main	X		X	Developmentally disabled needing institutional level of care or HCBS
ALTCS-EPD	Main	X		X	Elderly and physically disabled needing institutional level of care or HCBS
Newly Eligible Adults-Expansion State Adults	Hypo	X		X	Low-income adults at 0-133% FPL
IHS Services	Hypo		X	X	Medicaid services for AI/AN
TI 2.0	Main			X	Provider incentive payments
DSHP	Main			X	Designated State Health Program
Housing Initiative	Capped Hypo		X	X	Housing and Health Opportunities (H2O) services Health-Related Social Needs
Housing Initiatives Infrastructure	Capped Hypo		X	X	H2O infrastructure costs related to the provision of HRSN
ADM	N/A				All additional administrative costs that are directly attributable to the demonstration and are not described elsewhere and are not subject to budget neutrality.

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver;
WW – with waiver

116. Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of Title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00257/9). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable

calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. **Cost Settlements**. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.
b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.
c. **Pharmacy Rebates.** Because pharmacy rebates are included in the base expenditures used to determine the budget neutrality expenditure limit, the state must report the portion of pharmacy rebates applicable to the demonstration on the appropriate forms CMS-64.9 WAIVER and 64.9P WAIVER for the demonstration, and not on any other CMS-64.9 form (to avoid double counting). The state must have a methodology for assigning a portion of pharmacy rebates to the demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.
d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and/or in the STCs in section XVI, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.
e. **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in section XIII, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.
f. **Budget Neutrality Specifications Manual.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's

Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 7: MEG Detail for Expenditures and Member Month Reporting							
MEG (Waiver Name)	**Detailed Description**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
TANF/SOBRA	Medicaid mandatory low-income families	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	10/14/22	9/30/27
SSI	Aged, blind, and disabled	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	10/14/22	9/30/27
ALTCS-DD	Developmentally disabled needing institutional level of care or HCBS	Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	10/14/22	9/30/27
ALTCS-EPD	Elderly and physically disabled needing institutional level of care or HCBS	Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	10/14/22	9/30/27
Newly Eligible Adults-Expansion State Adults	Low-income adults 0-133% FPL	Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	10/14/22	9/30/27
IHS Services	Medicaid services for AI/AN	Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	N	10/14/22	9/30/27
TI 2.0	Provider incentive payments	Follow standard CMS 64.9 or 64.10 Category of Service Definitions	Date of service/Date of payment	MAP/ADM	N	10/14/22	9/30/27
DSHP	Designated State Health Program	Follow standard CMS 64.10 Category of Service Definitions	Date of Payment	ADM	N	10/14/22	9/30/27
Housing Initiatives	Housing and Health Opportunities (H2O) services Health-Related Social Needs	Follow standard CMS 64.9 or 64.10 Category of Service Definitions	Date of Service/Date of payment	MAP/ADM	N	10/14/22	9/30/27

Housing Initiatives Infrastructure	H2O infrastructure costs related to the provision of HRSN	Follow standard CMS 64.10 Category of Service Definitions	Date of payment	ADM	N	10/14/22	9/30/27
ADM	Report additional administrative costs that are directly attributable to the demonstration, are not described elsewhere, and are not subject to budget neutrality	Follow standard CMS 64.10 Category of Service Definitions	Date of payment	ADM	N	10/14/22	9/30/27

ADM – administration; DY – demonstration year; MAP – medical assistance payments; MEG – Medicaid expenditure group

117. Demonstration Years. Demonstration Years (DY) for this demonstration are defined in the table below.

Table 8: Demonstration Years		
Demonstration Year 12	October 14, 2022 to September 30, 2023	12 months
Demonstration Year 13	October 1, 2023 to September 30, 2024	12 months
Demonstration Year 14	October 1, 2024 to September 30, 2025	12 months
Demonstration Year 15	October 1, 2025 to September 30, 2026	12 months
Demonstration Year 16	October 1, 2026 to September 30, 2027	12 months

118. Budget Neutrality Monitoring Tool. The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing the demonstration's actual expenditures to the budget neutrality expenditure limits described in section XVI. CMS will provide technical assistance, upon request.[4]

[4] Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs

119. Claiming Period. The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

120. Future Adjustments to Budget Neutrality. CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

121. Budget Neutrality Mid-Course Correction Adjustment Request. No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process**. In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update

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requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

described in STC 121(c). If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration, are outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:
    i. Provider rate increases that are anticipated to further strengthen access to care;
    ii. CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors (such as not aging data correctly) or unintended omission of certain applicable costs of services for individual MEGs;
    iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;
    iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;
    v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;
    vi. High cost innovative medical treatments that states are required to cover; or,
    vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.
c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:
    i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,
    ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

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

XVI. MONITORING BUDGET NEUTRALITY

123. Limit on Title XIX Funding. The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of a Main Budget Neutrality Test, a Hypothetical Budget Neutrality Test, and a Capped Hypothetical Budget Neutrality Test, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

124. Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 6: Master MEG Chart and Table 7: MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

125. Calculation of the Budget Neutrality Limits and How They Are Applied. To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

126. Main Budget Neutrality Test. The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of the limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. However, excess expenditures from the Capped Hypothetical Budget Neutrality Test do not count as expenditures under the Main Budget Neutrality Test. The state is at risk for any amount over the capped hypothetical amount. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both."

Table 9: Main Budget Neutrality Test									
MEG	**PC or Agg***	**WOW Only, WW Only, or BOTH**	**Base Year**	**Trend Rate**	**DY 12**	**DY 13**	**DY 14**	**DY 15**	**DY 16**
TANF/SOBRA	PC	Both	2022	5.0%	$565.22	$593.48	$623.15	$654.31	$687.03
SSI	PC	Both	2022	4.7%	$1,244.42	$1,302.91	$1,364.15	$1428.27	$1,495.40
ALTCS-DD	PC	Both	2022	5.0%	$6,432.65	$6,754.29	$7,092.00	$7,446.60	$7,818.93
ALTCS-EPD	PC	Both	2022	4.7%	$5,993.02	$6,274.69	$6,569.60	$6,878.37	$7,201.65
TI 2.0	N/A	WW Only	2022	The state must have savings to offset these expenditures.					
DSHP	N/A	WW Only	2022	The state must have savings to offset these expenditures.					

*PC = Per Capita, Agg = Aggregate

127. Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other Title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

128. Hypothetical Budget Neutrality Test 1: Newly Eligible Adults-Expansion State Adults and IHS Services. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1.

MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 10: Hypothetical Budget Neutrality Test 1

MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year	Trend Rate	DY 12	DY 13	DY 14	DY 15	DY 16
Newly Eligible Adults-Expansion State Adults	PC	Both	2022	5.50%	$862.40	$909.84	$959.88	$1,012.67	$1,068.37
IHS Services	Agg	Both	2022	N/A	$74,200	$97,500	$103,300	$108,900	$114,800

129. Capped Hypothetical Budget Neutrality for Evidence-Based HRSN Initiatives. When expenditure authority is provided for specified HRSN initiatives in the demonstration (in this approval, as specified in Section VII), CMS considers these expenditures to be "capped hypothetical" expenditures; that is, the expenditures are eligible to receive FFP up to a specific aggregate spending cap per demonstration year, based on the state's expected expenditures. States can also receive FFP for capacity-building, infrastructure, and operational costs for the HRSN initiatives (STC 34); this FFP is limited by a sub-cap of the aggregate spending cap and is determined by CMS based on the amount the state expects to spend. Like all hypothetical expenditures, capped hypothetical expenditures do not need to be offset by savings, and cannot produce savings; however, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. To allow for capped hypothetical expenditures and to prevent them from resulting in savings that would apply to the rest of the demonstration, CMS currently applies a separate, independent Capped Hypothetical Budget Neutrality Test, which subjects capped hypothetical expenditures to pre-determined aggregate limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If actual HRSN initiative spending is less than the Capped Hypothetical Budget Neutrality Test's expenditure limit for a given demonstration year, the difference is not considered demonstration savings. Unspent HRSN expenditure authority under the cap for each demonstration year can be carried, shifted, or transferred across future demonstration years. However, unspent HRSN expenditure authority cannot roll over to the next

demonstration approval period. If the state's capped hypothetical spending exceeds the Capped Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to refund any FFP in excess of the cap to CMS. Demonstration savings from the Main Budget Neutrality Test cannot be used to offset excess spending for the capped hypothetical.

130. Capped Hypothetical Budget Neutrality Test: HRSN. Table 11 identifies the MEGs that are used for the Capped Hypothetical Budget Neutrality Test. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Capped Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from the Capped Hypothetical Budget Neutrality Test cannot be offset by savings under the Main Budget Neutrality Test or the Hypothetical Budget Neutrality Tests.

Table 11: Capped Hypothetical Budget Neutrality Test

MEG	Agg	WOW Only, WW Only, or Both	DY 12	DY 13	DY 14	DY 15	DY 16
Housing Initiatives (H2O)	Agg	Both	$96.35M	$96.35M	$96.35M	$96.35M	$96.35M
Housing Initiatives Infrastructure	Agg	Both	$13.5M	$13.5M	$13.5M	$13.5M	$13.5M

131. Composite Federal Share. The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

132. Exceeding Budget Neutrality. CMS will enforce the budget neutrality agreement over the demonstration period, which extends from October 14, 2022 to September 30, 2027. The Main Budget Neutrality Test for this demonstration period may incorporate carry-forward savings, that is, net savings from up to 10 years of the immediately prior demonstration approval period(s) (excluding temporary extension periods) (October 1, 2011 to September 30, 2021). If at the end of the demonstration approval period the Main Budget Neutrality Test or a Capped Hypothetical Budget Neutrality Test has been

exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

133. Budget Neutrality Savings Cap. The amount of savings available for use by the state during this demonstration period will be limited to the lower of these two amounts: 1) The savings amount the state has available in the current demonstration period, including carry-forward savings as described in STC 132 or 2) 15 percent of the state's projected total Medicaid expenditures in aggregate for this demonstration period. This projection will be determined by taking the state's total Medicaid spending amount in its most recent year with completed data and trending it forward by the President's Budget trend rate for this demonstration period. Fifteen percent of the state's total projected Medicaid expenditures for this demonstration period is $16,419,543,915.

134. Corrective Action Plan. If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the Table 12 as a guide for determining when corrective action is required.

Table 12: Budget Neutrality Test Corrective Action Plan Calculation

Demonstration Year	Cumulative Target Definition	Percentage
DY 12	Cumulative budget neutrality limit plus:	2.0 percent
DY 12 through DY 13	Cumulative budget neutrality limit plus:	1.5 percent
DY 13 through DY14	Cumulative budget neutrality limit plus:	1.0 percent
DY 14 through DY 15	Cumulative budget neutrality limit plus:	0.5 percent
DY 15 through DY 16	Cumulative budget neutrality limit plus:	0.0 percent

XVII. MONITORING ALLOTMENT NEUTRALITY

135. Reporting Expenditures Subject to the Title XXI Allotment Neutrality Agreement. The following describes the reporting of expenditures subject to the allotment neutrality agreement for this demonstration:

a. **Tracking Expenditures.** In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions outlined in section 2115 of the State Medicaid Manual.

b. **Use of Waiver Forms.** Title XXI demonstration expenditures will be reported on the following separate forms designated for CHIP (i.e., Forms CMS-21 Waiver and/or CMS-21P Waiver), identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). The state must submit separate CMS-21 waiver forms for each title XXI demonstration population.

c. **Premiums.** Any premium contributions collected under the demonstration shall be reported to CMS on the CMS-21 Waiver form (specifically lines 1A through 1D as applicable) for each title XXI demonstration population that is subject to premiums, in order to assure that the demonstration is properly credited with the premium collections.

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

136. Standard CHIP Funding Process. The standard CHIP funding process will be used during the demonstration. The state will continue to estimate matchable CHIP expenditures on the quarterly Forms CMS-21B for CHIP. On these forms estimating expenditures for the title XXI funded demonstration populations, the state shall separately identify estimates of expenditures for each applicable title XXI demonstration population.

a. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must report demonstration expenditures through Form CMS-21W and/or CMS-21P Waiver for the CHIP population. Expenditures reported on the waiver forms must be identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). CMS will reconcile expenditures reported on the CMS-21W/CMS-21P Waiver form with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

137. Title XXI Administrative Costs. All administrative costs (i.e., costs associated with the title XXI state plan and the title XXI funded demonstration populations identified in these STCs) are subject to the title XXI 10 percent administrative cap described in section 2105(c)(2)(A) of the Act.

138. Limit on Title XXI Funding. The state will be subject to a limit on the amount of federal title XXI funding that the state may receive on eligible CHIP state plan populations and the CHIP demonstration populations described in STC 16 during the demonstration period. Federal title XXI funds for the state's CHIP program (i.e., the approved title XXI state plan and the demonstration populations identified in these STCs) are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with CHIP state plan populations. Demonstration expenditures are limited to remaining funds.

139. Exhaustion of Title XXI Funds for CHIP Population. If the state exhausts the available title XXI federal funds in a federal fiscal year during the period of the demonstration, the state must continue to provide coverage to the approved title XXI separate state plan population.

XVIII. SCHEDULE OF DELIVERABLES

The state is held to all reporting requirements as outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

Date – Specific	Deliverable	Section Reference
No later than 180 days after approval date	Protocol for Assessment of Beneficiary Eligibility and Needs,	STC 36

Date – Specific	Deliverable	Section Reference
	Infrastructure Planning, and Provider Qualifications for H2O services	
No later than 90 days after approval date	Maintenance of Effort Baseline Calculation	STC 45
No later than 90 days after approval date	Targeted Investments 2.0 Incentivized Metrics and Funding Protocol	STC 52
No later than 150 days after approval date	DSHP Claiming Protocol	STC 58
No later than 9 months after approval date	Draft New Initiatives Implementation Plan	STC 84
No later than 60 days after receiving CMS comments	Revised Implementation Plan	STC 84
No later than 150 days after approval date	Draft Monitoring Protocol	STC 85
No later than 60 days after receiving CMS comments	Revised Monitoring Protocol	STC 85
No later than 180 calendar days after approval date	Draft Evaluation Design	STC 96
No later than 60 days after receiving CMS comments	Revised Evaluation Design	STC 97
One year prior to demonstration expiration or with extension application	Draft Interim Evaluation Report	STC 100(c)
No later than 60 days after receiving CMS comments	Revised Interim Evaluation Report	STC 100(d)
No later than 18 months after the expiration of this demonstration period	Draft Summative Evaluation Report	STC 101
No later than 60 days after receiving CMS comments	Revised Summative Evaluation Report	STC 101(a)
No later than 120 days after the end of the demonstration	Draft Close Out Report	STC 88
No later than 30 days after receiving CMS comments	Revised Close Out Report	STC 88(e)
Annually		

Date – Specific	Deliverable	Section Reference
90 days after the end of each DY	Annual Monitoring Report (including Q4 monitoring information and budget neutrality)	STC 86
No later than 60 days after receiving CMS comments	Revised Annual Monitoring Report	STC 86
Quarterly		
60 days following the end of the quarter	Quarterly Monitoring Reports	STC 86
30 days following the end of the quarter	Quarterly Expenditure Reports	STC 107

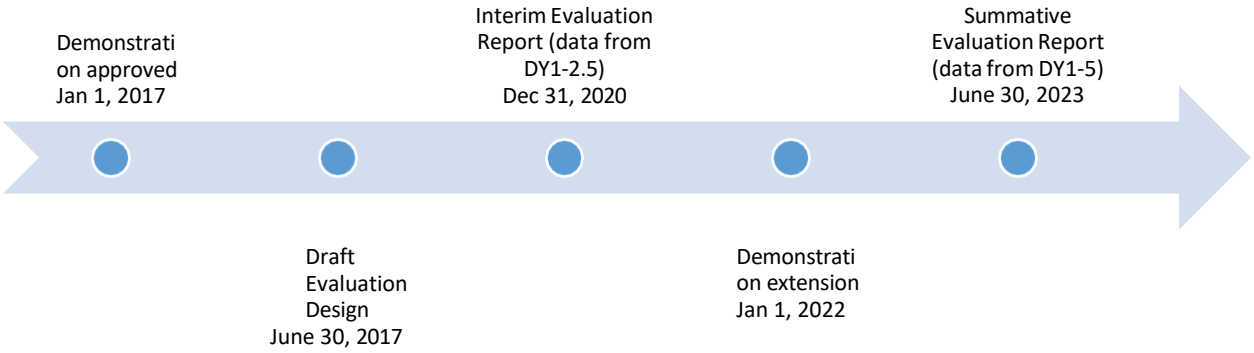
Attachment A
Developing the Evaluation Design

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the population of focus), and impacts of the demonstration (e.g., whether the outcomes observed in the population of focus differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of its draft Evaluation Design and subsequent evaluation reports. The graphic below depicts an example of this timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Designs

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If

the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

The state should attempt to involve partners who understand the cultural context in developing an evaluation approach and interpreting findings. Such partners may include community groups, beneficiaries, health plans, health care providers, social service agencies and providers, and others impacted by the demonstration. For example, the state's Request for Proposal for an independent evaluator could encourage research teams to partner with impacted groups.

All states with section 1115 demonstrations are required to conduct Interim and Summative Evaluation Reports, and the Evaluation Design is the roadmap for conducting these evaluations. The roadmap begins with the stated goals for the demonstration, followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

A. General Background Information;
B. Evaluation Questions and Hypotheses;
C. Methodology;
D. Methodological Limitations;
E. Attachments.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, or expansion of, the demonstration.
5. For extensions, amendments, and major operational changes: a description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how

the evaluation questions align with the hypotheses and the goals of the demonstration.
2. Address how the hypotheses and research questions promote the objectives of Titles XIX and/or XXI.
3. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets can be measured.
4. Include a Logic Model or Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve health and health care through specific interventions. A driver diagram depicts the relationship between the goal, the primary drivers that contribute directly to achieving the goal, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.
5. Include implementation evaluation questions to inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings. Implementation evaluation research questions can focus on barriers, facilitators, beneficiary and provider experience with the demonstration, the extent to which demonstration components were implemented as planned, and the extent to which implementation of demonstration components varied by setting.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, that the results are statistically valid and reliable, and that it builds upon other published research, using references where appropriate. The evaluation approach should also consider principles of equitable evaluations, and involve partners—such as community groups, beneficiaries, health plans, health care providers, social service agencies and providers, and others impacted by the demonstration who understand the cultural context—in developing an evaluation approach.

This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure.

Specifically, this section establishes:

1. *Methodological Design* – Provide information on how the evaluation will be designed. For

example, whether the evaluation will utilize pre/post data comparisons, pre-test or post-test only assessments. If qualitative analysis methods will be used, they must be described in detail.

2. *Focus and Comparison Populations* – Describe the characteristics of the focus and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3. *Evaluation Period* – Describe the time periods for which data will be included.

4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate.

   Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating, securing, and submitting for endorsement, etc.) Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, metrics drawn from the Behavioral Risk Factor Surveillance System (BRFSS) survey, and/or measures endorsed by National Quality Forum. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology.

5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.

6. *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative analysis measures that will adequately assess the effectiveness of the demonstration. This section should:

a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression).
b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).
c. Include a discussion of how propensity score matching and difference-in- differences designs may be used to adjust for differences in comparison populations over time, if applicable.
d. Consider the application of sensitivity analyses, as appropriate.

7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design for the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides more detailed information about the limitations of the evaluation. This could include limitations about the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize these limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

CMS also recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. For example, if a demonstration is long-standing, it may be difficult for the state to include baseline data because any pre-test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
   a. Non-complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
   b. Could now be considered standard Medicaid policy (CMS published regulations or guidance).

2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
   a. Operating smoothly without administrative changes;
   b. No or minimal appeals and grievances;
   c. No state issues with CMS-64 reporting or budget neutrality; and
   d. No Corrective Action Plans for the demonstration.

E. Attachments

1. **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation and prepare objective Evaluation Reports. The Evaluation Design should include a "No Conflict of Interest" statement signed by the independent evaluator.

2. **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated costs, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.

3. **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The final Evaluation Design shall incorporate milestones for the development and submission of the

Interim and Summative Evaluation Reports. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due.

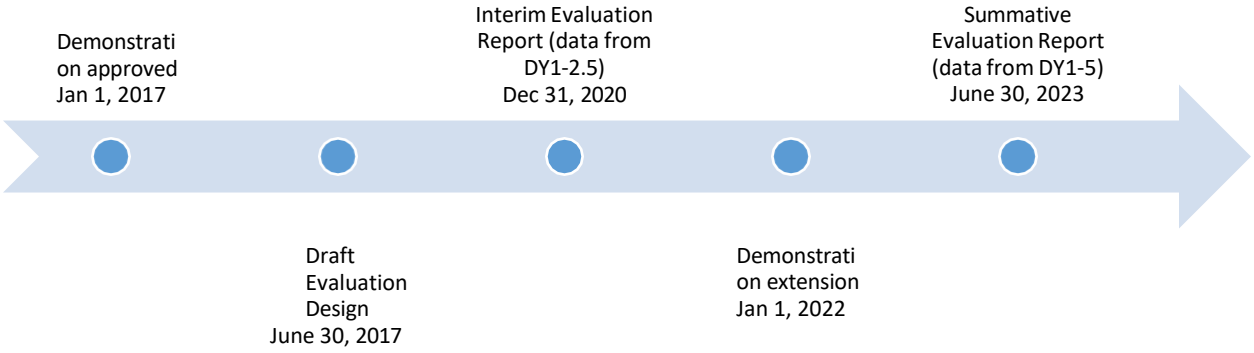
Attachment B
Preparing the Interim and Summative Evaluation Reports

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the population of focus), and impacts of the demonstration (e.g., whether the outcomes observed in the population of focus differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). The graphic below depicts an example of a deliverables timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Interim and Summative Evaluation Reports to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Reports
All states with Medicaid section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already-approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the methodology outlined in the approved Evaluation Design. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

When submitting an application for extension, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

CMS expects Interim and Summative Evaluation Reports to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115- demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state- monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the evaluation reports, the state should contact its demonstration team.

Intent of this Attachment
Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's evaluation report submissions must provide comprehensive written presentations of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

Required Core Components of Interim and Summative Evaluation Reports
The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and

J. Attachment(s).

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, or expansion of, the demonstration.
5. For extensions, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes. Additionally, the state should explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable).

C. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
2. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.
3. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
4. The inclusion of a Logic Model or Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration, consistent with the approved Evaluation Design. The Evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research, (using references), meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An Interim Evaluation Report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an Interim Evaluation Report.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on,

control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what was measured and how, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Methodological Design* – Whether the evaluation included an assessment of pre/post or post-only data, with or without comparison groups, etc.
2. *Focus and Comparison Populations* – Describe the focus and comparison populations, describing inclusion and exclusion criteria.
3. *Evaluation Period* – Describe the time periods for which data will be collected.
4. *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.
5. *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.
6. *Analytic Methods* – Identify specific statistical testing which was undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations – This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically, the state should answer the following questions:

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
    a. If the state did not fully achieve its intended goals, why not?
    b. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long-range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretations of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels. Interpreting the implications

of evaluation findings should include involving partners, such as community groups, beneficiaries, health plans, health care providers, social service agencies and providers, and others impacted by the demonstration who understand the cultural context in which the demonstration was implemented.

I. Lessons Learned and Recommendations – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders. Recommendations for improvement can be just as significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

Attachment C
Reimbursement for Critical Access Hospitals

Subject to the availability of state funds, beginning May 1, 2002, supplemental payments will be made to non-I.H.S., non-638 facility in-state hospitals, certified by Medicare as Critical Access Hospitals (CAHs) under 42 CFR 485, Subpart F and 42CFR 440.170(g). These supplemental CAH payments shall be made in addition to the other payments described in Attachments 4.19-A (inpatient hospital) and 4.19-B (outpatient hospital). Supplemental payments shall be made based on each CAH designated hospital's percentage of total inpatient and outpatient Title XIX reimbursement paid relative to other CAH designated hospitals for the time period from July 1 through June 30 of the previous year.

AHCCCS will allocate the amount available through legislative appropriation in the following manner:

1. Gather all adjudicated claims/encounters with dates of service from July 1 through June 30 of the prior year for each CAH-designated hospital.
2. Sum the AHCCCS payments for inpatient and outpatient services for the year to establish a hospital-specific hospital paid amount.
3. Total all AHCCCS payments for inpatient and outpatient services for the year to establish a total paid amount.
4. Divide the hospital paid amount by the total paid amount to establish the hospital's utilization percentage.
5. Divide the annual CAH appropriation by twelve to get the monthly CAH allocation.
6. Multiply each hospital's monthly relative utilization by the monthly CAH allocation to establish each hospital's monthly payment.

Funding will be distributed based on the number of CAH-designated hospitals in each month and their Medicaid utilization. Because there may be a different number of CAH-designated hospitals each month, the hospital-specific weightings and payments may fluctuate from month to month. The calculations will be computed monthly and the distribution of the CAH dollars to the CAH- designated hospitals will be made twice a year.

Attachment D
DSHP Claiming Protocol

Summary

To support the goals of health system transformation, the Arizona Health Care Cost Containment System (AHCCCS) will claim Federal Financial Participation (FFP) for Designated State Health Programs (DSHP). Specifically, this authority will allow AHCCCS to support the Targeted Investment (TI) 2.0 Program, Housing and Health Opportunities (H2O) Program, and related infrastructure. This authority will be available from Demonstration Year (DY) 12 to DY16. The DSHP will have an established limit in the amount of $440,890,944 total computable expenditures, in aggregate, for DY12-DY16. AHCCCS programs that will serve as DSHPs are described in Table A below, and the limits under which the State may claim matching funds for these expenditures are described in Table B, plus any unspent amounts from prior years. Table C lists detailed funding amounts for the DSHP program list. The DSHP-eligible amounts identified in Table C will be allocated based on 50% Federal Medical Assistance Percentage (FMAP) between the State and federal allocation. This protocol describes the methodology and guidelines by which AHCCCS will claim FFP for DSHP expenditures.

Table A. DSHP Summary List

Responsible Entity	Program	Approximate Annual Funding	Amount after 3.9% non-citizen adjustment
AHCCCS	Services to Individuals with Serious Mental Illness (SMI) - Maricopa County Intergovernmental Agreement (IGA) and Pima County IGA	$80,000,000	$76,880,000
AHCCCS	Trauma and Emergency Services	$31,100,000	$29,887,100
Arizona Department of Economic Security (DES)	Division of Developmental Disabilities (DDD)	$38,200,000	$36,710,200
Totals		**$149,300,000**	**$143,477,300**

Table B. Annual Limits in Total Computable Expenditures for DSHP

Annual Limits	DY12	DY13	DY14	DY15	DY16

Total Computable Expenditures	$88,178,188	$88,178,188	$88,178,188	$88,178,188	$88,178,188

Table C. DSHP Detailed Funding Amounts

Program Name	Annual Expenditures	Non-allowable	Non-Citizen (3.9%)	DSHP-Eligible
Services to Individuals with Serious Mental Illness (Maricopa County IGA)	$77,100,000	($16,000,000)	($3,006,900)	$58,093,100
Services to Individuals with Serious Mental Illness (Pima County IGA)	$2,900,000	($460,000)	($113,100)	$2,326,900
Trauma and Emergency Services	$31,100,000	($3,100,000)	($1,212,900)	$26,787,100
Arizona Department of Economic Security, Division of Developmental Disabilities (DES/DDD)	$38,200,000	($9,388,800)	($1,489,800)	$27,321,400
Totals	**$149,300,000**	**($28,948,800)**	**($5,822,700)**	**$114,528,500**

Prohibited DSHP Expenditures

As described in STC 55, prohibited DSHP expenditures are outlined below. AHCCCS has provided additional details on how such expenditures will be accounted for by each program in the subsequent DSHP Program Details section. Prohibited expenditures include, but are not limited to, the following:

- Any expenditures that are funded by federal grants or other federal sources (e.g., American Rescue Plan [ARP] Act funding, Health Resources and Services Administration [HRSA] grant funding, the Centers for Disease Control and Prevention [CDC], etc.), or that are included as part of any maintenance of effort (MOE) or non-federal share requirements of any federal grant,
- Expenditures associated with the provision of non-emergency care to individuals who do not meet citizenship or immigration status requirements to be eligible for Medicaid (i.e., 3.9% of total provider expenditures as noted in Table C are expended to meet this limitation),
- Bricks and mortar,
- Shelters, vaccines, and medications for animals,
- Coverage/services specifically for individuals who are not lawfully present or are undocumented,
- Revolving capital funds, and

- Non-specific projects for which the Centers for Medicare & Medicaid Services (CMS) lacks sufficient information to ascertain the nature and character of the project and whether it is consistent with the STCs.

Arizona's Financing and Accounting Systems

AZ360 is the State of Arizona's modernized, all-in-one, personnel and financial data management and services application. AZ360 features industry-proven, cloud-based technology and standardized processes. Expenditures made by AHCCCS are recorded in AZ360 as the financial system of record.

DSHP Claiming Process

As described in STC 58, AHCCCS will maintain supporting work papers which will be made available to CMS. AHCCCS will claim federal funds within two years after the calendar quarter in which the State disburses expenditures for the DSHPs. AHCCCS will ensure that:

- Sources of non-federal funding are compliant with section 1903(w) of the Act and applicable implementing regulations. To the extent that DSHPs receive federal funds from any other federal programs, such funds shall not be used as a source of non-federal share to support expenditures for DSHPs or DSHP-funded initiatives under this demonstration,
- Administrative costs associated with DSHPs that are not generally part of normal operating costs for service delivery are not included in any way as demonstration and/or other Medicaid expenditures,
- DSHP will be claimed at the FMAP administrative matching rate of 50%, and
- Expenditures will be claimed in accordance with the CMS-approved DSHP Claiming Protocol described.

DSHP Program Details

Services to Individuals with a Serious Mental Illness (SMI) Designation

Responsible Entity:

AHCCCS

Funding Sources:

IGA Funds provided by Maricopa County and Pima County.

Description:

Maricopa and Pima Counties provide funds to AHCCCS via IGAs to provide services to non-Medicaid individuals with SMI designations. AHCCCS contracts with managed care organizations (AHCCCS Complete Care – Regional Behavioral Health Agreement [ACC-RBHA]), who contract with providers for case management, peer support and planning, community-based supports, medication management services, and other medical services. Funding flows from the counties, to AHCCCS, to ACC-RBHAs, and then to providers. Eligible DSHP expenditures exclude any expenditures used to meet the AHCCCS MOE requirement for the Mental Health Block Grant and Substance Abuse Block Grant. The Substance Abuse and Mental Health Services Administration (SAMHSA) specifically excludes county funding as an eligible source for block grant MOE.

Eligible Population:

An individual is determined eligible to receive SMI services if they have a qualifying SMI diagnosis and functional impairment caused by the diagnosis. Qualifying diagnoses include anxiety, bipolar, major depression, obsessive-compulsive, dissociative, personality, psychotic, and post-traumatic stress disorders.

Functional impairment means long-term dysfunction in one of the following domains: (1) inability to live in an independent or family setting without supervision, (2) risk of serious harm to self or others, (3) dysfunction in role performance, or (4) risk of deterioration. Individuals are evaluated for SMI eligibility by a clinician and receive an initial SMI evaluation and a final SMI eligibility determination.
When an individual requests to receive behavioral health services they are also required to participate in a preliminary financial screening and eligibility process to identify third party payers and determine if they are eligible for Medicaid/Children's Health Insurance Program (CHIP), including submission of an application and completion of the eligibility determination process. If an individual receives an SMI determination but does not qualify for Medicaid/CHIP, they are eligible to receive services under this program.

All members receiving non-Medicaid funded services are required to have a Title XIX/XXI eligibility screening completed at intake and annually thereafter. Financial criteria includes ineligibility for Title XIX/XXI or other Public Program. Verification of an individual's identification and citizenship/lawful presence in the United States is completed through the AHCCCS Health-e-Arizona PLUS (HEAPlus) application process. Upon the final processing of a Title XIX/XXI and other Public Program screening/application, if the individual is determined ineligible for Title XIX/XXI or other Public Program benefits, the individual is eligible for covered services funded by Non-Title XIX/XXI funding sources.

Under this program, the individuals have a similar coverage benefit as the Medicaid/CHIP members determined SMI, subject to available funds. Individuals under this program may have no existing coverage, or may have coverage that does not reimburse for the level of services necessary to meet the individual's needs. This is determined through the evaluation of third party payors described above.

Services Provided:
Non-Title XIX/XXI Services and Funding
Title XIX/XXI Behavioral Health Service Benefit
Services include the following:

- Employment,
- Housing services,
- Case management,
- Personal care services,
- Rehabilitation,
- Behavioral health services,
- Substance use services and supports,
- Crisis Intervention services,
- Inpatient services,
- Intensive outpatient treatment, and
- Medical services such as medication, medical imaging, medical management, and Electroconvulsive Therapy (ECT).

Provider Description and Qualifications:
ACC-RBHAs contract with behavioral health providers, who then provide direct services. Providers are credentialed by the ACC-RBHAs to obtain, verify, and evaluate information regarding applicable licensure, accreditation, certification, educational and practice requirements to determine whether a provider has the required credentials to deliver specific covered services to members. Behavioral health for SMI program is a State program, operated through the Medicaid Agency. The counties provide one source of funding for this State-run program.

Budget Information and Processes:
The current budget codes and identifiers for this program's expenditures are recorded under Fund HC4503, Appropriation Category HC25600, Major Program BHSNONMED, within the Programs MARIBHS and PIMABHS.

AHCCCS has revised the annual funding from $80 million to $60.4 million after removing Court Ordered Evaluation/Screening. AHCCCS will ensure that room and board, residential treatment, and housing rental subsidies expenses will be excluded. The revised amount categories include health plan administration at $5 million and services at $56.5 million.

The process AHCCCS will take to ensure that funding is only including allowable DSHP expenditures will be on a quarterly basis, ACC-RBHAs report back to AHCCCS on the actual services provided in the form of ACC-RBHA financial statements. AHCCCS reviews quarterly financial statements from ACC-RBHAs to ensure non-permissible expenses will be removed and not claimed. Table D indicates how much funding each county currently pays.

Table D. SMI Funding by County by Year

Year	Maricopa County	Pima County	Total
2023	$69,942,470	$2,974,936	$72,917,406
2024	$73,381,444	$2,974,936	$76,356,380
2025	$76,992,368	$2,974,936	$79,967,304
2026	$80,783,837	$2,974,936	$83,758,773
2027	$84,764,879	$2,974,936	$87,739,815

AHCCCS makes monthly installment payments based on the annual contract amount to ACC-RBHAs under existing non-Medicaid services contracts. ACC-RBHAs make monthly installment payments based on annual contract amounts to behavioral health providers, who provide direct services to members. ACC-RBHAs reviews encounter services against the paid amounts received.

DSHP Exclusions:
AHCCCS identifies non-permissible expenses based on STC 55 and will exclude any unallowable expenses identified in the submitted ACC-RBHA financial statements. The ACC-RBHA financial statement separately identifies room and board expenses and residential treatment expenses. Room and board is a covered Non-Title XIX/XXI service, but is not funded by the DSHP sources identified.

The entire amount for SMI (Maricopa and Pima Counties) is county-provided funding that is given to AHCCCS and is passed through to the ACC-RBHA. The counties provide funding for Non-Title XIX/XXI individuals for State service costs. The county funding is the only funding within this State only program that is being utilized in the DSHP calculation. A portion of the funding is for county service costs (i.e., court ordered evaluation and screening), but AHCCCS has removed this expense from the DSHP estimate to CMS. The State general fund supports this program and is utilized in the MOE calculation for the federal behavioral health block grants; therefore, AHCCCS will not utilize that in the DSHP.

Trauma and Emergency Services

Responsible Entity:
AHCCCS

Funding Sources:
Trauma and Emergency Services Fund (through the Arizona Benefits Fund) consisting of tribal gaming revenues paid to the State of Arizona.

Description:
The Trauma and Emergency Services program operated by AHCCCS reimburses Arizona hospitals for Level 1 trauma center readiness costs and emergency services costs. Payments are made to Level 1 trauma centers based on the acuity-adjusted volume of trauma care provided and the professional, clinical, and administrative costs directly associated with the provision of that care. The intent is to provide funding for emergency costs that are not fully funded by reimbursements under Medicaid, Medicare, or other payers. Target populations are individuals served by hospital trauma centers, including both uninsured and Medicaid covered individuals.

Eligible Population:
Hospitals that are included in this reimbursement are all Level 1 trauma centers. All Level 1 hospitals are located in Maricopa County or Pima County with the exception of Flagstaff Medical Center which is located in Coconino County. The 14 hospitals that are Level 1 trauma hospitals cover a diverse population and geographical area in Arizona. Included in the 14 hospitals is the only public hospital in Arizona, Valleywise Health, the only dedicated children's hospital in Arizona, Phoenix Children's Hospital, and multiple hospitals that serve the downtown Phoenix area and many low-income individuals.

Services Provided:
In regard to trauma services that hospitals are reimbursed for, AHCCCS reimburses for physician staffing and direct support to the provision of Level 1 trauma care costs that a healthcare facility would not have incurred if it did not operate a trauma center facility. Hospitals report the trauma physician staffing related costs, trauma nonphysician direct care staffing costs, and administrative/other costs such as maintaining trauma registry, outreach/prevention and trauma certification.

The Arizona Administrative Code identifies the requirements of each different trauma level. In Arizona, there are only Level 1, Level III, and Level IV. Below are some examples of services/costs that are required for Level I trauma centers above the standard requirements for Level IV Arizona hospitals. As a result, the State of Arizona has provided this enhanced funding to assist hospitals in meeting these additional requirements and associated costs. Services provided include:

- Specialist on-call and available 24 hours day:
    - Neurosurgeon,
    - Critical care medicine physician,
    - Hand Surgeon,
    - Ophthalmic Surgeon,
    - Plastic Surgeon,
    - Thoracic Surgeon,
    - Cardiac Surgeon, and
    - Obstetrics/gynecologic surgeon.
- Operating Room immediately available 24 hours/day.

- ICU or critical care unit requirements including physician staffing, surgically directed and staffed ICU services.
- Respiratory Therapy Services available 24 hours/day.

Provider Qualifications:
AHCCCS only reimburses the hospitals directly but the majority of the costs identified above are for physician staffing and direct support to the provision of Level 1 trauma care at the trauma center. In addition, a portion of the payment under this program is for the difference between billed charges for trauma cases compared to reimbursements received for those cases.

Budget Information and Processes:
The current State budget codes and identifiers for this program's expenditures are recorded under appropriation category HC45100 in Arizona Financial Information System (AFIS), with all expenditures under Fund HC2494 (Trauma and Emergency Services Fund) in AFIS.

The State of Arizona allocates the trauma funds proportionally to each trauma hospital based on the reported data. No preference or larger share is given to one specific hospital or non-data specific criteria. In one of the trauma readiness methodologies, AHCCCS does calculate what Arizona believes is owed under the trauma readiness methodology but we remove the total payment the hospital reported for those cases. As a result, the Trauma and Emergency Services Fund payment is only for the unreimbursed costs that were not paid by any payor for this specific method.

The $26.9 million annual funding excludes non-eligible DSHP expenditures, but does not exclude the non-citizen adjustment.

- The Trauma and Emergency Services program has two parts: trauma payments and emergency department payments. AHCCCS is excluding emergency department payments and only includes trauma payments as the amount eligible for DSHP.
- In 2021 and 2022, the trauma payment amount was approximately $28 million. AHCCCS believes the future amounts will continue at the 2021/2022 level.
- In 2021 and 2022, emergency department payments totaled $3.1 million, but these are excluded from the figures reported as DSHP eligible.

Trauma payments to hospitals are eligible for DSHP. AHCCCS is not claiming emergency department payments. The procedure that AHCCCS uses to identify the allowable funding ensures that only costs that can be attributed to trauma physician staffing related costs, trauma non-physician direct care staffing costs, and administrative/other costs directly associated with Level 1 trauma that are not disallowed are included in the trauma center cost calculation.

Arizona does not break down the data between direct services, staffing, and administrative costs. Only direct costs associated with trauma cases and/or readiness costs are included in the distribution calculation. Only costs that can be attributed to the categories under the "services provided" section above are factored into trauma center costs calculation. A hospital may incur other costs that aren't included in the trauma physician staffing related costs, trauma nonphysician direct care staffing costs, and administrative/other costs. In addition, Arizona does allow allocation of health care facility overhead to be included in the trauma costs.

The Trauma and Emergency Services Fund covers both trauma payments and emergency department payments totaling approximately $31 million per year. Only the trauma payments are being considered for

the DSHP program.

Payment Methodologies:
Currently, Arizona makes two separate manual payments to the eligible hospitals. The first payment occurs in April and the second payment occurs in September. Payments are made directly from AHCCCS to the individual hospitals.

DSHP Exclusions:
AHCCCS ensures that only costs that can be attributed to trauma physician staffing related costs, trauma non-physician direct care staffing costs, and administrative/other costs directly associated with Level 1 trauma that are not disallowed are included in the trauma center cost calculation. AHCCCS will require each qualifying hospital to submit an attestation indicating that the costs reported to determine the allocation are for allowable activities under DSHP. AHCCCS will review annually to ensure allocations are for allowable activities under DSHP.

Developmentally Disabled Services

Responsible Entity:
Arizona Department of Economic Security (DES)

Funding Sources:
State General Fund Appropriation

Brief Description:
The Arizona Department of Economic Security, Division of Developmental Disabilities (DES/DDD) provides state-only early intervention and home and community-based services to individuals who are not eligible for Medicaid. DES/DDD directly contracts with independent providers for early intervention services, day treatment, habilitation, residential group homes, occupational therapy, physical therapy, and speech therapy. Funding is allocated annually through the State budget process.

Program:
The programs AHCCCS proposes to be used for DSHP are the state-only components of the DES/DDD program, which include the Arizona Early Intervention Program (AzEIP), state-only Home and Community-Based Services (HCBS) services, and state-only case management.

Eligible Population:
The target population is primarily children, specifically the early intervention population aged zero to three with, or at risk of, developmental delays. Developmental delays are based on diagnostic criteria in the areas of physical, cognitive, language/communication, social/emotional, and adaptive self-help childhood development. Individuals must be ineligible for Medicaid in order to receive state-only services. Children are ineligible for Medicaid primarily due to household income or assets in excess of established limits. Some individuals may have other insurance, in which cases state-only funding function as the payer of last resort. According to Arizona Revised Statutes § 36-596 paragraph A, DES/DDD, including all DES/DDD state-only funds, is the payor of last resort unless specifically prohibited by federal law.

Providers:
DES/DDD contracts with independent providers for early intervention services, day treatment, habilitation, residential group homes, occupational therapy, physical therapy, and speech therapy. AHCCCS will exclude

the state-funded Long Term Care (LTC) Services from DSHP as it was determined that this funding source is used entirely for room and board for residential LTC. AHCCCS will exclude residential group homes from DSHP funding.

Budget Information and Processes:
Funding is located within the DES appropriations. AHCCCS does not currently have access to specific budget coding details. AHCCCS intends to provide oversight by reviewing room and board which has its own appropriation category (DE2312). This appropriation category would allow AHCCCS to separate all room and board expenses from other expenses.

The current annual budget for the Developmentally Disabled Services program and the amount eligible for DSHP is shown in Table E.

Table E. DSHP Detailed Funding Amounts

Program Area	Annual Budget
Home and Community Based Services - State-Only ● Special Line Item (SLI) in ADES Budget ● Entire SLI is General Fund ● Appropriation Category DE22 in AFIS	$14,089,000
State-funded Long Term Care Services ● SLI in ADES Budget ● Total SLI of $42,669,300 - Only Claiming General Fund Portion ● Appropriation Category DE23 in AFIS	$9,388,800 (exclude)
Cost-Effectiveness Study - Client Services ● SLI in ADES Budget ● Total SLI of $8,420,000 - Only Claiming General Fund Portion ● Appropriation Category DE22C in AFIS	$7,200,000
Group Home Monitoring Program ● SLI in ADES Budget ● Entire SLI is General Fund ● Appropriation Category DE20G in AFIS	$1,200,000
Case Management - State-Only ● SLI in ADES Budget ● Entire SLI is General Fund ● Appropriation Category DE21 in AFIS	$6,354,000
Total	**$38,231,800**

AHCCCS will exclude the state-funded LTC services funding from DSHP as it was determined that this funding source is used entirely for room and board for residential LTC. The Group Home Monitoring Program funding is used to monitor whether clients' needs are met and staff actions are appropriate and does not include any room or board expenses.

The breakdown of direct HCBS services, staffing costs, and administrative or other indirect costs of $2 million of state-only funding used for DES operating costs, (staffing, administrative, and indirect costs) have already been excluded from the above $38,231,800 figure. The $38,231,800 does not include DES operating costs. AHCCCS works with DES to identify allowable funding. This process includes AHCCCS receiving quarterly reports from DES and manually reviewing to exclude any unallowable funding, including room and board expenses.

The source of non-federal revenue is an annual State general fund appropriation. DES/DDD exchanges a file with AHCCCS to identify individuals who are Medicaid-eligible and for whom Medicaid should pay for services, and providers must bill Medicaid first. For individuals with third party coverage, providers must bill insurance first and DES/DDD requires documentation of the denial of those claims in order to process a state-only payment. All expenditures for this program are net of costs that were avoided or revenues recovered.

Program for Infants and Toddlers with Disabilities (IDEA) Part C is not a funding source for this program. However, DES/DDD reports these state-only expenditures to the Arizona Department of Education (ADE) in order to demonstrate compliance with AHCCCS MOE requirements for IDEA Part C.

Payment Methodologies:

Case management services are provided directly by DES/DDD, while DES/DDD contracts with independent providers for early intervention services, day treatment, habilitation, residential group homes, occupational therapy, physical therapy, and speech therapy.

DSHP Exclusions:

For this program, AHCCCS does not have any other non-permissible expenses. Any DSHP expenditures reported from AFIS already exclude expenditures that are funded by federal grants or federal financial participation and other non-state, non-local government funding or revenue sources.

Actual expenditures are reduced by room and board expenditures. These are the only expenditures for services that are not Medicaid-like. The expenditures reported in AFIS do not include any payments made by ADES for non-medical services. In order to ensure that room and board expenditures are not included, DES will submit a data summary table to AHCCCS that identifies actual expenditures based on service category, including identification of the amount of expenditures for room and board services.

Actual expenditures are reduced by the expenditures reported as MOE for the IDEA Part C grant program. This process occurs quarterly and IDEA Part C MOE offset is calculated annually and applied to a single quarter. In order to ensure that expenditures reported as MOE for the IDEA Part C grant program are not included, DES will submit a data summary table to AHCCCS that identifies state expenditures reported as MOE for the IDEA Part C federal grant.

Finally, actual expenditures are reduced by the undocumented immigrant offset amount to exclude costs associated with services provided to undocumented immigrants.

Attachment E
Protocol for Assessment of Beneficiary Eligibility and Need, Infrastructure Planning, and Provider Qualifications (reserved)

Attachment F
New Initiatives Implementation Plan

Strategic Approach to Implementing Demonstration Policies - (STC 83)

Background

The involvement of Arizona's Behavioral Health System in addressing the housing needs of Arizonans began in 1989 with the *Arnold v. Sarn* lawsuit settlement, which required the State of Arizona to provide a combination of supportive housing, supported employment, and other community services to individuals living with a Serious Mental Illness (SMI) designation. In 2014, the State's requirements expanded to include an increase in the number of individuals receiving supportive housing and to adopt national quality standards outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA). In 2016, the oversight and administration of housing and services for persons living with an SMI designation was transferred to the Arizona Health Care Cost Containment System (AHCCCS) from the Arizona Department of Health Services (ADHS) in an effort to integrate the service delivery system.

To accomplish these housing goals and requirements, AHCCCS uses a general fund allocation of non-TXIX state-only funds to issue housing vouchers for as many people as possible under the fund source. If AHCCCS were a housing authority, it would be the third largest in the State of Arizona with an annual budget of $27.7 million in non-Medicaid, state-only funds to provide rent subsidies for almost 2,500 AHCCCS members living with an SMI designation.

AHCCCS' current housing programs follow a permanent supportive housing (PSH) model, an evidence based, cost effective strategy for addressing and improving health outcomes for persons experiencing homelessness. AHCCCS also collaborates with local housing authorities, tax credit programs, and the U.S. Department of Housing and Urban Development Continuum of Care (HUD CoC) program to provide PSH capacity for an additional 1,500 members.

While housing subsidies are central to PSH, another critical element is the integration of individualized wraparound services and housing/tenancy supports to ensure members are able to secure and maintain housing while addressing their core health and service needs. Under current AHCCCS policies, many key PSH wrap-around services are Medicaid reimbursable for persons living with an SMI designation or with behavioral health and/or substance use disorder needs.

Strategic Approach

As described in the Protocol for Assessment of Beneficiary Eligibility and Needs, and Provider Qualifications for H2O Services, AHCCCS plans to begin implementation with the most acute member population, inclusive of members who are experiencing homelessness, are living with an SMI designation, and are living with an active chronic health condition or are currently in a correctional facility. AHCCCS plans to leverage previous experiences and existing infrastructure as a starting place to implement the approved H2O services through a structured, phased-in approach.

AHCCCS has utilization, waitlist, and demographic data on the unmet housing needs of the H2O eligible population. The approved H2O services provide an opportunity for the State of Arizona to expand many of these activities, infuse much needed resources into the existing provider community, and integrate new providers such as Community-Based Organizations (CBOs) and localities into the agency's network to

expand the program's reach and ability to serve these members. AHCCCS will braid H2O funding into existing systems, and stand up new programming and providers to fill the existing gaps.

AHCCCS also recognizes a need to integrate new partners into the State's housing infrastructure. AHCCCS will utilize a third party administrator (TPA), known as the H2O Program Administrator (H2O-PA) to assist with successful program implementation, maintenance, and administration of the H2O program. As proposed, the H2O-PA will support AHCCCS in increasing provider enrollment for CBOs addressing Health Related Social Needs (HRSNs), verify member eligibility for H2O services following AHCCCS guidelines, coordinate H2O services with the Managed Care Organizations (MCOs) and providers, develop a streamlined process for H2O-providers to submit actions for reimbursement and ensure compatibility with Medicaid claims, monitor and track H2O service utilization data, and provide technical assistance to H2O-providers based on established AHCCCS policies. The H2O-PA will be procured over the next year to meet the planned October 1, 2024 go-live date for the H2O program.

All of the strategic approaches described above and throughout this document have been discussed and thoroughly vetted by the community of stakeholders in Arizona. Since the October 14, 2022 waiver approval, AHCCCS has engaged in three separate rounds of stakeholder engagement, holding workgroups specific to MCOs, providers, CBOs, tribes, and members. Decisions described in this document have been discussed with these partners, with consensus between these groups being paramount to the agency's decision to move forward with any of these program structures.

Once AHCCCS' proposed implementation plan is submitted to CMS, AHCCCS will move to update agency medical and contract policy manuals, and will update contractual requirements for MCOs consistent with approved implementation strategies. Updated policies, contracts, new provider types and provider requirements, H2O-PA requirements, and H2O member eligibility standards will be established and implemented consistent with the planned October 1, 2024, go-live date.

After initial implementation, AHCCCS plans to continue phasing-in the H2O program based on available resources and presenting members' needs. Eventually, the goal is to expand H2O resources to additional enrolled members, identified with high health care needs who are presenting as homeless or at risk of homelessness, including approved housing supports and necessary wraparound services. AHCCCS will use available data to identify additional populations that can benefit from H2O services, determine if community capacity exists to meet these needs, and analyze program improvements that need to be made through the administration of the H2O program. Furthermore, AHCCCS will host community meetings with Medicaid beneficiaries to identify potential barriers to H2O participation and use their feedback to inform decisions about the design, implementation, monitoring, and evaluation of the H2O initiative. AHCCCS anticipates hosting annual meetings to gather this information.

Plan for Establishing and/or Improving Data Sharing and Partnerships - STC 83 (a)

A key aspect of AHCCCS' approach to improving care coordination for members experiencing homelessness includes establishing statewide data sharing across multiple systems and affiliated organizations. Arizona has three Continuums of Care (CoC) that serve Maricopa County, Pima County, and the remaining 13 counties known as the Balance of State. AHCCCS currently has a process for sharing limited data from Arizona's three Homeless CoCs with the MCOs. Additionally, AHCCCS participates in a workgroup with the Arizona Department of Housing (ADOH) and representatives from the three CoCs to build a large-scale data sharing infrastructure for a statewide data warehouse that will include data from Arizona's three Homeless Management Information Systems (HMIS) and AHCCCS member data for

members that have signed an information release form. AHCCCS has also implemented a statewide Closed-Loop Referral System (CLRS) to allow health care providers to screen members for HRSNs and refer them to local community organizations for assistance.

International Classification of Diseases (ICD)-10 HRSN Z Code utilization will be an integral part of identifying members with HRSN needs. However, AHCCCS is aware that the current utilization of HRSN Z Codes for housing instability is highly underutilized and does not fully capture the number of Medicaid members who are experiencing homelessness. Until HRSN Z Code utilization rises to a point of data reliability, utilizing the additional data from HMIS will be essential when trying to identify Medicaid members who are experiencing homelessness and are eligible for H2O services. Additionally, the HMIS data can be used to identify members who receive housing assistance through alternative fund sources or those who return to homelessness after being housed through H2O services. AHCCCS will continually identify ways HMIS data integration can support monitoring and evaluation of member outcomes throughout the demonstration period.

Data Sharing Agreements and Data Matching with the CoCs for HMIS Data

AHCCCS holds data sharing agreements directly with the Maricopa County CoC and the Balance of State CoC to receive HMIS data on AHCCCS members experiencing homelessness. AHCCCS is working with the remaining CoC in Pima County to receive HMIS data which will result in receiving data from all three CoCs in the State of Arizona. The data sharing agreements have resulted in AHCCCS identifying thousands of members experiencing homelessness and connecting them quickly to follow-up and wraparound care. AHCCCS' process for data matching is as follows:

- Through a Business Associate Agreement (BAA) AHCCCS grants permission to the HMIS lead agency to access that population's information,
- The CoC grants permission to the HMIS lead agency through Board approval to access that population's HMIS Information,
- The HMIS lead agency generates a report from the HMIS system with the identifying information on the population (typically filtering a By Name Homeless list),
- The HMIS lead agency utilizes an AHCCCS-approved data clearinghouse in order to data match HMIS Information to AHCCCS eligibility information,
- If needed, the HMIS lead agency will also use AHCCCS Online and AHCCCS' Prepaid Medical Management Information System (PMMIS) to do a manual review if the eligibility clearinghouse indicates conflicting information,
- The HMIS lead agency downloads matching information and uses a business intelligence tool to link the AHCCCS information to the HMIS Information,
- The data is distributed to parties under the permissions granted by AHCCCS and the CoC,
- The member's MCO works to reach out to the member to connect them to care, and
- AHCCCS uses the report to identify members experiencing homelessness who are missing HRSN Z Codes.

Integration of Data from Arizona's HMIS via the Data Warehouse Enterprise for Linkage Arizona (DWEL AZ)

AHCCCS is currently developing statewide data sharing infrastructure to house and share information from Arizona's three HMIS along with limited health care information to improve care coordination for members experiencing homelessness, known as DWEL. This project is led by a collaboration between the HMIS CoCs, ADOH, AHCCCS, Arizona's statewide crisis provider, the Arizona Department of Economic Security (ADES), community stakeholder leaders from homeless shelters and human service providers, as well as members with lived experience. The goal of building the shared data warehouse is to improve the

provision of care for members, increase timely access to services, reduce the duplication of services, improve access to and utilization of resources, increase data quality, and increase communication among organizations serving members experiencing homelessness. A critical aspect of the project includes utilizing a Member Release of Information Form that will be signed by the member and will give permission to send their data to the data warehouse for care coordination. Establishing data sharing agreements with participating organizations is another critical aspect of the project. DWEL is scheduled to go live in 2024 and will include a user interface for front line staff at homeless shelters to view information including the member's MCO as well as limited information to note if the member has had a recent hospitalization, engaged crisis services, visited an emergency department, received inpatient care, or had a child within the last year. Being able to view limited service utilization will help front line staff identify if the member needs any follow up care or wraparound support that can be provided through H2O.

Connecting Arizona's Tribal Regional Behavioral Health Authorities

AHCCCS currently requires HMIS access and utilization for all housing staff at the MCOs. AHCCCS is leading an initiative to standardize MCO utilization and expectations in HMIS as well as standardized access to reporting granted by the CoCs. Additionally, AHCCCS will be working to get HMIS access to the Tribal Regional Behavioral Health Authorities (TRBHAs) for American Indian members.

Statewide Closed-Loop Referral System

Another approach AHCCCS is taking to improve data sharing throughout the State of Arizona includes the statewide CLRS, known as CommunityCares. The system is available to all AHCCCS providers and CBOs at no cost and is designed to allow health care providers to quickly and easily screen members for HRSN. The system has the Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE) tool preloaded to assess for HRSN, and has the capability to accept other evidence-based HRSN screening tools used by providers across the State of Arizona. CommunityCares went live in November 2022 and is increasing the number of participants throughout the State of Arizona. CommunityCares will be an additional tool for front-line workers to connect members to H2O services.

Key Partnerships Related to Health-Related Social Needs (HRSN) Service Delivery - STC 83(b)

AHCCCS is an active partner with providers and community organizations across the state who are focused on addressing HRSN. These organizations include the statewide Health Information Exchange (HIE), statewide CLRS vendor, statewide crisis provider, homeless shelters throughout Arizona, statewide Housing Administrator, other state agencies, county and city housing authorities and governing bodies, providers, members, advocacy organizations, associations, and MCOs. AHCCCS has provided information about H2O services that will become available in October 2024 to these organizations and will continue to provide updates and education throughout the development and implementation of the H2O program. AHCCCS plans to release information to partners incrementally, and the H2O-PA will play a vital role in assisting AHCCCS to establish a well trained network of providers and community partners that will implement the H2O program.

Gathering feedback from members, providers, MCOs, and community stakeholders has been essential as AHCCCS has developed the implementation strategy, and will continue to be essential during H2O implementation. AHCCCS will continue to engage with, and involve, the following groups in decision making as new services and policies are developed related to H2O.

Managed Care Organizations (MCOs)

AHCCCS has long been a leader in health care innovation, serving its members through the creative and effective use of managed care delivery systems. Throughout that time, AHCCCS has learned that, just as populations change, a Medicaid managed care program is most effective when it continually evolves and innovates, and AHCCCS views implementation of HRSN services, specifically the H2O program, as the next innovation that will improve member care and health outcomes by taking steps to effectively treat the whole person. With H2O, AHCCCS strives to build upon past successes to improve health outcomes for its members and ensures its long-term sustainability.

Beginning in the state fiscal year 2024, AHCCCS MCOs will be contractually required to address HRSN using the statewide CLRS, known as CommunityCares. The MCOs will also be responsible for increasing provider utilization of CommunityCares. Care Management staff providing one-on-one care management for AHCCCS members will be required to use CommunityCares to screen and refer members on their caseload. Providers and staff using CommunityCares are able to use any screening tool they like as long as it screens for homelessness/housing instability, food insecurity, transportation assistance, employment instability, utility assistance, interpersonal safety, justice/legal involvement, and social isolation/social support. If an MCO or provider is not yet enrolled with CommunityCares, they will be required to maintain a publicly available Community Resource Guide with information on local resources that address and provide support for health-related social needs. The Community Resource Guide will be updated annually and available on the MCO's website. The resources provided in the Community Resource Guide must be focused on the needs and geographic area of the MCO's member population.

As AHCCCS moves forward with H2O program implementation, MCO contracts and responsibilities will continue to evolve. Requirements to effectively coordinate care with their assigned members' existing care team, the H2O-PA, and any new providers that enter the member's care team as a result of participation in H2O will be included in the contracts beginning October 1, 2024. AHCCCS will leverage the relationship between the MCOs and the H2O-PA to ensure appropriate care coordination is occurring, warm handoffs are happening where necessary, and that no duplication of benefits are occurring.

Community Based Organizations (CBOs)

Over the next year, AHCCCS will build a diverse network of H2O service providers based on the existing relationships throughout the State of Arizona. Entities that comprise the H2O service provider network will include existing Medicaid providers, but will also include many CBOs with no previous experience billing Medicaid for services. A successful partnership with these CBOs will be essential to the successful implementation of the H2O program.

Engagement with CBOs to date has been a major source of information that helped shape many of the proposed implementation strategies, including the idea of the H2O-PA. As described by these partners, consistent, time sensitive, and targeted training will be necessary to ensure standardized and quality implementation of the proposed H2O program. Additionally, it is essential AHCCCS establishes a structure for CBOs to have a single point of contact through the H2O-PA for contracting and billing to ensure they have the capacity to serve all AHCCCS members across the State of Arizona, rather than requiring them to contract with multiple MCOs. The H2O-PA will assist CBOs in complying with all applicable Medicaid billing processes and practices.

AHCCCS has partnered with Corporation for Supportive Housing (CSH) to conduct a survey with CBOs in rural areas in order to understand the number and types of CBOs across the State of Arizona, clearly understand their unique challenges and needs when it comes to onboarding as a Medicaid provider and

meeting provider qualifications for H2O services. AHCCCS will use the results to inform the H2O-PA Request for Proposal (RFP) and work to ensure the H2O-PA services are specifically designed to meet the unique needs of CBOs. AHCCCS will continue to engage with and learn from these CBO partners throughout the implementation planning process.

Existing Medicaid Providers

In addition to CBOs, existing Medicaid providers will be paramount to successful implementation, especially related to the tenancy and pre-tenancy wraparound services. AHCCCS has an established network of integrated and behavioral health providers, health homes, who are familiar with delivering these kinds of wraparound services and supports to members living with an SMI designation and connecting them with existing HRSN resources.

Currently, health home providers are responsible for the coordination and provision of covered behavioral and physical health services. This includes a range of recovery focused services such as assessment, diagnostics, treatment planning, medication services, medical management, case management, transportation, peer and family support services, counseling, health and wellness groups, Supported Employment (SE), Assertive Community Treatment (ACT), and care coordination to ensure continuity of care with the member's Primary Care Provider (PCP). Additionally, the health home providers ensure follow-up and continuing care post-crisis engagement. AHCCCS Complete Care, Regional Behavioral Health Agreement (ACC-RBHA) contracts require that contractors identify and assign health homes for individuals living with an SMI designation within five days of enrollment with the contractor. Under the ACC-RBHA model, health homes are responsible for provision of whole-person care to members.

Health homes are responsible for ensuring that members are connected to all necessary services and supports, regardless of whether it is a Medicaid funded service. This includes connection to natural and community resources that can address HRSN, such as food, clothing, and housing. Once a member has been connected to a health home, they act as the responsible entity for ensuring that the member's needs are thoroughly assessed and that the member's treatment plan is responsive to all identified needs.

Throughout the initial phase of H2O implementation, AHCCCS will work with the H2O-PA, MCOs, CBOs, and individual providers to build a network that has capacity to meet the provider qualifications described in the Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for H2O Services, and one that can serve additional populations that will be included in future phases of implementation.

While the MCO and health home arrangement described above meets the needs of about 90% of the AHCCCS population, the remaining 10% of the Medicaid population, primarily the State's American Indian/Alaska Native (AI/AN) population is served through the American Indian Health Program (AIHP). AIHP functions differently than MCOs, wherein AIHP members can receive services from any AHCCCS-registered provider. Accordingly, they are not assigned a health home and the responsibility for care coordination lies on the Fee-For-Service (FFS) providers, except when the member is enrolled with a TRBHA or the member has voluntarily chosen to be empaneled with an American Indian Medical Home (AIMH).

For members who are enrolled with a TRBHA for their behavioral health assignment, the TRBHA is responsible for case management and care coordination as outlined in the Intergovernmental Agreements (IGAs). When available, AIHP members have the opportunity to become empaneled with an IHS/Tribal 638 facility that has met the criteria to become an AIMH for primary care case management and care

coordination. In general, the majority of AIHP members receive their health care services at an IHS/Tribal 638 facility. FFS providers, including IHS/Tribal 638 facilities and AIMHs, and TRBHAs will be able to help identify H2O eligible members and refer them to the H2O-PA to verify member eligibility and available services. The H2O-PA will then identify an H2O provider to refer the member to, alert the TRBHA, AIMH, or IHS/638 facility, and submit the referral to the H2O provider. The H2O provider would then be responsible for including the TRBHA, AIMH, or IHS/638 facility in ongoing coordination for the member during their involvement with H2O services.

H2O Program Administrator (H2O-PA)

As mentioned throughout this document, the proposed TPA known as the H2O-PA will serve a foundational role in successful implementation of the H2O program. As currently proposed, the H2O-PA will oversee several aspects of initial and ongoing implementation, including training, onboarding new CBOs/providers, H2O member eligibility and monitoring, data collection, provision of supporting documentation, and will serve as a claims clearinghouse for H2O providers. All of these functions will be accomplished in coordination with AHCCCS and the members' existing care team, including MCOs and existing providers, and informal supports.

Related to provider training, the H2O-PA will maintain capacity to provide standard training for all H2O providers, and ensure consistency as well as sharing of best practices across the State of Arizona. They will be able to evaluate outcomes in real time and work with providers who are not meeting outcome expectations. They will leverage AHCCCS policy to determine the appropriate training method and make adjustments based on the needs of the provider and provide timely and accurate responses to provider, member, and community questions related to H2O services and implementation.

Specific to onboarding new H2O providers, the H2O-PA will identify new providers who are not currently Medicaid providers and confirm they meet the identified H2O provider qualifications. They will ensure service delivery is culturally responsive and/or trauma-informed, and, if applicable, will assist providers with onboarding as Medicaid providers, including CBOs. They will ensure statewide standardization in the onboarding process for new H2O providers and monitor HRSN network capacity.

Related to data analysis, the H2O-PA will collect and analyze data, including ensuring statewide consistency in data collection and analysis. The H2O-PA will assist AHCCCS in utilizing the data in real time to identify providers struggling to meet performance measures and implement relevant technical assistance and oversight. Additional analysis will include monitoring of program outcomes based on service utilization and review of demographic disparities in housing referrals and/or lease up rates. AHCCCS will align efforts towards addressing demographic disparities in housing with CoC program efforts, informed by work at HUD. This includes ensuring H2O Providers use the CoC Race and Ethnicity Analysis Tool and align with strategies identified in CoC Race Equity Collaboratives. when possible. One example of how AHCCCS is working to address potential disparities in implementation is through the eligibility criteria, historically AHCCCS has focused targeted efforts on persons who meet high-cost high-need criteria, these efforts target populations who seek medical treatment and incur high costs. For H2O, AHCCCS is shifting to predictive modeling and providing eligibility to members who have diagnosed chronic health conditions from the point of diagnosis rather than waiting for costs to be incurred. AHCCCS anticipates this will help us reach a population of individuals who are not readily engaged in the health care system. The H2O-PA will provide dashboards that track program performance and provide AHCCCS with a pulse on the status of program implementation and targets on a daily basis.

On a broader scale, AHCCCS' Health Equity Committee is committed to researching and developing

processes that address health disparities to ensure health equity among all AHCCCS members. The committee has developed a Health Equity Toolkit that will be used internally to ensure new and revised AHCCCS policies and procedures include a focus on health equity. The committee is also focused on improving data collected on race, ethnicity, sex, gender, and sexual orientation to improve health equity and better serve AHCCCS members that may face systemic barriers. More information on AHCCCS' Health Equity Committee can be found here.

Because many new H2O providers will not have historically billed Medicaid, it is essential that AHCCCS allow for these organizations to operate in a manner that is consistent with reimbursement methodologies familiar to them. In addition, AHCCCS is aware that providers often must use a braided funding model in order to be able to operate with a "no wrong door" approach, having capacity to meet member needs regardless of funding criteria. AHCCCS seeks to standardize H2O invoicing processes to align with multiple fund sources such as Emergency Solutions Grant (ESG) and Community Development Block Grant (CDBG) to build a system that removes the administrative burden from the providers while ensuring compliance with funding expectations. Accordingly, the H2O-PA will establish a streamlined, standardized invoice process for CBOs and existing Medicaid providers to minimize administrative burden and ensure providers have the time and capacity to spend most of their time providing direct service to the members.

The H2O-PA will also have the responsibility of ensuring standard practices are utilized for reviewing eligibility of members across the State of Arizona based on the requirements set by AHCCCS. They will be responsible for reviewing the list of potentially eligible individuals provided by AHCCCS then verifying that the member meets the eligibility criteria and that the H2O provider has completed the screening tool and care management plan as outlined in the protocol. They will also track utilization of enhanced shelters and collaborate with the AHCCCS Housing Administrator to monitor rental assistance programs to ensure members do not exceed six months of the enhanced shelter service or rental assistance within the five year period and coordinate any necessary transitions with the member's care team.

Lastly, the H2O-PA will provide oversight and conduct onsite inspections at the enhanced shelters and other relevant H2O providers. They will be responsible for ensuring appropriate credentials and certifications are on-file, and will ensure that all appropriately qualified providers with capacity are offered as a choice to participating members.

AHCCCS Housing Administrator

On October 1, 2021, Arizona Behavioral Health Corporation (ABC) and HOM, Inc. (HOM) became the new centralized AHCCCS Housing Administrator for the non-TXIX AHCCCS Housing Program throughout the State of Arizona. ABC provides quality, affordable, and supportive housing for persons with behavioral health needs in Arizona. ABC contracts with HOM to administer rent payments and perform day-to-day housing program operations for the AHCCCS Housing Program. HOM has been a trusted partner of ABC for over 20 years and currently serves over 3,500 households in housing for ABC and other partners throughout Arizona.

The mission of the AHCCCS non-TXIX housing program is to provide safe, high quality, economically, and programmatically sustainable housing with individualized support services to ensure stable housing for all eligible members as a foundation to improve their physical and behavioral health outcomes, well-being, and self-determination. AHCCCS will implement additional contractual requirements within the AHCCCS Housing Administrator contract to ensure effective coordination of benefits for members participating in H2O. Key components of the contract expansion for H2O implementation include:

- Establishing partnerships and Memorandum of Understandings (MOUs) with public housing authorities across the State of Arizona to develop a pool of permanent housing vouchers available for members to transition from H2O rental assistance payment to an alternative long term subsidy,
- Develop a software system that allows for tracking members receiving H2O rental assistance, flagging when they are within 30 days of the six month maximum and to allow for seamless transition to alternative fund source within the software system,
- Track members move-in dates, exit dates, exit reasons to support monitoring and evaluation, and
- Provide onsite space for pre-tenancy and tenancy support staff to co-locate across the State of Arizona in order to provide members with ease of access to their support providers.

Tribes

Throughout the development of H2O, AHCCCS held a special tribal consultation and two tribal listening sessions to solicit tribal input on specific issues/considerations related to the housing needs of tribal populations, including tribal persons living in rural or frontier areas, in urban areas, and on reservations. Since the approval of H2O, AHCCCS has held several more tribal consultation meetings to gain feedback and provide updates on the implementation status of H2O.

Given the significant social risk factor of health that housing and homeless issues play for Arizona's American Indian/Alaska Native (AI/AN) population, it is critical that H2O-PA considers the supports that will address unique needs and cultural considerations of tribal communities and individual members. Specifically, the H2O-PA will need to help address concerns often faced by tribal communities including overcrowding, the prevalence of "couch surfing" as well as domestic violence.

AHCCCS plans to partner with the Southwest Tribal Housing Alliance, a non-profit organization that represents Indian Housing Authorities and Tribal Housing Departments in the southwest. AHCCCS will also be working with the non-profit organization Native American Connections who has extensive experience providing affordable and low-income housing programs as well as the provision of wraparound services.

AHCCCS will continue to partner with and learn from tribes throughout the planning and ultimate implementation of H2O. It is essential that AHCCCS partners with TRBHA, Indian Health Services (IHS), Tribal and Urban Indian facilities across the State of Arizona to ensure that appropriate training and referral pathways are established once H2O is implemented. Lastly, AHCCCS looks forward to strengthening existing and building new partnerships with tribal leaders, tribal health departments, and tribal housing departments, where appropriate, to ensure a successful coordination of benefits for tribal members participating in H2O.

Sister State Agencies

AHCCCS' partnerships with other Arizona State Agencies will play a vital role in the successful implementation of H2O. Across various projects and populations, AHCCCS often partners with the ADES, ADOH, ADHS, Arizona Governor's Office (GO), Arizona Department of Education (ADE), Arizona Department of Veterans Affairs (VA), Arizona Department of Corrections Rehabilitation & Reentry (ADCRR), and the Arizona Department of Administration (ADOA). Communication and collaboration with these entities will continue to ensure that overlapping populations are being served effectively, resources are being applied appropriately and funding is being utilized in a complementary manner to serve members as they achieve their health care goals.

Contexture - Arizona's Statewide Health Information Exchange (HIE) and CLRS Provider

Since 2007, AHCCCS has partnered with Contexture to administer a statewide HIE. Members give

permission to provide their health information to the HIE for improved care coordination. Providers are able to access member medical information using the HIE to better understand recent services the member has received. One example of an important tool AHCCCS providers through the HIE includes the receipt of daily reports for members enrolled at their clinic who have been admitted, transferred, or discharged from a hospital, known locally as the Hospital Admissions, Discharge, and Transfer (ADT) Report. This report enables health care providers to connect with members to provide follow up care. The HIE is a valuable resource for providers throughout the State of Arizona.

In November 2022, Contexture, in collaboration with AHCCCS, launched Arizona's Statewide CLRS, known as CommunityCares, to help AHCCCS providers quickly and easily screen and refer members for help with HRSNs. Contexture contracts with the software vendor Unite Us to provide the platform for CommunityCares. AHCCCS is eager to expand the utilization of CommunityCares throughout the State of Arizona over the coming years. It's important to note that while the HIE and CLRS are managed by Contexture, the CLRS and the HIE cannot be housed or accessed within the same platform and member information must be kept separately due to state regulations.

Plans for Changes to Information Technology (IT) Infrastructure - STC 83(c)

AHCCCS' Information System Division (ISD) will be responsible for internal system enhancements for the new H2O services. These system changes will allow AHCCCS to collect data on member characteristics, eligibility, consent, screening, referrals, and service provision. AHCCCS is planning to make the following enhancements to systems for H2O:

Member Eligibility through AHCCCS Online

- AHCCCS will provide a file of potential H2O members to the H2O-PA.
- The H2O-PA will confirm eligibility of potential H2O members.
- The H2O-PA will provide AHCCCS with H2O eligibility confirmation.
- AHCCCS will store eligibility information and update the AHCCCS Online portal for providers.
- AHCCCS will communicate eligibility to MCOs via a Unique Population File.
- The H2O-PA will outreach to appropriate contractors to facilitate services, this includes providing communication to the MCOs on the H2O service provider selected by the member.
- The H2O-PA will send AHCCCS a list of AHCCCS members receiving H2O services.
- The H2O-PA/MCO will send AHCCCS updates when a member is no longer eligible for H2O services.

Claims and Encounter System

- Providers will verify that a member is eligible for H2O using AHCCCS Online.
- Providers will submit claims to the H2O-PA.
- Claims will be flagged as H2O eligible services, using closed HCPC codes that will only be made available to H2O Providers.

AHCCCS will require validation of service received and submission of claims in order to track utilization and member receipt of the service.

Financial System

- Outreach and education services will be funded at 50% Federal Medical Assistance Percentage (FMAP) through the H2O infrastructure dollars. The H2O-PA will send invoices to AHCCCS for payment.
- For all other H2O services, AHCCCS has identified a set of closed codes to dedicate to H2O services. These codes will be open to H2O providers only and monitored through the H2O-PA for financial reporting.
- The H2O-PA will assist with tracking utilization of transitional housing services and will alert AHCCCS when the member has met the maximum amount of six months within the demonstration period.

Provider System

- The H2O-PA will be responsible for ensuring H2O providers meet provider qualifications as defined in the Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for H2O Services prior to onboarding and providing services.
- AHCCCS Provider Enrollment will create three new H2O provider types to assist with streamlined onboarding and system structure that supports administrative oversight and monitoring. The new provider types will include, Statewide Housing Administrator, Enhanced Shelter, and H2O Provider. Each provider type will have a series of requirements that need to be met during the credentialing process. The H2O-PA will assist the CBO's and existing Medicaid providers with completing the necessary applications and providing an attestation that provider requirements have been met, prior to becoming an AHCCCS registered provider.
- The H2O-PA will be designated as provider type 01, group payment ID.
- AHCCCS will utilize the H2O-PA in order to disseminate information on the new provider types to MCOs, providers, and stakeholders.

Transformed Medicaid Statistical Information System (TMSIS)

- AHCCCS will utilize the recipient exception code to mark a member as H2O eligible.
- AHCCCS will utilize a flag in claims/encounters to mark a service as an H2O service.

Tracking and Improving Access for Medicaid Members Enrolled in Other Programs - STC 83(d)

In Arizona, Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) are managed by the Arizona Department of Economic Security (ADES). The Women, Infants, and Children (WIC) program is managed by ADHS. Individuals and families are able to apply for Medicaid, SNAP, and TANF benefits using one statewide application. Applications can be submitted online through the Health-e-Arizona Plus (HEAPlus) application system, in person at a ADES office location, at one of Arizona's community assistor locations with the help of a care navigator, or completed using a paper form and mailed in. To apply for WIC in Arizona, an individual or family member can submit an application to ADHS using the WIC Arizona Participant Portal or make an appointment at their local county health department. To further support intergovernmental member coordination, in 2021, Arizona updated the HEAPlus application to include a pop-up notification to alert members that are eligible for SNAP that they

may also be eligible for WIC. The pop-up includes a direct link to help members apply for WIC. Member information is also sent to WIC when a member who is eligible for SNAP may be eligible for the WIC program.

Arizona has an online application system that allows individuals to apply for medical, nutrition, and cash assistance. Eligibility determination for Medicaid, is managed by ADES, with the exception for Arizona Long Term Care System (ALTCS) and FFS members, which is performed in-house by AHCCCS.

While AHCCCS, ADES, and ADHS provide these programs separately, AHCCCS and its sister agencies coordinate and collaborate often with regular leadership meetings and information sharing. For example, leaders from WIC provide education to AHCCCS' MCOs during quarterly meetings. During the meetings, information is provided on WIC services, updates, data, utilization, and ways members can access the program. AHCCCS, ADES, and ADHS have partnered to develop a multi-agency approach to enrollment in health and human services related public benefit systems in Arizona called Enroll Arizona. The goal of Enroll Arizona is to simplify navigation for consumers of the multiple public benefits systems into a single, user-friendly solution that streamlines back-end administration and reduces operational costs. The goal is to establish a health and human services one stop portal that provides a single online location to help Arizonans access services available to them. Lastly, AHCCCS' statewide HIE has drafted a five-year plan to identify opportunities to increase data sharing across agencies.

AHCCCS has a data sharing agreement and a process for AHCCCS to receive SNAP and TANF beneficiary information from ADES for members who are enrolled with AHCCCS. The AHCCCS team will be setting up a data sharing agreement with ADHS to receive WIC beneficiary information for members who are enrolled with AHCCCS. This information will be used to improve care coordination and enrollment for members, which may include an analysis of HRSN equity amongst state program beneficiaries and modifications to improve health equity. AHCCCS is assessing the value of adding an indicator to the eligibility portal to show when an AHCCCS member is also a beneficiary of WIC, SNAP, or TANF. A MARS-E compliant agreement and data sharing process would need to be established with ADHS to obtain WIC beneficiary data.

AHCCCS contracts with ABC and their subcontractor HOM Inc. to serve as the AHCCCS Housing Administrator and provide administrative oversight of the AHCCCS Housing Program. Together, ABC and HOM administer rent payments and perform day-to-day housing program operations, this includes management of the waitlist. Additionally, ABC and HOM Inc. administer HUD CoC programs and Mainstream voucher programs. Through their administrative oversight they have access to waitlist information and utilization for these programs. AHCCCS and the AHCCCS Housing Administrator will work in partnership to align prioritization criteria where possible in order to support members in H2O served with short-term rental assistance with meeting the program criteria and prioritization to transition to one of these programs within the six month period. AHCCCS Housing staff work directly with CoC programs in the development of coordinated entry assessment processes in order to support policy alignment for member prioritization. AHCCCS understands the importance of partnering with Public Housing Authorities (PHAs) in order to onboard additional long term subsidy resources for H2O eligible members to transition to within the six months. AHCCCS has identified local, state, and federal efforts that can be explored to improve and standardize partnerships with PHA's. This includes partnering with a local municipality on a pilot project to identify and solve system gaps when PHA's allocate vouchers to the H2O initiative. The state is currently in the process of aligning contract requirements, scope of work, outcomes, and priority populations with the local municipality and the pilot is scheduled to begin June of 2024. AHCCCS staff will work with the Maricopa CoC throughout the pilot to create a tool kit that can be shared with other PHA's throughout the

County. Next, the state has identified statewide strategies that can be explored to support the efforts towards system alignment. AHCCCS participates in the Governor's Interagency Community Council on Homelessness and Housing, the state has worked to ensure there are defined goals for state agencies to clearly define the housing continuum and explore opportunities for standardization at the state level. Strategies for alignment include, developing and aligning standard operating procedures such as definition of the intervention, provider qualifications, required training, staff to member ratios, frequency of contact requirements, program outcomes, assessment tools and expectations. Strategies also include administrative alignment with budget templates, program outcomes, program reporting, member prioritization, contract terms, and data sharing. Through statewide standardization across the housing continuum the state can better align funding mechanisms that support braided funding models without placing the administrative burden on providers. Lastly, the state has identified potential opportunities for federal alignment. The state was accepted in the Housing Accelerator program; the state has identified a core team of experts providing housing and supportive services throughout the state to utilize technical assistance through the Housing Accelerator to receive information and advocate for federal opportunities to support system standardization. An example includes, federal alignment of housing choice voucher application including processes and forms, this way a member can enter into 6 months of short-term rental assistance through H2O and have a seamless transition to an available HCV with a partnering PHA without needed to complete a new application or process because of nuances that are not necessary within a particular PHA. The AHCCCS Housing Administrator will be responsible for assisting the state with establishing partnerships with PHAs and tracking utilization of vouchers attributed to H2O.

Implementation Timeline - STC 83(e)

AHCCCS has outlined a timeline for implementing the H2O Program by coordinating with operations, policy, financial, and IT subject matter experts in order to achieve the October 1, 2024 go-live date. Implementing a new complex program requires a significant amount of effort, AHCCCS has already begun executing on the timeline in order to achieve the go-live date. However, key design features of the H2O Program still require executive decisions and have other dependencies such as the scope of the H2O-PA and the procurement of the H2O-PA. During and after the H2O-PA procurement process, the timeline may need to be adjusted. For example, AHCCCS will need to coordinate internally, with existing MCOs, and the newly procured H2O-PA in order to determine the approach of go-live on October 1, 2024. During the H2O-PA procurement and contracting process, AHCCCS will evaluate the need for a phased rollout of the H2O program based on geographic, demographic, or other factors during implementation. Ultimately, the H2O Program will be operationalized across the entire State of Arizona as these are critical services for many Arizonans. Additionally, the timeline is dependent on approvals from CMS on waiver related items in order to fully execute on the proposed implementation timeline.

An initial timeline for the implementation plan has been outlined in **Appendix A: Implementation Plan Timeline**. Key tasks by the following areas have been outlined: H2O program development; H2O-PA; policy development; systems enhancements; rate development; provider network building, engagement, and training; and H2O Go-Live. Specific milestones have been defined for each area that are critical for a successful implementation of the H2O Program.

Rate and Payment Methodologies - STC 83(f), STC 43, STC 83(g), STC 44, and STC 36(iv)

AHCCCS will develop and finalize rates by July 2024 to ensure ample time for feedback and operationalization is completed for the October 1, 2024, go-live date. The rate development process includes determining the appropriate payment method by service type, drafting of the initial rates, engaging stakeholders, and finalizing the rates.

AHCCCS will utilize the H2O-PA for all payment processing for the HRSN services as approved in STC 32 and subsequent H2O deliverables. Through the H2O-PA, a FFS payment model will be utilized to reimburse providers for all services. Since AHCCCS will utilize the H2O-PA for all payments, there is no need to include the HRSN services outlined in STC 32 for inclusion of the MCO capitation rate or to update the MLR. The MCOs will not be involved in the payment of the HRSN services.

Once the payment methodology has been finalized for each service and a determination has been made on the full scope of the H2O-PA, AHCCCS will work to begin updating necessary IT systems. Development and testing of the rates and IT systems updates will happen concurrently with the final approval of the rates to ensure all components are ready for go-live.

Service definitions identified in Exhibit 1 of the Protocol for Assessment of Beneficiary Eligibility and Need sand Provider Qualifications for H2O Services:

Service Name	Payment Approach/Methodology
Outreach and Education Services	• Modified Cost Reimbursement • Administrative Contract • Invoiced Based Payments
Transitional Housing- Apartment or Rental Unit (Rental Assistance)	• Cost-based reimbursement up to a cap • Six month's rent at 110% Fair Market Rent (FMR) based on household size which will be evaluated and approved on an annual basis • Include Statewide Housing Administrator management expenses in rate
Transitional Housing- Enhanced Shelter	Fee Schedule Based- Per Diem Rate
One-time transition and moving costs	Cost-based reimbursement up to a cap
Home accessibility modifications and remediation	Cost-based reimbursement up to a cap
Housing Pre-Tenancy Services	Fee Schedule Based- Healthcare Common Procedure Coding System (HCPCS) Unit of Service
Housing Tenancy Services	Fee Schedule Based- HCPCS Unit of Service

Partnership with State and Local Entities - STC 83(h) and STC 45

AHCCCS has a long history of partnering with State and local entities for care coordination for AHCCCS members. AHCCCS will expand these partnerships in order to assist beneficiaries in obtaining non-Medicaid funded housing and other supports upon the conclusion of temporary Medicaid payment for such supports. This process begins with the development of the H2O eligibility criteria and ensuring that priority

populations align with H2O eligibility. AHCCCS participates in various community discussions around data integration, prioritization schemas for Coordinated Entry, and special initiatives throughout the State of Arizona; this participation will allow AHCCCS to align prioritization schemas with local initiatives. For instance, in Maricopa County the Coordinated Entry Prioritization is based on the members status of chronic homelessness, their length of time experiencing homelessness, and their Vulnerability Index – Service Prioritization Decision Assistance Tool (VI SPDAT) score which helps to determine the level of acuity of an individual. AHCCCS will review the CoC housing prioritization list to identify members who are priority on the CoC list who meet H2O eligibility. These members may be prioritized to receive rental assistance and begin the lease up process prior to a CoC PSH subsidy being available. AHCCCS will work in partnership with the CoCs to ensure these members maintain CoC prioritization once housed in order for them to receive a transfer to a permanent housing subsidy when one becomes available.

In addition, AHCCCS will develop MOUs with local Public Housing Authorities (PHAs) who are interested in establishing a Bridge to Permanency model within their community. Currently, there are several PHAs who have homeless preference included in their strategic plan. These vouchers are often underutilized due to a lack of dedicated support services and the length of time it takes for a member to locate an affordable unit in their community. Through the Bridge to Permanency partnership, AHCCCS will be able to assist H2O eligible members with receiving Pre-Tenancy housing support and temporary rental assistance in order for them to lease a unit using temporary rental assistance until the PHA is able to transition the member to a permanent subsidy. AHCCCS will work in partnership with the PHA to identify the number of vouchers they can commit to the project. The statewide Housing Administrator will maintain an inventory of PHA transition subsidies. Members will be pulled from the waitlist and assisted with leasing a unit based on the projected number of long term subsidies becoming available within a six month period.

As described under the Housing Administrator section, AHCCCS currently provides rental assistance to eligible members through a state appropriation. AHCCCS will use permanent subsidies in the AHCCCS Housing Program as a transition of last resort if an alternative subsidy is not available within the six month period.

The enhanced shelter model plays an integral role in member stabilization and coordination within the homeless service sector. In Arizona, the community by name list is pulled from data from the HMIS. In order for a member to remain active on the community by name list they must have an open entry in an emergency shelter or receive a service transaction from an outreach or support service only provider every 90 days. In order to build upon this partnership with local entities AHCCCS will ensure enhanced shelter providers utilize HMIS for data entry and follow community data standards. This will ensure H2O eligible members have access to enhanced shelter services to move from unsheltered situations and remain active on the community by name list for a housing subsidy match.

Prior to implementation, AHCCCS will establish MOUs with local public housing authorities, CoC leads, Low-Income Housing Tax Credit (LIHTC) properties, municipalities, and shelter providers. The MOU will describe the partnership, data requirements, and subsidy commitment as indicated in the implementation plan.

Summary

AHCCCS has been conducting stakeholder engagement activities, holding workgroups with external entities, and working internally since the waiver approval on October 14, 2022 to develop the H2O Program. The H2O Implementation Plan was informed through these activities and outlines the necessary steps to

ensure a successful implementation of the H2O Program. The detailed timeline is outlined in Appendix A and is summarized below:

- H2O program development - Finalizing the H2O Program through October 2024.
- H2O-PA - Completing the procurement process of the H2O-PA by July 2024.
- Policy development - Updating and creating provider policies by August 2024.
- Systems enhancements - Completing system requirement gathering between AHCCCS, H2O-PA, and MCOs by September 2024.
- Rate development - Finalizing rates and implementing a billing process by September 2024.
- Provider network building, engagement, and training - Conducting outreach and developing an initial provider network by September 2024.
- H2O Go-Live - Determining a phased-in approach and meeting all milestones by September 2024.

The H2O-PA is critical to the success of the H2O Program and will support AHCCCS by increasing provider enrollment for CBOs addressing HRSNs, verifying member eligibility for H2O services following AHCCCS guidelines, coordinating H2O services with the MCOs and providers, developing a streamlined process for H2O-providers to submit actions for reimbursement and ensuring compatibility with Medicaid claims, monitoring and tracking H2O service utilization data, and providing technical assistance to H2O-providers based on established AHCCCS policies. AHCCCS will be procuring the H2O-PA over the next year and will coordinate with the procured vendor to determine an appropriate rollout strategy to ensure that the H2O Program is ready for the planned October 1, 2024 go-live date.

Appendix A: Implementation Plan Timeline

TASKS	10/23	11/23	12/23	1/23	2/24	3/24	4/24	5/24	6/24	7/24	8/24	9/24	10/24
H2O Program Development													
Stakeholder Feedback and Overall H2O System Design (November 2022 - October 2023)													
Come to consensus on eligibility criteria including definition of chronic conditions. (June 2023 – March 2024)													
Finalize and Submit Implementation Plan (May 2023 - October 2023)													
Milestone: CMS Approval of H2O Protocol													
Milestone: CMS Approval of New Initiatives Implementation Plan													
H2O-PA													
Review RFI on TPA Option, Conduct Meetings with MCOs, and Make Determination of H2O-PA RFP. (July 2023 – October 2023)													
Develop H2O-PA RFP. (September 2023 – January 2023)													
Post RFP, Evaluate, Select Vendor (February 2023 - May 2024)													
H2O-PA Award and Contract Signed (June 2024 - July 2024)													
Milestone: H2O-PA Contract Signed													
Policy Development													
Update MCO Contracts and AHCCCS Medical Policy Manual (AMPM) as necessary to align with H2O-PA responsibilities. (March 2024 – August 2024)													
H2O-PA develops policies for H2O service providers. (July 2024 – September 2024)													
Milestone: AHCCCS Approval of updated AMPM.													
Milestone: AHCCCS approval of MCO contracts.													
Systems Enhancements													
AHCCCS System Requirements (October 2023 - February 2024)													
AHCCCS System Development													

TASKS	10/23	11/23	12/23	1/23	2/24	3/24	4/24	5/24	6/24	7/24	8/24	9/24	10/24
(November 2023 - May 2024)													
MCO System Development (April 2024 – August 2024)													
H2O-PA System Development (July 2024 – September 2024													
System Testing (April 2024 - September 2024)													
Milestone: Technologies meet requirements for go-live.													
Rate Development													
Initial development of rates and stakeholder engagement. (October 2023 – March 2024)													
Finalize rates. (March 2024 – July 2024)													
Update billing process for H2O service providers and implement rates. (July 2024 – September 2024)													
Milestone: Ability for H2O service providers to submit invoices/claims to H2O-PA and be paid.													
Provider Network Building, Engagement, and Training													
AHCCCS to conduct initial outreach to potential H2O service providers. (April 2024 – June 2024)													
H2O-PA develop provider network. (July 2024 – September 2024)													
H2O-PA conducts initial provider education. (August 2024 – September 2024)													
H2O-PA conducts ongoing provider education, outreach, and maintenance of provider network. (October 2024 - Ongoing)													
Milestone: H2O service network meets requirements for coverage.													
H2O Go-Live													
Consider phased-in approach for go-live date. (November 2023 – March 2024)													
Final decisions on phased-in approach for go-live. (April 2024 – June 2024)													
Engage Medicaid beneficiaries post-implementation to identify potential barriers and inform future decisions.													

TASKS	10/23	11/23	12/23	1/23	2/24	3/24	4/24	5/24	6/24	7/24	8/24	9/24	10/24
(March 2025 and beyond)													
Milestone: H2O Go-Live October 1, 2024													

Attachment G
Monitoring Protocol (reserved)

Attachment H
Evaluation Design

Arizona Health Care Cost Containment System

Arizona Section 1115 Demonstration Waiver

Evaluation Design

January 2024

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Background

The Centers for Medicare & Medicaid Services (CMS) and federal law set standards for the minimum care states must provide Medicaid-eligible populations, while also giving States an opportunity to design and test their own strategies for funding and providing healthcare services. Section 1115 of the Social Security Act permits states to test innovative demonstration projects and evaluate state-specific policy changes to increase efficiency and reduce costs. On October 14, 2022, 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). The extension was approved for an additional five years effective October 14, 2022, through September 30, 2027.[1-1] The following eight Waiver programs have been implemented or extended:

- AHCCCS Complete Care (ACC)
- AHCCCS Complete Care–Regional Behavioral Health Agreement (ACC-RBHA)
- Arizona Long Term Care System (ALTCS)
- Comprehensive Health Plan (CHP)
- Housing and Health Opportunities (H2O)[1-2, 1-3]
- Prior Quarter Coverage (PQC) Waiver
- Targeted Investments (TI) 2.0[1-4]
- Tribal Dental Authority

ACC

On October 1, 2018, AHCCCS transitioned 1.5 million members to seven health plans with fully integrated physical health (PH) and behavioral health (BH) services. By joining PH and BH services under single health plans with their own networks of providers who treat all aspects of healthcare needs, providers are better able to facilitate care coordination and achieve better health outcomes. ACC plans are responsible for providing integrated PH and BH services for (1) adults who are determined not to have a serious mental illness (SMI) (excluding members enrolled with Department of Economic Security/Division of Developmental Disabilities [DES/DDD]); (2) children, including those with special healthcare needs (SHCN) (excluding members enrolled with DES/DDD and the Department of Child Safety [DCS] CHP); and (3) members determined to have an SMI who opt out and transfer to an ACC for the provision of PH services.

Seven ACC contracts were awarded to health plans across three geographical service areas (GSAs): all seven plans are available in the Central GSA (Maricopa, Pinal, and Gila counties); two plans serve the North GSA

1-1 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: Aug 3, 2023.

1-2 The evaluation of the H2O program is awaiting further guidance from CMS. A separate evaluation design for the H2O program will be submitted at a later date.

1-3 H2O will be implemented on October 1, 2024.

1-4 The TI 2.0 program will have a separate evaluation design.

(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) plus a third plan in Pima County.[1-5]

On November 26, 2018, AHCCCS submitted a request to amend the Special Terms and Conditions (STCs) of the previously approved Section 1115 Demonstration Waiver to "reflect the delivery system changes that resulted from the ACC managed care contract award".[1-6] Effective October 1, 2022, AHCCCS updated its contracts with ACC health plans to include RBHA responsibilities for those with an SMI designation called ACC-RBHAs. Following the contract update, four plans serve only the ACC population and three plans assumed RBHA responsibilities to serve both the ACC and SMI populations.

Through the Waiver extension, the ACC program seeks to continue to provide quality healthcare to members, ensuring access to care, maintaining, or improving member satisfaction, and continuing to operate as a cost-effective managed care delivery model.

ACC-RBHA

Historically, adult members received BH services through a geographically designated Regional Behavioral Health Authority (RBHA) contracted with AHCCCS, with few exceptions. BH services were covered separately from PH services. To improve care coordination, health outcomes, and efficiencies, AHCCCS took its first step toward integrated care through awarding one health plan the RBHA contract for Maricopa County, effective April 2014. The contract required that the RBHA add PH services for the SMI population it covered for BH services. In October 2015, RBHA contractors statewide began providing integrated care for members with an SMI.[1-7, 1-8] AHCCCS conducted its largest historical care integration initiative in 2018 by transitioning all acute care members without an SMI designation to seven ACC integrated healthcare plans which provided coverage for PH and BH care.

Effective October 1, 2022, RBHA contracts expired and were replaced with an integrated health system, AHCCCS Complete Care–Regional Behavioral Health Agreement, or ACC-RBHA, a program that awarded ACC contracts with RBHA services. Three health plans were awarded an ACC-RBHA contract: 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 ACC-RBHA plans, individuals with an SMI designation could receive both PH and BH benefits under one health plan. Additionally, ACC-RBHA GSAs aligned to match previous ACC and ALTCS GSAs.[1-9]

1-5 Arizona Health Care Cost Containment System. AHCCCS Complete Care: The Future of Integrated Healthcare. Available at: AHCCCS Complete Care: The Future of Integrated Healthcare Delivery (azahcccs.gov). Accessed on: Aug 3, 2023.

1-6 Arizona Health Care Cost Containment System. Re: Arizona's 1115 Waiver. AHCCCS Complete Care Technical Clarification [email]. November 26, 2018. Available at: https://www.azahcccs.gov/Resources/Downloads/ACC_TechnicalAmendmentCorrection_11262018.pdf. Accessed on: Aug 3, 2023.

1-7 NORC at the University of Chicago. *Supportive Services Expansion for Individuals with Serious Mental Illness: A Case Study of Mercy Maricopa Integrated Care.* August 18, 2017. Available at: https://es.mercycareaz.org/assets/pdf/news/NORC-MercyMaricopa-CaseStudy.pdf. Accessed on: Aug 3, 2023.

1-8 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: Aug 3, 2023.

1-9 Arizona Health Care Cost Containment System. *ACC-RBHA/TRBHA Map*. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/behavioralhealth.html. Accessed on: Aug 3, 2023.

Under the Waiver extension, the ACC-RBHA program will continue to provide quality healthcare to members with BH needs, ensuring access to care for members, and maintaining or improving member satisfaction with care while continuing to operate as a cost-effective managed care delivery model.

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 program for members who are elderly or who 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) that provides services through prepaid, capitated arrangements with managed care organizations (MCOs). ALTCS members with intellectual disabilities are serviced through a statewide MCO operated by DES/DDD. ALTCS aims to ensure that members are living in the least restrictive, most integrated settings possible and are actively engaged with and participating in their communities.

Under the Waiver extension, the ALTCS program will seek to provide quality healthcare to members with LTSS needs, ensuring access to care for members, and maintaining or improving member satisfaction while continuing to operate as a cost-effective managed care delivery model. The Waiver extension allows for 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 coronavirus disease 2019 (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 public health emergency (PHE) through the Waiver. 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.

CHP

On April 1, 2021, AHCCCS integrated PH and BH through replacement of the Comprehensive Medical and Dental Program (CMDP) with Mercy Care DCS CHP, with the goal of simplifying healthcare coverage and encouraging better care coordination for foster children. CHP operates as a single acute health plan under contract with AHCCCS for children who are determined to be Medicaid eligible and who are in DCS custody. 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 an independent living program, or in the custody of a probation department and placed in out-of-home care.

Through the Waiver extension, the CHP program will seek to provide quality healthcare to eligible foster children, ensuring access to care for members, maintaining or improving member satisfaction with care, and operating as a cost-effective managed care delivery model.

PQC

On January 18, 2019, CMS approved Arizona's request to amend the Waiver to allow AHCCCS to waive PQC retroactive eligibility.[1-10] 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 are 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.[1-11]

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 allows AHCCCS the opportunity to evaluate the progress toward the Waiver's goals of continuity of care and personal responsibility through encouraging members to maintain health coverage and reducing gaps in coverage when members "churn" (individuals moving on and off Medicaid repeatedly), therefore improving health outcomes, reducing costs to AHCCCS, and promoting the sustainability of the Medicaid program.

Tribal Dental Authority

Since the 2016 legislative session, Arizona has been working to restore limited AHCCCS coverage for dental 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 ALTCS. In 2017 the governor of Arizona restored the emergency dental benefit for adult AHCCCS members through the 2018 fiscal year budget. In 2020 the governor and the State legislature authorized AHCCCS to request approval from CMS to reimburse Indian Health Service (IHS) and Tribal 638 facilities to cover the cost of adult dental services that are eligible for 100 percent federal medical assistance percentage (FMAP), that are in excess of the $1,000 emergency dental limit for adult members in Arizona's State Plan and the $1,000 dental limit for individuals ages 21 years or older enrolled in the ALTCS program.[1-12]

American Indians and Alaskan Natives (AI/AN) 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 lack of practicing dentists in IHS or tribal health facilities in rural and frontier locations. On December 21, 2020, AHCCCS applied for permission to enable 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 the 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 $1000 emergency dental limit for adult members in Arizona's State plan and beyond the $1,000 dental limit for individuals ages 21 years or

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1-10 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: Aug 3, 2023.

1-11 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: Aug 3, 2023.

1-12 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: Aug 3, 2023.

older enrolled in ALTCS, when these services are provided by participating IHS facilities and/or participating facilities operated by tribes under the Indian Self Determination and Education Assistance Act (ISDEAA).

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

Previous Report Findings

For all programs that are a continuation of the prior demonstration period (October 1, 2016, through September 30, 2021), results from the August 2021 Interim Evaluation Report, approved by CMS on October 6, 2022, indicated general improvement in healthcare outcomes and delivery.[1-13] The Executive Summary of the Interim Evaluation Report is located in Appendix E. Results in the Summative Evaluation Report of the prior demonstration period will be submitted to CMS in March 2024. Results for ACC hypotheses were generally mixed. Two measures related to access to care improved while three worsened, and five measures related to quality of care improved while five worsened. Measures related to follow-up visits after hospital or emergency department (ED) stays for mental illness and opioid perscription management increased among the ACC-RBHA group, while measures relating to chronic condition management fell between the baseline and evaluation periods. The CHP program exhibited an increase among preventative visits or wellness services and management of BH conditions. Among the ALTCS Developmental Disability (ALTCS-DD) group, measures related to quality of life decreased; however, analysis of claims data showed improvements in preventive care and management of BH conditions. The ALTCS Elderly and Physically Disabled (ALTCS-EPD) group exhibited improvements in preventive care, access to care, and management of prescription medications, while there was a worsening among measures of managing chronic conditions and hospital readmissions. Analysis of the PQC waiver found that just over half of the measures showed improvement in the likelihood and continuity of member enrollment; however, results showed a worsening in access to care. Three measures for the TI program showed improvements after statistical analysis. No measures indicated a worsening for the TI population, and most measures showed favorable changes that were not statistically significant in part due to small sample sizes in the comparison group. These results should be interpreted with caution, as changes in rates may be heavily influenced by the COVID-19 PHE.

The independent evaluator will include a synthesis of results from the prior demonstration period's Summative Evaluation Report in the Interim Evaluation Report of the Waiver renewal, due to CMS by September 30, 2026.

Additional research questions and measures have been added to this evaluation design since the approval of the prior demonstration period's Interim Evaluation Report in October 2022. Table 1-1 lists the research questions that are new to each program for the Waiver renewal.

[1-13] Arizona Health Care Cost Containment System. Arizona Section 1115 Waiver Evaluation: Interim Evaluation Report. Available at: https://www.medicaid.gov/sites/default/files/2022-10/ahcccs-interim-eval-rprt.pdf. Accessed on: Dec 8, 2023.

Table 1-1—New Research Questions for the Waiver Renewal

Program	Research Question
ACC	**1.2**: What care coordination strategies or activities have providers been conducting during the renewal period? **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? **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?
ACC-RBHA	**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?
ALTCS	**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?
CHP	**2.1**: Do CHP members have the same or higher rates of appropriate immunizations in the remeasurement period as compared to the baseline?

2. Evaluation Questions and Hypotheses

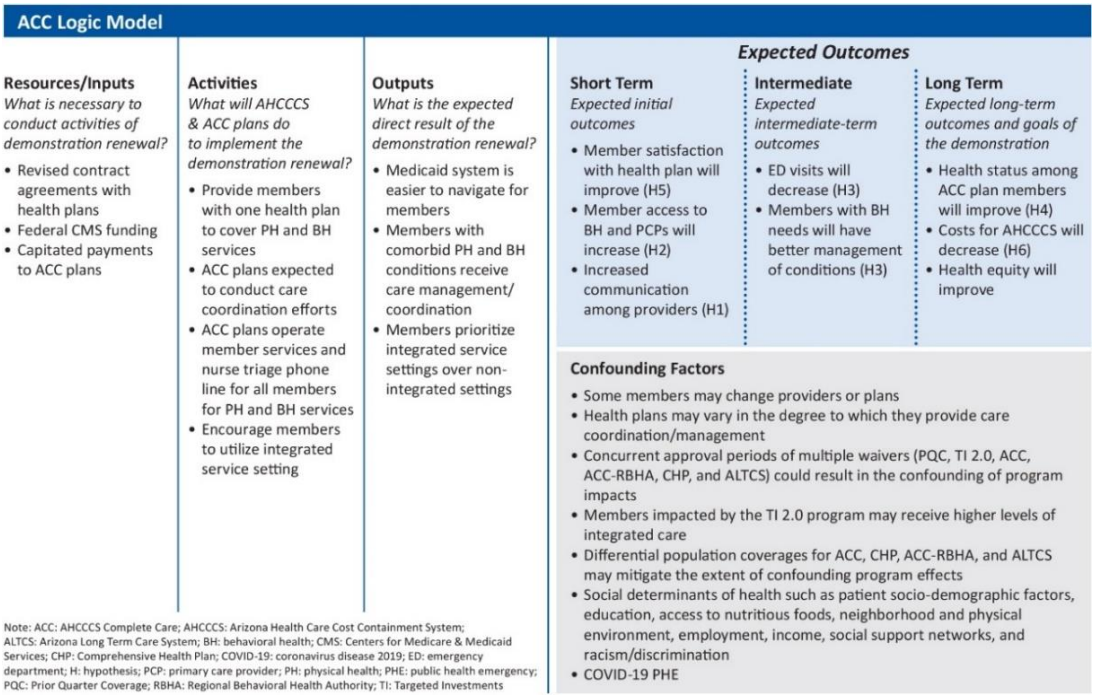
This section provides each program's logic model, hypotheses, research questions, and measures, which focus on evaluating the impact of the Arizona Health Care Cost Containment System (AHCCCS) Section 1115 Demonstration Waiver (referred to as the Waiver in this report).

ACC

Logic Model

Figure 2-1 illustrates that AHCCCS Complete Care (ACC) members, including the ACC population served by three AHCCC Complete Care-Regional Behavioral Health Agreement (ACC-RBHA) plans, should expect to find the Medicaid system easier to navigate. ACC members with physical health (PH) and behavioral health (BH) comorbidities will receive care coordination/management, and members will prioritize practices with integrated services over those with non-integrated services.[2-1] With an easier to navigate Medicaid system, member satisfaction should improve. With better care coordination/management, members with complex needs should see improved health outcomes, first shown by increased access to care and reduced utilization of emergency department (ED) visits. In the long term, this is expected to improve members' health and well-being while providing cost-effective care.

Figure 2-1—ACC Logic Model



[2-1] Care provided to members with a serious mental illness (SMI) will be evaluated in a separate component dedicated to the impacts of ACC-RBHA plans on this population.

Hypotheses and Research Questions

To comprehensively evaluate the ACC program, six hypotheses, listed in Table 2-1, will be tested using 16 research questions.

Table 2-1—ACC Hypotheses

ACC Hypotheses	
1	Health plans encourage and/or facilitate care coordination among primary care practitioners (PCPs) and BH practitioners.
2	Member access to appropriate care for routine medical conditions will be maintained or improved during the renewal period.
3	Quality of care will be maintained or improved during the renewal period.
4	Member self-assessed health outcomes will be maintained or improved during the renewal period.
5	Member satisfaction with their healthcare will be maintained or improved during the renewal period.
6	The ACC program provides cost-effective care.

Hypothesis 1 is designed to identify in detail the activities the plans conducted to further AHCCCS' goal of care integration by implementing strategies supporting care coordination and management. Barriers that persist during the renewal period will also be a focus of Hypothesis 1. These research questions will be addressed through semi-structured key informant interviews with representatives from the ACC health plans (including three ACC-RBHA plans that also serve the ACC population), as well as through beneficiary surveys and provider focus groups. The research questions and associated measures for Hypothesis 1 are presented in Table 2-2.

Table 2-2—Hypothesis 1 Research Questions and Measures

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
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
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?	
1-3	Percentage of members with follow-up after an ED visit for members with multiple high-risk chronic conditions
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

Hypothesis 2 will test whether access to care increased after the renewal of integrating BH and PH care into a single health plan. This hypothesis will be addressed using both claims/encounter data and beneficiary surveys. Where possible, rates will be calculated or reported both prior to and after the renewal of care integration. The measures and associated research questions associated with Hypothesis 2 are presented in Table 2-3.

Table 2-3—Hypothesis 2 Research Questions and Measures

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
2-2	Percentage of adults who accessed preventive/ambulatory health services
2-3	Percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation
2-4	Percentage of members who had a well-child visit in the first 30 months of life
2-5	Percentage of members 3–21 years of age who had a well-care visit with a PCP or obstetrician gynecologist (OB/GYN)
2-6	Percentage of members who reported they received care as soon as they needed
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
2-8	Percentage of members who reported they were able to schedule an appointment with a specialist as soon as they needed
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
2-10	Percentage of members who had engagement of SUD treatment

The primary goal of the renewal of ACC is to promote the health and wellness of its members by improving quality of care, particularly among those with both PH and BH conditions, which will be assessed under Hypothesis 3. This hypothesis will be addressed using both claims/encounter data and national/regional benchmarks. Where possible, rates will be calculated or reported both prior to and after the renewal of care integration. Table 2-4 describes the research questions and measures that AHCCCS will use to determine whether ACC is meeting the goal associated with Hypothesis 3.

Table 2-4—Hypothesis 3 Research Questions and Measures

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
3-2	Percentage of adolescents 13 years of age with appropriate immunizations
3-3	Percentage of adult members who reported having a flu shot or nasal flu spray
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
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
3-6	Percentage of members with a follow-up visit after hospitalization for mental illness
3-7	Percentage of members with a follow-up visit after an ED visit for mental illness

Hypothesis 3: Quality of care will be maintained or improved during the renewal period.	
3-8	Percentage of members with follow-up after an ED visit for SUD
3-9	Percentage of members diagnosed with a mental health 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?	
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
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
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

One of the primary goals of ACC is to provide higher-quality care for its members, ultimately leading to better health status, which will be evaluated under Hypothesis 4. To determine the overall health status among ACC members, the independent evaluator will utilize two survey questions asking members to report their overall health and overall mental or emotional health. The research questions and measures pertaining to Hypothesis 4 are listed in Table 2-5.

Table 2-5—Hypothesis 4 Research Questions and Measures

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
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

Hypothesis 5 seeks to measure member satisfaction with the ACC plans. Table 2-6 presents the measures and survey questions that will be used to assess member satisfaction.

Table 2-6—Hypothesis 5 Research Questions and Measures

Hypothesis 5: Member satisfaction with their healthcare will be maintained or improved during the renewal period.	
Research Question 5.1: Are members equally or more satisfied with their healthcare 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)
5-2	Percentage of members who reported a high rating of overall healthcare (8, 9, or 10 out of 10)

Hypothesis 6 (Table 2-7) seeks to measure the cost-effectiveness of the ACC program. A long-term goal of the ACC program is to provide cost-effective care for its members. Since cost effectiveness will not be evaluated solely based on the outcome of specific financial measurements, no specific measures are included under Hypothesis 6. The independent evaluator will calculate changes in total costs and examine cost drivers within the

Medicaid program consistent with guidance on analyzing costs associated with Section 1115 waivers.[2-2] The approach for assessing cost-effectiveness of ACC is described in detail in the Cost Effectiveness Analysis section.

Table 2-7—Hypothesis 6 Research Questions

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?
Research Question 6.2: What are the benefits/savings associated with the integration of care under ACC during the renewal period?

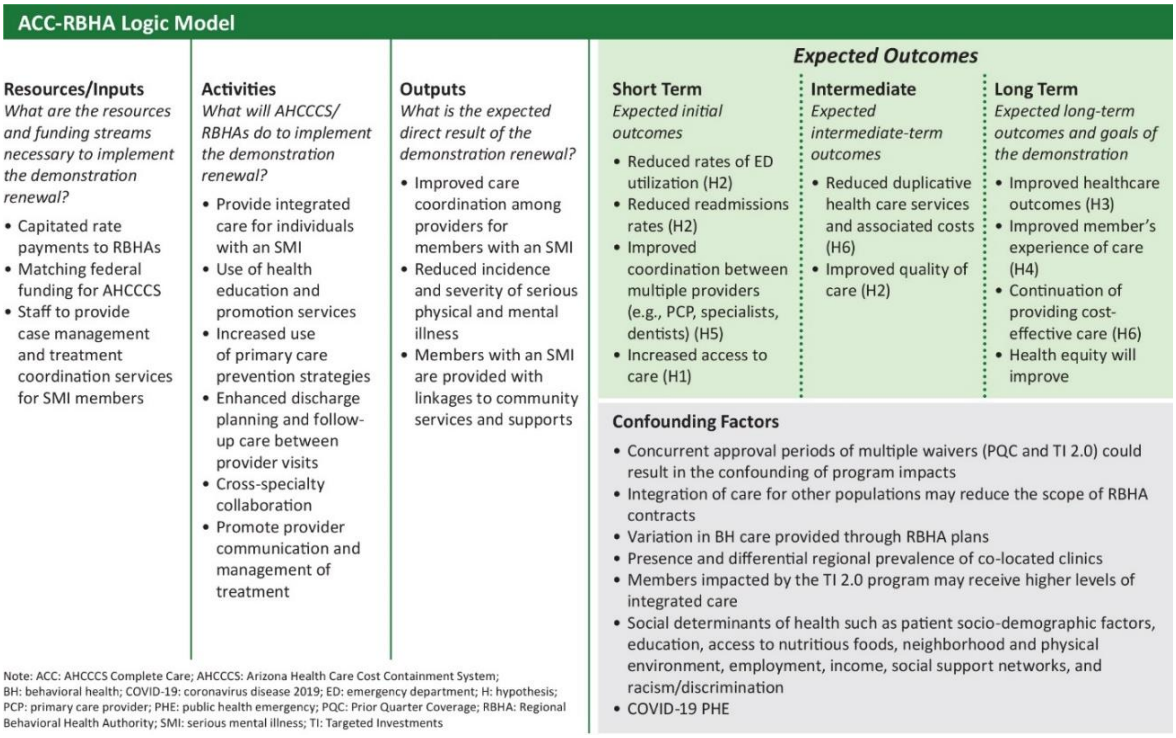
ACC-RBHA

Logic Model

Figure 2-2 illustrates that, given resources to fund ACC-RBHA, adult members with an SMI should continue to receive care coordination/management, their providers should follow enhanced discharge planning guidelines and conduct cross-specialty collaboration, thereby promoting communication among providers. By integrating PH and BH, member satisfaction is expected to be maintained or improved during the demonstration period. With better care coordination/management, members should have equal or improved access to care and utilization of ED visits resulting in equal or better health outcomes, overall health, and satisfaction with their health care experiences. In the long term, this is expected to improve members' health and well-being while providing cost-effective care.

2-2 United States Department of Health and Human Services. Appendix C: Approaches to Analyzing Costs Associated with Section 1115 Demonstrations for Beneficiaries with Serious Mental Illness/Serious Emotional Disturbance or Substance Use Disorders. Available at: https://www.hhs.gov/guidance/document/appendix-c-analyzing-costs-associated-demonstrations-smised-or-sud-0. Accessed on: Aug 2, 2023.

Figure 2-2—ACC-RBHA Logic Model



Hypotheses and Research Questions

To comprehensively evaluate the ACC-RBHA program, six hypotheses will be tested using 18 research questions. Table 2-8 lists the six hypotheses.

Table 2-8—ACC-RBHA Hypotheses

	ACC-RBHA Hypotheses
1	Member access to appropriate care for routine medical conditions will be maintained or improved during the renewal period.
2	Quality of care will be maintained or improved during the renewal period.
3	Health outcomes for adult members with an SMI enrolled in an ACC-RBHA will be maintained or improved during the renewal period.
4	Adult member satisfaction in ACC-RBHA health plans will be maintained or improved over the renewal period.
5	ACC-RBHAs encourage and/or facilitate care coordination among PCPs and BH practitioners.
6	ACC-RBHAs will provide cost-effective care for members with an SMI.

Hypothesis 1 will test whether access to care increased or was maintained throughout the demonstration renewal period. This hypothesis will be addressed using both claims/encounter data and beneficiary survey responses. The research question and measures associated with this hypothesis are listed in Table 2-9.

Table 2-9—Hypothesis 1 Research Questions and Measures

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 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
1-2	Percentage of adults who accessed preventive/ambulatory health services
1-3	Percentage of members who reported they received care as soon as they needed
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
1-5	Percentage of members who reported they were able to schedule an appointment with a specialist as soon as they needed
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
1-7	Percentage of members who had engagement of SUD treatment

The primary goal of providing integrated care for ACC-RBHA members with an SMI is to promote health and wellness by improving the quality of care. Hypothesis 2 will test whether the quality of care provided to members with an SMI improved or was maintained during the Waiver renewal. This hypothesis will be addressed using both claims/encounter data and beneficiary survey responses. The research questions and measures associated with the hypothesis are presented in Table 2-10.

Table 2-10—Hypothesis 2 Research Questions and Measures

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
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
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
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?	
2-5	Percentage of members who remained on antidepressant medication treatment
2-6	Percentage of members with a follow-up visit after hospitalization for mental illness
2-7	Percentage of members with a follow-up visit after an ED visit for mental illness
2-8	Percentage of members with follow-up 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 (total and by IP, intensive outpatient [IOP] or partial hospitalization, outpatient [OP], ED, or telehealth)

Hypothesis 2: Quality of care will be maintained or improved during the renewal period.	
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
2-12	Percentage of members with concurrent use of opioids and benzodiazepines
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
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?	
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

To determine the overall health status among ACC-RBHA members with an SMI, the independent evaluator will utilize two survey questions asking members to report their overall health and overall mental or emotional health. The measures and associated research questions are presented in Table 2-11.

Table 2-11—Hypothesis 3 Research Questions and Measures

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
3-2	Percentage of members who reported a rating of overall mental or emotional health as very good or excellent

Hypothesis 4 will measure member satisfaction and experience of care with the ACC-RBHAs, using three survey questions about members' ratings of the healthcare received from the ACC-RBHAs and providers. Table 2-12 presents the measures and survey questions that will be used to measure these outcomes.

Table 2-12—Hypothesis 4 Research Questions and Measures

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 healthcare compared to prior to the waiver renewal?	
4-1	Percentage of members who reported a high rating of overall healthcare (8, 9, or 10 out of 10)
4-2	Percentage of members who reported a high rating of health plan (8, 9, or 10 out of 10)
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

While ACC-RBHAs continued to provide integrated BH and PH care for their adult members with an SMI throughout the Waiver renewal period, there have been changes to care delivery for other AHCCCS members, namely the introduction of ACC in October 2018. Hypothesis 5 will consist of key informant interviews with health plan representatives, subject matter experts from AHCCCS, and providers to assess care coordination activities for the SMI population and identify any changes that could have resulted from the implementation of ACC. Table 2-13 presents the measures and research questions related to this hypothesis.

Table 2-13—Hypothesis 5 Research Questions and Measures

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
5-2	ACC-RBHA's reported challenges from any workforce shortages
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
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
5-5	AHCCCS' reported challenges from any workforce shortages
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
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

Hypothesis 6 (Table 2-14) will measure the cost-effectiveness of providing BH and PH care to members with an SMI through the ACC-RBHAs. A long-term goal of the ACC-RBHAs is to provide cost-effective care for their members. Because cost-effectiveness will not be evaluated solely based on the outcome of specific financial measurements, no specific measures are included under Hypothesis 6. The independent evaluator will calculate changes in total costs and examine cost drivers within the Medicaid program consistent with the guidance from the Centers for Medicare & Medicaid Services (CMS) on analyzing costs associated with Section 1115 demonstrations.[2-3] The approach for assessing cost effectiveness of the ACC-RBHAs is described in detail in the Cost-Effectiveness Analysis section.

Table 2-14—Hypothesis 6 Research Questions

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?
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?

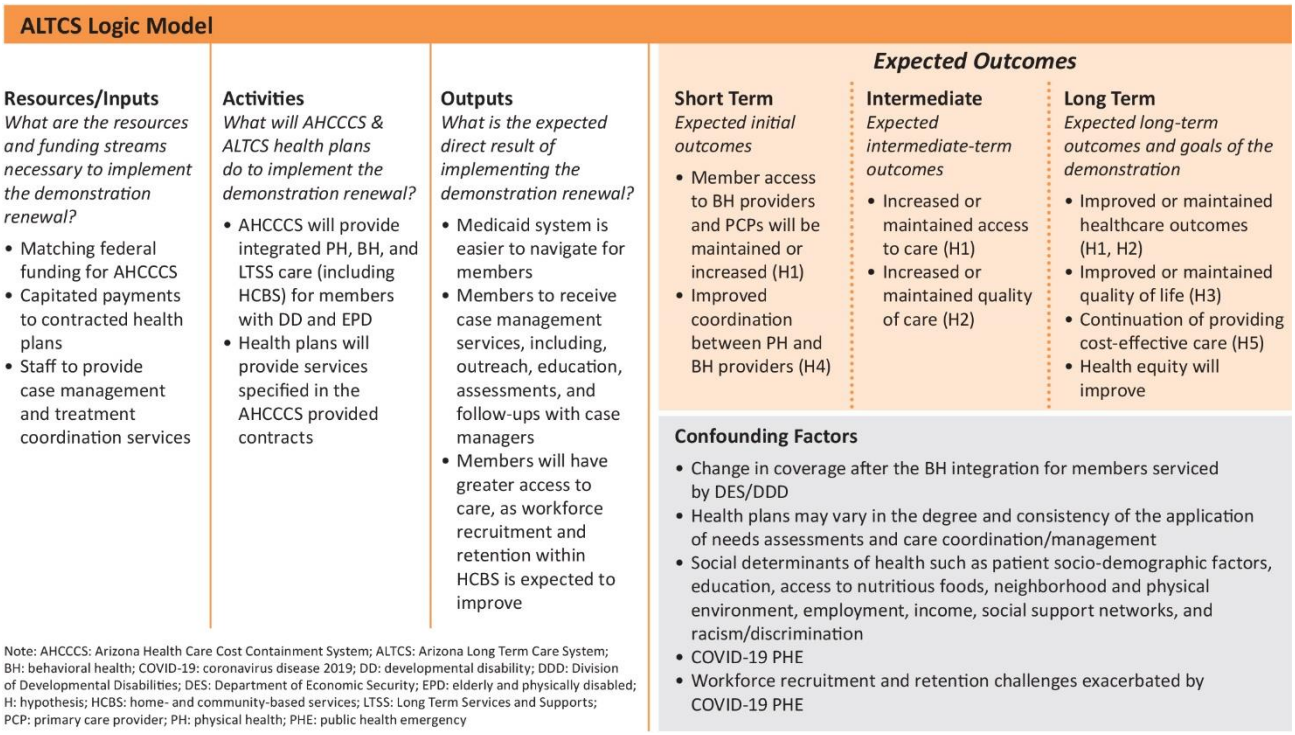
[2-3] Ibid.

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 to receive case management, and prioritize practices with integrated services over those with non-integrated services. With improvements to the navigation of the Medicaid system navigation, member access to care should improve. With better case management, members will likely see improved health outcomes, first shown by an increase in quality and access to care. In the long term, this is expected to improve members' health outcomes and well-being while providing cost-effective care.

Figure 2-3—ALTCS Logic Model



Hypotheses and Research Questions

To comprehensively evaluate the ALTCS program, five hypotheses will be tested using 17 research questions. Table 2-15 lists the five hypotheses.

Table 2-15—ALTCS Hypotheses

	ALTCS Hypotheses
1	Member access to appropriate care for routine medical conditions will be maintained or improved during the renewal period.
2	Quality of care will be maintained or improved during the renewal period.
3	Quality of life for members will be maintained or improved during the renewal period.
4	ALTCS encourages and/or facilitates care coordination among PCPs and BH practitioners.
5	ALTCS provides cost-effective care.

Hypothesis 1 is designed to determine if access to care will be maintained or improved during the renewal period. The measures to test this hypothesis and answer the associated research questions are listed below in Table 2-16.

Table 2-16—Hypothesis 1 Research Questions and Measures

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 elderly, physically disabled (EPD), and/or members with a developmental disability (DD) have the same or higher rates of access to care and primary care services compared to prior to waiver renewal?			
Measure	**Population**	**EPD**	**DD**
1-1	Percentage of members meeting minimum time/distance network standards	X	X
1-2	Percentage of members who accessed preventive/ambulatory health services	X	X
1-3	Percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation		X
1-4	Percentage of members who had well-child visits in the first 30 months of life		X
1-5	Percentage of members 3–21 years of age who had a well-care visit with a PCP or OB/GYN		X
Research Question 1.2: Do adult members who are elderly, physically disabled and/or members with DD have the same or improved rates of access to care as a result of the waiver renewal?			
Measure	**Population**	**EPD**	**DD**
1-6	Percentage of members who have a primary care doctor or practitioner		X
1-7	Percentage of members who had a complete physical exam in the past year	X	X
1-8	Percentage of members who had a dental exam in the past year	X	X
1-9	Percentage of members who had an eye exam in the past year	X	X
1-10	Percentage of members who had an influenza vaccine in the past year	X	X

To determine if quality of care is maintained or increased, Hypothesis 2 will evaluate measures associated with preventive care, BH care management, and utilization of care. The measures and associated research questions are presented in Table 2-17.

Table 2-17—Hypothesis 2 Research Questions and Measures

Hypothesis 2: Quality of care will be maintained or improved during the renewal period.			
Research Question 2.1: Do members who are elderly, physically disabled, and/or members with DD have the same or higher rates of preventive care compared to prior to waiver renewal?			
Measure	**Population**	**EPD**	**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	X	X
Research Question 2.2: Do members who are elderly, physically disabled, and/or members with DD have the same or better management of BH conditions compared to prior to waiver renewal?			
Measure	**Population**	**EPD**	**DD**
2-2	Percentage of members with a follow-up visit after hospitalization for mental illness	X	X
2-3	Percentage of adult members who remained on an antidepressant medication treatment	X	X
2-4	Percentage of members with follow-up after an ED visit for SUD	X	X
2-5	Percentage of members diagnosed with a mental health disorder	X	X
Research Question 2.3: Do adult members who are elderly, physically disabled have the same or better management of prescriptions compared to prior to waiver renewal?			
Measure	**Population**	**EPD**	**DD**
2-6	Percentage of members with dispensing events of high-risk medications	X	
2-7	Percentage of members who know what their prescription medications are for	X	
Research Question 2.4: Do members who are elderly, physically disabled, and/or members with DD have the same or higher rates of utilization of care compared to prior to waiver renewal?			
Measure	**Population**	**EPD**	**DD**
2-8	Number of emergent ED visits per 1,000 member months	X	X
2-9	Number of non-emergent ED visits per 1,000 member months		
2-10	Number of IP stays per 1,000 member months	X	X
2-11	Percentage of adult IP discharges with an unplanned readmission within 30 days	X	X

Hypothesis 3 evaluates if the quality of life for members remains the same or improves. The measures and associated research questions are presented in Table 2-18.

Table 2-18—Hypothesis 3 Research Questions and Measures

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?			
Measure	**Population**	**EPD**	**DD**
3-1	Percentage of members residing in their own home	X	X
3-2	Type of residence for adult members	X	X
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 elderly, physically disabled, and/or members with DD?			
Measure	**Population**	**EPD**	**DD**
3-3	Percentage of members who want to live somewhere else	X	X
3-4	Percentage of members who believe services and supports help them live a good life	X	X

Hypothesis 3: Quality of life for members will be maintained or improved during the renewal period.			
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 elderly, physically disabled and/or members with DD?			
Measure	**Population**	**EPD**	**DD**
3-5	Percentage of members able to go out and do things they like to do in the community	X	X
3-6	Percentage of members who have friends who are not staff or family members	X	X
3-7	Percentage of members who decide or have input in deciding their daily schedule		X
3-8	Percentage of members who usually like how they spend their time during the day	X	

Through key informant interviews, Hypothesis 4 assesses the experience of AHCCCS, the Department of Economic Security/Division of Developmental Disabilities (DES/DDD), and contracted plans continuing the care coordination efforts since integration in October 2019, including workforce shortages. Key informant interviews will also be used to assess any challenges reported by ALTCS Elderly and Physical Disability (ALTCS-EPD) and their contracted plans' during the renewal period, including workforce shortages. Finally, administrative claims/encounter data will be used to assess pertinent aspects of care coordination among the EPD population. The research questions and measures pertaining to this hypothesis are listed in Table 2-19.

Table 2-19—Hypothesis 4 Research Questions and Measures

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?			
Measure	**Population**	**EPD**	**DD**
4-1	DES/DDD and its contracted plans' reported barriers during the renewal period		X
4-2	DES/DDD and its contracted plans' reported challenges from any workforce shortages		X
4-3	ALTCS-EPD and its contracted plans' reported challenges from any workforce shortages	X	
Research Question 4.2: What care coordination strategies did DES/DDD and its contracted plans implement as a result of the waiver renewal?			
Measure	**Population**	**EPD**	**DD**
4-4	DES/DDD's reported evolution of care coordination since the integration period		X
Research Question 4.3: Did DES/DDD or its contracted plans encounter barriers to renewal of the waiver for care coordination strategies?			
Measure	**Population**	**EPD**	**DD**
4-5	DES/DDD and its contracted plans' reported barriers to implementing care coordination strategies		X
Research Question 4.4: Did AHCCCS encounter barriers related to the waiver renewal for members with DD or EPD?			
Measure	**Population**	**EPD**	**DD**
4-6	AHCCCS' reported barriers during the waiver renewal period	X	X
4-7	AHCCCS' reported challenges from any workforce shortages	X	X
Research Question 4.5: Did providers encounter barriers related to the waiver renewal for members with DD?			
Measure	**Population**	**EPD**	**DD**
4-8	Providers' reported evolution of care coordination since the integration period and remaining barriers during the renewal period		X

Hypothesis 4: ALTCS encourages and/or facilitates care coordination among PCPs and BH practitioners.			
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?			
Measure	**Population**	**EPD**	**DD**
4-9	Percentage of members with multiple high-risk chronic conditions who had follow-up after an ED visit	X	X
4-10	Percentage of members with patient engagement after discharge	X	X

Hypothesis 5 seeks to measure the cost-effectiveness of the ALTCS program. A long-term goal of ALTCS is to provide cost-effective care for its members. Because cost effectiveness will not be evaluated solely based on the outcome of specific financial measurements, no specific measures are included under Hypothesis 5. The independent evaluator will calculate changes in total costs and examine cost drivers within the Medicaid program consistent with CMS' guidance on analyzing costs associated with Section 1115 demonstrations.[2-4] The approach for assessing cost effectiveness of ALTCS is described in detail in the Methodology section, and the research questions are listed in Table 2-20.

Table 2-20—Hypothesis 5 Research Questions

Hypothesis 5: ALTCS provides cost-effective care.
Research Question 5.1: What are the costs associated with the waiver renewal?
Research Question 5.2: What are the benefits/savings associated with the waiver renewal?

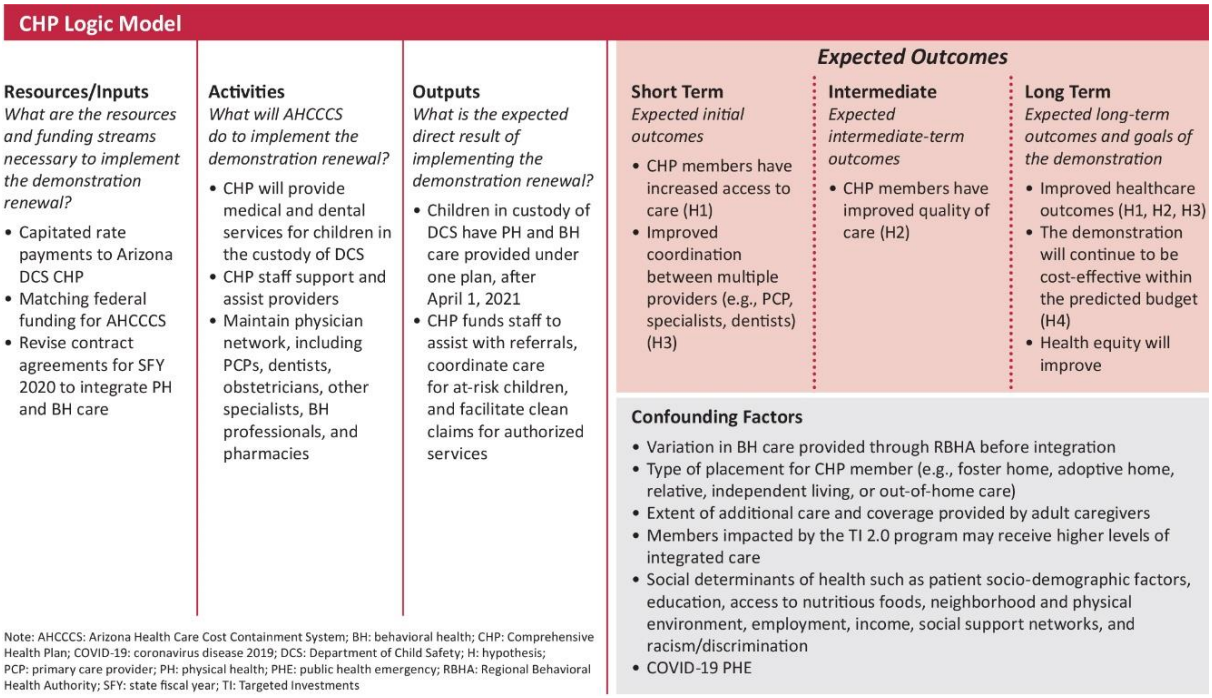
CHP

Logic Model

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

2-4 Ibid.

Figure 2-4—CHP Logic Model



Hypotheses and Research Questions

To comprehensively evaluate the CHP program, four hypotheses will be tested using 10 research questions. Table 2-21 lists the four hypotheses.

Table 2-21—CHP Hypotheses

	CHP Hypotheses
1	Member access to appropriate care for routine medical conditions will be maintained or improved during the integration period.
2	Quality of care will be maintained or improved during the integration period.
3	CHP encourages and/or facilitates care coordination among PCPs and BH practitioners.
4	CHP provides cost-effective care.

Hypothesis 1 is designed to determine whether the CHP activities during the Waiver maintain or improve member access to PCPs and specialists. Access to care will be assessed by focusing on members' PCPs, dental utilization, and opportunities to make appointments. The hypothesis will be addressed using claims/encounter data. The measures to test this hypothesis and answer the associated research questions are listed below in Table 2-22.

Table 2-22—Hypothesis 1 Research Questions and Measures

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 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
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 well-child visits in the first 30 months of life

Hypothesis 2 is designed to determine whether the CHP activities during the Waiver maintain or improve the quality of care provided to members. The research questions for this hypothesis will focus on preventive and wellness services, management of chronic conditions, mental health, and hospital utilization. This hypothesis will be addressed using claims/encounter data. The measures and associated research questions are presented in Table 2-23.

Table 2-23—Hypothesis 2 Research Questions and Measures

Hypothesis 2: Quality of care will be maintained or improved during the integration period.	
Research Question 2.1: Do CHP members have the same or higher rates of appropriate immunizations in the remeasurement period as compared to the baseline?	
2-1	Percentage of children 2 years of age with appropriate immunization status
2-2	Percentage of adolescents 13 years of age with appropriate immunizations
Research Question 2.2: Do 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
Research Question 2.3: Do 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
2-5	Percentage of members diagnosed with a mental health disorder
2-6	Percentage of members with follow-up after an ED visit for mental illness
2-7	Percentage of members with follow-up after hospitalization for mental illness
2-8	Percentage of members with a follow-up visit after an ED visit for SUD
Research Question 2.4: Do 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
2-10	Number of non-emergent ED visits per 1,000 member months
2-11	Number of IP stays per 1,000 member months

Hypothesis 3 (Table 2-24) is designed to identify in detail the activities CHP conducted to further AHCCCS' goal of care integration through implementing strategies supporting care coordination and management. Identifying barriers encountered during the transition to integrated care and implementing these strategies will also be a focus of Hypothesis 3. These research questions will be addressed through semi-structured key informant interviews with representatives from CHP.

Table 2-24—Hypothesis 3 Research Questions and Measures

Hypothesis 3: CHP encourages and/or facilitates care coordination among PCPs and BH practitioners.	
Research Question 3.1: What barriers did Mercy Care DCS CHP anticipate/encounter during the integration?	
3-1	Mercy Care DCS CHP's anticipated/reported barriers during transition
3-2	Mercy Care DCS CHP's reported challenges from any workforce shortages
Research Question 3.2: What care coordination strategies did Mercy Care DCS CHP plan/implement during integration?	
3-3	Mercy Care DCS CHP's planned/reported care coordination activities
Research Question 3.3: What barriers to implementing care coordination strategies did Mercy Care DCS CHP anticipate/encounter?	
3-4	Mercy Care DCS CHP's anticipated/reported barriers in implementing care coordination strategies

Hypothesis 4 (Table 2-25) seeks to measure the cost-effectiveness of CHP. A goal of CHP is to provide cost-effective care for its members. Because cost effectiveness will not be evaluated solely based on the outcome of specific financial measurements, no specific measures are included under Hypothesis 4. The independent evaluator will calculate changes in total costs and examine cost drivers within the Medicaid program consistent with CMS's guidance on analyzing costs associated with Section 1115 demonstrations.[2-5] The approach for assessing cost effectiveness of CHP is described in detail in the Cost Effectiveness Analysis section.

Table 2-25—Hypothesis 4 Research Questions

Hypothesis 4: CHP provides cost-effective care.
Research Question 4.1: What are the costs associated with the integration of care in the CHP?
Research Question 4.2: What are the benefits/savings associated with the integration of care in the CHP?

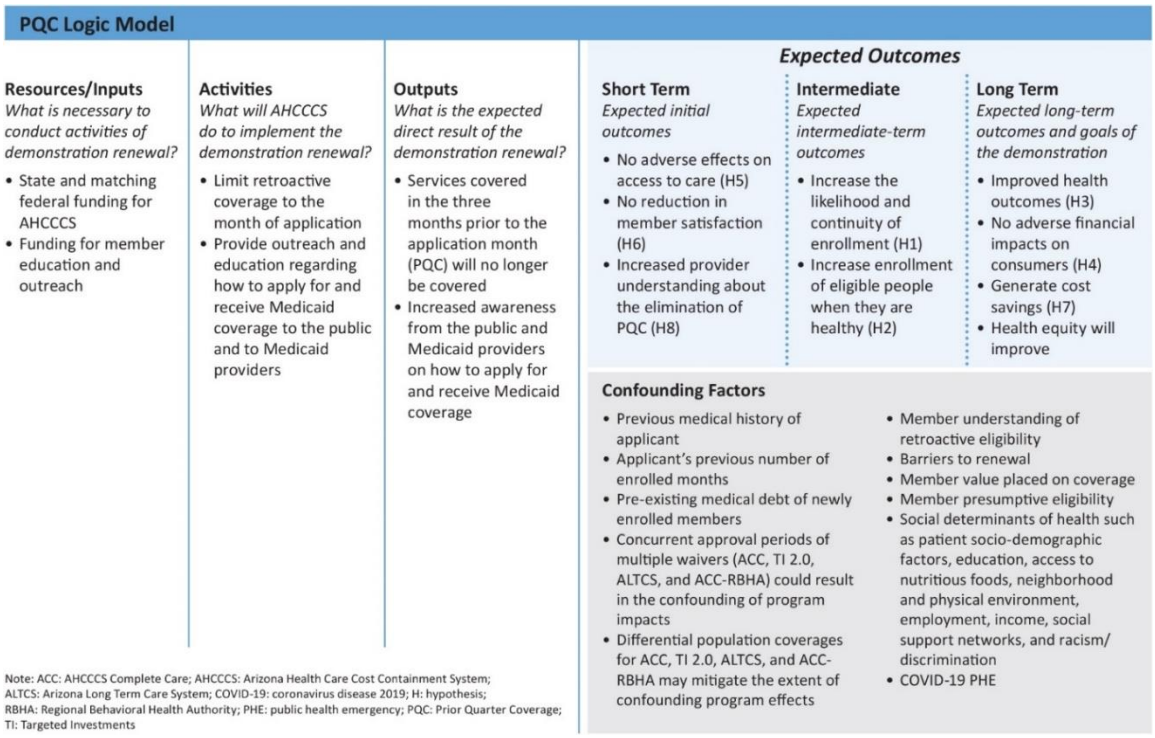
PQC

Logic Model

Figure 2-5 illustrates that providing outreach and education to the public and providers regarding the Waiver and limiting retroactive eligibility to the month of application is expected to lead to improved health outcomes, while having no negative effects on access to care and member satisfaction, as well as no negative financial impact to members. These expected outcomes will not all happen simultaneously. Any effects on access to care and member satisfaction are expected to occur first. Later, it is expected that there will be an increase in the likelihood and continuity of enrollment and in the enrollment of eligible people while they are healthy. This aligns with the set objectives of the amendment. Longer-term, there should be no financial impact on members, while generating cost savings to promote Arizona Medicaid sustainability. Ultimately, this should lead to improved health outcomes among members.

2-5 Ibid.

Figure 2-5—PQC Logic Model



Hypotheses and Research Questions

To comprehensively evaluate the Prior Quarter Coverage (PQC) Waiver program, seven hypotheses will be tested using 12 research questions. Table 2-26 lists the seven hypotheses.

Table 2-26—PQC Hypotheses

	PQC Hypotheses
1	Eliminating PQC will increase the likelihood and continuity of enrollment.
2	Eliminating PQC will increase enrollment of eligible people when they are healthy.
3	Health outcomes will be better for those without PQC compared to Medicaid members with PQC.
4	Eliminating PQC will not have adverse financial impacts on consumers.
5	Eliminating PQC will not adversely affect access to appropriate care for routine medical conditions.
6	Eliminating PQC will not result in reduced member satisfaction.
7	Eliminating PQC will generate cost savings over the renewal period.

Hypothesis 1 will test whether the demonstration renewal results in an increase in the likelihood and continuity of enrollment. The measures and associated research questions are listed in Table 2-27. Improvements in these outcomes would support the Waiver's goal of increasing enrollment and its continuity among eligible members.

Table 2-27—Hypothesis 1 Research Questions and Measures

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
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
1-3	Number of Medicaid enrollees per month by eligibility group and/or per-capita of State
1-4	Number of new Medicaid enrollees per month by eligibility group, as identified by those without a recent spell of Medicaid coverage
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
1-6	Average number of months with Medicaid coverage
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
1-8	Average number of months without Medicaid coverage for members who re-enroll after a gap of up to six months
1-9	Average number of gaps in Medicaid coverage for members who re-enroll after a gap of up to six months
1-10	Average number of days per gap in Medicaid coverage for members who re-enroll after a gap of up to six months

Hypothesis 2 will test whether eliminating PQC increases the number of healthy enrollees. The measure and associated research question are presented in Table 2-28.

Table 2-28—Hypothesis 2 Research Questions and Measures

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
2-2	Member reported rating of overall mental or emotional health
2-3	Percentage of members who reported prior year ED visit
2-4	Percentage of members who reported prior year hospital admission
2-5	Percentage of members who reported getting healthcare three or more times for the same condition or problem

A key goal of waiving PQC is that there will be improved health outcomes among both newly enrolled and established members. Hypothesis 3 will test this by determining if members without PQC have better outcomes than those with PQC or who have been enrolled since pre-implementation of the PQC waiver. The measures and associated research question are presented in Table 2-29.

Table 2-29—Hypothesis 3 Research Questions and Measures

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
3-2	Member reported rating of overall mental or emotional health for all members

It is crucial to evaluate the financial impact of the PQC waiver on Medicaid members. This evaluation can determine if there are any unintended consequences, such as consumers having additional expenses due to the PQC waiver not covering medical expenses during the prior quarter. Hypothesis 4 evaluates the impact of the PQC waiver by measuring reported member medical debt. The measure and associated research question are presented in Table 2-30.

Table 2-30—Hypothesis 4 Research Question and Measure

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

It is important to ensure that the PQC waiver does not have an impact on access to care. Hypothesis 5 assesses this by examining utilization of office visits and facility visits for members subject to the PQC waiver compared to national benchmarks. The measures and associated research questions are presented in Table 2-31.

Table 2-31—Hypothesis 5 Research Questions and Measures

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
5-2	Member response to getting an appointment for a check-up or routine care at a doctor's office or clinic
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, otolaryngologist [ENT], cardiologist)

As these changes will directly impact members, it is important to ensure that members remain satisfied with their healthcare. Hypothesis 6 seeks to quantify the impact of the implementation of the PQC waiver has on member satisfaction. The measure and associated research question are presented in Table 2-32.

Table 2-32—Hypothesis 6 Research Question and Measure

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 healthcare compared to prior to waiver renewal with PQC?	
6-1	Member rating of overall healthcare

Hypothesis 7 seeks to measure the cost effectiveness of eliminating the retroactive eligibility waiver for which a long-term goal is to provide cost-effective care for members. Because not all aspects of cost effectiveness will be evaluated solely based on the outcome of specific financial measurements, no specific measures are included under Research Questions 7-1 and 7-2 for Hypothesis 7. However, a measure is specified for Research Question 7-3. The independent evaluator will calculate changes in total costs and examine cost drivers within the Medicaid program consistent with CMS' guidance on analyzing costs associated with Section 1115 demonstrations.[2-6] The approach for assessing the cost effectiveness of eliminating PQC is described in detail in the Cost-Effectiveness Analysis section, and the Research Questions are listed in Table 2-33.

Table 2-33—Hypothesis 7 Research Questions and Measures

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?	
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

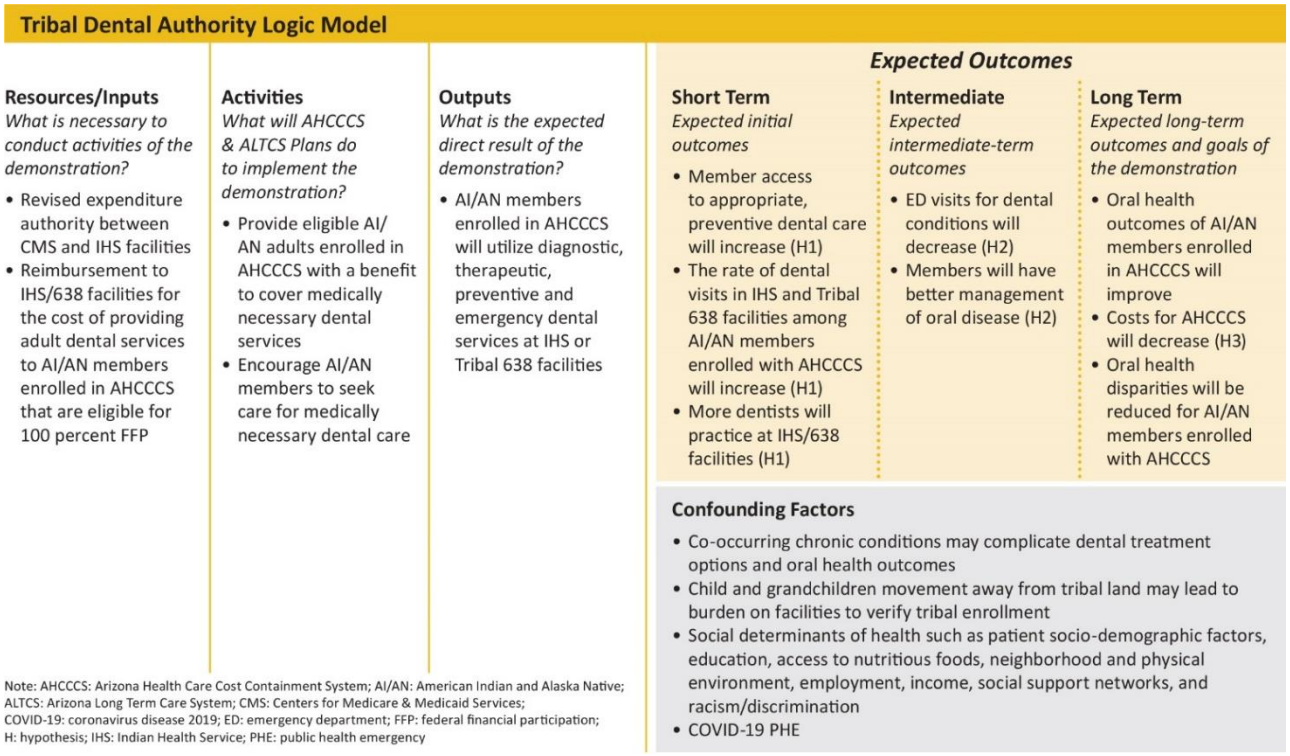
Tribal Dental Authority

Logic Model

Figure 2-6 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 its fee-for-service (FFS) program, the American Indian Health Program (AIHP), that are eligible for 100 percent federal financial participation (FFP) will ultimately lead to improved oral health outcomes and cost savings for AHCCCS. By providing eligible AI/AN adults with a benefit to cover medically necessary dental services and encouraging these members to seek medically necessary dental care, AHCCCS expects that in the short-term, member access to dental care will increase and more dentists will practice at IHS/638 facilities. This is hypothesized to lead to fewer ED visits and improved management of oral disease, which in the longer term will lead to improved oral health outcomes and a reduction in oral health disparities among targeted members.

2-6 Ibid.

Figure 2-6—Tribal Dental Authority Logic Model



Hypotheses and Research Questions

To comprehensively evaluate the Tribal Dental Authority program, four hypotheses will be tested using six research questions. Table 2-34 lists the four hypotheses.

Table 2-34—Tribal Dental Authority Hypotheses

	Tribal Dental Authority Hypotheses
1	Member access to appropriate, routine dental care will be maintained or improved during the renewal period.
2	Quality of care will be maintained or improved during the renewal period.
3	Member oral health outcomes will be maintained or improved during the renewal period.
4	The Tribal Dental Authority program provides cost-effective care.

Hypothesis 1 is designed to determine whether the Tribal Dental Authority activities during the Waiver maintain or improve member access to dental care providers. Access to dental care will be assessed by focusing on members' dental utilization and determining if the Waiver resulted in an increase in dental providers practicing in IHS/638 facilities. The hypothesis will be addressed using claims/encounter data and key informant interviews. The measures to test this hypothesis and answer the associated research questions are listed below in Table 2-35.

Table 2-35—Hypothesis 1 Research Questions and Measures

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 I and 638 facilities?	
1-1	Percentage of members meeting minimum time/distance network standards
1-2	Number of dental providers practicing in I facilities
1-3	IHS/Tribal 638 staff's reported change in practicing dental providers after the implementation of the expanded tribal dental benefit
1-4	IHS/Tribal 638 staff's reported barriers before, during, and shortly following the implementation of the expanded tribal dental benefit
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
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
1-7	Number of adult members receiving any covered service in the plan year

Hypothesis 2 is designed to determine whether the Tribal Dental Authority activities during the Waiver maintain or improve the quality of dental care provided to members enrolled in AHCCCS managed care or AIHP. The research questions for this hypothesis will focus on management of chronic conditions and hospital utilization. This hypothesis will be addressed using both claims/encounter data. The measures and associated research questions are presented in Table 2-36.

Table 2-36—Hypothesis 2 Research Questions and Measures

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?	
2-1	Percentage of enrolled adult members with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year
2-2	Percentage of enrolled adult members ages 30 years and older with history of periodontitis who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year
2-3	Percentage of enrolled adult members 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
2-4	Percentage of enrolled adult members 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
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
2-6	Percentage of ambulatory care sensitive dental condition ED visits among adults who visited a dentist after an ED visit

Hypothesis 3 is designed to determine whether the Tribal Dental Authority maintain or improve the oral health outcomes of members enrolled in AHCCCS managed care or AIHP receiving dental services. The measures and associated research questions are presented in Table 2-37.

Table 2-37—Hypothesis 3 Research Questions and Measures

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
3-2	Percentage of members with risk of dental caries
3-3	Percentage of members with periodontitis
3-4	Percentage of members with oral cancer
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

Hypothesis 4 (Table 2-38) seeks to measure the cost effectiveness of the Tribal Dental Authority program. A goal of the Tribal Dental Authority is to provide cost-effective care for members enrolled in AHCCCS managed care or AIHP. Because cost effectiveness will not be evaluated solely based on the outcome of specific financial measurements, no specific measures are included under Hypothesis 4. The approach for assessing cost effectiveness of the Tribal Dental Authority is described in detail in the Cost Effectiveness Analysis section.

Table 2-38—Hypothesis 4 Research Questions

Hypothesis 4: The Tribal Dental program provides cost-effective care.
Research Question 4.1: What are the costs associated with providing care under the Tribal Dental Authority?
Research Question 4.2: What are the benefits/savings associated with providing care under the Tribal Dental Authority?

3. Methodology

To assess the impact of the Arizona Health Care Cost Containment System (AHCCCS) Section 1115 Demonstration Waiver (the Waiver), a comparison of outcomes between the intervention group and a valid counterfactual—the intervention group had they not been exposed to the intervention—must be made. The gold standard for experimental design is a randomized controlled trial which would be implemented by first identifying an intervention population, and then randomly assigning individuals to the intervention and the rest to a comparison group, which would serve as the counterfactual. However, random assignment is rarely feasible or desirable in practice, particularly as it relates to healthcare policies.

As such, a variety of quasi-experimental or observational methodologies have been developed for evaluating the effect of policies on outcomes. The research questions presented in the previous section will be addressed using at least one of these methodologies. The selected methodology depends on data availability factors relating to: (1) data to measure the outcomes, (2) data for a valid comparison group, and (3) data during the time periods of interest—typically defined as the year prior to implementation and annually thereafter. Table 3-1 illustrates a sampling of standard analytic approaches and whether the approach requires data gathered at the baseline (i.e., pre-implementation); requires a comparison group; or allows for causal inference to be drawn. It also notes key requirements unique to a particular approach.

Table 3-1—Sampling of Analytic Approaches

Analytic Approach	Baseline Data	Comparison Group	Allows Causal Inference	Notes
Difference-in-Differences	✓	✓	✓	Trends in outcomes should be similar between comparison and intervention groups at baseline.
Interrupted Time Series	✓		✓	Requires sufficient data points prior to and following implementation.
Pre-Test/Post-Test	✓			

Given that each component of the Waiver (AHCCCS Complete Care [ACC], AHCCCS Complete Care – Regional Behavioral Health Agreement [ACC-RBHA], Arizona Long Term Care System [ALTCS], Comprehensive Health Plan [CHP], Prior Quarter Coverage [PQC] Waiver, and the Tribal Dental Authority) serves different populations, a comparison group will be specific to each program.

Evaluation Design Summary

ACC

Summary of Approach

The ACC program, which covers most Medicaid children and adults statewide, began in October 2018 and did not undergo substantive changes upon renewal of the Waiver in October 2022. A comprehensive evaluation of the ACC program and its associated coverage of integrated physical health (PH) and behavioral health (BH) in a single plan was conducted in the Interim Evaluation Report and forthcoming Summative Evaluation Report of the

federal fiscal year (FFY) 2017–2022 renewal period. As a result, this evaluation of the FFY 2023–2027 renewal period will primarily seek to determine whether ACC program goals were maintained or improved during this time period.

Because ACC covers approximately 93.8 percent of all managed care members in Arizona, the viability of an in-state counterfactual group not exposed to the intervention (i.e., ACC) is limited by several factors.

1. The number of members available for a potential comparison group is far smaller than the number of members enrolled in ACC plans, restricting the ability to apply often-used one-to-one matching techniques. Possible solutions include propensity score weighting or matching with replacement. The small pool for the eligible comparison group, however, increases the likelihood that the comparison group would be dominated by only a few individuals, leading to inaccurate and potentially misleading results.
2. A small comparison group reduces statistical power.
3. AHCCCS members not enrolled in an ACC plan are fundamentally different from those who are enrolled in an ACC plan. For example, the theoretical in-state comparison group would consist of those with a serious mental illness (SMI), foster children, those with developmental disabilities (DD), and the elderly and physically disabled. It is possible that these groups could serve as a comparison group with a risk-adjustment algorithm applied; however, this approach is unlikely to sufficiently adjust for the substantial differences across subpopulations to produce accurate and reliable results. Since Arizona does not have an all-payer claims database, it is not possible to identify and use an in-state low-income non-Medicaid population as a comparison group.

Despite these limitations, since ACC covers most children and adults on Medicaid, many measure rates for the ACC population may be compared to national benchmarks to provide context and relative performance of ACC plans.

Intervention and Comparison Populations

The intervention population will consist of members enrolled in an ACC plan at any point during each year of the demonstration period.

There is no viable in-state comparison group. Comparisons to national benchmarks will be made where available to provide context for interpreting results.

ACC-RBHA

Summary of Approach

The legacy Regional Behavioral Health Authority (RBHA) program was in existence prior to the current Waiver renewal period, which began on October 14, 2022. On October 1, 2022, AHCCCS implemented the following changes to the ACC-RBHA program:[3-1]

[3-1] Arizona Health Care Cost Containment System. Competitive Contract Expansion Implementation of ACC-RBHAs. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/Initiatives/BehavioralHealthServices/Members_ContractExpansionFAQs.pdf. Accessed on: Jun 23, 2023.

- Changed the name from RBHA to AHCCCS Complete Care Contractor with a Regional Behavioral Health Agreement (ACC-RBHA).
- Changed the health plans operating in certain counties.
- Operated a single crisis phone number for the entire State.
  - Previously, there were three different crisis numbers across the State (these will remain operable through October 1, 2023)

Although these changes may lead to some disruptions in care (for example, if members must choose a new primary care provider [PCP] due to the change in plans) the impact is not expected to be widespread and is therefore not a focus of the evaluation. The evaluation will primarily seek to determine whether program goals were maintained or improved throughout the renewal period.

Because the target population of the ACC-RBHA evaluation consists of adults with an SMI as defined by Arizona Revised Statute (A.R.S.) §36-550, there is unlikely to be a subset of AHCCCS members who have not gone through the formal SMI determination process and still exhibit similar characteristics. Because of the low likelihood of an in-state comparison group, the evaluation will leverage multiple data points before and after renewal to construct an interrupted time series (ITS) analysis.

Intervention and Comparison Populations

The intervention population will consist of members enrolled in an ACC-RBHA plan at any point during each year of the demonstration period.

There is no viable in-state comparison group.

ALTCS

Summary of Approach

The ALTCS program covers two distinct populations and plans:

- Elderly and/or physically disabled (ALTCS-EPD)
- Intellectually/developmentally disabled (ALTCS-DD)

There were no substantive changes to the ALTCS program upon renewal of the Waiver. The evaluation will therefore primarily seek to determine whether program goals were maintained or improved throughout the Waiver renewal period. For ALTCS-EPD, the Waiver renewal period (October 14, 2022, through September 30, 2027) will be compared to the prior demonstration period (October 1, 2016, through October 14, 2022). As BH services for members with DD were transitioned to ALTCS-DD health plans on October 1, 2019, the Waiver renewal period will be compared to the prior demonstration period (October 1, 2019, through October 14, 2022).

Given that ALTCS only impacts individuals with intellectual/developmental disabilities and individuals who are elderly and/or with physical disabilities, the viability of an in-state comparison group consisting of similar members is limited by several factors. There are few in-state people with DD who are not enrolled in Medicaid and ALTCS. While the number of people who are elderly and/or with physical disabilities who are not enrolled in Medicaid may be somewhat larger, the size of the in-state comparison group is estimated to be far smaller than the similar ALTCS population, thereby reducing the ability to use valid and robust matching techniques to ensure reliable results and reducing statistical power. Even if such an in-state population were sufficient and appropriate

as a comparison group, Arizona does not have an all-payer claims database with which to identify and calculate relevant measures for the comparison group. As a result, the evaluation will leverage multiple data points before and after renewal to construct an ITS analysis for most measures, as well as rely on out-of-state comparison groups for difference-in-differences (DiD) analyses of National Core Indicators (NCI) measures.

Intervention and Comparison Populations

The ALTCS-EPD population consists of individuals 65 years of age or older and/or medically require long-term care services. Long-term care service needs are determined by a pre-admission screening (PAS).[3-2]

The ALTCS-DD population consists of qualifying individuals with a diagnosis of cognitive disability, cerebral palsy, epilepsy, autism, or Down syndrome. Since children often do not have a specific diagnosis, individuals 6 years of age and under must either have one of the four previously mentioned diagnoses, be determined to be at risk for one of the four diagnoses, or demonstrate a delay that may lead to one of the four diagnoses. Similar to EPD eligibility, members with DD must qualify through the PAS and require institutional level of care.[3-3]

Although there is no viable in-state comparison group, the independent evaluator will leverage the weighted national average from all other states participating in the NCI survey to serve as an out-of-state comparison group for specific measures that employ a DiD approach.

CHP

Summary of Approach

CHP serves children in custody of Arizona Department of Child Safety (DCS) and has been in existence since prior to the current Waiver renewal period, with no substantive changes to the program with the renewal Waiver. However, AHCCCS integrated BH and PH services on April 1, 2021. The integration of BH and PH services was evaluated in the forthcoming Summative Evaluation Report of the FFY 2017–2022 Waiver renewal period. However, because the Summative Evaluation Report will contain one full year of post-implementation data, the evaluation of the FFY 2023–2027 renewal period will continue to build on the foundation set forth in the FFY 2017–2022 evaluation period to study lasting impacts of the transition to integrated care.

Given that CHP only impacts children in the custody of DCS and the unique healthcare needs of this population, the viability of an in-state comparison group consisting of similar members is limited. As such, the evaluation will leverage multiple data points before and after integration to construct an ITS analysis.

3-2 Arizona Health Care Cost Containment System. Medical Assistance Eligibility Policy Manual. Available at: https://www.azahcccs.gov/Resources/guidesmanualspolicies/eligibilitypolicy/eligibilitypolicymanual/Policy/Chapter_500_Non-Financial_Conditions_of_Eligibility/MA0509.htm. Accessed on: Jul 6, 2023.

3-3 Arizona Department of Economic Security. DDD Eligibility. Available at: https://des.az.gov/sites/default/files/10_DDD_Eligibility.pdf. Accessed on: Jul 6, 2023.

Intervention and Comparison Populations

The intervention group will consist of members enrolled in CHP at any point during each year of the renewal period. As described in the Background section, this includes children in:

- Foster homes.
- The custody of DCS and placed with a relative.
- The custody of DCS and placed in a certified adoptive home prior to the entry of the final order of adoption.
- The custody of DCS and in an independent living program as provided in A.R.S. § 8-521.
- The custody of a probation department and placed in out-of-home care.

CHP provides PH and BH care to eligible members from birth to 18 years of age, and up to age 21 in rare instances when the member is not Medicaid eligible.

There is no viable in-state comparison group.

PQC

Summary of Approach

Because the PQC waiver is hypothesized to increase the rate of enrollment among the eligible population, the Waiver has a partial focus on newly enrolled Medicaid members. Specifically, because PQC is expected to increase the rate of enrollment when individuals in the eligible population are healthy, and because there are no readily available administrative data or survey data for the eligible and unenrolled population, the independent evaluator will need to collect data for the evaluation from newly enrolled members. In the context of the PQC waiver, newly enrolled refers to members who satisfy two criteria:

1. Enrolled no earlier than the first day of the month prior to the month of sampling.
2. Experienced a gap in enrollment of at least two months immediately prior to the month of sampling.

Because many measures consider continuously enrolled members to be those enrolled for at least five out of the previous six months, the criteria defined for a newly enrolled member captures those persons who did not have a recent spell of continuous enrollment and who had recently enrolled. This represents the population of members for whom the PQC waiver is expected to increase the likelihood of enrollment when healthy. The evaluation design will therefore capture survey data from newly enrolled members at multiple points in time to assess whether their self-reported health status is increasing as expected. Self-reported health status will also be captured for other members meeting the traditional continuous enrollment criteria. This will also allow the independent evaluator to determine if the health status of members who are not newly enrolled increases over time after implementing the PQC waiver.

Outcomes that rely on State administrative data pertaining to enrollment by eligibility category and rates of enrollment can have intra-year (e.g., monthly) measurements taken both prior to and after implementation. This can serve to build pre- and post-implementation trends that can be evaluated via an ITS analysis and through a pre-test/post-test analysis. These analyses will not utilize a comparison group because no comparable populations exist within Arizona that would not be impacted by the elimination of PQC.

Intervention and Comparison Populations

Where pre-implementation administrative data are available, the intervention population will reflect members who apply for coverage both prior to and post the implementation of PQC. The intervention group will consist of all eligible members who apply for coverage after implementation, expected to be July 1, 2019, excluding pregnant or postpartum women, and infants and children under 19 years of age.

There is no viable in-state comparison group.

Tribal Dental Authority

Summary of Approach

Prior to the Tribal Dental Authority, AHCCCS reimbursed Indian Health Service (IHS) and Tribal 638 facilities for adult dental services that were eligible for 100 percent federal medical assistance percentage (FMAP) in excess of:

- The $1,000 emergency dental limit for adult members enrolled in the Arizona State Plan
- The $1,000 dental limit for individuals ages 21 years or older enrolled in the ALTCS program

The renewal of the Waiver on October 14, 2022, marked the start of the Tribal Dental Authority, which authorizes AHCCCS to reimburse expenditures for medically necessary diagnostic, therapeutic, and preventive dental services beyond the previous limits when services are performed by participating IHS facilities.

The evaluation will primarily seek to determine whether program goals were maintained or improved throughout the 2022–2027 Waiver renewal period compared to the baseline period.

Intervention and Comparison Populations

The Tribal Dental Authority population consists of all adult AHCCCS tribal members who were eligible to receive medically necessary dental services in an IHS or Tribal 638 facility.[3-4]

Given that the Tribal Dental Authority will impact all individuals who seek care at an IHS/Tribal 638 facility, the viability of an in-state comparison group consisting of similar members is limited. Instead, the independent evaluator may leverage Behavioral Risk Factor Surveillance System (BRFSS) data from American Indian/Alaska Native (AI/AN) Medicaid respondents from all other states that participated in the survey as an out-of-state comparison group for measures that utilize a DiD approach.

[3-4] Arizona Health Care Cost Containment System. Codes & Values 2021. Available at: https://www.azahcccs.gov/PlansProviders/Downloads/HealthPlans/FeeForService/HealthPlanIDNumbers.pdf. Accessed on: Jul 31, 2023.

Evaluation Periods

Table 3-2 presents the baseline, ramp-up, and evaluation periods of each Waiver program.[3-5]

Table 3-2—Evaluation Periods

Program	Baseline	Ramp-Up	Evaluation
ACC	October 1, 2018–September 30, 2022	—	October 1, 2022–September 30, 2027
ACC-RBHA	October 1, 2016–September 30, 2022	—	October 1, 2022–September 30, 2027
ALTCS-EPD	October 1, 2016–September 30, 2022	—	October 1, 2022–September 30, 2027
ALTCS-DD	October 1, 2019–September 30, 2022	—	October 1, 2022–September 30, 2027
CHP	October 1, 2016–September 30, 2020	October 1, 2020–September 30, 2021	October 1, 2021–September 30, 2027
PQC	July 1, 2016–June 30, 2019	—	July 1, 2019–June 30, 2027
Tribal Dental Authority	October 1, 2016–September 30, 2022	—	October 1, 2022–September 30, 2027

Evaluation Measures

ACC

Table 3-3 presents the evaluation measures, comparison groups, data sources, and analytic approaches for ACC.

Table 3-3—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

[3-5] To align the evaluation with annual measurement years, the evaluation periods for each program will generally begin October 1, 2022, even though the waiver was not formally approved until October 14, 2022.

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
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
	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

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	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
	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	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

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
immunizations compared to prior to the renewal period?	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
	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

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	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
	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

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	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 healthcare will be maintained or improved during the renewal period.				
Research Question 5.1: Are members equally or more satisfied with their healthcare 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
	5-2: Percentage of members who reported a high rating of overall healthcare (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; AHCCCS: Arizona Health Care Cost Containment System; ASIIS: Arizona State Immunization Information System; BH: behavioral health; BRFSS: Behavioral Risk Factor Surveillance System; ED: emergency department; IOP: intensive outpatient; IP: inpatient; ITS: interrupted time series; OB/GYN: obstetrician gynecologist; OP: outpatient; PCP: primary care provider

ACC-RBHA

Table 3-4 presents the evaluation measures along with the respective comparison groups, data sources, and analytic approaches for ACC-RBHA.

Table 3-4—ACC-RBHA 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 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
	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

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
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 management of BH conditions compared to prior to the waiver renewal?	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
	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

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	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 hospital utilization compared to prior to the waiver renewal?	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
	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

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
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 healthcare compared to prior to the waiver renewal?	4-1: Percentage of members who reported a high rating of overall healthcare (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
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	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
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
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: AHCCCS Complete Care; ACC-RBHA: ACC Contractor with a Regional Behavioral Health Agreement; AHCCCS: Arizona Health Care Cost Containment System; BH: behavioral health; ED: emergency department; IOP: intensive outpatient; IP: inpatient; ITS: interrupted time series; OP: outpatient; SMI: serious mental illness; SUD: substance use disorder

ALTCS

Table 3-5 presents the evaluation measures along with the respective comparison groups, data sources, and analytic approaches for ALTCS.

Table 3-5—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 elderly, physically disabled, 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
	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 elderly, physically disabled, 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 survey	- 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-IDD survey - NCI-AD survey	- Pre-test/post-test - DiD

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	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 survey - 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-IDD survey - 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-IDD survey - 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 elderly, physically disabled, 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 elderly, physically disabled, 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
	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	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
Research Question 2.3: Do adult members who are elderly, physically disabled 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 elderly, physically disabled, 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 survey - NCI-AD survey	- Pre-test/post-test - DiD
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 elderly, physically disabled, 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-IDD survey - 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 survey - NCI-AD survey	- Pre-test/post-test - DiD

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
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 elderly, physically disabled 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 survey - 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 survey - 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 survey	- 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 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	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
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: ALTCS provides cost-effective care.				
Research Question 5.1: What are the costs associated with the waiver renewal?	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 5.2: What are the benefits/savings associated with the waiver renewal?				

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; HEAplus: Health-e-Arizona Plus; IDD: intellectual and developmental disabilities; IOP: intensive outpatient; IP: inpatient; 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; SUD: substance use disorder

CHP

Table 3-6 presents the evaluation measures along with the respective comparison groups, data sources, and analytic approaches for CHP.

Table 3-6—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 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 CHP members have the same or higher rates of appropriate immunizations in the remeasurement period as compared to the baseline?	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
	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	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
Research Question 2.2: Do 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 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 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
	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

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	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: CHP encourages and/or facilitates care coordination among PCPs and BH practitioners.				
Research Question 3.1: What barriers did Mercy Care DCS CHP anticipate/encounter during the integration?	3-1: Mercy Care DCS CHP's anticipated/reported barriers during transition	N/A	- Key informant interviews - Provider focus groups	Qualitative synthesis
	3-2: Mercy Care 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 Mercy Care DCS CHP plan/implement during integration?	3-3: Mercy Care 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 Mercy Care DCS CHP anticipate/encounter?	3-4: Mercy Care 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 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 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

PQC

Table 3-7 presents the evaluation measures along with the respective comparison groups, data sources, and analytic approaches for the PQC waiver.

Table 3-7—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
	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

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	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
	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 healthcare 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

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
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
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 healthcare compared to prior to waiver renewal with PQC?	6-1: Member rating of overall healthcare	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

Tribal Dental Authority

Table 3-8 presents the evaluation measures along with the respective comparison groups, data sources, and analytic approaches for the Tribal Dental Authority.

Table 3-8—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
	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	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

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
compared to prior to the demonstration?	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
	2-3: Percentage of enrolled adults aged 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

Research Question	Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach
	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
	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

Data Sources

The evaluation of the Waiver will utilize a mixed-methods evaluation design. Quantitative methods include descriptive statistics showing change over time in both counts and rates for specific metrics, or ITS and trend analyses to assess whether the Waiver interventions affected changes across specific outcome measures. For select measures employing a DiD approach, an out-of-state comparison group will be considered. The weighted national average of other NCI-participating states will serve as the comparison group for the ALTCS-DD and ALTCS-EPD populations. AI/AN Medicaid members responding to the BRFSS survey from all other states that participated in the survey will be used a comparison group for one measure utilizing a DiD approach to assess the Tribal Dental Authority. Out-of-state Medicaid data through the Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF) may be used if deemed viable at the time each evaluation report is produced. A qualitative component of the Waiver will also be completed. Providers, subcontracted networks, and staff at AHCCCS and/or health plans will be interviewed to share their perceptions of and experience with the Waiver. In addition, beneficiary surveys will be utilized to better understand patient experience with the Waiver.

Multiple data sources, shown in Table 3-9, will be utilized to evaluate the program-specific hypotheses. In general, these include administrative data, State beneficiary survey data, aggregate data, national survey efforts and datasets, provider focus groups, and key informant interviews.

Table 3-9—Major Data Sources

Data Sources	Administrative Data	Member/Provider Location Data	State Beneficiary Surveys	National Benchmarks	Provider Focus Groups	Key Informant Interviews
ACC	X	X	X	X	X	X
ACC-RBHA	X	X	X		X	X
ALTCS	X	X		X		X
CHP	X	X		X	X	X
PQC	X		X	X	X	
Tribal Dental Authority	X	X				X

Administrative Data

Administrative data extracted from the Pre-Paid Medical Management Information System (PMMIS) will be used to calculate most measures proposed in this evaluation design. These data include administrative claims/encounter data, member eligibility, enrollment, and demographic data. Provider data will also be utilized as necessary to identify provider type and member attribution.

Use of fee-for-service (FFS) claims, and managed care encounters will be limited to final, paid status claims/encounters. Interim transaction and voided records will be excluded from all evaluations because these types of records introduce a level of uncertainty (from matching adjustments and third-party liabilities to the index claims) that can impact reported rates and cost calculations.

To evaluate the Tribal Dental Authority, the independent evaluator will assess whether administrative data from the PMMIS contains the necessary data fields to support calculation of dental measures. If additional data elements are required, the independent evaluator will work collaboratively with AHCCCS to obtain additional sources of data on dental services provided to individuals who seek care at an IHS or 638 Tribal facility.

State Beneficiary Surveys

State beneficiary surveys will be used to assess members' ability to obtain timely appointments, satisfaction and experience with healthcare, and their perception that their personal doctor seemed informed about the care they received from other providers. Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[3-6] surveys are often used to assess satisfaction with provided healthcare services and are adapted to elicit information addressing the research hypotheses related to members' continuity of healthcare coverage, and overall health status and utilization. Results will be compared against national benchmarks where available. The sampling frame for the survey will be identified through eligibility and enrollment data, with specific enrollment requirements being finalized upon inspection of the data. Typically, members are drawn from those enrolled continuously during the last six months of the measurement period, with no more than a one-month gap in enrollment.

Beneficiary surveys will be conducted for the ACC, PQC, and ACC-RBHA programs. To the extent possible, the independent evaluator will align multiple surveys to be distributed at the same time to increase response rates across all programs with overlapping populations. A range of sampling protocols will be considered including simple random samples; stratified random samples; multistage stratifications (i.e., cluster); and targeted oversamples. It is expected that cross-sectional surveys will be conducted once during 2025 and once during 2027.

Because evaluations for several concurrent waivers are planned, the State and its independent evaluator will seek to streamline survey administration across evaluations to minimize the number of separate survey rounds required, thereby minimizing the burden on members, and maximizing the response rate. Therefore, the sampling strategy described above may be revised based on enrollment across waivers. Two survey instruments will be used depending on the population:

- Children: CAHPS 5.0 Child Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®)[3-7] supplemental item set
- Adults: CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set

To maximize response rates, a mixed-mode methodology (e.g., mail and web-based) for survey data collection will be used. The addition of email reminders, when data are available, or pre-notification letters to members has been shown to increase response rates and will be incorporated into survey administration. The following sections describe the unique survey considerations for each program.

ACC

Members in ACC plans and ACC members in ACC-RBHA plans (i.e., non-SMI population) will be sampled to provide a statistically valid estimate at the program level. The estimate will provide sufficient statistical power to detect a difference in a rate of at least 10 percentage points with 95 percent confidence and 80 percent power for ACC adults and children separately. Assuming a response rate of approximately 15 percent with a 10 percent oversample, the maximum number of surveys to be sent is 2,845 for adults and 2,845 for children, for a total of 5,690 surveys in each round. Simple random sampling will be conducted pooled across all plans serving the ACC

[3-6] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[3-7] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

population. Separate samples will be drawn for adults and children. Two rounds of surveys are planned to assess member experience in state fiscal year (SFY) 2025 and SFY 2027.

ACC-RBHA

Similar to the ACC population, members with an SMI served by ACC-RBHA plans will be sampled to provide a statistically valid estimate at the program level. The estimate will provide sufficient statistical power to detect a difference in a rate of at least 10 percentage points with 95 percent confidence and 80 percent power. Assuming a response rate of approximately 15 percent with a 10 percent oversample, the maximum number of surveys to be sent is 2,845. Sampling will be conducting randomly pooled across all ACC-RBHA plans. Two rounds of surveys are planned to assess member experience in SFY 2025 and SFY 2027.

PQC

Measures pertaining to Hypotheses 2, 3, 4, 5, and 6 will be based on CAHPS and will include CAHPS-like questions specific to the PQC evaluation. The independent evaluator will conduct two rounds of surveys as part of the Waiver renewal evaluation to ask recipients about their self-reported health status. The elimination of PQC is not expected to reduce self-reported health. Rather, the elimination of PQC is expected to increase the enrollment of eligible individuals when they are healthy and reduce the disenrollment of individuals when they are healthy. The evaluation design will capture survey data from newly enrolled members at multiple points in time to assess whether their self-reported health status is increasing as expected.

Measures pertaining to Hypothesis 2 will also be based on CAHPS-like questions. Unlike a traditional CAHPS survey that is limited to members enrolled for at least five of the past six months, the self-reported data needed for Hypothesis 2 must also be collected for a sample of members who are newly enrolled. The sampling frame will be adjusted to include a sample of members who have been enrolled within the past month to capture the health status of members who did not have a recent spell of Medicaid coverage. All members will be eligible to be surveyed, and members who are newly enrolled will be compared to continuously enrolled members who have had sustained Medicaid coverage. This will allow for comparison of health status between members who are newly enrolled compared to those who have had sustained coverage. A second survey with the same questions will be administered to similar groups later in the Waiver to evaluate how health outcomes between members who are newly enrolled and those who are not newly enrolled have changed over time. Because CAHPS surveys are traditionally limited to members who have been enrolled for at least five of the past six months, and exclude any newly enrolled members, historical data do not exist to serve as a comparison. Additionally, this survey will not allow for causal inferences to be drawn regarding the impact of the PQC waiver. The survey results, however, will provide a descriptive statement about the self-reported health status of members over time to determine if the expected improvements manifest.

Adult members who are not pregnant or postpartum will be randomly sampled to provide a statistically valid estimate at the State level. The estimate will provide sufficient statistical power to detect a difference in a rate of at least 10 percentage points with 95 percent confidence and 80 percent power. Assuming a response rate of approximately 15 percent with a 10 percent oversample, the maximum number of surveys to be sent is 2,845. Sampling will be conducting randomly pooled across all ACC and ACC-RBHA plans. Two rounds of surveys are planned to assess member experience in SFY 2025 and SFY 2027.

Member and Provider Location Data

Member and provider data will be used to calculate the number and percentage of providers within a pre-defined time or distance from members. The PMMIS identifies provider addresses, and the Client Assessment and Tracking System (CATS) identifies member addresses.

ADHS

ASIIS

The Arizona State Immunization Information System (ASIIS) will be used to calculate measures pertaining to immunization history. ASIIS is Arizona's immunization registry, collects immunization information and demographic data. Providers are mandated under A.R.S §36-135 to report all immunizations administered to individuals ages 18 years and younger.[3-8]

National Benchmarks

National or regional benchmarks will be incorporated where possible to provide contextual references of performance for standardized HEDIS measures. Because national benchmarks are provided for state Medicaid managed care populations as a whole, their applicability across 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 general population, and therefore provides the most appropriate comparison to national benchmarks.

Additional Data Sources

T-MSIS

The independent evaluator will consider utilizing an out-of-state comparison group using member-level data if data are available and complete enough to support rigorous statistical testing of outcomes. One such source for member-level data is T-MSIS maintained and collected by the Centers for Medicare & Medicaid Services (CMS). All 50 states, Washington D.C., and two territories are currently submitting data monthly.[3-9] It is expected that T-MSIS will provide microdata containing information on eligibility, enrollment, demographics, and claims/encounters, which will support individual-level matching to PQC members. However, as of the submission date of this evaluation design, these data are not yet available, and the independent evaluator should be prepared to rely on alternative data sources for the comparison group, such as pre-intervention claims data or national survey data to provide additional context.

3-8 Arizona State Legislature. A.R.S. §36-135. Available at: https://www.azleg.gov/viewdocument/?docName=http://www.azleg.gov/ars/36/00135.htm. Accessed on: Jul 6, 2023.

3-9 Centers for Medicare & Medicaid Services. Transformed Medicaid Statistical Information System (T-MSIS). Available at: https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/index.html. Accessed on: Jul 30, 2023.

BRFSS

The independent evaluator will consider utilizing an out-of-state comparison group using member-level data if data are available and complete enough to support rigorous statistical testing of outcomes. One such source is the BRFSS. 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.[3-10] The questionnaire generally consists of two components: a core component and an optional component. Beneficiary surveys will be used to assess PQC Measure 3-1 (*General health status*) and ACC Measure 4-1 (*Percentage of members who reported a rating of overall health as very good or excellent*) among the Waiver population; however, rates will also be benchmarked against statewide and national rates from the BRFSS core module Health Status. Similarly, PQC Measure 4-1 (*Percentage of members who reported medical debt*) will use data from other states that utilize the BRFSS module Health Care Access, where available. The Medicaid coverage indicator from the optional/core (depending on the year) module Healthcare Access may be used to identify responses among individuals similar to AHCCCS members.[3-11] However, fewer than a dozen states included the optional Healthcare Access module in a given year historically, which may limit the availability and selection of potential benchmark states. For these measures, BRFSS results from other states will be used as a benchmark to provide context and triangulate findings to other states' Medicaid populations. Additionally, the Tribal Dental Authority Measure 3-1 (*Percentage of members with permanent teeth lost*) employs a DiD approach and will utilize data from the BRFSS core module Oral Health to construct a comparison group. Contingent on the availability of data, respondents to the BRFSS survey from all other states may serve as a comparison group to Waiver members.

To provide an understanding of the capabilities of the data for performing statistical analyses, the independent evaluator will calculate the statistical power associated with any out-of-state comparison group data and report the results.

NCI-IDD/NCI-AD

The NCI surveys national Medicaid members with intellectual or developmental disabilities. The NCI-Intellectual and Developmental Disabilities (NCI-IDD) and NCI-Aging and Disabilities (AD) surveys are conducted in-person, and it is expected that half of states participate each year. Arizona has participated in the NCI-IDD survey most years between SFY 2015 and SFY 2021 (the latest year available; Arizona did not participate in SFY 2020) and recently began conducting the NCI-AD surveys. Survey periods cycle annually between July 1 to June 30, with states submitting data by June 30. Each state is required to survey at least 400 individuals, allowing for a robust comparison. However, member-level data are not publicly available, and information is not publicly provided about the methodology and survey administration which could vary across states. State participation is voluntary, and states participation varies by year and survey section. Beginning in 2021, AHCCCS allocated funds to participate in both the NCI-IDD and NCI-AD surveys.[3-12] In addition to state-specific reports, NCI provides aggregate data that may be stratified by demographic factors, such as race/ethnicity, gender, and age, as

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3-10 Centers for Disease Control and Prevention. About BRFSS. Available at: https://www.cdc.gov/brfss/about/index.htm. Accessed on: Jul 20, 2023.

3-11 CAHPS surveys for this evaluation will be administered through both mail and telephone, while BRFSS is administered exclusively through telephone. This difference in survey administration mode may lead to biased comparisons.

3-12 Arizona Health Care Cost Containment System. Spending Plan for Implementation of the American Rescue Plan Act of 2021. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/Initiatives/ARPA/AHCCCS_ARPA_HCBS_SpendingPlan.pdf. Accessed on: Dec 8, 2023.

well as certain diagnoses and living arrangement. As of the writing of this evaluation design, rates for Arizona are available up to the 2020–2021 time period. This will serve as a baseline; and it is anticipated that follow-up rates will be available for Arizona in time to develop the Summative Evaluation Report. If follow-up rates are available, a DiD study design may be employed to compare rates among Arizona residents to the weighted national average of other NCI-participating states. Rates may be stratified by demographics or diagnoses within the limits of sample size and statistical power.

IPUMS-ACS

Data from the Integrated Public Use Microdata Series (IPUMS) American Community Survey (ACS) will be utilized to estimate the number of Medicaid-eligible individuals in Arizona, as part of the analysis of *Percentage of Medicaid enrollees per month by eligibility group out of estimated eligible Medicaid recipients* (PQC Measure 1-1) and *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* (PQC Measure 1-2). The IPUMS ACS is a "database providing access to over 60 integrated, high-precision samples of the American population drawn from 16 federal censuses, from the ACS of 2000–present."[3-13] The independent evaluator will extract data that include demographic information, employment, disability, income, and program participation such as Medicaid enrollment information.

HCRIS

Data reported by Medicare-certified institutions housed in the Healthcare Cost Report Information System (HCRIS) will be used to assess non-Medicare uncompensated care costs, including Medicaid shortfalls as part of the measure *Reported costs for uninsured and/or likely eligible Medicaid recipients among potentially impacted providers and/or provider networks* (PQC Measure 7-1). Institutions serving Medicare members are required to submit a cost report to CMS annually, which includes data on non-Medicare uncompensated care costs, non-Medicare and non-reimbursable Medicare bad debts, indigent care costs, charity care, and Medicaid shortfalls. Data from HCRIS will be used to assess facility-level uncompensated care costs and will be compared to states similar to Arizona that do not operate a retroactive eligibility waiver. There is approximately a one to two-year lag on reporting into the HCRIS system.

HCUP-SID

The Agency for Healthcare Research and Quality (AHRQ) supports the collection of healthcare databases from State data organizations, hospital associations, private data organizations, and the federal government. Healthcare Cost and Utilization Project State Inpatient Database (HCUP-SID) data is available as an alternate data source, or to supplement HCRIS data, to assess PQC Measure 7-1 (*Reported costs for uninsured and/or likely eligible Medicaid recipients among potentially impacted providers and/or provider networks*). HCUP includes the largest collection of longitudinal encounter-level hospital care data in the United States.[3-14] HCUP-SID encompasses over 95 percent of all United States hospital discharges, allows for cross-state comparisons, and contains information

[3-13] IPUMS USA. What is IPUMS USA. Available at: https://usa.ipums.org/usa/intro.shtml. Accessed on: Jul 3, 2023.
[3-14] Agency for Healthcare Research and Quality. Healthcare Cost and Utilization Project. Available at: https://www.hcup-us.ahrq.gov/overview.jsp. Accessed on: Jul 6, 2023.

on the charges and source of payment, including charity care and self-payment.[3-15] There is approximately a one-to-two-year lag on reporting into the HCUP-SID.

Focus Groups and Key Informant Interviews

Focus groups and key informant interviews will be conducted through a semi-structured interview protocol, transcribed, and imported into MAXQDA where the data will be coded to permit qualitative analysis. The transcripts, coding methodologies, and coded data will be used to answer the appropriate research questions.

Analytic Methods

Table 3-10 presents the analytic methods that will be used to evaluate the Waiver.

Table 3-10—Analytic Methods

Analytic Approach	Difference-in-Differences	Interrupted Time Series	Pre/post-test	National Benchmarks	Qualitative Synthesis	Cost-Effectiveness Analysis
ACC		X	X	X	X	X
ACC-RBHA		X	X		X	X
ALTCS	X	X	X	X	X	X
CHP		X	X	X	X	X
PQC		X	X	X	X	X
Tribal Dental Authority	X	X	X		X	X

DiD

A DiD analysis will be performed on all measures for which a suitable comparison group can be identified (ALTCS and Tribal Dental Authority). Specifically, the ALTCS program will compare rates to the weighted national average of participating states to rates among AHCCCS members. The Tribal Dental program will utilize a comparison group of AI/AN BRFSS respondents from all other states participating in the survey. This approach will compare 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 will be conducted with member-level rates, using a logistic regression model for measures with binary outcomes.

The logistic regression form of the DiD model is:

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

[3-15] Agency for Healthcare Research and Quality. Introduction to the HCUP State Inpatient Databases (SID). Available at: https://www.hcup-us.ahrq.gov/db/state/siddist/Introduction_to_SID.pdf. Accessed on: Jul 6, 2023.

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 (described in additional detail below), 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 is changed in the implementation period compared to the pre-implementation period.

For the ALTCS NCI measure employing a DiD approach, member-level data from the NCI surveys are not publicly available, and therefore rates from the Arizona NCI survey will be compared to a weighted national average of all other NCI-participating states. As such, the DiD model for NCI measures will not include any control variables to account for differences in the underlying population characteristics. For other DiD analyses in which member-level data is available, models will include adjustment for demographic characteristics such as age, sex, race/ethnicity, county of residence, as well as additional possible confounders such as Chronic Illness and Disability Payment System (CDPS) risk score, dual eligibility status, duration of Medicaid enrollment, etc.

The DiD approach will be used where possible, as it controls for any factors external to the program that are applied equally to both groups, such as the coronavirus disease 2019 (COVID-19) public health emergency (PHE). However, the method is still susceptible to external factors that may have differentially impacted one group and not the other. If sufficient pre-intervention data are available, it is possible to test if external factors are applied equally to the intervention and comparison groups by visually verifying that both groups exhibit parallel trends in the baseline period. In the absence of treatment, the intervention and comparison groups used in DiD should experience similar changes, manifested as parallel lines during the baseline period. If the parallel trend assumption does not hold, the two-period DiD may still be useful as data during the baseline and evaluation periods will be aggregated into a single pre-intervention and post-intervention average, respectively. Furthermore, the DiD model proposed estimates a single average treatment effect, under the assumption that any heterogeneity in the treatment effect is due to random variation. This assumption is explicit in the model set-up as the DiD treatment effect is represented by a single coefficient (β_3), and therefore any heterogeneity in treatment effects between individuals cannot be modeled. The independent evaluator recognizes the limitations of this approach and will therefore consider estimating additional models such as panel data models, fixed and random effects models, or hierarchical models. Results from adjusted models will be presented and interpreted keeping in mind the limitations of each approach.

ITS

When a suitable comparison group cannot be found and data can be collected at multiple points in time before and after the implementation of the program, an ITS methodology can be used. This analysis is quasi-experimental in design and will compare a trend in outcomes between the baseline period and the evaluation period for those who were subject to the program.

In ITS, the measurements taken before a demonstration was initiated are used to predict the outcome if the demonstration did not occur. The measurements collected after the demonstration are then compared to the predicted outcome to evaluate the impact the demonstration had on the outcome.

The ITS model is:

$$Y_t = \beta_0 + \beta_1\, time + \beta_2\, post + \beta_3\, time \times post + \gamma \mathbf{D'}_{it} + \mu_t$$

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, $time \times post$ is the interaction term between *time* and *post*, the vector **D'** represents any observed confounding variables that may account for differences between the intervention and comparison groups, and γ is a coefficient vector. For ITS analyses utilizing aggregate-level data, confounding variables will take the form of average values in the population, such as average age, average risk score, or percent female. For analysis utilizing individual-level data, control variables may include age, sex, race/ethnicity, county of residence, CDPS risk score, dual eligibility status, or duration of Medicaid enrollment. The intercept, 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, β_3 is the change in the slope for the measurements after the program, and μ_t is the error term.

Assuming that the measurements taken after the implementation of the Waiver would have been equal to the expectation predicted from the measurements taken before the Waiver in the absence of the intervention, any changes in the observed rates after implementation can be attributed to the program. However, as the ITS approach relies on a pre- and post-period, it is unable to differentiate between mechanisms that may have impacted observed changes; it is possible that external events could have occurred simultaneously with the Waiver and influenced the outcomes of interest. The independent evaluator will rely on best practices to mitigate the potentially confounding effect of simultaneously occurring confounding events such as the COVID-19 PHE as well as post-pandemic Medicaid "unwinding" by including the use of dummy variables for each time period. To account for the impact of the COVID-19 PHE, ITS models will incorporate dummy variables to adjust for the confounding effects if sufficient data is available. An indicator variable for quarter 2 (Q2) 2020 will represent the initial wave of the COVID-19 PHE-related shutdowns and stay-at-home orders, and a separate indicator variable for Q3 2020 through the end of Q1 2021 will reflect subsequent Arizona-specific public health orders. For measures calculated annually, an indicator variable for 2020 will be included in the model to adjust for the COVID-19 PHE. Furthermore, the independent evaluator will consider several sensitivity analyses to test the robustness of the main model results. As the Waiver overlaps with the COVID-19 PHE as well as post-pandemic Medicaid "unwinding", the independent evaluator will explore how the results change when excluding the years most impacted by these external events, or when estimating program effects separately by each year, rather than aggregating baseline years and evaluation years. A similar approach will be taken to account for the "unwinding" period in which the Medicaid continuous enrollment condition authorized ended and AHCCCS began redeterminations of eligibility.

A second assumption of the proposed ITS model is that a linear model can appropriately characterize the relationship between independent variables and the response variable. The independent evaluator will test this assumption by examining error autocorrelation; if subsequent error terms are highly correlated, then parameter estimates and variance obtained from the model may be biased, resulting in misleading conclusions. During analyses, the independent evaluator will take steps to test for autocorrelation and assess the model fit. If the linear model is a poor fit for the data, additional procedures will be explored such as transformation of the model to remove autocorrelation or estimating an autoregressive model.

A limitation of ITS is the need for sufficient data points both before and after program implementation.[3-16, 3-17. 3-18] To facilitate this methodology, the independent evaluator may consider additional baseline data points using prior year calculations, and/or calculating quarterly rates where feasible, if multiple years both pre-and post-implementation are available to control for seasonality.

Specifically, for the PQC evaluation, the independent evaluator will evaluate one measure for which data on a comparison group will not be available: *Percentage of Medicaid enrollees by eligibility group out of estimated eligible Medicaid recipients*. This measure is intended to be captured monthly through administrative program data. As such, the higher frequency can be used to construct pre- and post-implementation trends using ITS. An ITS approach can be utilized to draw causal inferences if sufficient data points exist before and after implementation, there are no concurrent shocks in the trend around program implementation, and any seasonal effects are adequately accounted for.

ACC, ACC-RBHA, ALTCS, CHP, PQC, and the Tribal Dental Authority will utilize the ITS approach.

Pre-test/post-test

For measures with consistent specifications over time for which national or regional benchmarks are not available, and which have too few observations to support an ITS analysis, rates will be calculated and compared both before and after program integration.[3-19] Statistical testing will be conducted through a Chi-square analysis. A Chi-square test allows for comparison between two groups that have a categorical outcome, such as survey results or numerator compliance, to determine if the observed counts are different than the expectation.

A pre-test/post-test analysis will be conducted for ACC, ACC-RBHA, ALTCS, CHP, PQC, and the Tribal Dental Authority.

Noninferiority Testing

To support testing of hypotheses that suggest program impacts will "be maintained or improve," the independent evaluator may consider employing noninferiority statistical testing.

For measures that use a DiD framework and are hypothesized to perform at least as well as or better than a comparison group, a prespecified fraction (δ) of the change in the comparison group (coefficient on time, β_2) is used to define an "equivalence range" which would conclude that the treatment group performed as well as the comparison group. The equivalence range is bounded by the change in rates for the comparison group, plus or minus 10 percent of the change in the comparison group. The change in the treatment group will be compared

3-16 Baicker, K., and Svoronos, T., (2019) "Testing the Validity of the Single ITS Design," *NBER Working Paper 26080.* Available at: https://www.nber.org/papers/w26080.pdf. Accessed on: Aug 21, 2023

3-17 Bernal, J.L., Cummins, S., Gasparrini, A. (2017) "Interrupted time series regression for the evaluation of public health interventions: a tutorial," *International Journal of Epidemiology*, 46(1): 348-355. Available at: https://doi.org/10.1093/ije/dyw098. Accessed on: Aug 21, 2023

3-18 Penfold, R. B., Zhang, F. (2013) "Use of Interrupted Time Series Analysis in Evaluating Health Care Quality Improvements," *Academic Pediatrics*, 13(6): S38 - S44. Available at: https://doi.org/10.1016/j.acap.2013.08.002. Accessed on: Aug 21, 2023.

3-19 Because measures are calculated on an annual reporting period, the post-implementation period during the current demonstration approval period of three years is insufficient to support an ITS analysis.

against this equivalence range using a 95 percent confidence interval. Figure 3-1 illustrates how the equivalence window will be calculated and how statistical significance will be determined.

Figure 3-1—Illustration of Non-Equivalence Testing Procedure

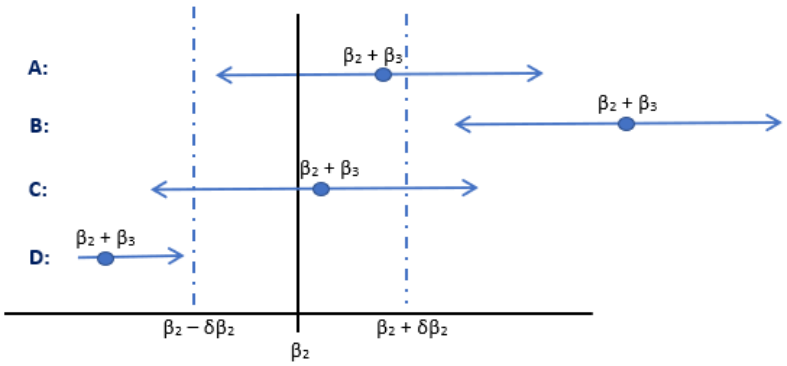


Table 3-11 defines the equivalence intervals used for each scenario in Figure 3-1.

Table 3-11—Noninferiority Equivalence Intervals

Desired Direction	Equivalence Interval	Noninferiority Threshold
Higher is better and $\beta_2 > 0$ OR Lower is better and $\beta_2 < 0$	$(\beta_2 - \delta\beta_2)$ to β_2	$(\beta_2 - \delta\beta_2)$
Lower is better and $\beta_2 > 0$ OR Higher is better and $\beta_2 < 0$	β_2 to $(\beta_2 + \delta\beta_2)$	$(\beta_2 + \delta\beta_2)$

In Figure 3-1, given a measure in which higher is better, the confidence interval in Scenario A, denoted by the arrows, includes β_2 but not the noninferiority threshold, $(\beta_2 - \delta\beta_2)$. Therefore, evidence supports the finding that the treatment group is not inferior to the comparison group. The confidence interval in Scenario B is above β_2, which suggests that the treatment group is superior to the comparison group. The confidence interval in scenario C spans both β_2 and $(\beta_2 - \delta\beta_2)$. Therefore, there is insufficient evidence to establish noninferiority and the results are inconclusive. The confidence interval in Scenario D falls below the noninferiority threshold $(\beta_2 - \delta\beta_2)$ and supports the finding that the treatment group is inferior to the comparison group.

Noninferiority testing within the DiD framework will be conducted for the ALTCS program.

Noninferiority testing may also be applied within the context of an ITS analysis by quantifying the overall effect size and comparing to the noninferiority threshold. Travis-Lumer, Goldberg, and Levine describe how the effect size may be quantified by comparing the model-based fitted values for the intervention period to the model-based counterfactual values.[3-20] If the outcome is based on continuous data, then Cohen's d will be used as the effect size. If the outcome is count data, then the relative risk will be calculated.

[3-20] Travis-Lumer Y, Goldberg Y, Levine, S (2022). "Effect size quantification for interrupted time series analysis: implementation in R and analysis for Covid-19 research," Emerging Themes in Epidemiology 19(9); Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9652048/. Accessed on: Aug 21, 2023.

Chi-Square Test

A Chi-square test allows for comparison between two groups that have a categorical outcome, such as survey results, to determine if the observed counts are different than the expectation. A test statistic is calculated that compares the observed results to the expected results and a Chi-square distribution is used to estimate the probability of the observed difference from the expected results being due to the Waiver.

A Chi-square test will be conducted for PQC.

Comparison to National Benchmarks

A comparison to national benchmarks approach will be utilized for the evaluation of ACC, ALTCS, CHP and PQC.

To provide additional context of rates and changes in rates after the transition to integrated care under these plans, the independent evaluator may compare rates from ACC, ALTCS, CHP, or PQC against national benchmarks without necessarily conducting formal statistical testing (e.g., DiD or pre-test/post-test approaches). Rates calculated for ACC, ALTCS, CHP, and PQC can be reported in the context of performance nationally. Although statistical testing through a DiD or pre-test/post-test approach would be preferable, these comparisons may be necessary if the level of data for the comparison group are not granular enough to support such statistical testing.

Post-Implementation Trend Analysis

Analysis of the Tribal Dental Authority may rely on analysis of the post-implementation trend if sufficient data on dental services are not available or not collected prior to its implementation. Data during the post-implementation period will be analyzed to assess how measures have changed over the course of the program. A regression line fit to the post-implementation data points will test for any statistically significant changes in measure rates.

Health Equity Analysis

In line with Waiver's goals of understanding social inequities and addressing health-related risk factors that play a prominent role in determining health outcomes, a health equity analysis will be conducted. A detailed assessment of changes in health disparities across time will be the primary analytic approach for assessing health equity. Outcome measures for relevant demographic subgroups (e.g., age, sex, race, ethnicity, geography, disability status, language spoke, etc.) will be compared to a reference group and assessed for statistically significant differences as well as clinically meaningful differences in relative percentages and effect sizes. When appropriate, more granular analyses will be conducted. For example, adult and child subgroup analyses detailed in the ACC evaluation design may include stratification by age category (e.g., under five years, 5–17, 18–24, 25–34, 35–44, 45–64).[3-21]

[3-21] Census Bureau. Exploring the Racial and Ethnic Diversity of Various Age Groups. Available at: https://www.census.gov/newsroom/blogs/random-samplings/2023/09/exploring-diversity.html. Accessed on: Dec 12, 2023.

Qualitative Synthesis

To evaluate the care coordination strategies implemented by health plans as a result of the Waiver, and to identify and understand barriers encountered by health plans and AHCCCS during and after the transition to each program, a series of semi-structured focus groups and key informant interviews with representatives from the health plans, AHCCCS, and providers will be conducted to obtain results for all plan-specific measures. A qualitative synthesis will be utilized to evaluate ACC, ACC-RBHA, ALTCS, CHP, PQC, and the Tribal Dental Authority.

Focus group participants and key informant interviewees will be recruited from nominees identified by the health plans, AHCCCS, and providers. Interviews and focus groups will invite input from representatives of all seven health plans and appropriate individuals identified by AHCCCS as having experience and subject matter expertise regarding the development and implementation of strategies to promote integration of PH and BH service delivery and care integration within the framework of the ACC.

AHCCCS will be asked to provide the names of up to three individuals each from pertinent organizations most familiar with the implementation activities performed by the State and the Waiver, including AHCCCS. Each of these individuals will be requested to participate in a 60 to 90-minute interview session to provide insights into the implementation of the Waiver. A limited number of key informant interviews should be sufficient in this scenario because there will be a limited number of staff at the agency with a working knowledge of the activities associated with the Waiver, and the challenges and successes that accompanied the implementation.

To recruit providers for the focus groups, the independent evaluator will begin by requesting a list of any providers from AHCCCS with whom they have experienced an above-average level of engagement and participation. Those providers most engaged in the program may also be those most able and willing to provide feedback on their experiences during implementation. The independent evaluator will attempt to recruit focus group participants from the providers suggested by AHCCCS initially. The independent evaluator will supplement the list provided by AHCCCS with participating providers in the Waiver stratified by geographic region; location within each region (e.g., urban versus rural providers); and by specialty. Because the providers are participating in the Waiver statewide, the independent evaluator will attempt to recruit focus group participants regionally across the AHCCCS-defined North, Central, and South geographical service areas (GSAs) within the State. Recruiting regionally, will allow for providers operating in large metropolitan areas, as well as smaller rural locations to participate. After stratifying the provider lists, the independent evaluator will sample to recruit providers representing the broadest spectrum of participating providers. By recruiting to maximize the variation in provider types and locations, the data obtained are likely to represent perspectives from a wide variety of participating providers. The recruitment goal is to have five to eight providers participate in each focus group. Focus group meetings will last approximately 90 minutes to allow sufficient time for all participants to voice their perspectives and explore each topic in detail. To facilitate provider participation—particularly for rural providers—focus groups will be held via a Webex teleconference with the option of participant video conferencing. Due to the self-selection of participants and the wide degree of variability across provider types, the focus group participants are not likely to constitute a statistically representative sample of providers within the State. The purpose of the focus group data, however, is not to obtain a statistically representative sample of respondents. Rather, the purpose of the focus group data collection is to obtain a rich set of contextualized descriptions that cannot easily be obtained through administrative data or survey data collection efforts.

A flexible protocol will be developed for focus groups and semi-structured interviews to be conducted with a sample of subjects with knowledge of the specific strategies developed and implemented as a result of ACC, the barriers encountered during the implementation of care coordination activities, and other barriers encountered

during the transition to ACC. Interview questions will be developed to seek information about the plans' strategies to promote PH and BH service delivery and care integration activities as well as any barriers encountered, including:

- Organizational structures and operational systems.
- Program design and implementation.
- Member engagement and communication.
- Provider/network relations and communication.

Early focus groups or interviews will inform the development and choice of topics and help inform the selection of additional interview subjects to round out the list of individuals to be interviewed for this project. In both formats, open-ended questions will be used to maximize the diversity and richness of responses and ensure a more holistic understanding of the subject's experience. Probing follow-up questions will be used as appropriate to elicit additional detail and understanding of critical points, terminology, and perspectives. The sessions will be recorded and transcribed with participant consent.

The information obtained from these focus groups and interviews will be synthesized with the results from other quantitative data analyses providing an in-depth discussion of each of the domains/objectives to be considered. As the key informant interviews are being conducted, the independent evaluator will perform ongoing and iterative review of the interview responses and notes to identify overall themes and common response patterns. Unique responses that are substantively interesting and informative will also be noted and may be used to develop probing questions for future interviews. The results of these preliminary analyses will be used to document the emergent and overarching themes related to each research question. The documentation of emergent themes will be reviewed iteratively to determine if responses to interview questions are continuing to provide new perspectives and answers, or if the responses are converging on a common set of response patterns indicating saturation on a particular interview question. As additional interview data are collected, the categories, themes, and relationships will be adjusted to reflect the broader set of concepts and different types of relationships identified. The documentation of emergent themes will also be used as an initial starting point for organizing the analysis of the interview data once all interviews are completed.

Following the completion of the focus groups and key informant interviews, the interview notes and transcripts will be reviewed using standard qualitative analysis techniques. The data will first be examined through open coding to identify key concepts and themes that may not have been captured as emergent themes during previous analyses. After identifying key concepts, axial coding techniques will be used to develop a more complete understanding of the relationships among categories identified by respondents in the data. The open and axial coding will be performed with a focus on identifying the dimensionality and breadth of responses to the research questions posed for the overall project. Interviewee responses will be identified through the analysis to illustrate and contextualize the conclusions drawn from the research and will be used to support the development of the final report.

Cost Effectiveness Analysis

The cost effectiveness analysis is designed to analyze the differences between actual and projected for the evaluation period. Note that the cost analyses do not refer to or attempt to replicate the formal Budget Neutrality test required for Section 1115 Demonstration Waivers, which sets a fixed target under which waiver expenditures must fall that was set at the time the waiver was approved. The methodology for analyzing the Waiver's costs is adapted from CMS' guidance for assessing the costs of substance use disorder (SUD) or SMI evaluations.[3-22]

Cost of care for Waiver members based on managed care plan payment amounts and FFS reimbursement amounts will be calculated for each member in each month. To identify the source of treatment cost drivers for members, total costs will be stratified by the categories of service presented in Table 3-12. Data will be aggregated across all members in order to calculate per-member per-month (PMPM) costs for each month of the Waiver and 24 months prior.[3-23] ITS analyses will be conducted for total cost of care, as well as for each level of cost stratification mentioned above. This method will project the cost experience of the Waiver population during the baseline period prior to the Waiver renewal forward in time to the evaluation period following the Waiver renewal. The projected costs will represent a counterfactual estimate of the costs of the waiver population during the evaluation period as if the Waiver had never been renewed. Thus, the method will compare the actual costs of the Waiver population in the evaluation period to the projected counterfactual costs of the waiver population in the evaluation period. Seasonality indicators and variables indicating time periods affected by the COVID-19 PHE and post-pandemic Medicaid "unwinding" will be included in the model to control for these factors.

Table 3-12—Categories of Service

Categories of Service
IP
OP (ED and Non-ED)
LTC
Professional
Pharmacy

Note: ED: emergency department; IP: Inpatient; LTC: long-term care; OP: outpatient

As the Waiver will provide additional coverage and services to members, it is possible that there is an initial increase in costs. The independent evaluator will also review the overall cost-effectiveness of the program in which any additional costs incurred through the program are contrasted and compared to observed benefits of the program. The cost-effectiveness analysis will 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

3-22 United States Department of Health and Human Services. Appendix C: Approaches to Analyzing Costs Associated with Section 1115 Demonstrations for Beneficiaries with Serious Mental Illness/Serious Emotional Disturbance or Substance Use Disorders. Available at: https://www.hhs.gov/guidance/document/appendix-c-analyzing-costs-associated-demonstrations-smised-or-sud-0. Accessed on: Aug 2, 2023.

3-23 CMS guidance describes constructing an ITS with member-level controls. However, due to a low prevalence of costs for most members—especially when stratified by category of service—robust statistical analysis at the member-level was not feasible. CMS guidance references literature on evaluating healthcare expenditures using a two-part model as one mechanism to account for this issue; however, the method described in the literature is not applied in an ITS framework, which relies on assessing trends in costs. Given the frequency of months in which members did not incur any costs and the unbalanced nature of the panel dataset, member-level trends could not be reliably estimated.

health outcomes overall. Furthermore, some benefits may manifest over the long-term and may not be measurable at the time of the evaluation.

Disentangling Confounding Events

Beginning on July 1, 2019, AHCCCS eliminated PQC for most Medicaid adults.[3-24] This program may introduce confounding effects since impacted members may alter their future care-seeking or enrollment and disenrollment decisions. The independent evaluator may leverage the differential timing between the introduction of each program and effective date of the elimination of PQC to help reduce the potential confounding effects. This is not expected to completely eliminate confounding effects. Without a valid comparison group, any observed changes (or lack thereof) in the rates cannot be completely separated from the impact of the elimination of PQC.

The COVID-19 PHE widely impacted the healthcare system and socioeconomic conditions more broadly beginning in approximately March 2020 with the COVID-19 PHE ending in May 2023.[3-25] The COVID-19 PHE has already exerted an arguably substantial force on the State of Arizona, its healthcare system, and its Medicaid population. Increases in Medicaid enrollment during the COVID-19 PHE are tied to substantial shifts in the disease conditions and comorbidities of the Medicaid population and may impact aggregate spending by AHCCCS. Social distancing efforts and stay-at-home orders interrupted routine care visits and effectively reduced the demand for many healthcare services to near zero. In an ideal evaluation, the independent evaluator would be able to control for many of these issues during the analysis. The ability to do so in the current context of the Waiver evaluation will depend on the availability of data and control variables.

The independent evaluator will consider methods that allow for the disentanglement of AHCCCS program impacts from results driven by COVID-19 or the policy response within Arizona and other states. There are four possible strategies to account for the potential confounding effects of the COVID-19 PHE. The final method chosen will depend on the measure and data availability at the time of the evaluation.

1. Controlling for the effects of the COVID-19 PHE using model covariates.
2. Excluding years/quarters most impacted by the COVID-19 PHE from the baseline period.
3. Estimate the demonstration effect separately for years most affected by the COVID-19 PHE.
4. Controlling by local area level measures of COVID-19 PHE burden.

First, controlling for the effects of the COVID-19 PHE by including covariates in the models allows for the separation of the effect of the demonstration from the COVID-19 PHE. For measures calculated quarterly, indicator variables will be added to the ITS model for each quarter of the year to adjust for seasonality in the trend. Adjustment for the COVID-19 PHE will be conducted by creating an indicator variable for Q2 2020 to represent the initial wave of the COVID-19 PHE-related shutdowns and stay-at-home orders, and a separate indicator variable for Q3 2020 through the end of Q1 2021 to reflect subsequent Arizona-specific public health orders. For measures calculated annually, an indicator variable for 2020 will be included in the model to adjust for the COVID-19 PHE.

3-24 Pregnant women, women who are 60 days or less postpartum, and infants and children under 19 years of age are excluded.

3-25 Centers for Disease Control and Prevention. End of the Federal COVID-19 Public Health Emergency (PHE) Declaration. Available at: https://www.cdc.gov/coronavirus/2019-ncov/your-health/end-of-phe.html. Accessed on: Jul 17, 2023.

Second, for this evaluation. the most affected years of the COVID-19 PHE (2020–2021) occur within the baseline period. If sufficient baseline data is available, the independent evaluator will consider excluding the most impacted years from the model as a sensitivity analysis. If removing the COVID-19 PHE-impacted data points significantly alters the conclusion of the statistical analysis, evaluators will indicate that the results were potentially biased by the COVID-19 PHE and interpret results in the context of this limitation.

The third method for disentangling the effect of the COVID-19 PHE will be calculating yearly demonstration effects separately in pre-test/post-test analyses. The years that are most impacted by the COVID-19 PHE (2020 and 2021) fall within the baseline period, thus, rather than aggregating the years into a single mean value for the entire baseline period and a single mean value for the entire evaluation period, the independent evaluator may consider additional comparisons to estimate the demonstration impact separately for each baseline year. If results vary dramatically across years, particularly for years affected by the COVID-19 PHE compared to years not affected by the COVID-19 PHE, then this may provide context for the COVID-19 PHE's impact separate from the demonstration.

Lastly, the independent evaluator will consider controlling for local effects of the COVID-19 PHE in pre-test/post-test and DiD analyses. When warranted, pre-test/post-test analyses will include county-level COVID-19 hospitalizations and deaths as model covariates, as a proxy for the severity of the COVID-19 PHE.

4. Methodological Limitations

Despite the planned rigor of the evaluation, there are several limitations that may impact the ability of the evaluation to attribute changes in performance metrics to the Arizona Health Care Cost Containment System (AHCCCS) Section 1115 Demonstration Waiver (the Waiver). One of the primary limitations to this evaluation is the lack of a viable in-state or out-of-state comparison group for many Waiver components. Without a suitable contemporaneous comparison group, changes in rates over time may be either fully or partially attributable to secular trends independent of the Waiver. A viable in-state comparison group is unlikely to be found for the following Waiver components:

- **AHCCCS Complete Care (ACC)**—The ACC program enrolls most adults and children on Medicaid.
- **ACC-Regional Behavioral Health Agreement (ACC-RBHA)—**Virtually all adult Medicaid members with a serious mental illness (SMI) are enrolled with an ACC-RBHA.
- **Arizona Long Term Care System (ALTCS)—**The ALTCS program covers all eligible Medicaid members who are elderly and/or physically disabled (EPD) or who have developmental disabilities (DD).
- **Comprehensive Health Plan (CHP)—**All children in the custody of the Arizona Department of Child Safety (DCS) are covered by CHP.
- **Prior Quarter Coverage (PQC)—**All non-pregnant or postpartum adults are subject to the Waiver.
- **Tribal Dental Authority—**This program extends dental services for adult American Indian/Alaska Native (AI/AN) populations enrolled in an AHCCCS plan who receive care at an Indian Health Service (IHS) or Tribal 638 facility.

For the above-mentioned programs that were implemented across their respective populations of eligible members in Arizona, no eligible comparison group realistically exists within the State, and therefore, no in-state comparison group is identified for any of the Waiver programs. An eligible population could therefore be drawn from another state, provided specific criteria were met. Ideally, the comparison state would have Medicaid members demographically similar to Arizona; a Medicaid system that was similar to Arizona in terms of eligibility, enrollment, and pre-integration policies and programs; a coronavirus disease 2019 (COVID-19) infection rate or likely infection rate (accounting for differentials in testing) comparable to Arizona; and have had a state policy response to the COVID-19 public health emergency (PHE) that was similar to Arizona's response. This combination of factors represents a particularly difficult challenge to surmount in identifying an eligible comparison group. The independent evaluator will consider and explore the use of member-level data from the Transformed Medicaid Statistical Information System (T-MSIS) in order to support an out-of-state comparison group if sufficient resources and relevant years of data are available. Simultaneously, the independent evaluator will continue to work toward identifying states that could be suitable candidates, either individually or combined and weighted to better reflect Arizona's unique characteristics for inclusion in the evaluation, under the assumption that data will be available if such a comparator state or states are identified. However, if ultimately T-MSIS is unavailable, and data cannot be obtained from another state with similar population characteristics and Medicaid policies and procedures in place, then a counterfactual comparison group will not be available. Although in-state comparison groups are not viable for the above programs, an out-of-state comparison group may be constructed using the weighted national average of participating states to National Core Indicator (NCI) and respondents to Behavioral Risk Factor Surveillance System (BRFSS) surveys from all other states that participated.

Additional details regarding why an in-state or out-of-state comparison group is not feasible are included below:

- **ACC-RBHA**—ACC-RBHAs enroll all adult Medicaid members with an SMI, leaving no viable in-state comparison group to estimate counterfactuals. The use of national benchmarks for general Medicaid populations as a comparison group would result in inappropriate comparisons, as members with an SMI differ systematically from the general Medicaid population. No national data could be identified that would provide a reliable and accurate comparison group at the national level. For this reason, no national comparison group can be used to estimate counterfactual results, and thereby determine the causal impacts of the program. Second, the use of an out-of-state comparison group comprised of aggregated rates from the adult Medicaid population designated with an SMI in another state is limited to the extent that the comparison state uses different criteria than Arizona uses to designate members with an SMI. Additionally, this limitation expands to the extent that the policies and procedures of the Medicaid system in the comparison state do not align with those of Arizona.
- **ALTCS**—Due to the unique population of ALTCS members, finding an in-state comparison group is very challenging since all eligible Medicaid EPD or DD members would receive care through ALTCS, removing any possibility for Medicaid members who are elderly and/or with a physical disability or members with DD to serve as a counterfactual. The use of an out-of-state comparison group comprised of aggregated rates from the EPD or DD Medicaid population designated in another state is also limited to the extent that the comparison state uses different criteria than Arizona uses to designate members as EPD or DD. Although an out-of-state comparison group for claims-based measures is limited, for NCI measures, there is an opportunity to compare Arizona rates to the weighted national average of other states participating in the NCI survey.
- **CHP**—Due to the unique needs and specialized care provided to CHP members, finding an in-state comparison group is very challenging. Children in DCS custody have designated case workers and care coordinators to ensure CHP members are receiving timely immunizations, screenings, and check-ups. Therefore, when comparing to in-state non-CHP members these children will have higher rates for certain measures which is not necessarily a reflection of CHP itself, but rather the unique population it serves. For these reasons, the independent evaluator should prioritize finding an out-of-state comparison group that also contains children in DCS custody. However, a limitation related to the use of an out-of-state comparison group is the comparability of that population, the design of the program delivering services to them, and the presence or absence of confounding quality improvement programs. While an out-of-state comparison group can provide a counterfactual design, the granularity of the data available may not allow for strong statistical controls over differences across the populations. Additionally, an independent evaluator is unlikely to be able to control for additional quality improvement programs that may impact a comparison group population.
- **PQC**—Comparison groups represent a unique challenge for this Waiver, particularly because the PQC waiver affects almost all new members except for pregnant women, women who are 60 days or less postpartum, and infants and children younger than 19 years of age. This greatly restricts the feasibility of an in-state comparison group. As a result, many measures listed in the Methodology section either do not have a viable comparison group or are contingent on the availability of out-of-state or aggregate data.
- **Tribal Dental Authority**—The Tribal Dental Authority covers all AI/AN who are at least 21 years old, enrolled in AHCCCS, and receive dental services at an IHS or Tribal 638 facility. Due to the specific oral needs of this population and the provision of care to all AI/AN adults enrolled in AHCCCS, it is challenging to identity a comparison group that accurately represents the needs of this population. As such, measures for this program will rely on comparing AI/AN AHCCCS members to members in other states that participated in the BRFSS core oral health module.

Therefore, the counterfactual comparison for the above programs is the comparison of performance measure rates across the baseline and evaluation periods of the Waiver. The results indicate whether the performance measure rates increased or decreased, and whether the results represented statistically significant changes in performance across time; however causal impacts specifically resulting from the Waiver will be difficult to determine due to the lack of viable comparison group. In addition to the common limitation of identifying comparison groups for the programs above, other program-specific limitations are described below.

ALTCS

Due to ALTCS serving such a unique population, it is impossible to compare ALTCS rates to national benchmarks since these are designed to represent the entire Medicaid population as opposed to EPD individuals or individuals with DD. Combined, this leaves only trending rates over time for much of the ALTCS population, utilizing an ITS approach, or obtaining comparative data from an out-of-state Medicaid authority. The independent evaluator will need to consider variation across performance measure year specifications since these differences could impact the rate calculation. Trending rates also limit comparability between measurement years since the member population can vary. While an interrupted time series (ITS) approach would allow for assessment of immediate and sustained trend changes for ALTCS rates across time, simultaneous factors external to ALTCS co-occurring during the same time period and insufficient pre-period and post-period data points may still present challenges to estimation of causal impact.

Although national benchmarks cannot serve as a viable comparison group, rates reported by National Core Indicators (NCI) provide insight into quality of care for individuals with DD, which allows an evaluator to compare Arizona specific rates to the weighted national average among all other NCI-participating states. For measures wherein NCI aggregate data are available and serves as a comparison group, the comparison of the ALTCS-DD and ALTCS-EPD populations to this counterfactual will be limited by the inability to perform any statistical matching or include statistical controls in the difference-in-differences (DiD) models to account for differences in the underlying population characteristics, since member-level data are not available through NCI.

PQC

Despite the methodology described in the Disentangling Confounding Events subsection of the Methodology section found earlier in this report, there are still limitations in fully isolating changes in rates attributable to the PQC waiver from other events, particularly from the transition to ACC health plans on October 1, 2018. Since this transition impacts most adults (and children) on Medicaid, comparisons to historical AHCCCS rates before ACC for the acute care population, who are the majority of members in PQC, may be confounded with the transition to ACC. The independent evaluator will identify any individuals impacted by PQC but not ACC to reduce this potential confounding; however, because those exposed to PQC but not ACC are likely to be systematically different (e.g., members enrolled in ALTCS or adults with an SMI) and relatively few in number, confounding effects from ACC may still remain.

Tribal Dental Authority

Isolation of the impact of the Tribal Dental Authority will rely on proper identification of the target population. If there are challenges to appropriate determination of Tribal membership, evaluation of the impact of this program may not represent the truth. Furthermore, calculation of measures for the Tribal Dental Authority will rely on the availability of data on dental services provided in an IHS or 638 Tribal Facility. If such data are not available or not collected prior to the implementation of the Tribal Dental Authority, then there will not be sufficient pre-demonstration data to support a baseline period. Use of analytic methods such as pre/post testing and ITS may not be possible and the ability to attribute changes in outcomes to the Tribal Dental Authority will be severely limited as the analysis will rely on an assessment of post-implementation trends over time. The independent evaluator will collaborate with AHCCCS to identify and obtain the necessary data elements to support the evaluation of the Tribal Dental Authority. Lastly, the global COVID-19 PHE represents a final key limitation to the evaluation design. The COVID-19 PHE impacted the healthcare industry and the entire population on a global scale, requiring substantial changes to the processes used in the delivery of healthcare. In Arizona, as in other locations, healthcare utilization was significantly reduced in 2020, and the impact on performance measure rates was evident in the evaluation results from the prior demonstration period. The independent evaluator will continue to take steps to account for the confounding impact of COVID-19, however it is possible that for some measures wherein the specifications for calculating rates require lengthy look back periods or sufficient data are unavailable, the analysis will not be able to disentangle COVID-19 impacts from program impacts.

Appendix A. Independent Evaluator

The Arizona Health Care Cost Containment System (AHCCCS) will select an independent evaluator with experience and expertise to conduct a scientific and rigorous Medicaid Section 1115 waiver evaluation that meets all the requirements specified in the Special Terms and Conditions (STCs). The independent evaluator will be required to have the following qualifications:

- Knowledge of public health programs and policy
- Experience in healthcare research and evaluation
- Understanding of AHCCCS programs and populations
- Expertise with conducting complex program evaluations
- Relevant work experience
- Skills in data management and analytic capacity
- Medicaid experience and technical knowledge

Based on State protocols, AHCCCS will follow established policies and procedures to acquire an independent entity or entities to conduct the waiver evaluation. In addition, AHCCCS will ensure that the selected independent evaluator does not have any conflicts of interest and will require the independent evaluator to sign a "No Conflict of Interest" statement.

Appendix B. Evaluation Budget

Due to the complexity and resource requirements of Arizona's Section 1115 Arizona Health Care Cost Containment System (AHCCCS) Demonstration Waiver (the Waiver), AHCCCS will need to conduct a competitive procurement to obtain an independent evaluator to perform the services outlined in this evaluation design. After selection of an evaluation vendor, a final budget will be prepared in collaboration with the selected independent evaluator. Tables B-1 through B-6 present the cost estimates for each program.

Table B-1—AHCCCS Complete Care (ACC) Cost Estimate

Evaluation Area/Task	SFY 24	SFY 25	SFY 26	SFY 27	SFY 28	SFY 29	SFY 30
Project Administration and Monitoring Reports							
Staff Costs	$ 11,666	$ 17,979	$ 16,268	$ 26,451	$ 27,440	$ 19,072	$ 703
Administrative Costs	$ 3,401	$ 5,241	$ 4,742	$ 7,710	$ 7,999	$ 5,560	$ 205
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ 15,067**	**$ 23,220**	**$ 21,010**	**$ 34,161**	**$ 35,439**	**$ 24,632**	**$ 908**
Key Informant Interviews							
Instrument Design							
Staff Costs	$ -	$ -	$ 4,432	$ 7,537	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ 1,292	$ 2,197	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 5,724**	**$ 9,734**	**$ -**	**$ -**	**$ -**
Administration							
Staff Costs	$ -	$ -	$ 7,357	$ 1,694	$ 3,659	$ -	$ -
Administrative Costs	$ -	$ -	$ 2,145	$ 494	$ 1,066	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 9,502**	**$ 2,188**	**$ 4,725**	**$ -**	**$ -**
Analysis							
Staff Costs	$ -	$ -	$ 3,498	$ -	$ 3,659	$ -	$ -
Administrative Costs	$ -	$ -	$ 1,020	$ -	$ 1,066	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 4,518**	**$ -**	**$ 4,725**	**$ -**	**$ -**
Proivder Focus Groups							
Instrument Design							
Staff Costs	$ -	$ -	$ 4,432	$ 8,794	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ 1,292	$ 2,563	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 5,724**	**$ 11,357**	**$ -**	**$ -**	**$ -**
Administration							
Staff Costs	$ -	$ -	$ 8,253	$ 1,694	$ 4,181	$ -	$ -
Administrative Costs	$ -	$ -	$ 2,406	$ 494	$ 1,219	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 10,659**	**$ 2,188**	**$ 5,400**	**$ -**	**$ -**
Analysis							
Staff Costs	$ -	$ -	$ 3,946	$ -	$ 4,181	$ -	$ -
Administrative Costs	$ -	$ -	$ 1,150	$ -	$ 1,219	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 5,096**	**$ -**	**$ 5,400**	**$ -**	**$ -**
Member/Beneficiary Surveys							
Instrument Design							
Staff Costs	$ -	$ 7,072	$ -	$ 11,120	$ -	$ -	$ -
Administrative Costs	$ -	$ 2,061	$ -	$ 3,241	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ 9,133**	**$ -**	**$ 14,361**	**$ -**	**$ -**	**$ -**
Administration							
Staff Costs	$ -	$ 2,653	$ -	$ 7,161	$ -	$ -	$ -
Administrative Costs	$ -	$ 773	$ -	$ 2,088	$ -	$ -	$ -
Other Costs	$ -	$ 70,619	$ -	$ 73,405	$ -	$ -	$ -
Total Costs	**$ -**	**$ 74,045**	**$ -**	**$ 82,654**	**$ -**	**$ -**	**$ -**
Analysis							
Staff Costs	$ -	$ -	$ 8,144	$ -	$ 22,370	$ -	$ -
Administrative Costs	$ -	$ -	$ 2,374	$ -	$ 6,521	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 10,518**	**$ -**	**$ 28,891**	**$ -**	**$ -**

Evaluation Area/Task	SFY 24	SFY 25	SFY 26	SFY 27	SFY 28	SFY 29	SFY 30
Measure Calculation and Analysis							
Data Collection/Validation							
Staff Costs	$ -	$ -	$ 20,965	$ -	$ 35,936	$ -	$ -
Administrative Costs	$ -	$ -	$ 6,111	$ -	$ 10,475	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 27,076**	**$ -**	**$ 46,411**	**$ -**	**$ -**
Code Development/Execution							
Staff Costs	$ -	$ -	$ 20,885	$ -	$ -	$ 3,967	$ -
Administrative Costs	$ -	$ -	$ 6,088	$ -	$ -	$ 1,157	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 26,973**	**$ -**	**$ -**	**$ 5,124**	**$ -**
Statistical Analysis							
Staff Costs	$ -	$ -	$ 33,605	$ -	$ -	$ 46,375	$ -
Administrative Costs	$ -	$ -	$ 9,796	$ -	$ -	$ 13,518	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 43,401**	**$ -**	**$ -**	**$ 59,893**	**$ -**
EHR Measure Calculation and Analysis							
Data Collection/Validation							
Staff Costs	$ -	$ -		$ -		$ -	$ -
Administrative Costs	$ -	$ -		$ -		$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Code Development/Execution							
Staff Costs	$ -	$ -		$ -	$ -		$ -
Administrative Costs	$ -	$ -		$ -	$ -		$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Reporting							
Interim Evaluation Report							
Staff Costs	$ -	$ -	$ 18,181	$ 9,304	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ 5,300	$ 2,712	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 23,481**	**$ 12,016**	**$ -**	**$ -**	**$ -**
Summative Evaluation Report							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ 33,041	$ 18,633
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ 9,631	$ 5,432
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 42,672**	**$ 24,065**
Total	**$ 15,067**	**$ 106,398**	**$ 193,682**	**$ 168,659**	**$ 130,991**	**$ 132,321**	**$ 24,973**

Table B-2—AHCCCS Complete Care-Regional Behavioral Health Agreement (ACC-RBHA) Cost Estimate

Evaluation Area/Task	SFY 24	SFY 25	SFY 26	SFY 27	SFY 28	SFY 29	SFY 30
Project Administration and Monitoring Reports							
Staff Costs	$ 11,666	$ 17,989	$ 16,268	$ 26,451	$ 27,440	$ 19,072	$ 703
Administrative Costs	$ 3,401	$ 5,244	$ 4,742	$ 7,710	$ 7,999	$ 5,560	$ 205
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ 15,067**	**$ 23,233**	**$ 21,010**	**$ 34,161**	**$ 35,439**	**$ 24,632**	**$ 908**
Key Informant Interviews							
Instrument Design							
Staff Costs	$ -	$ -	$ 4,432	$ 7,537	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ 1,292	$ 2,197	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 5,724**	**$ 9,734**	**$ -**	**$ -**	**$ -**
Administration							
Staff Costs	$ -	$ -	$ 7,357	$ 1,694	$ 3,659	$ -	$ -
Administrative Costs	$ -	$ -	$ 2,145	$ 494	$ 1,066	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 9,502**	**$ 2,188**	**$ 4,725**	**$ -**	**$ -**
Analysis							
Staff Costs	$ -	$ -	$ 3,498	$ -	$ 3,659	$ -	$ -
Administrative Costs	$ -	$ -	$ 1,020	$ -	$ 1,066	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 4,518**	**$ -**	**$ 4,725**	**$ -**	**$ -**
Proivder Focus Groups							
Instrument Design							
Staff Costs	$ -	$ -	$ 4,432	$ 8,794	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ 1,292	$ 2,563	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 5,724**	**$ 11,357**	**$ -**	$ -	**$ -**
Administration							
Staff Costs	$ -	$ -	$ 8,253	$ 1,694	$ 4,181	$ -	$ -
Administrative Costs	$ -	$ -	$ 2,406	$ 494	$ 1,219	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 10,659**	**$ 2,188**	**$ 5,400**	**$ -**	**$ -**
Analysis							
Staff Costs	$ -	$ -	$ 3,946	$ -	$ 4,181	$ -	$ -
Administrative Costs	$ -	$ -	$ 1,150	$ -	$ 1,219	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 5,096**	$ -	**$ 5,400**	**$ -**	**$ -**
Member/Beneficiary Surveys							
Instrument Design							
Staff Costs	$ -	$ 7,072	$ -	$ 11,120	$ -	$ -	$ -
Administrative Costs	$ -	$ 2,061	$ -	$ 3,241	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ 9,133**	**$ -**	**$ 14,361**	**$ -**	**$ -**	**$ -**
Administration							
Staff Costs	$ -	$ 2,653	$ -	$ 7,161	$ -	$ -	$ -
Administrative Costs	$ -	$ 773	$ -	$ 2,088	$ -	$ -	$ -
Other Costs	$ -	$ 35,310	$ -	$ 36,702	$ -	$ -	$ -
Total Costs	**$ -**	**$ 38,736**	**$ -**	**$ 45,951**	**$ -**	**$ -**	**$ -**
Analysis							
Staff Costs	$ -	$ -	$ 8,144	$ -	$ 22,370	$ -	$ -
Administrative Costs	$ -	$ -	$ 2,374	$ -	$ 6,521	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 10,518**	**$ -**	**$ 28,891**	**$ -**	**$ -**

Evaluation Area/Task	SFY 24	SFY 25	SFY 26	SFY 27	SFY 28	SFY 29	SFY 30
Measure Calculation and Analysis							
Data Collection/Validation							
Staff Costs	$ -	$ -	$ 20,965	$ -	$ 35,936	$ -	$ -
Administrative Costs	$ -	$ -	$ 6,111	$ -	$ 10,475	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 27,076**	**$ -**	**$ 46,411**	**$ -**	**$ -**
Code Development/Execution							
Staff Costs	$ -	$ -	$ 20,885	$ -	$ -	$ 3,967	$ -
Administrative Costs	$ -	$ -	$ 6,088	$ -	$ -	$ 1,157	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 26,973**	**$ -**	**$ -**	**$ 5,124**	**$ -**
Statistical Analysis							
Staff Costs	$ -	$ -	$ 33,605	$ -	$ -	$ 46,375	$ -
Administrative Costs	$ -	$ -	$ 9,796	$ -	$ -	$ 13,518	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 43,401**	**$ -**	**$ -**	**$ 59,893**	**$ -**
EHR Measure Calculation and Analysis							
Data Collection/Validation							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Code Development/Execution							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Reporting							
Interim Evaluation Report							
Staff Costs	$ -	$ -	$ 18,181	$ 9,304	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ 5,300	$ 2,712	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 23,481**	**$ 12,016**	**$ -**	**$ -**	**$ -**
Summative Evaluation Report							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ 33,041	$ 18,626
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ 9,631	$ 5,430
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 42,672**	**$ 24,056**
Total	**$ 15,067**	**$ 71,102**	**$ 193,682**	**$ 131,956**	**$ 130,991**	**$ 132,321**	**$ 24,964**

Table B-3—Arizona Long Term Care System (ALTCS) Cost Estimate

Evaluation Area/Task	SFY 24	SFY 25	SFY 26	SFY 27	SFY 28	SFY 29	SFY 30
Project Administration and Monitoring Reports							
Staff Costs	$ 11,666	$ 17,979	$ 16,268	$ 26,451	$ 27,440	$ 19,072	$ 703
Administrative Costs	$ 3,401	$ 5,241	$ 4,742	$ 7,710	$ 7,999	$ 5,560	$ 205
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ 15,067**	**$ 23,220**	**$ 21,010**	**$ 34,161**	**$ 35,439**	**$ 24,632**	**$ 908**
Key Informant Interviews							
Instrument Design							
Staff Costs	$ -	$ -	$ 4,432	$ 7,537	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ 1,292	$ 2,197	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 5,724**	**$ 9,734**	**$ -**	**$ -**	**$ -**
Administration							
Staff Costs	$ -	$ -	$ 7,357	$ 1,694	$ 3,659	$ -	$ -
Administrative Costs	$ -	$ -	$ 2,145	$ 494	$ 1,066	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 9,502**	**$ 2,188**	**$ 4,725**	**$ -**	**$ -**
Analysis							
Staff Costs	$ -	$ -	$ 3,498	$ -	$ 3,659	$ -	$ -
Administrative Costs	$ -	$ -	$ 1,020	$ -	$ 1,066	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 4,518**	**$ -**	**$ 4,725**	**$ -**	**$ -**
Proivder Focus Groups							
Instrument Design							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	$ -	**$ -**
Administration							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Analysis							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Member/Beneficiary Surveys							
Instrument Design							
Staff Costs	$ -	$ 7,072	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ 2,061	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ 9,133**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Administration							
Staff Costs	$ -	$ 2,653	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ 773	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ 3,426**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Analysis							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Evaluation Area/Task	SFY 24	SFY 25	SFY 26	SFY 27	SFY 28	SFY 29	SFY 30
Measure Calculation and Analysis							
Data Collection/Validation							
Staff Costs	$ -	$ -	$ 20,965	$ -	$ 35,936	$ -	$ -
Administrative Costs	$ -	$ -	$ 6,111	$ -	$ 10,475	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 27,076**	**$ -**	**$ 46,411**	**$ -**	**$ -**
Code Development/Execution							
Staff Costs	$ -	$ -	$ 20,885	$ -	$ -	$ 3,967	$ -
Administrative Costs	$ -	$ -	$ 6,088	$ -	$ -	$ 1,157	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 26,973**	**$ -**	**$ -**	**$ 5,124**	**$ -**
Statistical Analysis							
Staff Costs	$ -	$ -	$ 33,605	$ -	$ -	$ 46,375	$ -
Administrative Costs	$ -	$ -	$ 9,796	$ -	$ -	$ 13,518	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 43,401**	**$ -**	**$ -**	**$ 59,893**	**$ -**
EHR Measure Calculation and Analysis							
Data Collection/Validation							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Code Development/Execution							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Reporting							
Interim Evaluation Report							
Staff Costs	$ -	$ -	$ 18,181	$ 9,304	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ 5,300	$ 2,712	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 23,481**	**$ 12,016**	**$ -**	**$ -**	**$ -**
Summative Evaluation Report							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ 33,041	$ 18,633
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ 9,631	$ 5,432
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 42,672**	**$ 24,065**
Total	**$ 15,067**	**$ 35,779**	**$ 161,685**	**$ 58,099**	**$ 91,300**	**$ 132,321**	**$ 24,973**

Table B-4—Comprehensive Health Plan (CHP) Cost Estimate

Evaluation Area/Task	SFY 24	SFY 25	SFY 26	SFY 27	SFY 28	SFY 29	SFY 30
Project Administration and Monitoring Reports							
Staff Costs	$ 5,019	$ 10,673	$ 9,547	$ 14,446	$ 14,516	$ 11,553	$ 403
Administrative Costs	$ 1,463	$ 3,111	$ 2,783	$ 4,211	$ 4,232	$ 3,368	$ 117
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ 6,482**	**$ 13,784**	**$ 12,330**	**$ 18,657**	**$ 18,748**	**$ 14,921**	**$ 520**
Key Informant Interviews							
Instrument Design							
Staff Costs	$ -	$ -	$ 2,469	$ 4,396	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ 720	$ 1,282	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 3,189**	**$ 5,678**	**$ -**	**$ -**	**$ -**
Administration							
Staff Costs	$ -	$ -	$ 4,015	$ 968	$ 1,829	$ -	$ -
Administrative Costs	$ -	$ -	$ 1,170	$ 282	$ 533	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 5,185**	**$ 1,250**	**$ 2,362**	**$ -**	**$ -**
Analysis							
Staff Costs	$ -	$ -	$ 1,749	$ -	$ 1,829	$ -	$ -
Administrative Costs	$ -	$ -	$ 510	$ -	$ 533	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 2,259**	**$ -**	**$ 2,362**	**$ -**	**$ -**
Proivder Focus Groups							
Instrument Design							
Staff Costs	$ -	$ -	$ 2,469	$ 4,396	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ 720	$ 1,282	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 3,189**	**$ 5,678**	**$ -**	$ -	**$ -**
Administration							
Staff Costs	$ -	$ -	$ 4,463	$ 968	$ 2,091	$ -	$ -
Administrative Costs	$ -	$ -	$ 1,301	$ 282	$ 609	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 5,764**	**$ 1,250**	**$ 2,700**	**$ -**	**$ -**
Analysis							
Staff Costs	$ -	$ -	$ 1,973	$ -	$ 2,091	$ -	$ -
Administrative Costs	$ -	$ -	$ 575	$ -	$ 609	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 2,548**	**$ -**	**$ 2,700**	**$ -**	**$ -**
Member/Beneficiary Surveys							
Instrument Design							
Staff Costs	$ -	$ 4,299	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ 1,253	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ 5,552**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Administration							
Staff Costs	$ -	$ 1,062	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ 309	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ 1,371**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Analysis							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Evaluation Area/Task	SFY 24	SFY 25	SFY 26	SFY 27	SFY 28	SFY 29	SFY 30
Measure Calculation and Analysis							
Data Collection/Validation							
Staff Costs	$ -	$ -	$ 11,467	$ -	$ 19,789	$ -	$ -
Administrative Costs	$ -	$ -	$ 3,343	$ -	$ 5,768	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 14,810**	**$ -**	**$ 25,557**	**$ -**	**$ -**
Code Development/Execution							
Staff Costs	$ -	$ -	$ 11,376	$ -	$ -	$ 2,267	$ -
Administrative Costs	$ -	$ -	$ 3,316	$ -	$ -	$ 661	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 14,692**	**$ -**	**$ -**	**$ 2,928**	**$ -**
Statistical Analysis							
Staff Costs	$ -	$ -	$ 18,234	$ -	$ -	$ 25,367	$ -
Administrative Costs	$ -	$ -	$ 5,315	$ -	$ -	$ 7,395	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 23,549**	**$ -**	**$ -**	**$ 32,762**	**$ -**
EHR Measure Calculation and Analysis							
Data Collection/Validation							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Code Development/Execution							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Reporting							
Interim Evaluation Report							
Staff Costs	$ -	$ -	$ 9,800	$ 5,003	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ 2,857	$ 1,458	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 12,657**	**$ 6,461**	**$ -**	**$ -**	**$ -**
Summative Evaluation Report							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ 17,521	$ 10,139
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ 5,108	$ 2,956
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 22,629**	**$ 13,095**
Total	**$ 6,482**	**$ 20,707**	**$ 100,172**	**$ 38,974**	**$ 54,429**	**$ 73,240**	**$ 13,615**

Table B-5—Prior Quarter Coverage (PQC) Waiver Cost Estimate

Evaluation Area/Task	SFY 24	SFY 25	SFY 26	SFY 27	SFY 28	SFY 29	SFY 30
Project Administration and Monitoring Reports							
Staff Costs	$ 8,140	$ 14,029	$ 12,889	$ 19,370	$ 19,010	$ 15,305	$ 403
Administrative Costs	$ 2,373	$ 4,090	$ 3,757	$ 5,646	$ 5,542	$ 4,462	$ 117
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ 10,513**	**$ 18,119**	**$ 16,646**	**$ 25,016**	**$ 24,552**	**$ 19,767**	**$ 520**
Key Informant Interviews							
Instrument Design							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Administration							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Analysis							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Proivder Focus Groups							
Instrument Design							
Staff Costs	$ -	$ -	$ 3,704	$ 5,653	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ 1,080	$ 1,648	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 4,784**	**$ 7,301**	**$ -**	$ -	**$ -**
Administration							
Staff Costs	$ -	$ -	$ 5,910	$ 1,452	$ 2,874	$ -	$ -
Administrative Costs	$ -	$ -	$ 1,723	$ 423	$ 838	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 7,633**	**$ 1,875**	**$ 3,712**	**$ -**	**$ -**
Analysis							
Staff Costs	$ -	$ -	$ 2,825	$ -	$ 2,874	$ -	$ -
Administrative Costs	$ -	$ -	$ 824	$ -	$ 838	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 3,649**	**$ -**	**$ 3,712**	**$ -**	**$ -**
Member/Beneficiary Surveys							
Instrument Design							
Staff Costs	$ -	$ 6,179	$ -	$ 8,355	$ -	$ -	$ -
Administrative Costs	$ -	$ 1,801	$ -	$ 2,436	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ 7,980**	**$ -**	**$ 10,791**	**$ -**	**$ -**	**$ -**
Administration							
Staff Costs	$ -	$ 2,061	$ -	$ 4,489	$ -	$ -	$ -
Administrative Costs	$ -	$ 601	$ -	$ 1,308	$ -	$ -	$ -
Other Costs	$ -	$ 35,310	$ -	$ 36,702	$ -	$ -	$ -
Total Costs	**$ -**	**$ 37,972**	**$ -**	**$ 42,499**	**$ -**	**$ -**	**$ -**
Analysis							
Staff Costs	$ -	$ -	$ 6,448	$ -	$ 16,348	$ -	$ -
Administrative Costs	$ -	$ -	$ 1,880	$ -	$ 4,765	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 8,328**	**$ -**	**$ 21,113**	**$ -**	**$ -**

Evaluation Area/Task	SFY 24	SFY 25	SFY 26	SFY 27	SFY 28	SFY 29	SFY 30
Measure Calculation and Analysis							
Data Collection/Validation							
Staff Costs	$ -	$ -	$ 15,566	$ -	$ 26,720	$ -	$ -
Administrative Costs	$ -	$ -	$ 4,537	$ -	$ 7,789	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 20,103**	**$ -**	**$ 34,509**	**$ -**	**$ -**
Code Development/Execution							
Staff Costs	$ -	$ -	$ 15,312	$ -	$ -	$ 3,401	$ -
Administrative Costs	$ -	$ -	$ 4,463	$ -	$ -	$ 991	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 19,775**	**$ -**	**$ -**	**$ 4,392**	**$ -**
Statistical Analysis							
Staff Costs	$ -	$ -	$ 24,321	$ -	$ -	$ 34,256	$ -
Administrative Costs	$ -	$ -	$ 7,090	$ -	$ -	$ 9,986	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 31,411**	**$ -**	**$ -**	**$ 44,242**	**$ -**
EHR Measure Calculation and Analysis							
Data Collection/Validation							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Code Development/Execution							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Reporting							
Interim Evaluation Report							
Staff Costs	$ -	$ -	$ 13,106	$ 6,830	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ 3,820	$ 1,991	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 16,926**	**$ 8,821**	**$ -**	**$ -**	**$ -**
Summative Evaluation Report							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ 24,301	$ 13,100
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ 7,084	$ 3,819
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 31,385**	**$ 16,919**
Total	**$ 10,513**	**$ 64,071**	**$ 129,255**	**$ 96,303**	**$ 87,598**	**$ 99,786**	**$ 17,439**

Table B-6—Tribal Dental Authority Cost Estimate

Evaluation Area/Task	SFY 24	SFY 25	SFY 26	SFY 27	SFY 28	SFY 29	SFY 30
Project Administration and Monitoring Reports							
Staff Costs	$ 4,326	$ 7,801	$ 7,692	$ 11,588	$ 10,776	$ 8,015	$ 300
Administrative Costs	$ 1,261	$ 2,274	$ 2,242	$ 3,378	$ 3,141	$ 2,336	$ 88
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ 5,587**	**$ 10,075**	**$ 9,934**	**$ 14,966**	**$ 13,917**	**$ 10,351**	**$ 388**
Key Informant Interviews							
Instrument Design							
Staff Costs	$ -	$ -	$ 1,741	$ 3,768	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ 508	$ 1,099	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 2,249**	**$ 4,867**	**$ -**	**$ -**	**$ -**
Administration							
Staff Costs	$ -	$ -	$ 2,791	$ 726	$ 1,568	$ -	$ -
Administrative Costs	$ -	$ -	$ 814	$ 212	$ 457	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 3,605**	**$ 938**	**$ 2,025**	**$ -**	**$ -**
Analysis							
Staff Costs	$ -	$ -	$ 1,525	$ -	$ 1,568	$ -	$ -
Administrative Costs	$ -	$ -	$ 444	$ -	$ 457	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 1,969**	**$ -**	**$ 2,025**	**$ -**	**$ -**
Proivder Focus Groups							
Instrument Design							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	$ -	**$ -**
Administration							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Analysis							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Member/Beneficiary Surveys							
Instrument Design							
Staff Costs	$ -	$ 3,700	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ 1,078	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ 4,778**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Administration							
Staff Costs	$ -	$ 826	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ 241	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ 1,067**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Analysis							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Evaluation Area/Task	SFY 24	SFY 25	SFY 26	SFY 27	SFY 28	SFY 29	SFY 30
Measure Calculation and Analysis							
Data Collection/Validation							
Staff Costs	$ -	$ -	$ 8,794	$ -	$ 15,115	$ -	$ -
Administrative Costs	$ -	$ -	$ 2,563	$ -	$ 4,406	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 11,357**	**$ -**	**$ 19,521**	**$ -**	**$ -**
Code Development/Execution							
Staff Costs	$ -	$ -	$ 8,674	$ -	$ -	$ 1,700	$ -
Administrative Costs	$ -	$ -	$ 2,529	$ -	$ -	$ 496	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 11,203**	**$ -**	**$ -**	**$ 2,196**	**$ -**
Statistical Analysis							
Staff Costs	$ -	$ -	$ 13,752	$ -	$ -	$ 19,112	$ -
Administrative Costs	$ -	$ -	$ 4,009	$ -	$ -	$ 5,571	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 17,761**	**$ -**	**$ -**	**$ 24,683**	**$ -**
EHR Measure Calculation and Analysis							
Data Collection/Validation							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Code Development/Execution							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Reporting							
Interim Evaluation Report							
Staff Costs	$ -	$ -	$ 7,545	$ 4,458	$ -	$ -	$ -
Administrative Costs	$ -	$ -	$ 2,200	$ 1,300	$ -	$ -	$ -
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ 9,745**	**$ 5,758**	**$ -**	**$ -**	**$ -**
Summative Evaluation Report							
Staff Costs	$ -	$ -	$ -	$ -	$ -	$ 13,472	$ 7,298
Administrative Costs	$ -	$ -	$ -	$ -	$ -	$ 3,927	$ 2,127
Other Costs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 17,399**	**$ 9,425**
Total	**$ 5,587**	**$ 15,920**	**$ 67,823**	**$ 26,529**	**$ 37,488**	**$ 54,629**	**$ 9,813**

Appendix C. Timeline and Major Milestones

The following project timeline, presented in Figure C-1 has been prepared for the Section 1115 Arizona Health Care Cost Containment System (AHCCCS) Demonstration Waiver (the Waiver). This timeline is preliminary and subject to change based on approval of the evaluation design and implementation of the Waiver programs.

Figure C-1—Preliminary Project Timeline

Task	SFY2024		SFY2025				SFY2026				SFY2027				SFY2028				SFY2029				
	CY2024				CY2025				CY2026				CY2027				CY2028				CY2029		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1		
Prepare and Implement Study Design																							
Conduct kick-off meeting																							
Prepare analysis workplan																							
Data Collection																							
Obtain Arizona Medicaid claims/encounters																							
Obtain Arizona Medicaid member, provider, and eligibility/enrollment data																							
Obtain financial data																							
Integrate data; generate analytic dataset																							
Obtain EHR data																							
Integrate EHR data into processes																							
Conduct Analysis																							
Key Informant Interviews and Focus Groups																							
Develop protocols																							
Conduct interviews and focus groups																							
Conduct analyses																							
Non-Survey Analyses																							
Prepare and calculate metrics																							
Conduct statistical testing and comparison																							
Conduct NCI measures analysis																							
Survey Analyses																							
Develop survey instrument																							
Field survey; collect satisfaction data																							
Conduct survey analyses																							
Reporting																							
Draft Interim Evaluation Report																							
Final Interim Evaluation Report																							
Draft Summative Evaluation Report																							
Final Summative Evaluation Report																							

Note: CY: calendar year; EHR: electronic health record; NCI: National Core Indicators; SFY: state fiscal year; Q: quarter

Appendix D. Proposed Measure Specifications

The tables in this section provide the detailed measure specifications for the Section 1115 Arizona Health Care Cost Containment System (AHCCCS) Demonstration Waiver (the Waiver) evaluation.

ACC

Hypothesis 1: Health plans encourage and/or facilitate care coordination among primary care practitioners (PCPs) and behavioral health (BH) practitioners.

Research Question 1.1: What care coordination strategies or activities have AHCCCS Complete Care (ACC) plans been conducting during the renewal period?

Health plans' reported evolution of care coordination activities and continued barriers during the renewal period (Measure 1-1)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	N/A

Research Question 1.2: What care coordination strategies or activities have providers been conducting during the renewal period?

Providers' reported evolution of care coordination since the integration period and remaining barriers during the renewal period (Measure 1-2)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Provider focus groups
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	N/A

Research Question 1.3: Did care coordination strategies improve or maintain patient engagement and follow up care after an inpatient (IP) stay or emergency department (ED) visit during the renewal period?

Percentage of members with follow-up after an ED visit for members with multiple high-risk chronic conditions (Measure 1-3)	
Numerator/Denominator	Numerator: Number of members with a follow-up service within 7 days after the ED visit. Denominator: Number of members 18 years of age and older who have multiple high-risk chronic conditions with an ED visit who are continuously enrolled for 365 days prior to the ED visit and 7 days after with no more than one gap in enrollment of 45 days.
Comparison Population	N/A
Measure Steward	National Committee for Quality Assurance (NCQA)
Measure Name	Follow-Up After ED Visit for People With Multiple High-Risk Chronic Conditions (FMC)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/Post-test • Interrupted time series (ITS)
Frequency	Annually/Monthly

Research Question 1.4: Do members perceive their doctors to have better care coordination as a result of ACC renewal?

Percentage of members who reported their doctor seemed informed about the care they received from other health providers (Measure 1-4)	
Numerator/Denominator	Numerator: Number of members indicating their personal doctor seemed informed about the care they received from other health providers in response to Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[D-1] Denominator: Number of respondents to survey question regarding whether their doctor seemed informed about the care they received from other health providers
Comparison Population	N/A
Measure Steward	NCQA
CAHPS Question	Child: In the last 6 months, how often did your child's personal doctor seem informed and up to date about the care your child got from these doctors or other health providers? Adult: In the last 6 months, how often did your personal doctor seem informed and up to date about the care you got from these doctors or other health providers?
Data Source	• Beneficiary survey • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Comparison to national benchmarks • Pre-test/post-test • Subgroup analysis of children and adults
Frequency	N/A

[D-1] CAHPS is a registered trademark of the Agency for Healthcare Quality and Research.

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?

Percentage of members meeting minimum time/distance network standards (Measure 2-1)	
Numerator/Denominator	Numerator: Number of members meeting time/distance network standards for AHCCCS contractors Denominator: Number of members enrolled in ACC plan
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Member/provider data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Subgroup analysis of children and adults • Subgroup analysis by county and/or urbanicity • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of adults who accessed preventive/ambulatory health services (Measure 2-2)	
Numerator/Denominator	Numerator: Number of members with an ambulatory or preventive care visit Denominator: Number of members 20 years and older continuously enrolled for the measurement year with no more than one gap in enrollment of up to 45 days
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	Adults' Access to Preventive/Ambulatory Health Services (AAP)
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Comparison to national/regional benchmarks • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation (Measure 2-3)	
Numerator/Denominator	Numerator: Percentage of members under 21 years of age who received a comprehensive or periodic evaluation with a dental provider during the measurement year. Denominator: Members under 21 years of age continuously enrolled during the measurement year with no gaps in enrolment.
Comparison Population	N/A
Measure Steward	Centers for Medicare & Medicaid Services (CMS) Child Core Set
Measure Name	Oral Evaluation, Dental Services (OEV-CH)
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Comparison to national/regional benchmarks • Pre-test/post-test • Subgroup analysis of children and adults • ITS
Frequency	Annually/Monthly

Percentage of members who had a well-child visit in the first 30 months of life (Measure 2-4)	
Numerator/Denominator	Numerator: Number of members with well-child visits on different dates. Two rates are reported: • Six or more well child visits on different dates of service on or before the 15-month birthday • Two or more well child visits on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday. Denominator: Two rates are reported: • Number of members who turn 15 months old during the measurement year and are continuously enrolled between 31 days and 15 months of age with no more than one gap in enrollment of up to 45 days. • Number of members who turn 30 months old during the measurement year and are continuously enrolled between 15 months plus 1 day and 30 months of age with no more than one gap in enrollment of up to 45 days.
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	Well-Child Visits in the First 30 Months of Life (W30)
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Comparison to national/regional benchmarks • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of members 3-21 years of age who had a well-care visit with a PCP or obstetrician gynecologist (OB/GYN) (Measure 2-5)	
Numerator/Denominator	Numerator: Members with one or more well-care visits during the measurement year. Denominator: Number of members aged 3-21 years who are continuously enrolled during the measurement year with no more than one gap in enrollment of up to 45 days.
Comparison Population	N/A
Measure Steward	CMS Child Core Set
Measure Name	Children and Adolescents' Well-Care Visits (WCV)
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Comparison to national/regional benchmarks • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of members who reported they received care as soon as they needed (Measure 2-6)	
Numerator/Denominator	Numerator: Number of members indicating the ability to get needed care right away Denominator: Number of respondents to getting needed care survey question
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	N/A
CAHPS Question	Child: In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed? Adult: In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
Data Source	• Beneficiary survey • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Comparison to national/regional benchmarks • Pre-test/post-test • Subgroup analysis of children and adults
Frequency	N/A

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 (Measure 2-7)	
Numerator/Denominator	Numerator: Number of members indicating the ability to get an appointment for routine care as soon as they needed Denominator: Number of respondents to getting appointment for routine care survey question
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	N/A
CAHPS Question	Child: In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed? Adult: In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?
Data Source	• Beneficiary survey • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Comparison to national/regional benchmarks • Pre-test/post-test • Subgroup analysis of children and adults
Frequency	N/A

Percentage of members who reported they were able to schedule an appointment with a specialist as soon as they needed (Measure 2-8)	
Numerator/Denominator	Numerator: Number of members indicating the ability to get an appointment with a specialist as soon as they needed Denominator: Number of respondents to getting appointment with a specialist survey question
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	N/A
CAHPS Question	Child: In the last six months, how often did you get an appointment for your child to see a specialist as soon as you needed? Adult: In the last six months, how often did you get an appointment to see a specialist as soon as you needed?
Data Source	• Beneficiary survey • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Comparison to national/regional benchmarks • Pre-test/post-test • Subgroup analysis of children and adults
Frequency	N/A

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?

Percentage of members who had initiation of substance use disorder (SUD) treatment (Measure 2-9)	
Numerator/Denominator	Numerator: Number of members in the denominator who had initiation of treatment within 14 days of the index episode Denominator: Number of members aged 13 and over during the measurement year with an alcohol or opioid diagnosis and 194 days continuous enrollment prior to the SUD episode and 47 days after the index episode.
Comparison Population	N/A
Measure Steward	CMS Adult Core Set
Measure Name	Initiation and Engagement of SUD Treatment: Initiation of SUD Treatment (IET)
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• ITS • Comparison to national/regional benchmarks • Pre-test/post-test • Subgroup analysis of children and adults
Frequency	Annually/Monthly

Percentage of members who had engagement of SUD treatment (Measure 2-10)	
Numerator/Denominator	Numerator: Number of members in the denominator who had initiation of treatment within 14 days of the index episode and two or more engagement episodes within 34 days of the initiation episode Denominator: Number of members aged 13 and over during the measurement year with an alcohol or opioid diagnosis and 194 days continuous enrollment prior to the SUD episode and 47 days after the index episode.
Comparison Population	N/A
Measure Steward	CMS Adult Core Set
Measure Name	Initiation and Engagement of SUD Treatment: Engagement of SUD Treatment (IET)
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Comparison to national/regional benchmarks • Pre-test/post-test • ITS • Subgroup analysis of children and adults
Frequency	Annually/Monthly

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?

Percentage of children 2 years of age with appropriate immunization status (Measure 3-1)	
Numerator/Denominator	Numerator: Number of members in the denominator who had: four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates. Denominator: Number of children who turn 2 years of age during the measurement year who were continuously enrolled 12 months prior to the member's 2nd birthday and have no more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday.
Comparison Population	N/A
Measure Steward	CMS Child Core Set
Measure Name	Childhood Immunization Status (CIS)
Data Source	• State eligibility and enrollment data • Arizona State Immunization Information System (ASIIS) • Claims and encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Comparison to national/regional benchmarks • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of adolescents 13 years of age with appropriate immunizations (Measure 3-2)	
Numerator/Denominator	Numerator: Number of members in the denominator who had: one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates. Denominator: Number of adolescents 13 years of age who were continuously enrolled 12 months prior to the member's 13th birthday and have no more than one gap in enrollment of up to 45 days during the 12 months prior to the child's 13th birthday.
Comparison Population	N/A
Measure Steward	CMS Child Core Set
Measure Name	Immunizations for Adolescents (IMA)
Data Source	• State eligibility and enrollment data • ASIIS • Claims and encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Comparison to national/regional benchmarks • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of adult members who reported having a flu shot or nasal flu spray (Measure 3-3)	
Numerator/Denominator	Numerator: Number of members stating they had a flu shot or nasal flu spray since July 1 Denominator: Number of respondents to survey question about flu shot or spray
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	N/A
CAHPS Question	Child: N/A Adult: Have you had either a flu shot or flu spray in the nose since July 1, <year>?
Data Source	• Beneficiary survey • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Comparison to national/regional benchmarks • Pre-test/post-test
Frequency	N/A

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?

Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent (Measure 3-4)	
Numerator/Denominator	Numerator: Number of members in the denominator who had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year Denominator: Number of members aged 5-64 who were identified as having persistent asthma who were continuously enrolled during the measurement year and the year prior to the measurement year with no more than one gap in enrollment of up to 45 days during the continuous enrollment period
Comparison Population	N/A
Measure Steward	CMS Child and Adult Core Set
Measure Name	Asthma Medication Ratio (AMR)
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Comparison to national/regional benchmarks • ITS • Pre-test/post-test • Subgroup analysis of children and adults
Frequency	Annually/Monthly

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?

Percentage of adult members who remained on an antidepressant medication treatment (Measure 3-5)	
Numerator/Denominator	Numerator: Number of members in the denominator who remained on an antidepressant medication treatment. Two rates are reported: • Members who remained on antidepressant medication treatment for at least 84 days • Members who remained on antidepressant medication treatment for at least 180 days Denominator: Number of members aged 18 and older who were treated with antidepressant medication and had a diagnosis of major depression who were continuously enrolled from 105 days prior to the index prescription start date (IPSD) through 231 days after the IPSD with no more than one gap in enrollment of up to 45 days during the continuous enrollment period
Comparison Population	N/A
Measure Steward	CMS Adult Core Set
Measure Name	Antidepressant Medication Management (AMM)
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Comparison to national/regional benchmarks • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of members with a follow-up visit after hospitalization for mental illness (Measure 3-6)	
Numerator/Denominator	Numerator: Number of members with a discharge for mental illness and a follow-up visit with a mental health practitioner within 7 days after discharge Denominator: Number of members 6 years of age or older who were hospitalized for treatment of selected mental illness or intentional self-harm with continuous enrollment 30 days after discharge
Comparison Population	N/A
Measure Steward	CMS Child & Adult Core Set
Measure Name	Follow-Up After Hospitalization for Mental Illness (FUH)
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Comparison to national/regional benchmarks • ITS • Pre-test/post-test • Subgroup analysis of children and adults
Frequency	Annually/Monthly

Percentage of members with a follow-up visit after an ED visit for mental illness (Measure 3-7)	
Numerator/Denominator	Numerator: Number of ED visits in the denominator with a follow-up visit for mental illness within 7 days of the ED visit. Denominator: Number of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm with continuous enrollment from the date of the ED visit through 30 days after the ED visit.
Comparison Population	N/A
Measure Steward	CMS Child and Adult Core Set
Measure Name	Follow-Up After Emergency Department Visit for Mental Illness (FUM)
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Comparison to national/regional benchmarks • ITS • Pre-test/post-test • Subgroup analysis of children and adults
Frequency	Annually/Monthly

Percentage of members with a follow-up visit after an ED visit for SUD (Measure 3-8)	
Numerator/Denominator	Numerator: Number of ED visits in the denominator with a follow-up visit for SUD within 7 days of the ED visit. Denominator: Number of ED visits for members 13 years of age and older with a principal diagnosis of SUD and was continuously enrolled from the date of the ED visit through 30 days after the ED visit
Comparison Population	National/regional benchmarks
Measure Steward	CMS Child and Adult Core Set
Measure Name	Follow-Up After ED Visit for SUD (FUA)
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Comparison to national/regional benchmarks • ITS • Pre-test/post-test • Subgroup analysis of children and adults
Frequency	Annually/Monthly

Percentage of members diagnosed with a mental health disorder (Measure 3-9)	
Numerator/Denominator	Numerator: Number of members 1 year old and older diagnosed with a mental health disorder Denominator: Number of members 1 year old and older who are continuously enrolled with a gap in enrollment no greater than 45 days.
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	Diagnosed Mental Health Disorders (DMH)
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	N/A
Analytic Approach	• Comparison to national/regional benchmarks • ITS • Pre-test/post-test • Subgroup analysis of children and adults
Frequency	Annually/Monthly

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?

Percentage of adult members who have a prescription for opioids at high dosage (Measure 3-10)	
Numerator/Denominator	Numerator: Number of members in the denominator who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. Denominator: Number of members aged 18 and older with two or more prescriptions for opioids on different days with a cumulative days' supply of 15 or more.
Comparison Population	N/A
Measure Steward	CMS Adult Core Set/Pharmacy Quality Alliance (PQA)
Measure Name	Use of Opioids at High Dosage in Persons Without Cancer
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	No change or a decrease in the rate supports the hypothesis
Analytic Approach	• Comparison to national/regional benchmarks • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of adult members with a concurrent use of opioids and benzodiazepines (Measure 3-11)	
Numerator/Denominator	Numerator: Number of members in the denominator with concurrent use of prescription opioids and benzodiazepines. Denominator: Number of members aged 18 and older with 2 or more prescriptions for opioids on different days with a cumulative days' supply of 15 or more.
Comparison Population	N/A
Measure Steward	CMS Adult Core Set/PQA
Measure Name	Concurrent Use of Opioids and Benzodiazepines (COB)
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	No change or a decrease in the rate supports the hypothesis
Analytic Approach	• Comparison to national/regional benchmarks • ITS • Pre-test/post-test
Frequency	Annually/Monthly

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?

Number of emergent ED visits per 1,000 member months (Measure 3-12)	
Numerator/Denominator	Numerator: Number of ED visits with an emergent diagnosis code among members. Source for emergent diagnosis codes is currently being researched. Denominator: Number of member months among all adult members
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	N/A
Analytic Approach	• Comparison to national/regional benchmarks • ITS • Pre-test/post-test • Subgroup analysis of children and adults
Frequency	Annually/Monthly

Number of non-emergent ED visits per 1.000 member months (Measure 3-13)	
Numerator/Denominator	Numerator: Number of ED visits with a non-emergent diagnosis code among members. Source for non-emergent diagnosis codes is currently being researched. Denominator: Number of member months among all adult members
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	N/A
Analytic Approach	• Comparison to national/regional benchmarks • ITS • Pre-test/post-test • Subgroup analysis of children and adults
Frequency	Annually/Monthly

Number of IP stays per 1,000 member months (Measure 3-14)	
Numerator/Denominator	Numerator: Number of total IP stays. Denominator: Number of member months, divided by 1,000.
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	Inpatient Utilization—General Hospital/Acute Care (IPU)
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	N/A
Analytic Approach	• Comparison to national/regional benchmarks • ITS • Pre-test/post-test • Subgroup analysis of children and adults
Frequency	Annually/Monthly

Percentage of adult IP discharges with an unplanned readmission within 30 days (Measure 3-15)	
Numerator/Denominator	Numerator: Number of acute IP stays in the denominator followed by an unplanned acute readmission within 30 days. Denominator: Number of acute IP stays for members aged 18 to 64 who were continuously enrolled for 365 days prior to the index discharge date through 30 days after the index discharge date with no more than one gap in enrollment of up to 45 days.
Comparison Population	N/A
Measure Steward	CMS Adult Core Set
Measure Name	Plan All-Cause Readmissions (PCR)
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	No change or a decrease in the rate supports the hypothesis
Analytic Approach	• Comparison to national/regional benchmarks • ITS • Pre-test/post-test
Frequency	Annually/Monthly

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?

Percentage of members who reported a rating of overall health as very good or excellent (Measure 4-1)	
Numerator/Denominator	Numerator: Number of members indicating they had a high rating of overall health Denominator: Number of respondents to survey question regarding overall health
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	N/A
CAHPS Question	Child: In general, how would you rate your child's overall health? Adult: In general, how would you rate your overall health?
Data Source	• Beneficiary survey • National/regional benchmarks • Behavioral Risk Factor Surveillance System (BRFSS)
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Comparison to national/regional benchmarks • Pre-test/post-test • Subgroup analysis of children and adults
Frequency	N/A

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?

Percentage of members who reported a rating of overall mental or emotional health as very good or excellent (Measure 4-2)	
Numerator/Denominator	Numerator: Number of members indicating they had a high rating of mental or emotional health Denominator: Number of respondents to survey question regarding mental or emotional health
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	N/A
CAHPS Question	Child: In general, how would you rate your child's overall mental or emotional health? Adult: In general, how would you rate your overall mental or emotional health?
Data Source	• Beneficiary survey • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Comparison to national/regional benchmarks • Pre-test/post-test • Subgroup analysis of children and adults
Frequency	N/A

Hypothesis 5: Member satisfaction with their healthcare will be maintained or improved during the renewal period.

Research Question 5.1: Are members equally or more satisfied with their healthcare as a result of integrated care during the renewal period?

Percentage of members who reported a high rating of health plan (8, 9, or 10 out of 10) (Measure 5-1)	
Numerator/Denominator	Numerator: Number of members indicating they had a high rating of their health plan Denominator: Number of respondents to survey question regarding satisfaction of health plan
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	N/A
CAHPS Question	Child: Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your child's health plan? Adult: Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?
Data Source	• Beneficiary survey • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Comparison to national/regional benchmarks • Pre-test/post-test • Subgroup analysis of children and adults
Frequency	N/A

Percentage of members who reported a high rating of overall healthcare (8, 9, or 10 out of 10) (Measure 5-2)	
Numerator/Denominator	Numerator: Number of members indicating they had a high rating of their overall healthcare Denominator: Number of respondents to survey question regarding satisfaction of overall healthcare
Comparison Population	National/regional benchmarks
Measure Steward	NCQA
Measure Name	N/A
CAHPS Question	Child: Using any number from 0 to 10, where 0 is the worst healthcare possible and 10 is the best healthcare possible, what number would you use to rate all your child's health care in the last 6 months? Adult: Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?
Data Source	• Beneficiary survey • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Comparison to national/regional benchmarks • Pre-test/post-test • Subgroup analysis of children and adults
Frequency	N/A

ACC-RBHA

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 a serious mental illness (SMI) enrolled in an AHCCCS Complete Care-Regional Behavioral Health Agreement (ACC-RBHA) have the same or increased access to primary care services compared to prior to the waiver renewal?

Percentage of members meeting minimum time/distance network standards (Measure 1-1)	
Numerator/Denominator	Numerator: Number of members meeting time/distance network standards for AHCCCS contractors Denominator: Number of members enrolled in ACC-RBHA plan
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Member and provider data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Subgroup analysis of children and adults • Subgroup analysis by county and/or urbanicity • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of adults who accessed preventive/ambulatory health services (Measure 1-2)	
Numerator/Denominator	Numerator: Number of members with an ambulatory or preventive care visit Denominator: Number of members 20 years and older continuously enrolled for the measurement year with no more than one gap in enrollment of up to 45 days
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	Adults' Access to Preventive/Ambulatory Health Services (AAP)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypotheses
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Percentage of members who reported they received care as soon as they needed (Measure 1-3)	
Numerator/Denominator	Numerator: Number of members indicating the ability to get needed care right away Denominator: Number of respondents to getting needed care survey question
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	N/A
CAHPS Question	In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
Data Source	Beneficiary survey
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	Pre-test/post-test
Frequency	N/A

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 (Measure 1-4)	
Numerator/Denominator	Numerator: Number of members indicating the ability to get an appointment for routine care as soon as they needed Denominator: Number of respondents to getting appointment for routine care survey question
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	N/A
CAHPS Question	In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?
Data Source	Beneficiary survey
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	Pre-test/post-test
Frequency	N/A

Percentage of members who reported they were able to schedule an appointment with a specialist as soon as they needed (Measure 1-5)	
Numerator/Denominator	Numerator: Number of members indicating the ability to get an appointment with a specialist as soon as they needed Denominator: Number of respondents to getting appointment with a specialist survey question
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	N/A
CAHPS Question	In the last 6 months, how often did you get an appointment to see a specialist as soon as needed?
Data Source	Beneficiary survey
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	Pre-test/post-test
Frequency	N/A

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?

Percentage of members who had initiation of SUD treatment (Measure 1-6)	
Numerator/Denominator	Numerator: Number of members in the denominator who had initiation of SUD treatment within 14 days of the index episode Denominator: Number of members aged 13 and over during the measurement year with an SUD diagnosis and 194 days continuous enrollment prior to the episode and 47 days after the index episode.
Comparison Population	N/A
Measure Steward	CMS Adult Core Set
Measure Name	Initiation and Engagement of SUD Treatment: Initiation of SUD Treatment (IET)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Percentage of members who had engagement of SUD treatment (Measure 1-7)	
Numerator/Denominator	Numerator: Number of members in the denominator who had initiation of SUD treatment within 14 days of the index episode and two or more engagement episodes within 34 days of the initiation episode Denominator: Number of members aged 13 and over during the measurement year with an SUD diagnosis and 194 days continuous enrollment prior to the episode and 47 days after the index episode
Comparison Population	N/A
Measure Steward	CMS Adult Core Set

Percentage of members who had engagement of SUD treatment (Measure 1-7)	
Measure Name	Initiation and Engagement of SUD Treatment: Engagement of SUD Treatment (IET)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

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?

Percentage of members who reported having a flu shot or nasal flu spray (Measure 2-1)	
Numerator/Denominator	Numerator: Number of members stating they had a flu shot or nasal flu spray since July 1 Denominator: Number of respondents to survey question about flu shot or spray
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	N/A
CAHPS Question	Have you had either a flu shot or flu spray in the nose since July 1, <year>?
Data Source	Beneficiary survey
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	Pre-test/post-test
Frequency	N/A

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?

Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent (Measure 2-2)	
Numerator/Denominator	Numerator: Number of members in the denominator who had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year Denominator: Number of members aged 19-64 who were identified as having persistent asthma who were continuously enrolled during the measurement year and the year prior to the measurement year with no more than one gap in enrollment of up to 45 days during each year of continuous enrollment
Comparison Population	N/A
Measure Steward	CMS Child and Adult Core Set
Measure Name	Asthma Medication Ratio (AMR)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis

Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent (Measure 2-2)	
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Percentage of members with schizophrenia or bipolar disorder using antipsychotic medications who had a diabetes screening test (Measure 2-3)	
Numerator/Denominator	Numerator: Number of members in the denominator with a diabetes screening test Denominator: Number of members aged 18-64 with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and who were continuously enrolled for the measurement year with no more than one gap in enrollment of up to 45 days
Comparison Population	N/A
Measure Steward	CMS Adult Core Set
Measure Name	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Percentage of members with schizophrenia who adhered to antipsychotic medications (Measure 2-4)	
Numerator/Denominator	Numerator: Number of members in the denominator who remained on an antipsychotic medication for at least 80 percent of their treatment period Denominator: Number of members aged 19 to 64 with schizophrenia or schizoaffective disorder and were dispensed antipsychotic medication and who were continuously enrolled during the measurement year with no more than one gap in enrollment of up to 45 days
Comparison Population	N/A
Measure Steward	CMS Adult Core Set
Measure Name	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

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?

Percentage of members who remained on antidepressant medication treatment (Measure 2-5)	
Numerator/Denominator	Numerator: Number of members in the denominator who remained on an antidepressant medication treatment. Two rates are reported: Members who remained on antidepressant medication treatment for at least 84 days Members who remained on antidepressant medication treatment for at least 180 days Denominator: Number of members aged 18 and older who were treated with antidepressant medication and had a diagnosis of major depression who were continuously enrolled from 105 days prior to the index prescription start date (IPSD) through 231 days after the IPSD with no more than one gap in enrollment of up to 45 days during the continuous enrollment period
Comparison Population	N/A
Measure Steward	CMS Adult Core Set
Measure Name	Antidepressant Medication Management (AMM)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Percentage of members with a follow-up visit after hospitalization for mental illness (Measure 2-6)	
Numerator/Denominator	Numerator: Number of members with a discharge for mental illness and a follow-up visit with a mental health practitioner within 7 days after discharge. Denominator: Number of members 18 years of age or older who were hospitalized for treatment of selected mental illness or intentional self-harm with continuous enrollment 30 days after discharge.
Comparison Population	N/A
Measure Steward	CMS Adult Core Set
Measure Name	Follow-Up After Hospitalization for Mental Illness (FUH)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Percentage of members with a follow-up visit after an ED visit for mental illness (Measure 2-7)	
Numerator/Denominator	Numerator: Number of ED visits in the denominator with a follow-up visit for mental illness within 7 days of an ED visit for mental illness. Denominator: Number of ED visits for members 18 years of age and older with a principal diagnosis of mental illness or intentional self-harm with continuous enrollment from the date of the ED visit through 30 days after the ED visit
Comparison Population	N/A
Measure Steward	CMS Child and Adult Core Set
Measure Name	Follow-Up After Emergency Department Visit for Mental Illness (FUM)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Percentage of members with a follow-up visit after an ED visit for SUD (Measure 2-8)	
Numerator/Denominator	Numerator: Number of ED visits in the denominator with a follow-up visit for SUD within 7 days of the ED visit. Denominator: Number of ED visits for members 18 years of age and older with a principal diagnosis of SUD and were continuously enrolled from the date of the ED visit through 30 days after the ED visit
Comparison Population	N/A
Measure Steward	CMS Adult and Child Core Set
Measure Name	Follow-Up After ED Visit for SUD (FUA)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Percentage of members diagnosed with a mental health disorder (Measure 2-9)	
Numerator/Denominator	Numerator: Number of members 1 year old and older diagnosed with a mental health disorder Denominator: Number of members 1 year old and older who are continuously enrolled with a gap in enrollment no greater than 45 days.
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	Diagnosed Mental Health Disorders (DMH)
Data Source	• State eligibility and enrollment data • Claims/encounter data

Percentage of members diagnosed with a mental health disorder (Measure 2-9)	
Desired Direction	N/A
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Percentage of members receiving mental health services (total and by IP, IOP or partial hospitalization, OP, ED, or telehealth) (Measure 2-10)	
Numerator/Denominator	Numerator: Number of members utilizing mental health services. Stratified by the following services: • IP • IOP or partial hospitalization • OP • ED • Telehealth • Any service Denominator: Number of member months, divided by 12
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	Mental Health Utilization (MPT)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	N/A
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

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?

Percentage of members who have prescriptions for opioids at a high dosages (Measure 2-11)	
Numerator/Denominator	Numerator: Number of members in the denominator who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. Denominator: Number of members aged 18 and older with two or more prescriptions for opioids on different days with a cumulative days' supply of 15 or more.
Comparison Population	N/A
Measure Steward	CMS Adult Core Set / PQA
Measure Name	Use of Opioids at High Dosage in Persons Without Cancer (OHD)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or a decrease in the rate supports the hypothesis

Percentage of members who have prescriptions for opioids at a high dosages (Measure 2-11)	
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Percentage of members with concurrent use of opioids and benzodiazepines (Measure 2-12)	
Numerator/Denominator	Numerator: Number of members in the denominator with concurrent use of prescription opioids and benzodiazepines. Denominator: Number of members aged 18 and older with 2 or more prescriptions for opioids on different days with a cumulative days' supply of 15 or more.
Comparison Population	N/A
Measure Steward	CMS Adult Core Set / PQA
Measure Name	Concurrent Use of Opioids and Benzodiazepines (COB)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or a decrease in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

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?

Percentage of members who indicated smoking cigarettes or using tobacco (Measure 2-13)	
Numerator/Denominator	Numerator: Number of members indicating they smoked every day or some days Denominator: Number of respondents to smoking and tobacco use survey question
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	N/A
CAHPS Question	Do you now smoke cigarettes or use tobacco every day, some days, or not at all?
Measure Name	N/A
Data Source	Beneficiary survey
Desired Direction	No change or a decrease in the rate supports the hypothesis
Analytic Approach	Pre-test/post-test
Frequency	N/A

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?

Number of emergent ED visits per 1,000 member months (Measure 2-14)	
Numerator/Denominator	Numerator: Number of ED visits with an emergent diagnosis code among members. Source for emergent diagnosis codes is currently being researched. Denominator: Number of member months among all adult members
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	N/A
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Number of non-emergent ED visits per 1,000 member months (Measure 2-15)	
Numerator/Denominator	Numerator: Number of ED visits with a non-emergent diagnosis code among members. Source for non-emergent diagnosis codes is currently being researched. Denominator: Number of member months among all adult members
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	N/A
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Number of IP stays per 1,000 member months (Measure 2-16)	
Numerator/Denominator	Numerator: Number of total IP stays. Denominator: Number of member months, divided by 1,000.
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	Inpatient Utilization—General Hospital/Acute Care (IPU)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	N/A

Number of IP stays per 1,000 member months (Measure 2-16)	
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Percentage of IP discharges with an unplanned readmission within 30 days (Measure 2-17)	
Numerator/Denominator	Numerator: Number of acute IP stays in the denominator followed by an unplanned acute readmission within 30 days. Denominator: Number of acute IP stays for members aged 18 to 64 who were continuously enrolled for 365 days prior to the index discharge date through 30 days after the index discharge date with no more than one gap in enrollment of up to 45 days.
Comparison Population	N/A
Measure Steward	CMS Adult Core Set
Measure Name	Plan All-Cause Readmissions (PCR)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or a decrease in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

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?

Percentage of members who reported a rating of overall health as very good or excellent (Measure 3-1)	
Numerator/Denominator	Numerator: Number of members indicating they had a high rating of overall health Denominator: Number of respondents to survey question regarding overall health
Comparison Population	N/A
Measure Steward	NCQA
CAHPS Question	In general, how would you rate your overall health?
Measure Name	N/A
Data Source	Beneficiary survey
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	Pre-test/post-test
Frequency	N/A

Percentage of members who reported a rating of overall mental or emotional health as very good or excellent (Measure 3-2)	
Numerator/Denominator	Numerator: Number of members indicating they had a high rating of mental or emotional health Denominator: Number of respondents to survey question regarding mental or emotional health
Comparison Population	N/A
Measure Steward	NCQA
CAHPS Question	In general, how would you rate your overall mental or emotional health?
Measure Name	N/A
Data Source	Beneficiary survey
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	Pre-test/post-test
Frequency	N/A

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 healthcare compared to prior to the waiver renewal?

Percentage of members who reported a high rating of overall healthcare (8, 9, or 10 out of 10) (Measure 4-1)	
Numerator/Denominator	Numerator: Number of members indicating they had a high rating of their healthcare Denominator: Number of respondents to survey question regarding satisfaction of healthcare
Comparison Population	N/A
Measure Steward	NCQA
CAHPS Question	Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?
Measure Name	N/A
Data Source	Beneficiary survey
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	Pre-test/post-test
Frequency	N/A

Percentage of members who reported a high rating of health plan (8, 9, or 10 out of 10) (Measure 4-2)	
Numerator/Denominator	Numerator: Number of members indicating they had a high rating of their overall health plan Denominator: Number of respondents to survey question regarding satisfaction of overall plan
Comparison Population	N/A
Measure Steward	NCQA
CAHPS Question	Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?
Measure Name	N/A
Data Source	Beneficiary survey
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	Pre-test/post-test
Frequency	N/A

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?

Percentage of members who reported their doctor seemed informed about the care they received from other health providers (Measure 4-3)	
Numerator/Denominator	Numerator: Number of members indicating their personal doctor seemed informed about the care they received from other health providers Denominator: Number of respondents to survey question regarding whether their doctor seemed informed about the care they received from other health providers
Comparison Population	N/A
Measure Steward	NCQA
CAHPS Question	In the last 6 months, how often did your personal doctor seem informed and up to date about the care you got from these doctors or other health providers?
Measure Name	N/A
Data Source	Beneficiary survey
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	Pre-test/post-test
Frequency	N/A

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?

ACC-RBHAs' reported evolution of care coordination since the integration period and remaining barriers during the renewal period, including challenges from workforce shortages (Measure 5-1)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	N/A

ACC-RBHA's reported challenges from any workforce shortages (Measure 5-2)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews

ACC-RBHA's reported challenges from any workforce shortages (Measure 5-2)	
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	N/A

Research Question 5.2: Have care coordination strategies for members with an SMI changed as a result of ACC?

Reported changes in health plans' care coordination strategies for members with an SMI, including challenges from workforce shortages (Measure 5-3)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	N/A

Research Question 5.3: What care coordination strategies is AHCCCS conducting for its members with an SMI?

AHCCCS' reported care coordination strategies and activities for members with an SMI served by the ACC-RBHAs (Measure 5-4)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	N/A

AHCCCS" reported challenges from any workforce shortages (Measure 5-5)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	N/A

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?

Providers' reported evolution of care coordination since the integration period and remaining barriers during the renewal period (Measure 5-6)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Provider focus groups
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	N/A

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?

Percentage of members with follow-up after an ED visit for members with multiple high-risk chronic conditions (Measure 5-7)	
Numerator/Denominator	Numerator: Number of members with a follow-up service within 7 days after the ED visit. Denominator: Number of members 18 years of age and older who have multiple high-risk chronic conditions with an ED visit who are continuously enrolled for 365 days prior to the ED visit and 7 days after with no more than one gap in enrollment of 45 days.
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/Post-test • ITS
Frequency	Annually/Monthly

ALTCS

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 elderly, physically disabled, and/or members with a developmental disability (DD) have the same or higher rates of access to care and primary care services compared to prior to waiver renewal?

Percentage of members meeting minimum time/distance network standards (Measure 1-1)	
Evaluation Population	Members who are elderly and/or with a physical disability and members with DD
Age Group	All
Numerator/Denominator	Numerator: Number of members meeting time/distance network standards for AHCCCS contractors Denominator: Number of members enrolled in Arizona Long Term Care System (ALTCS) plan
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Member/provider data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Subgroup analysis of children and adults • Subgroup analysis by county and/or urbanicity • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of members who accessed preventive/ambulatory health services (Measure 1-2)	
Evaluation Population	Members who are elderly and/or with a physical disability and members with DD
Age Group	Adults
Numerator/Denominator	Numerator: Number of members with an ambulatory or preventive care visit Denominator: Number of members 20 years and older continuously enrolled throughout the measurement year with no more than one gap in enrollment of up to 45 days
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	Adults' Access to Preventive/Ambulatory Health Services (AAP)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation (Measure 1-3)	
Evaluation Population	Members with DD
Age Group	Children
Numerator/Denominator	Numerator: Percentage of members under 21 years of age who received a comprehensive or period evaluation with a dental provider during the measurement year. Denominator: Members under 21 years of age continuously enrolled during the measurement year with no gaps in enrolment.
Comparison Population	N/A
Measure Steward	CMS Child Core Set
Measure Name	Oral Evaluation, Dental Services (OEV-CH)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Percentage of members who had well-child visits in the first 30 months of life (Measure 1-4)	
Evaluation Population	Members with DD
Age Group	Children
Numerator/Denominator	Numerator: Number of members with well-child visits on different dates Two rates are reported: • Six or more well child visits on different dates of service on or before the 15-month birthday • Two or more well child visits on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday. Denominator: Two rates are reported: • Number of members who turn 15 months old during the measurement year and are continuously enrolled between 31 days and 15 months of age with no more than one gap in enrollment of up to 45 days. • Number of members who turn 30 months old during the measurement year and are continuously enrolled between 15 months plus 1 day and 30 months of age with no more than one gap in enrollment of up to 45 days.
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	Well-Child Visits in the First 30 Months of Life (W30)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of members 3–21 years of age who had a well-care visit with a PCP or OB/GYN (Measure 1-5)	
Evaluation Population	Members with DD
Age Group	Children
Numerator/Denominator	Numerator: Members with one or more well-care visit during the measurement year. Denominator: Number of members aged 3-21 years who are continuously enrolled during the measurement year with no more than one gap in enrollment of up to 45 days.
Comparison Population	N/A
Measure Steward	CMS Child Core Set
Measure Name	Children and Adolescents' Well-Care Visits (WCV)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Research Question 1.2: Do adult members who are elderly, physically disabled, and/or members with DD have the same or improved rates of access to care as a result of the waiver renewal?

Percentage of members who have a primary care doctor or practitioner (Measure 1-6)	
Evaluation Population	Members with DD
Age Group	Adults
Numerator/Denominator	Numerator: Number of respondents to National Core Indicator (NCI) survey who indicated they do have a primary care doctor or practitioner Denominator: Number of respondents to NCI survey
Comparison Population	Weighted national average of all other NCI-participating states
Measure Steward	NCI
Measure Name	Has a primary care doctor or practitioner
Survey Prompt	Has a primary care doctor or practitioner
Data Source	NCI-IDD
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• DiD • Pre-test/post-test
Frequency	Annually/Bi-annually

Percentage of members who had a complete physical exam in the past year (Measure 1-7)	
Evaluation Population	Members who are elderly and/or with a physical disability and members with DD
Age Group	Adults
Numerator/Denominator	Numerator: Number of respondents to NCI survey who indicated they had a physical exam in the past year Denominator: Number of respondents to NCI survey

Percentage of members who had a complete physical exam in the past year (Measure 1-7)	
Comparison Population	Weighted national average of all other NCI-participating states
Measure Steward	NCI
Measure Name	Had a complete physical exam in the past year
Survey Prompt	• NCI-IDD: Had a complete physical exam in the past year • NCI-AD: Had a physical exam/wellness visit in the past 12 months
Data Source	• NCI-IDD • NCI-AD
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• DiD • Pre-test/post-test
Frequency	Annually/Bi-annually

Percentage of members who had a dental exam in the past year (Measure 1-8)	
Evaluation Population	Members who are elderly and/or with a physical disability and members with DD
Age Group	Adults
Numerator/Denominator	Numerator: Number of respondents to NCI survey who indicated they had a dental exam in the past year Denominator: Number of respondents to NCI survey
Comparison Population	Weighted national average of all other NCI-participating states
Measure Steward	NCI
Measure Name	Had a dental exam in the past year
Survey Prompt	• NCI-IDD: Had a dental exam in the past year • NCI-AD: Had a dental visit in the past 12 months
Data Source	• NCI-IDD • NCI-AD
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• DiD • Pre-test/post-test
Frequency	Annually/Bi-annually

Percentage of members who had an eye exam in the past year (Measure 1-9)	
Evaluation Population	Members who are elderly and/or with a physical disability and members with DD
Age Group	Adults
Numerator/Denominator	Numerator: Number of respondents to NCI survey who indicated they had an eye exam in the past year Denominator: Number of respondents to NCI survey
Comparison Population	Weighted national average of all other NCI-participating states
Measure Steward	NCI
Measure Name	Had an eye exam in the past year
Survey Prompt	• NCI-IDD: Had an eye exam in the past year • NCI-AD: Has a vision exam in the past 12 months
Data Source	• NCI-IDD • NCI-AD
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• DiD • Pre-test/post-test
Frequency	Annually/Bi-annually

Percentage of members who had an influenza vaccine in the past year (Measure 1-10)	
Evaluation Population	Members who are elderly and/or with a physical disability and members with DD
Age Group	Adults
Numerator/Denominator	Numerator: Number of respondents to NCI survey who indicated they had a flu vaccine in the past year Denominator: Number of respondents to NCI survey
Comparison Population	Weighted national average of all other NCI-participating states
Measure Steward	NCI
Measure Name	Had a flu vaccine in the past year
Survey Prompt	• NCI-IDD: Had a flu vaccine in the past year • NCI-AD: Had a flu shot in the past 12 months
Data Source	• NCI-IDD • NCI-AD
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• DiD • Pre-test/post-test
Frequency	Annually/Bi-annually

Hypothesis 2: Quality of care will be maintained or improved during the renewal period.

Research Question 2.1: Do members who are elderly, physically disabled, and/or members with a DD have the same or higher rates of preventive care compared to prior to waiver renewal?

Percentage of members with persistent asthma who had a ratio of controller medications to total asthma medications of at least 50 percent (Measure 2-1)	
Evaluation Population	Members who are elderly and/or with a physical disability and members with DD
Age Group	Children and Adults
Numerator/Denominator	Numerator: Number of members in the denominator who had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year Denominator: Number of members aged 5-64 who were identified as having persistent asthma who were continuously enrolled during the measurement year and the year prior to the measurement year with no more than one gap in enrollment of up to 45 days during each year of continuous enrollment
Comparison Population	N/A
Measure Steward	CMS Child and Adult Core Sets
Measure Name	Asthma Medication Ratio (AMR)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Research Question 2.2: Do members who are elderly, physically disabled, and/or members with a DD have the same or better management of BH conditions compared to prior to waiver renewal?

Percentage of members with a follow-up visit after hospitalization for mental illness (Measure 2-2)	
Evaluation Population	Members who are elderly and/or with a physical disability and members with DD
Age Group	Children and Adults
Numerator/Denominator	Numerator: Number of members in the denominator and a follow-up visit with a mental health practitioner within 7 days after discharge Denominator: Number of members 6 years of age or older who were hospitalized for treatment of selected mental illness or intentional self-harm with continuous enrollment 30 days after discharge
Comparison Population	N/A
Measure Steward	CMS Child and Adult Core Sets
Measure Name	Follow-Up After Hospitalization for Mental Illness (FUH)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Percentage of adult members who remained on an antidepressant medication treatment (Measure 2-3)	
Evaluation Population	Members who are elderly and/or with a physical disability and members with DD
Age Group	Adults
Numerator/Denominator	Numerator: Number of members in the denominator who remained on an antidepressant medication treatment. Two rates are reported: • Members who remained on antidepressant medication treatment for at least 84 days • Members who remained on antidepressant medication treatment for at least 180 days Denominator: Number of members aged 18 and older who were treated with antidepressant medication and had a diagnosis of major depression who were continuously enrolled from 105 days prior to the index prescription start date (IPSD) through 231 days after the IPSD with no more than one gap in enrollment of up to 45 days during the continuous enrollment period
Comparison Population	N/A
Measure Steward	CMS Adult Core Set
Measure Name	Antidepressant Medication Management (AMM)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Percentage of members with a follow-up visit after an ED visit for SUD (Measure 2-4)	
Evaluation Population	Members who are elderly and/or with a physical disability and members with DD
Age Group	Children and Adults
Numerator/Denominator	Numerator: Number of ED visits in the denominator with a follow-up visit for SUD within 7 days of the ED visit. Denominator: Number of ED visits for members 13 years of age and older with a principal diagnosis of SUD and were continuously enrolled from the date of the ED visit through 30 days after ED visit
Comparison Population	N/A
Measure Steward	CMS Child and Adult Core Set
Measure Name	Follow-Up After ED Visit for SUD (FUA)
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Comparison to national/regional benchmarks • ITS • Pre-test/post-test • Subgroup analysis of children and adults
Frequency	Annually/Monthly

Percentage of members diagnosed with a mental health disorder (Measure 2-5)	
Evaluation Population	Members who are elderly and/or with a physical disability and members with DD
Age Group	Children and Adults
Numerator/Denominator	Numerator: Number of members 1 year old and older diagnosed with a mental health disorder Denominator: Number of members 1 year old and older who are continuously enrolled with a gap in enrollment no greater than 45 days.
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	Diagnosed Mental Health Disorders (DMH)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	N/A
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Research Question 2.3: Do adult members who are elderly, physically disabled have the same or better management of prescriptions compared to prior to waiver renewal?

Percentage of members with dispensing events of high-risk medications (Measure 2-6)	
Evaluation Population	Members who are elderly and/or with a physical disability
Age Group	Adults
Numerator/Denominator	Numerator: Two rates are reported: • Number of members aged 67 years or older who received at least two dispensing events for high-risk medications from the same drug class. • Number 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. Denominator: Number of eligible adults
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	Use of High-Risk Medications in Older Adults (DAE)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	N/A
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Percentage of members who know what prescription medications are for (Measure 2-7)	
Evaluation Population	Members who are elderly and/or with a physical disability
Age Group	Adults
Numerator/Denominator	Numerator: Number of respondents to NCI survey who indicated they know what their prescription medications are for Denominator: Number of respondents to NCI survey
Comparison Population	Weighted national average of all other NCI-participating states
Measure Steward	NCI
Measure Name	Knowledge of prescription medications
Survey Prompt	Knows what prescription medications are for
Data Source	NCI-AD
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• DiD • Pre-test/post-test
Frequency	Annually/Bi-Annually

Research Question 2.4: Do members who are elderly, physically disabled, and/or members with a DD have the same or higher rates of utilization of care compared to prior to waiver renewal?

Number of emergent ED visits per 1,000 member months (Measure 2-8)	
Evaluation Population	Members who are elderly and/or with a physical disability and members with DD
Age Group	Children and Adults
Numerator/Denominator	Numerator: Number of ED visits with an emergent diagnosis code among members. Further research on the source for emergent diagnosis codes will be required by the independent evaluator. Denominator: Number of member months among all adult members
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	N/A
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Number of non-emergent ED visits per 1,000 member months (Measure 2-9)	
Evaluation Population	Members who are elderly and/or with a physical disability and members with DD
Age Group	Children and Adults
Numerator/Denominator	Numerator: Number of ED visits with a non-emergent diagnosis code among members. Further research on the source for non-emergent diagnosis codes will be required by the independent evaluator. Denominator: Number of member months among all adult members

Number of non-emergent ED visits per 1,000 member months (Measure 2-9)	
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	N/A
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Number of IP stays per 1,000 member months (Measure 2-10)	
Evaluation Population	Members who are elderly and/or with a physical disability and members with DD
Age Group	Children and Adults
Numerator/Denominator	Numerator: Number of total inpatient stays Denominator: Number of member months, divided by 1,000
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	Inpatient Utilization—General Hospital/Acute Care (IPU)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	N/A
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Percentage of adult IP discharges with an unplanned readmission within 30 days (Measure 2-11)	
Evaluation Population	Members who are elderly and/or with a physical disability and members with DD
Age Group	Adults
Numerator/Denominator	Numerator: Number of acute inpatient stays in the denominator followed by an unplanned acute readmission within 30 days Denominator: Number of acute inpatient stays for members aged 18 to 64 who were continuously enrolled for 365 days prior to the index discharge date through 30 days after the index discharge date with no more than one gap in enrollment of up to 45 days.
Comparison Population	N/A
Measure Steward	CMS Adult Core Set
Measure Name	Plan All-Cause Readmissions (PCR)
Data Source	• State eligibility and enrollment data • Claims/encounter data

Percentage of adult IP discharges with an unplanned readmission within 30 days (Measure 2-11)	
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

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?

Percentage of members residing in their own home (Measure 3-1)	
Evaluation Population	Members who are elderly and/or with a physical disability and members with DD
Age Group	Children and Adults
Numerator/Denominator	Numerator: Number of AHCCCS members who live in their own home Denominator: AHCCCS members
Comparison Population	N/A
Measure Steward	AHCCCS
Measure Name	N/A
Data Source	• Prepaid Medical Management Information System (PMMIS) • Health-e-Arizona Plus (HEAplus)
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• DiD • Pre-test/post-test
Frequency	Annually

Type of residence for adult members with DD (Measure 3-2)	
Evaluation Population	Members who are elderly and/or with a physical disability and members with DD
Age Group	Adults
Numerator/Denominator	Numerator: Number of respondents to NCI survey who indicated they reside in their own home Denominator: Number of respondents to NCI survey
Comparison Population	Weighted national average of all other NCI-participating states
Measure Steward	NCI
Measure Name	Type of Residence
Survey Prompt	• NCI-IDD: Type of Residence • NCI-AD: Type of Residence
Data Source	• NCI-IDD • NCI-AD
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• DiD • Pre-test/post-test

Type of residence for adult members with DD (Measure 3-2)	
Frequency	Annually/Bi-Annually

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 elderly, physically disabled, and/or members with DD?

Percentage of members who want to live somewhere else (Measure 3-3)	
Evaluation Population	Members who are elderly and/or with a physical disability and members with DD
Age Group	Adults
Numerator/Denominator	Numerator: Number of respondents to NCI survey who indicated they want to live somewhere else Denominator: Number of respondents to NCI survey
Comparison Population	Weighted national average of all other NCI-participating states
Measure Steward	NCI
Measure Name	Wants to live somewhere else
Survey Prompt	• NCI-IDD: Wants to live somewhere else • NCI-AD: Wants to live somewhere else
Data Source	• NCI-IDD • NCI-AD
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• DiD • Pre-test/post-test
Frequency	Annually/Bi-Annually

Percentage of members who believe services and supports help them live a good life (Measure 3-4)	
Evaluation Population	Members who are elderly and/or with a physical disability and members with DD
Age Group	Adults
Numerator/Denominator	Numerator: Number of respondents to NCI survey who indicated services and supports help them live a good life Denominator: Number of respondents to NCI survey
Comparison Population	Weighted national average of all other NCI-participating states
Measure Steward	NCI
Measure Name	Services and supports help the person live a good life
Survey Prompt	• NCI-IDD: Services and supports help the person live a good life • NCI-AD: Services and supports help the person live a good life
Data Source	• NCI-IDD • NCI-AD
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• DiD • Pre-test/post-test
Frequency	Annually/Bi-Annually

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 elderly, physically disabled and/or members with DD?

Percentage of members able to go out and do things they like to do in the community (Measure 3-5)	
Evaluation Population	Members who are elderly and/or with a physical disability and members with DD
Age Group	Adults
Numerator/Denominator	Numerator: Number of respondents to NCI survey who indicated they are able to go out and do things in the community Denominator: Number of respondents to NCI survey
Comparison Population	Weighted national average of all other NCI-participating states
Measure Steward	NCI
Measure Name	Able to go out and do the things s/he like to do in the community
Survey Prompt	• NCI-IDD: Able to go out and do the things s/he like to do in the community • NCI-AD: Are as active in their community as they would like to be
Data Source	• NCI-IDD • NCI-AD
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• DiD • Pre-test/post-test
Frequency	Annually/Bi-Annually

Percentage of members who have friends who are not staff or family members (Measure 3-6)	
Evaluation Population	Members who are elderly and/or with a physical disability and members with DD
Age Group	Adults
Numerator/Denominator	Numerator: Number of respondents to NCI survey who indicated they have friends who are not staff or family members Denominator: Number of respondents to NCI survey
Comparison Population	Weighted national average of all other NCI-participating states
Measure Steward	NCI
Measure Name	Has friends who are not staff or family members
Survey Prompt	• NCI-IDD: Has 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
Data Source	• NCI-IDD • NCI-AD
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• DiD • Pre-test/post-test
Frequency	Annually/Bi-Annually

Percentage of members who decide or have input in deciding their daily schedule (Measure 3-7)	
Evaluation Population	Members with DD
Age Group	Adults
Numerator/Denominator	Numerator: Number of respondents to NCI survey who indicated they have input in deciding their daily schedule Denominator: Number of respondents to NCI survey
Comparison Population	Weighted national average of all other NCI-participating states
Measure Steward	NCI
Measure Name	Decides or has input in deciding daily schedule
Survey Prompt	Decides or has input in deciding daily schedule
Data Source	NCI-IDD
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• DiD • Pre-test/post-test
Frequency	Annually/Bi-Annually

Percentage of members who usually like how they spend their time during the day (Measure 3-8)	
Evaluation Population	Members who are elderly and/or with a physical disability
Age Group	Adults
Numerator/Denominator	Numerator: Number of respondents to NCI survey who indicated usually like how they spend their time during the day Denominator: Number of respondents to NCI survey
Comparison Population	Weighted national average of all other NCI-participating states
Measure Steward	NCI
Measure Name	Enjoyment of day
Survey Prompt	Usually likes how they spend their time during the day
Data Source	NCI-AD
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• DiD • Pre-test/post-test
Frequency	Annually/Bi-Annually

Hypothesis 4: ALTCS encourages and/or facilitates care coordination among PCPs and BH practitioners.

Research Question 4.1: Did Department of Economic Security/Division of Developmental Disabilities (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 and its contracted plans' reported barriers that persisted beyond the initial integration of care (Measure 4-1)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A

DES/DDD and its contracted plans' reported barriers that persisted beyond the initial integration of care (Measure 4-1)	
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews with AHCCCS, DES/DDD, and plans
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	N/A

DES/DDD and its contracted plans' reported challenges from any workforce shortages (Measure 4-2)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews with AHCCCS, DES/DDD, and plans
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	N/A

ALTCS-EPD and its contracted plans' reported challenges from any workforce shortages (Measure 4-3)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews with AHCCCS, DES/DDD, and plans
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	N/A

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's reported evolution of care coordination since the integration period (Measure 4-4)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews with AHCCCS, DES/DDD, and plans
Desired Direction	N/A

DES/DDD's reported evolution of care coordination since the integration period (Measure 4-4)	
Analytic Approach	Qualitative synthesis
Frequency	N/A

Research Question 4.3: Did DES/DDD or its contracted plans encounter barriers to renewal of the waiver for care coordination strategies?

DES/DDD and its contracted plans' reported barriers to implementing care coordination strategies (Measure 4-5)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews with AHCCCS, DES/DDD, and plans
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	N/A

Research Question 4.4: Did AHCCCS encounter barriers related to the waiver renewal for members with DD or EPD?

AHCCCS' reported barriers during the waiver renewal period (Measure 4-6)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews with AHCCCS
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	N/A

AHCCCS' reported challenges from any workforce shortages (Measure 4-7)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews with AHCCCS, DES/DDD, and plans
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	N/A

Research Question 4.5: Did providers encounter barriers related to the waiver renewal for members with DD?

Providers' reported evolution of care coordination since the integration period and remaining barriers during the renewal period (Measure 4-8)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key Informant Interviews with AHCCCS, DES/DDD, and plans
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	N/A

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?

Percentage of members with multiple high-risk chronic conditions who had follow-up after an ED visit (Measure 4-9)	
Numerator/Denominator	Numerator: Number of members with a follow-up service within 7 days after the ED visit. Denominator: Number of members 18 years of age and older who have multiple high-risk chronic conditions with an ED visit who are continuously enrolled for 365 days prior to the ED visit and 7 days after with no more than one gap in enrollment of 45 days.
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/Post-test • ITS
Frequency	Annually/Monthly

Percentage of members with patient engagement after discharge (Measure 4-10)	
Numerator/Denominator	Numerator: Number of members with patient engagement provided within 30 days after discharge. Denominator: Number of members 18 years and older who were discharged and enrolled on the date of discharge through 30 days after.
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/Post-test • ITS
Frequency	Annually/Monthly

CHP

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 Comprehensive Health Plan (CHP) members have the same or increased access to PCPs and specialists in the remeasurement period as compared to the baseline?

Percentage of members meeting minimum time/distance network standards (Measure 1-1)	
Numerator/Denominator	Numerator: Number of members meeting time/distance network standards for AHCCCS contractors Denominator: Number of members enrolled in CHP plan
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Member/provider data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Subgroup analysis by county and/or urbanicity • ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of members 3–21 years of age who had a well-care visit with a PCP or OB/GYN (Measure 1-2)	
Numerator/Denominator	Numerator: Members with one or more well-care visits during the measurement year. Denominator: Number of members aged 3-21 years who are continuously enrolled during the measurement year with no more than one gap in enrollment of up to 45 days.
Comparison Population	N/A
Measure Steward	CMS Child Core Set
Measure Name	Children and Adolescents' Well-Care Visits (WCV)
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation (Measure 1-3)	
Numerator/Denominator	Numerator: Percentage of members under 21 years of age who received a comprehensive or period evaluation with a dental provider during the measurement year. Denominator: Members under 21 years of age continuously enrolled during the measurement year with no gaps in enrolment.
Comparison Population	N/A
Measure Steward	CMS Child Core Set
Measure Name	Oral Evaluation, Dental Services (OEV-CH)
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Percentage of members who had well-child visits in the first 30 months of life (Measure 1-4)	
Numerator/Denominator	Numerator: Number of members with well-child visits on different dates Two rates are reported: • Six or more well child visits on different dates of service on or before the 15-month birthday • Two or more well child visits on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday. Denominator: Two rates are reported: • Number of members who turn 15 months old during the measurement year and are continuously enrolled between 31 days and 15 months of age with no more than one gap in enrollment of up to 45 days. • Number of members who turn 30 months old during the measurement year and are continuously enrolled between 15 months plus 1 day and 30 months of age with no more than one gap in enrollment of up to 45 days.
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	Well-Child Visits in the First 30 Months of Life (W30)
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Hypothesis 2: Quality of care will be maintained or improved during the integration period.

Research Question 2.1: Do CHP members have the same or higher rates of appropriate immunizations in the remeasurement period as compared to the baseline?

Percentage of children 2 years of age with appropriate immunization status (Measure 2-1)	
Numerator/Denominator	Numerator: Number of members in the denominator who had: four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates. Denominator: Number of children who turn 2 years of age during the measurement year who were continuously enrolled 12 months prior to the member's 2nd birthday and have no more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday.
Comparison Population	N/A
Measure Steward	CMS Child Core Set
Measure Name	Childhood Immunization Status (CIS)

Percentage of children 2 years of age with appropriate immunization status (Measure 2-1)	
Data Source	• State eligibility and enrollment data • ASIIS • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of adolescents 13 years of age with appropriate immunizations (Measure 2-2)	
Numerator/Denominator	Numerator: Number of members in the denominator who had: one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates. Denominator: Number of adolescents 13 years of age who were continuously enrolled 12 months prior to the member's 13th birthday and have no more than one gap in enrollment of up to 45 days during the 12 months prior to the child's 13th birthday.
Comparison Population	N/A
Measure Steward	CMS Child Core Set
Measure Name	Immunizations for Adolescents (IMA)
Data Source	• State eligibility and enrollment data • ASIIS • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Research Question 2.2: Do CHP members have the same or better management of chronic conditions in the remeasurement period as compared to the baseline?

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 (Measure 2-3)	
Numerator/Denominator	Numerator: Number of members in the denominator who had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year Denominator: Number of members aged 5-18 who were identified as having persistent asthma and continuously enrolled during the measurement year and year prior to the measurement year, with no more than one gap in enrollment of up to 45 days during each year of continuous enrollment
Comparison Population	N/A
Measure Steward	CMS Child and Adult Core Set
Measure Name	Asthma Medication Ratio (AMR)

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 (Measure 2-3)	
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Research Question 2.3: Do CHP members have the same or better management of BH conditions in the remeasurement period as compared to the baseline?

Percentage of children and adolescents on antipsychotics with metabolic monitoring (Measure 2-4)	
Numerator/Denominator	Numerator: Number of children and adolescents 1 – 17 years of age who had two or more antipsychotic prescriptions and had metabolic testing Denominator: Number of members aged 1 to 17 with at least two antipsychotic medication dispensing events of the same or different mediations, on different dates of service during the measurement year, and continuous enrollment during the measurement year with no more than one gap in enrollment of up to 45 days
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of members diagnosed with a mental health disorder (Measure 2-5)	
Numerator/Denominator	Numerator: Number of members 1 year old and older diagnosed with a mental health disorder Denominator: Number of members 1 year old and older who are continuously enrolled with a gap in enrollment no greater than 45 days.
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	Diagnosed Mental Health Disorders (DMH)
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	N/A

Percentage of members diagnosed with a mental health disorder (Measure 2-5)	
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of members with follow-up after an ED visit for mental illness (Measure 2-6)	
Numerator/Denominator	Numerator: Number of ED visits in the denominator with a follow-up visit for mental illness within 7 days of the ED visit. Denominator: Number of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm with continuous enrollment from the date of the ED visit through 30 days after the ED visit
Comparison Population	N/A
Measure Steward	CMS Child and Adult Core Set
Measure Name	Follow-Up After Emergency Department Visit for Mental Illness (FUM)
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Percentage of members with follow-up after hospitalization for mental illness (Measure 2-7)	
Numerator/Denominator	Numerator: Number of members with a discharge for mental illness and a follow-up visit with a mental health practitioner within 7 days after discharge Denominator: Number of members 6 to 17 years of age or older who were hospitalized for treatment of selected mental illness or intentional self-harm with continuous enrollment 30 days after discharge
Comparison Population	N/A
Measure Steward	CMS Child Core Set
Measure Name	Follow-Up After Hospitalization for Mental Illness (FUH)
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Percentage of members with a follow-up visit after an ED visit for substance use disorder (Measure 2-8)	
Numerator/Denominator	Numerator: Number of ED visits in the denominator with a follow-up visit for SUD within 7 days of the ED visit. Denominator: Number of ED visits for members 13 years of age and older with a principal diagnosis of SUD and was continuously enrolled from the date of the ED visit through 30 days after the ED visit
Comparison Population	N/A
Measure Steward	CMS Adult and Child Core Set
Measure Name	Follow-up after emergency department visit for SUD (FUA)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	N/A
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Research Question 2.4: Do CHP members have the same or lower hospital utilization in the remeasurement period as compared to the baseline?

Number of emergent ED visits per 1,000 member months (Measure 2-9)	
Numerator/Denominator	Numerator: Number of ED visits with an emergent diagnosis code among members. Further research on the source for emergent diagnosis codes will be required by the independent evaluator. Denominator: Number of member months among all adult members
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	N/A
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Number of non-emergent ED visits per 1,000 member months (Measure 2-10)	
Numerator/Denominator	Numerator: Number of ED visits with a non-emergent diagnosis code among members. Further research on the source for non-emergent diagnosis codes will be required by the independent evaluator. Denominator: Number of member months among all adult members
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A

Number of non-emergent ED visits per 1,000 member months (Measure 2-10)	
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	N/A
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Number of IP stays per 1,000 member months (Measure 2-11)	
Numerator/Denominator	Numerator: Number of total inpatient stays Denominator: Number of member months, divided by 1,000
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	Inpatient Utilization—General Hospital/Acute Care (IPU)
Data Source	• State eligibility and enrollment data • Claims/encounter data • National/regional benchmarks
Desired Direction	N/A
Analytic Approach	• ITS • Pre-test/post-test
Frequency	Annually/Monthly

Hypothesis 3: CHP encourages and/or facilitates care coordination among PCPs and BH practitioners.

Research Question 3.1: What barriers did Mercy Care DCS CHP anticipate/encounter during the integration?

Mercy Care DCS CHP's anticipated/reported barriers during transition, including any workforce shortages (Measure 3-1)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	• Key informant interviews • Provider focus groups
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	N/A

Mercy Care DCS CHP's reported challenges from any workforce shortages (Measure 3-2)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	• Key informant interviews • Provider focus groups
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	N/A

Research Question 3.2: What care coordination strategies did Mercy Care DCS CHP plan/implement during integration?

Mercy Care DCS CHP's planned/reported care coordination activities (Measure 3-3)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	• Key informant interviews • Provider focus groups
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	N/A

Research Question 3.3: What barriers to implementing care coordination strategies did Mercy Care DCS CHP anticipate/encounter?

Mercy Care DCS CHP's anticipated/reported barriers in implementing care coordination strategies (Measure 3-4)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	• Key informant interviews • Provider focus groups
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	N/A

PQC

Hypothesis 1: Eliminating prior quarter coverage (PQC) will increase the likelihood and continuity of enrollment.

Research Question 1.1: Do eligible people without PCQ enroll in Medicaid at the same rates as other eligible people with PQC?

Percentage of Medicaid enrollees per month by eligibility group out of estimated eligible Medicaid recipients (Measure 1-1)	
Numerator/Denominator	Numerator: Number of members covered by Medicaid (HINSCAID). Denominator: Number of individuals likely eligible for Medicaid last year based on IPUMS survey data on family income (FTOTINC), number of own children in household (NCHILD) and disability (DIFFREM, DIFFCARE, DIFFPHYS, DIFFMOB, DIFFSENS,).
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Integrated Public Use Microdata Series (IPUMS) American Community Surveys (ACS)
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	Pre-test/post-test
Frequency	Annually

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 (Measure 1-2)	
Numerator/Denominator	Numerator: Number of members beginning enrollment in Medicaid. Denominator: Number of individuals likely eligible for Medicaid based on IPUMS survey data on family income (FTOTINC), number of own children in household (NCHILD) and disability (DIFFREM, DIFFCARE, DIFFPHYS, DIFFMOB, DIFFSENS). Re-weighted to represent full Arizona population.
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • IPUMS ACS
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Number of Medicaid enrollees per month by eligibility group and/or per-capita of State (Measure 1-3)	
Numerator/Denominator	Numerator: Number of members beginning enrollment in Medicaid Denominator: Estimated current year population of Arizona
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A

Number of Medicaid enrollees per month by eligibility group and/or per-capita of State (Measure 1-3)	
Data Source	• State enrollment and eligibility data • State of Arizona Office of Economic Opportunity
Desired Direction	N/A
Analytic Approach	Rapid-cycle reporting—Statistical process control chart
Frequency	Annually

Number of new Medicaid enrollees per month by eligibility group, as identified by those without a recent spell of Medicaid coverage (Measure 1-4)	
Numerator/Denominator	Numerator: Number of members beginning enrollment in Medicaid who did not have Medicaid coverage for at least six months prior Denominator: N/A
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	State enrollment and eligibility data
Desired Direction	N/A
Analytic Approach	Rapid-cycle reporting—Statistical process control chart
Frequency	Annually

Research Question 1.2: What is the likelihood of enrollment continuity for those without PQC compared to other Medicaid members with PQC?

Percentage of Medicaid members due for renewal who complete the renewal process (Measure 1-5)	
Numerator/Denominator	Numerator: Members completing the renewal process Denominator: Members enrolled in Medicaid who were due for renewal during previous 12 months
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	State eligibility and enrollment data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Average number of months with Medicaid coverage (Measure 1-6)	
Numerator/Denominator	Numerator: Number of full months with Medicaid coverage Denominator: Number of Medicaid members
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A

Average number of months with Medicaid coverage (Measure 1-6)	
Data Source	State eligibility and enrollment data
Desired Direction	An increase in the number of months supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Research Question 1.3: Do members without PQC who disenroll from Medicaid have shorter enrollment gaps than other members with PQC?

Percentage of Medicaid members who re-enroll after a gap of up to six months (Measure 1-7)	
Numerator/Denominator	Numerator: Number of members who re-enrolled in Medicaid during evaluation period after a gap of up to 6 months Denominator: Number of members who disenrolled from Medicaid during the first six months of evaluation period
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	State eligibility and enrollment data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Average number of months without Medicaid coverage for members who re-enroll after a gap of up to six months (Measure 1-8)	
Numerator/Denominator	Numerator: Number of months without Medicaid coverage after disenrolling Denominator: Number of members who disenrolled from Medicaid during the first six months of evaluation period and subsequently re-enrolled
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	State eligibility and enrollment data
Desired Direction	A decrease in the number of months without coverage supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Average number of gaps in Medicaid coverage for members who re-enroll after a gap of up to six months (Measure 1-9)	
Numerator/Denominator	Numerator: Number of gaps in Medicaid coverage. A gap is defined as one day or more without Medicaid enrollment. Denominator: Number of members who disenrolled from Medicaid during the first six months of evaluation period and subsequently re-enrolled
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	State eligibility and enrollment data
Desired Direction	A decrease in the number of gaps supports the hypothesis
Analytic Approach	Pre-test/post-test
Frequency	Annually

Average number of days per gap in Medicaid coverage for members who re-enroll after a gap of up to six months (Measure 1-10)	
Numerator/Denominator	Numerator: Number of gap days in Medicaid coverage Denominator: Number of gaps in coverage for members who disenrolled from Medicaid during the first six months of evaluation period and subsequently re-enrolled. A gap is defined as one day or more without Medicaid enrollment
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	State eligibility and enrollment data
Desired Direction	No change or a decrease in the number of days per gap supports the hypothesis
Analytic Approach	Pre-test/post-test
Frequency	Annually

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?

Member reported rating of overall health (Measure 2-1)	
Numerator/Denominator	Numerator: Number of members who indicated high overall health rating in response to CAHPS question regarding overall health Denominator: Number of respondents to overall health survey question among members who have not had Medicaid coverage for the first six months of evaluation period
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	State beneficiary survey
Desired Direction	No change or an increase in the rating of overall health supports the hypothesis
Analytic Approach	Chi-square
Frequency	N/A

Member reported rating of overall mental or emotional health (Measure 2-2)	
Numerator/Denominator	Numerator: Number of members who indicated high overall mental or emotional health rating in response to CAHPS question regarding overall mental or emotional health Denominator: Number of respondents to overall mental or emotional health survey question among members who have not had Medicaid coverage for the first six months of evaluation period
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	State beneficiary survey
Desired Direction	No change or an increase in the rating of overall mental or emotional health supports the hypothesis
Analytic Approach	Chi-Square
Frequency	N/A

Percentage of members who reported prior year ED visit (Measure 2-3)	
Numerator/Denominator	Numerator: Number of members who reported any ED visits during previous 12 months Denominator: Number of respondents to ED visit survey question among members who have not had Medicaid coverage for the first six months of evaluation period
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	State beneficiary survey
Desired Direction	No change or a decrease in the rate supports the hypothesis
Analytic Approach	Chi-square
Frequency	N/A

Percentage of members who reported prior year hospital admission (Measure 2-4)	
Numerator/Denominator	Numerator: Number of members who reported any overnight hospital stays during previous 12 months Denominator: Number of respondents to overnight hospital stay survey question among members who have not had Medicaid coverage for the first six months of evaluation period
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	State beneficiary survey
Desired Direction	No change or a decrease in the rate supports the hypothesis
Analytic Approach	Chi-Square
Frequency	N/A

Percentage of members who reported getting healthcare three or more times for the same condition or problem (Measure 2-5)	
Numerator/Denominator	Numerator: Number of members who received healthcare services three or more times for the same condition Denominator: Number of respondents to multiple services for same condition survey question among members who have not had Medicaid coverage for the first six months of evaluation period
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	State beneficiary survey
Desired Direction	A decrease in the rate supports the hypothesis
Analytic Approach	Chi-Square
Frequency	N/A

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?

Member reported rating of overall health for all members (Measure 3-1)	
Numerator/Denominator	Numerator: Number of members who indicated high overall health rating in response to CAHPS question regarding overall health Denominator: Number of respondents to overall health survey question
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	• State beneficiary survey • BRFSS
Desired Direction	No change or an increase in the rating of overall health supports the hypothesis
Analytic Approach	• Comparison to national benchmarks • Pre-test/post-test
Frequency	N/A

Member reported rating of overall mental or emotional health for all members (Measure 3-2)	
Numerator/Denominator	Numerator: Number of members who indicated high overall mental or emotional health rating in response to CAHPS question regarding overall health Denominator: Number of respondents to overall mental or emotional health survey question
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	State beneficiary survey
Desired Direction	No change or an increase in the rating of overall mental or emotional health supports the hypothesis

Member reported rating of overall mental or emotional health for all members (Measure 3-2)	
Analytic Approach	• Comparison to national benchmarks • Pre-test/post-test
Frequency	N/A

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?

Percentage of members who reported medical debt (Measure 4-1)	
Numerator/Denominator	Numerator: Number of members indicating outstanding medical debt or difficulty paying medical bills Denominator: Number of respondents to outstanding medical debt or difficulty paying medical bills survey question
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	• State beneficiary survey • BRFSS
Desired Direction	No change or a decrease in the rate supports the hypothesis
Analytic Approach	Comparison to other states
Frequency	N/A

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?

Member response to getting needed care right away (Measure 5-1)	
Numerator/Denominator	Numerator: Number of members indicating the ability to get needed care right away Denominator: Number of respondents to getting needed care survey question
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	N/A
Data Source	State beneficiary survey
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Comparison to national benchmarks • Pre-test/post-test
Frequency	N/A

Member response to getting an appointment for a check-up or routine care at a doctor's office or clinic (Measure 5-2)	
Numerator/Denominator	Numerator: Number of members indicating the ability to get an appointment for a check-up or routine care at a doctor's office or clinic Denominator: Number of respondents to get an appointment for a check-up or routine care at a doctor's office or clinic survey question
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	N/A
Data Source	State beneficiary survey
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Comparison to national benchmarks • Pre-test/post-test
Frequency	N/A

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?

Percentage of members with a visit to a specialist (e.g., eye doctor, otolaryngologist [ENT], cardiologist) (Measure 5-3)	
Numerator/Denominator	Numerator: Number of members with a visit to a specialist during previous 12 months Denominator: Number of members enrolled in Medicaid during previous 12 months
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Comparison to national benchmarks • Pre-test/post-test
Frequency	N/A

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 healthcare compared to prior to waiver renewal with PQC?

Member rating of overall healthcare (Measure 6-1)	
Numerator/Denominator	Numerator: Number of members reporting a high-level of satisfaction with overall healthcare Denominator: Number of respondents to overall healthcare satisfaction survey question
Comparison Population	N/A
Measure Steward	NCQA
Measure Name	N/A

Member rating of overall healthcare (Measure 6-1)	
Data Source	State beneficiary survey
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	Pre-test/post-test
Frequency	N/A

Hypothesis 7: Eliminating PQC will generate cost savings over the term of the waiver.

Research Question 7.3: Do costs to non-AHCCCS entities stay the same or decrease after implementation of the waiver compared to before?

Reported costs for uninsured and/or likely eligible Medicaid recipients among potentially impacted providers and/or provider networks (Measure 7-1)	
Numerator/Denominator	Numerator: Total reported uncompensated care costs among likely Medicaid population, including Medicaid shortfalls. Denominator: Total number of facilities reporting uncompensated care costs.
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	• Healthcare Cost Report Information System (HCRIS) • Healthcare Cost and Utilization Project State Inpatient Database (HCUP-SID) • Provider Focus Groups
Desired Direction	No change or a decrease in rate supports the hypothesis
Analytic Approach	• ITS • Qualitative synthesis
Frequency	N/A

Tribal Dental Authority

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 Indian Health Service (IHS) and 638 facilities?

Percentage of members meeting minimum time/distance network standards (Measure 1-1)	
Numerator/Denominator	Numerator: Number of members meeting time/distance network standards for AHCCCS contractors Denominator: Number of members enrolled in the Tribal Dental Authority program
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Member/provider data
Desired Direction	No change or an increase in the rate supports the hypothesis

Percentage of members meeting minimum time/distance network standards (Measure 1-1)	
Analytic Approach	• Subgroup analysis by county and/or urbanicity • ITS • Pre-test/post-test • Post-implementation trend analysis
Frequency	Annually/Monthly

Number of dental providers practicing in IHS facilities (Measure 1-2)	
Numerator/Denominator	Numerator: Number of dental providers practicing in IHS facilities Denominator: N/A
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Member/provider data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• ITS • Pre-test/post-test • Post-implementation trend analysis
Frequency	Annually/Monthly

IHS/Tribal 638 staff's reported change in practicing dental providers after the implementation of the expanded tribal dental benefit (Measure 1-3)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	N/A

IHS/Tribal 638 staff's reported barriers before, during, and shortly following the implementation of the expanded tribal dental benefit (Measure 1-4)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews

IHS/Tribal 638 staff's reported barriers before, during, and shortly following the implementation of the expanded tribal dental benefit (Measure 1-4)	
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	N/A

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 (Measure 1-5)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Frequency	N/A

Research Question 1.2: Do members have the same or better access to routine, preventative dental services compared to prior to the demonstration?

Percentage of adult members who received a comprehensive or periodic oral evaluation (Measure 1-6)	
Numerator/Denominator	Numerator: Number of members aged 21 or older who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year Denominator: Number of members aged 21 or older who are eligible for the Tribal Dental Benefit in the plan year and are continuously enrolled for the measurement year with a gap of no more than 45 days. Note: This measure is a modified version of the DOE measure
Comparison Population	N/A
Measure Steward	Dental Quality Alliance (DQA)
Measure Name	Adapted Oral Evaluation for Adults (DOE)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	N/A
Analytic Approach	• Pre-test/post-test • ITS • Post-implementation trend analysis
Frequency	Annually/Monthly

Number of adult members receiving any covered service in the plan year (Measure 1-7)	
Numerator/Denominator	Numerator: Number of members 21 or older who received any covered dental service Denominator: Number of members aged 21 or older eligible for the Tribal Dental Benefit
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	N/A
Analytic Approach	• Pre-test/post-test • ITS • Post-implementation trend analysis
Frequency	Annually/Monthly

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?

Percentage of adult members with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year (Measure 2-1)	
Numerator/Denominator	Numerator: Number of members aged 21 or older with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year. Denominator: Number of members aged 21 or older eligible for the Tribal Dental Benefit and are continuously enrolled for the measurement year with a gap of no more than 31 days.
Comparison Population	N/A
Measure Steward	DQA
Measure Name	Oral Evaluation for Adults With Diabetes (DOE)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	N/A
Analytic Approach	• Pre-test/post-test • ITS • Post-implementation trend analysis
Frequency	Annually/Monthly

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 (Measure 2-2)	
Numerator/Denominator	Numerator: Number of members ages 30 or older who were treated for periodontitis and received an oral prophylaxis OR scaling/root planning OR periodontal maintenance visit at least two times. Denominator: Number of members aged 30 or older eligible for the Tribal Dental Benefit with a history of periodontitis. Note: A three-year lookback period is needed to identify prior diagnosis of periodontitis.
Comparison Population	N/A
Measure Steward	DQA
Measure Name	Non-Surgical Ongoing Periodontal Care for Adults With Periodontitis (POC)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	N/A
Analytic Approach	• Pre-test/post-test • ITS • Post-implementation trend analysis
Frequency	Annually/Monthly

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 (Measure 2-3)	
Numerator/Denominator	Numerator: Number of members ages 30 or older who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation Denominator: Number of members ages 30 or older eligible for the Tribal Dental Benefit with a history of periodontitis and are continuously enrolled for 180 days. Note: A three-year lookback period is needed to identify prior diagnosis of periodontitis.
Comparison Population	N/A
Measure Steward	DQA
Measure Name	Periodontal Evaluation in Adults with Periodontitis (PEV)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	N/A
Analytic Approach	• Pre-test/post-test • ITS • Post-implementation trend analysis
Frequency	Annually/Monthly

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 (Measure 2-4)	
Numerator/Denominator	Numerator: Number of members aged 21 and older at elevated caries risk who received at least two topical fluoride applications Denominator: Number of members aged 21 or older at elevated caries risk who are eligible for the Tribal Dental Benefit and are continuously enrolled for the measurement year with a gap of no more than 31 days.
Comparison Population	N/A
Measure Steward	DQA
Measure Name	Oral Evaluation for Adults (TFL)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	N/A
Analytic Approach	• Pre-test/post-test • ITS • Post-implementation trend analysis
Frequency	Annually/Monthly

Research Question 2.2: Do members have equal or lower ED or hospital utilization compared to prior to the demonstration?

Number of ED visits for ambulatory care sensitive dental conditions (Measure 2-5)	
Numerator/Denominator	Numerator: Number of ED visits among adults 21 or older with an ambulatory care sensitive non-traumatic dental condition Denominator: Member months for adults 21 or older eligible for the Tribal Dental Benefit.
Comparison Population	N/A
Measure Steward	DQA
Measure Name	Ambulatory Care Sensitive ED Visits for Non-Traumatic Dental Conditions in Adults (EDV)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	N/A
Analytic Approach	• Pre-test/post-test • ITS • Post-implementation trend analysis
Frequency	Annually/Monthly

Percentage of ambulatory care sensitive dental condition ED visits among adults who visited a dentist after an ED visit (Measure 2-6)	
Numerator/Denominator	Numerator: Number of ambulatory care sensitive non-traumatic dental condition ED visits in the reporting period, where the member visited a dentist within • Rate 1: 7 days of the ED visit • Rate 2: 30 days of the ED visit Denominator: Number of ambulatory care sensitive non-traumatic dental condition ED visits
Comparison Population	N/A
Measure Steward	DQA
Measure Name	Follow-up after ED visits for non-traumatic dental conditions in adults (EDF)
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	N/A
Analytic Approach	• Pre-test/post-test • ITS • Post-implementation trend analysis
Frequency	Annually/Monthly

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?

Percentage of members with permanent tooth loss (Measure 3-1)	
Numerator/Denominator	Numerator: Number of members who responded to the survey, stratified by tooth loss • Rate 1: 1-5 teeth lost • Rate 2: 6 or more, but not all, teeth lost • Rate 3: All teeth lost • Rate 4: No teeth lost Denominator: Number of American Indian/Alaska Native (AI/AN), Medicaid members in Arizona that responded to the survey
Comparison Population	AI/AN Medicaid members responding to the BRFSS survey from all other states that participated
Measure Steward	N/A
Measure Name	N/A
Data Source	• BRFSS
Desired Direction	N/A
Analytic Approach	• Pre-test/post-test • DiD • Post-implementation trend analysis
Frequency	Annually

Percentage of members with risk of dental caries (Measure 3-2)	
Numerator/Denominator	Numerator: Number of members identified as having a medium or high caries risk Denominator: Adults 21 or older eligible for the Tribal Dental Benefit
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	N/A
Analytic Approach	• Pre-test/post-test • ITS • Post-implementation trend analysis
Frequency	Annually/Monthly

Percentage of members with periodontitis (Measure 3-3)	
Numerator/Denominator	Numerator: Number of members diagnosed with periodontitis in the year prior to the measurement year Denominator: Adults 21 or older eligible for the Tribal Dental Benefit in the year prior to the measurement year
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	N/A
Analytic Approach	• Pre-test/post-test • ITS • Post-implementation trend analysis
Frequency	Annually/Monthly

Percentage of members with oral cancer (Measure 3-4)	
Numerator/Denominator	Numerator: Number of members diagnosed with oral cancer in the year prior to the measurement year Denominator: Adults 21 or older eligible for the Tribal Dental Benefit in the year prior to the measurement year
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data

Percentage of members with oral cancer (Measure 3-4)	
Desired Direction	N/A
Analytic Approach	• Pre-test/post-test • ITS • Post-implementation trend analysis
Frequency	Annually/Monthly

Research Question 3.2: Has the rate of emergency dental services decreased following implementation of the waiver?

Percentage/Number of members that utilized an emergency dental service (Measure 3-5)	
Numerator/Denominator	Numerator: Number of members who utilized an emergency dental service Denominator: Adults 21 or older eligible for the Tribal Dental Benefit
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	N/A
Analytic Approach	• Pre-test/post-test • ITS • Post-implementation trend analysis
Frequency	Annually/Monthly

Appendix E. August 2021 Interim Evaluation Report Executive Summary

Appendix E contains the Executive Summary of the Centers for Medicare & Medicaid Services (CMS)-approved Interim Evaluation Report for the Arizona Health Care Cost Containment System (AHCCCS) Section 1115 Demonstration Waiver. [E-1]

[E-1] Centers for Medicare & Medicaid Services. Approved Interim Evaluation Report. Available at: https://www.medicaid.gov/sites/default/files/2022-10/ahcccs-interim-eval-rprt.pdf. Accessed on: Jan 25, 2024.

Executive Summary

Medicaid is a joint federal-state program created by the Social Security Act of 1965 that provides free or low-cost health care coverage to 73 million qualifying low-income Americans, including pregnant women; families with children; people who are aged and have a disability; and, in some states, low-income adults without children. The Centers for Medicare & Medicaid Services (CMS) and federal law established standards for the minimum care states must provide Medicaid-eligible populations, while also giving states an opportunity to design and test their own strategies for providing and funding health care services to meet those standards. Section 1115 of the Social Security Act permits states to test innovative demonstration projects and evaluate state-specific policy changes with the overall goals of increasing efficiency and reducing costs without increasing Medicaid expenditures.

Pursuant to the Special Terms and Conditions (STCs) of Arizona's Section 1115 waiver demonstration, the Arizona Health Care Cost Containment System (AHCCCS) hired Health Services Advisory Group, Inc. (HSAG) as an independent evaluator to conduct a comprehensive evaluation of Arizona's Section 1115 waiver demonstration programs. The goal of this evaluation is to provide CMS and AHCCCS with an independent evaluation that ensures compliance with the Section 1115 waiver requirements; assist in both State and federal decision making about the efficacy of the demonstration; and enable AHCCCS to further develop clinically appropriate, fiscally responsible, and effective Medicaid demonstration programs. This is the second of two Interim Evaluation Reports for the six programs implemented under Arizona's Section 1115 waiver demonstration.[1]

Demonstration Overview

On September 30, 2016, CMS approved an extension of Arizona's Section 1115 waiver for an additional five-year period from October 1, 2016, through September 30, 2021 inclusive of the following six demonstrations:[2]

- AHCCCS Complete Care (ACC)
- Arizona Long Term Care System (ALTCS)
- Comprehensive Medical and Dental Program (CMDP)
- Regional Behavioral Health Authority (RBHA)
- Prior Quarter Coverage (PQC) Waiver
- Targeted Investments (TI) Program

Each of these programs, apart from PQC, covers a unique population or otherwise seeks to move AHCCCS toward whole person care including the integration of physical and behavioral health care services for all members.

The overarching goal of AHCCCS' Section 1115 waiver is to provide quality health care services delivered in a cost-effective manner through the employment of managed care models. The specific goals of AHCCCS' Section 1115 waiver are providing quality health care 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

[1] Two additional components, AHCCCS Works and AHCCCS Choice Accountability Responsibility Engagement (CARE) program, approved by CMS but have not been implemented are not included in this evaluation report.

[2] NORC. *Supportive Service Expansion for Individuals with Serious Mental Illness: A Case Study of Mercy Maricopa Integrated Care.* August 18, 2017. Available at: https://es.mercycareaz.org/assets/pdf/news/NORC-MercyMaricopa-CaseStudy.pdf. Accessed on: June 8, 2021.

model within the predicted budgetary expectations. Each of the separate demonstration components (ACC, ALTCS, CMDP, RBHA, PQC, and TI) incorporate key objectives that support the overarching goals of AHCCCS' Section 1115 waiver demonstration.

AHCCCS has embarked on a three-stage journey to provide integrated care for its members over the last 10 years: (1) administrative integration, (2) payer integration, and (3) provider integration.[3] Four of these demonstrations (ACC, CMDP, ALTCS, and RBHA) further AHCCCS' goal of payer-level integration by providing one plan for both behavioral health and acute care services for its beneficiaries. Prior to this payer-level integration, multiple payers were responsible for a member's care. The TI program is the first step towards a broader effort of provider integration by allocating incentive payments for participating providers who meet key milestones in developing an integrated practice and/or key outcomes among beneficiaries.

The waiver plans reach across diverse communities with different needs, encompassing relatively healthy adults and children, individuals with serious mental illness (SMI), seniors and individuals with disabilities, and children in foster care. The health care provided to these communities employs a common approach that incorporates the objectives of (1) providing quality health care 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 achieve these objectives, each of the waiver plans incorporates methods for improving the integration of physical and behavioral health care, the coordination of care, the medical management of care using best practices, along with continuous quality improvement, and promoting engagement and communication across the continuum of care. The TI program supports integration of care by providing financial and organizational support to encourage providers to integrate physical and behavioral health care services, for example, through modernizing their electronic health record (EHR) systems to make use of Arizona's health information exchange (HIE). The PQC waiver was designed to build a bridge to independence for low income beneficiaries by encouraging them to apply for Medicaid while healthy through the elimination of a lengthy retroactive enrollment period (the PQC waiver). The AHCCCS Works waiver was also approved by CMS, although it has not yet been put into action. Through that waiver, beneficiaries would be encouraged to participate in work, education, job training, or other volunteer services in their communities.

ACC

Through the ACC program, AHCCCS streamlined services for 1.5 million beneficiaries by transitioning them to seven new ACC managed care organizations (MCOs) that provide integrated physical and behavioral health care services on October 1, 2018. Specifically, the ACC plans serve the following AHCCCS populations: adults without an SMI, children (including those with special health care needs) not enrolled with DES/DDD and DCS/CMDP, and beneficiaries with an SMI who opt out and transfer to an ACC for the provision of their physical health services. The ACC contract was awarded to seven health plans across three geographical service areas (GSAs): Northern Arizona, Central Arizona, and Southern Arizona. As a part of the ACC contract, the seven health plans are expected to "develop specific strategies to promote the integration of physical and behavioral health care service delivery and care integration activities."[4] Strategies include implementing best practices in care coordination and care management for physical and behavioral health care, proactively identifying beneficiaries for engagement in care management, providing an appropriate level of care

[3] Snyder, J. AHCCCS Targeted Investments Program Sustainability Plan. March 29, 2019. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-target-stability-plan-20190812.pdf. Accessed on: June 8, 2021.

[4] AHCCCS Complete Care Contract #YH19-0001, Section D. Available at: https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH19/ACC_RFP_11022017.pdf. Accessed on: June 8, 2021.

management/coordination to beneficiaries with comorbid physical and behavioral health conditions, ensuring continuity and coordination of physical and behavioral health services across care providers, and others as described in the "Background" section.

ALTCS

ALTCS provides acute care, long-term care, behavioral care, and home- and community-based services (HCBS) to Medicaid beneficiaries at risk for institutionalization. MCOs that contracted with the State under ALTCS provide care to eligible beneficiaries who are elderly or have physical disabilities (EPD beneficiaries). These plans are referred to as ALTCS-EPD health plans. ALTCS also contracts with the Department of Economic Security/Division of Developmental Disabilities (DES/DDD), which serve Medicaid beneficiaries with developmental disabilities (DD).[5] On October 1, 2019, behavioral health care services for beneficiaries with DD were transitioned into ALTCS-DD health plans. Therefore, part of this waiver evaluation will assess changes in rates attributable to this integration of behavioral and physical health care, with results forthcoming in the Summative Evaluation Report. The goals of ALTCS are to ensure that beneficiaries are living in the most integrated settings and are actively engaged and participating in community life. ALTCS' goals are to improve the quality of care for beneficiaries by improving the consistency of services and access to primary care, reduce preventable hospital utilization, and improve the quality of life and satisfaction for ALTCS beneficiaries.

CMDP

The CMDP operates as an acute care health plan under contract with AHCCCS for children who are determined to be Medicaid eligible and in the custody of the Department of Child Safety (DCS). CMDP provides medical and dental services for children in foster homes, in the custody of DCS and placed with a relative, placed in a certified adoptive home prior to the entry of the final order of adoption, in an independent living program, or in the custody of a probation department and placed in out-of-home care. The CMDP's primary objectives are to proactively respond to the unique health care needs of Arizona's children in foster care with high-quality, cost-effective care and continuity of caregivers. Behavioral health services for CMDP children were covered through a RBHA until April 1, 2021. After this date, AHCCCS integrated behavioral health coverage into the new CMDP plan (now called Mercy Care DCS Comprehensive Health Plan [CHP]) to further simplify health care coverage and encourage better care coordination among this population.

RBHA

As part of the RBHA, adult AHCCCS beneficiaries with SMI continue to receive acute care and behavioral health services through a geographically designated RBHA contracted with AHCCCS. Historically, the RBHA provided coverage for behavioral health services for all AHCCCS beneficiaries with a few exceptions, notably beneficiaries enrolled in ALTCS-EPD. RBHA plans have provided integrated medical and behavioral health care for their beneficiaries with SMI through the Mercy Maricopa Integrated Care (MMIC) plan since April 2014 and expanded statewide in October 2015 through the Cenpatico Integrated Care and Health Choice Integrated Care health plans. The RBHA's goals are to streamline, monitor, and adjust care plans based on progress and outcomes; reduce hospital admissions and unnecessary emergency department (ED) and crisis service use; and provide beneficiaries with tools to self-manage their care to promote health and wellness by improving the quality of care.

[5] Arizona's Section 1115 Waiver Demonstration Annual Report. Available at: https://www.azahcccs.gov/Resources/Downloads/FY2017AnnualReportCMS.pdf. Accessed on: June 4, 2021.

PQC Waiver

On January 18, 2019, CMS approved Arizona's request to amend its Section 1115 demonstration project to waive PQC retroactive eligibility established by the Affordable Care Act (ACA) on January 1, 2014. PQC allows individuals who are applying for Title XIX retroactive coverage for up to three months prior to the month of application as long as the individual remains eligible for Medicaid during that time. By limiting the period of retroactive eligibility, members would be encouraged to apply for Medicaid without delays, promoting a continuity of eligibility and enrollment for improved health status; and Medicaid costs would be contained.[6] In turn this can provide support for the sustainability of the Medicaid program while more efficiently focusing resources on providing accessible high-quality health care and limiting the resource-intensive process associated with determining PQC eligibility.

TI Program

The TI program provides up to $300 million across the demonstration approval period (January 18, 2017, through September 30, 2021) to support the physical and behavioral health care integration and coordination for beneficiaries with behavioral health needs who are enrolled in AHCCCS. The TI program provides financial incentives to eligible Medicaid providers who meet certain benchmarks for integrating and coordinating physical and behavioral health care for Medicaid beneficiaries. A key step in the integration process for participating TI providers is to establish an executed agreement with Health Current, Arizona's HIE, and receiving admission-discharge-transfer (ADT) alerts. To participate in the TI program and receive incentive payments, providers and hospitals are required to meet specific programmatic milestones and performance benchmarks. The goal of the TI program is to improve health by providing financial incentives to encourage coordination and ultimately, the complete integration of care between primary care providers and behavioral health care providers.[7] The integration activities required of participating providers are expected to be continued and sustained systemwide by the AHCCCS MCOs that are accountable for whole person systems of care.[8]

Research Hypotheses

To comprehensively evaluate the six programs, 35 hypotheses were tested in total. Tabl lists the hypotheses that were evaluated for each program. Each hypothesis may be represented by more than one research question that could be evaluated by more than one measure. A complete list of evaluation hypotheses and research questions is provided in the "Evaluation Questions and Hypotheses" section. Appendix A also provides additional details on the methods, data sources, and associated measures for each of the research questions presented below.

[6] Snyder J. *Targeted Investments Program Sustainability Plan.* March 29, 2019. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-target-stability-plan-20190812.pdf. Accessed on: June 8, 2021.

[7] Vikki Wachino. AHCCCS. CMS Approval email message, Jan 18, 2017. Available at: https://www.azahcccs.gov/Resources/Downloads/CMSApprovalLetter_01-18-2017.pdf. Accessed on: June 8, 2021.

[8] Snyder J. *Targeted Investments Program Sustainability Plan.* March 29, 2019. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-target-stability-plan-20190812.pdf. Accessed on: June 8, 2021.

Table 1: Waiver Program Hypotheses

AHCCCS Complete Care (ACC)
H1: Health plans encourage and/or facilitate care coordination among primary care practitioners (PCPs) and behavioral health practitioners.
H2: Access to care will maintain or improve as a result of the integration of behavioral and physical care.
H3: Quality of care will maintain or improve as a result of the integration of behavioral and physical care.
H4: Beneficiary self-assessed health outcomes will maintain or improve as a result of the integration of behavioral and physical care.
H5: Beneficiary satisfaction with their health care will maintain or improve as a result of the integration of behavioral and physical care.
H6: The ACC program provides cost-effective care.
Arizona Long Term Care System (ALTCS)
H1: Access to care will maintain or improve over the waiver demonstration period.
H2: Quality of care will maintain or improve over the waiver demonstration period.
H3: Quality of life for beneficiaries will maintain or improve over the waiver demonstration period.
H4: ALTCS encourages and/or facilitates care coordination among PCPs and behavioral health practitioners.
H5: ALTCS provides cost-effective care.
Comprehensive Medical and Dental Program (CMDP)
H1: Access to care will be maintained or increase during the demonstration.
H2: Quality of care for beneficiaries enrolled in CMDP will be maintained or improve during the demonstration.
H3: CMDP encourages and/or facilitates care coordination among PCPs and behavioral health practitioners.
H4: CMDP provides cost-effective care.
Regional Behavioral Health Authority (RBHA)
H1: Access to care for adult beneficiaries with an SMI enrolled in a RBHA will be maintained or increase during the demonstration.
H2: Quality of care for adult beneficiaries with an SMI enrolled in a RBHA will be maintained or improve during the demonstration.
H3: Health outcomes for adult beneficiaries with an SMI enrolled in a RBHA will be maintained or improve during the demonstration.
H4: Adult beneficiary satisfaction in RBHA health plans will be maintained or improve over the waiver demonstration.
H5: RBHAs encourage and/or facilitate care coordination among PCPs and behavioral health practitioners.
H6: RBHAs will provide cost-effective care for beneficiaries with an SMI.
Prior Quarter Coverage (PQC) Waiver
H1: Eliminating prior quarter coverage will increase the likelihood and continuity of enrollment.
H2: Eliminating prior quarter coverage will increase enrollment of eligible people when they are healthy relative to those eligible people who have the option of prior quarter coverage.
H3: Health outcomes will be better for those without prior quarter coverage compared to Medicaid beneficiaries with prior quarter coverage.
H4: Eliminating prior quarter coverage will not have adverse financial impacts on consumers.
H5: Eliminating prior quarter coverage will not adversely affect access to care.
H6: Eliminating prior quarter coverage will not result in reduced member satisfaction.
H7: Eliminating prior quarter coverage will generate cost savings over the term of the waiver.
H8: Education and outreach activities by AHCCCS will increase provider understanding about the elimination of PQC.
Targeted Investments (TI)
H1: The TI program will improve physical and behavioral health care integration for children.
H2: The TI program will improve physical and behavioral health care integration for adults.
H3: The TI program will improve care coordination for AHCCCS-enrolled adults released from criminal justice facilities.
H4: The TI program will provide cost-effective care.
H5: Providers will increase the level of care integration over the course of the demonstration.
H6: Providers will conduct care coordination activities.

Results

The Interim Evaluation Report presents results for all performance measures with available data,[9] beneficiary surveys, key informant interviews, and provider focus groups across all six programs during the baseline period and most of the evaluation period. In total, this report addresses all 35 hypotheses. Among the hypotheses tested, 22 involve statistical testing of quantitative performance measure rates, beneficiary survey data, and national survey data. Six hypotheses relate to descriptive reporting and synthesis from qualitative data collection—one for each program. Six hypotheses relate to assessing the cost-effectiveness of each program, and one hypothesis related to TI provides a descriptive analysis of quantitative data (H5). Due to limitations in the data available for this interim report, the cost-effectiveness analysis does not split out all programs.

The COVID-19 pandemic impacted the health care industry and the entire population on a global scale, requiring substantial changes to the processes used in the delivery of health care. In Arizona, as in other locations, health care utilization was significantly reduced in 2020, and the impact on performance measure rates is evident in this Interim Evaluation Report. Because the COVID-19 pandemic generally led to a reduction in routine care and elective procedures,[10] measures that included all Medicaid beneficiaries regardless of diagnosis or service utilization experienced the largest impact (e.g., Annual Dental Visits or Adults' Access to Preventive/Ambulatory Health Services) compared to measures that required specific diagnosis or service to qualify for the denominator (e.g., Plan All-Cause Readmissions, or Follow-up After Hospitalization for Mental Illness).

Table 2–Table 7 presents a summary of results from statistical testing for performance measures and beneficiary surveys.[11] Most measures have a defined desired direction, where an increase in rates indicates a favorable change or for other measures a decrease in rates may indicate a favorable change. Certain measures, however, are dependent on context and do not necessarily have a favorable direction such as emergency department visits (a higher rate may indicate unnecessary utilization while a low rate may indicate inadequate access to care). For a measure to have improved it must have demonstrated a statistically significant change in the desired direction between the baseline and evaluation period. Similarly, for a measure to have worsened, it must have demonstrated a statistically significant change opposite to the desired direction between the baseline and evaluation period.[12]

The results in Table 2–Table 7 indicate that of 126 measures with a defined desired direction, about one third (32 percent) improved, one in five (21 percent) worsened, and nearly half (48 percent) did not change by a statistically significant amount.

[9] Immunization data were not available at time of analysis.
[10] See, e.g., Moynihan, R., et al., Impact of COVID-19 pandemic on utilisation of healthcare services: a systematic review, BMJ Open. 2021 Mar 16;11(3):e045343. doi: 10.1136/bmjopen-2020-045343. PMID: 33727273; PMCID: PMC7969768; available at https://pubmed.ncbi.nlm.nih.gov/33727273/
[11] Three hypotheses for ALTCS are separated by program and appear twice in Table 3.
[12] Statistical significance was determined based on the traditional confidence level of 95 percent.

ACC

Table 2: Summary of Measure Rate Changes Between Baseline and Evaluation Periods for ACC

Hypothesis	Improving	No Significant Difference	Worsening	No Desired Direction
ACC Hypothesis 1: Health plans encourage and/or facilitate care coordination among primary care practitioners (PCPs) and behavioral health practitioners.	0	1	0	0
ACC Hypothesis 2: Access to care will maintain or improve as a result of the integration of behavioral and physical care.	2	3	3	0
ACC Hypothesis 3: Quality of care will maintain or improve as a result of the integration of behavioral and physical care.	5	3	5	3
ACC Hypothesis 4: Beneficiary self-assessed health outcomes will maintain or improve as a result of the integration of behavioral and physical care	0	2	0	0
ACC Hypothesis 5: Beneficiary satisfaction with their health care will maintain or improve as a result of the integration of behavioral and physical care	0	2	0	0
Total	**7**	**11**	**8**	**3**

Results show that measures related to substance abuse treatment, management of opioid prescriptions, and management of chronic conditions improved during the evaluation period compared to baseline. Although eight of the 39 measures with defined direction exhibited a worsening during the evaluation period, five of these measures are related to preventive services or well-care visits, which declined sharply following the COVID-19 pandemic in 2020. Three measures related to medication adherence and follow-up visits did not significantly improve or worsen between the baseline and evaluation period.

ALTCS

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

Hypothesis	Improving	No Significant Difference	Worsening	No Desired Direction
ALTCS-DD Hypothesis 1: Access to care will maintain or improve over the waiver demonstration period.	2	5	1	0
ALTCS-DD Hypothesis 2: Quality of care will maintain or improve over the waiver demonstration period.	5	6	1	3
ALTCS-DD Hypothesis 3: Quality of life for beneficiaries will maintain or improve over the waiver demonstration period.	1	3	3	0
ALTCS-EPD Hypothesis 1: Access to care will maintain or improve over the waiver demonstration period.	1	0	0	0
ALTCS-EPD Hypothesis 2: Quality of care will maintain or improve over the waiver demonstration period.	5	3	2	3
ALTCS-EPD Hypothesis 3: Quality of life for beneficiaries will maintain or improve over the waiver demonstration period.	0	0	1	0
Total	**14**	**17**	**8**	**6**

Overall, results tended toward improvement for the ALTCS-DD and EPD populations. Generally, rates improved for preventive measures, such as adolescent well-care and well-child visits for the ALTCS-DD population and breast and cervical cancer screenings for the EPD population. Measures related to management of prescription opioids also improved for the ALTCS-EPD population, whereas these rates tended to have no change for the ALTCS-DD population.

CMDP

Table 4: Summary of Measure Rate Changes Between Baseline and Evaluation Periods for CMDP

Hypothesis	Improving	No Significant Difference	Worsening	No Desired Direction
CMDP Hypothesis 1: Access to care will be maintained or increase during the demonstration.	1	0	1	0
CMDP Hypothesis 2: Quality of care for beneficiaries enrolled in CMDP will be maintained or improve during the demonstration.	3	3	0	3
Total	**4**	**3**	**1**	**3**

Following the demonstration renewal for CMDP, children and adolescents generally had higher rates of visits for preventive or wellness services, follow-up visits, and improved management of behavioral health conditions, increasing across four measures. Rates of annual dental visits increased during the evaluation period, and although rates of children and adolescents with access to primary care practitioners (PCPs) decreased during the evaluation period, this decrease was not clinically substantive and largely driven by the COVID-19 pandemic in 2020.

RBHA

Table 5: Summary of Measure Rate Changes Between Baseline and Evaluation Periods for RBHA

Hypothesis	Improving	No Significant Difference	Worsening	No Desired Direction
RBHA Hypothesis 1: Access to care for adult beneficiaries with an SMI enrolled in a RBHA will be maintained or increase during the demonstration.	2	3	1	0
RBHA Hypothesis 2: Quality of care for adult beneficiaries with an SMI enrolled in a RBHA will be maintained or improve during the demonstration.	4	5	4	3
RBHA Hypothesis 3: Health outcomes for adult beneficiaries with an SMI enrolled in a RBHA will be maintained or improve during the demonstration.	0	2	0	0
RBHA Hypothesis 4: Adult beneficiary satisfaction in RBHA health plans will be maintained or improve over the waiver demonstration period.	1	2	0	0
Total	**7**	**12**	**5**	**3**

Following integration of care for beneficiaries with SMI, rates improved for six measures across three general domains: (1) access to primary care services, (2) follow-up visits after hospital or ED stays for mental illness, and (3) opioid prescription management, and another measure improved regarding rating of health plan. Although rates for measures of chronic condition management fell on average between the baseline and evaluation period,

two of the three measures that worsened trended upwards in recent years. Results from beneficiary surveys indicated a greater proportion of beneficiaries reported a high rating of health plan in 2021 compared to the beginning of the demonstration renewal period.

PQC

Table 6: Summary of Measure Rate Changes Between Baseline and Evaluation Periods for PQC

Hypothesis	Improving	No Significant Difference	Worsening	No Desired Direction
PQC Hypothesis 1: Eliminating prior quarter coverage will increase the likelihood and continuity of enrollment.	5	0	3	2
PQC Hypothesis 5: Eliminating prior quarter coverage will not adversely affect access to care.	0	0	1	0
Total	**5**	**0**	**4**	**2**

Results show that following the implementation of the PQC waiver, there were improvements in measures related to timely re-enrollment of beneficiaries who experienced a gap in coverage and shorter enrollment gaps among those beneficiaries. Three measures worsened, related to the percentage of estimated Medicaid-eligible population enrolled in Medicaid, beneficiaries completing the renewal process, and beneficiaries with visits to a specialist which was adversely impacted during the evaluation period due to the COVID-19 pandemic.

TI

Table 7: Summary of Measure Rate Changes Between Baseline and Evaluation Periods for TI

Hypothesis	Evaluation Year	Improving	No Significant Difference	Worsening	No Desired Direction
TI Hypothesis 1: The TI program will improve physical and behavioral health care integration for children.	2019	0	3	0	0
	2020	1	4	0	0
TI Hypothesis 2: The TI program will improve physical and behavioral health care integration for adults.	2019	3	2	0	2
	2020	2	5	0	2
TI Hypothesis 3: The TI program will improve care coordination for AHCCCS enrolled adults released from criminal justice facilities.	2019	0	6	0	2
	2020	0	8	0	2
Total	**2019**	**3**	**11**	**0**	**4**
	2020	**3**	**17**	**0**	**4**

Note: Results from 2021 CAHPS survey questions are included in total counts for 2020.

Two difference-in-differences (DiD) analyses were conducted for the TI program. Once between the baseline and ramp-up period (FFY 2019) and a second between the baseline and evaluation period (FFY 2020). The ramp-up DiD was conducted to assess preliminary impact of the TI program prior to potentially confounding effects from the COVID-19 Public Health Emergency (PHE) in 2020. Results demonstrate that after implementation in 2020

the TI program led to an improvement in the number of adolescents with well-care visits; adults with engagement of treatment for alcohol, opioid, or other drug abuse; and medication assisted treatment. During the ramp-up period in 2019, the TI program led to an improvement in adults with initiation and engagement of treatment for alcohol, opioid, or other drug abuse, and medication assisted treatment. While some findings suggested a marked improvement, such as measures related to management of opioid prescriptions among beneficiaries transitioning from the criminal justice system, sample sizes primarily within the comparison group were too small to yield statistically significant results. Providers across all areas of concentration (excluding criminal justice) generally increased their self-assessed integration status between demonstration years 2 and 3. At the end of year 2, there were 203 participating sites at the lowest integration level while by the end of year 3, there were only 53 such providers. Furthermore, 118 additional provider locations attested to meeting criteria for the top two levels of integration by the end of year 3 compared to year 2.

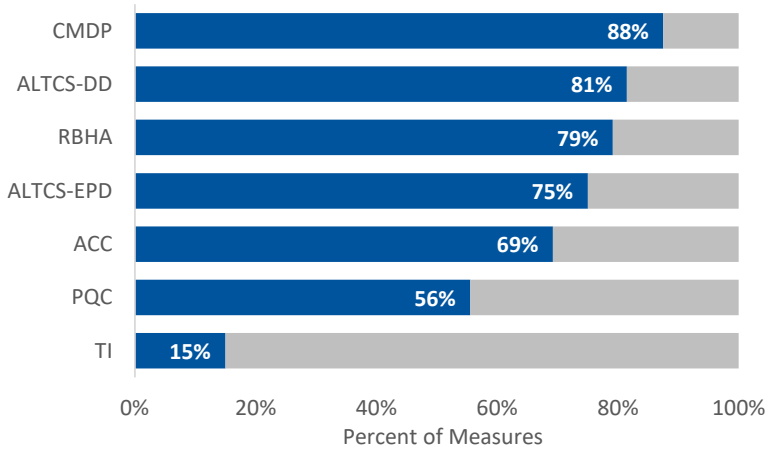
Conclusions

Quantitative Findings

The results from the statistical analysis of performance measure rate changes between baseline and evaluation periods are mixed, but with a tendency toward overall improvement. Of the 126 measures with a desired direction of change defined, 40 indicators exhibited improvements, while 26 exhibited worsening in the evaluation period. It is important to note that a decline among many service-based measures was driven by the COVID-19 public health emergency (PHE) in Federal Fiscal Year (FFY) 2020, which may have contributed to an observed decline or worsening in the rates. Among the hypotheses tested, 13 represent expectations that the AHCCCS demonstration programs will either maintain or improve care and outcomes for beneficiaries.[13] After adding measures exhibiting no significant difference in rates between the baseline and evaluation period to those that improved for these hypotheses, the number of measures that are consistent with the evaluation hypotheses increases to 83 out of 126.

The AHCCCS programs evaluated also demonstrate substantial variability in the proportion of measures consistent with research hypotheses, as illustrated in Figure 1.

Figure 1: Percentage of Measures Consistent with Research Hypothesis



[13] Three hypotheses for ALTCS are separated by program and appear twice in Table 3, and three hypotheses for TI assert the program will improve care.

- Analysis of the **CMDP** program data showed the largest percentage of measure results consistent with the tested hypotheses at 88 percent. All measures related to quality of care for beneficiaries supported the hypothesis and results were generally favorable for the access to care hypothesis considering these measures saw substantive impact from the COVID-19 pandemic.
- Among the 81 percent of measures supporting the tested hypotheses among the **ALTCS-DD** population, results suggest overall maintenance or improvement in the access to care and quality of care domains while results for quality of life were mixed for this population. Of the three hypotheses tested for the **ALTCS-EPD** population, the results suggested overall maintenance or improvement in access to care and the quality of care for the **ALTCS-EPD** population, and worsening in the quality of life hypothesis.
- Four hypotheses were tested for the **RBHA** program. Results for two hypotheses related to health outcomes (self-assessed health status) and beneficiary satisfaction showed measure rates were maintained or improved during the demonstration renewal period.
- For the hypotheses tested for the **ACC** program, the results were generally mixed. Two measures related to access to care improved while three worsened, and five measures related to quality of care improved but five others worsened. Measures related to self-assessed health outcomes and satisfaction overall did not have significant changes.
- Analysis of the **PQC** waiver shows 56 percent of measures were consistent with their hypothesis, primarily regarding improvement in the likelihood and continuity of beneficiary enrollment; however, results showed a worsening in access to care.
- Statistical analysis of the **TI** program shows results that were consistent with the tested hypotheses for 15 percent of the measures evaluated for the first year following implementation. No measures indicated a worsening for the **TI** population, with most measures showing favorable changes that were not statistically significant.

While the results of the statistical analysis can be interpreted as being consistent or inconsistent with the evaluation hypotheses, one limitation of the majority of analyses is an inability to explain why performance measure rates increased or decreased. The analyses in this Interim Evaluation Report do not include a comparison group for any of the demonstration programs except for the Targeted Investment (TI) program. A comparison group of similarly situated Medicaid beneficiaries who have not received the programming changes delivered by AHCCCS is critical for obtaining a proper counterfactual comparison. The evaluation design plan proposed the use of either the Transformed Medicaid Statistical Information System (T-MSIS) data from CMS, or data obtained from other states to form a counterfactual comparison group for AHCCCS' statewide programs. However, T-MSIS data were unavailable to be used in this report for the time periods covered, and data could not be obtained from another state with similar population characteristics and Medicaid policies and procedures in place. Consequently, a comparison group was not feasible, and the counterfactual comparison used in this report is the comparison of performance measure rates across the baseline and evaluation periods of the demonstration. The results indicate whether the performance measure rates increased or decreased, and whether the results represented statistically significant changes in performance. As the pre-post analyses did not include a comparison group, the results do not allow for drawing any direct causal conclusions regarding program impact.

Qualitative Findings

Qualitative analysis of transcripts from key informant interviews and limited focus group data provides critical pieces of context about the implementation of the AHCCCS demonstrations when interpreting the results. Two main points have emerged from the qualitative analysis that are important for this Interim Evaluation Report. First, there is general consensus that during the planning and development phases of the demonstration, AHCCCS provided stakeholders with excellent information and communication, maintaining transparency about what each

program would do and what issues would need to be addressed. AHCCCS also facilitated collaboration amongst all stakeholders, encouraging the MCOs to collaborate in developing resolutions for data sharing.

The second main theme to emerge was obtained from focus group participants for the ACC program, who indicated that operational differences across MCOs have created challenges that impact all providers, and may be particularly detrimental to smaller provider organizations. Specifically, focus group participants indicated that a greater level of statewide standardization with respect to beneficiary attribution, performance measure reporting, prior authorization processes, and value-based contracts would make navigating and coordinating operations across the increased number of MCOs easier to accomplish. While providers generally indicated agreement that increased competition was beneficial in the marketplace, the operational differences and flexibility provided by the MCO contracts for the ACC program have created an administrative burden among providers that may have shifted resources for some providers away from the intended goals of improved integration and care coordination.

The results presented in this Interim Evaluation Report are not the final results for the AHCCCS Medicaid 1115 Waiver Demonstration programs. The Summative Evaluation Report will include additional years of data, as well as additional qualitative data. If data for appropriate comparison groups are identified, the Summative Evaluation Report may also present results from more robust analyses for measures beyond the TI program.

Attachment I
Targeted Investments 2.0 Incentivized Metrics and Funding Protocol (reserved)

Attachment J
HCBS Quality Assessment and Performance Improvement Plan

Administrative Authority

1. Number and percent of issues identified in contract monitoring reports that were remediated as required by the State.

N = Number of initially rejected deliverables that were successfully resubmitted
D = Total number of rejected MCO deliverables

2. Number and percent of contract monitoring reviews required that were completed within the required timeframe.

N =Total Number of contract deliverables submitted timely
D = Total number of contract deliverables

Level of Care (LOC) or Eligibility

3. Number and percent of applicants who had an evaluation indicating the individual met the 1115 LOC or needs-based eligibility criteria prior to receiving services.

N= Number of applicants evaluated for institutional LOC.
D= Total number of applicants.

4. Number and percent of reviewed 1115 evaluations that were completed using the processes and instruments approved in the 1115 STCs.

N = Number of members evaluated using the Pre-Admission Screening (PAS) tool (as defined in the STCs)
D = Total number of HCBS recipients.

Qualified Providers

5. Number and percent of new 1115 providers who meet the State's certification standards, as required, prior to providing 1115 services.

N= Number of unique providers with claims/encounters for ALTCS members that are approved due to the providers being registered on the date of service.
D= Total number of unique providers with claims/encounters submitted for ALTCS members.

6. Number and percent of 1115 providers that continue to meet the State's certification standards at the time of review.

N = Number of providers that were approved for recredentialing during the measurement period
D = Total number of providers that went through the recredentialing process during the measurement period.

Service Plan

7. *Choice of services and providers:*
In at least 86 percent of the Person-Centered Service Plans (PCSPs) audited, the PCSPs documented

member choice of services and providers in accordance with the federally mandated PCSP process and requirements.

N = Number of PCSPs audited that documented member choice of services and providers
D = Total number of PCSPs audited

8. *Service plans address assessed needs and personal goals of 1115 participants:*
In at least 86 percent of the PCSPs audited, the PCSPs included documentation of member needs and progress towards person goals and desired outcomes in accordance with the federally mandated PCSP process and requirements.

N = Number of PCSPs audited that included documentation of member needs and progress towards meeting person goals
D = Total number of PCSPs audited

9. *Service plans are updated annually:*
In at least 86 percent of the PCSPs audited, there is documentation that the PCSPs were reviewed with members/HCDMs and revised at least once every 12 months in accordance with the federally mandated PCSP process and requirements.

N = Number of PCSPs audited that documented that the PCSPs were reviewed and revised at least once every 12 months
D = Total number of PCSPs audited

10. *Services are delivered in accordance with the service plan including the type, scope, amount, duration, and frequency specified in the service plan:*
In at least 86 percent of the PCSPs audited, the PCSPs included documentation of services including the type, scope, amount, duration, and frequency specified in the PCSPs, as well as verification of service delivery in accordance with the federally mandated PCSP process and requirements.

N = Number of PCSPs audited that included documentation of services and verification of service delivery, in accordance with the PCSP.
D = Total number of PCSPs audited

Health and Welfare

11. Number and percent of 1115 recipients who received information about how to report, abuse, neglect, exploitation and other critical incidents.

N = Number of members annually who were provided with information about how to report abuse, neglect, exploitation and other critical incidents
D = Total number of enrolled members

12. Number and percent of incident reviews/investigations that were initiated regarding reportable death, abuse, neglect, exploitation and unapproved restraints as required by the State Medicaid Agency (SMA).

N = Number of quality of care (QOC) concern investigations that were initiated regarding reportable death, abuse, neglect, exploitation, and unapproved restraints allegations
D = Total number of reported incidents specific to death, abuse, neglect, exploitation, and unapproved

restraints allegations

13. Number and percent of incident reviews/investigations involving reportable death, abuse, neglect, exploitation and unapproved restraints for participants that were completed as required by the SMA.

N = Number of QOC investigations involving reportable death, abuse, neglect, exploitation and unapproved restraints for participants that were completed
D = Total number of QOC investigations involving reportable death, abuse, neglect, exploitation and unapproved restraints

14. Number and percent of incidents reviewed involving abuse, neglect, exploitation and unapproved restraints that had a plan of prevention/documentation of a plan, developed as a result of the incident.

N = Number of substantiated QOC cases where corrective action plans are documented
D = Number of substantiated QOC cases

Financial Accountability

15. Number and percent of claims verified through a review of provider documentation that have been paid in accordance with the individual's service plan.

N = Number of claims verified through a review of provider documentation that have been paid in accordance with the individual's service plan
D = Total number of claims reviewed
Note: This metric will just be for the work done in the given year vs. claims specific to the current delivery period.

16. Number and percent of claims paid to 1115 service providers who are qualified to furnish 1115 services to 1115 recipients.

N = Total number of claims that are paid to qualified providers
D = Total number of claims reviewed

HCBS Settings Requirements

17. Number and percent of HCBS settings that meet Federal HCBS settings requirements

N = Number of HCBS settings that meet Federal HCBS settings requirements
D = Number of HCBS settings reviewed

APPENDIX K: Emergency Preparedness and Response and COVID-19 Addendum

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendments to its approved waiver, to multiple approved waivers in the state, and/or to all approved waivers in the state. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities[1] This appendix may be applied retroactively as needed by the state. Public notice requirements normally applicable under 1915(c) do not apply to information contained in this Appendix.

Appendix K-1: General Information

General Information:

A. State: Arizona

B. Waiver Title(s): Arizona Health Care Cost Containment System (AHCCCS)

C. Control Number(s):
1115 Demonstration Project No. 11-W-00275/9

D. Type of Emergency (The state may check more than one box):

X	**Pandemic or Epidemic**
◯	**Natural Disaster**
◯	**National Security Emergency**
◯	**Environmental**

[1] Numerous changes that the state may want to make may necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; or (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound

◯	**Other (specify):**

E. Brief Description of Emergency. *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state's mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

COVID-19 pandemic. This amendment will apply waiver-wide for each waiver included in this Appendix, to all individuals impacted by the virus or the response to the virus (e.g. closure of day programs, etc.)

F. Proposed Effective Date: January 1, 2022 **Anticipated End Date:** End of the calendar quarter in which the PHE ends.

G. Description of Transition Plan.

All activities will take place in response to the impact of COVID-19 as efficiently and effectively as possible based upon the complexity of the change.

H. Geographic Areas Affected:

These actions will apply across the Waiver to all individuals impacted by the COVID-19 virus

I. Description of State Disaster Plan (if available) ***Reference to external documents is acceptable:***

N/A

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a. ___Access and Eligibility:

i. ___Temporarily increase the cost limits for entry into the waiver.

[Provide explanation of changes and specify the temporary cost limit.]

ii. ___**Temporarily modify additional targeting criteria.**
[Explanation of changes]

b.___Services

i. ___**Temporarily modify service scope or coverage.**
[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. ___**Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.**
[Explanation of changes]

iii. ___**Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).**
[Complete Section A-Services to be Added/Modified During an Emergency]

iv. __**Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches). Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:**
[Explanation of modification, and advisement if room and board is included in the respite rate]:

v. ___**Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver).** [Explanation of changes]

c.__Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as

authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

d.___Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i.___Temporarily modify provider qualifications.

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

ii.___Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the provider type for each service].

iii.___Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

e.___Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

f._X_ Temporarily increase payment rates.

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider.]

The Administration shall make a lump sum payment to registered network providers who provide qualifying American Rescue Plan Act (ARPA) services with Arizona Fee for Service (FFS) Medicaid utilization for service periods during the PHE, and will use October 1, 2020 to March 31, 2021 as proxy utilization data for the lump sum payment. Registered network providers which qualify for these increases are outlined in the following link- https://azahcccs.gov/AHCCCS/downloads/Initiatives/ARPA/EligibleProviderTypesNon-DDD.pdf.

These lump sum payments are to compensate providers for costs of covered services furnished to Arizona Medicaid beneficiaries to improve the member's experience of care. Each registered network provider's lump sum payment shall be determined as follows:

1. Determine each provider's actual Medicaid utilization of qualifying services from October 1, 2020, to March 31, 2021.
2. Multiply the actual Medicaid utilization determined in item 1 by two.
3. The uniform percentage increase for providers will be 17.8%
4. The Administration will multiply the appropriate uniform percentage increase listed in item three by the total utilization determined in item two to calculate the lump sum payment for each provider.

Providers are required to distribute at least 80% of the lump sum amount to Direct Service Provider staff in the form of a temporary increase in salary, wages, bonuses, hiring/retention incentives, and/or stipends, including employee related expense costs.

For the lump sum payment above, the qualifying HCBS services include: Attendant care, respite care, home health, home delivered meals, personal care, therapy services, homemaker services, adult day health, habilitation services and assisted living facilities/adult foster care (including supervision, service coordination, personal care/directed services and recreation and socialization).

AHCCCS will not make any payments to providers that have a total lump sum payment of less than $1,000.

g. Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

h.___Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

i. __ Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.

[Specify the services.]

j. __Temporarily include retainer payments to address emergency related issues.

[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

k.___Temporarily institute or expand opportunities for self-direction.

[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards.]

l.___Increase Factor C.

[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m.___Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

Appendix K Addendum: COVID-19 Pandemic Response

1. HCBS Regulations

a. ☐ Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic.

2. Services

a. ☐ Add an electronic method of service delivery (e.g,. telephonic) allowing services to continue to be provided remotely in the home setting for:

i. ☐ Case management
ii. ☐ Personal care services that only require verbal cueing
iii. ☐ In-home habilitation
iv. ☐ Monthly monitoring (i.e., in order to meet the reasonable indication of need for services requirement in 1915(c) waivers).
v. ☐ Other *[Describe]:*

b. ☐ Add home-delivered meals

c. ☐ Add medical supplies, equipment and appliances (over and above that which is in the state plan)

d. ☐ Add Assistive Technology

3. Conflict of Interest: The state is responding to the COVID-19 pandemic personnel crisis by authorizing case management entities to provide direct services. Therefore, the case management entity qualifies under 42 CFR 441.301(c)(1)(vi) as the only willing and qualified entity.

a. ☐ Current safeguards authorized in the approved waiver will apply to these entities.

b. ☐ Additional safeguards listed below will apply to these entities.

4. Provider Qualifications

a. ☐ Allow spouses and parents of minor children to provide personal care services

b. ☐ Allow a family member to be paid to render services to an individual.

c. ☐ Allow other practitioners in lieu of approved providers within the waiver. *[Indicate the providers and their qualifications]*

d. ☐ Modify service providers for home-delivered meals to allow for additional providers, including non-traditional providers.

5. Processes

a. ☐ Allow an extension for reassessments and reevaluations for up to one year past the due date.

b. ☐ Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.

c. ☐ Adjust prior approval/authorization elements approved in waiver.

d. ☐ Adjust assessment requirements

e. ☐ Add an electronic method of signing off on required documents such as the person-centered service plan.

Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

First Name:	Alex
Last Name	Demyan
Title:	Deputy Assistant Director
Agency:	AHCCCS
Address 1:	801 E Jefferson Street
Address 2:	
City	Phoenix
State	Arizona
Zip Code	85034
Telephone:	602- 417-4130
E-mail	Alex.demyan@azahcccs.gov
Fax Number	

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Shreya
Last Name	Arakere
Title:	Waiver Manager
Agency:	AHCCCS
Address 1:	801 E Jefferson St
Address 2:	
City	Phoenix
State	AZ
Zip Code	85034
Telephone:	602-417-4611
E-mail	Shreya.arakere@azahcccs.gov
Fax Number	

8. Authorizing Signature

Signature:  State Medicaid Director or Designee	**Date:** 6/29/2022

First Name:	*Jami*
Last Name	*Snyder*
Title:	Director
Agency:	AHCCCS
Address 1:	801 E Jefferson Street
Address 2:	
City	Phoenix
State	Arizona
Zip Code	85034
Telephone:	602-417-4458
E-mail	Jami.snyder@azahcccs.gov
Fax Number	

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver that the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification should be readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification				
Service Title:				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:				
Service Definition (Scope)**:**				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
Not applicable				

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☐	Agency. List the types of agencies:

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Delivered Meals		

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☐	Provider managed

APPENDIX K: Emergency Preparedness and Response and COVID-19 Addendum

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendments to its approved waiver, to multiple approved waivers in the state, and/or to all approved waivers in the state. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.[i] This appendix may be applied retroactively as needed by the state. Public notice requirements normally applicable under 1915(c) do not apply to information contained in this Appendix.

Appendix K-1: General Information

General Information:

A. State: Arizona

B. Waiver Title(s): Arizona Health Care Cost Containment System (AHCCCS)

C. Control Number(s):
1115 Demonstration Project No. 11-W-00275/9

D. Type of Emergency (The state may check more than one box):

X	**Pandemic or Epidemic**
O	**Natural Disaster**
O	**National Security Emergency**
O	**Environmental**
O	**Other (specify):**

E. Brief Description of Emergency. *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state's mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

COVID-19 pandemic. This amendment will apply waiver-wide for each waiver included in this Appendix, to all individuals impacted by the virus or the response to the virus (e.g. closure of day programs, etc.)

F. Proposed Effective Date: Start Date: June 30, 2023, Anticipated **End Date:** November 11, 2023 (Six months after the end of the PHE)

G. Description of Transition Plan.

All activities will take place in response to the impact of COVID-19 as efficiently and effectively as possible based upon the complexity of the change.

H. Geographic Areas Affected:

These actions will apply across the waiver to all individuals impacted by the COVID-19 virus

I. Description of State Disaster Plan (if available) ***Reference to external documents is acceptable:***

N/A

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a.___ Access and Eligibility:

i.___ Temporarily increase the cost limits for entry into the waiver.
[Provide explanation of changes and specify the temporary cost limit.]

ii.___ Temporarily modify additional targeting criteria.
[Explanation of changes]

b.___ Services

i.___ Temporarily modify service scope or coverage.
[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. ___Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.
[Explanation of changes]

iii. ___Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).
[Complete Section A-Services to be Added/Modified During an Emergency]

iv. ___Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches). Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:
[Explanation of modification, and advisement if room and board is included in the respite rate]:

v.___ Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver). [Explanation of changes]

c.___ Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

d.___ Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i.___ Temporarily modify provider qualifications.
[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

ii.___ Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the .provider type for each service].

iii.___ Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

e. ___Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

f.___ Temporarily increase payment rates.

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider.]

g.___ Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

h.___ Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

i.___ Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.
[Specify the services.]

j.___ Temporarily include retainer payments to address emergency related issues.
[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

k.___ Temporarily institute or expand opportunities for self-direction.
[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards.]

l.___ Increase Factor C.
[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m.___ Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

Appendix K Addendum: COVID-19 Pandemic Response

1. **HCBS Regulations**
    a. ☐ Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic.

2. **Services**
    a. ☐ Add an electronic method of service delivery (e.g,. telephonic) allowing services to continue to be provided remotely in the home setting for:
        i. ☐ Case management
        ii. ☐ Personal care services that only require verbal cueing
        iii. ☐ In-home habilitation
        iv. ☐ Monthly monitoring (i.e., in order to meet the reasonable indication of need for services requirement in 1915(c) waivers).
        v. ☐ Other *[Describe]:*

    b. ☐ Add home-delivered meals
    c. ☐ Add medical supplies, equipment and appliances (over and above that which is in the state plan)
    d. ☐ Add Assistive Technology

3. **Conflict of Interest: The state is responding to the COVID-19 pandemic personnel crisis by authorizing case management entities to provide direct services. Therefore, the case management entity qualifies under 42 CFR 441.301(c)(1)(vi) as the only willing and qualified entity.**
    a. ☐ Current safeguards authorized in the approved waiver will apply to these entities.
    b. ☐ Additional safeguards listed below will apply to these entities.

4. **Provider Qualifications**
    a. ☒ Allow spouses and parents of minor children to provide personal care services.
    b. ☐ Allow a family member to be paid to render services to an individual.
    c. ☐ Allow other practitioners in lieu of approved providers within the waiver. *[Indicate the providers and their qualifications]*

d. ☐ Afford the state additional flexibility to allow for legally responsible individuals (parents and spouses) to receive payment for direct care services. Permitting parents of minor children to receive payment for direct care services. Removing the 40-hour maximum hours per week of services a member can receive if they have a spouse serving as the paid caregiver as well as allowing the spouse to provide the total amount of attendant care the member receives. The parents and spouses must be employed/contracted by an AHCCCS Registered Direct Care Service Agency.

Modify service providers for home-delivered meals to allow for additional providers, including non-traditional providers.

5. Processes

a. ☐ Allow an extension for reassessments and reevaluations for up to one year past the due date.

b. ☐ Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.

c. ☐ Adjust prior approval/authorization elements approved in waiver.

d. ☐ Adjust assessment requirements.

e. ☐ Add an electronic method of signing off on required documents such as the person-centered service plan.

Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

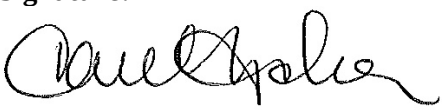
First Name:	Alex
Last Name	Demyan
Title:	Interim Assistant Director
Agency:	AHCCCS
Address 1:	801, E Jefferson Street
Address 2:	Click or tap here to enter text.
City	Phoenix
State	Arizona
Zip Code	85034
Telephone:	602-856-6795
E-mail	Alex.Demyan@azahcccs.gov
Fax Number	602-364-4590

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Shreya
Last Name	Arakere
Title:	Federal Waiver and Evaluation Administrator
Agency:	AHCCCS
Address 1:	801, E Jefferson Street
Address 2:	Click or tap here to enter text.
City	Phoenix
State	Arizona
Zip Code	85034
Telephone:	602-417-4611
E-mail	Shreya.Arakere@azahcccs.gov
Fax Number	Click or tap here to enter text.

8. Authorizing Signature

Signature: **Date: March 10, 2023**



State Medicaid Director or Designee

First Name:	*Carmen*
Last Name	*Heredia*
Title:	Director
Agency:	AHCCCS
Address 1:	801, E Jefferson Street
Address 2:	Click or tap here to enter text.
City	Phoenix
State	Arizona
Zip Code	85034
Telephone:	602-417-4458
E-mail	Carmen.Heredia@azahcccs.gov
Fax Number	602-256-6756

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver that the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification should be readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification					
Service Title:					
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
Service Definition (Scope)**:**					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☐	Agency. List the types of agencies:

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☐	Provider managed

[1] Numerous changes that the state may want to make may necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; or (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.

Attachment L
ALTCS Service Definitions

General Provider Qualifications:

AHCCCS registration (i.e. screening and enrollment under 42 CFR Part 445, Subpart E) is mandatory for consideration of payment by AHCCCS for services rendered by FFS providers, or payment by AHCCCS Contractors for services rendered by managed care contracted providers. All providers of AHCCCS-covered services are required to enroll with AHCCCS, comply with all federal, state, and local laws, rules, regulations, executive orders, and agency policies governing performance of the provider's duties. Additionally, providers must maintain a license issued under the authority of state law or a certification issued by a recognized body specific to the provider type enrolled under.

Providers may only render AHCCCS covered-services applicable to their scope of practice as defined by the state license or certification, and must comply with all applicable requirements as defined in the AHCCCS Medical Policy Manual (AMPM). AHCCCS is responsible for verifying that the provider qualifications specified for the service are followed prior to delivery of the service. Provider qualifications are re-verified in compliance with requirements in 42 CFR 455.414. Services with specific provider qualifications beyond these general requirements are detailed in the "Provider Qualifications" column below.

Service	Title XIX		Citation	Service Definition	Provider Qualifications
	EPD	DD			
Adult Day Health Services	X	N/A	A.R.S. §36-401	A program that provides planned care, supervision and activities, personal care, personal living skills training, meals, and health monitoring in a group setting during a portion of a continuous 24-hour period. Adult day health services also include preventive, therapeutic and restorative health-related services that do not include behavioral health services.	See general provider qualifications.
Attendant Care	X	X	AHCCCS Policy AMPM 1240-A	The attendant provides assistance with a combination of services including homemaking, personal care, and general supervision. General supervision includes: (a) Monitoring of a member who cannot be safely left alone, (b) Assisting with self-administration	AHCCCS policy requires the following for DCWs providing attendant care, personal care or homemaker services. ● Pass competency tests to provide care ● Obtain and maintain

				of medications, (when the member is physically unable to administer his/her medications, the member may direct the caregiver in this task), and (c) Monitoring the member's medical condition and ability to perform the activities of daily living.	CPR and First Aid certification ● Pass either a background check or obtain a fingerprint clearance card (depending on whether or not it is statutorily required) ● Pass an Adult Protective Service registry check ● Comply with agency required supervisory/monitoring visits See general provider qualifications for other applicable requirements.
Community Transition Services	X	X	Pg. 178 Technical Guide AMPM 1240-C	Community Transitions Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board including: (a) Security deposits that are required to obtain a lease on an apartment or home; (b) Essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) Services necessary for the individual's health and safety such as	See general provider qualifications.

				pest eradication and one-time cleaning prior to occupancy; (e) Moving expenses; (f) Necessary home accessibility adaptations; and, (g) Activities to assess need, arrange for and procure needed resources. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the person is unable to meet such expenses or when the services cannot be obtained from other sources. The Community Transition Service excludes the following: (a) Cash payments to members or significant others, (b) Rent, (c) Leisure/recreational devices (e.g. purchase of television or cable access, internet access, stereo), (d) Aesthetics/decorative items (e.g. picture frames and rugs), (e) Remodeling improvements to any Home or apartment with the exception of medically necessary home modifications that will be provided as a separate service, and (f) Grocery supplies including but not limited to food, personal hygiene, cleaning products	
Companion Care	X	X	AMPM 1250-H	Companion care service may be provided when a member is unable to be transported to medical appointments without assistance due to a member's support needs including assistance with personal care needs and/or supervision during an appointment that a medical practitioner is unable to provide. Members who are eligible to receive companion services if the member	The individual providing companion care must meet all employment qualifications and requirements established by their employer, and companion services must be identified within the scope of services the provider is authorized for before payment is authorized.

				requires this level of assistance during transport and during a medical appointment.	See general provider qualifications for other applicable requirements.
Emergency Alert System	X	X	AMPM 1240-D	Commonly referred to as a Medical Alert System, an Emergency Alert System is a device that can be used by an individual to seek emergency assistance when they live alone or would be alone for intermittent periods of time and unable to access emergency assistance through traditional means thereby putting the member at risk.	See general provider qualifications.
Family Support Services	X	X	AMPM 964	Family Support is directed toward restoration, enhancement, or maintenance of the family functioning to increase the family's ability to effectively interact and care for the member in the home and community. Family Support includes assisting the family to learn skills related to: (a) adjustment to the beneficiary's disability or aging process or significant life events or transitions, (b) enhancing and improving the health and well-being of the beneficiary and family unit, (c) navigating the health care system, self-advocacy, (d) development of natural supports and community support systems, (e) participating in the PCSP development, and implementation of individual and family goals and (f) long-term life planning.	See general provider qualifications requirements. Additionally, AHCCCS requires the following for staff providing the service: ● Lived experience in supporting a family member enrolled in the ALTCS program ● Demonstrate competency to provide the service
Habilitation	X	X	Pg. 159 tech guide	Services designed to assist LTC members in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-	See general provider qualifications.

				based settings.	
Home Delivered Meals	X	X	AMPM 1240-F	A service that provides a nutritious meal containing at least one third of the Federal recommended daily allowance for the member, delivered to the member's home	See general provider qualifications.
Home Modifications	X	X	AMPM 1240-I	Physical modifications to the Home as determined through an assessment of the member's needs and as identified in the member's service plan. Home modifications shall have a specific adaptive purpose aimed at increasing the member's ability to function with greater independence in his or her own Home thus reducing the risk of institutionalization.	Home modifications are rendered by enrolled providers that must be Residential Contractors as defined in AHCCCS policy, and be in good standing with the Registrar of Contractors. See general provider qualifications for other applicable requirements.
Homemaker Services	X	X	AMPM 1240-A	Assistance in the performance of activities related to household maintenance. The service is intended to preserve or improve the safety and sanitation of the member's living conditions and the nutritional value of food/meals for the member. Homemaker services include: (a) Cleaning tasks necessary to attain and maintain safe and sanitary living conditions for the member and pest control services, (b) Meal planning, food preparation and storage tasks necessary to provide food/meals that meet the nutritional needs of the member, (c) Laundry tasks, such as laundering the member's clothing, towels and bed linens. (d) Shopping for items such as food, cleaning and laundry supplies and personal hygiene supplies for the member only, (e) Other household duties and tasks, as included in the member's individualized service plan that are	AHCCCS policy requires the following for DCWs providing attendant care, personal care or homemaker services. ● Pass competency tests to provide care ● Obtain and maintain CPR and First Aid certification ● Pass either a background check or obtain a fingerprint clearance card (depending on whether or not it is statutorily required) ● Pass an Adult Protective Service registry check ● Comply with agency required supervisory/monitoring visits See general provider

				necessary to assist the member. This may include hauling water or bringing in wood or coal as indicated by the member's environment.	qualifications for other applicable requirements.
Personal Care	X	X	AMPM 1240-A Pg. 157 tech guide	Assistance to meet essential physical needs including assisting members with bathing, feeding, skin care, oral hygiene, toileting, ambulation, transferring, grooming, dressing, nail care, use of assistive devices, use of special appliances and/or prosthetic devices . A range of assistance to enable members to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the member to perform a task. Personal care services may be provided on an episodic or on a continuing basis. Health-related services that are provided may include skilled or nursing care and medication administration to the extent permitted by state law.	AHCCCS policy requires the following for DCWs providing attendant care, personal care or homemaker services. ● Pass competency tests to provide care ● Obtain and maintain CPR and First Aid certification ● Pass either a background check or obtain a fingerprint clearance card (depending on whether or not it is statutorily required) ● Pass an Adult Protective Service registry check ● Comply with agency required supervisory/monitoring visits See general provider qualifications for other applicable requirements.
Personal Care in Acute Care Hospitals	X	X	AMPM 1240-A	Assistance provided to a member in an acute care hospital setting that meets essential physical needs including: assisting members with bathing, feeding, skin care, oral hygiene, toileting, ambulation, transferring, grooming, dressing, nail care, use of assistive devices, use of special appliances and/or prosthetic devices . The provision of this service also includes general supervision to monitor a member who cannot be safely left	AHCCCS policy requires the following for DCWs providing attendant care, personal care or homemaker services. ● Pass competency tests to provide care ● Obtain and maintain CPR and First Aid certification ● Pass either a background check or

				alone including supporting communication and behavioral stabilization. HCBS Personal Care Services in Acute Care Hospitals: (a) Are provided to meet needs of the individual that are not met through the provision of acute care hospital services; (b) Are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide; (c) Must be identified in the individual's person-centered service plan; and (d) Will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.	obtain a fingerprint clearance card (depending on whether or not it is statutorily required) ● Pass an Adult Protective Service registry check ● Comply with agency required supervisory/monitoring visits See general provider qualifications for other applicable requirements.
Private Duty Nursing	X	X	Pg. 179 tech guide A.R.S. §32-1631-1651	Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of state law. These services are provided to a member at home.	Enrolled nurses shall operate within their scope of practice and shall be appropriately licensed/certified according to A.R.S. §32-1631-1651. See general provider qualifications for other applicable requirements.
Respite Care	X	X	AMPM 1250-D	Respite Care is provided as an interval of rest and/or relief to a family member or other individual caring for an ALTCS member. Respite Care may be provided by a respite provider coming to the member's home, or by admitting the member to a licensed institutional facility or an approved Alternative HCBS setting for the respite period. Respite care includes: (a) Supervision of the member for the respite period, (b) Provision of services during the Respite Care period which are within the respite provider's scope of practice, and	AHCCCS policy requires the following for DCWs providing respite care. ● Obtain and maintain CPR and First Aid certification ● Pass either a background check or obtain a fingerprint clearance card (depending on whether or not it is statutorily required) ● Pass an Adult Protective Service registry check

				(c) Provision of activities and services to meet the social, emotional, physical and behavioral needs of the member during the Respite Care period.	• Have the appropriate skills and training to meet the needs of the members See general provider qualifications for other applicable requirements.

Attachment M
DSHP Sustainability Plan (reserved)

Attachment N
Attestation Table

Arizona Provider Payment Rate Increase Assessment – Attestation Table		
The reported data and attestations pertain to provider payment rate increase requirements for the demonstration period of performance DY12 thru DY16		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-service Ratio**	**Medicaid Managed Care to Medicare Fee-for-service Ratio**
Primary Care Services	76.4%	76.6%
	STC 64(b)- AHCCCS FFS claims within the AHCCCS data warehouse for Federal Fiscal Year 2021	*STC 65(b)- MCO Encounters within the AHCCCS data warehouse for Federal Fiscal Year 2021*
Behavioral Health Services	80.4%	110.2%
	STC 64(b)- AHCCCS FFS claims within the AHCCCS data warehouse for Federal Fiscal Year 2021	*STC 65(b)- MCO Encounters within the AHCCCS data warehouse for Federal Fiscal Year 2021*
Obstetric Care Services	101.0%	83.4%
	STC 64(b)- AHCCCS FFS claims within the AHCCCS data warehouse for Federal Fiscal Year 2021	*STC 65(b)- MCO Encounters within the AHCCCS data warehouse for Federal Fiscal Year 2021*
In accordance with STCs 60 through 71, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments or Medicaid managed care pass-through payments under 42 CFR 438.6(a) and 438.6(d), I attest that at least an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points will be applied to each of the services in each of the three categories with a ratio below 80 percent in both fee-for-service and managed care delivery systems as applicable to the state's Medicaid or demonstration service delivery model. Such provider payment rate increases for each service will be effective beginning on **October 1, 2024** and will not be lower than the highest rate for that service code in DY12 plus an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points relative to the rate for the same or similar Medicare billing code through at least **September 30, 2027**. For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a Fee-For-Service delivery system or under a managed care delivery system, as applicable, the state agrees to define primary care, behavioral health and obstetric care, and to identify applicable service codes and provider types for each of these service categories in a manner consistent with other state and federal Medicaid program requirements, except that		

inpatient behavioral health services may be excluded from the state's definition. The services that comprise each service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services. For provider payment rates paid under a managed care delivery system, the data and methodology for any one of the service categories as provided in STC 65(b) will be based on Medicaid managed care provider payment rate and utilization data.

[Select the applicable effective date, must check either a. or b.]

X a. The effective date of the rate increases is the first day of DY14 and will be at least sustained, if not higher, through DY16.

☐ b. Arizona has a biennial legislative session that requires provider payment rate approval 43 Demonstration Approval: October 14, 2022 through September 30, 2027 and the timing of that session precludes the state from implementing the provider payment rate increase on the first day of DY14. Arizona will effectuate the rate increases no later than the CMS approved date of [insert date], and will sustain these rates, if not made higher, through DY16.

Arizona **does** make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and / or obstetric care.

For any such payments, I agree to submit by no later than **December 31, 2024** for CMS review and approval of the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), with an effective date no later than **October 1, 2024**.

Arizona **does** include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care.

For any such payments, I agree to submit the Medicaid managed care plans' provider payment rate increase methodology, including the information listed in STC 66 through the state-directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by an effective date no later than **October 1, 2024.**

If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 67, I attest that necessary arrangements will be made to assure that 100 percent of the two percentage point managed care plans' provider payment rate increase will be paid to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.

Arizona agrees not to use DSHP funding to finance any provider payment rate increase required under Section X, and will ensure that the entirety of a two percentage point increase is applied to the provider payment rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans.
Except as required by federal law, Arizona further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under Section X.
I, **Jeffery Tegen, Chief Financial Officer, Arizona Health Care Cost Containment System,** attest that the above information is complete and accurate. [*Provide signature*_____] [*Provide printed name of signatory* *Jeffery Tegen*_____] [*Provide date*_____1/12/2023_____]

Attachment O
Time-limited Expenditure Authority and Associated Requirements for the COVID-19 Public Health Emergency (PHE) Demonstration Amendment

Expenditure Authority

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period retroactively from March 1, 2020 and ending when all redeterminations for Medicaid and CHIP are conducted during the unwinding period.

1. **Continuous Coverage for Individuals Determined Ineligible for CHIP Due to a Change in Circumstances.** Expenditures to provide continued eligibility for CHIP enrollees who were determined to be ineligible for CHIP due to a change in circumstances and who are otherwise ineligible for Medicaid due to income above 133 percent of the federal poverty level (FPL) between March 1, 2020 and ending the earlier of the date when all redeterminations for Medicaid and CHIP beneficiaries are conducted during the unwinding period or May 31, 2024, with the following exceptions for enrollees who:
    a. Are deceased;
    b. Voluntarily withdraw from benefits;
    c. Are no longer Arizona residents;
    d. Were not eligible during the demonstration period, but were approved erroneously because of agency error or fraud or abuse attributed to the beneficiary or beneficiary's representative; or
    e. Turned 19 years of age during the demonstration period.

Monitoring and Evaluation Requirements

1. **Evaluation Design.** The state must submit an Evaluation Design to CMS within 60 days of the demonstration amendment approval. CMS will provide technical assistance on developing the Evaluation Design. For this demonstration amendment, the state will test whether and how the approved authority facilitated the state's response to the COVID-19 PHE, and helped promote the objectives of Medicaid. To that end, the evaluation will address thoughtful evaluation questions that support understanding the successes and challenges in implementing the expenditure authority. The state is required to post its Evaluation Design to the state's website within 30 days of CMS approval of the Evaluation Design, per 42 CFR 431.424(e).

2. **Final Report.** The state is required to submit a Final Report, which will consolidate monitoring and evaluation reporting requirements for these authorities. The state must submit the draft Final Report no later than one year after the expiration of the demonstration approval period. The Final Report should include a background description of the scope and objectives of the amendment, and in alignment with proposed evaluation questions and approaches in the approved Evaluation Design, an assessment of the implementation of the demonstration amendment, lessons learned thereof, and best practices for similar situations. The state will be required to track expenditures

associated with this amendment, including but not limited to, administrative costs and program expenditures. The Final Report shall include an assessment of the linkage between those expenditures and the state's response to the PHE. The state should customize the content of the Final Report to align with the specific scope of the demonstration amendment. CMS will provide additional technical assistance on the structure and content of the Final Report.

Attachment P
Approved DSHP List

The approved Designated State Health Program (DSHP) list below is subject to the limits in STC 55, including an aggregate limit of $440,890,944 total computable expenditures for DY12-16 and annual limits of $88,178,188 in total computable expenditures.

Program	**Description**	**DSHP-Eligible Expenditures**
Services to Individuals with Serious Mental Illness (SMI)-Maricopa County	Two counties in Arizona provide funds to AHCCCS via Intergovernmental Agreements (IGAs) to provide services to non-Medicaid individuals with SMI designations. AHCCCS contracts with managed care organizations who contract with providers for case management, peer support and planning, community-based supports, medication management services, and other medical services	$58,093,100
Services to Individuals with SMI- Pima County	Two counties in Arizona provide funds to AHCCCS via Intergovernmental Agreements (IGAs) to provide services to non-Medicaid individuals with SMI designations. AHCCCS contracts with managed care organizations who contract with providers for case management, peer support and planning, community-based supports, medication management services, and other medical services	$2,326,900
Trauma Services	Trauma and Emergency Services program operated by AHCCCS reimburses Arizona hospitals for Level 1 trauma center readiness costs and emergency services costs. Payments are made to Level 1 trauma centers based on the acuity-adjusted volume of trauma care provided and the professional, clinical, and administrative costs directly associated with the provision of that care. Target populations are individuals served by hospital trauma centers, including both uninsured and Medicaid covered individuals. AHCCCS is excluding emergency department payments and only includes trauma payments as the amount eligible for DSHP.	$26,787,100
Developmentally Disabled Services	The Arizona Department of Economic Security, Division of Developmental Disabilities (DES/DDD) provides state-only early intervention and HCBS to individuals who are not eligible for Medicaid. DDD directly contracts with independent providers for early intervention services, day treatment, habilitation, residential group homes, occupational therapy, physical therapy, and speech therapy. The programs are the state-only components of DDD, which include the Arizona Early Intervention Program (AzEIP), state-only HCBS services, and state-	$27,321,400

Program	Description	DSHP-Eligible Expenditures
	only case management.	
Total DSHP-Eligible Expenditures		**$114,528,500**