

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
200 Independence Avenue, SW, Rm. 314G  
Washington, DC 20201



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January 18, 2019

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

Dear Ms. Snyder:

Under section 1115 of the Social Security Act (the Act), the Secretary of Health and Human Services may approve any experimental, pilot, or demonstration project that, in the judgment of the Secretary, is likely to assist in promoting the objectives of certain Act programs including Medicaid. Congress enacted section 1115 of the Act to ensure that federal requirements did not “stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients.” S. Rep. No. 87-1589, at 19 (1962), *as reprinted in* 1962 U.S.C.C.A.N. 1943, 1961. As relevant here, section 1115(a)(1) of the Act allows the Secretary to waive compliance with the Medicaid program requirements of section 1902 of the Act, to the extent and for the period he finds necessary to carry out the demonstration project. In addition, section 1115(a)(2) of the Act allows the Secretary to provide federal financial participation for demonstration costs that would not otherwise be considered as federally matchable expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary.

For the reasons discussed below, the Centers for Medicare & Medicaid Services (CMS) is approving Arizona’s December 19, 2017, and April 6, 2018, requests to amend its section 1115 demonstration project, entitled “Arizona Health Care Cost Containment System (AHCCCS)” (Project Number 11-W-00275/09), in accordance with section 1115(a) of the Act.

This approval is effective January 18, 2019, through September 30, 2021, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire. CMS’s approval is subject to the limitations specified in the attached expenditure authorities, waivers, and special terms and conditions (STCs). Implementation of the waiver of retroactive eligibility may begin no sooner than April 1, 2019. Implementation of the AHCCCS Works (community engagement) program requirements may begin no sooner than January 1, 2020. The state may deviate from Medicaid state plan requirements only to the extent those requirements have been listed as waived or as not applicable to expenditures or individuals covered by expenditure authority.

### **Objectives of the Medicaid Program**

As noted above, the Secretary may approve a demonstration project under section 1115 of the Act if, in his judgment, the project is likely to assist in promoting the objectives of title XIX. The purposes of Medicaid include an authorization of appropriation of funds to “enabl[e] each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.” Act § 1901. This provision makes clear that an important objective of the Medicaid program is to furnish medical assistance and other services to vulnerable populations. But there is little intrinsic value in paying for services if those services are not advancing the health and wellness of the individual receiving them, or otherwise helping the individual attain independence. Therefore, we believe an objective of the Medicaid program, in addition to furnishing services, is to advance the health and wellness needs of its beneficiaries, and that it is appropriate for the state to structure its demonstration project in a manner that prioritizes meeting those needs.

Section 1115 demonstration projects present an opportunity for states to experiment with reforms that go beyond just routine medical care and focus on interventions that drive better health outcomes and quality of life improvements, and that may increase beneficiaries’ financial independence. Such policies may include those designed to address certain health determinants and those that encourage beneficiaries to engage in health-promoting behaviors and to strengthen engagement by beneficiaries in their personal health care plans. These tests will necessarily mean a change to the status quo. They may have associated administrative costs, particularly at the initial stage, and section 1115 acknowledges that demonstrations may “result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing.” Act § 1115(d)(1). But in the long term they may create incentives and opportunities that help enable many beneficiaries to enjoy the numerous personal benefits that come with improved health and financial independence.

Section 1115 demonstration projects also provide an opportunity for states to test policies that ensure the fiscal sustainability of the Medicaid program, better “enabling each [s]tate, as far as practicable under the conditions in such [s]tate” to furnish medical assistance, Act § 1901, while making it more practicable for states to furnish medical assistance to a broader range of persons in need. For instance, measures designed to improve health and wellness may reduce the volume of services consumed, as healthier, more engaged beneficiaries tend to consume fewer medical services and are generally less costly to cover. Further, measures that have the effect of helping individuals secure employer-sponsored or other commercial coverage or otherwise transition from Medicaid eligibility may decrease the number of individuals who need financial assistance, including medical assistance, from the state. Such measures may enable states to stretch their resources further and enhance their ability to provide medical assistance to a broader range of persons in need, including by expanding the services and populations they cover.<sup>1</sup> By the same

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<sup>1</sup> States have considerable flexibility in the design of their Medicaid programs, within federal guidelines. Certain benefits are mandatory under federal law, but many benefits may be provided at state option, such as prescription drug benefits, vision benefits, and dental benefits. Similarly, states have considerable latitude to determine whom

token, such measures may also preserve states' ability to continue to provide the optional services and coverage they already have in place.

Our demonstration authority under section 1115 of the Act allows us to offer states more flexibility to experiment with different ways of improving health outcomes and strengthening the financial independence of beneficiaries. Demonstration projects that seek to improve beneficiary health and financial independence improve the well-being of Medicaid beneficiaries and, at the same time, allow states to maintain the long-term fiscal sustainability of their Medicaid programs and to provide more medical services to more Medicaid beneficiaries. Accordingly, such demonstration projects advance the objectives of the Medicaid program.

### **Background on Medicaid Coverage in Arizona**

The current AHCCCS section 1115 demonstration project was implemented by the state of Arizona ("state") in 2011, and built on the state's original AHCCCS demonstration implemented in 1982. The state administers the delivery of Medicaid and Children's Health Insurance Program (CHIP) services (including acute care; long term services and supports; home and community-based services (HCBS); and including both mandatory and optional state plan services) to mandatory and optional state plan coverage groups (described in STC 16) through this AHCCCS demonstration. Arizona provides coverage to some non-mandatory populations through expenditure authority under the AHCCCS demonstration, such as certain groups of beneficiaries receiving HCBS. The state also covers some non-mandatory benefits through expenditure authority under the AHCCCS demonstration, including dental for those in the long term care system. On January 1, 2014, Arizona amended its state plan to include non-mandatory coverage of the new adult group (also known as the Patient Protection and Affordable Care Act (ACA) expansion population) described at section 1902(a)(10)(A)(i)(VIII) of the Act.

### **Extent and Scope of the Demonstration Amendments**

With approval of these demonstration amendments, Arizona will, beginning no sooner than January 1, 2020, require, as a condition of eligibility, that non-exempt beneficiaries in the new adult group at section 1902(a)(10)(A)(i)(VIII) of the Act, ages 19 through 49, engage in qualifying community engagement activities for at least 80 hours per month, and report monthly that they are meeting the community engagement requirements. Beneficiaries who successfully complete and report compliance on a monthly basis will have no disruption in coverage. Arizona will provide a three month grace period for individuals to meet the community engagement requirements once determined otherwise eligible. If a beneficiary does not fully comply with the

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their Medicaid programs will cover. Certain eligibility groups must be covered under a state's program, but many states opt to cover additional eligibility groups that are optional under the Medicaid statute. The optional groups include a new, non-elderly adult population (ACA expansion population) that was added to the Act at section 1902(a)(10)(A)(i)(VIII) by the Patient Protection and Affordable Care Act (ACA). Coverage of the ACA expansion population became optional as a result of the Supreme Court's decision in *NFIB v. Sebelius*, 567 U.S. 519 (2012). Accordingly, several months after the *NFIB* decision was issued, CMS informed the states that they "have flexibility to start or stop the expansion." CMS, *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid* at 11 (Dec. 10, 2012). In addition to expanding Medicaid coverage by covering optional eligibility groups and benefits beyond what the Medicaid statute requires, many states also choose to cover benefits beyond what is authorized by statute by using expenditure authority under section 1115(a)(2) of the Act. For example, recently, many states have been relying on this authority to expand the scope of services they offer to address substance use disorders beyond what the statute explicitly authorizes.

community engagement requirements, including failure to report compliance for any month after the three month grace period, the state will suspend the beneficiary's eligibility for two months. Beneficiaries with suspended eligibility will have their eligibility reactivated immediately after the end of the two-month suspension as long as they continue to meet all other eligibility criteria. Beneficiaries in suspension status may have their eligibility reinstated earlier if it is determined that a beneficiary qualifies for another category of Medicaid eligibility that is not subject to the community engagement requirements or is currently exempt from the requirements.

Beneficiaries can comply with the community engagement requirements by participating in a number of activities, such as employment (including self-employment); employment readiness activities, which include less than full-time education, job or life skills training, and health education classes; job search activities; or community service. Under the state's program, certain beneficiaries will be exempt from the community engagement requirements.

CMS is giving the state flexibility to exempt from the community engagement requirements beneficiaries whom the state believes are particularly vulnerable or whose circumstances could make it unreasonably difficult or impossible to participate in qualifying activities. This includes: pregnant women and women up to the end of the month in which the 60th day of post-pregnancy occurs; former foster youth up to age 26; beneficiaries with a serious mental illness (SMI); beneficiaries receiving temporary or permanent long-term disability benefits; beneficiaries who are medically frail; beneficiaries who are in active treatment with respect to a substance use disorder (SUD); full time high school, trade school, college, or graduate students; victims of domestic violence; beneficiaries who are homeless; designated caretakers of a child under age 18 or of a child who is 18 and is a full-time student in high school or trade school and is expected to graduate before he/she turns 19 (limit one caretaker per child); caregivers who are responsible for the care of an individual with a disability; beneficiaries with an acute medical condition (physical and/or behavioral) that would prevent them from complying with the requirements; and beneficiaries with a disability as defined by federal disabilities rights laws who are unable to comply with the requirements for disability-related reasons.

The state's program would also exempt beneficiaries who already participate in programs that incentivize community engagement, including those receiving Supplemental Nutrition Assistance Program (SNAP), Cash Assistance, or Unemployment Insurance income benefits; and beneficiaries participating in other AHCCCS approved work programs.

Third, and finally, the state requested an exemption for all American Indian/Alaska Native beneficiaries. CMS is approving an exemption from the AHCCCS Works requirements for beneficiaries who are members of federally recognized tribes. We believe this narrower exemption is consistent with the unique status of tribal governments.

AHCCCS will provide reasonable modifications for beneficiaries with disabilities who are not otherwise exempt and who need such modifications. In addition, the state will provide written notices, including information on resources available to beneficiaries who may require assistance completing the community engagement activities. AHCCCS Works will test whether the implementation of the AHCCCS Works requirements will enhance programmatic fiscal sustainability and lead to improved health outcomes and greater independence through

participation in qualifying activities that empower members to gain and maintain meaningful employment.

CMS is also approving an amendment to the AHCCCS demonstration that will give the state new flexibility in administering its demonstration program, and better enable it to furnish medical assistance in a manner that is cost-effective and sustainable. The waiver authority that CMS is approving will permit Arizona to grant eligibility to AHCCCS beneficiaries beginning the month they submit an application, and to waive the three month retroactive eligibility period. The following populations are exempt from the waiver of retroactive eligibility: pregnant women; women who are 60 days or less postpartum; infants under age 1; and children under age 19.

Arizona previously had authority to waive retroactive eligibility from January 18, 2001, through December 31, 2013. During that time period the waiver applied to all Medicaid beneficiaries in Arizona. From 2011 through 2013, the waiver of retroactive eligibility was part of the state's demonstration to provide health care services through a prepaid, capitated managed care delivery model, and it applied to all Medicaid beneficiaries. The goal of that demonstration was to test health care delivery systems to provide organized and coordinated health care for both acute and long term care.

Under this amendment, beginning no sooner than April 1, 2019, Arizona will test whether waiving retroactive coverage for certain groups of Medicaid beneficiaries encourages them to obtain and maintain health coverage, even when healthy, or to obtain health coverage as soon as possible after becoming eligible (e.g., if eligibility depends on a finding of disability or a certain diagnosis). The state will evaluate for the first time whether the new policy increases continuity of care by reducing gaps in coverage that can occur when beneficiaries churn on and off Medicaid or sign up for Medicaid only when sick, and facilitates receipt of preventive services when beneficiaries are healthy. In circumstances where Medicaid eligibility depends upon a finding of disability or a certain diagnosis (e.g., of breast or cervical cancer), the state will evaluate whether the policy encourages beneficiaries to apply for Medicaid (including through an application for Supplemental Security Income (SSI) in the case that an SSI determination also provides a Medicaid eligibility determination) as soon as possible after the relevant finding or diagnosis. For example, for those who are aged, blind, or disabled, or who may need long-term services and supports through Medicaid, the state will evaluate whether the policy encourages beneficiaries to apply for Medicaid expeditiously when they believe they meet the criteria for eligibility, to ensure primary or secondary coverage through Medicaid in case the need for services arises. By waiving retroactive eligibility for beneficiaries enrolled in AHCCCS (with exceptions for pregnant women, women who are 60 days or less postpartum, infants under age 1, and children under age 19), the demonstration will test in a new way the efficacy of measures that are designed to encourage eligible individuals to enroll as soon as possible, and, for certain populations, that are designed to encourage eligible individuals to maintain health coverage even while healthy. This feature of the demonstration is designed to encourage enrollment as soon as possible, to facilitate receipt of preventive care and other needed services, and to conserve Medicaid resources, with the ultimate objective of improving beneficiary health and better enabling Arizona, as far as practicable under the conditions in the state, to furnish medical assistance. Act § 1901.

The state will also evaluate the financial impacts of the waiver of retroactive eligibility. The state expects that the new waiver authority will enable the state to better contain Medicaid costs and more efficiently focus resources on providing accessible and high quality health coverage, thereby promoting the sustainability of its Medicaid program. As described in the amended STCs, if monitoring or evaluation data indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. Further, CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Medicaid.

To increase awareness of the new waiver authority and promote the objectives of the Medicaid program (e.g., continuity of coverage and care), Arizona will provide outreach and education about how to apply for and receive Medicaid coverage to the public, current beneficiaries, and providers who serve vulnerable populations that may be impacted by this change, such as those providing nursing facility or other long-term services and supports. This will help ensure that eligible individuals apply for and receive Medicaid coverage in a timely manner, as well as ensure that providers understand how to assist individuals in gaining coverage. The state will employ an outreach strategy in which materials will be made available through various methods such as mailings and on the state's Medicaid website. The state has a hospital presumptive eligibility strategy under which qualified hospitals provide immediate, temporary enrollment into Medicaid until a Medicaid application is submitted.

CMS is not approving Arizona's request to implement a five-year maximum lifetime limit for beneficiaries subject to, but who fail to comply with, the community engagement requirements. Instead, Arizona will impose a two-month eligibility suspension when beneficiaries fail to comply with community engagement requirements, which is expected to incentivize beneficiaries to participate in community engagement activities and take greater responsibility for their health and well-being. Separately, the state expects this requirement to support a pathway out of poverty.

CMS is unable to approve Arizona's request for demonstration expenditure authority at the medical assistance matching rate for the costs associated with the design, development, installation, operation, and administration of systems necessary to implement AHCCCS Works community engagement programs and activities. However, CMS can provide technical assistance if the state would be interested in learning whether costs to update state systems to reflect this approval may be federally matchable at the rates applicable to state expenditures on mechanized claims processing and information retrieval systems, or at the rate applicable to state administrative expenditures.

**Determination that the demonstration project is likely to assist in promoting Medicaid's objectives**

For reasons discussed below, the Secretary has determined that AHCCCS, as amended, is likely to assist in promoting the objectives of the Medicaid program.

**The demonstration promotes beneficiary health and financial independence.**

With approval of the amendments, Arizona and CMS will be able to evaluate the effectiveness of policies that are designed to promote the health and financial independence of Medicaid beneficiaries. Promoting beneficiary health and independence advances the objectives of the Medicaid program; indeed, in 2012, HHS specifically encouraged states to develop demonstration projects “aimed at promoting healthy behaviors” and “individual ownership in health care decisions” as well as “accountability tied to improvement in health outcomes.”<sup>2</sup>

AHCCCS Works’ community engagement requirement is designed to encourage beneficiaries to obtain employment and/or undertake other community engagement activities that may lead to improved health and wellness. It is also likely to promote the objective of helping beneficiaries attain or retain financial independence. The community engagement provisions generally require AHCCCS Works beneficiaries to work, look for work, or engage in activities that enhance their employability, such as job-skills training, education, and community service. The demonstration amendment will help the state and CMS evaluate whether the community engagement requirement helps adults in AHCCCS Works transition from Medicaid to financial independence, thus reducing dependency on public assistance.

CMS rejected a prior Arizona proposal to require that certain AHCCCS beneficiaries participate in work or other community engagement activities because it determined that the proposal would not promote Medicaid statutory objectives.<sup>3</sup> However, given the potential benefits of work and other forms of community engagement, we now believe that state Medicaid programs should be able to design and test incentives for beneficiary compliance with community engagement requirements.

Similarly, the waiver of retroactive eligibility, subject to specified exceptions, is also designed to promote improved continuity of coverage by discouraging gaps in coverage that can occur when beneficiaries churn on and off Medicaid or sign up for Medicaid only when sick, and by encouraging the receipt of preventive health services when beneficiaries are healthy. If eligible individuals who are able to enroll when healthy wait until they are sick to enroll in Medicaid, they may be less likely to obtain preventive services during periods when they are not enrolled due to out-of-pocket costs, potentially resulting in worse health outcomes. In circumstances where Medicaid eligibility depends upon a finding of disability or a certain diagnosis (e.g., of breast or cervical cancer), the state will evaluate whether the policy encourages beneficiaries to

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<sup>2</sup> CMS, *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid* at 15 (Dec. 10, 2012) (noting also that “states have considerable flexibility under ... [existing] law to design benefits for the new adult group and to impose cost-sharing, particularly for those individuals above 100% of the federal poverty level”), available at: <https://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf>.

<sup>3</sup> CMS, AHCCCS demonstration extension approval letter (2016), available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-demo-ext-09302016.pdf>.

apply for Medicaid (including through an application for SSI in the case that an SSI determination also provides a Medicaid eligibility determination) as soon as possible after the relevant finding or diagnosis. For example, for those who are aged, blind, or disabled, or who may need long-term services and supports through Medicaid, the state will evaluate whether the policy encourages beneficiaries to apply for Medicaid expeditiously when they believe they meet the criteria for eligibility, to ensure primary or secondary coverage through Medicaid in case the need for services arises. CMS is requiring the state's evaluation design to include hypotheses on the effects of the waiver on enrollment and eligibility continuity (including for different subgroups of individuals, such as individuals who are healthy, individuals with complex medical needs, prospective applicants, and existing beneficiaries in different care settings, including long-term care), as well as the effects of the demonstration amendment on health outcomes and the financial impact of the demonstration amendment (for example, an assessment of medical debt and uncompensated care costs).

**The demonstration will furnish medical assistance in a manner that improves the sustainability of the safety net.**

CMS has determined that AHCCCS, as amended, is likely to promote the objective of furnishing medical assistance because it provides coverage beyond what Arizona is required to provide. Under AHCCCS, the state provides medical assistance to populations, including certain groups of beneficiaries receiving HCBS, whose coverage is not mandated in statute, as well as benefits, including dental for those in long term care, which are not mandated in statute.

The AHCCCS Works community engagement requirements may impact overall coverage levels if the individuals subject to this demonstration provision choose not to comply with it. However, the demonstration as a whole is expected to further the Medicaid program's objectives to allow states to experiment with innovative means of deploying their limited state resources in ways that may allow them to provide services beyond the statutory minimum. Enhancing fiscal sustainability allows the state to provide services to Medicaid beneficiaries that it could not otherwise provide. The waiver of retroactive eligibility is also expected to enable the state to better contain Medicaid costs and more efficiently focus resources on providing accessible and high-quality health coverage, thereby promoting the sustainability of its Medicaid program.

By incentivizing community engagement and preventive care, as described above, AHCCCS, as amended, is also designed to lead to higher quality care at a sustainable cost. Promoting improved health and wellness ultimately helps to keep health care costs at sustainable levels. To the extent that the amendments help individuals achieve improved health and financial independence, the amended demonstration may make these individuals less costly for Arizona to care for, thus further advancing the objectives of the Medicaid program by helping Arizona stretch its limited Medicaid resources, ensure the long-term fiscal sustainability of the program, and ensure that the health care safety net is available to those Arizona residents who need it most. And, to the extent the community engagement requirement helps individuals achieve financial independence and transition to commercial coverage, the amended demonstration would enhance the state's ability to provide medical services to those who most need the safety net.

While CMS and the state are testing the effectiveness of incentive structures that attach penalties for failure to meet community engagement requirements, the program is designed to make compliance with these requirements achievable. Arizona has taken steps to include adequate beneficiary protections to ensure that the demonstration's community engagement requirements apply only to those beneficiaries who can reasonably be expected to meet them, to notify beneficiaries of their responsibilities, and to automatically reactivate Medicaid coverage following a suspension period. Any individual whose eligibility is suspended for failure to meet the requirements will have the right to appeal the state's decision consistent with all existing statutory and regulatory appeal and fair hearing protections.

Beneficiaries whose eligibility has been suspended for failure to meet community engagement requirements will have their eligibility automatically reactivated at the expiration of the suspension period as long as they meet all other eligibility criteria, and eligibility could be reactivated sooner if the state becomes aware that the beneficiary is no longer subject to the AHCCCS Works requirements. Furthermore, the incentives to meet the requirements, if effective, may result in individuals becoming ineligible because they have attained financial independence – a positive result for the individual.

As described in the STCs, if monitoring or evaluation data indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. Further, CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the beneficiaries' interest or promote the objectives of Medicaid.

### **Consideration of Public Comments**

To increase the transparency of demonstration projects, section 1115(d)(1) and (2) of the Act direct the Secretary to issue regulations providing for two periods of public comment on a state's application for a section 1115 project that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing. The first comment period occurs at the state level before submission of the section 1115 application and the second occurs at the federal level after the application is received by the Secretary.

Section 1115(d)(2)(A) and (C) of the Act further specify that comment periods should be "sufficient to ensure a meaningful level of public input," but the statute imposes no additional requirement on the states or the Secretary to address those comments, as might otherwise be required under a general rulemaking. Accordingly, the implementing regulations issued in 2012 provide that CMS will review and consider all comments received by the deadline, but will not provide written responses to public comments.<sup>4</sup>

CMS received 126 comments during the federal comment period on the AHCCCS Works amendment and 60 comments during the federal comment period on the waiver of retroactive eligibility amendment. Although CMS is not legally required to provide written responses to

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<sup>4</sup> 42 CFR § 431.416(d)(2); see also Medicaid Program; Review and Approval Process for Section 1115 Demonstrations; Application, Review, and Reporting Process for Waivers for State Innovation; Final Rules, 77 Fed. Reg. 11678, 11685 (Feb. 27, 2012) (final rule).

comments, CMS is addressing some of the central issues raised by the comments and summarizing CMS's analysis of those issues for the benefit of stakeholders. After carefully reviewing the public comments submitted, CMS has concluded that AHCCCS, as amended, is likely to promote the objectives of Medicaid.

### **General comments**

The majority of the comments CMS received opposed either the amendments as a whole or certain features of them. Many of those comments expressed general concerns that the amendments will negatively impact beneficiaries and will result in many poor citizens losing Medicaid. CMS shares the commenters' concern that everyone who needs Medicaid and meets programmatic eligibility criteria should have access to it. As previously stated, however, CMS believes the features of this demonstration are worth testing to determine whether there is a more effective way to furnish medical assistance to the extent practicable under the conditions in Arizona. That is why CMS has carefully reviewed the amended demonstration as a whole to ensure it is likely to promote sometimes competing Medicaid objectives.

Specifically, the amended demonstration is designed to improve health outcomes and reduce dependency on public assistance by incentivizing healthy behaviors (community engagement activities) and giving beneficiaries the choice either to engage in those behaviors or to stop participating in Medicaid. CMS has worked together with Arizona to include guardrails that will protect beneficiaries. These guardrails, which are contained in a set of assurances in the STCs (described in STC 38), include requirements that the state: screen beneficiaries and determine eligibility for other categories of Medicaid eligibility prior to a suspension, review for eligibility for insurance affordability programs prior to a suspension, provide full appeal rights prior to suspension, and maintain a system that provides reasonable modifications related to meeting the community engagement requirements to beneficiaries with disabilities, among other assurances. The STCs include a provision granting CMS the authority to discontinue the demonstration if the agency determines that it is not promoting Medicaid's objectives. Moreover, CMS will regularly monitor AHCCCS Works and will work with the state to resolve any issues that arise as Arizona works to implement the demonstration amendment.

Some comments argued that a demonstration cannot advance the Medicaid program's objectives if the project is expected to reduce Medicaid enrollment or Medicaid spending. We recognize that some individuals may choose not to comply with the community engagement requirements imposed by the AHCCCS Works program, and therefore may lose coverage, as may occur when individuals fail to comply with other requirements like participating in the redetermination process. But the goal of this policy is to incentivize compliance, not reduce coverage. Indeed, CMS has incorporated safeguards into the STCs intended to minimize coverage loss due to noncompliance, and CMS is committed to partnering with Arizona to ensure that the demonstration advances the objectives of Medicaid. Furthermore, we anticipate that some beneficiaries' income will increase above the Medicaid eligibility threshold as a result of the community engagement incentives, and that they will obtain employer-sponsored coverage or other commercial coverage once they no longer qualify for the Medicaid program. Finally, we note that in some cases, reductions in Medicaid costs can further the Medicaid program's objectives, such as when the reductions stem from reduced need for the safety net or reduced

costs associated with healthier, more independent beneficiaries. These outcomes promote the best interests of the beneficiaries whose health and independence are improved, while also helping states stretch limited Medicaid resources and ensure the long-term fiscal sustainability of the states' Medicaid programs.

As noted above, section 1115 of the Act explicitly contemplates that demonstrations may “result in an impact on eligibility”; furthermore, the amended demonstration as a whole is expected to provide greater access to coverage for low-income individuals than would be available absent the demonstration. Other comments predicted that the amendments will fail to achieve their intended effects. For instance, some comments argued that beneficiaries subject to the community engagement requirement will be unable to comply. To some extent, these comments reflect a misunderstanding of the nature of the community engagement requirement, which the commenters described as a work requirement. In fact, the community engagement requirement is designed to help beneficiaries achieve success, and CMS and Arizona have made every effort to devise a requirement that beneficiaries should be able to meet. For example, the community engagement requirement may be satisfied through an array of activities, including employment, employment readiness activities (including education, job skills training, life skills training, and health education classes), job search activities, and community service.

More generally, these comments reflect a misunderstanding of the nature of a demonstration project. It is not necessary for a state to show in advance that a proposed demonstration will in fact achieve particular outcomes; the purpose of a demonstration is to test hypotheses and develop data that may inform future decision-making. As HHS previously explained, demonstrations can “influence policy making at the [s]tate and Federal level, by testing new approaches that can be models for programmatic changes nationwide or in other [s]tates.” 77 Fed. Reg. at 11680. For example, the Temporary Assistance for Needy Families (TANF) work requirements that Congress enacted in 1996 were informed by prior demonstration projects. *See, e.g., Aguayo v. Richardson*, 473 F.2d 1090 (2d Cir. 1973) (upholding a section 1115 demonstration project that imposed employment requirements as conditions of AFDC eligibility). Regardless of the degree to which Arizona's demonstration project succeeds in achieving the desired results, the information it yields will provide policymakers real-world data on the efficacy of such policies. That in itself promotes the objectives of the Medicaid statute.

### **Comments addressing coverage losses**

Some commenters expressed concern that the state's requested changes to the demonstration will cause some individuals to lose Medicaid coverage, and for that reason, the demonstration cannot be considered consistent with the objectives of the Medicaid program. In its December 2017 amendment submission to CMS, Arizona noted that as of October 2017, there were 398,519 individuals enrolled in the new adult group. Of these, the state estimated that 137,755 would fall into one of three groups that the state requested to exempt from the AHCCCS Works requirements (those groups included American Indians, individuals determined to have a serious mental illness, and individuals who are at least 55 years old) and therefore would not potentially be subject to the AHCCCS Works requirements. The state estimated that 269,507 beneficiaries would not fall into the three above-mentioned exemption groups, but some unknown number of those 269,507 beneficiaries were expected to fall into other proposed AHCCCS Works

exemption categories. The remaining individuals were expected to be subject to the AHCCCS Works requirements, although an unknown number of these beneficiaries were expected to be already employed or engaged in activities that satisfy the community engagement requirements. CMS made several changes to the proposed demonstration at approval, including changes to the exemptions and additional beneficiary guardrails expected to help beneficiaries maintain enrollment (including the disapproval of the state's request for a five-year maximum lifetime limit for individuals subject to AHCCCS Works if they did not meet the requirements). Under the approved amendments to the demonstration, beneficiaries who are noncompliant with the AHCCCS Works requirements after the three month grace period are subject to a two month suspension of coverage, not a termination of eligibility, and there is no lifetime limit on coverage. The state provided estimates for annual changes in enrollment, although CMS recognizes that it is extremely difficult, if not impossible to predict the percentage of non-exempt beneficiaries who might not comply with the community engagement requirements, because to do so, the state must estimate how beneficiaries will respond to new incentives and eligibility requirements. While some beneficiaries may respond to the new AHCCCS Works requirements by choosing not to comply and forgoing coverage, the goal is for everyone participating in the program to successfully complete its requirements. That said, otherwise potentially eligible Medicaid beneficiaries lose coverage today for many reasons where they have failed to comply with program requirements.

We also note that Arizona provides coverage to individuals in the new adult group (described at section 1902(a)(10)(A)(i)(VIII) of the Act) that it is not required to cover. Any potential loss of coverage that may result from a demonstration amendment is properly considered in the context of a state's substantial discretion to eliminate non-mandatory benefits or to eliminate coverage for existing (but non-mandatory) populations, such as (in light of the Supreme Court's ruling in *NFIB v. Sebelius*) the ACA adult expansion population. As of October 2017, more than 398,000 individuals received medical assistance under the Arizona state plan and through the AHCCCS demonstration as a result of Arizona's decision to participate in the ACA adult eligibility expansion. Moreover, conditioning eligibility for Medicaid coverage on compliance with certain measures is an important element of the state's efforts, through experimentation, to improve beneficiaries' health and independence and enhance programmatic sustainability. To create an effective incentive for beneficiaries to take measures that promote health and independence, it may be necessary for states to attach penalties to failure to take those measures, including with conditions designed to promote health and financial independence. This may mean that beneficiaries who fail to comply will lose Medicaid coverage, at least temporarily. However, the incentive included in AHCCCS Works is not designed to encourage this result; rather, it is intended to incorporate achievable conditions of continued coverage. And any loss of coverage as the result of noncompliance must be weighed against the benefits Arizona hopes to achieve through the demonstration project, including both the improved health and independence of the beneficiaries who comply and the state's enhanced ability to stretch its Medicaid resources and maintain the fiscal sustainability of the program.

It would be counterproductive to deny states the flexibility they need to implement demonstration projects designed to examine innovative ways to incentivize beneficiaries to engage in behaviors that improve health outcomes and lower healthcare costs, as well as innovative ways to stretch limited state resources, given that states have the prerogative to

terminate coverage for non-mandatory services and populations. Because a demonstration project, by its nature, is designed to test innovations, it is not possible to know in advance the actual impact that its policies will have on enrollment. That is one of the metrics to be measured.

Furthermore, the Arizona Medicaid program covers other non-mandatory populations such as certain groups of beneficiaries receiving HCBS, as well as non-mandatory services such as dental for those in the long term care system. As a matter of federal law, it is a state's prerogative to reduce or eliminate non-mandatory coverage. Such judgments are left to the policy preferences of the state government and its electorate, and states are to be given great latitude in making tradeoffs in how the state furnishes medical assistance "as far as practicable under the conditions" in the state. Act § 1901. In evaluating Arizona's demonstration project, it is appropriate to consider the possibility of coverage loss against the benefits that may accrue to the beneficiaries subject to the AHCCCS Works requirements, as well as benefits that may accrue to the state's other Medicaid eligibility groups as a result of the beneficiaries who are subject to the AHCCCS Works requirements growing more independent, healthier, and less expensive to cover. Moreover, as noted above, the risk of coverage loss that some commenters attributed to this amendment is attenuated based on additional safeguards made to the approved AHCCCS Works program. Arizona will measure actual effects on enrollment as part of the demonstration amendment, and that information should be useful in informing future Medicaid policy.

Commenters also expressed concerns that the AHCCCS Works reporting requirements will cause beneficiaries' Medicaid coverage to be suspended because of failure to report their community engagement hours or because of clerical errors by Arizona's Medicaid agency. We note that beneficiaries will be screened for other bases of Medicaid eligibility and for insurance affordability programs prior to having their Medicaid coverage suspended, and that the beneficiary's Medicaid eligibility will be automatically reactivated following the two-month suspension period. CMS has worked closely with Arizona to ensure there are substantial beneficiary protections in place. The STCs provide for Arizona to educate and reach out to beneficiaries and contain assurances that Arizona will seek data from other sources, including SNAP, TANF, and other existing systems to permit beneficiaries to efficiently report community engagement hours or obtain an exemption. Clerical errors can occur in any program and are not reason to deny approval at the outset. Moreover, CMS will monitor the demonstration, and the STCs provide that CMS can withdraw waivers or expenditure authorities if it determines that continuing them would no longer be in the public interest or promote Medicaid's objectives.

### **Comments addressing proposal completeness**

Commenters expressed concern that the state did not include in its notice to the public estimates for how the AHCCCS Works amendment would affect enrollment for the new adult group, and argued that these estimates are essential for making valid budget neutrality conclusions. One commenter also raised concerns that the lack of this level of detail means that the state's submission did not satisfy the requirements for a complete amendment application as contained in the state's approved STCs.<sup>5</sup> The proposed AHCCCS Works amendment that the state

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<sup>5</sup> STC 7(a) of the AHCCCS STCs approved on December 29, 2017 stated "Demonstration of Public Notice 42 CFR Section 431.408 and Tribal Consultation. The state must provide documentation of the state's compliance with

submitted to CMS included in an appendix the state's abbreviated notice as described in 42 CFR § 431.408(a)(2)(ii). The state's abbreviated notice provided a link to a state web site where the public could find the state's full public notice. The full state public notice included budget neutrality worksheets with enrollment projections reflecting the estimated number of covered beneficiary member months for each year of the demonstration through 2021. The state estimated that enrollment in the new adult group would be the same with or without the demonstration, and was unable to estimate the extent to which individuals might lose coverage due to noncompliance with the community engagement requirement—an effect that, as discussed above, is particularly challenging to predict.

Additionally, as discussed above, the state's proposed AHCCCS Works amendment submitted to CMS in December 2017 included information on the number of individuals enrolled in the new adult group as of October 2017 (398,519) as well as the number of individuals the state identified as being subject to the AHCCCS Works community engagement requirements (269,507) after accounting for the number of individuals the state could identify as being part of three of its requested exemption populations, as described in the proposal (American Indians, individuals determined to have a serious mental illness, and individuals who are at least 55 years old).<sup>6</sup> The state acknowledged that it did not collect data on some of its proposed AHCCCS Works exemption categories and therefore assumed that the number of exempt individuals might be higher than what the state could estimate. Some of the assumptions underlying the state's original estimates no longer hold. For example, under the state's original proposal, some beneficiaries would have been subject to a five-year lifetime limit (a limitation that, as noted above, CMS is not approving). Furthermore, precise enrollment projections may not be possible where a state must estimate how beneficiaries will respond to new incentives and eligibility requirements. For example, due to the untested nature of the proposed community engagement requirements, it is unlikely that the state would have been able to accurately predict the number of beneficiaries that would participate or not participate in community engagement activities. Nonetheless, we believe that the state's estimate provided sufficient information for us to assess how many beneficiaries may be impacted by the AHCCCS Works proposal and to satisfy the requirements for a complete amendment application.

### **Comments addressing individual demonstration features**

#### *The community engagement requirement, AHCCCS Works*

The majority of the public comments expressed general disagreement with efforts to implement a community engagement requirement. Some commenters expressed concerns that the community engagement requirement would be burdensome on families or create barriers to coverage. To address commenters' concerns, the list of exemptions was expanded to allow consideration for families with dependent children or beneficiaries who provide care for other dependents. Arizona also accepted stakeholder feedback and expanded the list of qualifying activities available in order to comply with AHCCCS Works. Arizona will provide beneficiary outreach and education on how to comply with the new community engagement requirements, including,

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public notice process as specified in 42 CFR section 431.408 and documentation that the tribal consultation requirements outlined in paragraph 15 have been met.”

<sup>6</sup> CMS notes that the numbers provided by the state in its application on this point do not completely align, however, we believe that the misalignment was not sufficient to impact our analysis.

but not limited to, how to report compliance with community engagement requirements and how to attest to the need for an exemption. Arizona also provides beneficiaries with the opportunity to avoid the consequences for failure to comply with the requirement by demonstrating that they had a good cause not to meet it.

Commenters also expressed concern that there are not enough jobs in all locations for all beneficiaries subject to AHCCCS Works requirements. The state assures that it will assess areas within the state that experience high rates of unemployment, areas with limited economies and/or educational opportunities, and areas with lack of public transportation to determine whether there should be further exemptions from the community engagement requirements and/or additional mitigation strategies, so that the community engagement requirements will not be unreasonably burdensome for beneficiaries to meet.

Some commenters noted that most Medicaid beneficiaries are already working. CMS acknowledges that many beneficiaries are already working or attending school; therefore, those activities are included as qualifying activities that meet the community engagement requirement. CMS notes that the approved terms and conditions provide that a beneficiary may be deemed in compliance with the AHCCCS Works requirements if he or she receives earned income that is consistent with being employed or self-employed for at least 80 hours per month at the state minimum wage. In order to determine whether community engagement requirements adequately incentivize individuals to work as a condition of receiving Medicaid, the state will be required to track new employment among Medicaid beneficiaries.

Many commenters indicated that many beneficiaries not qualifying for Medicaid on the basis of disability may still have difficulty gaining and maintaining employment due to their medical or behavioral health conditions. To mitigate these concerns, Arizona assures that it will provide beneficiaries with disabilities protected by the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, or Section 1557 of the ACA with reasonable modifications, which could include the reduction of, or exemption from, community engagement requirements. Arizona will also provide exemptions for various groups, including beneficiaries determined to have a serious mental illness, beneficiaries who are medically frail, and beneficiaries who have an acute medical condition (physical and/or behavioral) that would prevent them from complying with the requirements.

When considered overall, CMS believes that the amended demonstration adequately protects beneficiaries with circumstances which could prevent them from meeting the community engagement requirements. Where beneficiaries subject to the AHCCCS Works requirements are capable of satisfying them, CMS believes that including these individuals advances the purposes of Medicaid by improving beneficiary health and financial independence and enhancing the program's fiscal sustainability. While some of the activities that meet the community engagement requirement may not immediately cause all beneficiaries to be financially independent, those activities are nonetheless positive steps for beneficiaries to take on their path to financial independence. In addition, participation in these activities may reduce social isolation, which multiple studies have linked to higher rates of mortality.<sup>7</sup> At the very least,

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<sup>7</sup> Julianne Holt-Lunstad, et al., *Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review*, 10 *Persp. on Psychol. Sci.* 227 (2015).

whether AHCCCS's community engagement requirements will lead to beneficiaries' financial independence is an open question, which is why this demonstration project is necessary to test whether the incentive structure will have the desired effect. That is also why CMS will regularly evaluate the effects of AHCCCS Works on affected beneficiaries and reserves the right to discontinue specific waiver and expenditure authorities if CMS determines that it would no longer be in the public interest or promote Medicaid's objectives to continue them. Moreover, even if those activities do not cause beneficiaries to become financially independent, they are nevertheless correlated with improved health outcomes, which itself furthers Medicaid's objectives.

Other commenters expressed concerns that the administration of the community engagement requirement would be burdensome and costly to the state. Although such measures may have associated administrative costs, particularly at the initial stage, in the long term they may help enable beneficiaries to enjoy the many personal benefits that come with improved health outcomes and increased financial independence.

#### *AHCCCS Works exemption for members of federally recognized tribes*

CMS received a few comments supporting the state's request to exempt American Indians from the AHCCCS Works program, and other comments discussed the proposed exemption in the context of legal considerations.

CMS is approving an exemption from the AHCCCS Works requirements for beneficiaries who are members of federally recognized tribes. We believe that this exemption is consistent with the unique status of tribal governments.

#### *Waiver of Retroactive Eligibility*

Commenters on the waiver of retroactive eligibility expressed concern that the waiver could increase uncompensated care costs for hospitals, skilled nursing facilities and other health care providers. Several commenters expressed concern that the waiver of retroactive eligibility will shift health care costs to beneficiaries and providers, increasing out-of-pocket spending and medical bankruptcies, and will lead to potential disruptions in care for individuals with complex medical conditions. CMS has taken these comments into consideration as part of its approval and will require the state to carefully evaluate how the waiver of retroactive eligibility is affecting: beneficiaries and providers; enrollment and eligibility continuity; health outcomes; and the financial impact. CMS will not permit the state to waive retroactive eligibility for pregnant women, for women who are 60 days or less postpartum, for infants under age 1, or for children under age 19. The state and CMS agree that it is essential to ensure potential recipients understand the importance of applying for AHCCCS timely and for providers and stakeholders who help individuals enroll in AHCCCS to update their business practices and information to help ensure individuals apply at the earliest opportunity. To increase awareness of this waiver authority and help ensure that it promotes the objectives of the Medicaid program as intended, Arizona will provide outreach and education to the public and to providers about how to apply for and receive Medicaid coverage. The state also has a hospital presumptive eligibility strategy under which qualified hospitals provide immediate, temporary enrollment into Medicaid until a

Medicaid application is submitted, which may help mitigate these concerns. Additionally, if there were a delay in processing a beneficiary's application, the beneficiary would still receive coverage beginning on the first day of the month in which the application was filed. Providing coverage back to the beginning of the month in which the application was filed will ensure that beneficiaries are not unintentionally penalized if application processing is delayed by no fault of the beneficiary.

Some commenters asserted that there is no experimental purpose associated with the waiver of retroactive eligibility. However, even though Arizona previously had a waiver of retroactive eligibility, this amendment is designed to test a new hypothesis: whether eliminating retroactive eligibility will encourage eligible individuals to enroll as soon as possible, and, for certain populations, whether eligible individuals are encouraged to obtain and maintain health coverage even while healthy. The state will evaluate for the first time whether the new policy increases continuity of care by reducing gaps in coverage that can occur when beneficiaries churn on and off Medicaid or sign up for Medicaid only when sick, and facilitates receipt of preventive services when beneficiaries are healthy. In circumstances where Medicaid eligibility depends upon a finding of disability or a certain diagnosis (e.g., of breast or cervical cancer), the state will evaluate whether the policy encourages beneficiaries to apply for Medicaid (including through an application for SSI in the case that an SSI determination also provides a Medicaid eligibility determination) as soon as possible after the relevant finding or diagnosis. For example, for those who are aged, blind, or disabled, or who may need long-term services and supports through Medicaid, the state will evaluate whether the policy encourages beneficiaries to apply for Medicaid expeditiously when they believe they meet the criteria for eligibility, to ensure primary or secondary coverage through Medicaid in case the need for services arises.

Some commenters expressed concerns that the waiver of retroactive eligibility will reduce coverage, and therefore it cannot promote Medicaid's objectives. The waiver of retroactive eligibility is likely to help promote Medicaid's objectives in at least two ways: (1) it may improve uptake of preventive services for certain beneficiaries and thus improve beneficiary health; (2) it is expected to improve the fiscal sustainability of Arizona's Medicaid program, which might help Arizona continue to provide Medicaid to the ACA expansion population, and continue to cover non-mandatory benefits and eligibility groups.

As part of its evaluation of the demonstration, Arizona will be required to test its hypothesis that the waiver will incentivize individuals to obtain and maintain health coverage, even when healthy, or to apply for coverage as soon as possible after the finding or diagnosis that gives rise to their Medicaid eligibility. Arizona will also be required to evaluate the impact of the waiver, with possible areas of focus for hypotheses that include, but are not limited to: the effects of the waiver on enrollment and eligibility continuity (including for different subgroups of individuals, such as individuals who are healthy, individuals with complex medical needs, prospective applicants, and existing beneficiaries in different care settings, including long-term care); the effects of the waiver on health outcomes; and the financial impact of the waiver (for example, such as an assessment of medical debt and uncompensated care costs).

As described in the STCs, if monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, or if evaluation data for this demonstration

indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. Further, CMS reserves the right to withdraw waivers at any time it determines that continuing the waivers would no longer be in the public interest or promote the objectives of Medicaid.

**Other Information**

CMS's approval of this demonstration amendment is conditioned upon compliance with the enclosed list of waiver and expenditure authorities and the STCs defining the nature, character and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Ms. Andrea Casart. She is available to answer any questions concerning your section 1115 demonstration. Ms. Casart's contact information is as follows:

Centers for Medicare & Medicaid Services  
Center for Medicaid and CHIP Services  
Mail Stop: S2-26-06  
7500 Security Boulevard  
Baltimore, MD 21244-1850  
Email: [andrea.casart@cms.hhs.gov](mailto:andrea.casart@cms.hhs.gov)

Official communications regarding program matters should be sent simultaneously to Ms. Casart and Mr. Dzung Hoang, Acting Associate Regional Administrator, in our San Francisco Regional Office. Mr. Hoang's contact information is as follows:

Centers for Medicare & Medicaid Services  
Division of Medicaid and Children's Health Operations  
90 7<sup>th</sup> Street, #5-300  
San Francisco, CA 94103-6706  
Email: [Dzung.Hoang@cms.hhs.gov](mailto:Dzung.Hoang@cms.hhs.gov)

If you have questions regarding this approval, please contact Ms. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Thank you for all your work with us over the past months to reach approval.

Sincerely,



Seema Verma

Enclosures

Page 19 – Ms. Jami Snyder

cc: Dzung Hoang, Acting Associate Regional Administrator, CMS San Francisco Regional Office