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Arizona 1115 Waiver Approval Overview

Date: October 19, 2022

Executive Summary

On October 14, the Centers for Medicare and Medicaid Services (CMS) approved the extension of the Arizona Health Care Cost Containment System (AHCCCS) Section 1115 Demonstration. The renewal preserves current programs, including integrated care for AHCCCS populations through AHCCCS Complete Care; the Arizona Long Term Care System; the Comprehensive Health Plan for children in foster care; and the Regional Behavioral Health Agreement that provides integrated care for individuals with serious mental illness (SMI), as well as retroactive eligibility. The waiver demonstration builds on these existing programs by approving innovative practices to enhance health outcomes through two new initiatives: the Targeted Investments 2.0 program and the Housing and Health Opportunities (H2O) program. Further, the approval authorizes the state to remove an exisiting limit on adult dental services for American Indian/Alaska Natives served by Indian Health Service (IHS) and Tribal 638 facilities. The statewide five-year waiver approval is effective October 14, 2022 through September 30, 2027.

Coverage, Access, and Quality

The AHCCCS demonstration promotes the following core goals:

1. Leveraging best practices across care management in physical and behavioral health care and identifying members who will benefit from care management.
2. Promoting integrated settings for elderly and physically disabled beneficiaries and individuals with development disabilities in addition to ensuring those members are actively engaged and involved in community life.
3. Responding to the distinct health care needs of children in foster care through high-quality, cost-efficient care and continuity of care givers.
4. Identifying high-risk members with an SMI and supporting their transition across care continuity as well as empowering beneficiaries with tools to self-manage care to foster health and wellness.
5. Promoting members to apply for Medicaid without delays, fostering continuous eligibility and enrollment for improved health status.
6. Improving and expanding housing opportunities and related interventions for beneficiaries who are at-risk for or are experiencing homelessness.
7. Implementing financial incentives to encourage coordination and comprehensive integration of primary care and behavioral health care to improve health for beneficiaries.

Housing and Health Opportunities (H2O) Program

The H2O program approval permits the State to provide coverage of certain services that address health-related social needs (HRSN). Specifically, the HRSN services the State will provide include short

term post-transition housing for up to six months, including associated utility assistance; housing supports; pre-tenancy and tenancy services; and medically necessary home modifications. The services will include case management, outreach, education, and infrastructure investments. Further, the State will provide these HRSN services to individuals experiencing homelessness or life transitions who meet specific clinical and social risk criteria such as SMI or high-need chronic health conditions.

Targeted Investment (TI) 2.0 Program

The TI 2.0 program authorizes $250 million total funding for the five-year waiver period. It evolves from the TI 1.0 by advancing point-of-care integration achievements and prioritizing the goal of improving health equity for targeted populations by addressing social determinants of health (SDOH). Interested providers must meet eligibility requirements that exemplify their preparedness to participate. Managed care organizations will be directed to make incentive payments to participating providers who meet the criteria for receiving payments with the intent of progressing the program goals. Each process or performance target will be associated with a specified incentive amount that providers can earn for meeting the requirement. The amount earned depends on the size of the organization and its performance compared to all other participants.

Waiver Requests Not Currently Approved:

Arizona and CMS are continuing discussions surrounding the state's pending requests:

- A limited benefit package of case management services for individuals being held in federal, state, local, and tribal correctional facilities for up to 30-days pre-release.
- Expenditure authority to receive reimbursement for traditional healing services provided by IHS and tribal facilities.
- Implementation of the AHCCCS Works community engagement program.

Financial Components

Consistent with recent waiver approvals in Massachusetts and Oregon, the AHCCCS 1115 extension waiver also includes the following approvals and requirements:

1. Medicaid-to-Medicare Provider Rate Ratio
    - As a condition of approval, Arizona is required to increase and (at least) maintain Medicaid fee-for-service provider base rates and Medicaid managed care payment rates in primary care, behavioral health, and obstetrics care, if the State's Medicaid-to-Medicare provider rate ratio is below 80% in any of these categories. In the case of Arizona, only primary care provider payments are below 80% of Medicare rates, and subsequently, are required to increase.
2. Changes to Federal Matching Funds for Designated State Health Program (DHSP) Funding
    - CMS continues to move away from its 2017 DSHP policy and will provide states with expanded 1115 waiver flexibility to use DSHP "freed up" state funding on a time-limited basis to implement new innovations and initiatives that support the objectives of the Medicaid program.

- CMS will require Arizona to contribute non-DSHP funds as the non-federal share, e.g., general fund revenues, intergovernmental transfers, of the identified initiatives on an annual basis. The expenditures for DSHP are capped at no more than 1.5% of the State's total Medicaid spending during the demonstration period.

3. Evaluation
   - The evaluation of the HRSN initiative must include a cost analysis to support developing comprehensive and accurate cost estimates of providing such services.
   - The evaluation of the H2O initiative must include a robust review of potential improvements in quality and effectiveness of downstream services and related expenses.

4. Changes to the Budget Neutrality Approach
   - CMS continues to move away from its 2018 budget neutrality policy to provide states with expanded flexibilities and budgets to implement innovative programs with a focus on advancing health equity and addressing disproportionate HRSNs.
   - CMS has revised its approach to allow for mid-course corrections in this demonstration approval, including calculation adjustments to allow for provider rate increases to provide flexibility and stability for the State over the life of a demonstration.
   - CMS is making several changes to give states greater access to funding while maintaining fiscal integrity. *See these changes in the table on the following page.*

Area of Focus	2018 SMD Guidance	Changes approved through AZ waiver	Anticipated Impact
Without Waiver (WOW) Baseline	Adjusted WOW per-member-per-month (PMPM) cost estimates to reflect only the recent actual PMPM costs	Uses a weighted average of AZ's historical WOW PMPM baseline and its actual PMPM costs	Expected to result in a slightly higher WOW baseline
Trend rate for Expected Expenditures	Used the lower of the state's historical trend rate or the President's Budget trend rate	Projected demonstration expenditures associated with each Medicaid Eligibility Group in the WOW baseline have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the new approval period	Increases budget room and aligns the demonstration trend rate with federal budgeting principles and assumptions
Demonstration "Savings" Rollover	CMS explained that it expected to permit states to roll over "savings" to a demonstration extension from only the most recent five years of prior approvals, and that there would be a transitional phase-down of accrued "savings"	The "savings" amount available for the extension approval period has been limited to the lower of: (1) The "savings" available in the current extension approval period plus net savings from up to 10 years of the immediately prior demonstration approval period(s); or (2) 15% of the state's projected total Medicaid expenditures in aggregate for the demonstration extension period	With less narrow limitations on savings rollover, states can access more "savings" from prior approval periods to fund program innovations described above
"Hypothetical" Expenditures for HRSN Infrastructure and Services	No explicit categorization of HRSN expenditures as hypothetical expenditures	CMS is treating certain HRSN expenditures as "hypothetical" expenditures. There is an additional sub-cap to HRSN infrastructure expenditures, referring to these expenditures as "capped hypothetical expenditures" in the Special Terms and Conditions (STCs) Unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year	States do not have to find demonstration "savings" to offset hypothetical expenditures, thereby freeing up funds/adding flexibility

Evaluation

The approved waiver STCs require the state's waiver evaluation design to include the following:

- In General
    - Must cover enrollment and renewal, access to providers, utilization of services, quality of care, and health outcomes.
    - Reporting must be stratified by demographic subpopulations of interest (e.g., sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography).
- Cooperation with Federal Evaluators and Learning Collaboration
    - As required under 42 CFR 431.420(f), the State will cooperate with CMS in federal evaluation including: commenting on design and other federal evaluation documents; providing data and analytic files; 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.
    - Requirement for data to be available for federal evaluation in state contracts with entities that collect, produce, or maintain data and files for the demonstration.
- Independent Evaluators
    - The State must use an independent party to conduct evaluation of the demonstration to ensure the necessary data is collected.
- Draft Evaluation Design
    - The State must submit a draft Evaluation Design for later than 180 calendar days after approval for CMS comment and approval.
    - If CMS comments, the State must submit a revised Evaluation Design within 60 calendar days.
    - Evaluation of the H2O program:
        - Beneficiary participation, screening, receipt of referrals and social services over time.
        - Narratively report on the adoption of information technology infrastructure to support data sharing between the State or partner entities assisting in the administration.
        - Enrollment and renewal metrics must capture baseline data and track progress via Monitoring Reports for percent of Medicaid renewals completed ex-parte and the percentage of Medicaid beneficiaries enrolled in other public benefit programs.
        - Assessment of the effectiveness of the HRSN services through analysis of how 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.
        - Effectiveness of the State's DSHP-funded initiatives in advancing the broader HRSN initiatives, including programs support (such as expanding coverage, improving access, reducing health disparities, and/or enhancing home-and-community-based services or services to address HRSN or behavioral health).
    - Evaluation of the TI 2.0 program
        - State must develop hypotheses and research questions for its TI 2.0 program to evaluate reduced 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.
- Evaluation Budget
    - Budget for evaluation must be included with the draft Evaluation Design.
    - Must include total estimated cost, 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.

- 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. When submitting an application for renewal, the Interim Evaluation Report should be posted to the State's website with the application for public comment.
- 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.