February 17, 2017

Ms. Jessica Woodard
Project Officer
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

RE: Arizona's 1115 Waiver Amendment: Targeted Investments Program Acceptance Letter

Dear Ms. Woodard:

This letter serves as the State of Arizona's formal acceptance of the Special Terms and Conditions for the amendment to the Section 1115 Waiver Demonstration project entitled, "Arizona Health Care Cost Containment System (AHCCCS)" (No. 11-W-00275/09), as set forth in CMS' approval letter dated January 18, 2017.

In addition, I would like to take this opportunity to request technical corrections to ensure the STCs accurately reflect the agreed terms between the State and CMS. Please see the enclosed document for our proposed technical changes.

My team and I sincerely appreciate the hard work and professionalism of the CMS staff and leadership who worked to finalize this very important initiative. We value our partnership and look forward to continue working with you.

Sincerely,

[redacted]

Thomas J. Betlach
Director

cc: Andrea Cassart, CMS
Bryan Zolynas, CMS

Technical Amendment Request for STCs

IX. TARGETED INVESMENTS PROGRAM

47. **Description.** Arizona will include directed lump sum payments in its capitation rates paid to managed care entities pursuant to 42 CFR 438.6(c). The managed care entities will be directed to use the funding to make specific incentive payments to certain providers to improve performance and increase physical and behavioral health care integration and coordination for individuals with behavioral health needs. The Targeted Investments Program will:

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

48. **Funding Limit**. Pursuant to 42 CFR 438.6(c), AHCCCS may include in the actuarially sound capitation rates paid to managed care entities up to $300 million total for the period of January 18, 2017, through September 30, 2021, in directed incentive payments to physical and behavioral health care providers that provide integrated services and care to Medicaid beneficiaries and achieve AHCCCS defined targets for performance improvement. In accordance with paragraph 74(f), the actual payment to the managed care entities may occur after September 30, 2021. The lump sum payments for the Targeted Investments Program will be paid to the managed care entities after the close of the contract period based on provider performance. The final amounts (including the targeted payment amounts) paid for the contract period must retrospectively be cost allocated across rate cells in an actuarially sound and justified manner and in alignment with the described payment adjustment in the approved template for payments made under 438.6(c). Additionally, the total of all payments under the contract must be actuarially sound and in compliance with part 438. These capitation rates, including the directed incentive payments and any associated taxes and managed care entity administration costs, are eligible for federal financial participation at the state's FMAP for individual rate cells affected by the incentive payments.

    Of the total $300 million, the state may expend up to $15 million to support the administration, including state level reporting and evaluation of the Targeted Investments Program. These administrative expenses will be eligible for federal financial participation at the administrative match rate of 50 percent.

    Pursuant to 42 CFR 438.6(c), AHCCCS will direct payment of the incentive payments to be distributed annually to physical and behavioral health providers based on demonstrated performance improvement and increased integration and coordination of

physical and behavioral health across three focus populations: (i) adults, (ii) children, and (iii) adults transitioning from a criminal justice facility. Payment of these directed incentive payments will be tied to performance improvement targets (including project milestones).

Table 4 – Estimated Annual Funding Distribution for the Targeted Investment Program

Programs	Year 1	Year 2	Year 3	Year 4	Year 5	Totals
Targeted Investments	$19 m.	$66.5 m.	$85.5 m.	$66.5 m.	$47.5 m.	$285 m.
Administration	$1m.	$3.5 m.	$4.5 m.	$3.5 m.	$2.5 m.	$15 m.
Totals	$20 m.	$70 m.	$90 m.	$70 m.	$50 m.	$300 m.

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

50. **Designated State Health Programs (DSHP).** Federal funding of DSHPs is to ensure the continuation of vital health care and provider support programs while the state devotes increased state resources during the period of this demonstration for Targeted Investments Program that will positively impact the Medicaid program, and result in savings to the federal government that will exceed the federal financial participation in DSHP funding.

a) To the extent that the state increases its Medicaid expenditures through its Targeted Investment program, and achieves the measures that are a condition for DSHP payment, the state may claim federal matching funding for certain DSHP expenditures to support the initial investment costs of the Targeted Investment program. The expectation, which will be addressed in the demonstration evaluation, is that long-term savings achieved through the targeted investment will offset the amount of time-limited federal DSHP funding, and that the state will be able to continue the targeted investment program on a self-sustaining basis after the initial demonstration approval period. DSHP expenditures cannot exceed the amount spent on the Targeted Investments Program and DSHP funding will also be subject to the annual and total DSHP spending limits in Table 5 and the reductions described in paragraph 56 and Table 6. DSHP funding is at-risk at the statewide level based on the state's ability to meet system transformation targets, as described in Table 7. DSHP funding will be phased down over the demonstration period. No payments will be available for DSHP expenditures that are claimed under Medicaid or are reimbursed by third parties. DSHP expenditures may be claimed following procedures and subject to limits as described in the Table 5 below.

b) FFP may be claimed for expenditures made for services provided by the following two state programs beginning January 18, 2017 through September 30, 2021:

i. Division of Developmental Disabilities (DDD), Arizona Early Intervention program (AzEIP)
ii. Services to Individuals with Serious Mental Illness (SMI) under Arizona Revised Statute (A.R.S.) §§ 11-297.

Table 5 – Total Computable Annual DSHP Limits

	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
DSHP	$6,274,400	$21,137,600	$27,177,000	$21,137,600	$15,098,300

51. DSHP Claiming Protocol.

a) CMS must approve a DSHP claiming protocol for eligible DSHP expenditures, including identification of fund sources and types of expenditures. The DSHP protocol must be approved by CMS and will be attached to these STCs. The state must comply with the protocol in order to draw down FFP and document expenditures in accordance with the protocol.

b) In order to claim FFP for DSHP expenditures, the state will provide CMS a summary worksheet that identifies DSHP expenditures by program each quarter.

c) For all eligible DSHP expenditures, the state will have available for CMS:

i. Certification or attestation of expenditures.
ii. Actual expenditure data from state financial information system or state client sub-system.

d) The protocol will describe the procedures used that ensure that FFP is not claimed for the non-permissible expenditures listed in paragraph 52 below.

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

52. Prohibited DSHP Expenditures. The following types of expenditures are not permissible DSHP expenditures:

a) Grant funding to test new models of care
b) Construction costs (bricks and mortar)
c) Room and board expenditures
d) Animal shelters and animal vaccines
e) School based programs for children
f) Unspecified projects
g) Debt relief and restructuring

h) Costs to close facilities
i) HIT/HIE expenditures
j) Services provided to undocumented individuals
k) Sheltered workshops
l) Research expenditures
m) Rent and/or Utility Subsidies that are normally funded by the United States Department of Housing and Urban Development and United States Department of Agriculture (USDA) or other state/local rental assistance programs
n) Prisons, correctional facilities, services for incarcerated individuals and services provided to individuals who are civilly committed and unable to leave
o) Revolving capital fund
p) Expenditures made to meet a maintenance of effort requirement for any federal grant program
q) Administrative costs
r) Cost of services for which payment was made by Medicaid or CHIP (including from managed care plans)
s) Cost of services for which payment was made by Medicare or Medicare Advantage
t) Funds from other federal grants
u) Needle-exchange programs
v) Abortions that would not be allowable if furnished under Medicaid or CHIP
w) Costs associated with funding federal matching requirements.

53. DSHP Claiming Process.

a) The state will establish standard documentation of each DSHP's expenditures, to be specified in the DSHP Protocol.
b) The state will report all expenditures for DSHP payments to eligible programs on the form CMS-64.9P Waiver under the waiver name "TIP DSHP." Federal funds must be claimed within two years following the calendar quarter in which the state incurs DSHP expenditures for services received during the performance period described above in paragraph 50(b). Claims cannot be submitted for state expenditures generated from services from programs identified in paragraph 50(b) above incurred after September 30, 2021. Sources of non-federal funding must be permitted by section 1903(w) of the Act and any applicable regulations.

54. Evaluation of the Targeted Investments Program. The state shall submit an update to its 1115 demonstration evaluation design no later than 120 days after the approval of the amendment to implement the Targeted Investments Program and in accordance with Section X, Evaluation of the Demonstration.

55. Sustainability of Physical and Behavioral Health Care Integration and Coordination. Because funding will decrease each year after year 3 and end after year 5, the state must submit a plan for ongoing support for the sustainability of increased behavioral health care integration and care coordination. The state must submit a draft sustainability plan for CMS comment by March 31, 2019. The sustainability plan should include, but is not limited to, the following elements:

a) The scope of the behavioral health care integration activities that the state wants to maintain including analysis of alternative integration models like Integrated Care models or health homes under sections 1905(t)(1) or 1915(g) of the Act; and
b) The strategy to secure resources to maintain the integration activities.

56. **Reduction in DSHP Expenditures for Failure to Meet Statewide System Transformation Targets.** The DSHP will be reduced in the prospective demonstration year if the state does not meet the targets for TI participating providers for the previous year. Reductions in table 6 will be prorated by focus population: 4 percent for criminal justice, 53 percent for adult and 43 percent for child, in which targets described in paragraph 57 are not met.

Table 6 – Total Computable DSHP Reductions for Each Demonstration Year

	Year 1	Year 2	Year 3	Year 4	Year 5
Percentage at Risk	0%	0%	10%	15%	20%
Total Amount at Risk	$0	$0	$2,717,700	$3,170,640	$3,019,660

57. **Statewide Focus Population Measures.** The state will submit revised baselines in the 2017 annual report to CMS to update the baseline in Table 8 below. Table 8 below describes the performance measures and targets that the state is required to meet in the previous year in order for the state to qualify for DSHP funding in Years 3 through 5. The state shall report its progress for these measures each year in the annual report described in paragraph 41.

Table 8 – Statewide Focus Population Measures and Targets

Child Physical and Behavioral Health Integration Measures			
Year of DSHP	**Proposed Measure**	**Numerator and Denominator Definition**	**Proposed Target**
3	Practice has executed an agreement with AzHeC and routinely receives ADT ~~feeds~~ alerts Baseline: to be ~~measured~~ calculated during Year 1	numerator: An executed agreement with AzHeC and AzHeC confirmation of practice routine receipt of ADT ~~feeds~~alerts denominator: P~~ediatricp~~rimary care and behavioral health practices participating in the child integration project	5 points over baseline
4	Well-child visits in the third, fourth, fifth and sixth years of life for children with a	numerator: AHCCCS members with a BH diagnosis who are age 3-6 years as of the last calendar day of the measurement	2 points over

	behavioral health diagnosis (HEDIS, modified) Baseline: To be ~~measured~~ calculated during Year 1	year, and are attributed to a ~~participating~~ primary care provider participating in the child integration project, who have at least one well-child visit with any PCP during the measurement year~~.~~[1] denominator: AHCCCS members with a BH diagnosis who are age 3–6 years as of the last calendar day of the measurement year and are attributed to a child integration project participating primary care provider~~.~~	baseline
5	Well-child visits in the third, fourth, fifth and sixth years of life for children with a behavioral health diagnosis (HEDIS, modified) Baseline: To be ~~measured~~ calculated during Year 1	numerator: AHCCCS members with a BH diagnosis who are age 3-6 years as of the last calendar day of the measurement year, and are attributed to a~~participating~~ primary care provider participating in the child integration project, who have at least one well-child visit with any PCP during the measurement year denominator: AHCCCS members with a BH diagnosis who are age 3–6 years as of the last calendar day of the measurement year and are attributed to a child integration project participating primary care provider~~.~~	5 points over baseline

Adult Physical and Behavioral Health Integration Measures			
Year of DSHP	**Proposed Measure**	**Numerator and Denominator Definition**	**Proposed Target**
3	Practice has executed an agreement with AzHeC and routinely receives ADT ~~feeds~~ alerts Baseline: To be ~~measured~~ calculated during Year 1	numerator: An executed agreement with AzHeC and AzHeC confirmation of practice routine receipt of ADT ~~feeds~~ alerts denominator: Adult primary care and behavioral health practices participating in the adult integration project	5 points over baseline

[1] Well-care visit as defined in the HEDIS 2017 Well-Care Value Set. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child or be within the Targeted Investment provider entity.

4	Follow-up after hospitalization for mental illness (HEDIS, modified[2]) Baseline: To be calculated during Year 1	numerator: AHCCCS members 18 years of age and older at any time during the measurement period who had a follow-up visit with a mental health practitioner within 7 days after a denominator-qualifying discharge, including visits that occur on the date of discharge.[3] denominator: Acute hospital discharges of AHCCCS members 18 years of age and older at any time during the measurement period for treatment of selected mental illness diagnoses[4] for members discharged from an adult integration project-participating hospital or attributed to an adult integration project-participating primary care or behavioral health provider	2 points over baseline
5	Follow-up after hospitalization for mental illness (HEDIS, modified) Baseline: T~~t~~o be ~~measured~~ calculated during Year 1	numerator: AHCCCS members 18 years of age and older at any time during the measurement period who had a follow-up visit with a mental health practitioner within 7 days after a denominator-qualifying discharge, including visits that occur on the date of discharge denominator: Acute hospital discharges of AHCCCS members 18 years of age and older at any time during the measurement period for treatment of selected mental illness diagnoses for members discharged from an adult integration project-participating hospital or attributed to an adult integration project-participating primary care or behavioral health provider	4 points over baseline

[2] Modified to apply only to adults, as the HEDIS specifications include those six years and older in the denominator.
[3] The follow-up visit must be with a mental health practitioner as defined by the following NCQA HEDIS value sets: FUH Stand Alone Visits Value Set, (FUH Visits Group 1 Value Set *and* FUH POS Group 1 Value Set), and FUH Visits Group 2 Value Set *and* FUH POS Group 2 Value Set.
[4] A principal diagnosis of mental illness is defined by the NCQA HEDIS Mental Illness Value Set. Inpatient stay is defined by the Inpatient Stay Value Set, but excludes the Nonacute Inpatient Stay Value Set.

Care Coordination Measures for Medicaid Enrolled Released from Criminal Justice Facilities			
Year of DSHP	**Proposed Measure**	**Numerator and Denominator Definition**	**Proposed Target**
3	Practice has executed an agreement with AzHeC and routinely receives ADT ~~feeds~~ alerts Baseline: To be ~~measured~~ calculated during Year 1	numerator: An executed agreement with AzHeC and AzHeC confirmation of practice routine receipt of ADT ~~feeds~~ alerts denominator: Integrated practices participating in the justice transition	100%
4	Adults access to preventive/ambulatory health services (HEDIS, modified[5]) Baseline: To be calculated during Year 1	numerator: AHCCCS members age 20-44 years during the measurement period recently released from a criminal justice facility and assigned to a probation or parole office at which a new integrated clinic has been situated who had one or more ambulatory or preventive care visits[6] during the measurement year denominator: AHCCCS members age 20-44 years during the measurement period recently released from a criminal justice facility and assigned to a probation or parole office at which a new integrated clinic has been situated	2 points over baseline
5	Adults access to preventive/ambulatory health services (HEDIS, modified) Baseline: To be ~~measured~~ calculated during Year 1	numerator: AHCCCS members age 20-44 years during the measurement period recently released from a criminal justice facility and assigned to a probation or parole office at which a new integrated clinic has been situated who had one or more ambulatory or preventive care visits during the measurement year denominator: AHCCCS members age 20-44 years during the measurement period recently released from a criminal justice facility and assigned to a probation or parole office at which a new integrated	5 points over baseline

[5] Modified to apply to only those AHCCCS members recently released from a criminal justice facility at which a new integrated clinic has been situated. "Recently released" is defined as excluding those individuals released 60 days prior to end of the measurement period.

[6] Visits defined by the following NCQA HEDIS measure sets: Ambulatory Visits Value Set and Other Ambulatory Visits Value Set.

		clinic has been situated	