CENTERS FOR MEDICARE & MEDICAID SERVICES WAIVER LIST

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

TITLE: **Arizona Medicaid Section 1115 Demonstration**

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

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

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

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

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

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

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

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

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

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

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

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

non-covered activities.

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

To the extent necessary to enable the state to not provide medical assistance for any month prior to the month in which a beneficiary's Medicaid application is filed. The waiver of retroactive eligibility does not apply to applicants who would have been eligible at any point within the three-month period immediately preceding the month in which an application was received, as a pregnant woman (including during the 60-day period beginning on the last day of the pregnancy), an infant under age 1, or a child under age 19.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

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

TITLE: **Arizona Medicaid Section 1115 Demonstration**

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

Medicaid Costs Not Otherwise Matchable

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

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

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

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

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

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

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

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

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

7. Expenditures related to:

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

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

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

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

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

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

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

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

13. Expenditures to provide certain dental services up to a cost of $1,000 per person annually to individuals age

21 or older enrolled in the ALTCS program, excluding beneficiaries who are American Indian/Alaskan Native (AI/AN) who are addressed in Expenditure 15.

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

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

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

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

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

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

Title XIX requirements not applicable to these demonstration expenditures.

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

To the extent necessary to allow the state to offer the applicable benefits package to an individual who meets the qualifying eligibility criteria for the H2O program HRSN services, including during a phase in process as described in STC 30.

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

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

Title XXI Costs Not Otherwise Matchable

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

22. **Expenditures for KidsCare Expansion**. Expenditures for all state plan and demonstrations services for individuals under age 19 who meet all eligibility criteria for the Children's Health Insurance Program (CHIP) with incomes above 200 percent up to and including 300 percent of the federal poverty level (FPL) as described in STC 6 and 19 who are not otherwise covered as of February 16, 2024, subject to approval by the state legislature.

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

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

TITLE: Arizona Medicaid Section 1115 Demonstration

AWARDEE: Arizona Health Care Cost Containment System (AHCCCS)

I. PREFACE

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

The STCs have been arranged into the following subject areas:

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

II. PROGRAM OVERVIEW AND HISTORICAL CONTEXT

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

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

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

The Targeted Investments 1.0 Program was expected to:

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

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

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

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

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

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

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

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

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

III. GENERAL PROGRAM REQUIREMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IV. ELIGIBILITY

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

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

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

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

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

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

18. Waiver of Retroactive Eligibility. The state will not provide medical assistance for any month prior to the month in which a beneficiary's Medicaid application is filed, except for a pregnant woman (including during the 60-day period beginning on the last day of the pregnancy), an infant under age 1, or a child under age 19. The waiver of retroactive eligibility applies to all populations described in STC 17 who are not pregnant (including during the 60-day period beginning on the last day of the pregnancy), an infant under age 1, or a child under age 19.

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

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

Subject to STC 6:

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

V. DEMONSTRATION PROGRAMS

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

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

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

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

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

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

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

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

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

AHCCCS' receipt of the RBHA recommendation.

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

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

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

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

furnished; and

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

g. **ALTCS Benefits and Services**

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

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

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

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

    a. **Alternative HCBS Settings include:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VI. HCBS QUALITY ASSURANCE AND REPORTING REQUIREMENTS

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

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

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

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

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

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

29. HCBS Beneficiary Protections.

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

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

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

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

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

VII. HOUSING AND HEALTH OPPORTUNITIES

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

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

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

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

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

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

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

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

34. HRSN Infrastructure.

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

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

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

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

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

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

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

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

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

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

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

Specifically, the protocol must include the following information:

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

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

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

37. Service Delivery.

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

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

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

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

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

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

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

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

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

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

HRSN services.

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

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

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

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

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

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

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

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

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

VIII. TARGETED INVESTMENTS 2.0 PROGRAM

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

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

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

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

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

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

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

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

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

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

51. Structure for Initiatives and Incentives.

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

performance measure targets.

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

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

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

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

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

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

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

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

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

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

IX. DESIGNATED STATE HEALTH PROGRAMS (DSHP)

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

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

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

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

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

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

56. Prohibited DSHP Expenditures.

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

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

57. DSHP-Funded Initiatives.

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

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

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

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

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

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

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

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

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

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

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

X. PROVIDER PAYMENT RATE INCREASE REQUIREMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

XI. PAYMENTS UNDER THE DEMONSTRATION.

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

XII. DELIVERY SYSTEMS

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

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

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

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

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

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

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

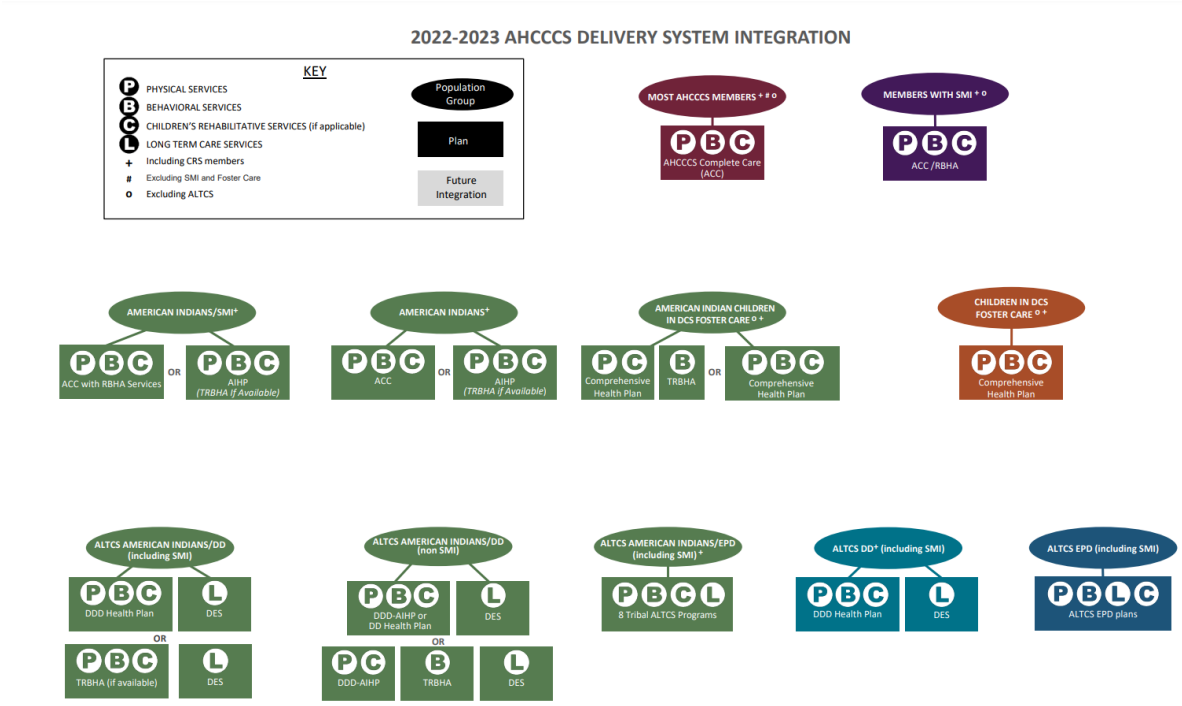
78. American Indians/Alaska Natives (AI/AN). Medicaid-eligible AI/AN may, but are not required to, participate in managed care with the following exceptions:

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

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

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

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



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

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

XIII. MONITORING AND REPORTING REQUIREMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

XIV. EVALUATION OF THE DEMONSTRATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

XV. GENERAL FINANCIAL REQUIREMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

XVI. MONITORING BUDGET NEUTRALITY

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

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

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

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

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

*PC = Per Capita, Agg = Aggregate

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

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

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

Table 10: Hypothetical Budget Neutrality Test 1

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

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

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

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

Table 11: Capped Hypothetical Budget Neutrality Test

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

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

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

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

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

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

Table 12: Budget Neutrality Test Corrective Action Plan Calculation

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

XVII. MONITORING ALLOTMENT NEUTRALITY

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

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

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

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

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

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

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

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

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

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

XVIII. SCHEDULE OF DELIVERABLES

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

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

Date – Specific	Deliverable	Section Reference
	Infrastructure Planning, and Provider Qualifications for H2O services	
No later than 90 days of approval date	Targeted Investments 2.0 Incentivized Metrics and Funding Protocol	STC 52
No later than 120 days of approval date	DSHP Claiming Protocol	STC 58
No later than 9 months of approval date	Draft New Initiatives Implementation Plan	STC 84
No later than 60 days of receiving CMS comments	Revised Implementation Plan	STC 84
No later than 150 days of approval date	Draft Monitoring Protocol	STC 85
No later than 60 days of receiving CMS comments	Revised Monitoring Protocol	STC 85
No later than 180 calendar days from approval date	Draft Evaluation Design	STC 98
No later than 60 days of receiving CMS comments	Revised Evaluation Design	STC 99
One year prior to demonstration expiration or with extension application	Draft Interim Evaluation Report	STC 102(c)
No later than 60 days of receiving CMS comments	Revised Interim Evaluation Report	STC 102(d)
No later than 18 months after the expiration of this demonstration period	Draft Summative Evaluation Report	STC 103
No later than 60 days of receiving CMS comments	Revised Summative Evaluation Report	STC 103(a)
No later than 120 days after the end of the demonstration	Draft Close Out Report	STC 88
No later than 30 days after receiving CMS comments	Revised Close Out Report	STC 88(e)
Annually		
90 days after the end of each DY	Annual Monitoring Report (including Q4 monitoring information and budget neutrality)	STC 86

Date – Specific	Deliverable	Section Reference
No later than 60 days of receiving CMS comments	Revised Annual Monitoring Report	STC 86
Quarterly		
60 days following the end of the quarter	Quarterly Monitoring Reports	STC 86
30 days following the end of the quarter	Quarterly Expenditure Reports	STC 109

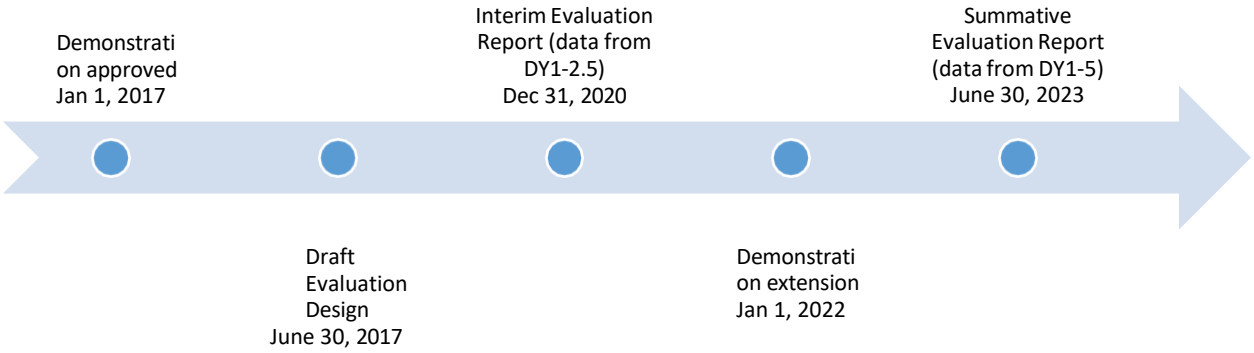
Attachment A
Developing the Evaluation Design

Introduction

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

Submission Timelines

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



Expectations for Evaluation Designs

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

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

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

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

The format for the Evaluation Design is as follows:

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

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

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

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

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

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

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

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

Specifically, this section establishes:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

E. Attachments

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

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

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

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

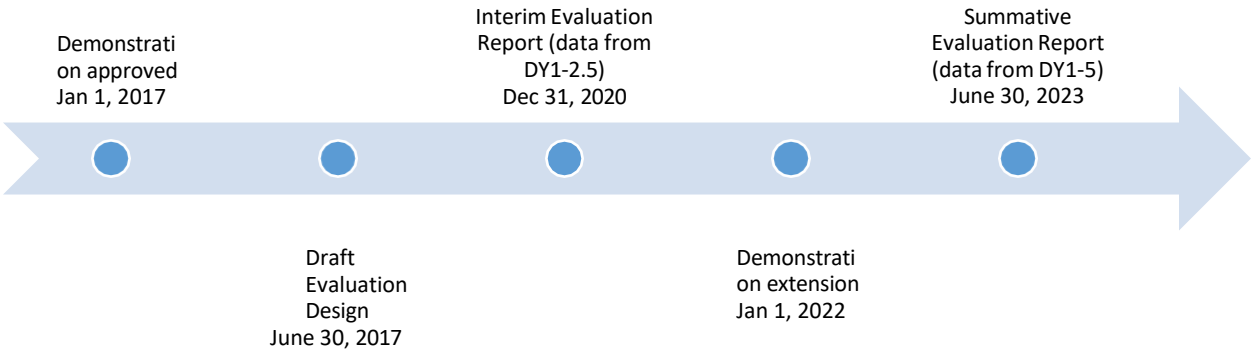
Attachment B
Preparing the Interim and Summative Evaluation Reports

Introduction

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

Submission Timelines

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



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

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

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

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

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

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

J. Attachment(s).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attachment C
Reimbursement for Critical Access Hospitals

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

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

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

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

Attachment D
Targeted Investments 2.0 Program DSHP Claiming Protocol (reserved)

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

Attachment F
Implementation Plan (reserved)

Attachment G
Monitoring Protocol (reserved)

Attachment H
Evaluation Design (reserved)

Attachment I
Targeted Investments 2.0 Incentivized Metrics and Funding Protocol (reserved)

Attachment J
HCBS Quality Assessment and Performance Improvement Plan

Administrative Authority

1. Number and percent of issues identified in contract monitoring reports that were remediated as required by the State.

N = Number of initially rejected deliverables that were successfully resubmitted
D = Total number of rejected MCO deliverables

2. Number and percent of contract monitoring reviews required that were completed within the required timeframe.

N =Total Number of contract deliverables submitted timely
D = Total number of contract deliverables

Level of Care (LOC) or Eligibility

3. Number and percent of applicants who had an evaluation indicating the individual met the 1115 LOC or needs-based eligibility criteria prior to receiving services.

N= Number of applicants evaluated for institutional LOC.
D= Total number of applicants.

4. Number and percent of reviewed 1115 evaluations that were completed using the processes and instruments approved in the 1115 STCs.

N = Number of members evaluated using the Pre-Admission Screening (PAS) tool (as defined in the STCs)
D = Total number of HCBS recipients.

Qualified Providers

5. Number and percent of new 1115 providers who meet the State's certification standards, as required, prior to providing 1115 services.

N= Number of unique providers with claims/encounters for ALTCS members that are approved due to the providers being registered on the date of service.
D= Total number of unique providers with claims/encounters submitted for ALTCS members.

6. Number and percent of 1115 providers that continue to meet the State's certification standards at the time of review.

N = Number of providers that were approved for recredentialing during the measurement period
D = Total number of providers that went through the recredentialing process during the measurement period.

Service Plan

7. *Choice of services and providers:*
In at least 86 percent of the Person-Centered Service Plans (PCSPs) audited, the PCSPs documented

member choice of services and providers in accordance with the federally mandated PCSP process and requirements.

N = Number of PCSPs audited that documented member choice of services and providers
D = Total number of PCSPs audited

8. *Service plans address assessed needs and personal goals of 1115 participants:*
In at least 86 percent of the PCSPs audited, the PCSPs included documentation of member needs and progress towards person goals and desired outcomes in accordance with the federally mandated PCSP process and requirements.

N = Number of PCSPs audited that included documentation of member needs and progress towards meeting person goals
D = Total number of PCSPs audited

9. *Service plans are updated annually:*
In at least 86 percent of the PCSPs audited, there is documentation that the PCSPs were reviewed with members/HCDMs and revised at least once every 12 months in accordance with the federally mandated PCSP process and requirements.

N = Number of PCSPs audited that documented that the PCSPs were reviewed and revised at least once every 12 months
D = Total number of PCSPs audited

10. *Services are delivered in accordance with the service plan including the type, scope, amount, duration, and frequency specified in the service plan:*
In at least 86 percent of the PCSPs audited, the PCSPs included documentation of services including the type, scope, amount, duration, and frequency specified in the PCSPs, as well as verification of service delivery in accordance with the federally mandated PCSP process and requirements.

N = Number of PCSPs audited that included documentation of services and verification of service delivery, in accordance with the PCSP.
D = Total number of PCSPs audited

Health and Welfare

11. Number and percent of 1115 recipients who received information about how to report, abuse, neglect, exploitation and other critical incidents.

N = Number of members annually who were provided with information about how to report abuse, neglect, exploitation and other critical incidents
D = Total number of enrolled members

12. Number and percent of incident reviews/investigations that were initiated regarding reportable death, abuse, neglect, exploitation and unapproved restraints as required by the State Medicaid Agency (SMA).

N = Number of quality of care (QOC) concern investigations that were initiated regarding reportable death, abuse, neglect, exploitation, and unapproved restraints allegations
D = Total number of reported incidents specific to death, abuse, neglect, exploitation, and unapproved

restraints allegations

13. Number and percent of incident reviews/investigations involving reportable death, abuse, neglect, exploitation and unapproved restraints for participants that were completed as required by the SMA.

N = Number of QOC investigations involving reportable death, abuse, neglect, exploitation and unapproved restraints for participants that were completed
D = Total number of QOC investigations involving reportable death, abuse, neglect, exploitation and unapproved restraints

14. Number and percent of incidents reviewed involving abuse, neglect, exploitation and unapproved restraints that had a plan of prevention/documentation of a plan, developed as a result of the incident.

N = Number of substantiated QOC cases where corrective action plans are documented
D = Number of substantiated QOC cases

Financial Accountability

15. Number and percent of claims verified through a review of provider documentation that have been paid in accordance with the individual's service plan.

N = Number of claims verified through a review of provider documentation that have been paid in accordance with the individual's service plan
D = Total number of claims reviewed
Note: This metric will just be for the work done in the given year vs. claims specific to the current delivery period.

16. Number and percent of claims paid to 1115 service providers who are qualified to furnish 1115 services to 1115 recipients.

N = Total number of claims that are paid to qualified providers
D = Total number of claims reviewed

HCBS Settings Requirements

17. Number and percent of HCBS settings that meet Federal HCBS settings requirements

N = Number of HCBS settings that meet Federal HCBS settings requirements
D = Number of HCBS settings reviewed

APPENDIX K: Emergency Preparedness and Response and COVID-19 Addendum

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendments to its approved waiver, to multiple approved waivers in the state, and/or to all approved waivers in the state. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities[1] This appendix may be applied retroactively as needed by the state. Public notice requirements normally applicable under 1915(c) do not apply to information contained in this Appendix.

Appendix K-1: General Information

General Information:

A. State: Arizona

B. Waiver Title(s): Arizona Health Care Cost Containment System (AHCCCS)

C. Control Number(s):
1115 Demonstration Project No. 11-W-00275/9

D. Type of Emergency (The state may check more than one box):

X	**Pandemic or Epidemic**
◯	**Natural Disaster**
◯	**National Security Emergency**
◯	**Environmental**

[1] Numerous changes that the state may want to make may necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; or (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound

◯	**Other (specify):**

E. Brief Description of Emergency. *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state's mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

COVID-19 pandemic. This amendment will apply waiver-wide for each waiver included in this Appendix, to all individuals impacted by the virus or the response to the virus (e.g. closure of day programs, etc.)

F. Proposed Effective Date: January 1, 2022 **Anticipated End Date:** End of the calendar quarter in which the PHE ends.

G. Description of Transition Plan.

All activities will take place in response to the impact of COVID-19 as efficiently and effectively as possible based upon the complexity of the change.

H. Geographic Areas Affected:

These actions will apply across the Waiver to all individuals impacted by the COVID-19 virus

I. Description of State Disaster Plan (if available) ***Reference to external documents is acceptable:***

N/A

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a. ___Access and Eligibility:

i. ___Temporarily increase the cost limits for entry into the waiver.

[Provide explanation of changes and specify the temporary cost limit.]

ii. ___**Temporarily modify additional targeting criteria.**
[Explanation of changes]

b.___Services

i. ___**Temporarily modify service scope or coverage.**
[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. ___**Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.**
[Explanation of changes]

iii. ___**Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).**
[Complete Section A-Services to be Added/Modified During an Emergency]

iv. __**Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches). Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:**
[Explanation of modification, and advisement if room and board is included in the respite rate]:

v. ___**Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver).** [Explanation of changes]

c.__Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as

authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

d.___Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i.___Temporarily modify provider qualifications.

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

ii.___Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the provider type for each service].

iii.___Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

e.___Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

f._X_ Temporarily increase payment rates.

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider.]

The Administration shall make a lump sum payment to registered network providers who provide qualifying American Rescue Plan Act (ARPA) services with Arizona Fee for Service (FFS) Medicaid utilization for service periods during the PHE, and will use October 1, 2020 to March 31, 2021 as proxy utilization data for the lump sum payment. Registered network providers which qualify for these increases are outlined in the following link- https://azahcccs.gov/AHCCCS/downloads/Initiatives/ARPA/EligibleProviderTypesNon-DDD.pdf.

These lump sum payments are to compensate providers for costs of covered services furnished to Arizona Medicaid beneficiaries to improve the member's experience of care. Each registered network provider's lump sum payment shall be determined as follows:

1. Determine each provider's actual Medicaid utilization of qualifying services from October 1, 2020, to March 31, 2021.
2. Multiply the actual Medicaid utilization determined in item 1 by two.
3. The uniform percentage increase for providers will be 17.8%
4. The Administration will multiply the appropriate uniform percentage increase listed in item three by the total utilization determined in item two to calculate the lump sum payment for each provider.

Providers are required to distribute at least 80% of the lump sum amount to Direct Service Provider staff in the form of a temporary increase in salary, wages, bonuses, hiring/retention incentives, and/or stipends, including employee related expense costs.

For the lump sum payment above, the qualifying HCBS services include: Attendant care, respite care, home health, home delivered meals, personal care, therapy services, homemaker services, adult day health, habilitation services and assisted living facilities/adult foster care (including supervision, service coordination, personal care/directed services and recreation and socialization).

AHCCCS will not make any payments to providers that have a total lump sum payment of less than $1,000.

g. Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

h.___Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

i. __ Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.

[Specify the services.]

j. __Temporarily include retainer payments to address emergency related issues.

[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

k.___Temporarily institute or expand opportunities for self-direction.

[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards.]

l.___Increase Factor C.

[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m.___Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

Appendix K Addendum: COVID-19 Pandemic Response

1. HCBS Regulations

a. ☐ Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic.

2. Services

a. ☐ Add an electronic method of service delivery (e.g,. telephonic) allowing services to continue to be provided remotely in the home setting for:

i. ☐ Case management
ii. ☐ Personal care services that only require verbal cueing
iii. ☐ In-home habilitation
iv. ☐ Monthly monitoring (i.e., in order to meet the reasonable indication of need for services requirement in 1915(c) waivers).
v. ☐ Other *[Describe]:*

b. ☐ Add home-delivered meals

c. ☐ Add medical supplies, equipment and appliances (over and above that which is in the state plan)

d. ☐ Add Assistive Technology

3. Conflict of Interest: The state is responding to the COVID-19 pandemic personnel crisis by authorizing case management entities to provide direct services. Therefore, the case management entity qualifies under 42 CFR 441.301(c)(1)(vi) as the only willing and qualified entity.

a. ☐ Current safeguards authorized in the approved waiver will apply to these entities.

b. ☐ Additional safeguards listed below will apply to these entities.

4. Provider Qualifications

a. ☐ Allow spouses and parents of minor children to provide personal care services

b. ☐ Allow a family member to be paid to render services to an individual.

c. ☐ Allow other practitioners in lieu of approved providers within the waiver. *[Indicate the providers and their qualifications]*

d. ☐ Modify service providers for home-delivered meals to allow for additional providers, including non-traditional providers.

5. Processes

a. ☐ Allow an extension for reassessments and reevaluations for up to one year past the due date.

b. ☐ Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.

c. ☐ Adjust prior approval/authorization elements approved in waiver.

d. ☐ Adjust assessment requirements

e. ☐ Add an electronic method of signing off on required documents such as the person-centered service plan.

Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

First Name:	Alex
Last Name	Demyan
Title:	Deputy Assistant Director
Agency:	AHCCCS
Address 1:	801 E Jefferson Street
Address 2:	
City	Phoenix
State	Arizona
Zip Code	85034
Telephone:	602- 417-4130
E-mail	Alex.demyan@azahcccs.gov
Fax Number	

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Shreya
Last Name	Arakere
Title:	Waiver Manager
Agency:	AHCCCS
Address 1:	801 E Jefferson St
Address 2:	
City	Phoenix
State	AZ
Zip Code	85034
Telephone:	602-417-4611
E-mail	Shreya.arakere@azahcccs.gov
Fax Number	

8. Authorizing Signature

Signature:  State Medicaid Director or Designee	**Date:** 6/29/2022

First Name:	*Jami*
Last Name	*Snyder*
Title:	Director
Agency:	AHCCCS
Address 1:	801 E Jefferson Street
Address 2:	
City	Phoenix
State	Arizona
Zip Code	85034
Telephone:	602-417-4458
E-mail	Jami.snyder@azahcccs.gov
Fax Number	

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver that the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification should be readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification				
Service Title:				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:				
Service Definition (Scope)**:**				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
Not applicable				

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☐	Agency. List the types of agencies:

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Delivered Meals		

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☐	Provider managed

APPENDIX K: Emergency Preparedness and Response and COVID-19 Addendum

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendments to its approved waiver, to multiple approved waivers in the state, and/or to all approved waivers in the state. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.[i] This appendix may be applied retroactively as needed by the state. Public notice requirements normally applicable under 1915(c) do not apply to information contained in this Appendix.

Appendix K-1: General Information

General Information:

A. State: Arizona

B. Waiver Title(s): Arizona Health Care Cost Containment System (AHCCCS)

C. Control Number(s):
1115 Demonstration Project No. 11-W-00275/9

D. Type of Emergency (The state may check more than one box):

X	**Pandemic or Epidemic**
O	**Natural Disaster**
O	**National Security Emergency**
O	**Environmental**
O	**Other (specify):**

E. Brief Description of Emergency. *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state's mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

COVID-19 pandemic. This amendment will apply waiver-wide for each waiver included in this Appendix, to all individuals impacted by the virus or the response to the virus (e.g. closure of day programs, etc.)

F. Proposed Effective Date: Start Date: June 30, 2023, Anticipated **End Date:** November 11, 2023 (Six months after the end of the PHE)

G. Description of Transition Plan.

All activities will take place in response to the impact of COVID-19 as efficiently and effectively as possible based upon the complexity of the change.

H. Geographic Areas Affected:

These actions will apply across the waiver to all individuals impacted by the COVID-19 virus

I. Description of State Disaster Plan (if available) ***Reference to external documents is acceptable:***

N/A

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a.___ Access and Eligibility:

i.___ Temporarily increase the cost limits for entry into the waiver.
[Provide explanation of changes and specify the temporary cost limit.]

ii.___ Temporarily modify additional targeting criteria.
[Explanation of changes]

b.___ Services

i.___ Temporarily modify service scope or coverage.
[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. ___Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.
[Explanation of changes]

iii. ___Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).
[Complete Section A-Services to be Added/Modified During an Emergency]

iv. ___Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches). Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:
[Explanation of modification, and advisement if room and board is included in the respite rate]:

v.___ Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver). [Explanation of changes]

c.___ Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

d.___ Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i.___ Temporarily modify provider qualifications.
[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

ii.___ Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the .provider type for each service].

iii.___ Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

e. ___Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

f.___ Temporarily increase payment rates.

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider.]

g.___ Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

h.___ Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

i.___ Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.
[Specify the services.]

j.___ Temporarily include retainer payments to address emergency related issues.
[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

k.___ Temporarily institute or expand opportunities for self-direction.
[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards.]

l.___ Increase Factor C.
[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m.___ Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

Appendix K Addendum: COVID-19 Pandemic Response

1. **HCBS Regulations**
    a. ☐ Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic.

2. **Services**
    a. ☐ Add an electronic method of service delivery (e.g,. telephonic) allowing services to continue to be provided remotely in the home setting for:
        i. ☐ Case management
        ii. ☐ Personal care services that only require verbal cueing
        iii. ☐ In-home habilitation
        iv. ☐ Monthly monitoring (i.e., in order to meet the reasonable indication of need for services requirement in 1915(c) waivers).
        v. ☐ Other *[Describe]:*

    b. ☐ Add home-delivered meals
    c. ☐ Add medical supplies, equipment and appliances (over and above that which is in the state plan)
    d. ☐ Add Assistive Technology

3. **Conflict of Interest: The state is responding to the COVID-19 pandemic personnel crisis by authorizing case management entities to provide direct services. Therefore, the case management entity qualifies under 42 CFR 441.301(c)(1)(vi) as the only willing and qualified entity.**
    a. ☐ Current safeguards authorized in the approved waiver will apply to these entities.
    b. ☐ Additional safeguards listed below will apply to these entities.

4. **Provider Qualifications**
    a. ☒ Allow spouses and parents of minor children to provide personal care services.
    b. ☐ Allow a family member to be paid to render services to an individual.
    c. ☐ Allow other practitioners in lieu of approved providers within the waiver. *[Indicate the providers and their qualifications]*

d. ☐ Afford the state additional flexibility to allow for legally responsible individuals (parents and spouses) to receive payment for direct care services. Permitting parents of minor children to receive payment for direct care services. Removing the 40-hour maximum hours per week of services a member can receive if they have a spouse serving as the paid caregiver as well as allowing the spouse to provide the total amount of attendant care the member receives. The parents and spouses must be employed/contracted by an AHCCCS Registered Direct Care Service Agency.

Modify service providers for home-delivered meals to allow for additional providers, including non-traditional providers.

5. Processes

a. ☐ Allow an extension for reassessments and reevaluations for up to one year past the due date.

b. ☐ Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.

c. ☐ Adjust prior approval/authorization elements approved in waiver.

d. ☐ Adjust assessment requirements.

e. ☐ Add an electronic method of signing off on required documents such as the person-centered service plan.

Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

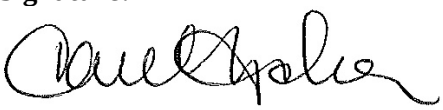
First Name:	Alex
Last Name	Demyan
Title:	Interim Assistant Director
Agency:	AHCCCS
Address 1:	801, E Jefferson Street
Address 2:	Click or tap here to enter text.
City	Phoenix
State	Arizona
Zip Code	85034
Telephone:	602-856-6795
E-mail	Alex.Demyan@azahcccs.gov
Fax Number	602-364-4590

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Shreya
Last Name	Arakere
Title:	Federal Waiver and Evaluation Administrator
Agency:	AHCCCS
Address 1:	801, E Jefferson Street
Address 2:	Click or tap here to enter text.
City	Phoenix
State	Arizona
Zip Code	85034
Telephone:	602-417-4611
E-mail	Shreya.Arakere@azahcccs.gov
Fax Number	Click or tap here to enter text.

8. Authorizing Signature

Signature: **Date: March 10, 2023**



State Medicaid Director or Designee

First Name:	*Carmen*
Last Name	*Heredia*
Title:	Director
Agency:	AHCCCS
Address 1:	801, E Jefferson Street
Address 2:	Click or tap here to enter text.
City	Phoenix
State	Arizona
Zip Code	85034
Telephone:	602-417-4458
E-mail	Carmen.Heredia@azahcccs.gov
Fax Number	602-256-6756

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver that the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification should be readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification					
Service Title:					
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
Service Definition (Scope)**:**					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☐	Agency. List the types of agencies:

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☐	Provider managed

[1] Numerous changes that the state may want to make may necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; or (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.

Attachment L
ALTCS Service Definitions

General Provider Qualifications:

AHCCCS registration (i.e. screening and enrollment under 42 CFR Part 445, Subpart E) is mandatory for consideration of payment by AHCCCS for services rendered by FFS providers, or payment by AHCCCS Contractors for services rendered by managed care contracted providers. All providers of AHCCCS-covered services are required to enroll with AHCCCS, comply with all federal, state, and local laws, rules, regulations, executive orders, and agency policies governing performance of the provider's duties. Additionally, providers must maintain a license issued under the authority of state law or a certification issued by a recognized body specific to the provider type enrolled under.

Providers may only render AHCCCS covered-services applicable to their scope of practice as defined by the state license or certification, and must comply with all applicable requirements as defined in the AHCCCS Medical Policy Manual (AMPM). AHCCCS is responsible for verifying that the provider qualifications specified for the service are followed prior to delivery of the service. Provider qualifications are re-verified in compliance with requirements in 42 CFR 455.414. Services with specific provider qualifications beyond these general requirements are detailed in the "Provider Qualifications" column below.

Service	Title XIX		Citation	Service Definition	Provider Qualifications
	EPD	DD			
Adult Day Health Services	X	N/A	A.R.S. §36-401	A program that provides planned care, supervision and activities, personal care, personal living skills training, meals, and health monitoring in a group setting during a portion of a continuous 24-hour period. Adult day health services also include preventive, therapeutic and restorative health-related services that do not include behavioral health services.	See general provider qualifications.
Attendant Care	X	X	AHCCCS Policy AMPM 1240-A	The attendant provides assistance with a combination of services including homemaking, personal care, and general supervision. General supervision includes: (a) Monitoring of a member who cannot be safely left alone, (b) Assisting with self-administration	AHCCCS policy requires the following for DCWs providing attendant care, personal care or homemaker services. ● Pass competency tests to provide care ● Obtain and maintain

				of medications, (when the member is physically unable to administer his/her medications, the member may direct the caregiver in this task), and (c) Monitoring the member's medical condition and ability to perform the activities of daily living.	CPR and First Aid certification ● Pass either a background check or obtain a fingerprint clearance card (depending on whether or not it is statutorily required) ● Pass an Adult Protective Service registry check ● Comply with agency required supervisory/monitoring visits See general provider qualifications for other applicable requirements.
Community Transition Services	X	X	Pg. 178 Technical Guide AMPM 1240-C	Community Transitions Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board including: (a) Security deposits that are required to obtain a lease on an apartment or home; (b) Essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) Services necessary for the individual's health and safety such as	See general provider qualifications.

				pest eradication and one-time cleaning prior to occupancy; (e) Moving expenses; (f) Necessary home accessibility adaptations; and, (g) Activities to assess need, arrange for and procure needed resources. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the person is unable to meet such expenses or when the services cannot be obtained from other sources. The Community Transition Service excludes the following: (a) Cash payments to members or significant others, (b) Rent, (c) Leisure/recreational devices (e.g. purchase of television or cable access, internet access, stereo), (d) Aesthetics/decorative items (e.g. picture frames and rugs), (e) Remodeling improvements to any Home or apartment with the exception of medically necessary home modifications that will be provided as a separate service, and (f) Grocery supplies including but not limited to food, personal hygiene, cleaning products	
Companion Care	X	X	AMPM 1250-H	Companion care service may be provided when a member is unable to be transported to medical appointments without assistance due to a member's support needs including assistance with personal care needs and/or supervision during an appointment that a medical practitioner is unable to provide. Members who are eligible to receive companion services if the member	The individual providing companion care must meet all employment qualifications and requirements established by their employer, and companion services must be identified within the scope of services the provider is authorized for before payment is authorized.

				requires this level of assistance during transport and during a medical appointment.	See general provider qualifications for other applicable requirements.
Emergency Alert System	X	X	AMPM 1240-D	Commonly referred to as a Medical Alert System, an Emergency Alert System is a device that can be used by an individual to seek emergency assistance when they live alone or would be alone for intermittent periods of time and unable to access emergency assistance through traditional means thereby putting the member at risk.	See general provider qualifications.
Family Support Services	X	X	AMPM 964	Family Support is directed toward restoration, enhancement, or maintenance of the family functioning to increase the family's ability to effectively interact and care for the member in the home and community. Family Support includes assisting the family to learn skills related to: (a) adjustment to the beneficiary's disability or aging process or significant life events or transitions, (b) enhancing and improving the health and well-being of the beneficiary and family unit, (c) navigating the health care system, self-advocacy, (d) development of natural supports and community support systems, (e) participating in the PCSP development, and implementation of individual and family goals and (f) long-term life planning.	See general provider qualifications requirements. Additionally, AHCCCS requires the following for staff providing the service: ● Lived experience in supporting a family member enrolled in the ALTCS program ● Demonstrate competency to provide the service
Habilitation	X	X	Pg. 159 tech guide	Services designed to assist LTC members in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-	See general provider qualifications.

				based settings.	
Home Delivered Meals	X	X	AMPM 1240-F	A service that provides a nutritious meal containing at least one third of the Federal recommended daily allowance for the member, delivered to the member's home	See general provider qualifications.
Home Modifications	X	X	AMPM 1240-I	Physical modifications to the Home as determined through an assessment of the member's needs and as identified in the member's service plan. Home modifications shall have a specific adaptive purpose aimed at increasing the member's ability to function with greater independence in his or her own Home thus reducing the risk of institutionalization.	Home modifications are rendered by enrolled providers that must be Residential Contractors as defined in AHCCCS policy, and be in good standing with the Registrar of Contractors. See general provider qualifications for other applicable requirements.
Homemaker Services	X	X	AMPM 1240-A	Assistance in the performance of activities related to household maintenance. The service is intended to preserve or improve the safety and sanitation of the member's living conditions and the nutritional value of food/meals for the member. Homemaker services include: (a) Cleaning tasks necessary to attain and maintain safe and sanitary living conditions for the member and pest control services, (b) Meal planning, food preparation and storage tasks necessary to provide food/meals that meet the nutritional needs of the member, (c) Laundry tasks, such as laundering the member's clothing, towels and bed linens. (d) Shopping for items such as food, cleaning and laundry supplies and personal hygiene supplies for the member only, (e) Other household duties and tasks, as included in the member's individualized service plan that are	AHCCCS policy requires the following for DCWs providing attendant care, personal care or homemaker services. ● Pass competency tests to provide care ● Obtain and maintain CPR and First Aid certification ● Pass either a background check or obtain a fingerprint clearance card (depending on whether or not it is statutorily required) ● Pass an Adult Protective Service registry check ● Comply with agency required supervisory/monitoring visits See general provider

				necessary to assist the member. This may include hauling water or bringing in wood or coal as indicated by the member's environment.	qualifications for other applicable requirements.
Personal Care	X	X	AMPM 1240-A Pg. 157 tech guide	Assistance to meet essential physical needs including assisting members with bathing, feeding, skin care, oral hygiene, toileting, ambulation, transferring, grooming, dressing, nail care, use of assistive devices, use of special appliances and/or prosthetic devices . A range of assistance to enable members to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the member to perform a task. Personal care services may be provided on an episodic or on a continuing basis. Health-related services that are provided may include skilled or nursing care and medication administration to the extent permitted by state law.	AHCCCS policy requires the following for DCWs providing attendant care, personal care or homemaker services. ● Pass competency tests to provide care ● Obtain and maintain CPR and First Aid certification ● Pass either a background check or obtain a fingerprint clearance card (depending on whether or not it is statutorily required) ● Pass an Adult Protective Service registry check ● Comply with agency required supervisory/monitoring visits See general provider qualifications for other applicable requirements.
Personal Care in Acute Care Hospitals	X	X	AMPM 1240-A	Assistance provided to a member in an acute care hospital setting that meets essential physical needs including: assisting members with bathing, feeding, skin care, oral hygiene, toileting, ambulation, transferring, grooming, dressing, nail care, use of assistive devices, use of special appliances and/or prosthetic devices . The provision of this service also includes general supervision to monitor a member who cannot be safely left	AHCCCS policy requires the following for DCWs providing attendant care, personal care or homemaker services. ● Pass competency tests to provide care ● Obtain and maintain CPR and First Aid certification ● Pass either a background check or

				alone including supporting communication and behavioral stabilization. HCBS Personal Care Services in Acute Care Hospitals: (a) Are provided to meet needs of the individual that are not met through the provision of acute care hospital services; (b) Are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide; (c) Must be identified in the individual's person-centered service plan; and (d) Will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.	obtain a fingerprint clearance card (depending on whether or not it is statutorily required) ● Pass an Adult Protective Service registry check ● Comply with agency required supervisory/monitoring visits See general provider qualifications for other applicable requirements.
Private Duty Nursing	X	X	Pg. 179 tech guide A.R.S. §32-1631-1651	Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of state law. These services are provided to a member at home.	Enrolled nurses shall operate within their scope of practice and shall be appropriately licensed/certified according to A.R.S. §32-1631-1651. See general provider qualifications for other applicable requirements.
Respite Care	X	X	AMPM 1250-D	Respite Care is provided as an interval of rest and/or relief to a family member or other individual caring for an ALTCS member. Respite Care may be provided by a respite provider coming to the member's home, or by admitting the member to a licensed institutional facility or an approved Alternative HCBS setting for the respite period. Respite care includes: (a) Supervision of the member for the respite period, (b) Provision of services during the Respite Care period which are within the respite provider's scope of practice, and	AHCCCS policy requires the following for DCWs providing respite care. ● Obtain and maintain CPR and First Aid certification ● Pass either a background check or obtain a fingerprint clearance card (depending on whether or not it is statutorily required) ● Pass an Adult Protective Service registry check

				(c) Provision of activities and services to meet the social, emotional, physical and behavioral needs of the member during the Respite Care period.	• Have the appropriate skills and training to meet the needs of the members See general provider qualifications for other applicable requirements.

Attachment M
DSHP Sustainability Plan (reserved)

Attachment N
Attestation Table

Arizona Provider Payment Rate Increase Assessment – Attestation Table		
The reported data and attestations pertain to provider payment rate increase requirements for the demonstration period of performance DY12 thru DY16		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-service Ratio**	**Medicaid Managed Care to Medicare Fee-for-service Ratio**
Primary Care Services	76.4%	76.6%
	STC 64(b)- AHCCCS FFS claims within the AHCCCS data warehouse for Federal Fiscal Year 2021	*STC 65(b)- MCO Encounters within the AHCCCS data warehouse for Federal Fiscal Year 2021*
Behavioral Health Services	80.4%	110.2%
	STC 64(b)- AHCCCS FFS claims within the AHCCCS data warehouse for Federal Fiscal Year 2021	*STC 65(b)- MCO Encounters within the AHCCCS data warehouse for Federal Fiscal Year 2021*
Obstetric Care Services	101.0%	83.4%
	STC 64(b)- AHCCCS FFS claims within the AHCCCS data warehouse for Federal Fiscal Year 2021	*STC 65(b)- MCO Encounters within the AHCCCS data warehouse for Federal Fiscal Year 2021*
In accordance with STCs 60 through 71, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments or Medicaid managed care pass-through payments under 42 CFR 438.6(a) and 438.6(d), I attest that at least an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points will be applied to each of the services in each of the three categories with a ratio below 80 percent in both fee-for-service and managed care delivery systems as applicable to the state's Medicaid or demonstration service delivery model. Such provider payment rate increases for each service will be effective beginning on **October 1, 2024** and will not be lower than the highest rate for that service code in DY12 plus an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points relative to the rate for the same or similar Medicare billing code through at least **September 30, 2027**. For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a Fee-For-Service delivery system or under a managed care delivery system, as applicable, the state agrees to define primary care, behavioral health and obstetric care, and to identify applicable service codes and provider types for each of these service categories in a manner consistent with other state and federal Medicaid program requirements, except that		

inpatient behavioral health services may be excluded from the state's definition. The services that comprise each service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services. For provider payment rates paid under a managed care delivery system, the data and methodology for any one of the service categories as provided in STC 65(b) will be based on Medicaid managed care provider payment rate and utilization data.

[Select the applicable effective date, must check either a. or b.]

X a. The effective date of the rate increases is the first day of DY14 and will be at least sustained, if not higher, through DY16.

☐ b. Arizona has a biennial legislative session that requires provider payment rate approval 43 Demonstration Approval: October 14, 2022 through September 30, 2027 and the timing of that session precludes the state from implementing the provider payment rate increase on the first day of DY14. Arizona will effectuate the rate increases no later than the CMS approved date of [insert date], and will sustain these rates, if not made higher, through DY16.

Arizona **does** make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and / or obstetric care.

For any such payments, I agree to submit by no later than **December 31, 2024** for CMS review and approval of the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), with an effective date no later than **October 1, 2024**.

Arizona **does** include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care.

For any such payments, I agree to submit the Medicaid managed care plans' provider payment rate increase methodology, including the information listed in STC 66 through the state-directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by an effective date no later than **October 1, 2024.**

If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 67, I attest that necessary arrangements will be made to assure that 100 percent of the two percentage point managed care plans' provider payment rate increase will be paid to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.

Arizona agrees not to use DSHP funding to finance any provider payment rate increase required under Section X, and will ensure that the entirety of a two percentage point increase is applied to the provider payment rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans.
Except as required by federal law, Arizona further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under Section X.
I, **Jeffery Tegen, Chief Financial Officer, Arizona Health Care Cost Containment System,** attest that the above information is complete and accurate. [*Provide signature*_____] [*Provide printed name of signatory* *Jeffery Tegen*_____] [*Provide date*_____1/12/2023_____]

Attachment O
Time-limited Expenditure Authority and Associated Requirements for the COVID-19 Public Health Emergency (PHE) Demonstration Amendment

Expenditure Authority

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period retroactively from March 1, 2020 and ending when all redeterminations for Medicaid and CHIP are conducted during the unwinding period.

1. **Continuous Coverage for Individuals Determined Ineligible for CHIP Due to a Change in Circumstances.** Expenditures to provide continued eligibility for CHIP enrollees who were determined to be ineligible for CHIP due to a change in circumstances and who are otherwise ineligible for Medicaid due to income above 133 percent of the federal poverty level (FPL) between March 1, 2020 and ending the earlier of the date when all redeterminations for Medicaid and CHIP beneficiaries are conducted during the unwinding period or May 31, 2024, with the following exceptions for enrollees who:
    a. Are deceased;
    b. Voluntarily withdraw from benefits;
    c. Are no longer Arizona residents;
    d. Were not eligible during the demonstration period, but were approved erroneously because of agency error or fraud or abuse attributed to the beneficiary or beneficiary's representative; or
    e. Turned 19 years of age during the demonstration period.

Monitoring and Evaluation Requirements

1. **Evaluation Design.** The state must submit an Evaluation Design to CMS within 60 days of the demonstration amendment approval. CMS will provide technical assistance on developing the Evaluation Design. For this demonstration amendment, the state will test whether and how the approved authority facilitated the state's response to the COVID-19 PHE, and helped promote the objectives of Medicaid. To that end, the evaluation will address thoughtful evaluation questions that support understanding the successes and challenges in implementing the expenditure authority. The state is required to post its Evaluation Design to the state's website within 30 days of CMS approval of the Evaluation Design, per 42 CFR 431.424(e).

2. **Final Report.** The state is required to submit a Final Report, which will consolidate monitoring and evaluation reporting requirements for these authorities. The state must submit the draft Final Report no later than one year after the expiration of the demonstration approval period. The Final Report should include a background description of the scope and objectives of the amendment, and in alignment with proposed evaluation questions and approaches in the approved Evaluation Design, an assessment of the implementation of the demonstration amendment, lessons learned thereof, and best practices for similar situations. The state will be required to track expenditures

associated with this amendment, including but not limited to, administrative costs and program expenditures. The Final Report shall include an assessment of the linkage between those expenditures and the state's response to the PHE. The state should customize the content of the Final Report to align with the specific scope of the demonstration amendment. CMS will provide additional technical assistance on the structure and content of the Final Report.

Attachment P
Approved DSHP List

Program	Description	DSHP-Eligible Expenditures
Services to Individuals with Serious Mental Illness (SMI)-Maricopa County	Two counties in Arizona provide funds to AHCCCS via Intergovernmental Agreements (IGAs) to provide services to non-Medicaid individuals with SMI designations. AHCCCS contracts with managed care organizations who contract with providers for case management, peer support and planning, community-based supports, medication management services, and other medical services	$58,093,100
Services to Individuals with SMI- Pima County	Two counties in Arizona provide funds to AHCCCS via Intergovernmental Agreements (IGAs) to provide services to non-Medicaid individuals with SMI designations. AHCCCS contracts with managed care organizations who contract with providers for case management, peer support and planning, community-based supports, medication management services, and other medical services	$2,326,900
Trauma Services	Trauma and Emergency Services program operated by AHCCCS reimburses Arizona hospitals for Level 1 trauma center readiness costs and emergency services costs. Payments are made to Level 1 trauma centers based on the acuity-adjusted volume of trauma care provided and the professional, clinical, and administrative costs directly associated with the provision of that care. Target populations are individuals served by hospital trauma centers, including both uninsured and Medicaid covered individuals. AHCCCS is excluding emergency department payments and only includes trauma payments as the amount eligible for DSHP.	$26,908,000
Developmentally Disabled Services	The Arizona Department of Economic Security, Division of Developmental Disabilities (DES/DDD) provides state-only early intervention and HCBS to individuals who are not eligible for Medicaid. DDD directly contracts with independent providers for early intervention services, day treatment, habilitation, residential group homes, occupational therapy, physical therapy, and speech therapy. The programs are the state-only components of DDD, which include the Arizona Early Intervention Program (AzEIP), state-only HCBS services, and state-only case management.	$27,321,400
Total DSHP-Eligible Expenditures		**$114,649,400**