AHCCCS Housing & Health Opportunities (H2O)
Draft Waiver Amendment

March 19, 2021

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I. SUMMARY

The Arizona Health Care Cost Containment System (AHCCCS) is requesting an amendment to the 1115 Research and Demonstration Waiver to seek waiver and expenditure authority to implement the AHCCCS Housing and Health Opportunities (H2O) demonstration. The goal of the AHCCCS H2O demonstration is to enhance and expand housing services and interventions for AHCCCS members who are homeless or at risk of becoming homeless. Under this demonstration proposal, the agency will seek to:

- Increase positive health and wellbeing outcomes for target populations including the stabilization of members' mental health conditions, reduction in substance use, improvement in the utilization of primary care and prevention services, and increased member satisfaction,
- Reduce the cost of care for individuals successfully housed through decreased utilization of crisis services, emergency department utilization, and inpatient hospitalization, and
- Reduce homelessness and improve skills to maintain housing stability.

The AHCCCS H2O demonstration targets individuals who are experiencing homelessness or at risk of homelessness and who have at least one or more of the following conditions or circumstances:

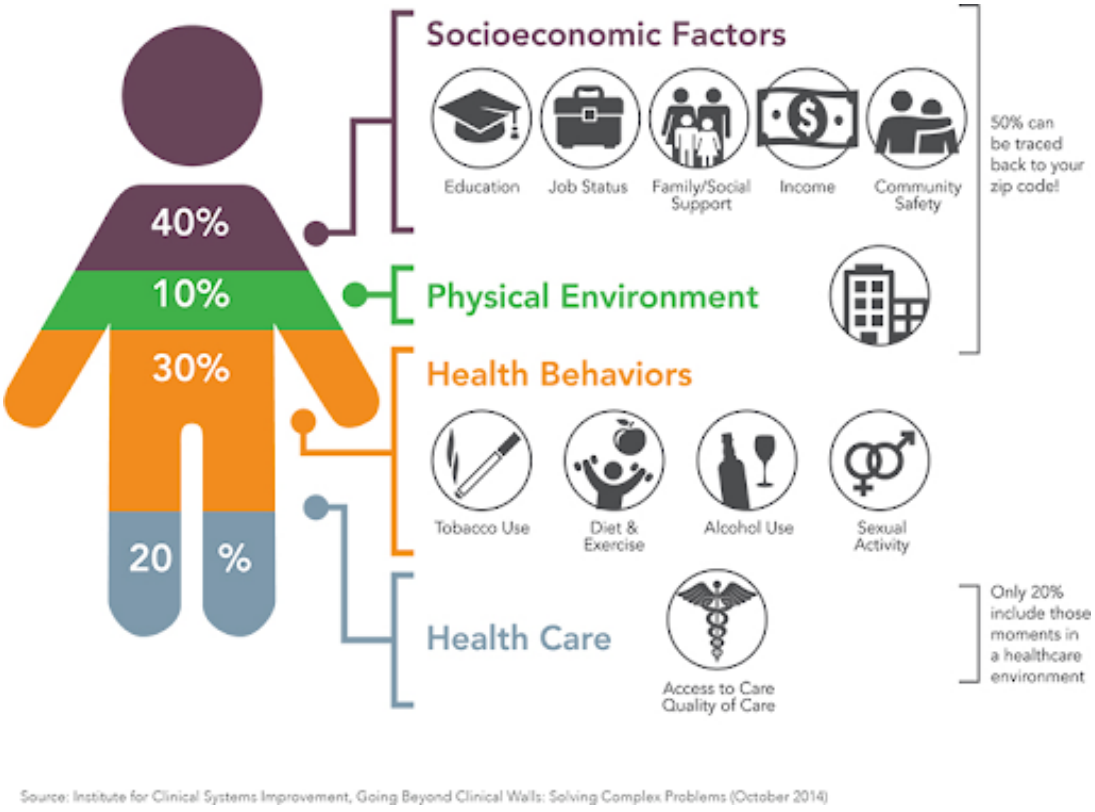
- Individuals with a Serious Mental Illness (SMI) designation or in need of behavioral health and/or substance use treatment,
- Individuals determined high risk or high cost based on service utilization or health history,
- Individuals with repeated avoidable emergency department visits or crisis utilization,
- Individuals who are pregnant,
- Individuals with chronic health conditions and/or co-morbid conditions (e.g., end-stage renal disease, cirrhosis of the liver, HIV/AIDS, co-occurring mental health conditions, physical health conditions, and/or substance use disorder),
- Individuals at high risk of experiencing homelessness upon release from an institutional setting (e.g., Institutions for Mental Disease/IMDs, psychiatric inpatient hospitals, correctional facility),
- Young adults ages 18 through 24 who have aged out of the foster care system, and
- Individuals in the Arizona Long Term Care System (ALTCS) who are medically able to reside in their own home and require affordable housing in order to transition from an institutional setting.

II. OVERVIEW

The Correlation Between Housing & Health Outcomes

There is now national recognition of the important role that social and economic factors, such as housing, healthy food, and income, play in a whole person approach to health care, especially among Medicaid members. While quality and timely health care services are essential, research shows that a person's socio-economic status, behaviors, and physical environment are the primary drivers of health, contributing as much as 80 percent to health outcomes (Figure 1).

Figure 1: Social Determinants Of Health Factors Influencing A Person's Health Outcome



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

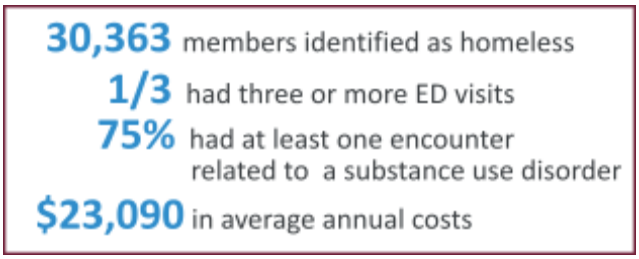
Access to safe, quality, affordable housing, and the ability to maintain housing, are among the most critical drivers of health. The annual United States Department of Housing and Urban Development (HUD) Point in Time (PIT) Survey for Arizona shows significant increases in persons experiencing homelessness. Between 2017 and 2019, the number of persons experiencing homelessness across Arizona increased 12 percent to over 10,000 individuals. The documented increase in homelessness, in conjunction with limited shelter capacity resulted in a 43 percent increase in the number of unsheltered persons in this time period. Furthermore, the number of individuals experiencing chronic homelessness in Arizona increased by 21 percent.[1] Due to a higher prevalence of chronic mental health or health care issues, persons experiencing chronic homelessness also had a 20 percent greater likelihood of being unsheltered.

Homelessness and housing instability is strongly correlated with high rates of morbidity and mortality, including a high prevalence of serious mental illness and substance use disorder, as well as infectious diseases, such as HIV (human immunodeficiency virus), hepatitis C, and tuberculosis.[2] Homelessness

[1]HUD defines individuals with chronic homelessness as those with: 1) a continuous homeless episode of at least one year or more, or four or more episodes of homelessness in the past three years with total time homeless of a year or more; and 2) who have one or more disabling conditions. A disabling condition may include SMI, SUD, a chronic physical health condition, or physical disability.

[2]Hwang, Stephen W. "Homelessness And Health". Canadian Medical Association Journal (CMAJ), 164(2): 229–233, 2001, Accessed 10 Jan 2021.

Goss, Christopher. "Cost and Incidence of Social Comorbidities in Low-Risk Patients with Community-Acquired Pneumonia Admitted to a Public Hospital." PubMed, Dec. 2003, pubmed.ncbi.nlm.nih.gov/14665494.



also has negative impacts on children. Infants born into homelessness have lower birth weights and are more likely to die within the first 12 months of life.[3] Children who are homeless are sick four times more frequently than children who are not homeless, and they have higher incidences of chronic diseases.[4] Furthermore, children who are homeless are more likely to demonstrate delayed development and are twice as likely to have learning disabilities as compared to their peers.[5]

Households experiencing homelessness face numerous barriers to appropriate health care which are often compounded by the lack of housing. For persons or families who are homeless, accessing outpatient and preventative health services competes with more immediate needs, such as obtaining food and shelter. Consequently, many individuals who are homeless are susceptible to avoidable hospital admissions, longer hospital stays, and frequent emergency department (ED) visits.[6] This combination of hospital utilization and health diagnoses equates to high health care expenditures for persons who are experiencing homelessness. Nationally, the average cost for a person enrolled in Medicaid experiencing homelessness is four and a half times higher—$26,000 per year—compared to $8,057 for a person enrolled in Medicaid not experiencing homelessness.[7]

AHCCCS data also shows that persons who are homeless have complex service needs and access emergency care more often. Furthermore, consistent with national statistics, the average annual cost of care for members identified as homeless, $23,090, exceeds the average annual cost of care for all

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Allen, D. “HIV Infection among Homeless Adults and Runaway Youth, United States, 1989-1992. Field Services Branch.” PubMed, Nov. 1994, pubmed.ncbi.nlm.nih.gov/7848596.
Zolopa, A. “HIV and Tuberculosis Infection in San Francisco’s Homeless Adults. Prevalence and Risk Factors in a Representative Sample.” PubMed, 10 Aug. 1994, pubmed.ncbi.nlm.nih.gov/8040981.
Gelberg, Lillian. “Health, Homelessness, and Poverty: A Study of Clinic Users.” JAMA Internal Medicine | JAMA Network, 1 Nov. 1990, jamanetwork.com/journals/jamainternalmedicine/article-abstract/614142.

[3] Bassuk, E. “Homeless Pregnant Women: Two Generations at Risk.” PubMed, July 1993, pubmed.ncbi.nlm.nih.gov/8372902.
Crawford, Devan M, et al. Pregnancy and Mental Health of Young Homeless Women. Apr. 2011, www.ncbi.nlm.nih.gov/pmc/articles/PMC3383651/.

[4] Weinreb, Linda. “Determinants of Health and Service Use Patterns in Homeless and Low-Income Housed Children.” American Academy of Pediatrics, 1 Sept. 1998, pediatrics.aappublications.org/content/102/3/554.short.
Gelberg, Lillian. “Health, Homelessness, and Poverty: A Study of Clinic Users.” JAMA Internal Medicine | JAMA Network, 1 Nov. 1990, jamanetwork.com/journals/jamainternalmedicine/article-abstract/614142.

[5] Zima, B. T., et al. “Sheltered Homeless Children: Their Eligibility and Unmet Need for Special Education Evaluations.” American Journal of Public Health, vol. 87, no. 2, 1997, pp. 236–40. Crossref, doi:10.2105/ajph.87.2.236.
Rafferty, Yvonne, and Marybeth Shinn. “The Impact of Homelessness on Children.” American Psychologist, vol. 46, no. 11, 1991, pp. 1170–79. Crossref, doi:10.1037/0003-066x.46.11.1170.

[6] Salhi, Bisan. “Homelessness and Emergency Medicine: A Review of the Literature.” Wiley Online Library, 1 May 2018, onlinelibrary.wiley.com/doi/10.1111/acem.13358.
Hwang, Stephen W., et al. “A Comprehensive Assessment of Health Care Utilization Among Homeless Adults Under a System of Universal Health Insurance.” American Journal of Public Health, vol. 103, no. S2, 2013, pp. S294–301. Crossref, doi:10.2105/ajph.2013.301369.

[7] Moses, Kathy et al. "Supportive Housing For Chronically Homeless Medicaid Enrollees: State Strategies". Center For Health Care Strategies, Inc, 2016, Accessed 22 Feb 2021; MACPAC. “Medicaid Spending by State, Category, and Source of Funds, FY 2019.” Macpac.gov, MACStats: Medicaid and CHIP Data Book, 2020, www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-16.-Medicaid-Spending-by-State-Category-and-Source-of-Funds-FY-2019-millions.pdf.

AHCCCS enrollees generally by $16,082.[8] AHCCCS recently assessed the crisis, inpatient, and behavioral health care utilization of 30,363 members who were identified as homeless. A third of these members had three or more ED visits and 38 percent had three or more inpatient stays over the 18 month period reviewed. The estimated annual cost of care for homeless individuals, at $23,090, is consistent with national cost profiles. In addition to the presence of mental health needs, 75 percent of identified members experiencing homelessness had at least one encounter related to a substance use disorder treatment. For those members identified as homeless who had an SMI designation, 26 percent had three or more inpatient stays, 48 percent had three or more ED visits, and 89 percent also received SUD treatment. The average annual cost for these members was $66,784.

Given this linkage between housing instability and avoidable health care utilization and costs, it is imperative for policymakers to focus on more cost-effective opportunities to address the combined housing and health care needs of individuals experiencing housing instability. Providing access to housing with individualized, quality, wraparound services for individuals who are experiencing homelessness, has consistently been shown in studies to increase housing stability, reduce or end homeless episodes or recidivism, improve substance use treatment compliance and outcomes, improve recovery trajectories for persons struggling with mental health, and stabilize or improve physical health conditions. These changes often result in a shift away from reliance on crisis-centered, inpatient, and/or emergency department services, and an increased use of primary and preventative health or community based social services and natural supports. This housing related shift ultimately generates significant cost savings and cost avoidance over the long term. Housing individuals who are homeless has similarly been shown to substantially reduce the service and cost impacts on other institutional systems, including homeless shelters, police and crisis services, and the criminal justice system.

Arizona's Journey Towards Recognizing Housing as a Social Determinant of Health

The Arizona Medicaid system's involvement in addressing the housing needs of Arizonans began in 1989 through the Arnold v. Sarn lawsuit settlement, which required the State of Arizona to provide a combination of supportive housing, supported employment, and Assertive Community Treatment (ACT), as well as peer and family services to individuals with an SMI designation in Maricopa County. In 2014, the parties reached an exit agreement to the lawsuit, which included specific requirements for the State to increase the number of individuals receiving ACT, supportive housing and employment services, and peer and family supports. The State was also required to adopt national quality standards outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA), and conduct annual independent quality service reviews to evaluate the delivery of care to the SMI population. In 2016, oversight of housing and services for persons with an SMI designation was transferred to AHCCCS as part of the statutory transfer of behavioral health services from Arizona Department of Health Services (ADHS) to consolidate the administration of physical and behavioral health services under one agency in an effort to integrate the service delivery system.

AHCCCS Housing Delivery System

AHCCCS' housing programs follow a permanent supportive housing (PSH) model, an evidence based, cost effective strategy for addressing and improving health outcomes for persons experiencing homelessness, including those with serious mental illness, physical health conditions, and substance use disorders.

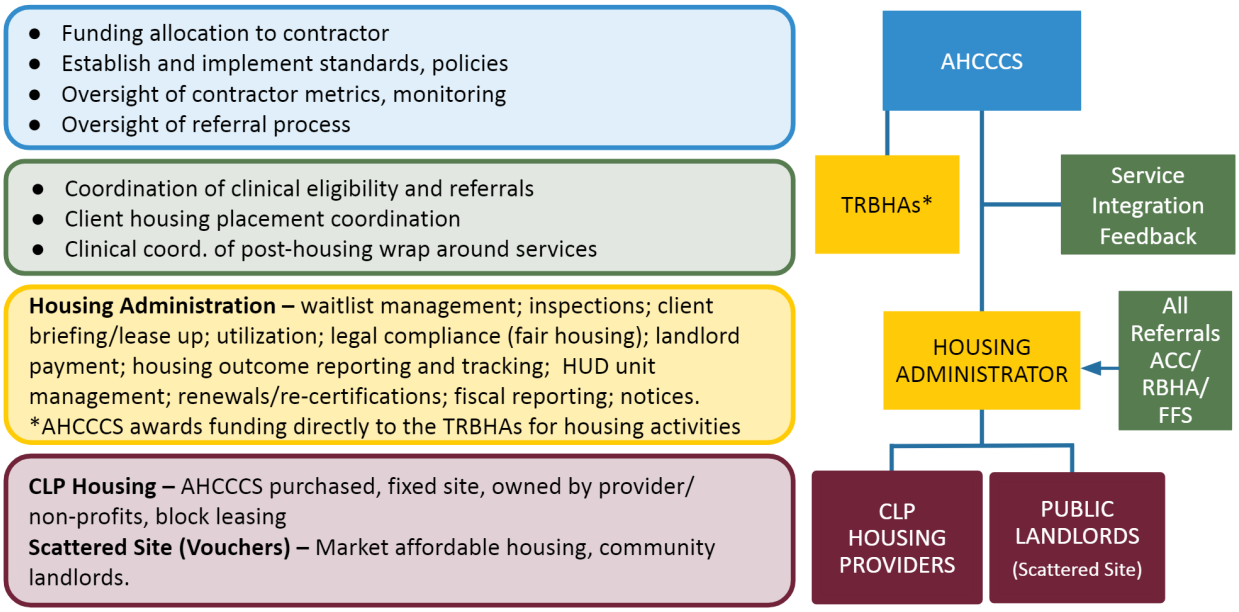
[8]MACPAC. "Medicaid Spending by State, Category, and Source of Funds, FY 2019." Macpac.gov, MACStats: Medicaid and CHIP Data Book, 2020, www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-16.-Medicaid-Spending-by-State-Category-and-Source-of-Funds-FY-2019-millions.pdf.

The first component of AHCCCS' PSH model is access to safe, habitable, affordable housing. AHCCCS housing programs prioritize those households (including single adults or families) who are experiencing homelessness or at imminent risk of homelessness (particularly in situations where an individual is being discharged from an ED or inpatient setting). If AHCCCS were a housing authority, it would be the third largest in the state of Arizona with an annual budget of $27.7 million in non-Medicaid, state-only funds to provide rent subsidies for almost 3,000 AHCCCS members with an SMI designation, and for a small number of high need individuals in need of behavioral health and/or substance use treatment. AHCCCS housing subsidies support members in community embedded, site-based, and scattered site programs. A limited portion of the AHCCCS Housing funds may also be used for eviction prevention.

AHCCCS also administers the State SMI Housing Trust Fund (SMI HTF) of approximately $2 million per year, to expand housing capacity for persons with an SMI designation. Since 2017, SMI HTF has been invested to construct or acquire 246 new affordable housing units for AHCCCS members with an SMI designation. AHCCCS also collaborates with local housing authorities, tax credit programs, and the HUD Continuum of Care (HUD CoC) to provide PSH capacity for an additional 1,500 members.

The majority of AHCCCS housing funds are currently administered through three Regional Behavioral Health Authorities (RBHAs), which are Managed Care Organizations (MCOs). Each RBHA is responsible for a specific Geographic Service Area (GSA) of the state, and is contractually responsible for the administration of housing programs within their network. In order to standardize housing processes, increase accountability, maximize limited AHCCCS housing funds, and improve member care and experience, beginning October 1, 2021, housing administrative functions will be subcontracted to a single statewide AHCCCS Housing Program Administrator (HPA). Under the revised structure, the clinical functions of member assessment for PSH eligibility and housing need, ongoing care coordination, and delivery of Medicaid-compensable wraparound services will remain with the MCOs and their provider networks (Figure 2). AHCCCS directly administers the balance of the housing funds for the Tribal Regional Behavioral Health Authorities (TRBHAs), and will continue to do so on and after October 1, 2021.

Figure 2: AHCCCS Medicaid Housing Delivery System (Effective 10/1/21)



While housing subsidies are central to PSH, the second critical "supportive" element is the integration of individualized wraparound services and tenancy supports to ensure members are able to secure and maintain housing while addressing their core health and service needs. Under current AHCCCS policies, most key PSH wraparound services are Medicaid reimbursable for persons with an SMI designation or with behavioral health and/or substance use disorder needs. These services are provided through AHCCCS' contracted MCOs and provider networks, and are targeted to identify, assess, engage, and house persons who are experiencing homelessness or transitioning from institutional settings (Figure 3).

Figure 3: Medicaid Wraparound Housing Services

Medicaid Covered Behavioral Health Services	Related Pre-Housing Activities (Attain Housing)	Related Activities In Housing (Sustain Housing)
• Case Management and Coordination of Care • Group Counseling • Pre-Employment Training • Supportive Employment • Individual & Family Peer Support • Group Peer Support • Health Promotion • Medication Assistance • Substance Use Counseling • Skills Training and Development	• Securing ID and Documents • Completing Housing Applications • Understanding Lease/Legal Notices • Housing Search • Disability Accommodation Requests • Move-In Coordination • Attending Housing Briefings • Budgeting and Financial Planning • Coaching for Interviews, Landlord Visits or Housing Negotiations	• Crisis/Conflict Management • Budgeting • Pre and Post Employment Supports • Benefit Applications • Life Skills • Connection to Family, Natural and Community Supports • Landlord and Neighbor Communication • Substance Use Disorder Treatment Supports • Lease Renewal

To leverage and maximize housing resources and services with existing housing subsidies and supports, AHCCCS requires its MCOs (and their providers of these wraparound services) to coordinate and participate in the HUD CoC within their GSAs in order to:

- Identify members experiencing homelessness who are Medicaid members and may be eligible for AHCCCS housing and services, and
- Coordinate with HUD CoC and other mainstream housing and service programs to explore those housing benefits for AHCCCS members.

This coordination includes accessing and utilizing the HUD CoC required Homeless Management Systems (HMIS).

AHCCCS Housing Program Outcomes

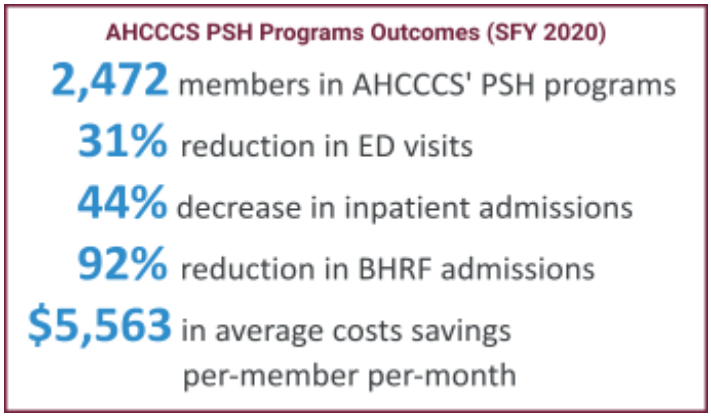
AHCCCS and its MCOs have assessed the efficacy of their state funded PSH programs to document PSH related improvements in health outcomes and reduced Medicaid costs. In 2018, the University of Chicago's National Opinion Research Center (NORC) evaluated AHCCCS' Mercy Care RBHA PSH programs to verify reduced cost and improved outcomes for members with an SMI designation who reside in Maricopa County, the most populous county in Arizona. The NORC study demonstrated that members with an SMI who were enrolled in PSH and receiving wraparound tenancy services experienced a 20 percent reduction in psychiatric hospitalizations, a 24 percent decrease in total cost of care per quarter, and a per member savings of over $5,000 per month.[9] The cost savings were driven by reductions in behavioral health costs, including psychiatric hospitalizations.

[9] NORC at the University of Chicago. "The Impact of Housing Programs and Services on Health Care Costs, Quality, and Member Experience" 2018. https://www.mercycareaz.org/assets/pdf/news/Housing-Report.pdf

In November 2020, a separate evaluation by Arizona Complete Health - Complete Care Plan (AzCH), AHCCCS' RBHA for the southern GSA in Arizona, found similar results. Physical and behavioral health care utilization rates and costs before and after PSH placement were assessed for 152 identified members experiencing homelessness and enrolled in AHCCCS' AzCH PSH programs. Comparing member health care costs from the six months prior to housing to the six months after housing placement showed a decrease in ED visits by 45 percent, a decline in inpatient hospital admissions by 53 percent, and a reduction in crisis utilization by 49 percent. In contrast, utilization of primary care and preventive health care increased by 56 percent. Overall, the total cost savings related to PSH placement averaged $4,300 per member per month. These cost savings were attributed to reductions in ED and inpatient admissions, demonstrating a decline of 48 percent and 58 percent respectively.

AHCCCS' RBHA for the northern GSA, Health Choice Arizona (HCA), evaluated health care costs before and after PSH placement for 214 members. Enrollment in PSH yielded a 16 percent reduction in costs in 12 months. The overall health care cost savings related to PSH placement totaled $1.1 million dollars.

AHCCCS recently conducted its own evaluation of its PSH across all GSAs by reviewing member utilization and costs six months prior and post PSH placement for a cohort of 2,472 persons in AHCCCS' PSH programs in State Fiscal Year (SFY) 2020. The review yielded results consistent with the previous RBHA evaluations. The analysis showed a decrease in utilization in the six months after housing placement, including a decrease in ED visits by 31 percent, an inpatient admissions decrease of 44 percent, and a decrease in admissions into Behavioral Health Residential Facilities (BHRF) of 92 percent. In addition, these housing interventions resulted in an average per member per month cost savings of $5,563.[10]



Current Gaps In AHCCCS' Housing Delivery System

Arizona has made tremendous progress in providing PSH for individuals with an SMI designation, but the issue of homelessness and housing insecurity remain a significant health challenge. Arizona is in the midst of an affordable housing crisis. Vacancy rates are below 5 percent for all rental units with lower vacancies for affordable units. A report by the National Low Income Housing Coalition showed that Arizona needs another 134,758 units to meet the needs of its existing population that fall into the category of "Extremely Low Income" (less than 30 percent of Area Median Income), which would include almost all persons identified as homeless.[11] Lack of supply has increased demand resulting in rapidly increasing rent costs. HUD Fair Market Rent (FMR) rates have increased in six of Arizona's seven Arizona HUD defined FMR geographic regions since 2019 and the average rent for an efficiency unit statewide has increased by 14 percent.

[10] It should be noted that COVID-19 impacts to utilization were inconsequential

[11] National Low Income Housing Coalition. Arizona Housing Data (2020): nlihc.org/housing-needs-by-state/arizona.

PSH relies upon the availability of affordable housing capacity in order to apply subsidies and house members. The increased need for PSH due to increased numbers of persons experiencing homelessness who have the highest medical acuity, combined with reduced housing capacity, has made it difficult to place AHCCCS members in housing. AHCCCS has a PSH waitlist of approximately 2,800 members with an SMI designation and, for those members with housing subsidies, it is taking an average of almost four months for a member designated SMI with case manager assistance to find appropriate housing in the community. Waitlists for members in need of behavioral health and/or substance use treatment are similar in number and AHCCCS has far fewer housing subsidies through its state housing funding to meet this need. Furthermore, the AHCCCS integrated health care system and other mainstream systems are experiencing excessive strain to fulfill their obligations to avoid institutional discharges to homelessness due to this lack of viable shelter or housing settings. The lack of effective community re-integration increases the likelihood of recidivism to homelessness or institutional settings. In this challenging environment of limited housing placements and longer waits for housing placement, outreach and other community based wraparound service strategies as well as transitional housing subsidies become imperative for timely, effective discharge coordination, to maintain engagement and follow up service delivery, and to assist members in managing long and difficult housing processes. Similarly, access to flexible funding for housing move-in costs (e.g., deposits or fees) or eviction prevention related rental assistance reduces housing barriers and increases housing retention while reducing recidivism to homelessness and/or the utilization of costly health care resources.

Additionally, through participation in collaborative homeless outreach and housing efforts, AHCCCS has compared HMIS homeless data to its enrollment and eligibility data. These comparisons have repeatedly shown that only 15 to 20 percent of members who are homeless and chronically homeless have been designated SMI for purposes of eligibility for AHCCCS Medicaid housing supports and services. The majority of members identified as homeless (almost 80 percent) are non-SMI members. In contrast, over 80 percent of AHCCCS' state-only funded housing, are dedicated to persons with an SMI designation. Despite the differences in PSH housing and service availability and delivery, unengaged members who are experiencing homelessness and are in need of behavioral health and/or substance use treatment have similar needs for PSH and incur costs similar to those of homeless SMI members. A cost comparison for inpatient, crisis, and emergency department utilization for the top 50 homeless members with an SMI designation, versus the top 50 homeless members without an SMI designation, showed SMI members incurred only 20 percent higher cost than non-SMI members.

These factors and the high potential costs associated with members with high-acuity and in need of behavioral health and/or substance use treatment, along with the prevalence of these members in the homeless population, make increased PSH availability and expanded services a critical part of AHCCCS' H2O demonstration project.

III. WAIVER AMENDMENT PROPOSAL DETAILS

Proposed Changes to Benefit Coverage under the Demonstration as Amended

AHCCCS is seeking waiver and expenditure authority to improve health care delivery and health outcomes for AHCCCS members who are homeless or at risk of becoming homeless using strategies designed to fill identified gaps, expand existing evidence based practices, and reduce barriers to housing. This proposal will ensure targeted members experiencing homelessness or chronic housing instability attain safe housing and integrated services in order to end their housing crises and achieve improved health outcomes. The AHCCCS H2O demonstration focuses on three critical strategies:

1. Strengthening homeless outreach strategies to make sure that current members and prospectively eligible members of the target populations are identified and connected to housing interventions and integrated care services,

2. Securing funding for housing to ensure members can attain and maintain housing stability, and

3. Enhancing and expanding individualized wraparound housing services and supports to ensure housing stability becomes a platform to leverage improved health outcomes and reduce recidivism for a broader population of homeless or at-risk populations that require permanent supportive housing.

Each component of AHCCCS' strategy will seek to:

- Utilize evidence based permanent supportive housing practices to increase positive health outcomes for target populations, including stabilization of a member's mental health conditions, reduction of substance use, improved utilization of primary care and prevention services, and increased member satisfaction,

- Reduce the cost of care for housed members through decreased utilization of crisis services, emergency department utilization, and inpatient hospitalizations,

- Reduce homelessness and improve skills to maintain housing stability, and

- Integrate, support, and leverage existing AHCCCS and community initiatives, programs, and expertise to ensure a full continuum of services and supports, including critical social services are available to beneficiaries.

Strategy 1: Strengthening Homeless Outreach and Service Engagement

Homeless outreach is an essential step toward identifying and engaging people experiencing long-term or multiple episodes of homelessness. In addition, it is equally important to develop the rapport and relationships necessary for supporting a member's transition to affordable housing and connection to needed treatment and services. AHCCCS is seeking to implement the outreach and engagement strategies described below to fully identify, engage, assess, follow up, and connect all eligible members experiencing homelessness to appropriate PSH supports and services.

1.1 Homeless Outreach and Engagement Services

AHCCCS is seeking waiver authority to offer outreach services to expand the reach and effectiveness of Medicaid providers in identifying and successfully connecting all eligible or potentially eligible members experiencing homelessness to available services and supports. Outreach is a recognized, evidence-based intervention and core element of effective service delivery for individuals who are experiencing homelessness, especially for members with acute behavioral health needs who may avoid congregate service sites or shelters due their mental health condition.[12] Outreach is critical to engaging homeless members who are already enrolled in Medicaid as well as identifying unenrolled members who may be eligible for service or may have presumed AHCCCS eligibility due to their homelessness.

AHCCCS' outreach and engagement request is directly informed by its oversight of the SAMHSA Projects for Assistance in Transition from Homelessness (PATH) grant for Arizona and by its participation in the

[12] "Solutions." National Alliance to End Homelessness, 6 Mar. 2019, endhomelessness.org/ending-homelessness/solutions.

Downtown Homeless Pilot (the Downtown Pilot), a collaborative effort to identify, engage, and house persons experiencing chronic homelessness residing unsheltered in downtown Phoenix. The Downtown Pilot braided funding and multi-disciplinary agencies and disciplines to create a member focused outreach, service, and housing continuum to move persons experiencing chronic homelessness to PSH. Key service partners included PATH homeless outreach teams, a locally funded transitional shelter, the Maricopa County CoC and Coordinated Entry program, AHCCCS MCOs, and providers of Medicaid reimbursable housing wraparound services. Housing subsidy supports included dedicated Housing Choice Vouchers from three Public Housing Authorities and AHCCCS state funded Bridge Housing subsidies. The project successfully matriculated 75 percent of pilot enrolled persons experiencing chronic homelessness to PSH subsidized housing placement.[13] While the Pilot relied on limited grants to fund outreach teams, it demonstrated the opportunity to leverage Medicaid reimbursement for outreach activities to engage individuals experiencing homelessness.

1.2 Enhance Screening and Discharge Coordination

AHCCCS is seeking waiver authority to cover reentry services for Medicaid-eligible individuals with serious behavioral and physical health conditions who are at high risk of experiencing homelessness upon release from prison or jail. Services will begin 30 days prior to their release in order to create community linkages and ensure that they receive needed coordination of care, physical and behavioral health services, medication and medication management, and critical social support upon release into the community. Studies have shown that "in-reach" provided before release can be an effective strategy for ensuring continuity of care.[14] The reentry services that will be provided under the H2O demonstration for this target population include:

- Provision of one-to-one case management and/or educational services to prepare individuals for stable, long-term housing (e.g., identifying housing preferences and developing a housing support plan),
- Coordinating the individual's move into stable housing including by assisting with housing applications, utility set-up, and reinstatement,
- Developing an integrated discharge and care plan that will identify the medical, behavioral health and social needs necessary to support a stable and successful community life, and
- Establishing linkage with physical and behavioral health providers, including peer supports to facilitate continuity care upon release.

In addition to this waiver authority request described above, AHCCCS will continue to strengthen screening and discharge coordination within key entry and transition points in the health care system, including EDs, inpatient (acute and behavioral health) facilities, and other crisis facilities. With immediate contact, engagement, and coordination prior to and at discharge, members will have a better chance of successfully navigating barriers, including finding appropriate shelter or housing, maintaining post-institutional medical or program requirements (e.g., medication routines, clinical follow up, probation requirements), and connecting directly with providers that can provide individualized approaches to increase member motivation for improved outcomes post-release. AHCCCS has helped to

[13] Most individuals served the Downtown Pilot were individuals behavioral health conditions and an average of 10 years of homelessness

[14] Guyer, Jocelyn, et al. "State Strategies for Establishing Connections to Health Care for Justice-Involved Populations: The Central Role of Medicaid." Commonwealth Fund.Org, Jan. 2019, www.commonwealthfund.org/sites/default/files/2019-01/Guyer_state_strategies_justice_involved_Medicaid_ib.pdf.

create many successful discharge coordination programs, including co-located justice and behavioral health clinics, co-located outreach or homeless services in institutional settings, and homeless coordination efforts such as the Downtown Pilot.

1.3 Enhance and Support Data Collection
Additionally, in conjunction with the waiver authorities requested under the H2O demonstration proposal, AHCCCS will enhance and support data collection and administrative coordination processes with other systems of care including homeless programs, justice and correctional systems, and other state agency programs to improve informed care coordination and maximize available resources. Through AHCCCS' investment in a Closed Loop Referral System for housing, homelessness, and other social risk factor referrals, as well as AHCCCS' work with homeless HMIS systems, AHCCCS has demonstrated the value of using appropriate compliant data sharing strategies to coordinate care between systems. Data sharing is particularly useful in identifying high risk or high cost members who avail themselves of multiple services systems and programs.

Limited trial programs have already begun to demonstrate the potential impact of intersystem data sharing. Since March, AHCCCS has linked HMIS homeless COVID-19 data in Maricopa County with AHCCCS eligibility and enrollment data, allowing the agency to identify members who experience homelessness and who have reported being COVID-19 positive or symptomatic. AHCCCS is then able to notify its MCOs so they may outreach and coordinate care for these members. In the first four months, over 50 persons experiencing homelessness identified through this data share were shown to have no current provider and were newly connected or re-connected to integrated health care services by the MCO. Data from this initiative is currently being used to identify other service coordination efforts including increased assessments for serious mental illness and prioritization of housing/service coordination.

Strategy 2: Securing Housing Funding for Members Who are Homeless or At-Risk of Homelessness

Once members experiencing homelessness have been identified, engaged, and assessed, finding housing for them can be complicated and time-consuming. Moreover, medical and behavioral health institutions need appropriate, safe, and stable discharge destinations in order for members to maintain engagement and treatment goals while their long-term housing is secured. With the strategies described in this section, AHCCCS will support members to stay engaged in treatment. The agency will streamline the housing processes and reduce financial barriers so that members are able to secure housing as quickly as possible, thereby reducing the duration and frequency of homeless episodes and avoidable ED and hospital utilization.

2.1 Community Reintegration and Immediate Post Homeless Housing Services
AHCCCS is seeking waiver authority to fund the provision of short-term, transitional housing (up to 18 months) for individuals leaving homelessness or an institutional setting. Community Reintegration Housing will offer temporary housing to individuals transitioning from homelessness or an institutional setting, allowing for the provision of needed clinical and social service support and stabilization prior to moving to an independent living arrangement. Individuals receiving Community Reintegration Housing will also receive Medicaid compensable, intensive, pre-housing wraparound services such as skills training while in the transitional setting.

Community Reintegration Housing may include temporary rent or voucher assistance to allow a discharge to housing with a goal of allowing the member to assume the rent and ongoing tenancy upon

termination of the service transition (similar to a HUD Rapid Re-Housing Program or Veteran Transition in Place model). Alternatively, transitional settings may include small congregate transitional shelter settings with outpatient behavioral health and pre-tenancy wraparound supports to maintain safety and stability of discharges while attaining housing. These beds will be designated for high risk or high acuity members.

The Downtown Pilot demonstrated the efficacy of low barrier, small occupancy transitional shelter and bridge housing vouchers. These vouchers provided immediate housing/shelter for persons who volunteered to leave the street, as well as those being discharged from institutions. Immediate shelter with appropriate behavioral health services, even on a transitional basis, increased the ongoing likelihood of engagement, provided additional assessment opportunities, promoted ongoing coordination with integrated health care, facilitated care plan compliance, and reduced the probability of homeless recidivism.

2.2 Community Transitional Services

AHCCCS is seeking waiver authority to expand the provision of Community Transitional Services for the targeted populations in the H2O demonstration proposal. Community Transitional Services provide financial assistance for non-recurring, move-in expenses to assist members in obtaining housing. Key eligible expenses will include fees to secure identification or documentation required for housing, housing application or leasing fees, security deposits, set-up fees for utilities or service access (including telephone, electricity, heating, and water), limited relocation expenses, and the costs of providing essential furniture, appliances, move-in kits, or supplies needed to establish and maintain the household. Funding these services will reduce a major time and financial barrier to housing, especially in the crucial initial move-in and start-up periods.

Community Transitional Services are currently Medicaid reimbursable for AHCCCS ALTCS members who are transitioning out of a nursing facility to a community based setting. Community Transitional Services are especially critical in the current housing market, as chronically homeless members generally lack income to cover these expenses. Waiver authority for the H2O demonstration will ensure available services for existing SMI homeless members as well as all members of the targeted populations who are experiencing homelessness or insecure housing.

2.3 Eviction Prevention Services

AHCCCS is seeking waiver authority to provide eviction prevention services to assist members in maintaining tenancies. Eviction prevention services include, but are not limited to, payment of back rent, late fees or charges, utility bills or restart costs, and limited damage reimbursement to landlords. These interventions can prevent evictions and a return to homelessness or housing crisis due to behaviors related to financial hardship, substance use relapse, or mental health episodes. As with housing supports related to move-in, eviction prevention assistance available through AHCCCS is limited primarily to members with SMI designation or members in need of behavioral health and/or substance use treatment currently in housing programs. The H2O demonstration will expand this service to all targeted members in the H2O demonstration.

Strategy 3: Enhancing Wraparound Services and Supports to Ensure Housing Stability for Improved Health Outcomes, Reduced Recidivism, and Reduced Decompensation

PSH is predicated on the availability of not only of housing subsidies and physical units, but of quality, individualized, housing-focused tenancy supports to assist members in securing housing (pre-tenancy supports), maintaining the housing, and engaging in ongoing medical and behavioral health services to

address the primary causes of the individual's homelessness or housing instability. AHCCCS proposes to implement the following strategies to enhance Medicaid housing wraparound services and supports.

3.1 Home Modification Services
AHCCCS is seeking waiver authority to expand the agency's ability to pay for home modification and remediation services to ensure habitability of housing beyond members currently enrolled in ALTCS. Home modification and remediation services include, but are not limited to installation of ramps and handrails to facilitate barrier-free member access to his or her home for those members experiencing homelessness with physical disabilities or limitations, in addition to their behavioral health needs.

3.2 Pre-Tenancy and Tenancy Supportive Services
AHCCCS is seeking waiver authority to extend the provision of tenancy support services beyond the currently eligible population of individuals with an SMI designation or in need of behavioral health and/or substance use treatment. In doing so, AHCCCS will reduce the length of time a member experiences homelessness, increase the likelihood of securing and maintaining housing, reduce ongoing system costs related to homeless recidivism, and promote primary care and other preventative health care strategies. Services that sustain tenancy will also include financial assistance for home modifications and eviction prevention.

AHCCCS will consider strategies for incentivizing or engaging community based organizations (CBOs) to increase access to social service resources. Key CBO services that may be leveraged include assistance with legal identification, securing employment and benefits including SSI/SSDI Outreach, Access, and Recovery (SOAR) benefit programs, housing move in supplies and furniture programs, or wraparound housing supports in mainstream voucher programs.

Proposed Additional Eligibility Requirements under the Demonstration as Amended
Arizona's 1115 Waiver demonstration proposal will target AHCCCS members who are homeless or at risk of becoming homeless and who have at least one or more of the following conditions or circumstances:

- Individuals with an SMI designation or in need of behavioral health and/or substance use treatment,
- Individuals determined high risk or high cost based on service utilization or health history,
- Individuals with repeated avoidable emergency department visits or crisis utilization,
- Individuals who are pregnant,
- Individuals with chronic health conditions and/or co-morbid conditions (e.g., end-stage renal disease, cirrhosis of the liver, HIV/AIDS, co-occurring mental health conditions, physical health conditions, and/or substance use disorder),
- Individuals at high risk of experiencing homelessness upon release from an institutional setting (e.g., Institutions for Mental Disease/IMDs, psychiatric inpatient hospitals, correctional facility),
- Young adults ages 18 through 24 who have aged out of the foster care system, and
- Individuals in the ALTCS program who are medically able to reside in their own home and require affordable housing in order to transition from an institutional setting.

All proposed services and enhancements will be implemented statewide and will take into consideration the unique needs of Arizona's diverse urban and rural communities. Special consideration will also be given to racial and ethnic populations who may be disparately impacted or have more limited access to housing and housing supports and services including American Indian/Alaska Native (AI/AN) members.

AHCCCS recently began the evaluation of its housing programs to determine if housing utilization and access reflected the racial diversity of AHCCCS enrollees and the homeless population. One immediate potential equity issue that has been identified is unique needs and housing barriers for eligible AI/AN members. AI/AN members are disproportionately overrepresented in both the general homeless population (9 percent) and in AHCCCS identified homeless SMI members (10 percent) compared to the state population (5 percent). By comparison only 4 percent of current AHCCCS members housed in AHCCCS' voucher/subsidy programs are AI/AN. While housing utilization by tribal members varies by RBHA/TRBHA and GSA and their proximity to reservations and tribal populations, AHCCCS must conduct a more in depth analysis to determine the existing need and the resources that may be of benefit to tribal communities throughout the state. AHCCCS is currently holding listening sessions with tribal leadership, behavioral health and health care providers, and housing providers to identify possible barriers related to geography, cultural norms, service system coordination both on reservations and off, tribal housing needs or shortages, and member service needs.

Proposed Cost Sharing Requirements under the Demonstration as Amended
The cost sharing for persons impacted by this proposed 1115 Waiver amendment will not vary from AHCCCS' current program features as described in the current State Plan and demonstration.

Proposed Changes to the Delivery System under the Demonstration as Amended
The delivery system for persons impacted by this proposed 1115 Waiver amendment will not vary from AHCCCS' current program features as described in the current State Plan and demonstration.

IV. REQUESTED WAIVER & EXPENDITURE AUTHORITIES

Waiver Authorities Requested	Brief Description
Section 1902(a)(10)(B) Amount, duration and scope of services, and comparability	To the extent necessary to enable the state to limit housing services and supports under the AHCCCS H2O demonstration to certain targeted groups of AHCCCS beneficiaries.
Expenditure authority for services not covered under section 1905 of the Social Security Act	To the extent necessary to enable the state to claim federal financial participation for expenditures for housing services and supports, to the extent not encompassed under the Section 1905(a) definition of medical assistance. This includes, but is not limited to, expenditures for room and board that are otherwise not compensable under the State Plan.

V. EVALUATION DESIGN

Arizona's 1115 Waiver Evaluation design will be modified to incorporate the AHCCCS H2O demonstration proposal. The table below outlines the proposed hypotheses for this 1115 Waiver amendment and potential performance measures that would allow AHCCCS to effectively test each of the specific hypotheses.

Objectives	Proposed Hypotheses	Potential Approaches
The AHCCCS Housing and Health Opportunities (H2O) demonstration will increase housing attainment and stabilization, positive health and wellbeing outcomes for target populations, reduce the cost of care for individuals successfully housed, and support state efforts to reduce homelessness and improve ongoing housing stability.	The AHCCCS H2O demonstration will improve health outcomes for AHCCCS members.	Data will be drawn from a variety of sources including, but not limited to: ● Member surveys, ● State eligibility and enrollment data, ● Claims/encounter data, ● Administrative program data (PMMIS), ● T-MSIS, ● National/regional benchmarks, ● Key informant interviews & focus groups, ● Leasing and housing data from AHCCCS housing programs, ● Permanent supportive housing fidelity reporting, ● Data from Homeless Management Information System (HMIS) and other system coordination.
	The AHCCCS H2O demonstration will improve management of behavioral health conditions for AHCCCS members.	
	The AHCCCS H2O demonstration will improve management of chronic conditions for AHCCCS members.	
	The AHCCCS H2O demonstration will decrease avoidable hospital utilization including emergency department utilization.	
	The AHCCCS H2O demonstration will increase utilization of primary care and preventative health services.	
	The AHCCCS H2O demonstration will yield improved member satisfaction with care.	
	The AHCCCS H2O demonstration will reduce homelessness and homeless recidivism of AHCCCS members.	
	The AHCCCS H2O demonstration will improve ongoing housing stability for AHCCCS members.	
	The AHCCCS H2O demonstration will increase timely housing placement for AHCCCS members.	
	The AHCCCS H2O demonstration will increase engagement and assessment of Medicaid eligible but unenrolled individuals who are experiencing chronic homelessness.	

	The AHCCCS H2O demonstration will improve discharge coordination of identified homeless members and reduce discharges to homelessness.	
	The AHCCCS H2O demonstration will yield cost-effective care for AHCCCS members.	

VI. PUBLIC NOTICE PROCESS

Pursuant to the terms and conditions that govern Arizona's 1115 Waiver demonstration, Arizona must provide documentation of its compliance with demonstration of Public Notice process (42 CFR 431.408), the tribal consultation requirements pursuant to Section 1902(a)(73) of the Act as amended by Section 5006(e) of the American Recovery and Reinvestment Act of 2009, and the tribal consultation requirements outlined in STC 13.

Public Website

The AHCCCS H2O demonstration proposal was posted on the AHCCCS website for public comment on March 19, 2021 at www.azahcccs.gov/HousingWaiverRequest. The web page includes a summary of the waiver amendment request, the schedule (dates and times) of public forums across the state, this draft Waiver amendment proposal, and budget neutrality worksheets. In addition to the website posting, AHCCCS is using social media accounts and electronic mail to notify interested parties about Arizona's Waiver amendment proposal.

Publication of Public Notice in the Arizona Administrative Register

On March 19, 2021, public notice of the AHCCCS H2O demonstration proposal was published in the Arizona Administrative Register. The notice included a summary description of the 1115 Waiver amendment request, the locations, dates and times of the public hearings, instructions on how to submit comments, and a link to where copies of Arizona's Waiver amendment proposal are available for public review and comments.

Stakeholder Meetings

AHCCCS will present the details about AHCCCS' H2O demonstration proposal at two virtual public forum meetings on March 31, 2021 and April 8, 2021 and will conduct a virtual Tribal Consultation meeting on April 5, 2021. In addition, AHCCCS' H2O demonstration proposal will be presented at the State Medicaid Advisory Committee (SMAC) meeting on April 14, 2021. Details regarding the public forum meetings, including TC and SMAC, can be found below.

Public Forum Meeting	Meeting Dates & Times	Meeting Web Link & Call-in Information
Public Forum #1	**March 31, 2021** **1:00 p.m. - 3:00 p.m. MST**	**Meeting link:** https://ahcccs.zoom.us/s/89469967126?pwd=Q2FmOUtBZVA4UjVHcjViZUdEVmxRdz09 **Passcode**: AHCCCS2!

		Call-in numbers: 408-638-0968, 669-900-6833, 253-215-8782, 346-248-7799, 646-876-9923 877-853-5257 (Toll Free), 888 475 4499 (Toll Free), 833-548-0276 (Toll Free) or 833-548-0282 (Toll Free) **Webinar ID:** 894 6996 7126 **Passcode**: 65647117
Public Forum #2	**April 8, 2021** **2:00 p.m. - 4:00 p.m. MST**	**Meeting Link:** https://ahcccs.zoom.us/j/88263070979?pwd=bmdFcHlkWjE1UFNabDE3WkF1dWU1UT09 **Passcode:** AHCCCS2! **Call-in numbers:** 346-248-7799, 408-638 0968, 669-900-6833 or 253-215-8782 or 312 626 6799 833-548 0282 (Toll Free), 877-853-5257 (Toll Free), 888-475 4499 (Toll Free) or 833-548-0276 (Toll Free) **Webinar ID:** 882 6307 0979 **Passcode**: 10613032
Special Tribal Consultation	**April 5, 2021** **12:00 p.m. - 2:00 pm MST**	**Meeting Registration link:** https://ahcccs.zoom.us/webinar/register/WN_NgCnjmcJQ2Wd01kHq0lsbA **Call-in numbers:** 346-248-7799, 408-638-0968 or 669-900-6833, 253-215-8782, 312-626-6799 833-548-0282 (Toll Free), 877-853-5257 (Toll Free), 888-475-4499 (Toll Free) or 833-548-0276 (Toll Free) **Webinar ID:** 854 1196 6314 **Passcode:** 77045474
State Medicaid Advisory Committee (SMAC) Meeting	**April 14, 2021** **1:00 p.m. - 3:00 pm MST**	**Meeting Link:** https://ahcccs.zoom.us/s/89849751173?pwd=b2xKVEN0elo4eVo0eHlFQU4yK1hMQT09 **Passcode**: SMAC2021! **Call-in numbers:** 833 548 0282 (Toll Free) or 877 853 5257 (Toll Free) **Webinar ID:** 898 4975 1173 **Audio Passcode:** 156227777

AHCCCS
Arizona Health Care Cost Containment System

APPENDIX A:
BUDGET NEUTRALITY REPORT

Arizona Health Care Cost Containment System
Budget Neutrality Status by Federal Fiscal Year
Total Funds - All Populations
For the Period October 1, 2016 - September 30, 2021
Updated 9/20

	Estimate	Estimate	Estimate	Estimate	Estimate		Pop	2.0%
Without Waiver	2017	2018	2019	2020	2021		Exp	4.0%
Expenditure Limit Calculation	DY 6	DY 7	DY 8	DY 9	DY 10	Total		
Member Months								
TANF/SOBRA	13,482,714	12,917,762	12,664,544	13,634,561	14,043,897	66,743,478		
SSI	2,241,231	2,275,213	2,290,383	2,270,211	2,440,426	11,517,464		
ALTCS-EPD	362,059	369,046	383,832	375,790	373,863	1,864,590		
ALTCS-DD	367,160	384,901	405,830	429,543	460,660	2,048,094		
Newly Eligible Adults	1,344,121	1,303,370	1,288,157	1,354,338	1,542,792	6,832,778		
Expansion State Adults	3,819,185	3,737,844	3,829,011	4,147,232	4,347,427	19,880,699		
Combined	21,616,470	20,988,136	20,861,757	22,211,675	23,209,065	108,887,103		
Without Waiver PMPM								
TANF/SOBRA	749.11	782.82	818.05	854.86	893.33			
SSI	1,162.52	1,209.02	1,257.38	1,307.68	1,359.99			
ALTCS-EPD	6,016.98	6,239.61	6,470.48	6,709.89	6,958.16			
ALTCS-DD	6,462.96	6,721.48	6,990.34	7,269.95	7,560.75			
Newly Eligible Adults	344.80	358.51	362.24	376.73	441.58			
Expansion State Adults	600.68	649.52	713.12	741.64	877.79			
Weighted	925.89	983.79	1,042.95	1,073.97	1,139.49			
Without Waiver Expenditure Limit								
TANF/SOBRA	10,100,035,885	10,112,282,449	10,360,230,219	11,655,640,800	12,545,834,500	54,774,023,853		
SSI	2,605,475,862	2,750,778,021	2,879,881,777	2,968,709,500	3,318,955,000	14,523,800,160		
ALTCS-EPD	2,178,501,762	2,302,703,112	2,483,577,279	2,521,509,600	2,601,398,600	12,087,690,353		
ALTCS-DD	2,372,940,394	2,587,104,373	2,836,889,682	3,122,756,100	3,482,935,100	14,402,625,649		
Newly Eligible Adults	463,446,215	467,267,022	466,619,567	510,219,800	681,258,800	2,588,811,404		
Expansion State Adults	2,294,099,974	2,427,810,870	2,730,558,996	3,075,753,100	3,816,143,600	14,344,366,540		
Total	20,014,500,091	20,647,945,848	21,757,757,520	23,854,588,900	26,446,525,600	112,721,317,959		
DSH Allotment	160,509,328	162,832,936	166,932,007	169,491,286	120,105,286	779,870,843		
Total Without Waiver Expenditure Limit	20,175,009,420	20,810,778,784	21,924,689,527	24,024,080,186	26,566,630,886	113,501,188,802		
With Waiver Expenditures								
TANF/SOBRA	3,943,965,278	4,013,319,586	4,002,226,228	4,481,134,800	5,474,797,300	21,915,443,192		
SSI	1,965,933,865	2,072,927,606	2,104,291,504	2,169,186,600	2,751,583,100	11,063,922,675		
ALTCS-EPD	1,386,780,684	1,437,707,472	1,544,257,849	1,572,376,800	1,670,521,000	7,611,643,805		
ALTCS-DD	1,382,278,096	1,568,572,942	1,813,888,664	1,996,670,500	2,282,371,900	9,043,782,102		
Newly Eligible Adults	463,446,215	467,267,022	466,619,567	510,219,800	681,258,800	2,588,811,404		
Expansion State Adults	2,294,099,974	2,427,810,870	2,730,558,996	3,075,753,100	3,816,143,600	14,344,366,540		
DSHP	13,165,373	21,137,600	27,306,100	20,975,000	14,991,000	97,575,073		
Targeted Investments	19,325,179	70,000,000	90,000,000	70,000,000	50,000,000	299,325,179		
AI/AN Uncompensated Care	3,208,226	-	-	-	-	3,208,226		
SNCP/DSHP	95,000,000	22,500,000	-	-	-	117,500,000		
Expenditure Subtotal	11,567,202,890	12,101,243,098	12,779,148,908	13,896,316,600	16,741,666,700	67,085,578,196		
DSH	160,509,328	162,832,936	166,932,007	169,491,286	120,105,286	779,870,843		
Total With Waiver Expenditures	11,727,712,218	12,264,076,034	12,946,080,915	14,065,807,886	16,861,771,986	67,865,449,039		
With Waiver Expenditure PMPMs								
TANF/SOBRA	292.52	310.68	316.02	328.66	389.83			341.81
SSI	877.17	911.09	918.75	955.50	1,127.50			993.72
ALTCS-EPD	3,830.26	3,895.74	4,023.26	4,184.19	4,468.27			4,351.56
ALTCS-DD	3,764.78	4,075.26	4,469.58	4,648.36	4,954.57			4,834.29
Newly Eligible Adults	344.80	358.51	362.24	376.73	441.58			391.80
Expansion State Adults	600.68	649.52	713.12	741.64	877.79			771.31
DY1-DY5 BN Carry-over 29,327,890,565								
DY6-DY10 BN Variance	8,447,297,201	8,546,702,750	8,978,608,612	9,958,272,300	9,704,858,900			
Phase-Down of DY6-DY10 Variance	2,111,824,300	2,136,675,687	2,244,652,153	2,489,568,075	2,426,214,725			
Cumulative DY-DY10 Variance	31,439,714,865	33,576,390,552	35,821,042,705	38,310,610,780	40,736,825,505	**40,736,825,505**		
Variance by Waiver Group								
TANF/SOBRA	6,156,070,607	6,098,962,863	6,358,003,991	7,174,506,000	7,071,037,200	32,858,580,661		
SSI	639,541,997	677,850,415	775,590,273	799,522,900	567,371,900	3,459,877,485		
ALTCS-EPD	791,721,078	864,995,640	939,319,430	949,132,800	930,877,600	4,476,046,548		
ALTCS-DD	990,662,298	1,018,531,431	1,023,001,018	1,126,085,600	1,200,563,200	5,358,843,547		
Newly Eligible Adults	-	-	-	-	-	-		
Expansion State Adults	-	-	-	-	-	-		
DSHP	(13,165,373)	(21,137,600)	(27,306,100)	(20,975,000)	(14,991,000)	(97,575,073)		
Targeted Investments	(19,325,179)	(70,000,000)	(90,000,000)	(70,000,000)	(50,000,000)	(299,325,179)		
AI/AN Uncompensated Care	(3,208,226)	-	-	-	-	(3,208,226)		
SNCP/DSHP	(95,000,000)	(22,500,000)	-	-	-	(117,500,000)		
	8,447,297,201	8,546,702,750	8,978,608,612	9,958,272,300	9,704,858,900	45,635,739,763		

Arizona Health Care Cost Containment System
Budget Neutrality Status by Federal Fiscal Year
Total Funds - All Populations
For the Period October 1, 2011 - September 30, 2016
Updated 10/19

Without Waiver Expenditure Limit Calculation	Actual 2012 DY 1	Actual 2013 DY 2	Actual 2014 DY 3	Actual 2015 DY 4	Estimate 2016 DY 5	Total
Member Months						
TANF/SOBRA	11,704,352	11,622,919	11,797,802	12,538,049	13,087,930	60,751,052
SSI	1,957,433	1,995,474	2,075,547	2,174,958	2,214,163	10,417,575
AC	1,633,495	969,125	206,508	-	-	2,809,128
ALTCS-EPD	343,281	346,428	353,798	359,999	359,110	1,762,616
ALTCS-DD	294,427	307,374	320,872	336,869	350,821	1,610,363
Family Planning Extension	50,024	55,971	14,885	-	-	120,880
Expansion State Adults		-	1,822,917	3,359,603	3,705,353	8,887,873
Combined	15,983,012	15,297,291	16,592,329	18,769,478	19,717,377	86,359,487
Without Waiver PMPM						
TANF/SOBRA	585.28	615.71	647.73	681.41	716.85	651.42
SSI	885.41	938.53	994.84	1,054.53	1,117.81	1,002.09
AC	562.30	600.57	600.08	-	-	608.25
ALTCS-EPD	4,737.37	4,983.71	5,242.86	5,515.49	5,802.30	5,263.14
ALTCS-DD	4,922.38	5,217.72	5,530.78	5,862.63	6,214.39	5,578.13
Family Planning Extension	16.60	18.01	12.77	-	-	16.78
Expansion State Adults	-	-	623.83	579.09	579.03	588.24
Weighted	786.98	846.07	879.78	893.96	928.85	870.92
Without Waiver Expenditure Limit						
TANF/SOBRA	6,850,319,393	7,156,396,545	7,641,806,370	8,543,594,521	9,382,041,921	39,574,158,751
SSI	1,733,125,663	1,872,815,893	2,064,844,970	2,293,567,986	2,475,005,667	10,439,360,179
AC	918,520,667	582,023,481	123,922,054	36,049,882	48,139,177	1,708,655,261
ALTCS-EPD	1,626,248,054	1,726,496,688	1,854,914,415	1,985,571,530	2,083,663,007	9,276,893,693
ALTCS-DD	1,449,280,104	1,603,790,699	1,774,672,617	1,974,937,424	2,180,136,769	8,982,817,613
Family Planning Extension	830,631	1,008,110	190,026	-	-	2,028,767
Expansion State Adults	-	-	1,137,188,645	1,945,504,765	2,145,499,317	5,228,192,727
Total	12,578,324,512	12,942,531,416	14,597,539,097	16,779,226,108	18,314,485,858	75,212,106,990
DSH Allotment	154,369,963	161,973,765	160,771,261	160,408,856	159,816,238	797,340,083
Total Without Waiver Expenditure Limit	12,732,694,475	13,104,505,181	14,758,310,358	16,939,634,964	18,474,302,096	76,009,447,074
With Waiver Expenditures						
TANF/SOBRA	3,415,708,532	3,582,361,477	3,539,898,256	3,600,524,014	3,982,347,227	18,120,839,506
SSI	1,349,499,952	1,426,826,711	1,545,627,761	1,739,284,853	1,848,114,631	7,909,353,908
AC	918,520,667	582,023,481	123,922,054	36,049,882	48,139,177	1,708,655,261
ALTCS-EPD	1,061,603,724	1,166,651,266	1,195,332,840	1,243,620,369	1,262,822,459	5,930,030,658
ALTCS-DD	939,086,691	1,005,552,496	1,067,544,797	1,170,346,154	1,252,959,914	5,435,490,052
Family Planning Extension	830,631	1,008,110	190,026	-	-	2,028,767
Expansion State Adults	-	-	1,137,188,645	1,945,504,765	2,145,499,317	5,228,192,727
AI/AN Uncompensated Care	22,866,717	97,192,513	53,888,765	13,437,080	7,647,155	195,032,230
SNCP/DSHP	296,636,120	558,334,298	240,250,917	135,561,857	116,750,000	1,347,533,192
Expenditure Subtotal	8,004,753,034	8,419,950,352	8,903,844,061	9,884,328,974	10,664,279,880	45,877,156,301
DSH	155,762,651	163,280,200	162,283,023	152,801,559	170,272,775	804,400,208
Total With Waiver Expenditures	8,160,515,685	8,583,230,552	9,066,127,084	10,037,130,533	10,834,552,655	46,681,556,509
With Waiver Expenditure PMPMs						
TANF/SOBRA	291.83	308.22	300.05	287.17	304.28	
SSI	689.42	715.03	744.68	799.69	834.68	
AC	562.30	600.57	600.08	-	-	
ALTCS-EPD	3,092.52	3,367.66	3,378.57	3,454.51	3,516.53	
ALTCS-DD	3,189.54	3,271.43	3,327.01	3,474.19	3,571.51	
Family Planning Extension	16.60	18.01	12.77	-	-	
Expansion State Adults	-	-	623.83	579.09	579.03	
Budget Neutrality Variance	4,572,178,790	4,521,274,629	5,692,183,274	6,902,504,431	7,639,749,441	**29,327,890,565**
Cumulative Variance	4,572,178,790	9,093,453,419	14,785,636,693	21,688,141,124	29,327,890,565	
Variance by Waiver Group						
TANF/SOBRA	3,434,610,861	3,574,035,068	4,101,908,114	4,943,070,507	5,399,694,694	21,453,319,245
SSI	383,625,711	445,989,182	519,217,209	554,283,133	626,891,036	2,530,006,271
AC	-	-	-	-	-	-
ALTCS-EPD	564,644,330	559,845,422	659,581,575	741,951,161	820,840,548	3,346,863,035
ALTCS-DD	510,193,413	598,238,203	707,127,820	804,591,270	927,176,855	3,547,327,561
Family Planning Extension	-	-	-	-	-	-
Expansion State Adults	-	-	-	-	-	-
DSH	(1,392,688)	(1,306,435)	(1,511,762)	7,607,297	(10,456,537)	(7,060,125)
AI/AN Uncompensated Care	(22,866,717)	(97,192,513)	(53,888,765)	(13,437,080)	(7,647,155)	(195,032,230)
SNCP/DSHP	(296,636,120)	(558,334,298)	(240,250,917)	(135,561,857)	(116,750,000)	(1,347,533,192)
	4,572,178,790	4,521,274,629	5,692,183,274	6,902,504,431	7,639,749,441	29,327,890,565
	480.84	507.57	518.90	518.68	534.55	
		5.6%	2.2%	0.0%	3.1%	

Arizona Health Care Cost Containment System
Budget Neutrality Status by Federal Fiscal Year
Total Funds - All Populations
For the Period October 1, 2021 - September 30, 2026
Updated 9/20

Without Waiver Expenditure Limit Calculation	Estimate 2022 DY 1	Estimate 2023 DY 2	Estimate 2024 DY 3	Estimate 2025 DY 4	Estimate 2026 DY 5	Total
Member Months						
TANF/SOBRA	14,324,775	14,611,270	14,903,496	15,201,566	15,505,597	74,546,704
SSI	2,489,235	2,539,019	2,589,800	2,641,596	2,694,427	12,954,076
ALTCS-EPD	381,340	388,967	396,746	404,681	412,775	1,984,510
ALTCS-DD	469,873	479,271	488,856	498,633	508,606	2,445,239
Newly Eligible Adults	1,573,648	1,605,121	1,637,223	1,669,968	1,703,367	8,189,327
Expansion State Adults	4,434,376	4,523,063	4,613,524	4,705,795	4,799,911	23,076,668
Combined	23,673,246	24,146,711	24,629,645	25,122,238	25,624,683	123,196,524
Without Waiver PMPM						
TANF/SOBRA	408.44	428.07	448.88	470.92	493.95	
SSI	1,179.51	1,233.02	1,290.26	1,350.61	1,413.43	
ALTCS-EPD	4,674.37	4,886.45	5,113.28	5,352.44	5,601.39	
ALTCS-DD	5,193.99	5,455.93	5,735.58	6,031.85	6,342.55	
Newly Eligible Adults	462.45	484.55	507.87	532.67	558.68	
Expansion State Adults	919.30	963.22	1,009.58	1,058.87	1,110.59	
Weighted	752.50	788.32	826.37	866.67	908.80	
Without Waiver Expenditure Limit						
TANF/SOBRA	5,850,803,114	6,254,703,864	6,689,826,264	7,158,751,246	7,659,043,614	33,613,128,101
SSI	2,936,072,619	3,130,666,106	3,341,515,523	3,567,760,736	3,808,378,051	16,784,393,035
ALTCS-EPD	1,782,526,927	1,900,667,101	2,028,676,457	2,166,032,795	2,312,114,619	10,190,017,898
ALTCS-DD	2,440,516,301	2,614,867,073	2,803,873,559	3,007,680,279	3,225,857,299	14,092,794,510
Newly Eligible Adults	727,737,815	777,762,588	831,495,537	889,534,052	951,640,521	4,178,170,514
Expansion State Adults	4,076,500,747	4,356,719,827	4,657,710,658	4,982,819,569	5,330,715,560	23,404,466,360
Total	17,814,157,522	19,035,386,558	20,353,097,998	21,772,578,676	23,287,749,663	102,262,970,417
DSH Allotment	70,805,286	74,800,143	78,885,143	83,062,143	87,460,300	395,013,014
Total Without Waiver Expenditure Limit	17,884,962,807	19,110,186,701	20,431,983,141	21,855,640,819	23,375,209,963	102,657,983,432
With Waiver Expenditures						
TANF/SOBRA	5,818,833,600	6,208,229,900	6,592,022,700	7,066,780,200	7,633,394,600	33,319,261,000
SSI	2,924,492,600	3,120,199,600	3,313,090,400	3,551,699,100	3,836,474,400	16,745,956,100
ALTCS-EPD	1,775,496,500	1,894,312,800	2,011,419,200	2,156,281,600	2,329,172,300	10,166,682,400
ALTCS-DD	2,425,796,200	2,588,130,400	2,748,128,700	2,946,048,900	3,182,263,100	13,890,367,300
Newly Eligible Adults	724,069,100	772,523,800	820,281,200	879,357,900	949,864,800	4,146,096,800
Expansion State Adults	4,055,950,100	4,327,374,200	4,594,892,500	4,925,816,700	5,320,768,700	23,224,802,200
Targeted Investment 2	18,500,000	36,000,000	48,000,000	36,000,000	21,500,000	160,000,000
Housing Initiatives	90,000,000	90,000,000	90,000,000	90,000,000	90,000,000	450,000,000
Traditional Healing	21,723,600	21,723,600	21,723,600	21,723,600	21,723,600	108,618,000
Native American Adult Dental	74,200	97,500	103,300	114,800	121,100	510,900
Expenditure Subtotal	17,854,935,900	19,058,591,800	20,239,661,600	21,673,822,800	23,385,282,600	102,212,294,700
DSH	70,805,286	74,800,143	78,885,143	83,062,143	87,460,300	395,013,014
Total With Waiver Expenditures	17,925,741,186	19,133,391,943	20,318,546,743	21,756,884,943	23,472,742,900	102,607,307,714
With Waiver Expenditure PMPMs						
TANF/SOBRA	406.21	424.89	442.31	464.87	492.30	
SSI	1,174.86	1,228.90	1,279.28	1,344.53	1,423.86	
ALTCS-EPD	4,655.94	4,870.11	5,069.79	5,328.34	5,642.72	
ALTCS-DD	5,162.66	5,400.14	5,621.55	5,908.25	6,256.84	
Newly Eligible Adults	460.12	481.29	501.02	526.57	557.64	
Expansion State Adults	914.66	956.74	995.96	1,046.76	1,108.51	
DY6-DY10 BN Carry-over 11,408,934,941						
DY1-DY6 BN Variance	(40,778,378)	(23,205,242)	113,436,398	98,755,876	(97,532,937)	
Phase-Down of DY1-DY5 Variance	-	-	28,359,100	24,688,969	-	
Cumulative DY-DY5Variance	11,368,156,562	11,344,951,321	11,373,310,420	11,397,999,389	11,300,466,453	**11,300,466,453**

APPENDIX B:
HOUSING WAIVER AMENDMENT PUBLIC NOTICE

NOTICES OF PUBLIC INFORMATION

Notices of Public Information contain corrections that agencies wish to make to their notices of rulemaking; miscellaneous rulemaking information that does not fit into any other category of notice; and other types of information required by statute to be published in the Register.

Because of the variety of Notices of Public Information, the Office of the Secretary of State has not established a specific publishing format for these notices. We do however require agencies to use a numbered list of questions and answers and follow our filing requirements by presenting receipts with electronic and paper copies.

NOTICE OF PUBLIC INFORMATION

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

1115 RESEARCH AND DEMONSTRATION WAIVER AMENDMENT REQUEST

[M21-16]

1. Name of the Agency: Arizona Health Care Cost Containment System Administration (AHCCCS)

2. The public information: AHCCCS 1115 Research and Demonstration Waiver Amendment Request

Pursuant to the Special Terms and Conditions of Arizona's approved demonstration project, the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency, is required to provide a public notice consistent with 42 C.F.R. § 431.408 of its intent to submit a Section 1115 Waiver amendment to the Center of Medicare and Medicaid Services (CMS). AHCCCS is requesting an amendment to the 1115 Research and Demonstration Waiver to seek waiver and expenditure authority to implement the AHCCCS Housing and Health Opportunities (H2O) demonstration. The goal of the AHCCCS Housing and Health Opportunities (H2O) demonstration is to enhance and expand housing services and interventions for AHCCCS members who are homeless or at risk of becoming homeless.

I. Proposed Delivery System under the Demonstration

The delivery system for persons impacted by this proposed 1115 Waiver amendment will not vary from the AHCCCS' current program features as described in the current State Plan and demonstration.

II. Proposed Eligibility Requirements under the Demonstration

Arizona's 1115 Waiver amendment request will target AHCCCS members who are homeless or at risk of becoming homeless and who have at least one or more of the following conditions or circumstances:

- Individuals with a Seriously Mentally Ill (SMI) designation or a general mental health and/or substance use disorder (GMH/SU);
- Individuals determined high risk or high cost based on service utilization or health history, including individuals with repeated avoidable emergency department visits or crisis utilization;
- Individuals who are pregnant;
- Individuals who have a chronic condition, and/or co-morbid conditions (e.g., end stage renal disease, cirrhosis of the liver, HIV/AIDS, co-occurring mental health conditions, physical health conditions, and/or substance use disorder);
- Individuals at high risk of experiencing homelessness upon release from an institutional setting (e.g., Institutions for Mental Disease, inpatient hospitals, correctional facility); and
- Arizona Long Term Care System (ALTCS) members who are medically able to reside in their own home with wraparound services who require affordable housing in order to transition from an institutional setting.

III. Proposed Benefit Coverage under the Demonstration

AHCCCS is requesting waiver and expenditure authority to enhance and expand housing services and interventions for AHCCCS members who are homeless or at risk of becoming homeless. With these additional resources, the agency will seek to:

- Increase positive health and wellbeing outcomes for target populations including the stabilization of mental health conditions, reduction in substance use, improvement in the utilization of primary care and prevention services, and increased member satisfaction.
- Reduce the cost of care for individuals successfully housed through decreased utilization of crisis services, emergency department utilization, and inpatient hospitalization.
- Support state efforts to reduce homelessness and improve ongoing housing stability.

These goals will be achieved through the following three key strategies.

Strategy 1: Strengthen homeless outreach and service engagement

- Offer outreach and engagement services, allowing Medicaid providers to provide dedicated outreach staff with behavioral health qualifications and experience to identify and successfully connect all eligible or potentially eligible members experiencing homelessness to available services and supports, including transitional living arrangements and rental subsidies.

- Strengthen the coordination between the community, governmental agencies, and providers when an individual leaves an institutional setting and connect the individual to available housing supports and services. Such activities would also include "in-reach" or co-location of outreach or housing navigation within key access or transition points in the behavioral and health care system, or other mainstream settings including emergency rooms, inpatient behavioral health facilities, jails, or other crisis facilities.
- Enhance and support data collection and administrative coordination with other systems of care including homeless programs, justice and correctional systems, and other state agency programs to foster informed care coordination and the maximization of available resources.

Strategy 2: Secure funding for housing for members who are homeless or at-risk of homelessness

- Fund short-term, transitional housing (up to 18 months) for individuals leaving an institutional setting, allowing for the provision of Medicaid compensable intensive pre-housing wraparound services, and stabilization in a temporary setting prior to moving into permanent housing.
- Expand the agency's ability to offer financial assistance for move-in costs or Community Transition Services beyond those members enrolled with the ALTCS program (e.g., deposits, fees, and furniture).
- Fund the provision of eviction prevention services to assist members in maintaining tenancies (e.g., payment for back rents, fees, or charges to avoid immediate eviction).

Strategy 3: Enhance individualized wraparound housing services and supports to ensure housing stability as a platform to leverage improved health outcomes and reduce recidivism

- Expand the agency's ability to pay for home modification (e.g., installation of ramps and other home repairs or upgrades) beyond members currently enrolled in ALTCS to prevent long term placement in an institutional setting.
- Expand the agency's ability to pay for pre-tenancy and tenancy supportive services (e.g., housing navigation and skills training to teach independent living skills) to individuals experiencing chronic homelessness.

IV. Proposed Cost Sharing Requirements under the Demonstration

The cost sharing requirements for persons impacted by this proposed demonstration amendment will not change from the AHCCCS' current program features as described in the current State Plan and demonstration.

V. Hypothesis and Evaluation Parameters of the Demonstration

AHCCCS will test the following objectives and hypotheses under the proposed 1115 Waiver amendment request.

Objectives and hypotheses begin on next page.

Objectives	Proposed Hypotheses	Potential Approaches
The AHCCCS Housing and Health Opportunities (H2O) demonstration will increase housing attainment and stabilization, positive health and wellbeing outcomes for target populations, reduce the cost of care for individuals successfully housed, and support state efforts to reduce homelessness and improve ongoing housing stability.	The AHCCCS H2O demonstration will improve health outcomes for AHCCCS members.	Data will be drawn from a variety of sources including, but not limited to: • Member survey • State eligibility and enrollment data • Claims/encounter data •Administrative program data (PMMIS) • T-MSIS • National/regional benchmarks • Key informant interviews & focus groups • Leasing and housing data from AHCCCS housing programs. • Permanent supportive housing fidelity reporting • Data from Homeless Management Information System (HMIS) and other system coordination
	The AHCCCS H2O demonstration will improve management of behavioral health conditions for AHCCCS members.	
	The AHCCCS H2O demonstration will improve management of chronic conditions for AHCCCS members.	
	The AHCCCS H2O demonstration will decrease avoidable hospital utilization including emergency department utilization.	
	The AHCCCS H2O demonstration will yield improved member satisfaction with care.	
	The AHCCCS H2O demonstration will reduce homeless of AHCCCS members, increase timely housing placement, improve ongoing housing stability, and reduce homeless recidivism for AHCCCS members.	
	The AHCCCS H2O demonstration will increase engagement and assessment of unenrolled but eligible chronically homeless members in the homeless population.	
	The AHCCCS H2O demonstration will yield cost-effective care for AHCCCS members.	
	The AHCCCS H2O demonstration will reduce length of stay and cost of care in Behavioral Health Residential Facilities (BHRF) and other residential treatment facilities for target populations.	
	The AHCCCS H2O demonstration will increase utilization of primary care and preventative health services.	
	The AHCCCS H2O demonstration will improve discharge coordination of identified homeless members and reduce discharges to homelessness.	

VI. Waiver and Expenditure Authorities

The table below summarizes the authorities AHCCCS is seeking under this 1115 Waiver amendment request.

Waiver Authority Requested	Brief Description
Section 1902(a)(10)(B) Amount, duration and scope of services, and comparability	To the extent necessary to enable the state to limit housing services and supports under the AHCCCS Housing and Health Opportunities (H2O) demonstration to certain targeted groups of AHCCCS beneficiaries.
Expenditure authority for services not covered under section 1905 of the Social Security Act	To the extent necessary to enable the state to claim federal financial participation for expenditures for housing services and supports, to the extent not encompassed under the Section 1905(a) definition of medical assistance. This includes, but is not limited to, expenditures for room and board that are otherwise not compensable under the State Plan.

VII. Public Comment Submission Process

All public hearings (also called community forums) where the public can provide comments and questions about the proposed 1115 Waiver amendment request will be held electronically to promote physical distancing and to mitigate the spread of COVID-19. The meetings will have online video streaming and telephonic conference capabilities to ensure statewide accessibility and will be held during the following times:

Community Forum Meeting # 1
Date: March 31, 2021
Time: 1:00-3:00 p.m. AZ time
Zoom Conference Link:
https://ahcccs.zoom.us/s/89469967126?pwd=Q2FmOUtBZVA4UjVHcjViZUdEVmxRdz09
Passcode: AHCCCS2!

Call-in Information:
+1 408 638 0968; or
+1 669 900 6833; or
+1 253 215 8782; or
+1 346 248 7799; or
+1 646 876 9923; or
+1 301 715 8592; or
+1 312 626 6799; or
877 853 5257 (Toll Free); or
888 475 4499 (Toll Free); or
833 548 0276 (Toll Free); or
833 548 0282 (Toll Free).
Webinar ID: 894 6996 7126
Passcode: 65647117

Community Forum Meeting # 2
Date: April 8, 2021
Time: 2:00-4:00 p.m. AZ time
Zoom Conference Link:
https://ahcccs.zoom.us/j/88263070979?pwd=bmdFcHlkWjE1UFNabDE3WkF1dWU1UT09
Passcode: AHCCCS2!

Call-in Information:
+1 346 248 7799; or
+1 408 638 0968; or
+1 669 900 6833; or
+1 253 215 8782; or
+1 312 626 6799; or
+1 646 876 9923; or
+1 301 715 8592; or

833 548 0282 (Toll Free); or
877 853 5257 (Toll Free); or
888 475 4499 (Toll Free); or
833 548 0276 (Toll Free).
Webinar ID: 882 6307 0979
Passcode: 10613032

Arizona State Medicaid Advisory Committee (SMAC) Meeting
Date: April 14, 2021
Time: 1:00-3:00 p.m. AZ time
Zoom Conference Link:
https://ahcccs.zoom.us/s/89849751173?pwd=b2xKVEN0elo4eVo0eHlFQU4yK1hMQT09
Passcode: SMAC2021!
Call-in Information:
833 548 0282 (Toll Free); or
877 853 5257 (Toll Free).
Webinar ID: 898 4975 1173
Audio Passcode: 15622777

Special Tribal Consultation
Date: April 5, 2021
Time: Noon-2:00 p.m. AZ time
Zoom Registration Link:
https://ahcccs.zoom.us/webinar/register/WN_NgCnjmcJQ2Wd01kHq0lsbA

Call-in Information:
+1 346 248 7799; or
+1 408 638 0968; or
+1 669 900 6833; or
+1 253 215 8782; or
+1 312 626 6799; or
+1 646 876 9923; or
+1 301 715 8592; or
833 548 0282 (Toll Free); or
877 853 5257 (Toll Free); or
888 475 4499 (Toll Free); or
833 548 0276 (Toll Free).
Webinar ID: 854 1196 6314
Passcode: 77045474

Comments and questions about the proposed 1115 Waiver amendment request can also be submitted by email to: waiverpublicinput@azahcccs.gov or by mail to: AHCCCS, c/o Division of Community Advocacy and Intergovernmental Relations (DCAIR);
801 E. Jefferson Street, MD 4200, Phoenix, AZ 85034. All comments must be received by **May 3, 2021.** More information about the proposed 1115 Waiver amendment, including the proposed 1115 Waiver application and the full public notice and public input process, can be found on https://www.azahcccs.gov/HousingWaiverRequest.