DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

October 14, 2022

Jami Snyder
Director
Arizona Health Care Cost Containment System
801 East Jefferson Street
Phoenix, Arizona 85034

Dear Ms. Snyder:

The Centers for Medicare & Medicaid Services (CMS) is approving Arizona's request for a five-year extension of the demonstration titled, "Arizona Health Care Cost Containment System" (AHCCCS) (Project Number 11-W-00275/9) (the "demonstration"), in accordance with section 1115(a) of the Social Security Act (the Act). CMS is concurrently approving the demonstration amendment titled, "Housing and Health Opportunities" (H2O). Approval of this request will extend many longstanding demonstration authorities and allow the state, through various waiver and expenditure authorities, to test the efficacy of innovative practices aimed at promoting consistently high-quality, evidence-based, coordinated, and integrated care with the combined goals of providing medical assistance services and improving the health of communities and populations served through the demonstration. This approval is effective from October 14, 2022 through September 30, 2027, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire.

As reflected in the statute, the primary objective of the Medicaid program is to furnish medical assistance. Arizona already maximizes the populations eligible for medical assistance through AHCCCS. This demonstration is expected to promote the objective of furnishing medical assistance by strengthening access to high-quality care for all those with Medicaid coverage.

CMS's approval is subject to the limitations specified in the attached waiver and expenditure authorities, special terms and conditions (STC), and any supplemental attachment defining the nature, character, and extent of federal involvement in this project. The state may deviate from Medicaid state plan requirements only to the extent those requirements have been listed as waived or not applicable to expenditures under the demonstration.

Extent and Scope of Demonstration Extension and Amendment

The extension of the AHCCCS demonstration includes the continuation of longstanding authorities and programs, which make up a crucial part of Arizona's Medicaid system. This

approval includes the extension of 1) AHCCCS Complete Care (ACC), the statewide managed care system, which provides physical and behavioral health services to the majority of Arizona's Medicaid population; 2) the Arizona Long Term Care System (ALTCS), which provides physical, behavioral, long-term care services and supports, including home-and-community based services, to targeted populations; 3) the Comprehensive Health Plan (CHP) for children in foster care; and 4) the AHCCCS Complete Care - Regional Behavioral Health Agreement (ACC-RBHA), which provides integrated care for individuals with a serious mental illness (SMI). The extension approval will also continue the existing waiver of retroactive eligibility.

With this extension, CMS is updating expenditure authority language that authorizes payment to participating IHS facilities and participating facilities operated by tribes under the Indian Self-Determination and Education Assistance Act (ISDEAA) for services that were previously covered under Arizona's state plan. The updated language clarifies that this expenditure authority includes medically necessary diagnostic, therapeutic, and preventative dental services for American Indian/Alaskan Native (AI/AN) beneficiaries beyond the current $1000 emergency dental limit for adult members in Arizona's state plan and beyond the $1,000 dental limit for individuals age 21 or older enrolled in the ALTCS program, when these services are provided by participating IHS facilities and/or participating facilities operated by tribes under the ISDEAA. This update is consistent with the original purpose of this expenditure authority, which was to address the fiscal burden on these facilities of providing certain services that are not covered under the state plan, and to evaluate the impact of providing this coverage on the financial viability of these facilities. Additionally, providing this dental coverage is expected to reduce health disparities by improving oral health among tribal members and reducing the disproportionate number of AI/AN beneficiaries affected by oral disease.

CMS is also approving a new Targeted Investments (TI) 2.0 program with the approval of this extension. TI 2.0 will direct managed care organizations to make specific incentive payments to providers that meet the criteria for receiving these payments with the goal of improving health equity for targeted populations through addressing health-related social needs (HRSN). Each required process or performance target will have an incentive amount associated with it and providers will receive an incentive payment for each requirement that is met. Providers will also receive an incentive payment for completing the application process that includes new baseline deliverables and becoming approved for participation in TI 2.0. Participating providers, which include primary care, behavioral health, integrated clinics, and justice clinics, must meet eligibility requirements that demonstrate their readiness for participation in TI 2.0. These requirements include utilization of an electronic health record system capable of bidirectional data sharing; established procedures for screening all patients for social risks, coordinating referrals, and identifying, tracking, and coordinating care for high-risk beneficiaries; and documented protocols for using beneficiary-centered, culturally sensitive, evidence-based practices in trauma-informed care. Over the demonstration period, providers will receive incentive payments to implement certain processes and meet outcomes-based metrics as set forth in the STCs.

In this demonstration extension, CMS also is authorizing the state to provide coverage of certain services that address certain HRSN through the Housing and Health Opportunities (H2O) amendment. CMS is authorizing increased coverage of certain services that address HRSN, as

evidence indicates that these HRSN services are a critical driver of an individual's access to health services that help to keep them well.[1,2] These services include pre-tenancy and tenancy supports, community and transitional housing supports for individuals with a clinical need or transitioning out of institutional care, congregate settings, a homeless shelter or out of homelessness, or the child welfare system. Specifically, in Arizona, these services include short-term post-transition housing for up to six months, including associated utility assistance, housing supports, pre-tenancy and tenancy sustaining services, and medically necessary home modifications. The services will also include case management, outreach, and education, as well as infrastructure investments to support those services.

Services authorized in this demonstration to address HRSN must be clinically appropriate for the eligible beneficiary. In Arizona, HRSN services will be provided for individuals experiencing life transitions, including individuals who are experiencing homelessness and meet specific clinical and social risk criteria, such as beneficiaries with a health need as documented in their medical record, including but not limited to a SMI, high-cost high-needs chronic health conditions or co-morbidities, or enrolled in the ALTCS.

Coverage of targeted HRSN services is likely to assist in promoting the objectives of Medicaid because it is expected to help individuals stay connected to coverage and access needed health care. Lack of stable housing may impede an individual's ability to enroll in coverage and access needed health care. Such circumstances may create physical, social, or emotional conditions that are counterproductive to the otherwise positive effects of the health care services an individual does receive, including through Medicaid.[3] The housing services authorized in the demonstration can be expected to stabilize the housing situations of eligible Medicaid enrollees and thus increase the likelihood that they will keep receiving and benefitting from the Medicaid-covered services to which they are entitled.

Coverage of targeted, clinically-appropriate HRSN services will also provide a regular source of needed care to meet individuals' comprehensive health needs. This is likely to directly improve their health outcomes as well as improve their use of other clinical services. For example, individuals with poor health who also experience housing insecurity are likely to frequently use the emergency department for their care.[4] By providing the short-term services needed to

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[1]As discussed in a letter to State Health Officials issued on January 7, 2021, https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf, addressing Social Determinants of Health can more effectively improve population health, reduce disability, and lower overall health care costs in the Medicaid program. While "social determinants of health" is a broad term that relates to the health of all people, HRSN relates more specifically to an individual's adverse conditions reflecting needs that are unmet and contribute to poor health. See also https://www.healthaffairs.org/do/10.1377/forefront.20191025.776011/full/.

[2] Bachrach, D., Pfister, H., Wallis, K., Lipson, M. *Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment*. The Commonwealth Fund; 2014; https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2014_may_1749_bachrach_addressing_patients_social_needs_v2.pdf.

[3] Schilbach, F., Schofield, H., Mullainathan, S. *The Psychological Lives of the Poor*. American Economic Review: Papers & Proceedings; 2016; http://dx.doi.org/10.1257/aer.p20161101.

[4] December 18, 2020. QuickStats: Rate of Emergency Department (ED) Visits,* by Homeless Status† and Geographic Region§ — National Hospital Ambulatory Medical Care Survey, United States, 2015–2018. https://www.cdc.gov/mmwr/volumes/69/wr/mm6950a8.htm#:~:text=During%202015%E2%80%932018%2C%20th

stabilize individuals' housing, this demonstration will test whether health outcomes and utilization of appropriate care improve.

Moreover, the Medicaid statute, including both Sections 1905 and 1915 of the Act, reflects the critical role of upstream services (i.e., those that help avert more intensive medical interventions) in meeting the medical assistance needs of certain Medicaid-eligible populations (e.g., individuals with disabilities). For example, medical assistance made available under a waiver authorized under section 1915(c) of the Act is provided as a home and community-based alternative to avoid the need for more intensive institutional-based care. Medical assistance made available under a state plan option authorized under section 1915(i) of the Act provides that same package of home and community-based services to individuals meeting needs-based criteria that are less stringent than criteria required for institutional placement. These services are also intended to avert a need for nursing facility care. Both provisions authorize services, including habilitation services like pre-tenancy and tenancy support services, with a goal of preventing decline in beneficiary health that would require more intensive services. Similarly, medical assistance covering interventions aimed at improving asthma management and mitigating asthma triggers is another example of how the Medicaid statute gives states authority to help reduce beneficiary need for acute care services (e.g., emergency department visits).

Available evidence[5] suggests that there may be populations in addition to those eligible under 1915(c) or 1915(i) criteria that would benefit clinically from the section 1915(c) or 1915(i) services described above, as well as additional upstream HRSN services that would benefit targeted populations, and that additional research is needed on the effects of providing those types of services to a broader group of people. This demonstration will test whether expanding eligibility for these services to additional populations or providing additional services will improve the health outcomes of certain Medicaid beneficiaries. The demonstration will also test whether providing additional services will help Medicaid beneficiaries to maintain their coverage by preventing the health-related incidents that could lead to enrollment churn. Moreover, access to these services for individuals with poorer health outcomes may also help to reduce health disparities. Expanding who can receive these services is expected to help a broader range of Medicaid beneficiaries receive the medical assistance to which they are entitled and benefit from it, and this demonstration will test this hypothesis. These services are also expected to further help to reduce health disparities that are often rooted in social and economic disadvantages.[6] Thus, broadening the availability of certain HRSN services is expected to promote coverage and access to care, improve health outcomes, reduce disparities, and create long-term, cost-effective alternatives or supplements to traditional medical services.

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ere%20were,the%20rate%20for%20nonhomeless%20persons; *see also* May 2002. Emergency Department Use Among the Homeless and Marginally Housed: Results From a Community-Based Study. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447161/.

[5] September 23, 2021. ASPE Contractor Project Report: Building the Evidence Base for Social Determinants of Health Interventions. https://aspe.hhs.gov/reports/building-evidence-base-social-determinants-health-interventions.

[6] April, 1, 2022. Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Effort. https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf.

CMS's authorization of infrastructure spending as part of this HRSN framework, such as paying for health information technology system investments and provider network investments for low-resourced providers that furnish covered services to beneficiaries, is expected to improve the availability and quality of the services delivered. CMS also expects the state to maintain existing state funding and efforts for HRSN services, without this demonstration authority supplanting existing efforts, and to have in place partnerships with other state and local entities to coordinate possible pathways to permanency for services to be provided without demonstration authorities.

With this AHCCCS demonstration, CMS is approving federal matching funds for Designated State Health Programs (DSHP) to enable the state to implement certain new demonstration initiatives that CMS has determined are likely to assist in promoting the objectives of Medicaid. In December 2017, CMS issued State Medicaid Director (SMD) Letter #17-005, titled "Phase-out of expenditure authority for Designated State Health Programs in Section 1115 Demonstrations," in which CMS announced it no longer would accept state proposals for new or extended section 1115 demonstrations that rely on federal matching funds for DSHP.[7] The 2017 SMD Letter explained that CMS has approved section 1115 demonstrations that provided federal funding for DSHP that had previously been funded only with state funds, because (absent the section 1115 authority) state expenditures on these programs did not qualify for federal matching funds. CMS approved this federal match under a section 1115 demonstration only if the state had budget neutrality "savings" for the current demonstration approval period. These approvals enabled the state to use the "freed up" state dollars that would otherwise have been spent on the DSHP on demonstration expenditures.

Recently, states have proposed demonstrations that seek federal matching funds for a state-funded DSHP so that they can "free up" state funding for Medicaid coverage initiatives and/or new HRSN services and related infrastructure investments. CMS has now decided to approve section 1115 demonstrations that provide federal funding for DSHPs, under certain circumstances. These approvals will limit both the size and scope of DSHP, and apply additional parameters and guardrails, in order to address the concerns described in the 2017 SMD letter. Federal expenditure authority for DSHP will be provided only if the state uses the "freed up" state funding on a new demonstration initiative that CMS has determined is likely to assist in promoting the objectives of Medicaid, such as improving access to high-quality covered services. CMS expects that any new DSHP-funded initiative will add to the state's Medicaid program, not supplant existing services or programs.

The December 2017 SMD Letter described concerns about the consistency of approving federal DSHP funding and the federal-state financial partnership established under the Medicaid statute. In addition, the letter indicated that demonstrations that had previously included authority for DSHP had not made a compelling case that federal DSHP funding is a prudent federal investment. CMS's revised approach to DSHP addresses these concerns. First, CMS remains committed to the federal-state financial partnership as a hallmark of Medicaid. As described in the STCs, the state will be required to contribute state funds for expenditures under the DSHP-supported demonstration initiative. DSHP authority will be time-limited, and the state will be

[7] December 15, 2017. SMD#17-005 RE: Phase-out of expenditure authority for Designated State Health Programs (DSHP) in Section 1115 Demonstrations. https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/smd17005_78.pdf.

required to submit a sustainability plan which describes the scope of DSHP-supported initiatives the state wants to maintain, and the strategy to secure resources to maintain these initiatives beyond the current demonstration approval period.

Medicaid is a state-federal partnership, and allocation of state resources is fundamental to that partnership. As described in the STCs, the state will be required to demonstrate commitment to the proposed DSHP-funded initiative by contributing non-DSHP funds (e.g., general revenue, intergovernmental transfers) as the non-federal share of the DSHP-supported initiative on an annual basis. In order to respond to previous concerns about federal spending on DSHP, CMS is capping the expenditures for DSHP at no more than 1.5 percent of the state's total Medicaid spending during the demonstration period. CMS has determined that this cap on the total amount of federal expenditure authority and the limited duration of federal funding for DSHP will appropriately balance the goals of ensuring adequate federal funding to support needed Medicaid program innovation and fiscal accountability. The cap is based on a range of estimates from state proposals of the likely cost of the DSHP-supported initiatives over the course of a five-year period, and set at a mid-point in that range. With this AHCCCS demonstration extension, CMS is approving authority for DSHP to enable the state to implement new initiatives that provide a defined set of covered services and supports to address HRSN and the above described TI 2.0 Program. As with prior DSHP approvals, the state can seek federal matching funds up to the amount of the approved DSHP cap only if budget neutrality "savings" are available for that purpose. The state will be permitted to use the freed-up state funding that results from approval of the federal matching funds for its DSHP only on initiatives that are consistent with the objectives of the Medicaid statute. The approved DSHP-funded initiatives in this extension meet that standard because they are intended to improve access to covered services. Additionally, approving the federal match for the state's DSHP is likely to help improve health outcomes through improved coverage of services for Medicaid beneficiaries and other low-income populations in the state. Furthermore, by expanding and streamlining access to services, the DSHP-supported initiatives could also help enhance the efficiency and quality of care.

Requirements for DSHP are further defined in the STCs – as are program types excluded from DSHP funding – and the state may not claim FFP for DSHP until the specific state programs for which FFP is claimed are approved by CMS. CMS has generally not approved DSHP requests for expenditures that are already eligible for federal Medicaid matching funds or other sources of federal funding, that are generally part of normal operating costs that would be included in provider payment rates, or that are not likely to promote the objectives of Medicaid (e.g. bricks and mortar, animal shelters and vaccines, and revolving capital funds). The specific state programs will be limited to programs that are population- or public health-focused, aligned with the objectives of the Medicaid program with no likelihood that the program will frustrate or impede the primary objective of Medicaid to provide coverage of services for low- income and vulnerable populations, and serve a community largely made up of low-income individuals.

CMS is committed to improving access to quality care for all Medicaid beneficiaries and is engaged in an "all of Medicaid" approach to promote coverage, access to and quality of care, and health outcomes for all beneficiaries, thereby helping to strengthen coverage and mitigate known health disparities. Research shows that increasing Medicaid payments to providers improves

beneficiaries' access to health care services and the quality of care received.[8] To that end, as a condition of approval for expenditure authority in Arizona, for the DSHP and expenditure authorities 16, 18, and 19, the state will be required to increase and (at least) sustain Medicaid fee-for-service provider base payment rates and Medicaid managed care payment rates in primary care, behavioral health, and obstetrics care, should the state's Medicaid to Medicare provider rate ratio be below 80 percent in any of these categories.

For Arizona, at this time, only primary care provider payment levels in the fee-for-service delivery system are below 80 percent of Medicare rates and must be increased. The state must attest that the rate increases will be implemented according to the STCs, and that the state will not decrease provider payment rates for other Medicaid- or demonstration-covered services for the purpose of making state funds available to finance these required provider rate increases (i.e., cost-shifting). The state must also sustain the increase for the remaining years of the demonstration.

Under the demonstration's STCs, the state is required to submit a New Initiatives Implementation Plan for CMS review and approval. The New Initiatives Implementation Plan should describe key policies being tested under this demonstration and provide operational details not captured in the STCs regarding implementation of those demonstration policies. At a minimum, the Implementation Plan must include definitions and parameters of key policies, such as the HRSN and DSHP authorities, and describe the state's strategic approach to implementing the policies, including goals and milestones as well as associated timelines for meeting them, for both program policy implementation and infrastructure investments, as applicable.

Budget Neutrality

Under section 1115(a) demonstrations, states can test innovative approaches to operating their Medicaid programs if CMS determines that such demonstrations are likely to assist in promoting the objectives of the Medicaid statute. CMS has long required, as a condition of demonstration approval, that demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs in that state likely would have been without the demonstration. In requiring demonstrations to be budget neutral, CMS is constantly striving to achieve a balance between its interest in preserving the fiscal integrity of the Medicaid program and its interest in facilitating state innovation through section 1115 approvals. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the "without waiver" (WOW) costs). Historically, if a state's "with waiver" (WW) costs for a demonstration approval period were less than the expenditure limit for that period, the unspent funds or "savings" rolled over

[8] Polsky, D., Richards, M. Basseyn, S., et al. *Appointment Availability after Increases in Medicaid Payments for Primary Care.* The New England Journal of Medicine; 2015; https://www.nejm.org/doi/10.1056/NEJMsa1413299; Decker, S. L., *Medicaid Physician Fees and the Quality of Medical Care of Medicaid Patients in the USA*. Review of Economics in the Household; 2007; https://link.springer.com/article/10.1007/s11150-007-9000-7.

into the next approval period, which meant that the state could incur higher WW costs during the new approval period.

CMS and states have generally been applying an approach to calculating budget neutrality that CMS described in a 2018 State Medicaid Director (SMD) Letter.[9] The approach described in the 2018 SMD Letter included certain features that limited the extent to which states could roll over unspent "savings" from one approval period to the next when CMS extended a demonstration, and which were thereby intended to preserve the fiscal integrity of the Medicaid program. Based on CMS's and states' experience implementing the approach described in the 2018 SMD Letter, it has become apparent to CMS that this approach may limit states' future ability to continue testing and developing innovative demonstration programs that are likely to assist in promoting the objectives of Medicaid. Therefore, in this approval, CMS has reevaluated and is modifying certain aspects of the budget neutrality approach described in the 2018 SMD Letter, in an attempt to better support state innovation, in line with section 1115 of the Act, while maintaining its commitment to fiscal integrity. While CMS evaluates each demonstration proposal on a case-by-case basis, CMS anticipates that it will apply these or similar updates in its approach to budget neutrality consistently to all similarly situated states, going forward.

Under this approval, CMS is departing from the budget neutrality approach described in the 2018 SMD Letter in two key ways. First, CMS is making several changes that are intended to give states greater access to funding, including "savings" from prior approval periods, while still maintaining fiscal integrity. These changes include an updated approach to calculating the WOW baseline, which refers to the projected expenditures that could have occurred absent the demonstration and which, as described above, is the basis for the budget neutrality expenditure limit for each approval period.

Under this approval, CMS calculated the WOW baseline by using a *weighted average* of the state's *historical* WOW per-member-per-month (PMPM) baseline and its *recent actual* PMPM costs, rather than taking the approach described in the 2018 SMD Letter, which was to adjust WOW PMPM cost estimates to reflect only the *recent actual* PMPM costs. This updated approach is expected to result in a slightly higher WOW baseline, while still primarily reflecting the state's most recent expenditures. In addition, under this approval, projected demonstration expenditures associated with each Medicaid Eligibility Group in the WOW baseline have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the new approval period. In contrast, under the approach described in the 2018 SMD Letter, CMS would use the *lower of* the state's historical trend or the President's Budget trend rate. Using the President's Budget trend rate instead aligns the demonstration trend rate with federal budgeting principles and assumptions. Additionally, while CMS will still limit the extent to which demonstration savings can be "rolled over" to a new approval period, the limitations will be less narrow than those that apply under the approach described in the 2018 SMD Letter. In the 2018 SMD Letter, CMS explained that it expected to permit states to roll over savings to a demonstration extension from only the most recent five years of prior approvals, and that there would be a transitional phase-down of accrued savings. Under this approval, the savings amount available for the extension approval period has been limited to the

[9] August 22, 2018. SMD#178-009 RE: Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects. https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf.

lower of (1) the savings available to the state in the current extension approval period plus net savings from up to ten years of the immediately prior demonstration period(s) (excluding temporary extension periods); or (2) fifteen percent of the state's projected total Medicaid expenditures in aggregate for the demonstration extension period. This change will permit Arizona to access more "savings" from prior approval periods than it would otherwise be able to do under the approach described in the 2018 SMD Letter, and thus will better permit Arizona to fund the program innovations described above. At the same time, CMS will limit the "savings" Arizona can access, thereby preserving the Medicaid program's fiscal integrity. These adjustments to the 2018 approach improve the balance between the availability of expenditure authority to support program innovation and the need for fiscal restraint. CMS expects these updates will continue to ensure fiscal integrity by limiting savings rollover from one approval period to the next. However, they are also expected to give Arizona access to more funding than it would otherwise have been able to access, and thus, more ability to implement demonstration projects that are likely to assist in promoting the objectives of the Medicaid program, than it would have had under the approach described in the 2018 SMD Letter.

In a second key change from the approach described in the 2018 SMD Letter, CMS is treating certain HRSN expenditures as "hypothetical" for purposes of Arizona's budget neutrality calculation. As described in the 2018 SMD Letter, CMS effectively treats a hypothetical expenditure like an expenditure that the state could have made absent the demonstration, when calculating budget neutrality. As a result, hypothetical expenditures are included in both the WOW baseline and the estimate of the WW expenditures under the demonstration. States do not have to find demonstration "savings" to offset hypothetical expenditures. However, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued "savings" from hypothetical expenditures. That is, "savings" are not generated from a hypothetical population or service if the state does not spend up to the hypothetical expenditure limit. To allow for hypothetical expenditures, while preventing them from resulting in "savings," CMS applies a separate, independent budget neutrality "supplemental test" for hypothetical expenditures. These supplemental budget neutrality tests subject the hypothetical expenditures to predetermined limits to which the state and CMS agree, and that CMS approves, during negotiations. If the state's WW hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending by finding "savings" elsewhere in the demonstration or to refund the federal matching funds to CMS. In the 2018 SMD Letter, CMS explained that it has historically considered demonstration expenditures to be "hypothetical" in the following circumstances: (1) when they are for populations or services that the state could otherwise have covered under its Medicaid state plan or other title XIX authority, such as a waiver under section 1915 of the Act; or (2) when a WOW spending baseline is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates (e.g., CMS has treated demonstration expenditures on the "adult group" described in section 1902(a)(10)(A)(i)(VIII) of the Act as hypothetical for this reason).

Under this approval, certain HRSN expenditures are considered "hypothetical" expenditures and are included in the budget neutrality WOW baseline. Some of these expenditures, as discussed above, are expenditures for services that the state could otherwise cover under other title XIX authority, such as tenancy supports for certain beneficiaries. Treating those expenditures as

hypothetical is consistent with how CMS has historically treated similar expenditures. While other approved HRSN expenditures could not otherwise be covered under title XIX authority, such as expenditures on section 1915(c) and 1915(i) services for beneficiaries who would not otherwise be eligible for them under section 1915, there are insufficient or inconsistent data to calculate a WOW baseline for at least some of these expenditures. Treating those expenditures as hypothetical is also consistent with how CMS has historically treated similar expenditures.

As discussed above, based on robust academic-level research, it appears likely that these expenditures could improve the quality and effectiveness of downstream services that can be provided under state plan authority.[10] And, as also discussed above, covering HRSN services is expected to improve enrollees' health, reducing health disparities that are often rooted in social and economic disadvantages for these beneficiaries. At the same time, predicting the downstream effects on overall Medicaid program costs of covering certain evidence-based HRSN services is extremely difficult, making it hard for CMS to pinpoint the estimated fiscal impact of these expenditures on demonstration budget neutrality or on the state's overall Medicaid program. Treating demonstration HRSN expenditures as hypothetical will give the state the flexibility to test these worthy innovations, especially as CMS anticipates that they might result in overall reductions in future Medicaid program costs.

Historically, CMS has often authorized expenditures through section 1115 demonstrations subject to expenditure limits. In this case, to ensure that treating certain HRSN expenditures as hypothetical will not have a significant negative impact on Medicaid fiscal program integrity, CMS is applying a budget neutrality spending cap to the HRSN service expenditures and an additional sub-cap to HRSN infrastructure expenditures, and is referring to these expenditures as "capped hypothetical expenditures" in the STCs. The caps on expenditures for HRSN services and related infrastructure activities differ from the usual limit CMS places on hypothetical expenditures under the "supplemental test" discussed above in several respects. First, ordinarily, if a state exceeds the hypothetical expenditure limit, it can offset the additional costs with savings from the rest of the demonstration. That will not be permitted with these HRSN expenditures. However, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. Second, the expenditures subject to the cap are narrowly defined to reflect only expenditures associated with services that research indicates are likely to have certain positive downstream effects, as discussed above. Third, the upper limit on the cap is based on a range of estimates of the likely cost of these expenditures over the course of a five-year period, and set at a mid-point in that range. While this cap deviates from the traditional approach to hypothetical expenditures, it is consistent with CMS's historical approach to maintaining budget neutrality in Medicaid demonstrations and it does not alter the underlying financing structure of the Medicaid program. This cap will ensure that the state maintains its investment in the state plan benefits to which

[10] Lipson, D. J. *Medicaid's Role in Improving the Social Determinants of Health: Opportunities for States*. National Academy of Social Insurance; 2017; https://www.nasi.org/wp-content/uploads/2017/06/Opportunities-for-States_web.pdf; Whitman, A., De Lew, N., Chappel, A., et al. *Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts*. Assistant Secretary for Planning and Evaluation; 2022; https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf.

enrollees are entitled while testing the benefit of the HRSN services described above. This cap will not apply to any other benefits or services.

Finally, CMS is revising the approach to adjusting the budget neutrality calculation in the middle of a demonstration approval period. Historically, CMS has limited its review of state requests for "mid-course" budget neutrality adjustments to situations that necessitate a corrective action plan, in which expenditure data indicate a state is likely to exceed its budget neutrality expenditure limit. CMS has updated its approach to mid-course corrections in this demonstration approval to provide flexibility and stability for the state over the life of a demonstration. This update identifies, in the STCs, a list of circumstances under which a state's baseline may be adjusted, based on actual expenditure data, to accommodate circumstances that are either out of the state's control, (for example, expensive new drugs that the state is required to cover enter the market); and/or the effect is not a condition or consequence of the demonstration, for example, unexpected costs due to a public health emergency; and/or the new expenditure (while not a new demonstration-covered service or population that would require the state to propose an amendment to the demonstration) is likely to further strengthen access to care (for example, a legislated increase in provider rates). CMS also explains in the STCs what data and other information the state should submit to support a potentially approvable request for an adjustment. CMS considers this a more rational, transparent, and standardized approach to permitting budget neutrality modifications during the course of a demonstration.

Requests Not Being Approved at this Time

CMS and Arizona are continuing discussions regarding the state's pending requests, which are components of the state's strategy to improve consistent access and outcomes for individuals enrolled in Arizona's Medicaid program. Arizona requested to provide a limited benefit package of case management services for individuals being held in federal, state, local, and tribal correctional facilities for up to 30-days pre-release. CMS is supportive of increasing pre-release services for the justice involved populations and of supporting individuals' transitioning from institutional settings back into the community, and will continue to work with the state on this component of its proposal.

The state also requested expenditure authority to receive reimbursement for traditional healing services provided by Indian Health Service (IHS) and tribal facilities. CMS recognizes the state's goals of addressing disparities in the American Indian and Alaska Native community and will continue to work with the state on this request.

In the extension application the state requested authority to allow verbal consent in lieu of a written signature for up to 30-days for person-centered service plans for ALTCS beneficiaries. Due to stakeholder feedback received subsequent to the state's extension submission, the state requested to withdraw this request from consideration during extension negotiations.

Lastly, CMS is not approving the state's request to implement the AHCCCS Works community engagement program, consistent with the determination reached in CMS' June 24, 2021 letter to the state.

Monitoring and Evaluation

Consistent with the STCs for the AHCCCS demonstration, the state submitted its draft Interim Evaluation Report for the prior demonstration approval period on December 28, 2020, which was finalized on May 10, 2022.[11] The report evaluated each of the key demonstration policy components from their implementation through 2021 with corresponding pre-implementation periods. With limited implementation period for several of the demonstration components, which also overlapped with the COVID-19 Public Health Emergency (PHE), it was difficult to draw conclusive findings for the effects of several of the policies. Nevertheless, the report presented preliminary evidence of promising trends on a number of outcomes related to health care access and quality of care.

For example, under the ACC component of the demonstration, the rate of certain outcome measures improved (e.g., increases in mental health services use and declines in emergency department [ED] visits), however findings related to primary and preventive care utilization demonstrated both positive and negative results. Under the ALTCS program, the share of beneficiaries who accessed preventive or ambulatory care services increased between 2015 and 2020, both among beneficiaries with developmental disabilities and those who were elderly with physical disabilities. The children in foster care who received services under the Comprehensive Medical and Dental Program (a population who will be served through the CHP with this demonstration extension) experienced greater access to care and quality of care as illustrated through higher rates of visits for preventive or wellness services, follow-up visits after hospitalization, and improved management of behavioral health conditions after the implementation of the program. In the RBHA program, beneficiaries with SMI experienced the same or better management of behavioral health conditions following the integration of acute and behavioral care for this population. In particular, there was an increase in the rate of follow-up visits after an ED visit or a hospitalization for mental illness in the intervention period. The waiver of retroactive eligibility was associated with stable or slightly increasing enrollment rates and new enrollment rates, and slightly shorter gaps in coverage among those who re-enroll after a gap of up to 6 months. However, enrollment declined among the parent and disabled eligibility groups as did the overall share of beneficiaries with visits to a specialist. For the TI 1.0 program, while there were no impacts on most measures assessed under this program component, the program was associated with an increase in adults with initiation and engagement of treatment for alcohol, opioid, or other drug abuse, and medication assisted treatment. TI providers reported an increase in self-assessed integration status between the second and third year of the demonstration.

With this extension of the AHCCCS demonstration, consistent with CMS requirements for section 1115 demonstrations, and as outlined in the demonstration's STCs, the state is required to conduct systematic monitoring and robust evaluation of the demonstration per applicable CMS guidance and technical assistance. The overall demonstration, including novel initiatives, such as the H2O and TI 2.0 initiatives that are being authorized for the first time under this demonstration extension and amendment, must be rigorously monitored and evaluated. Evidence indicating substantial and sustained directional change inconsistent with the

[11] The AHCCCS Interim Evaluation Report is currently under CMS review and will be posted publicly once approved by CMS.

demonstration goals, such as sustained trends indicating substantially increased difficulty accessing services, could form a basis for CMS to initiate the process for withdrawing specific authorities within the demonstration.

The demonstration's monitoring activities must support tracking the state's progress towards meeting the goals and milestones—including relative to their projected timelines—of the demonstration's program and policy implementation and infrastructure investments. The state must report on metrics that relate to the demonstration key policy components, including H2O and TI 2.0. The demonstration's metrics reporting must cover categories including, but not limited to: enrollment and renewal, access to providers, utilization of services, and quality of care and health outcomes. The state is required to do robust reporting of quality of care and health outcomes aligned with the demonstration's policy composition and objectives, to be reported for all demonstration populations. Such reporting must also be stratified by demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography) and demonstration component, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities. To that end, CMS underscores the importance of the state's reporting of quality of care and health outcomes metrics known to be important for closing key equity gaps in Medicaid/CHIP (e.g., the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritizing key outcome measures and their clinical and non-clinical (i.e., social) drivers of health. In coordination with CMS, the state is expected to select such measures for reporting in alignment with a critical set of equity-focused measures CMS is finalizing as part of its upcoming guidance on the Health Equity Measure Slate.

For the demonstration's H2O program, in addition to reporting on the metrics described above, the state must track beneficiary participation, screening, receipt of referrals and social services over time, as well as narratively report on the adoption of information technology infrastructure to support data sharing between the state or partner entities assisting in the administration of the demonstration and social services organizations. Specifically in the context of the H2O program, the state's enrollment and renewal metrics must capture baseline data and track progress via Monitoring Reports for the percent of Medicaid renewals completed ex-parte (administratively), as well as the percentage of Medicaid beneficiaries enrolled in other public benefit programs (such as, Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)) for which they are eligible. These reports must also provide status updates in accordance with the Monitoring Protocol on the implementation of infrastructure investments tied to the HRSN initiatives.

In order to ensure a link between DSHP-funded initiatives and improvements in access to medical assistance and beneficiary health outcomes, CMS and the state will coordinate to use the set of metrics described above, with applicable demographic stratification. In addition, the state must demonstrate through its annual monitoring reporting to CMS improvements in Medicaid fee-for-service base provider reimbursement rates and reimbursement rates for providers enrolled in managed care to the extent required by the DSHP-related STCs. If the state, health plans, or health care providers will contract or partner with organizations to implement the demonstration,

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

Furthermore, as required by 42 CFR 431.424 and the STCs, and consistent with current CMS guidance, Arizona must develop a comprehensive and meaningful evaluation of the demonstration as approved herein to assess whether the demonstration components are effective in producing the desired outcomes for its beneficiaries and providers, as well as for the state's overall Medicaid program. The demonstration evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding of the demonstration's impact on beneficiary coverage, access to and quality of care, and health outcomes, as well as its effectiveness in achieving the policy goals and objectives. Furthermore, to the extent feasible, the state must collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes and help inform how the demonstration's various policies might support reducing such disparities.

For all components of the demonstration, including those that are being extended from the prior approval period, the state must—as applicable—develop and test evaluation hypotheses and research questions in alignment with program goals, and assess care coordination, access to and utilization of primary and behavioral health services, and reductions in use of avoidable inpatient and ED services. The state also must collect necessary data to accommodate CMS's evaluation expectations to rigorously assess the effects of the state's waiver of retroactive eligibility on beneficiaries and providers, for example, by examining outcomes such as likelihood of enrollment and enrollment continuity, health status, and financial status.

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

The evaluation must also assess the effectiveness of the infrastructure investments authorized through the demonstration to support the development and implementation of the HRSN initiatives. The state must also examine whether and how local investments in housing supports change over time in concert with new Medicaid funding toward those HRSN services. In addition, in light of how demonstration HRSN expenditures are being treated for purposes of budget neutrality, the evaluation of the HRSN initiative must include a cost analysis to support developing comprehensive and accurate cost estimates of providing such services. Evaluation of the H2O initiative is also required to include a robust assessment of potential improvements in the quality and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications.

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

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

CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and experience with the various demonstration policies, including but not limited to the H2O and waiver of prior quarter coverage components, beneficiary experience with access to and quality of care, as well as changes in incidence of beneficiary medical debt. In addition, the state is strongly encouraged to evaluate the implementation of the demonstration programs in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—or barriers to—implementation. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Consideration of Public Comments

To increase the transparency of demonstration projects, sections 1115(d)(1) and (2) of the Act direct the Secretary to issue regulations providing for two periods of public comment on a state's

application for a section 1115 demonstration that would result in an impact on eligibility, enrollment, services, cost-sharing, or financing. The first comment period occurs at the state level before submission of the section 1115 application, and the second comment period occurs at the federal level after the application is received by the Secretary.

As enacted by the Affordable Care Act (ACA), and incorporated under section 1115(d)(2)(A) and (C) of the Act, comment periods should be "sufficient to ensure a meaningful level of public input," but the statute imposes no additional requirement on the states or the Secretary to provide an individualized response to address those comments, as might otherwise be required under a general rulemaking. Accordingly, the implementing regulations issued in 2012 provide that CMS will review and consider all comments received by the deadline, but will not provide individualized written responses to public comments (42 CFR 431.416(d)(2)).

The state's public comment period for the AHCCCS section 1115 demonstration extension request was held from October 2, 2020 through November 30, 2020. The state held an additional public comment period for the H2O demonstration amendment, which was open from March 19, 2021 through May 3, 2021.

The federal comment period for the AHCCCS extension request was open from January 4, 2021 through February 3, 2021 and the H2O amendment was open for comments from June 7, 2021 through July 7, 2021. A total of 56 comments were received to the AHCCCS extension request, 29 of which supported the extension and 27 of which opposed it. The H2O amendment received 70 comments: 64 in support of the amendment, 1 in opposition, and 5 unrelated.

In response to the AHCCCS extension a total of three out of the 29 comments supported the TI 2.0 program. One specifically highlighted that the expansion component of the program will allow more beneficiaries to experience continuous care, and another stated that the expansion will improve access to care, have more coordination between primary care and behavioral health services, and increased coordination with community-based organizations. CMS agrees with these comments and supports the goal of expanding the state's current program to implement the TI 2.0 program, in order to provide incentive payments to participating providers to more fully integrate and coordinate physical and behavioral health care and to improve health equity for targeted populations.

Three comments supported the discontinuation of the Choice Accountability Responsibility Engagement (CARE) program, and thirteen opposed the community engagement provisions. The CARE program and community engagement provisions have both been terminated. CARE was removed from the demonstration when Arizona received a temporary extension on September 30, 2021, and community engagement was terminated effective June 24, 2021. There were three comments in response to the allowance of verbal informed consent, and the state withdrew this request during the extension negotiation process.

Nine comments that opposed the extension request objected to the waiver of retroactive eligibility on the basis that it could cause more medical debt, health complications, and disruptions in care among beneficiaries, as well as lead to safety-net hospitals and providers not being reimbursed for care. Further, two commenters stated this waiver limits access to health coverage among low-income individuals. CMS will continue to work with the state to collect

robust data to measure the effects of the waiver of retroactive eligibility on beneficiaries and providers.

Four comments opposed the application on procedural grounds, arguing the AHCCCS extension application is incomplete and the proposal is not experimental as managed care is now a state plan option. CMS determined that the extension application was complete and included all necessary components as described in the completeness letter from January 4, 2021. CMS also believes that the proposal is sufficient to justify a section 1115 demonstration.

Comments were also received regarding the proposal's traditional healing and justice-involved initiative provisions. At this time, these aspects of the request are not being approved with this approval, and CMS will take those comments into consideration as part of our review of these requests in the future.

The vast majority of comments received in regards to the H2O amendment supported it, citing the importance of services targeting HRSN to optimize health and mitigate inequities and poor health outcomes. Many comments highlighted the evidence-based connection between housing and a reduction in emergency medical care and claimed that this will result in cost savings to the healthcare system. Numerous comments also stated that this amendment aligns with the purpose of the Medicaid program. CMS agrees with these comments and supports the aims of the demonstration to increase positive health outcomes for target populations, to reduce the cost of care for individuals successfully housed through decreased utilization of crisis services, and to reduce homelessness and improve skills to maintain housing stability.

Several comments expressed concerns over the H2O amendment. One comment stated that Medicaid cannot be solely relied upon to fill the gap in affordable housing; it is outside of the scope of this amendment to fill the gap in affordable housing by offering housing to every individual experiencing housing insecurity. Another commenter expressed that offering housing to homeless individuals will not rectify substance use disorders or correct unhealthy behaviors. It is the position of CMS that offering HRSN services to targeted populations, where clinically appropriate, has the potential to make a meaningful difference in the effectiveness of downstream services towards equity and the health of the targeted individuals. Further, CMS believes that the state's proposal constitutes a valid experiment where the impact of HRSN services on health outcomes can be monitored and rigorously evaluated through a set of equity measures and service-specific outcome measures. This amendment will provide the new HRSN services to a targeted population for a limited time, that will support addressing underlying needs that drive a majority of an individual's health outcomes, as well as reducing health disparities that are often rooted in social and economic disadvantages.

Other Information

The award is subject to CMS receiving written acceptance of this award within thirty days of the date of this approval letter. Your project officer Ms. Kelsey Smyth is available to answer any questions concerning implementation of the state's section 1115(a) demonstration, and her contact information is as follows:

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We appreciate your state's commitment to improving the health of people in Arizona, and we look forward to partnering with you on the AHCCCS section 1115(a) demonstration. If you have questions regarding this approval, please contact Ms. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,

Daniel Tsai
Deputy Administrator and Director

Enclosures

cc: Brian Zolynas, State Monitoring Lead, Medicaid and CHIP Operations Group