ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Arizona Demonstration Renewal Proposal (2027-2032)

November 2026

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I. Summary

The Arizona Health Care Cost Containment System (AHCCCS) is requesting a five-year renewal of Arizona's Demonstration project under Section 1115 of the Social Security Act. Arizona's existing Demonstration project is currently approved through September 30, 2027, and the application is seeking a renewal period from October 1, 2027, through September 30, 2032. Arizona operates the nation's oldest continuously running Section 1115 Demonstration and remains the only state to have delivered its entire Medicaid program through a statewide, mandatory, risk-based managed care model since inception. That model continues to produce among the lowest per-enrollee costs in the country while maintaining access and quality, and it remains the foundation on which this renewal builds.

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

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

Consistent with federal requirements, the Demonstration will remain budget neutral, and AHCCCS will demonstrate budget neutrality under the methodology established by the Working Families Tax Cut legislation and recent CMS guidance. If CMS has not completed its review before September 30, 2027, Arizona requests a temporary extension of the current demonstration under 42 CFR 431.412(c)(4) for the period during which this renewal remains under review. Through this renewal, Arizona seeks to continue a Medicaid program that is accountable to taxpayers, responsive to members, and durable through a period of substantial federal change.

Approval of Arizona's renewal application by the Centers for Medicare & Medicaid Services (CMS) will allow the State to continue operating and building upon its nationally recognized managed care model. Renewal of the Demonstration will extend authority for Arizona to implement programs and initiatives including, but not limited to:

- Mandatory managed care
- Home and community-based services for individuals in the Arizona Long Term Care System (ALTCS)
- Administrative simplifications that reduce inefficiencies in eligibility determination
- Integrated health plans for AHCCCS members
- Housing and Health Opportunities (H2O)

- Reentry Services
- Waiver of Prior Quarter Coverage for specific populations
- Traditional Healing Services delivered through IHS and Tribally operated health facilities
- KidsCare Eligibility Expansion

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

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

AHCCCS also reminds CMS, in Section V, that it remains open to continuing discussions regarding previously submitted proposals that remain under review and negotiation.

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

II. AHCCCS Demonstration Historical Background

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

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

Inception of Managed Care and Early Program Development

Since 1982, AHCCCS has had the unique distinction of being the first state to operate under a mandatory managed care model and the only state to have done so from the start of its program. This public-private relationship has continued to mature and evolve over time, enabling the state to ensure that members receive high-quality care while also maximizing efficiency and containing costs.

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

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

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

Arizona continues to lead the nation in operating a cost-effective managed care model. In fact, Arizona's Medicaid program has one of the lowest per-enrollee costs among states at only $9,213 per-enrollee compared with the national average of $10,426 per-enrollee.[2]

Behavioral Health and Population Expansion

Arizona continued to build upon the Demonstration in 1990 when AHCCCS first began a five-year phased approach to including comprehensive behavioral health services within the Medicaid program. The initial approach started with children determined to have serious emotional disturbance (SED) under the age of 18 who required residential care. This was then followed by additional populations including children without an SED in 1991, adults with a serious mental illness (SMI) designation in 1992, and finally general mental health

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

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

and/or substance use services for the remaining adult population in 1995. For many years, these services were carved out of the ACC plans and delivered through a separate system administered by the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (DBHS) who was contracted with AHCCCS to serve as an MCO and manage care delivery. ADHS/DBHS established sub capitated managed care contracts with behavioral health organizations, known as Regional Behavioral Health Authorities (RBHAs), that were responsible for delivering behavioral health services for the majority of AHCCCS members. This structure represented how care was delivered in Arizona until 2016 when DBHS merged with AHCCCS to further supplement the transformative initiative of integrating physical and behavioral health services which are now both administered by AHCCCS.

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

The Effects of the Great Recession on Arizona's Demonstration

While Arizona had previously achieved notable progress in expanding access to service and populations, the 2008 Great Recession posed significant challenges for Arizona's Medicaid program, testing the State's ability to balance sustained coverage with preservation of the program amid a time of rapidly shifting fiscal conditions. The rapid growth of the Medicaid program, coupled with revenue declines, placed a tremendous strain on the State's General Fund. As a result, the Arizona Legislature made cuts of 21.7 percent to the AHCCCS budget for State Fiscal Year (SFY) 2012. This was the largest Medicaid budget reduction nationally and was more than twice that of the next highest state cut. These reductions necessitated difficult but deliberate policy choices to stabilize the program which included:

- **Elimination of the Health Insurance for Parents (HIFA) Program**: In 2009, AHCCCS eliminated the Health Insurance for Parents (HIFA) program which typically covered parents of KidsCare children who had income between 100 percent and 200 percent of the FPL.
- **KidsCare Enrollment Freeze**: Due to the reduction in funds available for state match, new enrollment within the KidsCare program was frozen from 2010 to 2016, resulting in a drop of enrollment from 45,280 children down to just 528 children. This freeze was lifted in 2016, and the KidsCare program's financial eligibility was further expanded through the 1115 Demonstration in 2024 as highlighted within this renewal application.
- **Proposition 204 AHCCCS Enrollment Freeze**: In 2011, the Arizona Legislature and Governor passed a budget that froze AHCCCS enrollment for the Proposition 204 population. This enrollment freeze and phase-out plan was approved by CMS later that year. This freeze was in effect until 2013 and resulted in an enrollment drop from 230,123 members to 67,770 members. However, enrollment has since been further expanded to the new adult group under the Affordable Care Act (ACA).
- **Copay Implementation**: AHCCCS received Demonstration authority from 2011 to 2013 to implement

mandatory copay requirements for childless adult members.

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

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

Integration of Physical and Behavioral Health Services

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

Historically, most AHCCCS members received behavioral health services through the RBHAs while physical health and medical care were delivered by separate MCOs (known as acute plans). Through a strategic, phased process, AHCCCS integrated care for its members under the same MCO, beginning with children with qualifying CRS conditions. This integration was first started in 2013, when CMS approved Arizona's waiver amendment request to create a single, statewide integrated health plan contract to oversee all physical health, behavioral health, and specialty services for children with special health care needs enrolled in the CRS program. Arizona then received additional waiver approval from CMS to establish a first of its kind integrated RBHA which brought physical health, behavioral health, and social support services together in one plan for individuals with a SMI designation. Implementation of the program began in Maricopa County and subsequently expanded statewide in 2015.

Early independent studies illustrated how this integration has led to improvements in health outcomes for members with SMI. In 2018, Mercer conducted a study that determined over 75 percent of the program

indicators demonstrated improvement following integration when compared to the pre-integration period for members in Maricopa County. Specifically, the study showed that all measures of ambulatory care, preventive care, and chronic disease management improved, with two measures related to medication maintenance compliance for asthma both increasing by more than 30 percent.[3] Another study conducted by NORC at the University of Chicago demonstrated that members with SMI enrolled in Mercy Maricopa Integrated Care (MMIC), who were also receiving supportive housing services, experienced a 20 percent reduction in psychiatric hospitalizations, with a 24 percent decrease in total cost of care, with savings driven by reductions in behavioral health costs.[4]

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

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

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

Personal Responsibility Initiatives through Arizona's Demonstration

Arizona has consistently explored ways to incorporate personal responsibility concepts into its Medicaid program, using the 1115 Demonstration as a platform to test approaches that encourage engagement in work,

[3] Mercer. (2018). Independent Evaluation of Arizona's Integration Efforts. https://www.azahcccs.gov/shared/Downloads/News/CRS_SMI_IndependentEvaluationReport_11_27_18.pdf
[4] NORC at the University of Chicago. (2017). Case Study: Supportive Service Expansion for Individuals with Serious Mental Illness: A Case Study of Mercy Maricopa Integrated Care. https://www.mercycareaz.org/assets/pdf/news/NORC-MercyMaricopa-CaseStudy.pdf

education, and health management. These efforts have focused on promoting greater self-sufficiency, improving health awareness, and supporting more consistent interaction with the health care system, while continuing to preserve access to essential services.

AHCCCS Works - Arizona's Community Engagement Program

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

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

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

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

AHCCCS CARE (Choice, Accountability, Responsibility, Engagement)

In 2016, Arizona received approval to implement AHCCCS CARE, an initiative aimed at adults with incomes above 100 percent of the federal poverty level. The program introduced monthly premium requirements and limited cost-sharing applied after services were received, alongside incentives tied to timely payments and completion of defined health-related activities. The intent was to strengthen understanding of health coverage and prepare members for transitions to commercial insurance. Despite receiving federal approval, the program was ultimately not put into operation and was removed from the demonstration authority during the previous Waiver renewal.

Retroactive Eligibility Waiver

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

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

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

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

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

Several temporary authorities introduced during the emergency period produced meaningful improvements in access, member experience, and care delivery. As a result, AHCCCS pursued continuation of a handful of policies beyond the end of the public health emergency through subsequent Section 1115 demonstration amendments. Key examples include:

- **Home Delivered Meals for ALTCS Members**: Home delivered meals were initially approved by CMS and implemented for ALTCS members during the PHE to address increasing challenges faced by individuals living in the community. This service provides members with nutritious meals delivered directly to their homes, with each meal meeting at least one-third of the federally recommended daily allowance. Recognizing the value of this support, Arizona subsequently made home delivered meals a permanent

component of the 1115 Demonstration for all ALTCS members and expanded the service to also include individuals with intellectual and/or developmental disabilities.

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

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

III. Current Demonstration Goals, Objectives and Evaluation

Arizona's Demonstration strives to provide, through the employment of a managed care model and robust long term care delivery system, quality health care services to members while at the same time achieving cost effectiveness to ensure long term stability of the program. Specific goals for Arizona's Demonstration are:

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

To assess the performance of Arizona's Demonstration and identify areas for future refinement, AHCCCS

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

Demonstration Evaluation Deliverables & Activities

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

Evaluation Design

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

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

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

In addition to the approved evaluation designs, AHCCCS is developing evaluation designs for recently approved Demonstration authorities. The State finalized an updated evaluation design for the Traditional Health Care Practices (THCP) Demonstration, which was submitted to CMS on July 28, 2026. Development of the THCP evaluation design began in late 2025 and has involved extensive collaboration with Tribal stakeholders, Tribal health representatives, and the independent evaluator (HSAG). Through this process, AHCCCS has worked to ensure that the evaluation design appropriately measures the Demonstration's goals and outcomes while respecting the cultural significance of traditional healing practices, Tribal sovereignty, and Tribal data governance considerations.

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

Interim Evaluation

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

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

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

Summative Evaluation

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

Summary of Interim Evaluation Findings

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

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

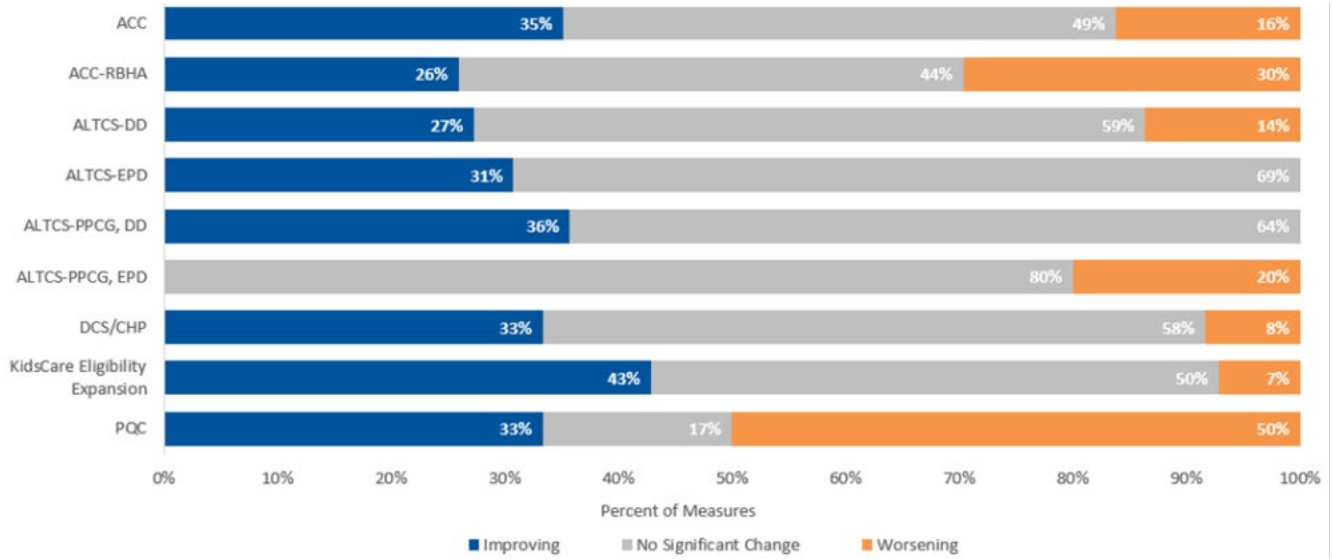
Key improvements were observed in preventive care, substance use disorder treatment engagement, opioid prescribing practices, enrollment continuity, and care coordination for members with complex physical and behavioral health needs. Early baseline findings from the Housing and Health Opportunities (H2O)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

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

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

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

Figure 1 - Percentage of Measures Consistent with Research Hypotheses



ACC Evaluation Findings

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

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

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

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

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

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

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

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

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

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

Figure 3 below utilized PMMIS data to determine the percentage of members initiating and engaging in substance abuse treatment.

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

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

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

Note: pp: percentage point.

Data Source: PMMIS data were used in the analysis of RQ 2.2.

[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.

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

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

ACC-RBHA Evaluation Findings

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

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

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

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

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

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

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

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

Figure 5 below utilized PMMIS data to assess the management of opioid prescriptions for ACC-RBHA members.

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

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

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

Note: FFY: federal fiscal year; pp: percentage point.

Data Source: PMMIS data were used in the analysis of RQ 2.4.

[1]Rates are adjusted for the effect of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in 2020.

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

[3]Change in Rate compares the rate or number in the baseline period (10/01/2016–09/30/2022) to the average rate or number in the evaluation period (10/1/2022–09/30/2024).

ALTCS Evaluation Findings

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

ALTCS-DD

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

ALTCS-EPD

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

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

Figure 6 below utilized NCI-IDD surveys to assess ALTCS-DD member satisfaction with living arrangements. A DiD analysis compared Arizona rates and national rates.

Figure 6 - ALTCS-DD member satisfaction with living arrangements

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

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

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

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

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

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

Figure 7 below used NCI-AD surveys responses to examine ALTCS-EPD member satisfaction with living arrangements.

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

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

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

Note: No baseline data were available for the the EPD population because the survey was not conducted. N represents the number of responses. ALTCS: Arizona Long Term Care System; EPD: elderly and physically disabled; pp: percentage point.

Data Source: NCI-AD Adult Consumer Survey data were used in the analysis of RQ 3.2.

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

ALTCS-DD

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

ALTCS-EPD

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

Figure 8 below utilized PMMIS, PPCG utilization, and ALTCS placement data to identify the number and types of services provided to members through the PPCG service model, which provides services to minor children enrolled in ALTCS.

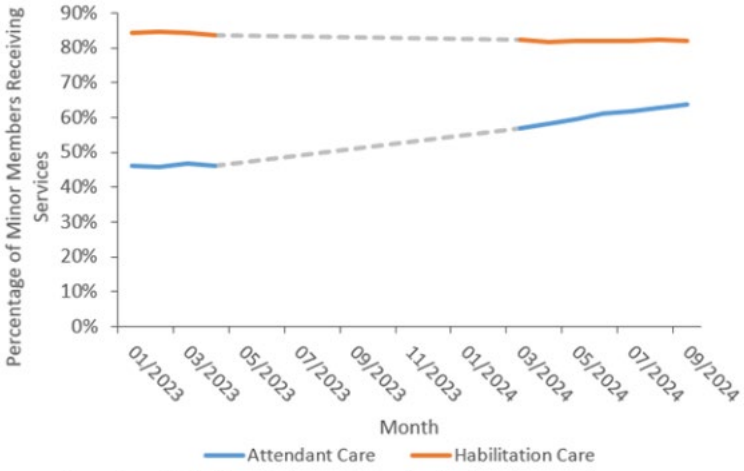
Figure 8 - Number and types of services provided to members through the PPCG service model

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

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

Figure 9 illustrates ALTCS-DD members who utilized services under the PPCG service model. Data were unavailable from May 2023 to February 2024, as indicated by gray dashed lines, which may lead to lower average rates during this period.

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



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

DCS/CHP Evaluation Findings

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

The *Percentage of children 2 years of age with appropriate immunization status* increased for 11 out of 13 indicators. Three indicators—measles, mumps, and rubella (MMR); pneumococcal conjugate; and rotavirus—increased by statistically significant margins of 2.5, 4.4, and 6.5 percentage points, respectively, between the baseline and evaluation periods. (p=0.025, p=0.001, and p<0.001).

Figure 10 below utilized PMMIS data to assess changes in the percentage of children and adolescents with appropriate immunizations.

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

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

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

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

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

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

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

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

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

- The *Percentage of children and adolescents on antipsychotics with metabolic monitoring* decreased by 2.3 percentage points between the baseline and evaluation periods (p=0.085); however, the evaluation period observed rates exceeded the baseline trend projection, indicating the rate of decline was not sustained in the evaluation period (p<0.001 for FFY 2022 and FFY 2023, and p=0.006 for FFY 2024).

- The *Percentage of members diagnosed with a mental health disorder* increased between the baseline and evaluation periods by 15.3 percentage points (p<0.001); however, the evaluation period observed rates were lower than the baseline trend projection by 13.9 percentage points or more, indicating that the rate did not increase as fast as expected in the evaluation period (p<0.001 for all years).
- The *Percentage of members with a follow-up visit within 7 days after a hospitalization for mental illness* increased by 5.2 percentage points between the baseline and evaluation periods (p=0.001).

Figure 11 below utilized PMMIS data to assess the changes in members' management of BH conditions between the baseline and evaluation periods.

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

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

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

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

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

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

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

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

H2O Evaluation Findings

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

Key Findings:

- The Number of emergent and non-emergent ED visits per 1,000 member months were higher for H2O members compared to waitlist members. For emergent ED visits, differences between the two groups increased from 116.5 visits per 1,000 member months (p<0.001) in FFY 2022 to 184.8 visits per 1,000 member months (p<0.001) in FFY 2024. Similarly, differences in the number of non-emergent ED visits per 1,000 member months increased from 9.3 (p<0.001) in FFY 2022 to 18.7 (p<0.001) in FFY 2024.

- The Number of IP stays per 1,000 member months was greater for H2O members compared to waitlist members, and the difference increased throughout the baseline period. The difference increased by 17 stays per 1,000 member months (p<0.001) in FFY 2022 to 38 stays per 1,000 member months (p<0.001) in FFY 2024.
- The Risk-adjusted ratio of observed to expected acute IP and observation stay discharges was higher among H2O members than waitlist members by between 0.4 and 0.7 (p<0.001), representing relative differences of 38 percent ([1.8 / 1.3] -1) and approximately 54 percent ([2.0 / 1.3] -1).
- Figure 12 below utilized PMMIS, H2O-PA, and AHP waitlist data to identify H2O members and members on the AHP waitlist in FFY 2025 to determine their hospital and institutional care utilization in the three years prior to H2O implementation. As H2O was not implemented until October 2024, before and after comparisons cannot be made in this Interim Evaluation Report. Instead, H2O and AHP waitlist member utilization of hospital and institutional care rates are compared during the baseline period.

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

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

*p<0.1, **p<0.05, ***p<0.001
Note: ED: emergency department; H2O: Housing Health Opportunities; IP: inpatient; pp: percentage points; PQI: Prevention Quality Indicator.
Data Source: PMMIS, H2O-PA, and H2O Waitlist data were used in the analysis of RQ 2.3.
Baseline Period: 10/01/2021–09/30/2024.

KidsCare Evaluation Findings

Key Findings:

- KidsCare enrollment declined from a peak of 73,737 members in March 2023 to 56,725 members in

April 2025, with the decline coinciding with the unwinding of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) continuous enrollment provision.

- Enrollment in the KidsCare Expansion began in April 2024 and increased steadily to 21,460 members by April 2025.

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

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

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

Figure 13 below utilizes ACS data to identify changes in the uninsured rate among children in Arizona during the baseline and evaluation periods and compared to trends among states with similar Children's Health Insurance Program (CHIP) requirements.[5]

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

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

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

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

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

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

Tribal Dental Authority Evaluation Findings

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

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

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

covered dental service averaged approximately 12.65 percent during the evaluation period.

Figure 14 below utilized PMMIS data to assess whether the Tribal Dental Authority improved member access to dental services.

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

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

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

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

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

Figure 15 below leveraged PMMIS data to determine the percentage of members who utilized an emergency dental service[6] during the evaluation period.

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

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

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

Targeted Investments (TI 2.0) Evaluation Findings

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

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

Figures 16 and 17 below represent two claims-based measures that assessed ED utilization among child and adolescent beneficiaries.

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

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

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

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

Measure 2-15: Number of ED visits among children and adolescents					
Evaluation Year	**Group**	**Baseline**	**Evaluation**	**Log DiD Estimate** (P-Value)	**DiD Rate Ratio** [95% CI]
2023	TI	83,287 *N = 53,699*	92,107 *N = 58,922*	-0.0035 (0.36)	0.997 [0.985, 1.01]
	Non-TI	169,078 *N = 111,510*	174,859 *N = 114,019*		

Note: N represents the count of unique patients.

PQC Evaluation Findings

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

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

The average number of months with Medicaid coverage within each federal fiscal year (FFY) increased slightly between the baseline period and FFY 2024. The evaluation also found that overall Medicaid enrollment declined relative to the pre-implementation period, that members who disenrolled were less likely to re-enroll, and that members who did re-enroll had more enrollment gaps. AHCCCS will continue to monitor these measures as the retroactive coverage period changes under federal law in 2027. Due to the impact of the continuous enrollment provision authorized during the COVID-19 PHE, FFY 2020 through FFY 2023 experienced an increase in enrollment continuity. To better estimate the impact of the PQC waiver, the analysis for Measure 1-6 (Average number of months with Medicaid coverage) does not include COVID-19 PHE-impacted years.

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

COVID-19 PHE-affected months. The second table displays the average number of months with Medicaid coverage per year.

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

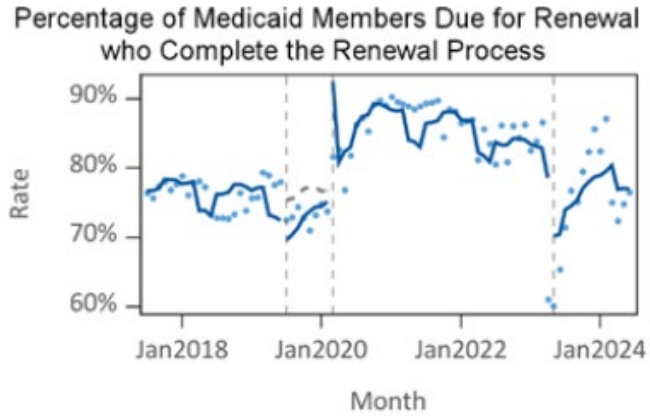


Figure 19 - Projected and observed Medicaid renewal completion rates including PHE affected months

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

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

External Quality Review

In accordance with Section 1932(c)(2) of the Social Security Act and 42 CFR 438.350–438.370, Arizona conducts annual External Quality Reviews (EQRs) for each contracted managed care organization. These reviews are performed by an independent External Quality Review Organization (EQRO) and include validation of performance measures, reviews of performance improvement projects and compliance with federal managed care requirements, and other assessments of health plan performance to evaluate the quality, timeliness, and accessibility of services provided to Medicaid members. AHCCCS contracts with Health Services Advisory Group (HSAG) to serve as its EQRO. A summary of the EQR activities conducted during the current demonstration period and their key findings is provided in Appendix B. Annual EQR Technical Reports are publicly available on the AHCCCS website. Appendix B also includes a summary of the State's most recent CMS-416 EPSDT report.

IV. Current Program Features to Continue Under Demonstration Renewal

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

Eligibility

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

Waiver of Retroactive Coverage (Prior Quarter Coverage)

Arizona's Demonstration authorizes AHCCCS to limit retroactive coverage to the first day of the month of application for all Medicaid members, except for pregnant women, women who are 60 days or less postpartum, and children under 19 years of age. Pregnant women, postpartum women, and children under the age of 19 are eligible for Medicaid coverage for up to three months prior to the month in which their application was submitted. Beginning on January 1, 2027, retroactive eligibility for these populations will be limited to two months in alignment with Section 71112 of the Working Families Tax Cut legislation.

AHCCCS is requesting the authority to continue to limit retroactive coverage to the first day of the month of application for the same populations as currently covered within the waiver. This waiver authority is in close alignment with the Working Families Tax Cut legislation and will allow the agency to further evaluate the Demonstration's progress toward achieving the goals of continuity of care and personal responsibility, and to assess the impact to individuals and providers.

Former Foster Youth Eligibility Extension (Out-of-State Former Foster Care Youth Amendment)

Approved by CMS on June 13, 2025, the Former Foster Youth Amendment authorizes Arizona to extend eligibility for full Medicaid benefits for FFCY under age 26, who turned age 18 on or before December 31, 2022, who "aged out" of foster care in another state or a tribe in another state and were enrolled in Medicaid while in foster care, currently reside in Arizona, and are not otherwise eligible for Medicaid. AHCCCS currently offers transitional medical care for children leaving foster care that are between the ages of 18 to 26 and typically refers to this group as the Young Adult Transitional Insurance (YATI) population. Although the SUPPORT Act requires Medicaid programs to extend Medicaid eligibility for FFY who aged out of any state on or after 1/1/2023, this Waiver authority allows Arizona to further extend this eligibility to also include individuals who aged out prior to 1/1/2023. Specifically, the Waiver authorizes full Medicaid state plan benefits to FFY who:

- Are under age 26,
- Turned 18 on or before December 31, 2022,

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

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

KidsCare Expansion

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

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

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

Delivery System

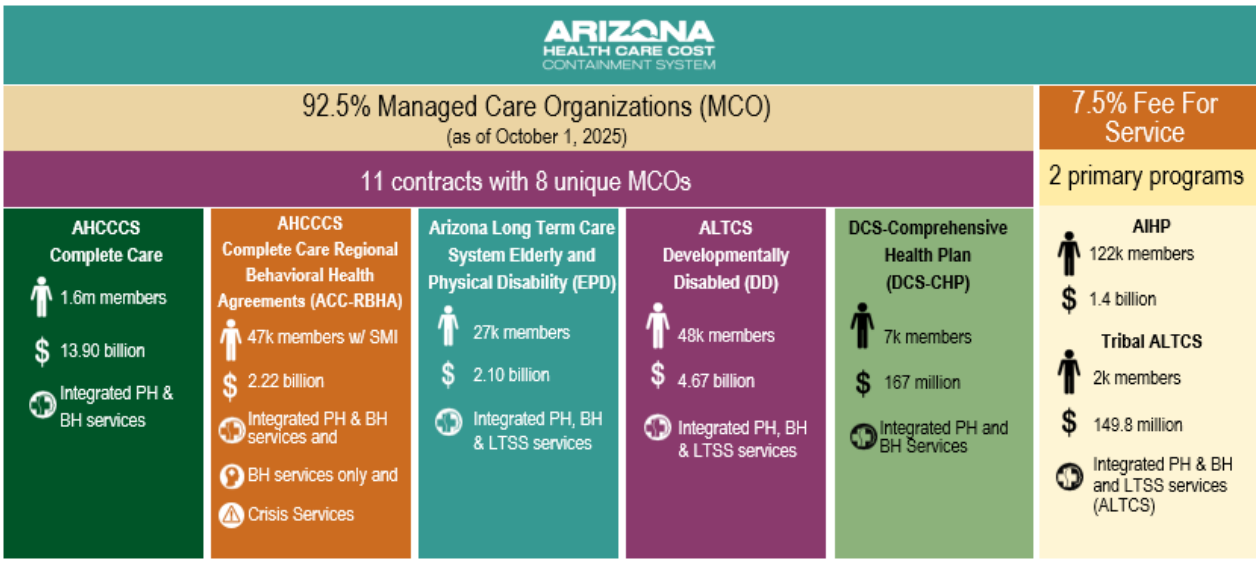
Arizona's Demonstration provides the authority to operate a statewide, mandatory managed care model designed to coordinate high-quality care while also promoting efficient use of resources to ensure long term

stability of the program. Through this approach, AHCCCS works in partnership with private health plans to deliver comprehensive services while maintaining fiscal discipline. Although managed care has served as the cornerstone of Arizona's Medicaid program, it has also continued to evolve and expand to meet the needs of Arizona's Medicaid members. Today, managed care is applied broadly across populations and service areas offering an effective solution to coordinate long-term services and supports, behavioral health, and other target services for other specialty populations such as individuals who are dually eligible for Medicare and Medicaid and children in Arizona's foster care system. Currently, approximately 90 percent of AHCCCS members receive services through managed care arrangements. Arizona's delivery system is highlighted in figure 20 below.

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

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

Figure 20 - AHCCCS Delivery System Overview



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

AHCCCS is also requesting continuation of the authorities that support its delivery system and financing arrangements, including automatic re-enrollment into a member's prior health plan, direct payments to Indian Health Service, tribal, and Urban Indian Organization providers outside the managed care contracts, direct payments to Critical Access Hospitals, the fee-for-service upper payment limit authority, Medicare Part B premium payments for certain ALTCS members, and non-medical transportation to and from H2O services and ALTCS home and community-based services. Each is listed in Section VII.

AHCCCS continues to operate its demonstration with heightened monitoring and oversight of the services it authorizes. After identifying fraudulent behavioral health providers that were exploiting the program and targeting members, AHCCCS suspended payments to those providers, rebuilt its provider enrollment and oversight processes, and referred cases for prosecution. AHCCCS will carry those controls into the renewal period, including provider screening and revalidation, electronic visit verification for home and community-based services, and analysis of claims and encounter data to identify aberrant billing, and will report on program integrity activity in its monitoring reports to CMS.

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

In addition to its managed care delivery system, Arizona's current Demonstration authorizes supplemental payments to Indian Health Service (IHS) and tribally operated 638 facilities to offset uncompensated care costs for services provided by such facilities to Medicaid-eligible adults in the case the state reduces or eliminates services from the Medicaid State Plan. This program is commonly referred to as the Tribal Uncompensated Care Waiver.

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

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

Benefits

Arizona's Demonstration maintains a comprehensive benefit structure designed to ensure consistency and access across delivery systems. AHCCCS proposes to continue to provide the full range of currently authorized benefits, with standardized coverage available to members regardless of their managed care plan selection. Acute care members receive a uniform benefit package across all contracted plans, and the same approach

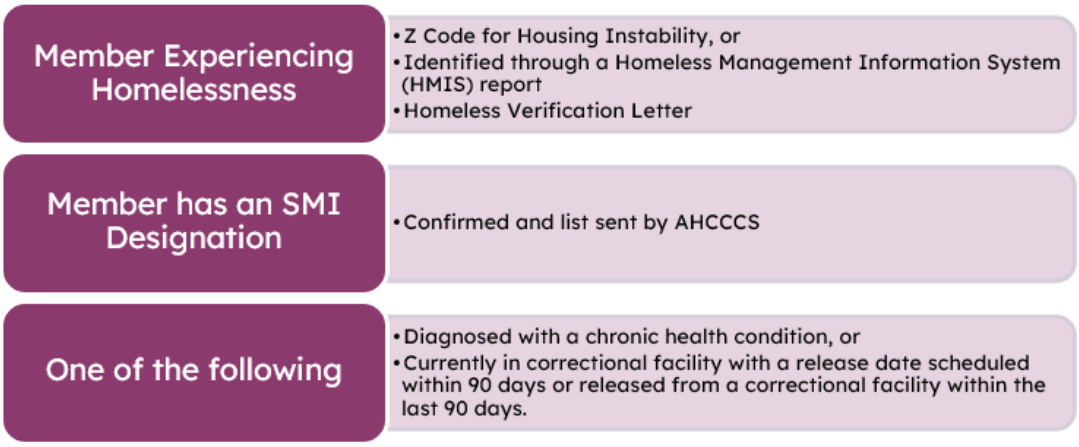
applies within the ALTCS program, where services are aligned across contractors to ensure consistent access. AHCCCS is seeking the appropriate authorities to continue the following approved waiver services into the next Demonstration period.

Housing and Health Opportunities (H2O)

The Housing and Health Opportunities (H2O) Program provides short-term housing assistance and wraparound supportive services to some of the state's most vulnerable populations, including individuals with an SMI designation and who are experiencing homelessness and who are either diagnosed with a chronic health condition or have recent justice system involvement as further outlined in figure 21 below. Within this Demonstration renewal, Arizona is seeking to continue the existing authorities which authorize the H2O program based on early results showing measurable progress against the state's objectives and expected outcomes.

Early data findings are encouraging. Based on internal analysis of H2O member month and encounter/claim data for members who have an H2O exception code which compared the period after H2O eligibility to the twelve months preceding it, emergency department utilization among eligible members fell 11.7 percent and inpatient utilization fell 19 percent, with a corresponding decline in per member per month expenditures. Those findings are preliminary, reflect a pre-post comparison without a contemporaneous control group, may partly reflect a return toward prior utilization levels because members were prioritized for enrollment at a point of high and rising use of hospital care, and are detailed later in this section, but they are consistent with the program's design objective of reducing avoidable high-cost utilization within a short implementation window. The program pairs time-limited rental assistance with housing navigation and care coordination, operates as a bridge to long-term housing resources rather than an ongoing subsidy, and is supported by the provider oversight and program integrity controls described below.

Figure 21: H2O Member Eligibility Criteria



H2O was shaped by years of cross-system collaboration in Arizona that revealed a persistent and widespread gap that resulted in many individuals falling in between the housing and healthcare systems despite significant state and federal investments to minimize homelessness. H2O was designed to close that gap by intentionally aligning Medicaid with housing resources like HUD Continuum of Care (CoC) and Public Housing Authorities (PHAs), using Medicaid to fund the time-limited services and supports needed to stabilize people and begin

healing, while helping connect them to longer-term housing solutions where possible. The Demonstration targets individuals experiencing homelessness who also have high healthcare needs and costs, with the goal of not only improving outcomes and stability but also demonstrating that better coordination across systems can reduce avoidable healthcare spending. The program was designed to reduce reliance on high-cost crisis services and promote long-term recovery and stabilization by redirecting Medicaid funds from costly emergency and inpatient care to more preventative housing supports.

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

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

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

H2O Program Features to Continue Under the Demonstration

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

Figure 22: H2O Program Features to Continue Under the Demonstration

Program Feature	Description
H2O Services	AHCCCS proposes maintaining the existing H2O service continuum and program structure, including Outreach and Education services funded under the H2O Infrastructure benefit. AHCCCS also seeks to continue Transitional Housing services delivered through the two currently approved models: Enhanced Shelter and Short-Term Rental Assistance. Additional core program features AHCCCS seeks to continue include Housing Pre-Tenancy Supports, Tenancy Sustaining Supports, Move-In Assistance, and Home Modifications. These services remain foundational components of the H2O demonstration designed to support housing stabilization, successful

	community integration, and improved health outcomes for eligible members. All H2O services are further defined within the approved H2O Protocol and Implementation Plan in addition to state policy (AHCCCS Medical Provider Manual (AMPM) Chapter 1700)
H2O Provider Onboarding	AHCCCS designed the H2O Program with a provider structure intended to balance strong accountability with increased accessibility for qualified community-based providers. The model was intentionally developed to ensure that providers can achieve meaningful member outcomes while also reducing unnecessary administrative barriers that have historically limited participation by community-based organizations (CBOs) in the Medicaid delivery system. The H2O provider type structure creates a more flexible pathway for enrollment by removing requirements that are not applicable to the supportive housing services delivered under the demonstration, while maintaining rigorous oversight mechanisms to address fraud, waste, and abuse. This structure has allowed AHCCCS to expand provider capacity by creating viable participation opportunities for trusted CBOs that have longstanding experience serving vulnerable populations, including in rural and underserved communities throughout Arizona. Through this approach, organizations known for delivering high-quality housing and outreach services have been able to enroll as H2O providers and deliver critical Outreach and Education and supportive housing services to Medicaid members experiencing homelessness or housing instability statewide.
H2O Program Administrator	To support successful implementation, AHCCCS contracted with a single H2O Program Administrator through the state procurement process and utilized H2O Infrastructure funding to establish significant administrative oversight and technical assistance functions. This administrative structure supports providers through onboarding and operational implementation while ensuring ongoing monitoring of service delivery, compliance, quality, and program integrity. In addition, the administrator provides robust technical assistance and training intended to strengthen provider performance and promote high-quality, high-frequency member engagement.

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

System Accountability and Integration with Other State and Federal Housing Programs

From the onset, the H2O program was designed with program integrity, transparency, accountability, and the reduction of fraud, waste, and abuse (FWA) as key priorities to ensuring successful implementation and long-term sustainability of the program. AHCCCS also intentionally designed the H2O operational structure to

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

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

To further support integration and reduce duplication of services, the H2O program was intentionally designed to operate in coordination with existing federal, state, and local housing systems rather than as a standalone housing resource. As a result, AHCCCS determined that H2O service documentation would occur within Arizona's Homeless Management Information System (HMIS), creating alignment with HUD Continuum of Care (CoC) programs and other community housing resources. This allows H2O supportive housing services to complement existing housing subsidies and rental assistance programs. For example, in situations where a HUD CoC program funds a member's rental assistance, H2O may provide intensive community-based supportive services focused on housing stabilization, healthcare engagement, independent living skills, income and benefits acquisition, community integration, and connection to employment and vocational rehabilitation resources.

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

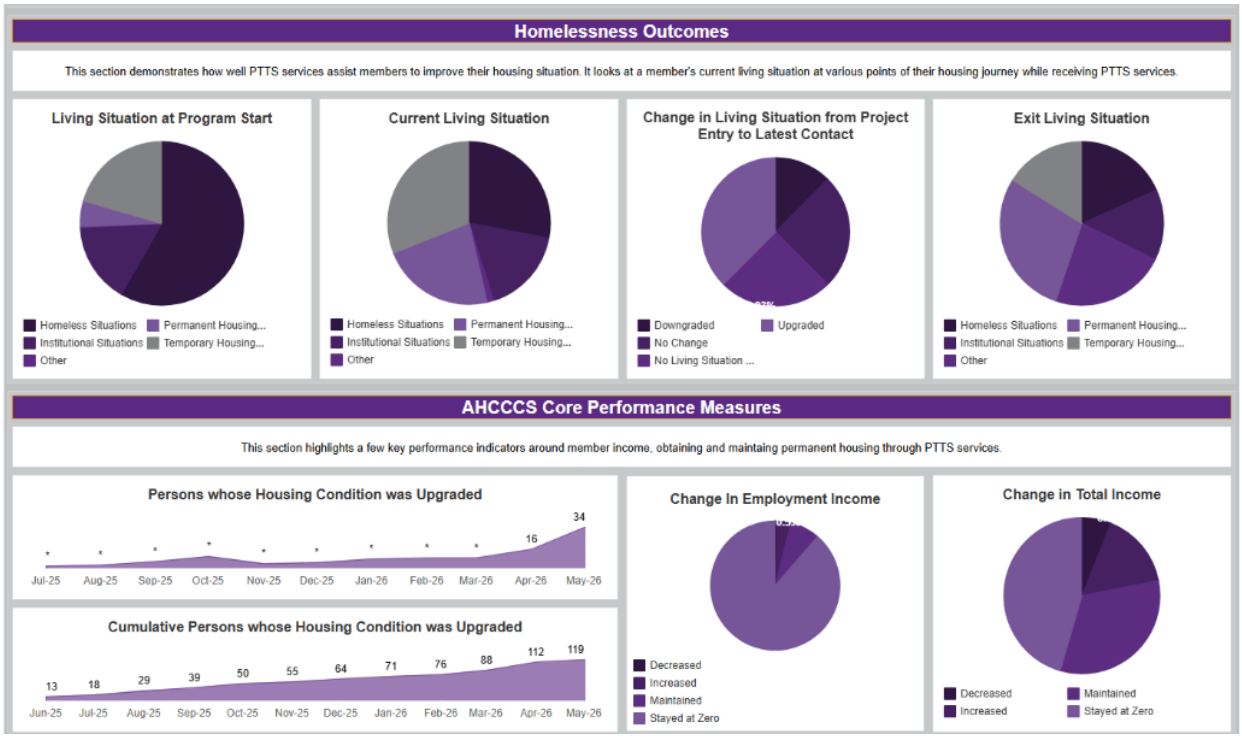
H2O Program Administrator & Program Health Dashboard

The H2O Dashboard is a public-facing data and reporting platform designed to provide transparent, real-time insight into implementation and outcomes of Arizona's H2O program. It tracks key program metrics related to member eligibility, provider participation, outreach activities, service utilization, and housing support interventions across the state. The dashboard integrates data collected through HMIS and H2O provider reporting to monitor outcomes such as housing stability, engagement in supportive services, and changes in

member living situations. AHCCCS and the H2O Program Administrator use the dashboard to identify trends, monitor provider performance, and inform technical assistance and quality improvement efforts. This centralized reporting structure supports statewide standardization, strengthens program integrity oversight, and aligns with CMS priorities for transparency, accountability, and data-driven monitoring.[7]

An example dashboard showing H2O's homelessness outcomes and core performance measures is shown in figure 23 below.

Figure 23: H2O Program Health Dashboard Example



H2O Objectives, Goals, and Early Outcomes

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

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

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

address.

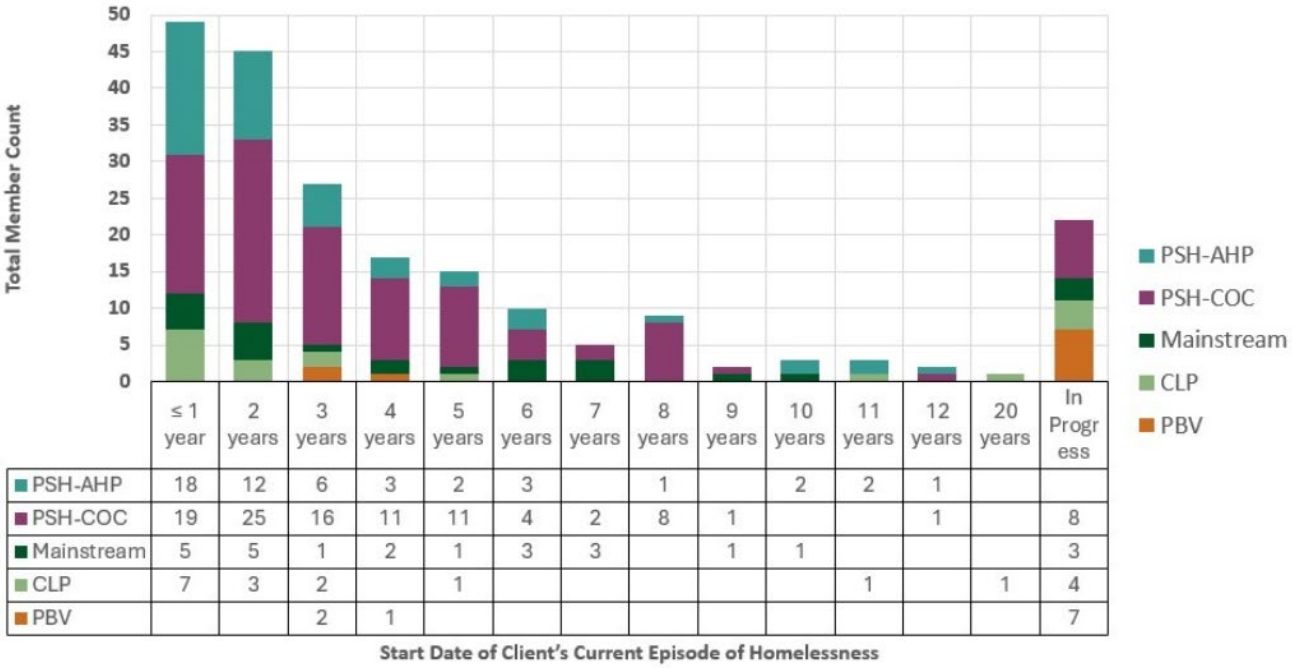
As discussed in Section III above, AHCCCS has finalized development of the Waiver Interim Evaluation Report for all Demonstration programs including H2O. However, given the ramp up period and delayed go-live date when compared to the rest of the Demonstration the H2O claims data currently available for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

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

Statewide Housing Administrator – Short Term Rental Subsidy Tracking

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

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



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

Internal AHCCCS H2O Program Analysis

To supplement the Waiver Interim Evaluation Report and account for the timing of H2O implementation in relation to the Evaluation deliverables, AHCCCS has initiated additional analysis to generate actionable insights on key aspects of the program, including the characteristics of the H2O target population, per member per month cost trends, and overall utilization patterns, in order to inform ongoing implementation and program refinement.

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

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

Recurring CCW Condition	Unhoused Count	Unhoused %	Housed Count	Housed %	Unhoused Per Capita	Housed Per Capita	Per Capita Difference
None	8,520	52%	25,162	56%	$22,024	$13,049	$8,975
Hypertension**	2,453	15%	4,532	10%	$59,505	$33,290	$26,216
Diabetes**	1,245	8%	4,369	10%	$60,141	$39,956	$20,186
Asthma	963	6%	1,228	3%	$56,866	$35,927	$20,939
Hyperlipidemia	948	6%	2,902	6%	$61,206	$33,329	$27,877

Rheumatoid Arthritis/ Osteoarthritis	593	4%	2,632	6%	$42,059	$22,649	$19,410
Anemia	574	4%	806	2%	$60,130	$36,696	$23,434
Chronic Obstructive Pulmonary Disease	418	3%	1,172	3%	$48,950	$34,113	$14,837
Hypothyroidism	383	2%	1,273	3%	$64,457	$42,513	$21,944
Pneumonia	221	1%	258	1%	$53,669	$60,008	-$6,340
Total*	**16,379**	**100%**	**44,707**	**100%**	**$39,700**	**$23,178**	**$16,522**

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

The data demonstrates substantial per capita differences across multiple chronic health conditions, reinforcing the connection between housing instability and poor health outcomes for highly vulnerable Medicaid populations. These findings support the underlying H2O program design and indicate that housing stabilization, coupled with supportive services, represents a meaningful intervention strategy to improve health outcomes and reduce avoidable healthcare expenditures. While these analyses are distinct from the federally required independent evaluation, they provide important real-time insight into the populations being served and the early impact of targeted housing interventions under the H2O demonstration.

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

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

Figure 26: H2O Members PMPM by Event Month

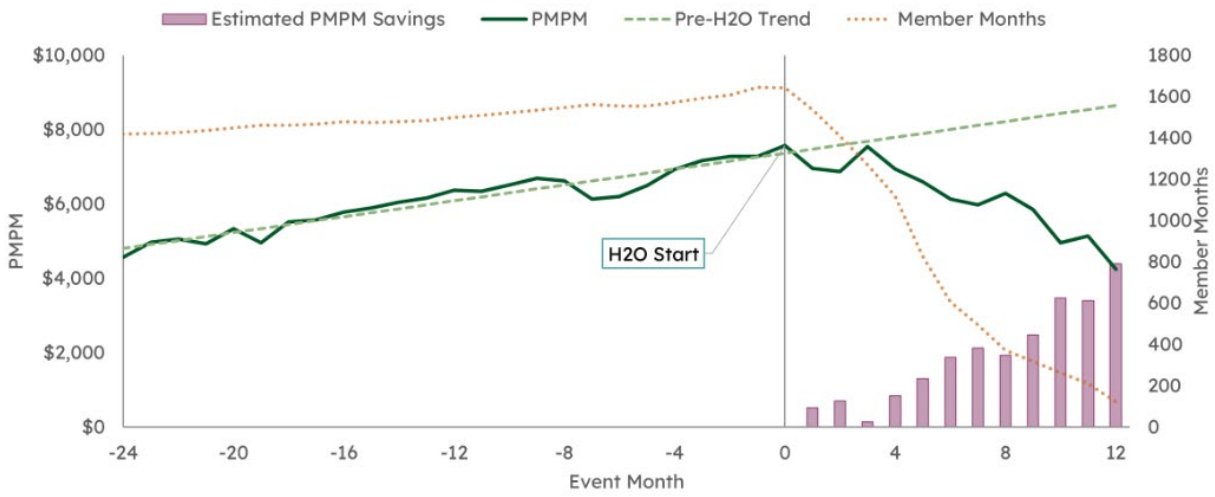
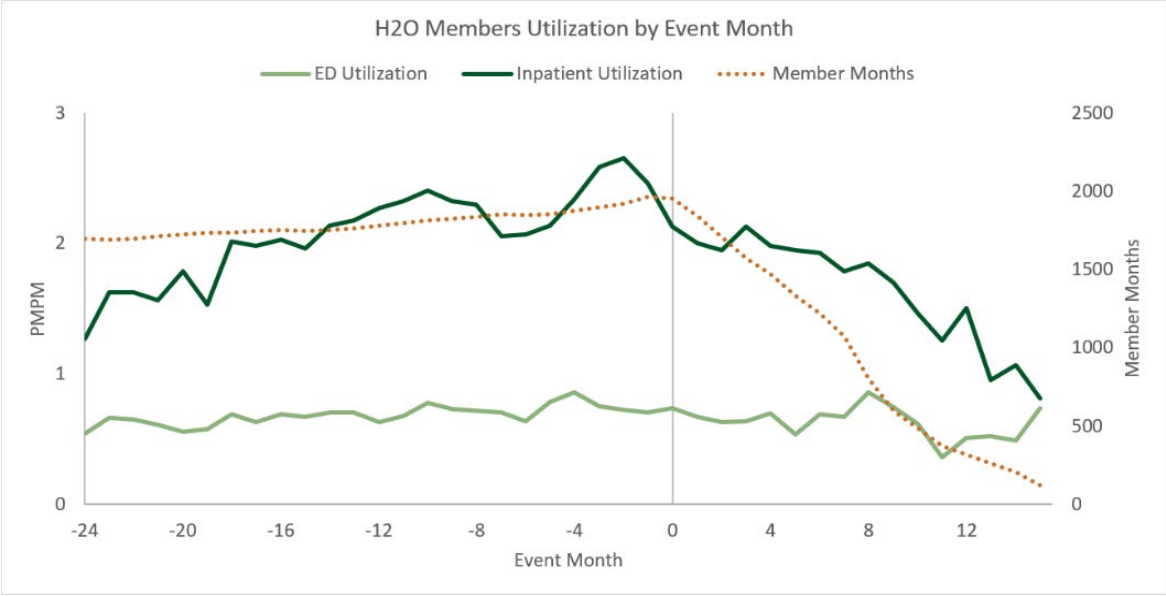


Figure 27: PMPM H2O Eligible Member Utilization



These preliminary results show a visual upward trend in Emergency Department (ED) and Inpatient utilization prior to H2O eligibility determination followed by a downward trend once eligibility triggers services. A similar trend is seen for PMPM Medicaid expenditure. Comparing months after eligibility to the 12-month period prior to eligibility, ED utilization decreased 11.7% and Inpatient utilization decreased 19%. These results are preliminary and may change as more data become available. Even at this early stage, they suggest that H2O is meeting its goals of reducing expenditures and lowering emergency department and inpatient utilization for eligible members.

Dental Waiver Services

Arizona has taken incremental steps over the past decade to rebuild adult dental coverage following reductions made during the Great Recession. Beginning in 2016, the state authorized a limited dental benefit of $1,000 per contract year for individuals enrolled in the ALTCS program. The following year, emergency dental services for

adult AHCCCS members were reinstated through the Medicaid State Plan. Building on these efforts, in 2020 the Governor and the Arizona Legislature authorized ARS 36-2907 and 36-2939 directing AHCCCS to pursue federal authority to expand reimbursement for dental services provided through Indian Health Service (IHS) and tribally operated 638 facilities, particularly designed to extend coverage for services that exceed the existing $1,000 limits in both the Medicaid State Plan and the ALTCS program. Through this renewal, AHCCCS is seeking to continue the authority for both dental programs.

ALTCS Dental Benefit

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

Tribal Dental Benefit

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

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

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

Through this renewal, AHCCCS is seeking to continue its existing federal expenditure authority for the Tribal Dental program which will carry over many of the same goals from the previous Demonstration period of improving oral health outcomes, reducing health disparities, and enhancing the overall care experience for

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

AI/AN members by expanding access to preventive and routine dental services within trusted, community-based care settings.

Traditional Healing

In partnership with Tribal leadership across Arizona, AHCCCS pursued and received approval for a first-in-the-nation initiative to recognize and reimburse traditional healing services within the Medicaid program, commonly referred to as the Traditional Health Care Practices (THCP) Demonstration. The initial Demonstration request was submitted in 2015 and later refined in 2020 to reflect continued collaboration with Tribal partners and evolving program design. CMS approved Arizona's approach in October 2024, and the program went live one year later on October 1, 2025. Traditional healing is a culturally grounded system of care developed and practiced by generations of Tribal healers. These methods support physical, mental, emotional, and spiritual well-being, and reflect the values, beliefs and practices of Arizona's Tribal communities. The initiative is intended to broaden access to culturally appropriate services and support improved health outcomes by aligning care delivery with the practices and preferences of American Indian and Alaska Native (AI/AN) members.

The development and rollout of this initiative has been guided by the Traditional Healing Workgroup, a community-led advisory body composed of Tribal leaders, representatives from Indian Health Service (IHS), Tribally operated 638 facilities, Urban Indian Organizations (UIOs), traditional healers, and other Tribal-serving partners. The Workgroup has and continues to play a central role in shaping how these services are incorporated into the Medicaid program, helping ensure that care remains consistent with the values, practices, and priorities of the communities served.

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

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

Traditional Healing Program Overview

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

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

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

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

Parents and Spouse as Paid Caregivers

Background

As discussed in the historical background section above, Arizona's PPCG service delivery model emerged from the state's response to unprecedented workforce shortages and service delivery challenges exacerbated during the COVID-19 PHE. To minimize disruption in care for AHCCCS members requiring home and community-based services (HCBS), AHCCCS obtained federal approval in April 2020 to allow parents to receive reimbursement for providing extraordinary care to their minor children when traditional caregiving resources were unavailable, insufficient or presented an exposure risk to members with chronic health conditions or already compromised immune systems. The model proved instrumental in maintaining access to care, reducing service disruptions, and allowing families more flexibility during a period of significant uncertainty. Following several extensions, CMS approved the incorporation of the PPCG service delivery model into Arizona's 1115 Demonstration on February 16, 2024, establishing it as a permanent component of the state's long-term care service delivery system.

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

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

Post-Approval Implementation

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

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

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

- During the 2025 Arizona Legislative Session, the Legislature enacted statutory changes designed to establish additional program safeguards and strengthen oversight of the PPCG model. Among other provisions, the legislation mirrored guardrails required in the 1115 Waiver STCs including directing AHCCCS and DES to implement a standardized assessment methodology for determining when attendant care and habilitation services provided to minor members constitute extraordinary care and a 40-hour weekly limit on paid attendant care and habilitation services furnished by a parent per child. The legislation required further program integrity and cost-control measures including restrictions on reimbursement for services provided while a child is in school or another clinical setting and outside specified service hours, a six-month Arizona residency requirement for participating parents, limitations on provider agency employment arrangements, and additional reporting and electronic verification requirements.
- AHCCCS has since implemented several additional program reforms. The 40-hour weekly limitation on paid caregiver services provided by parents became effective July 1, 2025, and remains an important component of the state's efforts to balance member access with program stewardship responsibilities. The agency also developed and implemented a PPCG attestation process that clearly defines parent responsibilities and expectations within the program and requires participating caregivers to formally acknowledge those requirements. In addition, AHCCCS incorporated parent-specific caregiver indicators into its Electronic Visit Verification (EVV) system, with the associated data module becoming operational on October 1, 2025, improving transparency, monitoring, and compliance oversight.
- Beyond reforms specific to PPCG, AHCCCS has also undertaken broader policy changes affecting the authorization and evaluation of extraordinary care services. The agency worked to better define extraordinary care needs, establish appropriate service parameters while preserving flexibility for medically necessary exceptions, and strengthen assessment methodologies used to evaluate the needs of minor members receiving home and community-based services. As directed by the Legislature, AHCCCS revised policies governing the Home and Community-Based Services Needs Tool (HNT) and developed an Extraordinary Care Review (ECR) process to identify and accommodate children whose

care needs exceed standard service thresholds. These efforts were conducted in partnership with DES, clinicians, managed care organizations, and other stakeholders. This HNT and ECR process is further described in the State's new Waiver request below.

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

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

Closing

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

Reentry Demonstration

Overview

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

To qualify for services under the Reentry Demonstration, an individual must be an inmate of a public institution and be incarcerated in a correctional facility, have been determined eligible for Medicaid or CHIP if not for their

incarceration status, and have an expected release date within 90 days. Pre-release services will be provided to eligible individuals in participating jails, prisons, youth correctional facilities, and tribal correctional facilities. By focusing services during the period immediately preceding release, the demonstration is intended to establish connections to healthcare and supportive services before an individual's return to the community, helping to reduce disruptions in care and improve continuity of treatment and care coordination upon reentry.

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

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

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

Implementation Progress

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

To date, implementation activities have focused heavily on stakeholder engagement, education, and program development. These efforts have been closely coordinated with Arizona's ongoing implementation of the Consolidated Appropriations Act (CAA) juvenile justice requirements, which share many of the same objectives and operational considerations as the Reentry Demonstration. While the CAA requirements apply to a more limited population consisting primarily of justice-involved youth and certain former foster youth, provide a narrower service package focused on targeted case management and screening and diagnostic services

consistent with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements, and authorize services during a shorter 30-day pre-release period, they have provided valuable implementation experience that has informed the state's broader reentry planning efforts.

In addition to this early implementation planning, AHCCCS has also developed and submitted required CMS implementation deliverables. This has included completion of both the Reentry Demonstration Implementation Plan and Reinvestment Plan, which outlines the state's operational strategy, oversight framework, and reinvestment commitments associated with the Demonstration. These deliverables were most recently updated and resubmitted to CMS on May 29, 2026, and are currently under federal review. Key components of AHCCCS's Reentry Implementation Plan are highlighted in Figure 28 below.

Figure 28: Reentry Implementation Plan Key Features

Program Feature	Description
Facility Readiness and Onboarding	AHCCCS has proposed a phased implementation approach that will initially focus on facilities operated by the Arizona Department of Juvenile Corrections (ADJC), leveraging the agency's experience implementing the CAA juvenile justice requirements. Expansion to additional correctional facilities will occur based on demonstrated readiness and operational capacity. Prior to participation, each facility will undergo a comprehensive readiness assessment designed to evaluate operational alignment, fiscal planning, information-sharing capabilities, staffing resources, and clinical preparedness. These assessments will serve as a critical component of the onboarding process and help ensure successful implementation across participating facilities.
Eligibility and Enrollment	AHCCCS will leverage existing data-sharing agreements to facilitate the exchange of booking and release information between correctional facilities and the Medicaid agency. For facilities that do not currently have data-sharing arrangements in place, AHCCCS will establish the necessary agreements and develop additional data exchange capabilities to support timely identification of eligible individuals and seamless activation of pre-release services. In addition, AHCCCS plans to enroll correctional facilities as Community Partner-Assistor Organizations (CP-AOs), enabling facility staff to assist eligible individuals with Medicaid and CHIP applications prior to release. This approach will help ensure that individuals who are not already enrolled in coverage can establish eligibility and access Demonstration services before returning to the community.
Service Delivery	Under the Reentry Demonstration, eligible individuals will have access to certain Medicaid and CHIP services for up to 90 days prior to release from incarceration. AHCCCS intends to primarily operationalize service delivery through partnerships with community-based providers, which will allow individuals to establish relationships with providers before release and create stronger connections to post-release healthcare resources. This approach is intended to support continuity of care and reduce disruptions in treatment as individuals transition back into the community. Service delivery and care coordination activities will be jointly supported by managed care organization (MCO) Justice Liaisons and correctional facility staff to ensure individuals receive timely access to approved demonstration services and appropriate transition planning.

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

Closing

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

V. Proposed Changes to the Current Demonstration

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

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

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

anticipated benefits for members, providers, and the broader healthcare delivery system.

AHCCCS will implement each change described in this section through amendments to its managed care contracts with reasonable lead time for contractors to prepare, and will reflect any new or modified requirements, including changes to authorization timeframes, eligibility verification, H2O protocol requirements, and reporting, in actuarially sound capitation rates developed in accordance with 42 CFR 438.4. AHCCCS will also coordinate with its contractors on member and provider communications before each change takes effect.

Traditional Healing

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

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

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

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

Eliminating the CCA requirement is expected to reduce administrative burden, improve provider participation, and expand access to traditional healing services for AI/AN members. Importantly, this approach would extend the reach of the demonstration to individuals who may not meet eligibility criteria for IHS services or who

reside outside of tribal service areas, while maintaining alignment with the program's emphasis on cultural integrity, community leadership, and self-determination.

Sunset the Targeted Investments 2.0 Program

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

AHCCCS recognizes that participating primary care, behavioral health, integrated clinic, and justice clinic providers made substantial investments in staff, data systems, community partnerships, and workflows to meet TI 2.0 requirements. Consistent with STC 9, AHCCCS will submit any transition and phase-out plan CMS requires for the authorities Arizona is not requesting to continue.

H2O Technical Corrections to Service, Provider, and Eligibility Descriptions

Alignment of the H2O Program with Current Federal Priorities

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

Fiscal Stewardship and the New Budget Neutrality Standard

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

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

The program is also structured to contain its own exposure. H2O funds time-limited assistance rather than an

ongoing subsidy, and the model is built to transition members to permanent housing resources administered by HUD Continuum of Care programs, Public Housing Authorities, and Mainstream and Project-Based Voucher programs. Medicaid pays for the clinical and tenancy support services that stabilize the member, not for permanent rent. That design keeps Medicaid from supplanting other federal and non-federal housing funding, which is a consideration CMS applies directly in evaluating whether demonstration expenditures are appropriate. Arizona commits that H2O expenditures will not supplant existing state, local, or other federal funding for housing or homelessness services, and AHCCCS will describe how that funding has been maintained in its monitoring reports to CMS.

Ending Street Homelessness and Restoring Accountability

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

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

H2O is closely aligned with the Executive Order's emphasis on treatment, recovery, accountability, and self-sufficiency for individuals experiencing street homelessness who have a serious mental illness. Every H2O participant receives housing assistance together with behavioral health treatment, care coordination, and tenancy support, and the program's design objective is transition to non-Medicaid housing resources rather than continued reliance on public programs. More importantly for purposes of this demonstration, H2O is a targeted health-related intervention for a defined Medicaid population, accompanied by utilization monitoring and evaluation, and it is on that basis that Arizona requests its continuation.

Supporting Work and Self-Sufficiency

Section 71119 of the Working Families Tax Cut legislation added section 1902(xx) of the Social Security Act, which conditions eligibility for certain adults on community engagement beginning January 1, 2027. Individuals with a serious mental illness designation are excluded from that requirement by statute, but many H2O participants have household members, and some participants themselves, who will be subject to it, and stable housing is a precondition for meeting it.

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

Technical Changes to Certain Service Descriptions and Provider Requirements

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

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

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

Flexibility in Defining Chronic Physical Health Conditions for H2O Eligibility

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

Early program experience and data analysis have highlighted certain chronic physical health conditions that appear to disproportionately impact members who are both seriously mentally ill (SMI) and experiencing homelessness, including populations associated with high healthcare utilization and expenditures. By allowing for adjustments to the qualifying condition criteria based on ongoing evaluation of utilization patterns, outcomes, and actuarial data, AHCCCS would be better positioned to direct H2O services to those members with the greatest combined health and housing needs.

This flexibility would enable the demonstration to remain responsive to evolving trends and emerging evidence without altering its foundational parameters. Enrollment caps, budget neutrality assumptions, and overall

program scope would remain unchanged. Rather, the proposed approach would enhance the precision of targeting within the existing framework, supporting improved outcomes for high-need populations while strengthening the overall effectiveness of the demonstration.

Conclusion

Arizona requests continuation of the H2O expenditure authorities, with the technical changes described above, because H2O is a targeted, time-limited, and accountable intervention for a defined Medicaid population; because preliminary data are consistent with reductions in the highest-cost categories of Medicaid utilization for that population; because the program operates with a single statewide administrator, public dashboard reporting, and integration with existing federal and local housing systems that prevents duplication; and because the State has structured the request to support the actuarial certification required by section 1115(g). Arizona will continue to monitor utilization, member outcomes, transitions to permanent housing, and fiscal performance, and will work with CMS on any refinements necessary to keep the program consistent with federal requirements and fiscally sustainable.

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

Background

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

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

As part of this rulemaking, AHCCCS conducted extensive stakeholder outreach. AHCCCS held four public forums; two were focused on education and insight into rulemaking and policy efforts, and two were focused on in-depth insight into revised policies and how to engage in the policy public comment process. The public comment process for the revised policies closed on November 24, 2025, with over 4,600 public comments received. One of the major themes/areas of comment was the Extraordinary Care Review process with many stakeholders centering on the need for standardized forms, uniform guidance, policy clarification, and defining

extraordinary care when compared to parental responsibility. It was also noted that families needed appropriate time to engage ECR clinician decision makers to ensure that sufficient background information could be considered as part of the decision-making process.

Extraordinary Care Review

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

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

Timeliness Waiver Request

While AHCCCS initially intended to create the ECR process outside of existing prior authorization time limitations, guidance from AHCCCS' EQRO, and subsequent correspondence with CMS has confirmed that the ECR process may not violate the prior authorization timelines without waiver authority. While prior authorization timelines are generally critical to ensuring that members receive timely care, the ECR process is distinct and was born from member and advocacy requests that the extraordinary review consideration for direct care and habilitation hours include enough time for a thorough review of appropriate clinical records and not be a rushed process. Unlike requests for medical and acute services, direct care and habilitation services are long-term needs, and the members and advocates have emphasized the importance of accuracy of review, over expediency.

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

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

To best support members in receiving a complete and accurate clinical evaluation, AHCCCS is requesting a waiver from the federal requirements under 42 CFR 438.210(d), as incorporated in managed care contracts under section 1903(m)(2)(A) of the Act. This waiver will allow AHCCCS to extend ECR timelines beyond standard authorization requirements, providing additional time for clinicians to conduct thorough evaluations and for HCDMs to collect and review necessary documentation to support informed determinations. This authority would ensure that adequate time is dedicated to understanding member-specific considerations, needs, and care preferences in alignment with person-centered practices. Federal rules require standard authorization decisions within 7 calendar days, with an extension of up to 14 additional calendar days when the member or provider requests it or the plan justifies the need (42 CFR 438.210(d)(1)). AHCCCS is requesting authority to allow up to 28 calendar days for decisions subject to an Extraordinary Care Review. Additionally, if an extenuating circumstance is identified where additional time may be needed to the benefit of the family (e.g. the member is hospitalized, the HCDM is ill), AHCCCS is requesting authority to allow up to 14 additional calendar days when the member or health care decision-maker requests the extension.

AHCCCS also notes that the CYE 2025 External Quality Review found that the ACC and ALTCS-EPD contractors reviewed that year scored below 95 percent on the Coverage and Authorization of Services standard, and that corrective action plans are in place for CYE 2026. The Extraordinary Care Review is a defined assessment process for a small number of members with extraordinary needs, and the requested timeframe applies only to that review. It does not alter the standard and expedited authorization timeframes that apply to all other service requests, which AHCCCS continues to enforce through its compliance reviews.

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

Closing

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

Enhanced Residential Treatment

Arizona intends to submit before July 2027 an Amendment to this Waiver Proposal, which will seek authority to establish the AHCCCS SMI Enhanced Residential Treatment Pilot Program pursuant to SB 1630 (A.R.S. 36-2979). The legislation authorizes the state, contingent upon federal approval, to deliver enhanced residential treatment services to a finite number of adults determined to have SMI who meet defined clinical and financial criteria. Because the statutory authority requires significant stakeholder engagement with members, families, providers, contractors, and other critical stakeholders before implementing the legislation, AHCCCS intends to conduct that stakeholder engagement in the second half of 2026, before seeking federal authority to implement the program. No authority for the pilot is requested in this renewal, and no expenditures for it are included in the prospective analysis in Appendix C.

Modifications to Hospital Presumptive Eligibility and Accepting Self-Attestation

Background

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

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

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

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

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

Prohibition of Residency Self-Attestation

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

Federal regulations already permit the State to verify residency through electronic data sources or other reasonable procedures (42 CFR 435.956(c)(1)). The waiver AHCCCS requests is therefore limited to the case-by-case exception in 42 CFR 435.952(c)(3) as it applies to State residency, and AHCCCS requests it under section 1902(a)(4) of the Act insofar as it incorporates that regulation.

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

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

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

Elimination of Hospital Presumptive Eligibility

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

hospitals seeking qualified entity status.

Consistent with broader state and federal efforts to strengthen program integrity and improve eligibility verification processes, the Arizona Legislature directed AHCCCS to seek authority to eliminate the HPE program. The Legislature determined that eliminating this pathway would help ensure that eligibility determinations are based on complete and verified information while reducing administrative complexity associated with maintaining a program that has seen little to no utilization in Arizona.

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

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

Given the legislative directive, absence of participating hospitals and utilization, and the state's continued focus on verified eligibility determinations, AHCCCS is seeking waiver authority from section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, and to discontinue Expenditure Authority 14, as necessary to eliminate the Hospital Presumptive Eligibility program in Arizona.

Closing

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

Because the state-law directive underlying these two requests is scheduled to repeal after June 30, 2027 absent further legislative action, AHCCCS requests that these authorities take effect only while state law directs AHCCCS to implement them. If the directive lapses, AHCCCS will notify CMS and request that the authorities be withdrawn.

Previously Submitted Requests Remaining Under Separate CMS Review

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

VI. Goals and Objectives of the Proposed Demonstration Renewal

Current Demonstration Goals, Objectives & Evaluation

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

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

To evaluate the effectiveness and success of Arizona's Demonstration and to identify future opportunities for improvement, AHCCCS contracted with Health Services Advisory Group (HSAG) to conduct an independent evaluation. This evaluation was designed to meet the Special Terms and Conditions (STCs) of Arizona's current 1115 Demonstration, including testing specific hypotheses and performance measures that evaluate the following Demonstration programs: AHCCCS Complete Care (ACC), Arizona Long-Term Care System (ALTCS), Department of Child Safety Comprehensive Health Plan (DCS CHP), AHCCCS Complete Care Regional Behavioral Health Agreements (ACC-RBHA), and Waiver of Prior Quarter Coverage (PQC). The goals and objectives of each proposal within the Demonstration renewal have been shown in Figure 29 below.

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

Objectives	Proposed Hypothesis	Potential Approaches
AHCCCS Complete Care (ACC)		
The ACC Demonstration will provide quality healthcare to members, ensuring access to care for members, maintaining or improving member satisfaction with care, and continuing to operate as a cost-effective managed care delivery model.	Health plans will encourage and/or facilitate care coordination among PCPs and behavioral health practitioners.	Data will be drawn from a variety of sources including: • Member survey • State eligibility and enrollment data • Claims/encounter data • Administrative program data (PMMIS) • T-MSIS • National/regional benchmarks • Key informant interviews & focus groups
	Access to care will be maintained and enhanced as a result of the integration of behavioral and physical care.	
	Quality of care will be maintained or enhanced as a result of the integration of behavioral and physical care.	
	Member self-assessed health outcomes will be maintained or improved as a result of the integration of behavioral and physical care.	
	Member satisfaction with the health care received will be maintained or will increase as a result of the integration of behavioral and	

	physical care.	
	The ACC program will provide cost-effective care.	
Arizona Long Term Care System (ALTCS)		
The ALTCS Demonstration will provide quality healthcare to members with needs for LTSS, ensuring access to care for members, maintaining or improving member satisfaction with care, and will continue to operate as a cost-effective managed care delivery model.	ALTCS health plans will encourage and/or facilitate care coordination among PCPs and behavioral health practitioners.	Data will be drawn from a variety of sources including: • Member survey • State eligibility and enrollment data • Claims/encounter data • Administrative program data (PMMIS) • T-MSIS • National/regional benchmarks • Key informant interviews & focus groups
	Access to care will be maintained or expanded over the waiver Demonstration.	
	Quality of care will be maintained or enhanced over the waiver Demonstration.	
	Health outcomes for members enrolled in ALTCS will be maintained or improved during the Demonstration.	
	Quality of life for members will be maintained or enhanced over the waiver Demonstration.	
	ALTCS will provide cost-effective care.	
Comprehensive Health Plan (DCS CHP)		
The DCS CHP Demonstration will provide quality healthcare to eligible foster children, ensuring access to care for members, maintaining or improving member satisfaction with care, and will continue to operate as a cost-effective managed care delivery model.	DCS CHP will encourage and/or facilitate care coordination among PCPs and behavioral health practitioners.	Data will be drawn from a variety of sources including: • Member survey • State eligibility and enrollment data • Claims/encounter data • Administrative program data (PMMIS) • T-MSIS • National/regional benchmarks • Key informant interviews & focus groups
	Access to care will be maintained or increased during the Demonstration.	
	Quality of care for members enrolled in CMDP will be maintained or enhanced during the Demonstration.	
	Health outcomes for members enrolled in CMDP will be maintained or improved during the Demonstration.	
	Member satisfaction with the health care received will be maintained or will increase during the Demonstration.	
	DCS CHP will provide cost-effective care.	
Regional Behavioral Health Authorities (RBHA)		
The RBHA demonstration will	RBHAs will encourage and/or facilitate care	Data will be drawn from a

provide quality healthcare to members with behavioral health needs, ensuring access to care for members, maintaining or improving member satisfaction with care, and will continue to operate as a cost-effective managed care delivery model.	coordination among PCPs and behavioral health practitioners.	variety of sources including: • Member survey • State eligibility and enrollment data • Claims/encounter data • Administrative program data (PMMIS) • T-MSIS • National/regional benchmarks • Key informant interviews & focus groups
	Access to care for members with an SMI enrolled in a RBHA will be maintained or increased during the Demonstration.	
	Quality of care for members with an SMI enrolled in a RBHA will be maintained or enhanced during the Demonstration.	
	Health outcomes for members with an SMI enrolled in a RBHA will be maintained or improved during the Demonstration.	
	Member satisfaction in RBHA health plans will be maintained or improved over the waiver Demonstration.	
	RBHAs will provide cost-effective care for members with an SMI.	
Waiver of Prior Quarter Coverage		
The Waiver of Prior Quarter Coverage will encourage members to obtain and continuously maintain/retain health coverage.	The implementation of the proposal will not adversely affect access to care.	Data will be drawn from a variety of sources including: • Member survey • State eligibility and enrollment data • Claims/encounter data • Administrative program data (PMMIS) • T-MSIS • National/regional benchmarks
	The implementation of the proposal will not reduce member satisfaction.	
	The implementation of the proposal will not adversely affect health outcomes	
Former Foster Youth Amendment		
The AHCCCS Former Foster Youth Eligibility and Enrollment demonstration will promote continuity of care, simplify administrative burden and reduce unnecessary churn of individuals' eligibility to access Medicaid Services.	The AHCCCS Former Foster Youth - Eligibility and Enrollment demonstration will maintain or improve health outcomes for AHCCCS members.	Data will be drawn from a variety of sources including: • Member survey • State eligibility and enrollment data • Claims/encounter data • Administrative program data (PMMIS) • T-MSIS
	The AHCCCS Former Foster Youth - Eligibility and Enrollment demonstration will maintain or improve the management of chronic conditions for AHCCCS members.	
	The AHCCCS Former Foster Youth - Eligibility	

	and Enrollment demonstration will maintain or improve the management of chronic conditions for AHCCCS members.	• National/regional benchmarks • Key informant interviews & focus groups
	The AHCCCS Former Foster Youth - Eligibility and Enrollment demonstration will maintain or increase utilization of primary care and preventative health services.	
	The AHCCCS Former Foster Youth - Eligibility and Enrollment demonstration will maintain or improve member satisfaction with care.	
	The AHCCCS Former Foster Youth - Eligibility and Enrollment demonstration will promote continuity of care for its members.	
	The AHCCCS Former Foster Youth - Eligibility and Enrollment demonstration will yield cost-effective care for AHCCCS members.	
KidsCare Expansion		
The AHCCCS KidsCare Expansion demonstration will reduce the number of uninsured children and maintain or increase the number of annual dental visits, child and adolescent well-care visits, and metabolic monitoring for children and adolescents on antipsychotics.	The AHCCCS KidsCare Expansion Amendment will maintain or improve health outcomes for AHCCCS members.	Data will be drawn from a variety of sources including: • Member survey • State eligibility and enrollment data • Claims/encounter data • Administrative program data (PMMIS) • T-MSIS • National/regional benchmarks • Key informant interviews & focus groups
	The AHCCCS KidsCare Expansion Amendment will maintain or improve the management of chronic conditions for AHCCCS members.	
	The AHCCCS KidsCare Expansion Amendment will maintain or improve access to care for AHCCCS members.	
	The AHCCCS KidsCare Expansion Amendment will maintain or increase the utilization of primary care and preventative health services.	
	The AHCCCS KidsCare Expansion Amendment will maintain or improve member satisfaction with care.	
	The AHCCCS KidsCare Expansion Amendment will promote continuity of care for its members.	
	The AHCCCS KidsCare Expansion Amendment will yield cost-effective care for AHCCCS	

	members.	
Parents and Spouses as Paid Caregivers (PPCG and SPCG)		
The AHCCCS Parents and Spouses as Paid Caregivers delivery model Demonstration will increase member satisfaction, ensure delivery of medically appropriate services in the community, and promote positive health and well-being outcomes for the target population.	The AHCCCS PPCG and SPCG Demonstrations will maintain or increase the rate of children in the ALTCS program being served in the home.	Data will be drawn from a variety of sources including: • Member survey • State eligibility and enrollment data • Claims/encounter data • Administrative program data (PMMIS) • T-MSIS • National/regional benchmarks
	The AHCCCS PPCG and SPCG Demonstrations will yield improved member satisfaction with care.	
	The AHCCCS PPCG and SPCG Demonstrations will mitigate the DCW shortage by increasing timely accessibility to care providers.	
	The AHCCCS PPCG and SPCG Demonstrations will improve ongoing care stability for the target population.	
	The AHCCCS PPCG and SPCG Demonstrations yield cost-effective care for AHCCCS members.	
Supplemental Payments to IHS and Tribal 638 Facilities (Tribal Uncompensated Care)		
Ensure the viability of the IHS and 638 systems for the provision of care and maintain or improve access to care to American Indians.	Implementing uncompensated care payments to IHS and 638 facilities will allow staffing levels to be maintained or increased.	Data will be drawn from a variety of sources including: • Member survey • State eligibility and enrollment data • Claims/encounter data • Administrative program data (PMMIS) • T-MSIS • National/regional benchmarks • Key informant interviews & focus groups
	Uncompensated care payments to IHS and 638 facilities will increase capacity to provide care and services resulting in AHCCCS IHS members receiving health care services.	
Housing and Health Opportunities (H2O)		
The AHCCCS Housing and Health Opportunities (H2O) demonstration will increase housing attainment and	The AHCCCS H2O demonstration will improve health outcomes for AHCCCS members.	Data will be drawn from a variety of sources including, but not limited to: • Member surveys
	The AHCCCS H2O demonstration will improve management of behavioral health conditions	

stabilization, positive health and wellbeing outcomes for target populations, reduce the cost of care for individuals successfully housed, and support state efforts to reduce homelessness and improve ongoing housing stability.	for AHCCCS members.	• State eligibility and enrollment data • Claims/encounter data • Administrative program data (PMMIS) • T-MSIS • National/regional benchmarks • Key informant interviews & focus groups • Leasing and housing data from AHCCCS housing programs • Permanent supportive housing fidelity reporting • Data from Homeless Management Information System (HMIS) and other system coordination
	The AHCCCS H2O demonstration will improve management of chronic conditions for AHCCCS members.	
	The AHCCCS H2O demonstration will decrease avoidable hospital utilization including emergency department utilization.	
	The AHCCCS H2O demonstration will increase utilization of primary care and preventative health services.	
	The AHCCCS H2O demonstration will yield improved member satisfaction with care.	
	The AHCCCS H2O demonstration will reduce homelessness and homeless recidivism of AHCCCS members.	
	The AHCCCS H2O demonstration will improve ongoing housing stability for AHCCCS members.	
	The AHCCCS H2O demonstration will increase timely housing placement for AHCCCS members	
	The AHCCCS H2O demonstration will increase engagement and assessment of Medicaid eligible but unenrolled individuals who are experiencing chronic homelessness.	
	The AHCCCS H2O demonstration will improve discharge coordination of identified homeless members and reduce discharges to homelessness.	
	The AHCCCS H2O demonstration will yield cost-effective care for AHCCCS members.	
Tribal Dental Authority		
AHCCCS members receiving services in IHS and 638 facilities will have improved access to dental services while maintaining or	The rate of dental visits will be maintained or improved in IHS and 638 facilities for AHCCCS members.	Data will be drawn from a variety of sources including: • Member survey • State eligibility and enrollment data
	Health outcomes of members will be maintained or improved.	

improving member outcomes/experience.	Oral health disparities will be reduced for American Indian and Alaska Native members.	• Claims/encounter data • Administrative program data (PMMIS) • T-MSIS • National/regional benchmarks • Key informant interviews & focus groups
Traditional Healing		
Traditional healing and the state's proposed UIO expansion will enhance access to care for American Indian members while maintaining or improving member health and satisfaction with care.	Implementation of traditional healing services will yield improved member satisfaction. Traditional healing services will improve the health outcomes of members. Availability of traditional healing services in allopathic primary care settings will increase the utilization of primary care services.	Data will be drawn from a variety of sources including: • Member survey • State eligibility and enrollment data • Claims/encounter data • Administrative program data (PMMIS) • T-MSIS • National/regional benchmarks • Key informant interviews & focus groups
Reentry		
The Reentry Demonstration will facilitate members access to certain healthcare services and case management while incarcerated and allow them to establish relationships with community-based providers from whom they can receive services upon reentry to their communities.	The Reentry Demonstration will increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in correctional facility settings prior to release. The Reentry Demonstration will improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry. The Reentry Demonstration will improve coordination and communication between correctional systems, Medicaid and CHIP systems, managed care plans (as applicable), and community-based providers	Data will be drawn from a variety of sources including: • Member survey • State eligibility and enrollment data • Claims/encounter data • Administrative program data (PMMIS) • T-MSIS • National/regional benchmarks • Key informant interviews & focus groups

	The Reentry Demonstration will increase additional investments in health care and related services, aimed at improving the quality of care for individuals in correctional facility settings, and in the community to maximize successful reentry post-release.	
	The Reentry Demonstration will improve connections between correctional facility settings and community services upon release to address physical and behavioral health needs, and health-related social needs.	
	The Reentry Demonstration will reduce all-cause deaths in the near-term post-release.	
	The Reentry Demonstration will reduce the number of emergency department visits and inpatient hospitalizations among recently incarcerated Medicaid and CHIP individuals through increased receipt of preventive and routine physical and behavioral health care.	
	The Reentry Demonstration will provide interventions for certain behavioral health conditions, including use of stabilizing medications like long-acting injectable antipsychotics and medication for addiction treatment for SUDs where appropriate, with the goal of reducing overdose and overdose-related death in the near-term post-release.	
ECR Timeliness Waiver		
The ECR Timeliness Waiver will improve clinical appropriateness and consistency of service authorizations, reduce administrative burden, and ensure beneficiaries receive timely access to medically necessary services.	The ECR Timeliness Waiver will promote ECR exception service authorization requests in having a lower rate of overturned denials and fewer beneficiary appeals and grievances.	Data will be drawn from a variety of sources including: • Member survey • State eligibility and enrollment data • Claims/encounter data • Administrative program data (PMMIS) • T-MSIS • National/regional benchmarks • Key informant
	The ECR Timeliness Waiver will yield improved member satisfaction.	
	The ECR Timeliness Waiver will yield cost-effective care for members.	

		interviews & focus groups
Modifications to Hospital Presumptive Eligibility and Accepting Self-Attestation		
The requests to modify Hospital Presumptive Eligibility and use of self-attestation will strengthen program integrity and the Medicaid eligibility determination process.	The implementation of the proposal will not adversely affect access to care. The implementation of the proposal will not reduce member satisfaction. The implementation of the proposal will not adversely affect health outcomes.	Data will be drawn from a variety of sources including: • Member survey • State eligibility and enrollment data • Claims/encounter data • Administrative program data (PMMIS) • T-MSIS • National/regional benchmarks

VII. Requested Waiver and Expenditure Authorities

Figure 30 below identifies the waiver and expenditure authorities Arizona requests to continue, modify, discontinue, or newly establish under this renewal.

Figure 30 – Status of Existing Demonstration Authorities

Waiver #	Title	Summarized Description	Status Under Extension
Waiver Authorities			
1.	**Eligibility Based on Institutional Status** Section 1902(a)(10)(A)(ii)(V) (42 CFR 435.236)	Allows the state to exclude hospitalized individuals and others in medical institutions for more than 30 days from automatically becoming eligible for long term care services if they do not meet the level of care standard for long term care. AHCCCS would otherwise be required to provide long term care services to acute care individuals with income up to 300% of the FPL who may not be at risk of institutionalization but are in the hospital for more than 30 days.	Continue
2.	**Comparability; Amount, Duration, Scope of Services**	Permits the State to offer different/additional services based on different care arrangements Arizona Long Term Care System (ALTCS) beneficiaries and their	Continue

	Section 1902(a)(10)(B); 1902(a)(17) (42 CFR 440.240 and 440.230)	legally responsible parents and spouses via the Paid Caregivers Model. This authority also permits the State to offer coverage through MCOs that provide additional or different benefits to enrollees, than those otherwise available for other eligible individuals.	
3.	**Estate Recovery** Section 1902(a)(18) (42 CFR 433.36)	Relieves the state from creating an estate recovery program for acute care enrollees age 55 and older who receive long term care services.	Continue
4.	**Freedom of Choice** Section 1902(a)(23)(A) (42 CFR 431.51)	Permits the state to operate a statewide mandatory managed care system. AHCCCS members are able to choose from at least two primary care physicians within their health care plan. Other protections are in place to ensure quality and continuity of care through policy, contract and standards. Additionally, this authority enables AHCCCS to impose a limitation on providers on charges associated with noncovered activities.	Continue
5.	**Retroactive Eligibility** Section 1902(a)(10) and (a)(34) (as amended by section 71112 of Public Law 119-21) (42 CFR 435.915)	Permits the state to limit retroactive coverage to the month of application for AHCCCS members, except for a pregnant woman (including during the 60-day period beginning on the last day of the pregnancy), an infant under age 1, or a child under age 19.	Modify
6.	**Coverage of Certain Screening, Diagnostic, and Targeted Case Management Services for Eligible Juveniles in the 30 Days Prior to Release** Section 1902(a)(84)(D)	Permits the state to provide coverage of screening, diagnostic, and targeted case management services as required by section 1902(a)(84)(D) of the Act at a level equal to or greater than would be required under the state plan through the Reentry Demonstration.	Continue
7.	**Coverage of Certain Screening, Diagnostic, Referral, and Case Management Services for**	Permits the state to provide coverage of screening, diagnostic, referral, and targeted case management services as required by section 2102(d)(2) of the Act at a level equal to or greater than would be required	Continue

	Targeted Low-Income Children in the 30 Days Prior to Release Section 2102(d)(2)	under the state plan through the Reentry Demonstration.	
Medicaid Expenditures Related to Administrative Simplification and Delivery Systems			
1.	**Managed Care Freedom of Choice**	Permits the state to claim as medical assistance payments to MCOs who do not meet requirements of 1903(m)(2)(A) and 1932(a) to limit the choice of managed care plans for individuals enrolled in ACC, ACC-RBHA, DCS CHP, and ALTCS. This authority also permits the state to restrict beneficiary disenrollment based on 42 CFR 438.56(d)(2)(v) for causes.	Continue
2.	**Managed Care Re-Enrollment**	Allows the state to automatically re-enroll a member into the same health plan as was previously enrolled if the member lost eligibility within 90 days. AHCCCS would otherwise only have two months to re-enroll a member into the same health plan pursuant to section 1903(m)(2)(H) of the Act and 42 CFR 438.56(g).	Continue
3.	**Managed Care Tribal Providers**	Permits AHCCCS to contract 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 their 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 are covered through direct payments by the State to these providers.	Continue
4.	**Direct Payments to Critical Access Hospitals**	Permits direct payments to Critical Access Hospitals (CAH) for services provided to AHCCCS enrollees in the Acute Care and ALTCS managed care programs that are not consistent with the requirements of 42 CFR 438.60.	Continue

5.	**Fee-For-Service Upper Payment Limit**	Permits AHCCCS to claim federal financial participation for items and services provided to AHCCCS fee-for service members that exceed the amounts allowable under Section 1902(a)(30)(A) of the Act and the upper payment limitation and actual cost requirements of 42 CFR 447.250 through 447.280 (regarding payments for inpatient hospital and long-term care facility services), 447.300 through 447.321 (regarding payment methods for other institutional and non-institutional services) and 447.512 through 447.518(b) (regarding payment for drugs).	Continue
6.	**HCBS Alternative Residential Settings**	Permits the State to claim as medical assistance expenditures for HCBS through ALTCS for those over 18 who reside in Alternative Residential Settings classified as residential Behavioral Health facilities.	Continue
Medicaid Expenditures Related to Expansion of Existing Eligibility Groups based on Eligibility Simplification			
7a.	**ALTCS Income Disregard**	Permits AHCCCS to claim federal financial participation for medical assistance furnished to ALTCS enrollees who are eligible only as a result of the disregard from eligibility of income currently excluded under section 1612(b) of the Act, and medical assistance that would not be allowable for some of those enrollees but for the disregard of such income from post-eligibility calculations.	Continue
7b.	**300% of Federal Benefit Rate**	Permits AHCCCS to claim federal financial participation for medical assistance furnished to ALTCS enrollees who are financially eligible with income equal to or less than 300 percent of the Federal Benefit Rate and who are eligible for ALTCS based on the functional, medical, nursing, and social needs of the individual.	Continue
7c.	**Children/ Spouses in Separation**	Permits AHCCCS to claim federal financial participation for medical assistance furnished to some dependent children or spouses who qualify for ALTCS based on a disregard of income and resources of legally responsible relatives or spouses during the month of separation from those relatives or spouses.	Continue
7d.	**QMB, SLMB, QI-1, SSI MAO, ISM income**	Permits AHCCCS to claim federal financial participation for medical assistance furnished to individuals who are	Continue

	disregard	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).	
7e.	**SSI-MAO**	Permits AHCCCS to claim federal financial participation for medical assistance furnished to individuals who are eligible based only on an alternate budget calculation for ALTCS and SSI-MAO income eligibility determinations when spousal impoverishment requirements of Section 1924 of the Act do not apply or when the applicant/recipient is living with a minor dependent child.	Continue
7f.	**Disregard of Interest – Eligibility Groups**	Permits AHCCCS to claim federal financial participation for medical assistance furnished to individuals who are eligible only based on the disregard of interest and dividend from resources, and are in the following eligibility groups: i. The Pickle Amendment Group under 42 CFR 435.135; ii. The Disabled Adult Child under Section 1634(c) of the Act; iii. Disabled Children under Section 1902(a)(10)(A)(i)(II) of the Act; and iv. The Disabled Widow/Widower group under Section 1634(d) of the Act.	Continue
7g.	**Disregard of Interest – Post Eligibility Calculations**	Permits AHCCCS to claim federal financial participation for medical assistance furnished to ALTCS enrollees under the eligibility group described in Section 1902(a)(10)(A)(ii)(V) of the Act that exceeds the amount that would be allowable except for a disregard of interest and dividend from the post eligibility calculations.	Continue
7h.	**Disregard of Excess Resources**	Permits AHCCCS to claim federal financial participation for medical assistance provided to individuals who would be eligible but for excess resources under the "Pickle Amendment," Section 503 of Public Law 94-566; Section 1634(c) of the Act (disabled adult children); or Section 1634(b) of the Act (disabled widows and widowers).	Continue
7i.	**Disregard of Quarterly**	Permits AHCCCS to claim federal financial participation	Continue

	Income Totaling Less than $20	for medical assistance that would not be allowable but for the disregard of quarterly income totaling less than $20 from the post-eligibility determination.	
8.	**SSI Eligibility**	Allows AHCCCS to extend eligibility past the timeframes specific in 42 CFR §435.1003 for demonstration participants who lose SSI eligibility for a period of up to 2 months from the SSI termination effective date.	Continue
9.	**Medicare Part B Premiums**	Permits AHCCCS to pay for Medicare Part B premiums on behalf of individuals enrolled in ALTCS with income up to 300 percent of the FBR who are also eligible for Medicare, but do not qualify as a QMB, SLMB or QI; are eligible for Medicaid under a mandatory or optional Title XIX coverage group for the aged, blind, or disabled (SSI-MAO); are eligible for continued coverage under 42 CFR 435.1003; or are in the guaranteed enrollment period described in 42 CFR 435.212 and the State was paying their Part B premium before eligibility terminated.	Continue
10.	**ALTCS PAS**	Allows AHCCCS to extend ALTCS eligibility to individuals under the age of 65 who meet the applicable financial criteria but are not disabled, but who are found to be at risk of needing nursing facility services based on medical illness or intellectual disability on the preadmission screening instrument.	Continue
11.	**Home and Community Based Services**	Permits AHCCCS to claim federal financial participation for expenditures associated with the provision of HCBS to individuals enrolled in ALTCS with income levels up to 300 percent of the SSI income level, as well as individuals enrolled in the ALTCS Transitional program.	Continue
Other Medicaid Expenditure Authorities Related to Arizona's Demonstration			
12.	**HCBS Parents and Spouses as Paid Caregivers**	Permits AHCCCS to claim federal financial participation for expenditures associated with the provision of personal care services provided by spouses of eligible ALTCS beneficiaries, and personal care and habilitation services provided by legally responsible parents for eligible minor ALTCS beneficiaries, that are inconsistent with the requirements of 42 CFR 440.167.	Continue

13.	**ALTCS Adult Dental Benefit**	Allows expenditures to provide certain dental services up to a cost of $1,000 per person annually to individuals age 21 or older enrolled in the Arizona Long Term Care System, excluding AI/AN beneficiaries addressed in expenditure 15 below.	Continue
14.	**Hospital Presumptive Eligibility**	Permits AHCCCS to claim federal financial participation for all state plan and demonstration covered services for pregnant women during their hospital presumptive eligibility period. AHCCCS is seeking to discontinue this authority.	Discontinue
15.	**Tribal Dental and Tribal Uncompensated Care**	Permits AHCCCS to claim federal financial participation for medically necessary diagnostic, therapeutic, and preventative dental services provided to AI/AN members by IHS and tribal 638 facilities. Also permits payments to IHS and tribal 638 facilities for any Medicaid coverable services that were eliminated from, reduced, or limited in the Arizona Medicaid State Plan on or after September 2010 provided by such facilities.	Continue
16.	**Targeted Investment (TI) 2.0 Program**	Permits AHCCCS to claim federal financial participation for expenditures under contracts with managed care entities that pay incentive payments to providers that meet targets specified in the contract as described in the Demonstrations STCs. AHCCCS is seeking to discontinue this authority.	Discontinue
17.	**Designated State Health Programs (DSHP)**	Permits AHCCCS to claim federal financial participation for expenditures for designated programs which are otherwise state-funded, and not otherwise eligible for Medicaid payment. AHCCCS is seeking to discontinue this authority in alignment with the April 10, 2025, CMS State Medicaid Director Letter.	Discontinue
18.	**Health-Related Social Needs (HRSN) Services**	Permits AHCCCS to claim federal financial participation for expenditures related to H2O services not otherwise	Continue

		eligible for Medicaid payments.	
19.	**HRSN Infrastructure**	Permits AHCCCS to claim federal financial participation for expenditures related to H2O administrative costs and infrastructure not otherwise eligible for Medicaid payments.	Continue
20.	**Traditional Health Care Practices (THCP)**	Permits AHCCCS to claim federal financial participation for expenditures for THCP received through IHS or Tribal 638 facilities. AHCCCS is seeking to modify this authority to also authorize expenditures for THCP delivered by UIOs without the use of a care coordination agreement. Services furnished directly by Urban Indian Organizations, rather than through IHS or tribal facilities, are matched at the State's regular federal medical assistance percentage.	Modify
21.	**Pre-Release Services**	Permits AHCCCS to claim federal financial participation for expenditures for pre-release services provided to qualifying Medicaid individuals for up to 90 days immediately prior to the expected date of release from a correctional facility that is participating in the Reentry Demonstration.	Continue
22.	**Pre-Release Administrative Cost**	Permits AHCCCS to claim federal financial participation for capped expenditures for payments for allowable administrative costs, supports, transitional non-service expenditures, infrastructure and interventions, which may not be recognized as medical assistance under section 1905(a) and may not otherwise qualify for federal matching funds under section 1903.	Continue
23.	**Non-Medical Transportation**	Permits AHCCCS to claim federal financial participation for expenditures for non-medical transportation not otherwise covered under title XIX of the Act for qualified individuals.	Continue
24.	**Out of State Former Foster Care Youth**	Permits AHCCCS to claim federal financial participation for expenditures to extend eligibility for Medicaid state plan benefits to former foster care youth (FFCY) who are under age 26, who turned 18 on or before December 31, 2022, who were in foster care under the	Continue

		responsibility of another state or a tribe in such other state on the date of attaining 18 years of age (or such higher age as the state has elected for termination of Federal foster care assistance under title IV-E of the Act), were enrolled in Medicaid on the date of aging out of foster care, and are now applying for Medicaid in Arizona.	
Medicaid Requirements Not Applicable to These Demonstration Expenditures			
25.	**Comparability; Amount, Duration, Scope of Services** Section 1902(a)(10)(B); Section 1902(a)(17)	Permits the state to offer the applicable benefits package to an individual who meets the qualifying eligibility criteria for the H2O program HRSN services, including during a phase in process.	Continue
26.	**Comparability; Amount, Duration, Scope of Services; Freedom of Choice** Section 1902(a)(10)(B); Section 1902(a)(17); Section 1902(a)(23)	Permits the state to offer the coverage described in Expenditure Authority 15 (Tribal Dental and Tribal Uncompensated Care) only to American Indian/Alaska Native (AI/AN) beneficiaries and only if the covered services are provided by participating IHS or Tribal 638 facilities.	Continue
27.	**Comparability; Freedom of Choice** Section 1902(a)(10)(B); Section 1902(a)(23)	Permits the state to offer the coverage described in Expenditure Authority 20 (Traditional Health Care Practices) only if the covered traditional health care practices are received through Indian Health Service facilities or facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act. AHCCCS is seeking to modify this authority to include traditional health care practices delivered by Urban Indian Organizations without a care coordination agreement.	Modify
28.	**Statewideness** Section 1902(a)(1)	Permits the state to provide pre-release services, as authorized under this demonstration, to qualifying individuals on a geographically limited basis, in accordance with the Reentry Demonstration Implementation Plan.	Continue
29.	**Amount, Duration, and Scope of Services and Comparability**	Permits the state to provide only a limited set of pre-release services to qualifying individuals that is different than the services available to all other	Continue

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

Figure 31 below summarizes the authorities that AHCCCS is seeking under this waiver renewal proposal.

The waivers listed in Figures 30 and 31 are requested under section 1115(a)(1) of the Social Security Act, which permits the Secretary to waive requirements of section 1902 of the Act. The expenditure authorities are requested under section 1115(a)(2), and the CHIP authorities under section 1115 as applied to title XXI by section 2107(e)(2)(A).

Figure 31 – Newly Requested Waiver Authorities

Proposed Demonstration	Waiver Authority Requested	Summarized Description
Long Term Services and Supports (LTSS) Extraordinary Care Review Timeliness Waiver	Section 1115(a)(2) expenditure authority for managed care contracts that do not meet section 1903(m)(2)(A) of the Act insofar as it incorporates 42 CFR	AHCCCS is seeking Section 1115 waiver authority to waive existing service authorization timeframe requirements to allow for an additional ECR review. This authority would provide additional time for clinicians to conduct thorough evaluations and for HCDMs to collect and review necessary documentation to support informed determinations. Federal rules permit a standard authorization decision to take up to 7 calendar days, extendable by up to 14 additional calendar days (42 CFR 438.210(d)(1)(ii)).

	438.210(d)	AHCCCS requests authority to allow up to 28 calendar days for decisions subject to an Extraordinary Care Review, with the member's existing authorized services continuing during the review.
Elimination of Residency Self-Attestation	Section 1902(a)(4) of the Act, insofar as it incorporates 42 CFR 435.952(c)(3), solely with respect to verification of State residency	Pursuant to HB 4160 (Laws 2026, Chapter 132), AHCCCS seeks Section 1115 waiver authority to no longer accept residency self-attestation and instead require independent verification of Arizona residency before Medicaid coverage is approved. The change would strengthen program integrity by ensuring accurate eligibility determinations and reducing potential duplicate enrollment across states while preserving existing eligibility protections. Because 42 CFR 435.956(c)(1) already permits the State to verify residency, this request is limited to the case-by-case special-circumstances exception in 42 CFR 435.952(c)(3).
Elimination of Hospital Presumptive Eligibility (HPE)	Section 1902(a)(47)(B) of the Act (42 CFR 435.1110)	Pursuant to HB 4160 (Laws 2026, Chapter 132), AHCCCS is seeking Section 1115 waiver authority to eliminate Arizona's Hospital Presumptive Eligibility (HPE) program. This is intended to strengthen program integrity by ensuring eligibility determinations are based on complete and verified information while reducing the administrative burden associated with maintaining a minimally utilized program.
H2O Technical Corrections and Chronic Condition Flexibility	No new waiver or expenditure authority. Continues Expenditure Authorities 18 and 19 and Not Applicable item 25. Requires revision of the H2O Protocol under STC 37 and Attachment E, and STC language permitting AHCCCS to update the list of qualifying chronic physical health conditions through the protocol without a demonstration amendment.	AHCCCS requests approval of the technical corrections to H2O service descriptions and provider requirements described in Section V, and of STC language allowing the chronic physical health conditions used in H2O eligibility to be refined through the approved protocol process. These changes do not add new services or populations.
Parents as Paid Caregivers Provider Residency Requirement	No new waiver or expenditure authority. Requires modification of the Special Terms and Conditions describing the Parents	AHCCCS requests approval to require that a parent be a resident of Arizona for at least six months before qualifying as a paid caregiver under the PPCG program, as required by Laws 2025, Chapter 93 subject to CMS approval.

	as Paid Caregivers program (Expenditure Authority 12) to add a provider qualification.	

VIII. Budget Neutrality

Arizona's Demonstration is required to be budget-neutral, meaning that federal spending under the Demonstration cannot exceed what it would have been in absence of the waivers and expenditure authorities. Appendix C presents Arizona's budget neutrality assessment under the methodology in the current Special Terms and Conditions, including historical expenditures for the current demonstration period and projected expenditures for the renewal period (October 1, 2027, through September 30, 2032). Beginning January 1, 2027, section 1115(g) of the Social Security Act, added by section 71118 of the Working Families Tax Cut legislation, requires the Chief Actuary of CMS to certify budget neutrality before a renewal may be approved. State Medicaid Director Letter #26-003 describes the analyses CMS intends to use for that certification, including a classification of each demonstration authority as a Medicaid Authorizable Populations and Services activity or a section 1115-only activity and financial impact analyses of the section 1115-only activities. Because CMS will act on this request after January 1, 2027, AHCCCS will provide those analyses as CMS issues further guidance and requests additional information under 42 CFR 431.412, and requests early technical assistance from CMS to prepare them.

IX. Public Notice Process

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

On September 30, 2026, following a public comment period held from July 23 through September 6, 2026, AHCCCS submitted its renewal application to the Centers for Medicare & Medicaid Services (CMS). In October 2026, CMS notified AHCCCS that the renewal application did not meet two federal completeness requirements under 42 C.F.R. 431.408. Specifically, the budget neutrality materials made available for public comment needed to include actual expenditure data for the current demonstration period, and at least one of the two required public forums needed to be held in-person or in a hybrid format. On October 15, 2026, AHCCCS withdrew its initial application and is now conducting an additional 30-day public comment period that includes two hybrid public forums and an updated budget neutrality workbook reflecting historical actual expenditures. The policies and programs proposed in the renewal have not changed. AHCCCS anticipates resubmitting its renewal application to CMS in December 2026, following completion of the additional public comment period. Comments submitted during the initial public comment period remain part of the official record.

Public Website:

The Demonstration renewal request was posted on the AHCCCS website for public comment on November 12, 2026, at: https://www.azahcccs.gov/Resources/Federal/waiverrenewalrequest.html.

The web page includes a summary of Arizona's Demonstration renewal request, the schedule (dates and times) of public forums across the state, this draft Demonstration renewal proposal, and budget neutrality worksheets. In addition to the website posting, AHCCCS will use social media, newsletters, and electronic mail to notify interested parties about Arizona's Demonstration renewal proposal.

Publication of Public Notice in Arizona Newspapers:

To satisfy the public notice requirements set forth in 42 CFR § 431.408(a)(2), AHCCCS will publish an abbreviated notice of Arizona's demonstration renewal request in newspapers serving Arizona cities with populations of at least 100,000 residents. These notices will be published during the week of November 9, 2026, to provide stakeholders and the public with information regarding the proposed renewal and opportunities for public comment.

Specifically, the abbreviated notice will be published in the following newspapers and media outlets. Cities with populations of at least 100,000 residents have specifically been identified.

Figure 32 – Publication of Public Notice in Arizona Newspapers

Newspaper	Circulating Locations
Arizona Business Gazette – Republic Edition	Maricopa County (Phoenix Metropolitan Area) – Phoenix, Mesa, Chandler, Glendale, Scottsdale, Peoria, Tempe, Surprise, Goodyear, Buckeye, and Avondale.
Arizona Daily Star	Pima County - Tucson
Yuma Daily Sun	Yuma County - Yuma
Daily Territorial	Pinal County – San Tan Valley

Stakeholder Meetings:

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

In addition to these forums, the public will have the opportunity to submit written feedback on AHCCCS' Waiver Renewal Proposal by email at waiverpublicinput@azahcccs.gov or by mail to AHCCCS, c/o Division of Public Policy and Strategic Planning; 150 N. 18th Ave., Phoenix, AZ 85007. Details regarding the second set of public forum meetings can be found in figure 33 below.

To ensure consideration of comments, AHCCCS is asking for all public comments to be submitted by Monday, December 14, 2026.

Figure 33 – Public Forums for Secondary Public Comment Period

Public Forum Meeting	Meeting Date & Time	Meeting Web Link & Call-in Information
AHCCCS Waiver Renewal Public Forum #3 (Hybrid)	**Date:** November 13, 2026 **Time:** 11:00 a.m. – 12:30 p.m. AZ Time	**In-Person Location**: Joel D Valdez Main Library - Tortilita Room, Third Floor 101 N. Stone Ave. Tucson, AZ 85701 **Zoom Registration**: https://ahcccs.zoom.us/webinar/register/WN_G_eJHKzhTNuEKf6ki8njUg#/registration Or Join by phone (US): +1.719.359.4580 | +1.253.205.0468 | +1.253.215.8782 | +1.346.248.7799 | +1.408.638.0968 | +1.669.444.9171 | +1.669.900.6833 | +1.564.217.2000 | +1.646.876.9923 | +1.646.931.3860 | +1.689.278.1000 | +1.301.715.8592 | +1.305.224.1968 | +1.309.205.3325 |+1.312.626.6799 | +1.360.209.5623 | +1.386.347.5053 | +1 507.473.4847 Webinar ID: 894 8907 2534 Passcode: 61662696
AHCCCS Waiver Renewal Public Forum #4 (Hybrid)	**Date:** November 18, 2026 **Time:** 9:00 a.m. – 10:30 a.m. AZ Time	In-Person Location: AHCCCS Building – Grand Canyon Conference Room, Second Floor 150 N 18th Ave, Phoenix, AZ 85007 Zoom Registration: https://ahcccs.zoom.us/webinar/register/WN_VBR9W_5ZTYa0gszpCwW5Nw#/registration Or Join by phone (US): +1.719.359.4580 | +1.253.205.0468 | +1.253.215.8782 | +1.346.248.7799 | +1.408.638.0968 | +1.669.444.9171 | +1.669.900.6833 | +1.646.931.3860 | +1.689.278.1000 | +1.301.715.8592 | +1.305.224.1968 | +1.309.205.3325 | +1.312.626.6799 | +1.360.209.5623 | +1.386.347.5053 | +1.507.473.4847 | +1.564.217.2000 | +1.646.876.9923

		Webinar ID: 829 5260 4022 Passcode: 20666961

AHCCCS intends to notify Tribal leaders via letter on November 12, 2026, of the additional public comment period. The issues raised during the initial public comment period's Tribal Consultation and AHCCCS' responses are summarized in the Initial Public Notice Summary below.

Additionally, during the current demonstration period, AHCCCS held the annual post-award public forums required by 42 CFR 431.420(c) through the states' existing SMAC, BAC, and OIFA Advisory Committee, and other regularly standing meetings. Meeting dates, agendas, and slides for the SMAC and BAC meetings can be found on each of their respective webpages. AHCCCS has summarized each forum, and the comments received in the corresponding quarterly and annual reports to CMS. In preparation for this renewal, AHCCCS also held waiver listening sessions in June 2026, before the draft renewal proposal was released for public comment.

X. Initial Public Notice Summary

As part of Arizona's initial Demonstration renewal public comment period which took place from July 23, 2026, to September 6, 2026, AHCCCS acknowledged, reviewed, and considered all comments received through the public input process. Overall, AHCCCS directly engaged more than 472 stakeholders across the state and received 118 written comments and 82 verbal comments from stakeholders, including but not limited to, members, providers, health plans, public health organizations, advocates, healthcare associations, and advocacy groups. Below is a summary of the key themes that emerged from the initial public comment process along with an AHCCCS response to each. However, it is important to note that this summary does not encapsulate all comments and perspectives heard throughout the input process. AHCCCS accepted and considered five written comments received after the September 6, 2026, close of the comment period, and honored the requests of two commenters that their identifying information be withheld from public posting.

Recommendations AHCCCS is not Able to Include in This Renewal

Many commenters recommended additions or changes that AHCCCS has not incorporated into this application. In most cases the decision is not a judgment about the merit of the recommendation. It reflects one or more of four limits on what AHCCCS may request or implement through this renewal, and the responses that follow identify which limit applies.

First, some recommendations would require AHCCCS to do something federal law does not permit, or would require federal authority CMS does not grant. Federal Medicaid funding is generally not available for room and board outside of institutional settings (42 U.S.C. § 1396n(c)(1); 42 C.F.R. § 441.310(a)(2)), which limits the extent to which rental assistance or recovery housing can be financed as a Medicaid service. Section 1905(a) of the Social Security Act excludes federal matching funds for services to individuals ages 21 through 64 in institutions for mental diseases, except under the conditions CMS has established for demonstrations serving individuals with substance use disorders or serious mental illness. Services furnished directly by Urban Indian Organizations are matched at the State's regular federal medical assistance percentage rather than the 100

percent rate available for services received through Indian Health Service and Tribal facilities (42 U.S.C. § 1396d(b)). Preventive services furnished under the State Plan, including services of community health workers, must be recommended by a physician or other licensed practitioner (42 C.F.R. § 440.130(c)). And the community engagement and six-month redetermination requirements enacted in Public Law 119-21 are federal statutory requirements that AHCCCS must implement as Congress enacted them.

Second, some recommendations are permitted by federal law but would require AHCCCS to make an election that state law has not authorized. A.R.S. § 36-3302, enacted by Laws 2025, Chapter 93 (House Bill 2945), prohibits AHCCCS from submitting a new amendment, or including a new provision in a waiver extension, that expands eligibility for Title XIX or Title XXI coverage to populations not authorized by Title 36, Chapter 29 as of January 1, 2025, adds new categories of covered services or benefits not so authorized, or would increase annual utilization of the affected services by more than ten percent, unless the Legislature has authorized the change by statute. Recommendations to add Food as Medicine services, a distinct recovery housing benefit, or prospective payment for community health worker services fall within that requirement, and recommendations to broaden H2O or other program eligibility may as well, depending on their effect on utilization. Even where a change is not subject to that requirement, AHCCCS must monitor utilization of the affected services for three years and must seek legislative authorization or termination of the change if utilization grows by more than ten percent (A.R.S. § 36-3302(C) and (D)).

Third, beginning January 1, 2027, section 1115(g) of the Social Security Act permits CMS to approve this renewal only if the Chief Actuary of CMS certifies that the demonstration is not expected to increase federal Medicaid expenditures. A recommendation that would add expenditures without a demonstrable offset would make that certification more difficult and could place approval of the entire demonstration at risk.

Fourth, some recommendations concern matters governed by the State Plan, managed care contracts, provider rates, or administrative rules rather than by the demonstration, including provider reimbursement levels, managed care plan performance, eligibility application processes, and the delivery system for crisis services.

Housing and Health Opportunities (H2O)

Public comments regarding the H2O initiative were overwhelmingly supportive and represented a broad range of stakeholders, including members, providers, community-based organizations, healthcare associations, and health plans. Commenters generally expressed strong support for continuation of the initiative and frequently encouraged AHCCCS to pursue opportunities to expand the program beyond its current target population.

Many commenters specifically recommended expanding eligibility to additional populations, including individuals with general mental health and substance use disorders as well as members enrolled in the Elderly and Physically Disabled (EPD) program. Commenters also encouraged AHCCCS to evaluate whether additional chronic conditions should qualify for participation, including conditions such as chronic obstructive pulmonary disease (COPD), arthritis, anemia, and other diagnoses that may demonstrate similar or greater health and cost burdens as compared to currently eligible conditions.

Several commenters additionally noted that preliminary outcomes observed within the current target population suggest the model may have broader applicability if expanded to additional populations. Commenters cited the preliminary reductions in emergency department and inpatient utilization among H2O

members and the transition of members to long-term housing resources, and several noted the potential for reduced overall healthcare and system costs.

Commenters additionally expressed support for AHCCCS's efforts to publicly share program data and outcomes and encouraged the agency to continue investing in data-sharing capabilities, infrastructure, and provider network supports necessary to strengthen implementation and long-term sustainability of the initiative.

Other commenters recommended changes to how H2O operates. A supportive housing organization recommended opening the H2O provider network to homelessness service, Tribal, and culturally specific organizations that have not previously participated in Medicaid, with capacity-building support, and recommended a strategy to address differences in access between urban and rural areas. A provider association described H2O as relatively new and evolving and asked AHCCCS to work with providers on participation and administrative requirements. A health plan association stated that further discussion of funding will be needed for the program to continue. A mental health advocacy organization asked AHCCCS to confirm that removing references to SOAR, the Housing First model, and harm reduction from the H2O protocol will not result in more restrictive eligibility or new treatment prerequisites. A professional association asked that pregnant and postpartum individuals be explicitly included, and a recovery housing organization asked AHCCCS to establish recovery housing as a distinct covered benefit.

AHCCCS Response: AHCCCS appreciates the overwhelmingly positive feedback received regarding the H2O initiative and the early successes stakeholders have observed through implementation of the program. AHCCCS also appreciates the thoughtful recommendations to expand H2O eligibility to additional populations and chronic health conditions, as well as stakeholder recognition of the important role housing-related services can play in improving health outcomes, housing stability, employment, community integration, and overall well-being.

AHCCCS acknowledges stakeholder interest in expanding the program's reach; however, as the demonstration continues to mature, the agency believes it is important to maintain the program's existing structure and eligibility framework to allow sufficient time for longitudinal data collection, outcome measurement, and continuous quality improvement activities. This approach will help ensure that H2O can demonstrate its effectiveness in improving member outcomes and reducing Medicaid expenditures through robust evaluation and validated performance measurement over time.

AHCCCS looks forward to reviewing the Waiver Summative Evaluation Report following the conclusion of the current demonstration period, which will provide a more comprehensive assessment of program effectiveness using mature post-implementation data that have undergone full validation in accordance with CMS evaluation requirements. Findings from these evaluations will help inform future program considerations and potential opportunities for refinement.

While AHCCCS is not proposing broad eligibility expansions at this time, the agency is seeking additional flexibility through this waiver renewal to refine the chronic physical health conditions associated with H2O eligibility criteria. This proposed flexibility is intended to enhance targeting precision within the existing framework and ensure services are directed toward members with the greatest combined health and housing needs. AHCCCS believes this approach will support improved outcomes for high-need populations while further strengthening the overall effectiveness of the demonstration.

AHCCCS confirms that removing references to SOAR, the Housing First model, and harm reduction from the H2O protocol is a change in terminology only. It does not alter H2O eligibility criteria, does not add a treatment or sobriety prerequisite to receiving H2O services, and does not change the clinical and tenancy support functions of the program. Pregnant and postpartum members who meet H2O eligibility criteria are eligible for H2O services. AHCCCS will continue to work with the H2O Housing Program Administrator, providers, and communities on network participation and rural access, including participation by Tribal and culturally specific organizations that meet provider requirements. AHCCCS is not proposing a distinct recovery housing benefit, because federal Medicaid funding is generally not available for room and board outside of institutional settings and a new category of covered services would require legislative authorization under A.R.S. § 36-3302. AHCCCS also recognizes that the housing-related components of H2O will be reviewed as section 1115-only activities under the budget neutrality methodology that applies to approvals on or after January 1, 2027, and that the State's share of their cost is subject to legislative appropriation, with any change implemented through the phase-out process in the Special Terms and Conditions and corresponding adjustments to capitation rates.

At this time, AHCCCS is not making any additional changes to the H2O proposal as a result of the public comments received.

Arizona Long Term Care Services (ALTCS)

Public comments consistently highlighted the importance of the ALTCS program and its delivery of HCBS, with many commenters describing these services as critical to maintaining quality of life, continuity of care, and independence for eligible members. Commenters emphasized that ALTCS enables many individuals to receive services in the least restrictive setting possible, allowing members to remain safely in their homes and communities while also helping families avoid housing instability, workforce disruptions, and other significant hardships associated with institutional care.

While commenters strongly supported continuation of the ALTCS program, many also identified workforce shortages as a significant challenge. Numerous comments emphasized ongoing difficulties accessing in-home caregivers, direct care workers (DCWs), and other long-term services and supports providers, and encouraged continued efforts to strengthen and stabilize the HCBS workforce.

Commenters also provided recommendations for future program improvements. Some encouraged AHCCCS to explore expanded use of assistive technologies, remote supports, and other innovative service delivery approaches to increase independence and improve access to care for individuals with disabilities. Other commenters recommended enhancements to the existing home-delivered meals benefit, including consideration of medically tailored nutrition supports designed to better address the clinical and nutritional needs of members.

Several commenters expressed concerns regarding the complexity of the ALTCS application and eligibility determination process. These commenters described the process as cumbersome, citing documentation requirements and challenges associated with in-person interviews, and encouraged AHCCCS to evaluate opportunities to streamline eligibility and enrollment processes while maintaining program integrity.

In addition, at least one commenter requested that AHCCCS explore additional residential service options for Division of Developmental Disabilities (DDD) members receiving HCBS services.

AHCCCS Response: AHCCCS appreciates the comments received regarding the Arizona Long Term Care System (ALTCS) program and the many personal experiences shared by members, families, caregivers, providers, and advocates highlighting the critical role ALTCS plays in supporting Arizonans with long-term care needs. AHCCCS recognizes the importance of home and community-based services (HCBS) in promoting independence, preserving quality of life, and allowing eligible members to receive services in the least restrictive setting appropriate to their needs.

AHCCCS also acknowledges stakeholder concerns regarding direct care workforce shortages and the challenges many members face in accessing caregivers and other HCBS providers. Strengthening Arizona's direct care workforce remains a key priority for the agency. AHCCCS has supported innovative service delivery models, including Parents as Paid Caregivers and Spouses as Paid Caregivers, to help address workforce shortages and expand access to needed services. The agency recognizes that workforce challenges are often particularly acute in rural communities and looks forward to the implementation of the Rural Health Transformation Program (RHTP), which includes a dedicated strategic goal focused on building the rural health workforce. Through initiatives such as the Rural Health Workforce Training and Development Program, RHTP will support recruitment and retention of healthcare professionals through financial incentives, workforce development efforts, expanded education and training opportunities, residency programs, and career pathways beginning in K-12 education.

AHCCCS appreciates stakeholder recommendations regarding the use of assistive technologies, remote supports, and other innovative approaches to care delivery. The agency continues to evaluate opportunities to incorporate these technologies in ways that appropriately supplement and support existing services while ensuring they do not supplant necessary direct care and member-centered supports. AHCCCS will continue assessing the role these innovations may play in improving independence, access to care, and long-term program sustainability.

AHCCCS also recognizes concerns raised regarding the ALTCS application and eligibility determination process and remains committed to identifying opportunities for administrative improvements where feasible. However, eligibility and enrollment processes are generally governed through existing Medicaid authorities, operational policies, and federal requirements rather than the Section 1115 demonstration itself. As such, these concerns will continue to be evaluated through existing AHCCCS administrative processes and policy review efforts.

In addition, AHCCCS appreciates comments regarding residential setting options available to members receiving HCBS. AHCCCS is not proposing any change in this renewal to the settings in which members receiving services through the Division of Developmental Disabilities (DDD) may receive HCBS. Any future change to the Alternative HCBS Settings available to DDD members would be submitted to CMS as a demonstration amendment with its own public notice and comment period.

AHCCCS agrees that the value of home and community-based services depends on whether authorized services are delivered. AHCCCS will work with its independent evaluator to consider measures of authorized and delivered services, unfilled hours, and time to service initiation in the evaluation design for the renewal period, and will continue to monitor network adequacy for institutional and specialized placements through its managed care oversight. Concerns about care in a specific facility are addressed through AHCCCS quality of care processes and through state licensing and adult protective services authorities, and AHCCCS encourages anyone with such a concern to report it through those channels.

AHCCCS is not proposing additional changes to the ALTCS program as a result of public comments received through this waiver renewal process. The agency will continue evaluating opportunities related to remote supports and other service delivery innovations as implementation and stakeholder engagement efforts continue.

Parents and Spouses as Paid Caregivers (PPCG and SPCG)

Public comments reflected significant support for both the Parents as Paid Caregivers (PPCG) and Spouses as Paid Caregivers (SPCG) service models. Many commenters shared personal experiences describing how the programs have helped address longstanding caregiver shortages and enabled families to meet caregiving needs that had previously gone unmet.

Several commenters stated that caregiver supports available through PPCG and SPCG provided access to services that had been difficult or impossible to obtain through private insurance coverage or traditional service delivery arrangements. Commenters frequently described these programs as essential tools for maintaining family stability and supporting individuals with complex care needs in their homes and communities.

Although support for the programs was widespread, several commenters also raised questions and concerns regarding program administration and long-term sustainability. Areas identified for further consideration included caregiver safeguards, appeals processes, program oversight, operational requirements, and the potential implications of recent state legislation on future program implementation.

The most frequent specific recommendation, concerned the policies for spouses and parents as paid caregivers. Commenters described the current policy as limiting a member's total delivered care to 40 hours per week when a familial caregiver provides paid care, and asked that those caregivers be permitted to provide up to 40 hours while a non-family provider delivers any additional assessed hours, consistent with the structure of the PPCG model. One commenter asked that the 40-hour limit for spouses be removed. Commenters also asked AHCCCS to clarify that the 40-hour PPCG limit applies to the hours for which a parent may be paid rather than to the member's total authorized care, to document authorized hours that go unfilled, and to account for limitations in historical PPCG data identified in a recent Auditor General report before drawing conclusions about program cost. Two commenters opposed PPCG or recommended limiting it to children who require nursing-level care, and one provider organization supported reasonable, well-designed cost-control and oversight measures.

AHCCCS Response: AHCCCS appreciates the comments received regarding the Parents as Paid Caregivers (PPCG) and Spouses as Paid Caregivers (SPCG) service delivery models, as well as the many personal experiences shared by members and families regarding the positive impact these programs have had in addressing caregiver shortages and supporting individuals with complex needs in home and community-based settings. AHCCCS recognizes the important role these models have played in promoting continuity of care, preserving family stability, and ensuring members can access medically necessary services when traditional provider capacity may be limited.

As discussed throughout this waiver renewal application, AHCCCS continues to evaluate and implement a variety of programmatic reforms intended to strengthen cost containment, improve program integrity, and ensure the delivery of medically necessary services through the PPCG model. These efforts have included

enhanced transparency, monitoring, and compliance oversight activities, such as incorporating parent-specific caregiver indicators within the Electronic Visit Verification (EVV) system. AHCCCS has also implemented broader policy reforms related to the authorization and evaluation of extraordinary care services, including efforts to better define extraordinary care needs, establish appropriate service parameters while preserving flexibility for medically necessary exceptions, and strengthen assessment methodologies used to evaluate the needs of minor members receiving home and community-based services.

AHCCCS believes these reforms will help ensure continued access to needed services while strengthening accountability, consistency, and program sustainability. Many of these efforts are also directly related to and supported by Arizona's request to implement the Long-Term Services and Supports (LTSS) Extraordinary Care Review Timeliness Waiver, as described elsewhere within this application.

AHCCCS appreciates the detailed comments regarding the hour limit that applies when a spouse/parent is the paid caregiver. AHCCCS is not proposing to change that limit through this renewal. A change that would increase the hours of paid care delivered to members would be evaluated against the legislative authorization and utilization requirements of A.R.S. § 36-3302. AHCCCS will address in its program guidance how the 40-hour weekly limit established by A.R.S. § 36-3311 applies to members whose assessed needs exceed that amount, and will take into account the data limitations identified by commenters in monitoring and evaluating the program.

At this time, AHCCCS is not proposing any changes to the PPCG or SPCG service delivery models as a result of the public comments received. AHCCCS will continue monitoring program performance and evaluating opportunities for ongoing improvement through existing program oversight and stakeholder engagement processes.

Extraordinary Care Review Timeliness Waiver

Provider associations, health plans, and a community health center association supported the request to extend the timeframe for Extraordinary Care Reviews to up to 28 calendar days, noting that the standard authorization timeframe of seven calendar days that applies to rating periods beginning on or after January 1, 2026, under 42 C.F.R. § 438.210(d)(1)(i) is not sufficient for complex reviews. Families and advocates supported the purpose of the request but asked for safeguards to ensure that additional time does not delay or reduce services. They asked that a member's existing services continue while a review is pending and during any appeal, that undisputed hours be authorized promptly for new members, that an expedited process be available when delay would threaten health or placement, that families be told what information is outstanding and be able to participate, that the full 28 days be used only when needed, that decisions be issued in writing with reasons, and that AHCCCS publicly report the volume, timeliness, and outcomes of reviews. A provider association asked that the protection for existing services be stated in the Special Terms and Conditions and that the provider agency of record be notified when a review begins and ends.

AHCCCS Response: AHCCCS requests this waiver to allow a more thorough, person-centered review, not to delay services. During an Extraordinary Care Review, a member's existing authorized services remain in place, and AHCCCS proposes that this protection be reflected in the Special Terms and Conditions governing the waiver. The extended timeframe applies only to the Extraordinary Care Review. It does not alter the expedited

authorization timeframe required by 42 C.F.R. § 438.210(d)(2), or members' notice and appeal rights under 42 C.F.R. Part 438, Subpart F. AHCCCS will work with its contractors to ensure that families are told what information is outstanding and have an opportunity to participate, that decisions are documented in writing with the reasons for them, and that provider agencies of record are notified when a review begins and concludes. AHCCCS will include the volume, timeliness, and outcomes of Extraordinary Care Reviews in its monitoring reports to CMS for this authority.

Traditional Healing Services

Public comments generally supported the proposal to expand access to Traditional Healing and Cultural Practices services to Urban Indian Organizations (UIOs). Many commenters expressed interest in participating in the continued development and implementation of the model and emphasized the importance of ensuring culturally responsive care options are available to American Indian and Alaska Native members.

Several commenters also reiterated challenges associated with participation under the current model, particularly those related to Care Coordination Agreement requirements. Stakeholders noted that these requirements have limited participation opportunities for certain Urban Indian Organizations and encouraged AHCCCS to continue evaluating approaches that would support broader access and implementation.

Commenters additionally sought clarification regarding various aspects of the proposed expansion, including implementation timelines, the relationship between waiver approval and the legislatively authorized pilot period, and opportunities for both Tribal Nations and Urban Indian Organizations to provide ongoing input throughout program development and implementation.

The National Council of Urban Indian Health asked AHCCCS to identify the effective date for Urban Indian Organization participation, to consider submitting the change as a standalone amendment so participation would not wait for the renewal period, and to identify the source of the non-federal share, because services furnished directly by Urban Indian Organizations are matched at the regular federal medical assistance percentage. An association of Tribal health organizations asked AHCCCS to retain the Tribal Uncompensated Care authority required by state law, the Tribal Dental Benefit, and Tribally led design of traditional healing services with respect for Tribal data sovereignty. During Tribal Consultation, participants also asked AHCCCS to establish a Tribal workgroup on the renewal, to remind CMS of the federal trust responsibility when applying the new budget neutrality methodology, to consider a Tribal epidemiology center as evaluator of traditional healing services, and to share data on Tribal members served by H2O and Reentry.

AHCCCS Response: AHCCCS appreciates the comments received regarding the Traditional Healing and Cultural Practices initiative and the strong support expressed for expanding access to these services through participation by Urban Indian Organizations (UIOs). AHCCCS recognizes the importance of culturally responsive care and values the perspectives shared by Tribal Nations, Urban Indian Organizations, providers, and community stakeholders throughout the public comment process.

AHCCCS also appreciates the feedback regarding challenges associated with the current program structure, particularly concerns related to Care Coordination Agreement requirements. The agency acknowledges that these requirements have created barriers for some organizations interested in participating in the initiative. Through this waiver renewal, AHCCCS looks forward to working with CMS to support expansion of the

Traditional Healing and Cultural Practices model by allowing Urban Indian Organizations to participate without the use of a Care Coordination Agreement, thereby increasing opportunities for access while maintaining program integrity and alignment with demonstration objectives.

AHCCCS remains committed to meaningful tribal consultation and stakeholder engagement throughout the development, negotiation, and implementation of this proposal. The agency will continue to rely heavily on the guidance, expertise, and recommendations provided through the Traditional Healing Workgroup, Tribal Nations, Urban Indian Organizations, and other tribal stakeholders to inform ongoing program design and operational considerations.

AHCCCS also acknowledges stakeholder requests for clarification regarding implementation timelines and the interaction between federal waiver approval and the legislatively authorized pilot period. The agency recognizes the existing time constraints associated with state legislative authorization and looks forward to engaging in discussions with CMS regarding these considerations following submission of the waiver renewal application. AHCCCS remains committed to ensuring stakeholders have opportunities for ongoing input throughout the negotiation and implementation process.

At this time, AHCCCS is not proposing additional modifications to the Traditional Healing and Cultural Practices proposal beyond those included in this waiver renewal application.

AHCCCS considered submitting Urban Indian Organization participation as a separate amendment. Because CMS guidance provides that an amendment approved on or after January 1, 2027, and before renewal requires actuarial certification of the entire demonstration, AHCCCS has included the change in this renewal and will discuss implementation timing with CMS in light of the legislatively authorized pilot period. AHCCCS acknowledges that services furnished directly by Urban Indian Organizations, rather than through Indian Health Service or Tribal facilities, are matched at the State's regular federal medical assistance percentage under section 1905(b) of the Social Security Act, and that the non-federal share must be identified before implementation. AHCCCS is requesting continuation of the Tribal Uncompensated Care and Tribal Dental authorities, will continue to rely on Tribes to define traditional healing practices and practitioners, and will continue to consult with Tribes on implementation, evaluation, including the potential role of a Tribal epidemiology center, and the data requests made during Tribal Consultation.

Budget Neutrality

Eight organizations, including hospital, health plan, long-term care, community health center, and business associations, commented on the budget neutrality methodology that will apply to Section 1115 approvals on or after January 1, 2027, under section 1115(g) of the Social Security Act and State Medicaid Director Letter #26-003. Commenters were concerned that limits on the use of accumulated savings and the treatment of administrative costs could constrain states, like Arizona, whose demonstrations have produced savings, and urged AHCCCS and CMS to preserve the ability to reinvest those savings. One provider association recommended that the application explain how core ALTCS home and community-based services will be classified under the new methodology, identify the Title XIX authority under which each could be furnished, and commit to a seamless transition for members and providers if CMS determines that any of those services should be authorized under another authority. Other commenters recommended that budget neutrality be assessed

on total cost and outcome trajectories rather than on individual expenditure lines.

AHCCCS Response: AHCCCS shares these concerns and has prepared this application to support a chief actuary certification under section 1115(g). As described in Section VIII, AHCCCS will classify each demonstration authority as a Medicaid Authorizable Populations and Services activity or a section 1115-only activity, identify the Title XIX basis for each Medicaid Authorizable Populations and Services designation, including the home and community-based services furnished through ALTCS, and provide a financial impact analysis for each section 1115-only activity, as CMS issues guidance and requests that information during its review.

Hospital Presumptive Eligibility and Verification of Residency

Six organizations representing patients, clinicians, and people with mental illness opposed eliminating Hospital Presumptive Eligibility, ending self-attestation of residency, or both. Commenters were concerned that people in crisis, people experiencing homelessness, people leaving incarceration, recent movers, and pregnant individuals may not have documentation readily available and could experience delays in coverage and care, and one commenter recommended that AHCCCS instead expand hospital presumptive eligibility to additional populations. The Arizona Hospital and Healthcare Association and Arizona LeadingAge did not oppose the changes but asked AHCCCS to publish Hospital Presumptive Eligibility utilization data, to assess the effect on post-acute admissions, and to establish an expedited eligibility process at hospital admission, discharge, and post-acute admission. Forum participants asked whether residency verification applies at renewal, how individuals experiencing homelessness will demonstrate residency, and why Arizona would require verification when federal regulations permit self-attestation.

AHCCCS Response: AHCCCS proposes these changes at the direction of the Arizona Legislature. Federal regulations permit, but do not require, a state to accept an applicant's attestation of residency, and state law (Laws 2026, Chapter 132) now directs AHCCCS to verify residency before approving coverage. Section 1902(a)(47)(B) of the Social Security Act and 42 C.F.R. § 435.1110 require states to permit qualified hospitals to make presumptive eligibility determinations, which is why AHCCCS requests a waiver of those provisions rather than implementing the change administratively, and why AHCCCS is not able to adopt the recommendation to expand hospital presumptive eligibility. AHCCCS will verify residency through electronic data sources wherever possible, will provide the opportunity to resolve discrepancies that federal regulations require, and will work with hospitals and post-acute providers on expedited processing of applications at admission and discharge. AHCCCS will also publish Hospital Presumptive Eligibility utilization data.

Retroactive Coverage

Four patient organizations and a professional association opposed continuing to limit retroactive coverage, and asked AHCCCS to provide at least the retroactive period that applies under Public Law 119-21 beginning January 1, 2027, one month for the expansion population and two months for other populations, citing medical debt and delayed care. One association asked AHCCCS to exempt, or to clarify the treatment of, Elderly and Physically Disabled members who are admitted to assisted living or nursing facilities in the middle of a month. A health plan association supported continuation of the Prior Quarter Coverage policy.

AHCCCS Response: AHCCCS requests continuation of the retroactive coverage waiver as described in Section IV. Retroactive coverage continues for pregnant women, women within 60 days postpartum, and children under 19, and beginning January 1, 2027, will be limited to two months for those populations consistent with section 71112 of Public Law 119-21. AHCCCS will clarify in implementation how the waiver applies to members determined eligible for ALTCS following a mid-month admission, and will continue to evaluate the effect of the waiver on members and providers as required under the demonstration.

Reentry, KidsCare, Former Foster Youth, and Tribal Dental

Commenters uniformly supported continuation of the Reentry initiative, the KidsCare expansion to 225 percent of the federal poverty level, the former foster youth authority, and the Tribal Dental Benefit. Commenters on Reentry recommended connecting members to Continuum of Care and H2O housing resources, tracking housing status and connection to care at 7, 30, and 90 days after release, extending data exchange to homeless management information systems, including pregnant and postpartum women, and expanding promptly to adult correctional facilities. Several asked about Tribal correctional facilities and implementation funding, and forum participants asked about medication supply, transportation, and activation of coverage at release.

AHCCCS Response: AHCCCS appreciates the support for these authorities and requests their continuation. AHCCCS will consider the implementation recommendations for Reentry, including connections to housing resources and measures of connection to care after release, as it implements pre-release services and develops monitoring and evaluation for the renewal period.

Targeted Investments 2.0 Transition

Commenters did not object to concluding Targeted Investments 2.0 but asked AHCCCS to publish a transition strategy identifying which integration and care coordination practices will be sustained after the program ends, noting that providers cannot maintain program infrastructure without continued financing.

AHCCCS Response: AHCCCS will develop a transition plan for Targeted Investments 2.0 before the program concludes on September 30, 2027, consistent with the Special Terms and Conditions governing expiring authorities, and will identify the practices AHCCCS expects to sustain through managed care contract requirements and value-based purchasing arrangements.

Previously Submitted Requests

Few commenters addressed the five-year lifetime limit. A mental health advocacy organization asked AHCCCS to oppose or substantially limit the proposal because mental illness is episodic, and recommended broad behavioral health exemptions, simple documentation, notice, and appeal rights. A long-term care association asked that residents of affordable senior housing, assisted living, and supportive housing be exempt. Forum participants asked how the limit would be measured, how it would interact with six-month redeterminations and community engagement requirements, and how its exemptions compare to federal law. On institutions for mental diseases, the same advocacy organization supported coverage of medically necessary stays, and forum participants asked why the 2017 request remains pending.

AHCCCS Response: AHCCCS submitted the five-year lifetime limit to CMS on March 28, 2025, as part of the AHCCCS Works amendment request, as required by A.R.S. § 36-2903.09. That request remains under separate CMS review. AHCCCS's 2017 request for authority to cover services in institutions for mental diseases also remains under separate review. As described in Section V, AHCCCS anticipates addressing institution for mental diseases authority for adults with serious mental illness, on terms consistent with CMS guidance, through the Enhanced Residential Treatment amendment it intends to submit before July 2027.

SMI Enhanced Residential Treatment Pilot

Although the pilot is not part of this renewal, several commenters addressed it. Family advocates and an organization representing families of homicide victims supported the pilot and asked that it address anosognosia, not exclude individuals with co-occurring conditions or justice involvement, prioritize medication continuity, include family support and participation, serve individuals stepping down from secure or forensic settings, and track outcomes after discharge. A person with lived experience of serious mental illness supported housing, peer, and crisis alternatives but opposed an emphasis on medication adherence and on court-ordered treatment history as criteria. Other commenters asked that the pilot use the least restrictive setting, complement rather than replace community services, clarify whether it will serve members who need secured settings, and include people with lived experience and families in its design.

AHCCCS Response: AHCCCS is not requesting authority for the pilot in this renewal because the legislation authorizing the pilot requires stakeholder engagement before proposing pilot details. The comments received will be provided to the stakeholder process required under SB 1630 and considered in the design of the future amendment, which will be subject to its own public notice and comment.

Implementation of Federal Eligibility Requirements

Several commenters addressed the community engagement and six-month redetermination requirements enacted in Public Law 119-21. Commenters recommended that AHCCCS distinguish procedural from substantive coverage loss, track reinstatement and gaps in coverage, route notices for members in behavioral health residential facilities through their behavioral health plans, continue coverage while information is verified, coordinate outreach with health plans and providers, and avoid any period of ineligibility following disenrollment.

AHCCCS Response: The community engagement and six-month redetermination requirements are federal statutory requirements that apply to Arizona under the State Plan. They are not proposed in this renewal, and AHCCCS will implement them as federal law requires. AHCCCS will consider the recommendations regarding notice, continuity of coverage, and reporting in that implementation. This renewal does not propose a period of ineligibility following disenrollment.

Other Comments

Food as Medicine Proposal

Although a nutrition or food as medicine initiative was not included in the state 's waiver renewal proposal, AHCCCS received a significant number of comments encouraging the agency to explore development of a Medicaid Food as Medicine model through Arizona's Section 1115 demonstration.

Comments were uniformly supportive of further consideration of Food as Medicine approaches and frequently emphasized the role that nutritious and medically appropriate food may play in supporting individuals with chronic and serious health conditions. Commenters generally described Food as Medicine as a potential component of whole-person care that could complement many of Arizona's existing 1115 programs and improve health outcomes for Medicaid members.

Many commenters noted that nutrition can play a meaningful role in chronic disease management, recovery, and an individual's ability to remain healthy and safely integrated within their homes and communities. Several commenters also cited the potential for Food as Medicine interventions to reduce avoidable healthcare utilization, including emergency department visits, inpatient admissions, readmissions, complications related to chronic conditions, and overall healthcare expenditures.

Non-Waiver Related Comments

AHCCCS also received several comments regarding policies and programs that extend beyond the specific proposals included in this waiver renewal application. Many of these comments addressed areas that may be evaluated and addressed through existing agency authorities, operational processes, stakeholder engagement activities, Medicaid State Plan authorities, or other administrative mechanisms outside the waiver renewal process.

Topics raised by commenters varied in topics but included items such as streamlining application and eligibility processes, strengthening managed care oversight and accountability, addressing provider workforce shortages, evaluating provider reimbursement levels, exploring value-based payment arrangements, and providing additional clarification regarding existing policies, procedures, and program requirements.

AHCCCS Response: AHCCCS appreciates the significant stakeholder interest in the potential development of Food as Medicine initiatives within Arizona's Medicaid program and values the perspectives shared regarding the role nutrition may play in supporting improved health outcomes for Medicaid members. The agency recognizes that access to nutritious and medically appropriate food can be an important component of whole-person care and may complement efforts to address chronic disease management, recovery, community integration, and long-term health outcomes. The agency agrees that Food as Medicine approaches may align well with several existing whole-person care initiatives currently operating under Arizona's Section 1115 demonstration, including H2O, the Reentry Initiative, ALTCS, and other programs designed to address whole person care. AHCCCS will continue evaluating the potential feasibility, effectiveness, and operational considerations associated with a potential future nutrition-based intervention.

At this time, however, AHCCCS is not proposing a new Food as Medicine initiative as part of this waiver renewal application. AHCCCS reminds stakeholders of the legislative requirements established through A.R.S. 36-3302, enacted in 2025, which require the agency to obtain authorization from the Arizona Legislature before submitting a waiver request that expands eligibility, adds new categories of services, or would result in an annual increase in utilization greater than ten percent for affected services. The agency will continue monitoring developments in this area and evaluating opportunities that may be appropriate for future

consideration.

Finally, AHCCCS acknowledges all comments submitted throughout the waiver renewal process, including those related to programs, policies, and administrative processes that fall outside the specific scope of this waiver application. The agency carefully considers stakeholder feedback as an important component of program planning, policy development, and ongoing quality improvement efforts. Many of the issues raised by commenters may be more appropriately addressed through existing agency authorities, stakeholder engagement activities, Medicaid State Plan authorities, administrative processes, or future state policy development efforts rather than through the Section 1115 waiver itself. AHCCCS will ensure that all comments received through this waiver renewal process are reviewed and evaluated by the appropriate agency teams for consideration as part of ongoing programmatic and operational activities.

XI. Appendix