March 8, 2017

Jessica Woodard
Project Officer, Division of State Demonstrations, Waivers & Managed Care
Center for Medicaid, CHIP and Survey & Certification
Centers for Medicare and Medicaid Services
Mailstop: S2-01-16
7500 Security Blvd.
Baltimore, Maryland 21244-1850

Dear Ms. Woodard:

In accordance with Special Terms and Conditions paragraph 41, enclosed please find the Quarterly Progress Report for October 1, 2016 through December 31, 2016, which also includes the Quarterly Budget Neutrality Tracking Schedule, the Quarterly Quality Initiative and the Arizona Medicaid Administrative Claiming Random Moment Time Study results.

If you have any questions about the enclosed report, please contact Mohamed Arif at (602) 417- 4573.

Sincerely,

Elizabeth Lorenz
Assistant Director
AHCCCS Office of Intergovernmental Relations

Enclosure

cc: Brian Zolynas
Hee Young Ansell
Susan Ruiz

AHCCCS Quarterly Report
October 1, 2016 through December 31, 2016

TITLE

Arizona Health Care Cost Containment System – AHCCCS
A Statewide Approach to Cost Effective Health Care Financing

Section 1115 Quarterly Report
Demonstration Year: 34
Federal Fiscal Quarter: 1nd (October 1, 2016 – December 31, 2016)

INTRODUCTION

As written in Special Terms and Conditions, paragraph 41, the State submits quarterly progress reports to CMS. Quarterly reports inform CMS of significant demonstration activity from the time of approval through completion of the Demonstration.

ENROLLMENT INFORMATION

Table 1 contains a summary of the number of unduplicated enrollees for quarter October 1, 2016 – December 31, 2016, by population categories. The table also includes the number of voluntarily and involuntary disenrolled members during this period.

Population Groups	Number Enrollees	Number Voluntarily Disenrolled-Current Qtr	Number Involuntarily Disenrolled-Current Qtr
Acute AFDC/SOBRA	1,222,742	1,692	250,636
Acute SSI	189,221	133	27,103
Prop 204 Restoration	502,546	575	69,375
Adult Expansion	124,102	183	27,843
LTC DD	30,373	24	2,167
LTC EPD	31,558	33	4,106
Non-Waiver	14,181	75	4,598
Total	**2,114,723**	**2,715**	**385,828**

Table 2 is a snapshot of the number of current enrollees (as of January 1, 2017) by funding categories as requested by CMS.

State Reported Enrollment in the Demonstration (as requested)	Current Enrollees
Title XIX funded State Plan [1]	**1,380,978**
Title XXI funded State Plan [2]	**13,389**
Title XIX funded Expansion[3]	**397,802**
• **Prop 204 Restoration (0-100% FPL)**	316,007

[1] SSI Cash and Related, 1931 Families and Children, 1931 Related, TMA, SOBRA child and pregnant, ALTCS, FTW, QMB, BCCP, SLMB, QI-1
[2] KidsCare
[3] Prop 204 Restoration & Adult Expansion

• **Adult Expansion (100% - 133% FPL)**	81,795
Enrollment Current as of	1/1/17

OPERATIONAL/POLICY DEVELOPMENTS/ISSUES

Waiver Update

CMS approved Arizona's request to extend its Medicaid demonstration, entitled "Arizona Health Care Cost Containment System (AHCCCS)". On September 30, 2016, CMS approved the new Waiver for a 5-year period from October 1, 2016 to September 30, 2021. The Waiver allows AHCCCS to continue many of the existing waiver authorities to maintain current efficiencies and flexibilities and includes new authorities designed to modernize Medicaid.

New Authorities:

Arizona received CMS approval to implement the AHCCCS CARE program—Choice Accountability Responsibility Engagement (CARE). AHCCCS CARE is designed to engage the adult members with incomes over 100% of the Federal Poverty Level (FPL) to improve health literacy and prepare for a transition into private health coverage. Under this initiative, the state may require that members pay monthly contributions in amounts not more than two percent of household income and utilization-based copayment-like charges on a limited set of services, subject to Medicaid's aggregate cap of five percent of household income.

Arizona also received approval through the passage of SB 1507 (discussed below) to add a new $1000 per year/per member dental benefit for ALTCS members.

On January 18, 2017, the Centers for Medicare and Medicaid Services (CMS) approved Arizona's request to implement the Targeted Investments (TI) Program to support the state's ongoing efforts to integrate the health care delivery system for AHCCCS members. The TI Program will fund time-limited, outcomes-based projects aimed at building the necessary infrastructure to create and sustain integrated, high-performing health care delivery systems that improve care coordination and drive better health and financial outcomes for some of the most complex and costly AHCCCS populations. The TI projects will target the following populations:

- Adults with behavioral health needs;
- Children with behavioral health needs, including children with or at risk for Autism Spectrum Disorder (ASD), and children engaged in the child welfare system; and
- Individuals transitioning from incarceration who are AHCCCS-eligible.

Extension of Previous Authorities:

Specifically, the Waiver permits Arizona to continue to administer:

- Mandatory managed care delivery system for mandatory and optional Medicaid state plan populations;
- Home and community based services for people in the long term care program (ALTCS);
- Administrative simplifications that reduce the inefficiencies in eligibility;
- Integrated health plans for persons with serious mental illness and children with special healthcare needs; and
- Safety Net Care Pool (SNCP) payments to Phoenix Children's Hospital through 2017.

Technical Amendments:

CMS has also revised the special terms and conditions (STCs) and waiver and expenditure authorities to update certain requirements in accordance with CMS policy and to remove authorities that are obsolete or expired, including:

- The authorities that restrict individuals from disenrolling from managed care without cause have been time limited to align with new managed care regulations. Effective October 1, 2017, beneficiaries will be allowed 90 days to change managed care plans without cause.
- The waiver of retroactive eligibility under section 1902(a)(34) of the Act that expired on December 31, 2013 has been removed.
- The authority of the Disproportionate Share Hospital (DSH) Funding has been shifted from the Waiver to the State Plan, effective October 1, 2018.
- Waiver was also updated to reflect the merger between the Arizona Department of Health Services Division of Behavioral Health Services and AHCCCS.

Outstanding Issues:

Arizona continues to work with CMS on the American Indian Medical Home proposal, which will take the form of a State Plan amendment when finalized, as well as coverage of traditional healing services.

State Plan Update

During the reporting period, the following State Plan Amendments (SPA) were filed and/or approved:

SPA #	Description	Filed	Approved	Eff. Date
Title XIX				
SPA 16-011	Updates the State Plan to add podiatrist services under the other licensed practitioner benefit.	9/20/16	11/29/16	8/6/16
SPA 16-010-A	Updates rates for freestanding psychiatric hospitals for the period beginning October 1, 2016.	10/14/16	12/8/16	10/1/16

SPA 16-010-D	Updates reimbursement for Nursing Facilities rates for the period beginning October 1, 2016.	10/20/16	11/1/16	10/1/16
SPA 16-007	Updates the State Plan to include Freestanding Hospital-based Emergency Departments as a reimbursable provider under outpatient hospital services.	8/30/16	11/15/16	1/1/17
SPA 16-006	Revises the state plan to describe community paramedicine, otherwise referred to as Treat and Refer.	8/26/16	10/24/16	10/1/16
Title XXI				
None				

Legislative Update

No new updates. The Arizona Legislature adjourned Sine Die on May 7th, 2016.

CONSUMER ISSUES

In support of the quarterly report to CMS, presented below is a summary of advocacy issues received in the Office of Client Advocacy (OCA) for the quarter October 1, 2016 – December 31, 2016.

Table 1 **Advocacy Issues**	**Oct.**	**Nov.**	**Dec.**	**Total**
9+Billing Issues	26	27	30	**83**
• **Member reimbursements**				
• **Unpaid bills**				
Cost Sharing	5	3	3	**11**
• **Co-pays**				
• **Share of Cost (ALTCS)**				
• **Premiums (Kids Care, Medicare)**				
Covered Services	26	33	27	**86**
Eligibility Issues by Program				
Can't get coverage due to :				
ALTCS				
• **Resources**	5	2	1	**8**
• **Income**				
• **Medical**				
DES				
• **Income**	68	64	63	**195**

• Incorrect determination				
• Improper referrals				
Kids Care	3	0	1	**4**
• Income				
• Incorrect determination				
SSI/Medical Assistance Only	12	9	9	**30**
• Income				
• Not categorically linked				
Information	87	102	79	**268**
• Status of application				
• Eligibility Criteria				
• Community Resources				
• Notification (Did not receive or didn't understand)				
Medicare	4	2	2	**8**
• Medicare Coverage				
• Medicare Savings Program				
• Medicare Part D				
Prescriptions	15	33	26	**74**
• Prescription coverage				
• Prescription denial				
Issues Referred to other Divisions:				
1.Fraud-Referred to Office of Inspector General (OIG)	0	0	0	**0**
2.Quality of Care-Referred to Division of Health Care Management (DHCM)	8	5	6	**19**
• Health Plans/Providers (Caregiver issues, Lack of providers)				
• Services (Equipment, Nursing Homes, Optical and Surgical)				
Total	259	280	247	**786**

Note: Categories of good customer services, bad customer service, documentation, policy, and process are captured under the category it may relate to.

Table 2 **Issue Originator**	**Oct.**	**Nov.**	**Dec.**	**Total**
Applicant, Member or Representative	228	245	197	670
CMS	3	4	2	9

Governor's Office	6	0	3	9
Ombudsmen/Advocates/Other Agencies…	19	28	43	90
Senate & House	3	3	2	8
Total	**259**	**280**	**247**	**786**

Note: This data was compiled from the OCA logs from the OCA Client Advocate and the Member Liaison.

COMPLAINTS AND GRIEVANCES

In support of the quarterly report to CMS, presented below is a summary of the number of complaints and grievances filed on behalf of beneficiaries participating in the SMI and CRS integration projects, broken down by access to care, health plan and provider satisfaction.

SMI Member Grievances and Complaints	Oct-16	Nov-16	Dec-16	Total
Access to Care	52	46	40	138
Health Plan	140	126	114	380
Provider Satisfaction	334	305	325	964
Total	526	477	479	**1482**

CRS Member Grievances and Complaints	Oct-16	Nov-16	Dec-16	Total
Access to Care	0	0	0	0
Health Plan	4	3	3	10
Provider Satisfaction	7	9	3	19
Total	**11**	**12**	**6**	**29**

OPT-OUT FOR CAUSE

Attached is a summary of the opt-out requests filed by individuals with SMI in Maricopa County and Greater Arizona, broken down by months, health plans, counties, reasons for opt-out requests, opt-out outcome, and post-appeal opt-out outcomes.

QUALITY ASSURANCE/MONITORING ACTIVITY:

Attached is a description of AHCCCS' Quality Assurance/Monitoring Activities during the quarter. The attachment also includes updates on implementation of the AHCCCS Quality Assessment and Performance Improvement Strategy, in accordance with Balanced Budget Act (BBA) requirements.

ENCLOSURES/ATTACHMENTS

Attached you will find the SMI opt-out for cause data (Attachment 1), Quality Assurance/Monitoring Activities including the CRS update for the quarter (Attachment 2), Arizona Medicaid Administrative Claiming (MAC) Random Moment Time Study (RMTS) results (Attachment 3), and the Budget Neutrality Tracking Schedule (Attachment 4)

STATE CONTACT(S)

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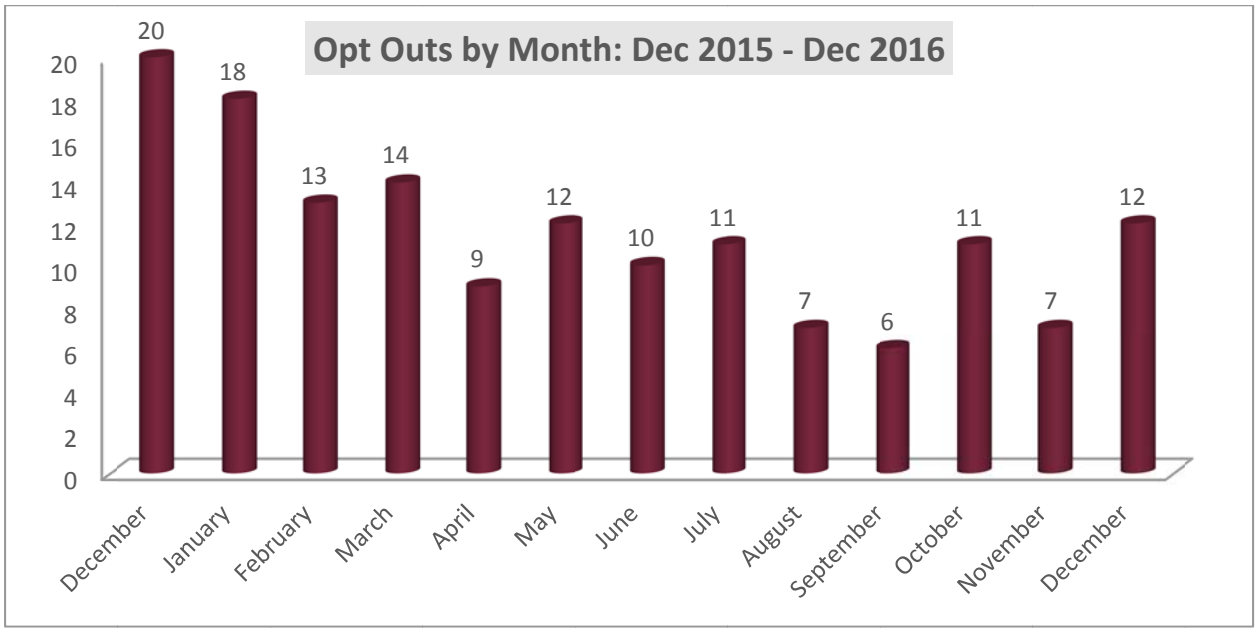
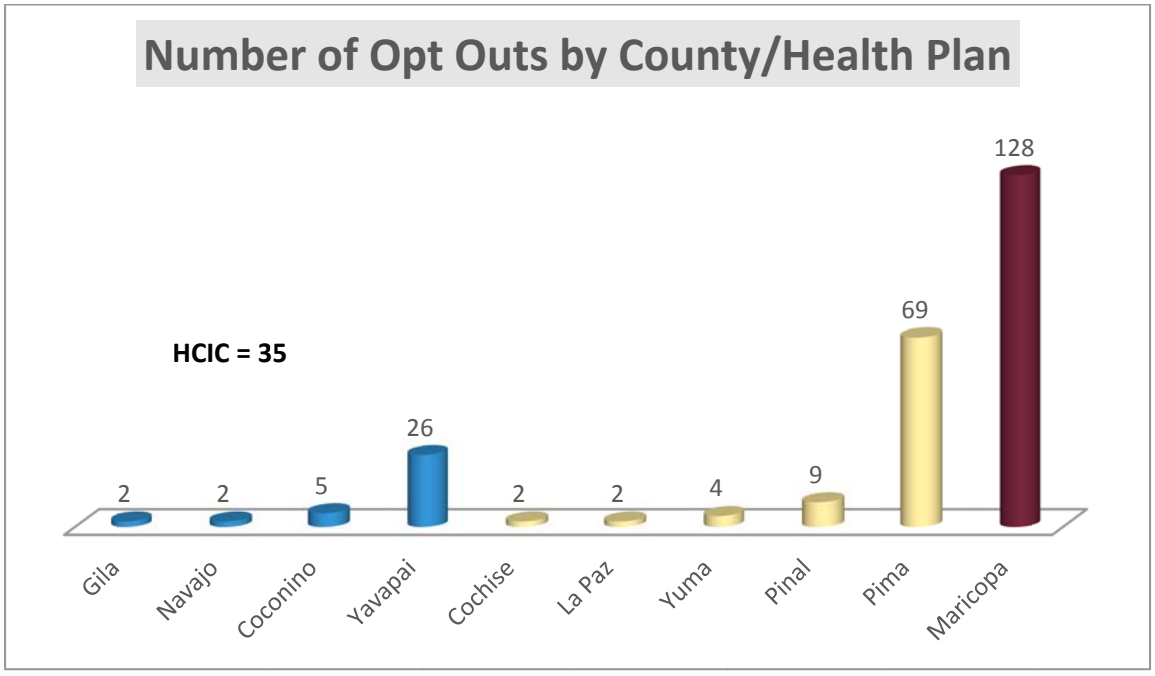
DATE SUBMITTED TO CMS

March 8, 2017

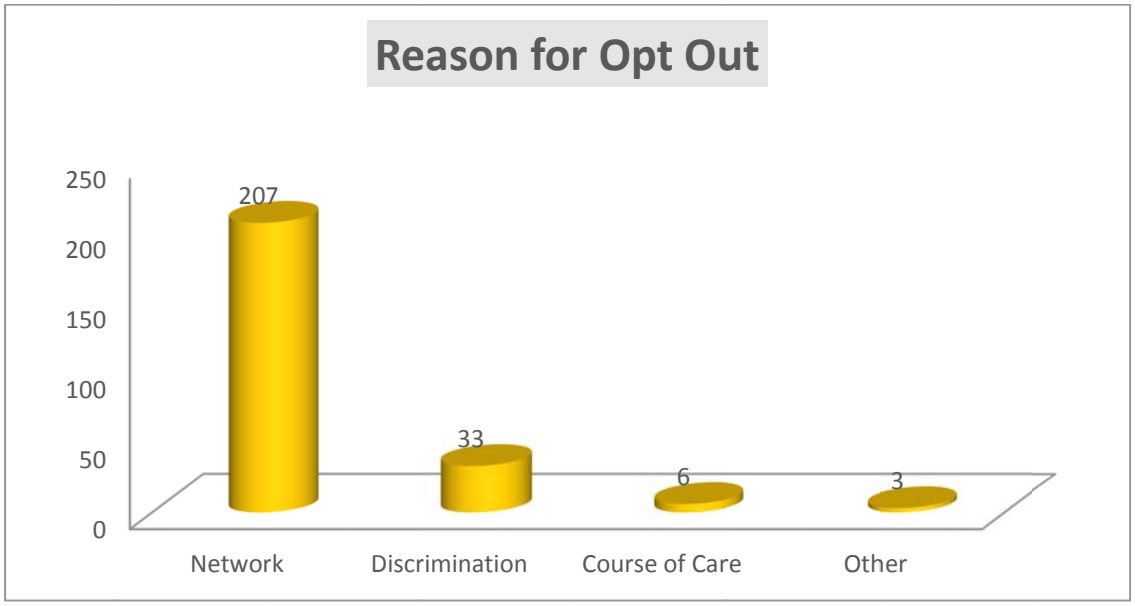
Attachment 1: SMI Opt-Out for Cause Report



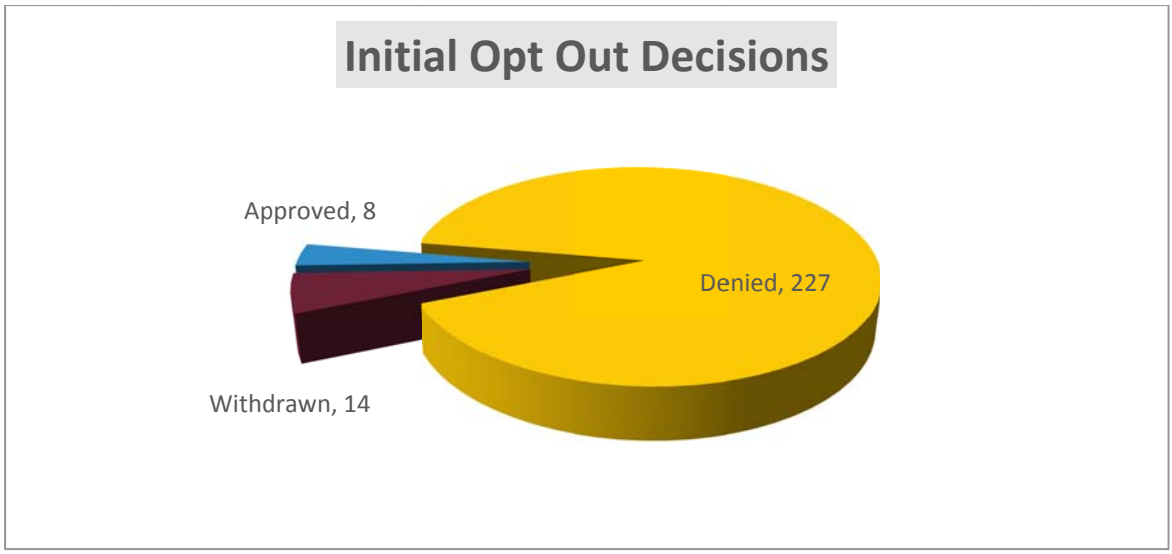
Dec 2015 - Dec 2016 Opt-Out Request												
Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	July-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
20	18	13	14	9	12	10	11	7	6	11	7	12



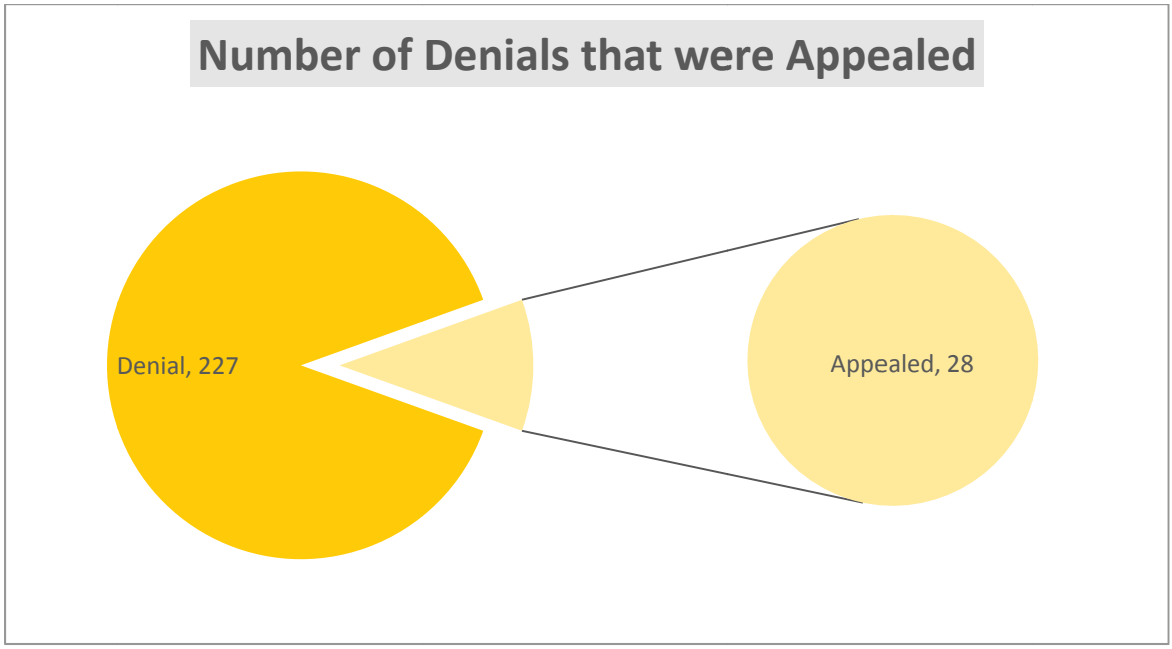
Number of Opt-Out by County /Health Plans: Oct. 2015 - June 2016		
HCIC	Gila	2
HCIC	Navajo	2
HCIC	Coconino	5
HCIC	Yavapai	26
HCIC	**Total**	**35**
CIC	La Paz	2
CIC	Cochise	2
CIC	Yuma	4
CIC	Pinal	9
CIC	Pima	69
CIC	**Total**	**86**
MMIC	Maricopa	**128**
Grand Total	**All Counties**	**249**



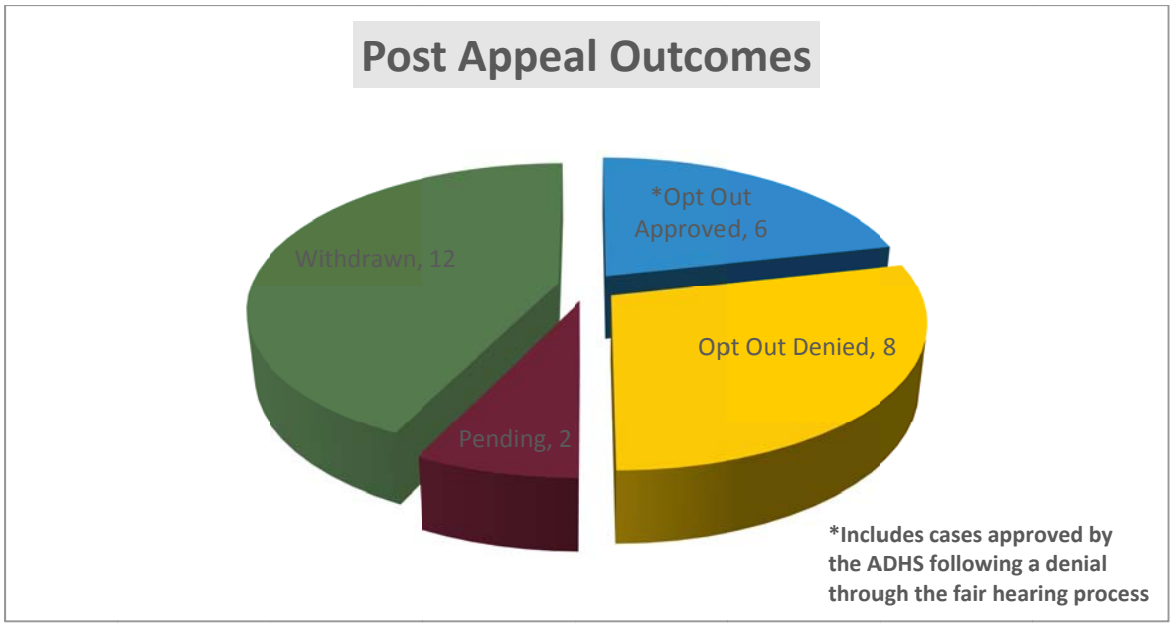
Network	Discrimination	Other	Course of Care
207	**33**	**6**	**3**



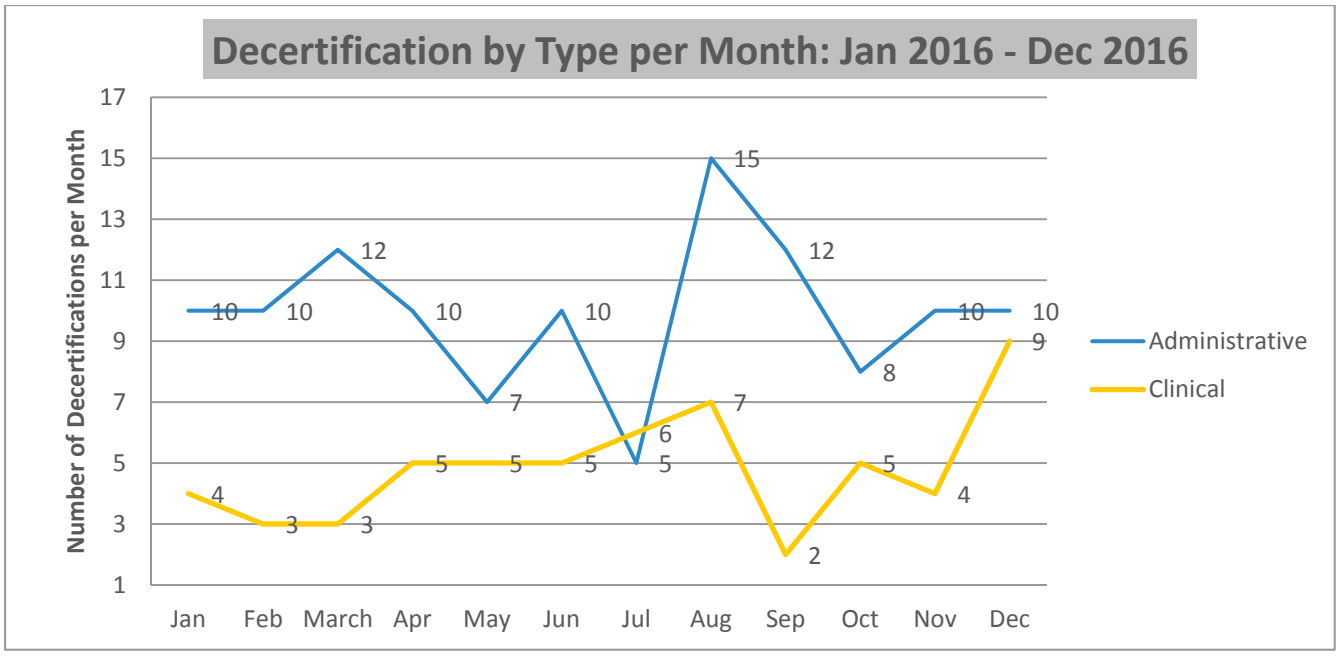
Oct 15- June 2016 Opt Out Decisions			
Denied	**Withdraw**	**Approved**	**Pending**
227	14	8	0



Out of the 227 denied Opt Out request only 28 appealed the decision.



Oct 15- Jan 2016 Post Appeal Opt Out Outcomes	
Pending	2
Withdrawn	12
Denied	8
Approved	6



Jan 2016 - Dec 2016 Opt Out Request												
	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	July-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Admin	10	10	12	10	7	10	5	15	12	8	10	10
Clinical	4	3	3	5	5	5	6	7	2	5	4	9

Note:

There are two established mechanisms for changing an individual's designation and service eligibility as Seriously Mentally Ill (SMI) as follows:

- Clinical decertification. Eligibility for SMI services is based upon a clinical determination involving whether a person meets a designated set of qualifying diagnostic and functional criteria. Clinical decertification involves a review of the criteria to establish whether or not an individual continues to meet SMI criteria. If a clinical review finds that a person no longer meets the established criteria, the person's SMI eligibility is removed. In this case the person will be eligible for behavioral health services under the general mental health (GMH) program category. These determinations are made by CRN.

- Administrative decertification. This process is an administrative option that allows for an individual to elect to change their behavioral health category from SMI to GMH. This process is available to individuals who have a designation of SMI in the system but have not received behavioral health services for two or more years. This process is facilitated by AHCCCS.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Attachment II to the

Section 1115 Quarterly Report

Quality Assurance/Monitoring Activity

Demonstration/Quarter Reporting Period

Demonstration Year: 34

Federal Fiscal Quarter 1/2017 (10/01/2016 – 12/31/2016)

Prepared by the Division of Health Care Management
February 2017

Introduction

This report describes the Arizona Health Care Cost Containment System (AHCCCS) quality assurance and monitoring activities that took place during the third quarter of federal fiscal year 2016, as required in STC 37 of the States' Section 1115 Wavier. This report also includes updates related to AHCCCS' Quality Assessment and Performance Improvement Strategy, in accordance with the Balanced Budget Act requirements.

The AHCCCS Division of Health Care Management (DHCM) is responsible for directly overseeing the quality of health care services provided to its members enrolled with managed care organizations. DHCM is also responsible for the administrative and financial functions of the contracted health plans (Contractors). DHCM, in conjunction with other AHCCCS Divisions, sister agencies and community partners, continually focus on the provision of "comprehensive, quality health care for those in need", as delineated in the Agency mission.

DHCM is the division that houses the Clinical Quality Management (CQM) and Maternal and Child Health (MCH)/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Units. Those two units are the primary driver of efforts outlined in the Quality Strategy and the teams closely collaborate to ensure thoughtful processes for members, stakeholders, policies, and improvement activities.

The following sections provide an update on the State's progress and activities under each of the components of the 1115 Wavier and AHCCCS Quality Strategy.

Stakeholder Involvement

The success of AHCCCS can be attributed, in part, to concentrated efforts by the agency to foster partnerships with its sister agencies, contracted Managed Care Organizations (MCOs – also referred to as "Contractors"), providers, and the community. During the first quarter of CYE 2017, AHCCCS continued these ongoing collaborations to improve the delivery of health care and related services to Medicaid recipients and KidsCare members, including those with special health care needs. AHCCCS also continued to address common issues and solve problems through ongoing networking activities. Feedback from sister agencies, providers and community organizations are included in the Agency's process for identifying priority areas for quality improvement and the development of new initiatives. AHCCCS has also made a concentrated effort to include member and stakeholder feedback in most facets of Agency operations, including Policy Committee, quarterly meetings, new advisory councils, and specialty workgroups (e.g. Autism and Foster Care).

Collaborative Stakeholders

The AHCCCS CQM and MCH/EPSDT teams partner with a number of stakeholders, including but not limited to:

Arizona Department of Health Services (ADHS) Bureau of Tobacco and Chronic Disease	*Attorney General's Health Care Committee*
ADHS Bureau of USDA Nutrition Programs	*Healthy Mothers/Healthy Babies*
ADHS Immunization Program and Vaccines for Children Program	*Arizona Health-E Connection/Health Information Network of Arizona*
ADHS Office of Environmental Health – Targeted Lead Screening	*Arizona Diabetes Steering Committee*
Arizona Early Intervention Program (AzEIP)	*Injury Prevention Advisory Council*
Arizona Head Start Association	*Arizona Newborn Screening Advisory Committee*
Task Force on Prevention of Prenatal Exposure to Alcohol and other Drugs	*First Things First*
Arizona Medical Association	*Arizona Women, Infants, And Children Program*
Arizona Chapter of the American Academy of Pediatrics	*Strong Families*
The Arizona Partnership for Immunization (TAPI)	*ADHS Emergency Preparedness Office*
Arizona Perinatal Trust	*National Alliance on Mental Illness (NAMI) Arizona*

Innovative Practices

AHCCCS is continually reviewing opportunities to improve the effectiveness of Arizona's health care delivery system as well as methods to promote optimized health for members, transparency, and efficiency. There are teams throughout the Agency that promote innovation for both internal and external processes. Below are some of the efforts in which the Quality, MCH, and EPSDT teams are involved.

Developing and Implementing Projects to Improve the Delivery System

Administrative Simplification

Following successful efforts around Administrative Simplification, the Clinical team has since taken on several new initiatives to enhance the knowledge and understanding of behavioral health care. The Medical Management Unit, which regularly partners with the QM and MCH/EPSDT units, added a Behavioral Health Coordinator to support efforts for the Clinical team as a whole. The addition of a Behavioral Health Coordinator enhances the ability for clinical considerations, service delivery, program and contract development to encompass a holistic approach in all aspects of care.

Within CQM and MCH/EPSDT departments, other activities designed to enhance integration have involved utilization of performance and quality measurement activities that provide a greater focus on specific aspects of integrated care. Highlights include:

- Required tracking of performance on frequency of diabetic screening for individuals with schizophrenia or bipolar disorder;

- Tracking performance on prenatal and postnatal timeliness of care with supplemental training to contracted health plan staff, relative to physical and behavioral health aspects of perinatal mood disorders
- Implementation of regular community-based meetings open to AHCCCS membership; meeting focus is to enhance member/stakeholder involvement and investment in performance and quality improvement activities for physical and behavioral health care

Integration Efforts

Integration efforts are ongoing at AHCCCS, as demonstrated by an ALTCS/EPD Request for Proposal. The anticipated implementation date is October 1st, 2017. A major emphasis of this RFP, involves the need for bidders to identify how they will approach care and treatment of ALTCS/EPD individuals emphasizing integrated care practices (e.g. health homes, electronic health records, coordinated care management, increased use of Arizona's model of behavioral health service delivery alongside traditional ALTCS physical health care activities). Although Arizona's ALTCS model has historically provided integrated care that included behavioral health treatment, emphasis has been added to promote greater use of Arizona's behavioral health model, particularly with regard to individuals with a designation for serious mental illness (SMI).

Arizona Association of Health Plans (AzAHP)

The Arizona Association of Health Plans (AzAHP) is an Association comprised of most health plans that contract with AHCCCS for Medicaid business. The Association led an effort, with the support of AHCCCS, in selecting and implementing a credential verification organization (CVO) that would be utilized by all AHCCCS Contractors. The purpose of moving this initiative forward was to reduce the burden of submission of applications, documents and attestations on providers that are contracted with multiple Medicaid health plans. The credentialing process for primary source verification was implemented in the first quarter of this fiscal year.

The Association is a welcome partner for AHCCCS because it offers a singe point of contact for the Contractors and promotes consistency across the system. The Association works closely with AHCCCS to discuss Contractor concerns, barriers, and challenges to the efforts they are asked to undertake. It also provides valuable feedback for consideration as the direct link to the care and services being provided. AHCCCS utilizes the Association to provide stakeholder insight and to collaborate and promote new initiatives.

Identifying Priority Areas for Improvement

AHCCCS has established an objective, systematic process for identifying priority areas for improvement. This process involves a review of data from both internal and external sources, while also taking into account such factors as: (1) the prevalence of a particular condition and

population affected, (2) the resources required by both AHCCCS and its Contractors to conduct studies and effect improvement, (3) whether the areas currently are priorities of CMS or state leadership and/or can be combined with existing initiatives, (3) whether current priority areas coincide with CMS and state leadership, and (4) if CMS priorities can be combined with current initiatives. Of importance is whether initiatives focused on the topic area are actionable and have the potential to result in improved quality improvement, member satisfaction and system efficiencies. Contractor input is also sought in prioritizing areas for improvement.

During the first quarter, two initiatives focused on specific Contractor involvement and improvement for the EPSDT population and children within Arizona's Foster Care System.

- Coordination with the Arizona Early Intervention Program (AzEIP) – One of the most challenging parts of the care delivery system has always been how the MCOs coordinate care with AzEIP for one of the youngest and most vulnerable populations served. AzEIP focuses on early intervention for members up to three years of age; their efforts to ensure services are sometimes blurred with the requirements of the MCOs. As an ongoing effort to promote care coordination and system clarification the MCH/EPSDT Manager undertook extensive efforts to create detailed flow charts that outline the process from multiple points of entry and across many different MCO types, and member conditions. These flow charts have been promoted at several stakeholder groups, with collaborative feedback and sought. Once the charts go through final review, the tools will be made available on the AHCCCS website.

- Behavioral health care for children in the foster care system. Development of these metrics focused on children served under Comprehensive Medical and Dental Plan (CMDP), Arizona's health plan for children in Arizona's Foster Care system. AHCCCS' goal for these measures is to identify whether access and timeliness standards are met as well as overall utilization trends for CMDP children needing behavioral health care.

<u>Establishing Realistic Outcome-Based Performance Measures</u>

AHCCCS has long been a leader in developing, implementing and holding Contractors accountable to performance measure goals. AHCCCS developed and implemented HEDIS-*like* measures before HEDIS existed. AHCCCS' consistency in performance expectations has resulted in many performance measures performing at a rate close to the NCQA HEDIS national Medicaid mean. For AHCCCS, the HEDIS-*like* measures have been a reasonable indicator of health care accessibility, availability and quality. AHCCCS has transitioned to measures found in the CMS Core measure sets that provide a better opportunity to shift the system towards indicators of standardized health care outcomes, access to care, and patient satisfaction. This transition will also result in the ability to compare AHCCCS' rates with those of other states as the measure sets are implemented.

AHCCCS has developed new performance measure sets for all lines of business. Additional measures have also been incorporated into contracts for all lines of business. These measures include behavioral health measures for adults such as: "Follow-up After Hospitalization for Mental Illness", "Mental Health Utilization" and "Use of Opioids at High Dosage". The new measures and related Minimum Performance Standards/Goals became effective October 1, 2016. This date aligns with the new contract begin date for all lines of business. The AHCCCS decision to transition to a new measure set was partially driven by a desire to align with measures sets, such as the CHIPRA Core Measure Set, the Adult Core Measure Set, Meaningful Use, and other measure sets being implemented by CMS. AHCCCS has also aligned the measure sets with contracts to reflect changes on measures implemented by CMS for the current contract year.

It is AHCCCS' goal to continue development and implementation of additional Core measures as the data sources become valid and reliable. Initial measures were chosen based on a number of criteria that included member needs, system ability to impact/improve results, alignment with national measure sets, and comparability across lines of business.

The health care system is evolving in relation to measuring quality. It is in a transitional phase in that the data sources and methodologies that previously existed will no longer be enough. The systems, data sources and processes to fully achieve the next level in clinical outcomes and satisfaction measures are not yet fully developed or implemented. Informatics, such as electronic health records, health information exchanges plus data and information available through public health connectivity, are yet to become fully available. Transitioning the AHCCCS measure sets is anticipated to support the adoption of electronic health records and use of the health information exchanges. This will, in turn, result in efficiencies and data/information designed to achieve the following: (1) transform care practices, (2) improve individual patient outcomes, (3) guide population health management, (4) improve patient satisfaction with the care experience, (5) increase efficiencies and, (6) reduce health care costs.

CYE 2017 Performance Measure Crosswalk

Measures	Acute	ALTCS E/PD	GMS/SA	SMI	CM DP	CRS	DDD		HEDIS	CMS Adult Core Measures	CHIPRA Core Measures
ADULT MEASURES											
Inpatient Utilization	X	X		X	X	X	X		X		
ED Utilization	X	X		X	X	X	X		X		

Hospital Readmission	X	X		X			X		X	
Follow-Up After Hospitalization for Mental Health, 7 Days		X	X	X		X			X	
Follow-Up After Hospitalization for Mental Health, 30 Days		X	X	X		X			X	
Adults' Access to Preventive/Ambulatory Health Services	X	X		X			X	X		
Breast Cancer Screening	X			X			X		X	
Cervical Cancer Screening	X			X			X		X	
Chlamydia Screening in Women	X			X			X		X	
Colorectal Screening	X			X				X		
CDC - HbA1c Testing	X	X		X			X		X	
CDC - HbA1c Poor Control (>9.0%)	X	X		X			X		X	
CDC - Eye Exam	X	X		X			X	X		
Flu Shots for Adults, Ages 18 and Older* (FVA)	X	X		X			X		X	
Diabetes Admissions, Short-Term Complications (PQI-01)	X	X		X			X		X	
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI-05)	X	X		X			X		X	
Asthma in Younger Adults Admissions (PQI-15)	X			X			X		X	

Heart Failure Admission Rate (PQI-08)	X	X		X			X			X	
Timeliness of Prenatal Care: Prenatal Care Visit in the First Trimester or Within 42 days of Enrollment	X			X							X
Timeliness of Prenatal Care: Postpartum Care Rate	X			X						X	
Mental Health Utilization	X	X	X	X		X			X		
Use of Opioids From Multiple Providers	X	X	X	X		X	X			X	
Screening for Clinical Depression and Follow-Up Plan		X								X	
Annual Monitoring for Patients on Persistent Medications: Combo Rate		X		X			X			X	
Advance Directives		X									
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication				X						X	
CHILDRENS MEASURES											
Children's Access to PCPs, by age: ***12-24 mo.***	X				X	X	X				X
Children's Access to PCPs, by age: ***25 mo.- 6 yrs.***	X				X	X	X				X
Children's Access to PCPs, by age: ***7 - 11 yrs.***	X				X	X	X				X
Children's Access to PCPs, by age: ***12 - 19 yrs.***	X				X	X	X				X

Well-Child Visits: ***15 mo.***	X					X					X
Well-Child Visits: ***3 - 6 yrs.***	X				X	X	X				X
Adolescent Well-Child Visits: ***12–21 yrs.***	X				X	X	X				X
Children's Dental Visits **(ages 2-21)**	X				X (2-18 yrs)	X	X				X
Weight Assessment and counseling - Body Mass Index (BMI) Assessment for Children/Adolescents	X	X			X	X	X				X
EPSDT Participation	X	X (18-21 yrs)		X (18-21 yrs)	X	X	X				
Percentage of Eligibles Who Received Preventive Dental Services	X	X			X	X	X				
SEAL: Dental Sealants for Children Ages 6-9 at Elevated Caries Risk	X	X			X	X	X				X
Developmental Screening in the First Three Years of Life	X	X			X	X	X				X
Human Papillomavirus Vaccine for Female Adolescents	X				X	X	X				X
Use of Multiple Concurrent Antipsychotics in Children and Adolescents			X		X						X
Childhood Immunization Status											
DTaP	X				X	X	X				X
IPV	X				X	X	X				X
MMR	X				X	X	X				X
Hib	X				X	X	X				X
HBV	X				X	X	X				X
VZV	X				X	X	X				X
PCV	X				X	X	X				X
Hep A	X				X	X	X				X
Rotavirus	X				X	X	X				X
Influenza	X				X	X	X				X
Combination 3	X				X	X	X				X

(4:3:1:3:3:1:4)											
Immunizations for Adolescents											
Adolescent Meningococcal	X				X	X	X				X
Adolescent Tdap/Td	X				X	X	X				X
Combination 1	X				X	X	X				X

Identifying, Collecting and Assessing Relevant Data

Performance Measures

AHCCCS has implemented several efforts over the past few years in preparation for the performance measure transition described above. First and foremost, the Agency undertook extensive internal planning efforts, including evaluation of new requirements, future goals and desired capabilities, as well as barrier identification and associated risk. One risk identified, was the possibility that the reduction of information system and data analytic staff resources would not allow the level of review and validation of performance measure programming necessary to ensure the validity and accuracy of Performance Measurement activities. To address this concern, the Agency is utilizing its External Quality Review Organization to perform the measurement calculations. AHCCCS has finalized the contract with an external vendor to support future performance measurements.

Contractors have been provided the data to enhance their planning and implementation efforts related to the new performance measures, as well as sustaining and improving continuing measures. Some of these efforts will include new work groups, new reporting mechanisms, increased opportunities for technical assistance, and a more transparent reporting process with plans for proactive reporting prior to the end of the measurement period. Such efforts should facilitate the Contractors' ability to make necessary adjustments/final pushes and payment reform initiatives that align with performance measure thresholds.

Performance Improvement Projects

Providing Incentives for Excellence and Imposing Sanctions for Poor Performance

AHCCCS regularly monitors Contractors to ensure compliance with contractually-mandated performance measures. Contracts outline Minimum Performance Standards (MPS) that the Contractor must meet and Goals that the Contractor should strive to achieve. Those measures are evaluated to determine what regulatory actions should be taken. At a minimum, measures that fail to meet the MPS will require a Corrective Action Plan. Additional actions could include mandatory technical assistance, Notices to Cure, and financial sanctions.

AHCCCS has implemented a payment reform initiative (PRI) for the Acute Care population that is designed to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, and those related to child and adolescent health. This PRI process will be performed annually on a contract year basis. Starting with FFY15, AHCCCS also implemented a payment reform initiative for the ALTCS EPD population as well. The EPD Quality Measures target ED Utilization, Readmissions, Diabetes Management and Flu Shots.

The Acute Care requirement of total payments under all contracts executed with health care providers governed by shared-savings arrangements, increases to 10 percent in FFY15. For ALTCS EPD a minimum of five percent of the value of total payments under all EPD contracts executed (1.5% for D-SNP contracts) with health care providers must be governed by shared-savings arrangements.

Performance Improvement Projects (PIPs)

AHCCCS has a Performance Improvement Project under way with Contractors for all lines of business, which is designed to improve enrollee health outcomes and satisfaction.

- E-Prescribing - The purposes of this Performance Improvement Project (PIP) is to increase the number of prescribers electronically prescribing at least one prescription and increase the percentage of prescriptions which are submitted electronically, in order to improve patient safety. The baseline measurement period for this PIP is Contract Year Ending (CYE; federal fiscal year) 2014. Baseline data has been collected, validated and released to Contractors.

- Developmental Screening - The purpose of the Developmental Screening PIP is to increase the number of early life screenings for members at 9-, 18-, and 24-months of age to ensure that developmental delays are identified early and referred for appropriate follow-up and treatment. The PIP measure will focus on the number of children who receive a developmental screening at the appropriate age intervals versus the total number of children in each age group. Although not formally tied to the PIP measurement, AHCCCS will be evaluating whether or not follow-up appointments are scheduled and maintained for any concerns identified through the screening process. Additionally, AHCCCS will monitor the care coordination process and Contractor oversight of the screening and referral processes. The baseline measurement will be reflective of Contract Year Ending (CYE; *federal fiscal year*) 2016 and the baseline rates will be generated in Q2 of 2017.

Including Medical Quality Assessment and Performance Improvement Requirements in AHCCCS Contracts

Contracts with health plans are reviewed at least annually to ensure that they include all federally required elements prior to renewal. In addition, contracts are reviewed for clarity and for opportunities to strengthen expectations and/or promote new opportunities.

Regular Monitoring and Evaluating of Contractor Compliance and Performance

AHCCCS monitors and evaluates access to care, organizational structure and operations, clinical and non-clinical quality measurement and performance improvement outcomes through the following methods.

- *On-site Operational Reviews* - Operational and Financial Reviews (ORs) are used by AHCCCS to evaluate Contractor compliance related to access/availability and quality of services, including implementation of policies and procedures and progress toward plans of correction to improve quality of care and service for members.

- *Review and analysis of periodic report* - A number of contract deliverables are used to monitor and evaluate Contractor compliance and performance. AHCCCS reviews, provides feedback and approves these reports as appropriate.

    - Quarterly EPSDT and Adult Monitoring Reports - AHCCCS requires CRS, Acute, ALTCS and RBHA Contractors to submit quarterly EPSDT and Adult Monitoring Reports demonstrating their efforts to sustain or improve annual performance rates for all contractually mandated performance measure as well as their efforts to inform families/caregivers and providers of EPSDT/Adult services. AHCCCS has developed a template for Contractors to report data on member and provider outreach, as well as Contractor rates for various EPSDT and adult services. The template prompts Contractors to evaluate the effectiveness of activities, including care coordination, follow up and new or revised interventions to improve quality and access to care. These reports are received and reviewed on a quarterly basis

    - Annual Plans - QM/QI, EPSDT, MCH and Dental – AHCCCS requires all lines of business to submit an annual plan which will address details of the Contractors methods for achieving optimal outcomes for their members. A separate report is submitted for Quality Management and Improvement (QM/QI).

- *Review and analysis of program-specific Performance Measures and Performance Improvement Projects* - AHCCCS considers a Performance Improvement Project (PIP) as a planned process of data gathering, evaluation, and analysis to determine interventions or activities that are anticipated to have a positive outcome. PIPs are designed to improve the quality of care and service delivery and usually last at least four years. While

Contractors may select and implement their own PIPs to address problems specific to their plans, AHCCCS mandates other program-wide PIPs in which Contractors must participate, and monitors performance until each Contractor meet requirements for demonstrable and sustained improvement.

Another method by which AHCCCS monitors the quality and appropriateness of care provided to members is through Performance Measures. Contractors submit encounter data to AHCCCS, which measures each plan's performance and evaluates its compliance in meeting contractual performance standards for specific health care services. Under their contracts with AHCCCS, Contractors are required to improve their rates for Performance Measures and achieve specific goals for each. AHCCCS requires corrective action plans from Contractors that do not meet the Minimum Performance Standard, or that show a statistically significant decline in their rates. Contractors also could face significant financial sanctions if they do not improve performance to a level that meets or exceeds the minimum standard.

- *External Quality Reviews* - AHCCCS has selected a vendor as a result of a Request for Proposal (RFP). The vendors' contracts began April 1, 2014.

Maintaining an Information System that Supports Initial and Ongoing Operations

AHCCCS maintains a robust information system (PMMIS) that documents all members, their claims and encounter data, plus many other data points. PMMIS data feeds into the AHCCCS Data Warehouse, which is the centralized system, used for data analytics. There is a newly formed Data Integrity team that supports maintaining valid, accurate, and reliable data; this team is made up of data users and system experts from across the Agency and meets at least quarterly to discuss any issues or opportunities around the data and systems. AHCCCS has focused on building data expertise within every division of the Agency, promoting data analytics as the cornerstone of operations and monitoring/oversite activities.

Reviewing and Revising the Quality Strategy

AHCCCS is working to implement the new Managed Care Rule and is revising the Agency's Quality Strategy to be reflective of the new requirements, as well as a cohesive reflection of the numerous efforts underway around integrated care and increased member satisfaction, as well as good clinical outcomes. CQM will be leading a cross-functional Agency team to draft a functional Quality Strategy that brings together the requirements of the Rule as well as the mission, vision, and operational goals of the Agency.

Attachment 3: Arizona Health Care Cost Containment System (AHCCCS) Quarterly Random Moment Time Study Report October 2016 – December 2016

The October through December 2016 quarter for the Medicaid School Based Claiming (MSBC) program Random Moment Time Study (RMTS) was completed successfully with the administrative, direct service, and personal care time study cost pools.

Active Participants

The "*Medicaid Administrative Claiming Program Guide*" mandates that all school district employees identified by the district's RMTS coordinator as being qualified to provide direct services or administrative activities participate in a RMTS. Staff rosters are updated by RMTS coordinators on a quarterly basis to ensure accuracy of participants in the time study. The table below shows the number of participants in the administrative, direct service, and personal care time study staff pools at the beginning of the quarter.

Staff Pool	October - December 2016
Administrative	3,149
Direct Service	3,168
Personal Care	4,867

The table below demonstrates the administrative, direct service, and personal care time study achieved the 85% return rate in the October to December 2016 quarter.

The return rate reflects number of responses received divided by the total number of moments generated per quarter.

Return Rate

Cost Pool	Moments Generated	Valid Response	Return Rate
Administrative	3,200	3,093	96.66%
Direct Service	3,400	3,268	96.12%
Personal Care	3,500	3,059	87.40%

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended December 31, 2016

I. CALCULATION OF BUDGET NEUTRALITY LIMIT BY DEMONSTRATION YEAR (WITHOUT WAIVER CEILING FEDERAL SHARE)

WAIVER PERIOD OCTOBER 1, 2011 THROUGH SEPTEMBER 2021:

	FFY 2012 PM/PM	Trend Rate	DY 01 PM/PM	Effective FMAP	Federal Share PM/PM	Member Months QE 12/11	QE 3/12	QE 6/12	QE 9/12	Total	Federal Share Budget Neutrality Limit	
AFDC/SOBRA	556.34	1.052	585.28	69.84%	408.78	2,932,551	2,920,237	2,914,117	2,938,855	11,705,760	$ 4,785,097,912	
SSI	835.29	1.06	885.41	69.10%	611.79	487,576	489,001	489,023	491,661	1,957,261	1,197,426,312	
AC [1]			562.09	69.74%	391.97	527,244	430,723	365,132	310,396	1,633,495	640,288,791	
ALTCS-DD	4643.75	1.06	4922.38	67.38%	3316.47	72,519	73,155	73,965	74,820	294,459	976,563,725	
ALTCS-EPD	4503.21	1.052	4737.37	67.50%	3197.93	85,460	85,506	85,730	86,512	343,208	1,097,553,461	
Family Plan Ext [1]		1.058	17.04	90.00%	15.33	12,471	12,424	12,440	12,689	50,024	767,009	
											$ 8,697,697,210	MAP Subtotal
											103,890,985	Add DSH Allotment
											$ 8,801,588,195	Total BN Limit

	DY 02 PM/PM			Member Months QE 12/12	QE 3/13	QE 6/13	QE 9/13	Total		
AFDC/SOBRA	615.71	68.85%	423.92	2,911,505	2,891,265	2,903,099	2,918,991	11,624,860	$ 4,927,965,654	
SSI	938.53	67.86%	636.90	494,735	497,114	499,734	503,341	1,994,924	1,270,566,590	
AC [1]	601.22	68.73%	413.22	274,990	248,817	228,204	217,114	969,125	400,463,139	
ALTCS-DD	5217.72	65.83%	3434.66	75,639	76,467	77,281	78,035	307,422	1,055,890,379	
ALTCS-EPD	4983.71	66.01%	3289.97	86,829	86,076	86,303	87,133	346,341	1,139,452,206	
Family Plan Ext [1]	18.42	90.00%	16.58	13,104	13,824	14,187	14,856	55,971	927,946	
									$ 8,795,265,914	MAP Subtotal
									106,384,369	Add DSH Allotment
									$ 8,901,650,283	Total BN Limit

	DY 03 PM/PM			Member Months QE 12/13	QE 3/14	QE 6/14	QE 9/14	Total		
AFDC/SOBRA	647.73	70.55%	456.99	2,891,863	2,839,466	2,955,787	3,113,711	11,800,827	$ 5,392,834,293	
SSI	994.84	69.27%	689.12	506,704	514,266	523,000	528,953	2,072,923	1,428,492,222	
AC [1]	600.72	69.85%	419.59	206,419	87	2	-	206,508	86,648,225	
ALTCS-DD	5530.78	67.35%	3725.09	78,841	79,683	80,672	81,758	320,954	1,195,582,128	
ALTCS-EPD	5242.86	67.53%	3540.32	87,679	87,893	88,734	89,359	353,665	1,252,085,896	
Family Plan Ext [1]	12.99	90.00%	11.69	14,885	-	-	-	14,885	174,071.00	
Expansion State Adults [1]	624.09	85.37%	532.78	-	444,018	624,439	756,132	1,824,589	972,104,541	
									$ 10,327,921,376	MAP Subtotal
									108,086,519	Add DSH Allotment
									$ 10,436,007,895	Total BN Limit

	DY 04 PM/PM			Member Months QE 12/14	QE 3/15	QE 6/15	QE 9/15	Total		
AFDC/SOBRA	681.41	71.43%	486.70	3,146,369	3,085,250	3,105,767	3,210,136	12,547,522	$ 6,106,892,937	
SSI	1054.53	70.24%	740.71	536,250	542,659	543,208	543,083	2,165,200	1,603,794,151	
AC	0.00	68.42%	0.00	-	-	-	-	-	-	
ALTCS-DD	5862.63	68.54%	4018.17	82,725	83,827	84,833	85,609	336,994	1,354,099,552	
ALTCS-EPD	5515.49	68.68%	3788.29	90,010	89,877	89,924	90,011	359,822	1,363,109,702	
Family Plan Ext	0.00	90.00%	0.00	-	-	-	-	-	-	
Expansion State Adults	585.89	87.73%	514.02	817,997	836,193	846,272.00	866,855.00	3,367,317	1,730,852,134	
									$ 12,158,748,476	MAP Subtotal
									109,707,817	Add DSH Allotment
									$ 12,268,456,293	Total BN Limit

	DY 05 PM/PM			Member Months QE 12/15	QE 3/16	QE 6/16	QE 9/16	Total		
AFDC/SOBRA	716.85	71.51%	512.60	3,262,759	3,258,784	3,243,535	3,328,741	13,093,819	$ 6,711,949,379	
SSI	1117.81	70.54%	788.47	547,594	549,525	545,185	545,963	2,188,267	1,725,379,657	
AC	0.00	88.99%	0.00	-	-	-	-	-	-	
ALTCS-DD	6214.39	68.96%	4285.55	86,374	87,134	88,241	89,188	350,937	1,503,957,122	
ALTCS-EPD	5802.30	69.08%	4008.39	89,870	89,437	89,553	89,635	358,495	1,436,988,218	
Family Plan Ext	0.00	90.00%	0.00	-	-	-	-	-	-	
Expansion State Adults	570.22	90.67%	516.99	916,929	930,756	930,461	937,173	3,715,319	1,920,788,529	
									$ 13,299,062,906	MAP Subtotal
									110,036,940	Add DSH Allotment
									$ 13,409,099,846	Total BN Limit

	DY 06 PM/PM			Member Months QE 12/16	QE 3/17	QE 6/17	QE 9/17	Total		
AFDC/SOBRA	754.12	71.13%	536.43	3,374,625				3,374,625	1,810,239,690	
SSI	1184.87	70.49%	835.18	544,399				544,399	454,671,722	
AC	0.00	77.06%	0.00	-				-	-	
ALTCS-DD	6587.25	69.24%	4560.77	89,747				89,747	409,315,306	
ALTCS-EPD	6104.02	69.23%	4225.73	88,447				88,447	373,753,288	
Family Plan Ext	0.00	90.00%	0.00	-				-	-	
Expansion State Adults	531.39	91.13%	484.24	952,823				952,823	461,394,482	
									$ 3,509,374,490	MAP Subtotal
									111,027,272	Add DSH Allotment
									$ 3,620,401,762	Total BN Limit

[1] Pursuant to the CMS 1115 Waiver, Special Term and Condition 61(a)(iii), the Without Waiver PMPM is adjusted to equal the With Waiver PMPM for the AC, the Expansion State Adults and the Family Planning Extension Program eligibility groups.

Based on CMS-64 certification date of 12/31/2016

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended December 31, 2016

II. WAIVER COSTS AND VARIANCE FROM BUDGET NEUTRALITY LIMIT - BY QUARTER, BY DATE OF PAYMENT

	Budget Neutrality Limit - Federal Share			Expenditures from CMS-64 - Federal Share												
WAIVER PERIOD OCTOBER 1, 2011 THROUGH SEPTEMBER 30, 2016:	MAP	DSH	Total	AFDC/SOBRA	SSI	AC	ALTCS-DD	ALTCS-EPD	Family Plan	DSH/CAHP	SNCP/DSHP	UNC CARE	MED	Exp St Adults	Total	VARIANCE
QE 12/11	$ 2,217,724,206	$ 103,890,985	$ 2,321,615,191	$ 502,890,921	$ 191,249,757	$ 175,610,617	$ 151,638,753	$ 164,685,415	$ 167,197	$ -	$ -	$ -	$ 458,635	$ -	$ 1,186,701,295	$ 1,134,913,896
QE 3/12	2,177,984,130	-	2,177,984,130	577,297,998	217,984,093	165,596,401	156,526,315	176,620,644	179,167	572,050	-	-	(4,080)	-	1,294,772,588	883,211,542
QE 6/12	2,153,188,750	-	2,153,188,750	581,722,121	227,516,987	145,886,387	115,946,434	179,020,266	185,175	79,564,550	100,950,000	4,480,769	(889)	-	1,435,271,800	717,916,950
QE 9/12	2,148,800,125	-	2,148,800,125	579,782,505	222,428,252	118,032,081	205,664,611	175,615,524	201,702	6,248,670	14,312,682	18,367,266	294	-	1,340,653,587	808,146,538
QE 12/12	2,208,638,828	106,384,369	2,315,023,197	617,247,020	242,322,491	118,103,369	159,452,070	179,452,256	230,267	11,346,623	95,263,307	14,871,980	-	-	1,438,289,383	876,733,814
QE 3/13	2,191,137,195	-	2,191,137,195	589,464,629	239,092,492	96,180,297	163,937,798	192,970,394	257,756	867,795	32,840,000	28,744,095	-	-	1,344,355,256	846,781,939
QE 6/13	2,192,853,420	-	2,192,853,420	588,378,705	241,298,377	88,125,077	102,142,130	187,310,029	227,668	78,756,901	111,555,510	17,514,148	-	-	1,415,308,545	777,544,875
QE 9/13	2,202,636,471	-	2,202,636,471	596,611,333	237,327,560	84,327,037	230,955,206	190,188,088	228,524	558,280	144,169,561	35,937,456	-	-	1,520,303,045	682,333,426
QE 12/13	2,361,611,983	108,086,519	2,469,698,502	623,051,060	253,112,363	84,773,209	180,587,089	208,608,187	221,957	6,098,257	128,610,551	20,561,018	-	-	1,505,623,691	964,074,811
QE 3/14	2,496,587,933	-	2,496,587,933	609,066,404	242,247,737	19,448,214	172,865,678	191,271,321	(15,809)	3,076,720	-	14,814,313	-	231,876,797	1,484,651,375	1,011,936,558
QE 6/14	2,658,514,541	-	2,658,514,541	584,523,581	274,963,993	(3,697,277)	132,811,366	206,922,285	(9,314)	4,725,871	46,518,282	17,460,925	-	343,805,363	1,608,025,075	1,050,489,466
QE 9/14	2,811,206,919	-	2,811,206,919	642,058,425	286,491,486	1,044,222	234,971,144	202,325,318	735	83,398,590	14,595,643	716,900	-	398,971,566	1,864,574,029	946,632,890
QE 12/14	3,022,399,216	109,707,817	3,132,107,033	768,767,395	322,908,117	24,114,620	197,157,685	209,877,907	254	9,813,379	78,963,846	3,397,109	-	411,351,488	2,026,351,800	1,105,755,233
QE 3/15	3,010,676,970	-	3,010,676,970	643,924,687	297,141,870	3,771,216	198,833,968	208,709,812	(475)	1,474,261	-	2,362,678	-	397,361,264	1,753,579,281	1,257,097,689
QE 6/15	3,030,470,357	-	3,030,470,357	676,953,007	301,501,985	1,376,095	136,222,624	210,766,873	(1,609)	111,644,096	32,871,414	4,867,076	-	434,840,685	1,911,042,246	1,119,428,111
QE 9/15	3,095,201,934	-	3,095,201,934	660,928,120	297,720,765	(1,214,417)	269,436,928	218,219,020	(26)	1,465,978	(14,698,940)	2,512,551	-	449,692,969	1,884,062,948	1,211,138,986
QE 12/15	3,308,703,821	110,036,940	3,418,740,761	745,437,161	343,103,540	21,576,137	214,617,413	214,987,023	-	9,941,072	-	-	-	473,302,437	2,022,964,783	1,395,775,978
QE 3/16	3,316,858,576	-	3,316,858,576	648,184,948	312,291,893	(1,729,262)	213,667,327	224,085,947	(1)	20,729,076	43,581,049	3,093,001	-	482,776,013	1,946,679,991	1,370,178,585
QE 6/16	3,310,676,480	-	3,310,676,480	634,709,981	301,905,309	(1,180,414)	215,370,099	223,597,734	(3)	106,020,956	48,305,720	2,494,969		439,313,652	1,970,538,003	1,340,138,477
QE 9/16	3,362,824,028	-	3,362,824,028	669,689,230	311,948,359	(750,198)	221,278,330	214,057,429	(685)	504,237	-	2,161,386		491,624,231	1,910,512,319	1,452,311,709
QE 12/16	3,509,374,490	111,027,272	3,620,401,762	693,694,761	331,020,951	2,802,954	225,745,743	223,415,036	(5,466)	3,195,395	39,578,110	2,726,671	-	524,641,615	2,046,815,770	1,573,585,992
QE 3/17			-												-	-
QE 6/17			-												-	-
QE 9/17			-												-	-
	$ 56,788,070,372	$ 649,133,902	$ 57,437,204,274	$ 13,234,383,992	$ 5,695,578,377	$ 1,142,196,365	$ 3,899,828,711	$ 4,202,706,508	$ 1,867,014	$ 540,002,757	$ 917,416,735	$ 197,084,311	$ 453,960	$ 5,079,558,080	$ 34,911,076,810	$ 22,526,127,464

Last Updated: 2/23/2017

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
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III. SUMMARY BY DEMONSTRATION YEAR

	Federal Share of Budget Neutrality Limit	Federal Share of Waiver Costs on CMS-64	Annual Variance	As % of Annual Budget Neutrality Limit	Cumulative Federal Share of Budget Neutrality Limit	Cumulative Federal Share of Waiver Costs on CMS-64	Cumulative Federal Share Variance	As % of Cumulative Budget Neutrality Limit
WAIVER PERIOD OCTOBER 1, 2011 THROUGH DECEMBER, 2016								
DY 01	$ 8,801,588,195	$ 5,636,491,519	$ 3,165,096,676	35.96%				
DY 02	8,901,650,283	5,841,167,827	3,060,482,456	34.38%				
DY 03	10,436,007,895	6,477,569,448	3,958,438,447	37.93%				
DY 04	12,268,456,293	7,400,617,638	4,867,838,655	39.68%				
DY 05	13,409,099,846	7,768,559,938	5,640,539,908	42.07%				
DY 06	3,620,401,762	1,786,670,440	1,833,731,322	50.65%	$ 57,437,204,274	$ 34,911,076,810	$ 22,526,127,464	39.22%
	$ 57,437,204,274	$ 34,911,076,810	$ 22,526,127,464					

Arizona Health Care Cost Containment System
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IV. Schedule C as Adjusted for Manual Entries and Waiver PMPM Groupings

Schedule C Waiver 11-W00275/9

Total Computable

Waiver Name	01	02	03	04	05	06	Total
AC	917,858,193	582,446,023	123,965,199	23,156,932	(633,793)	(97,584)	1,646,694,970
AFDC/SOBRA	3,415,765,021	3,585,628,822	3,540,708,453	3,610,324,610	3,792,589,607	830,621,827	18,775,638,340
ALTCS-EPD	1,062,023,826	1,167,261,286	1,195,674,152	1,247,205,145	1,235,730,462	285,319,732	6,193,214,603
ALTCS-DD	939,086,691	1,005,552,539	1,067,545,705	1,170,385,446	1,250,598,273	320,030,323	5,753,198,977
DSH/CAHP	155,762,651	161,526,080	162,262,955	161,375,784	153,634,100	5,245,950	799,807,520
Expansion State Adults	0	0	1,138,491,409	1,969,821,528	2,115,346,429	504,674,585	5,728,333,951
Family Planning Extension	830,631	1,008,110	190,026	(1,337)	(763)	(123)	2,026,544
MED	673,818	0	0	0	0	0	673,818
SNCP/DSHP	296,636,120	558,334,298	240,250,917	119,071,612	115,407,642	41,147,594	1,370,848,183
SSI	1,349,593,910	1,427,657,637	1,544,559,932	1,726,809,173	1,742,632,759	400,182,472	8,191,435,883
Uncomp Care IHS/638	22,866,717	97,192,513	53,888,765	13,437,080	7,647,155	2,290,500	197,322,730
Subtotal	8,161,097,578	8,586,607,308	9,067,537,513	10,041,585,973	10,412,951,871	2,389,415,276	48,659,195,519
New Adult Group	0	0	108,394,756	303,791,070	473,055,907	105,402,074	990,643,807
Total	8,161,097,578	8,586,607,308	9,175,932,269	10,345,377,043	10,886,007,778	2,494,817,350	49,649,839,326

Federal Share

Waiver Name	01	02	03	04	05	06	Total
AC	640,077,757	400,324,715	86,589,234	15,843,799	(563,946)	(75,194)	1,142,196,365
AFDC/SOBRA	2,385,725,394	2,468,721,864	2,498,075,692	2,578,832,750	2,712,140,242	590,888,050	13,234,383,992
ALTCS-EPD	716,911,452	770,561,889	807,395,601	856,636,839	853,677,578	197,523,149	4,202,706,508
ALTCS-DD	632,712,981	661,923,949	719,012,884	802,167,470	862,434,185	221,577,242	3,899,828,711
DSH/CAHP	104,828,265	106,090,329	109,089,385	110,477,860	105,884,622	3,632,296	540,002,757
Expansion State Adults	0	0	971,954,458	1,728,768,387	1,918,577,329	460,257,906	5,079,558,080
Family Planning Extension	767,009	927,946	174,071	(1,212)	(689)	(111)	1,867,014
MED	453,960	0	0	0	0	0	453,960
SNCP/DSHP	199,636,108	366,713,968	161,520,692	81,516,426	79,538,947	28,490,594	917,416,735
SSI	932,530,558	968,835,488	1,069,911,601	1,212,968,330	1,229,241,390	282,091,010	5,695,578,377
Uncomp Care IHS/638	22,848,035	97,067,679	53,845,830	13,406,989	7,630,280	2,285,498	197,084,311
Subtotal	5,636,491,519	5,841,167,827	6,477,569,448	7,400,617,638	7,768,559,938	1,786,670,440	34,911,076,810
New Adult Group	0	0	108,394,756	303,791,070	473,055,907	105,402,074	990,643,807
Total	5,636,491,519	5,841,167,827	6,585,964,204	7,704,408,708	8,241,615,845	1,892,072,514	35,901,720,617

Adjustments to Schedule C Waiver 11-W00275/9

Total Computable

Waiver Name	01	02	03	04	05	06	Total
AC	313,572	210,756	87,745	(7)	326	73	612,465
AFDC/SOBRA	1,014,881	1,090,143	990,293	5,056,392	4,912,060	2,404,639	15,468,409
SSI	365,158	399,101	398,723	2,391,771	2,371,156	1,199,735	7,125,644
Expansion State Adults	-	-	223,239	3,043,744	3,208,358	1,641,502	8,116,843
ALTCS-DD (Cost Sharing)[1]	-	-	-	-	-	-	-
CAHP[2]	(1,693,611)	(1,700,000)	(1,700,000)	(10,491,900)	(10,491,900)	(5,245,950)	(31,323,361)
Total	-	-	-	-	-	-	-

Federal Share

Waiver Name	01	02	03	04	05	06	Total
AC	211,034	138,424	58,991	(5)	225	51	408,719
AFDC/SOBRA	683,014	716,006	665,774	3,461,607	3,385,392	1,664,972	10,576,765
SSI	245,752	262,130	268,062	1,637,406	1,634,201	830,697	4,878,248
Expansion State Adults	-	-	150,083	2,083,747	2,211,200	1,136,576	5,581,606
ALTCS-DD (Cost Sharing)[1]	-	-	-	-	-	-	-
CAHP[2]	(1,139,800)	(1,116,560)	(1,142,910)	(7,182,755)	(7,231,017)	(3,632,296)	(21,445,338)
Total	-	-	-	-	-	-	-

[1] The CMS 1115 Waiver, Special Term and Condition 42,d requires that premiums collected by the State shall be reported on Form CMS-64 Summary Sheet line 9,D. The

[2] The Critical Access Hospital Payment (CAHP) waiver expenditures are included in the AFDC\SOBRA, AC, SSI, and Expansion State Adults rate development while the expenditures are required to be reported on separate Forms CMS-64.9 and CMS-64.9P Waiver. This adjustment transfers the CAHP expenditures to the AFDC\SOBRA, AC, SSI and Expansion State Adults waiver categories for budget neutrality comparison purposes. The CAHP expenditures are allocated to the waiver categories in the same proportion as the capitation payments made for the CAHP service period.

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IV. Schedule C as Adjusted for Manual Entries and Waiver PMPM Groupings

Revised Schedule C Waiver 11-W00275/9

Total Computable

Waiver Name	01	02	03	04	05	06	Total
AC	918,171,765	582,656,779	124,052,944	23,156,925	(633,467)	(97,511)	1,647,307,435
AFDC/SOBRA	3,416,779,902	3,586,718,965	3,541,698,746	3,615,381,002	3,797,501,667	833,026,466	18,791,106,749
ALTCS-EPD	1,062,023,826	1,167,261,286	1,195,674,152	1,247,205,145	1,235,730,462	285,319,732	6,193,214,603
ALTCS-DD	939,086,691	1,005,552,539	1,067,545,705	1,170,385,446	1,250,598,273	320,030,323	5,753,198,977
DSH/CAHP	154,069,040	159,826,080	160,562,955	150,883,884	143,142,200	-	768,484,159
Expansion State Adults	-	-	1,138,714,648	1,972,865,272	2,118,554,787	506,316,087	5,736,450,794
Family Planning Extension	830,631	1,008,110	190,026	(1,337)	(763)	(123)	2,026,544
MED	673,818	-	-	-	-	-	673,818
SNCP/DSHP	296,636,120	558,334,298	240,250,917	119,071,612	115,407,642	41,147,594	1,370,848,183
SSI	1,349,959,068	1,428,056,738	1,544,958,655	1,729,200,944	1,745,003,915	401,382,207	8,198,561,527
Uncomp Care IHS/638	22,866,717	97,192,513	53,888,765	13,437,080	7,647,155	2,290,500	197,322,730
Subtotal	8,161,097,578	8,586,607,308	9,067,537,513	10,041,585,973	10,412,951,871	2,389,415,276	48,659,195,519
New Adult Group	-	-	108,394,756	303,791,070	473,055,907	105,402,074	990,643,807
Total	8,161,097,578	8,586,607,308	9,175,932,269	10,345,377,043	10,886,007,778	2,494,817,350	49,649,839,326

Federal Share

Waiver Name	01	02	03	04	05	06	Total
AC	640,288,791	400,463,139	86,648,225	15,843,794	(563,721)	(75,143)	1,142,605,084
AFDC/SOBRA	2,386,408,408	2,469,437,870	2,498,741,466	2,582,294,357	2,715,525,634	592,553,022	13,244,960,757
ALTCS-EPD	716,911,452	770,561,889	807,395,601	856,636,839	853,677,578	197,523,149	4,202,706,508
ALTCS-DD	632,712,981	661,923,949	719,012,884	802,167,470	862,434,185	221,577,242	3,899,828,711
DSH/CAHP	103,688,465	104,973,769	107,946,475	103,295,105	98,653,605	0	518,557,419
Expansion State Adults	-	-	972,104,541	1,730,852,134	1,920,788,529	461,394,482	5,085,139,686
Family Planning Extension	767,009	927,946	174,071	(1,212)	(689)	(111)	1,867,014
MED	453,960	-	-	-	-	-	453,960
SNCP/DSHP	199,636,108	366,713,968	161,520,692	81,516,426	79,538,947	28,490,594	917,416,735
SSI	932,776,310	969,097,618	1,070,179,663	1,214,605,736	1,230,875,591	282,921,707	5,700,456,625
Uncomp Care IHS/638	22,848,035	97,067,679	53,845,830	13,406,989	7,630,280	2,285,498	197,084,311
Subtotal	5,636,491,519	5,841,167,827	6,477,569,448	7,400,617,638	7,768,559,938	1,786,670,440	34,911,076,810
New Adult Group	-	-	108,394,756	303,791,070	473,055,907	105,402,074	990,643,807
Total	5,636,491,519	5,841,167,827	6,585,964,204	7,704,408,708	8,241,615,845	1,892,072,514	35,901,720,617

Calculation of Effective FMAP:

AFDC/SOBRA						
Federal	2,386,408,408	2,469,437,870	2,498,741,466	2,582,294,357	2,715,525,634	592,553,022
Total	3,416,779,902	3,586,718,965	3,541,698,746	3,615,381,002	3,797,501,667	833,026,466
Effective FMAP	0.69843785	0.688494943	0.705520612	0.714252345	0.715082144	0.711325566
SSI						
Federal	932,776,310	969,097,618	1,070,179,663	1,214,605,736	1,230,875,591	282,921,707
Total	1,349,959,068	1,428,056,738	1,544,958,655	1,729,200,944	1,745,003,915	401,382,207
Effective FMAP	0.690966365	0.678612826	0.692691458	0.70240867	0.705371249	0.704868581
ALTCS-EPD						
Federal	716,911,452	770,561,889	807,395,601	856,636,839	853,677,578	197,523,149
Total	1,062,023,826	1,167,261,286	1,195,674,152	1,247,205,145	1,235,730,462	285,319,732
Effective FMAP	0.67504272	0.660145161	0.675263908	0.686845177	0.690828303	0.692287027
ALTCS-DD						
Federal	632,712,981	661,923,949	719,012,884	802,167,470	862,434,185	221,577,242
Total	939,086,691	1,005,552,539	1,067,545,705	1,170,385,446	1,250,598,273	320,030,323
Effective FMAP	0.673753538	0.658268885	0.673519532	0.685387427	0.689617284	0.692363273
AC						
Federal	640,288,791	400,463,139	86,648,225	15,843,794	(563,721)	(75,143)
Total	918,171,765	582,656,779	124,052,944	23,156,925	(633,467)	(97,511)
Effective FMAP	0.697351863	0.68730538	0.698477781	0.684192482	0.889898405	0.77061531
Expansion State Adults						
Federal	-	-	972,104,541	1,730,852,134	1,920,788,529	461,394,482
Total	-	-	1,138,714,648	1,972,865,272	2,118,554,787	506,316,087
Effective FMAP			0.853685814	0.87732911	0.906650393	0.911277547
New Adult Group						
Federal	-	-	108,394,756	303,791,070	473,055,907	105,402,074
Total	-	-	108,394,756	303,791,070	473,055,907	105,402,074
Effective FMAP			1	1	1	1

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V. Budget Neutrality Member Months and Cost Sharing Premium Collections

Budget Neutrality Member Months:	AFDC/SOBRA	SSI	ALTCS-DD	ALTCS-EPD	AC	MED	Family Plan Ext	Expan St Adults	New Adult Group
Quarter Ended December 31, 2011	2,932,551	487,576	72,519	85,460	527,244	467	12,471		
Quarter Ended March 31, 2012	2,920,237	489,001	73,155	85,506	430,723	-	12,424		
Quarter Ended June 30, 2012	2,914,117	489,023	73,965	85,730	365,132	-	12,440		
Quarter Ended September 30, 2012	2,938,855	491,661	74,820	86,512	310,396	-	12,689		
Quarter Ended December 31, 2012	2,911,505	494,735	75,639	86,829	274,990	-	13,104		
Quarter Ended March 31, 2013	2,891,265	497,114	76,467	86,076	248,817	-	13,824		
Quarter Ended June 30, 2013	2,903,099	499,734	77,281	86,303	228,204	-	14,187		
Quarter Ended September 30, 2013	2,918,991	503,341	78,035	87,133	217,114	-	14,856		
Quarter Ended December 31, 2013	2,891,863	506,704	78,841	87,679	206,419	-	14,885		
Quarter Ended March 31, 2014	2,839,466	514,266	79,683	87,893	87	-	-	444,018	39,013
Quarter Ended June 30, 2014	2,955,787	523,000	80,672	88,734	2	-	-	624,439	86,566
Quarter Ended September 30, 2014	3,113,711	528,953	81,758	89,359	-	-	-	756,132	122,942
Quarter Ended December 31, 2014	3,146,369	536,250	82,725	90,010	-	-	-	817,997	149,849
Quarter Ended March 31, 2015	3,085,250	542,659	83,827	89,877	-	-	-	836,193	191,212
Quarter Ended June 30, 2015	3,105,767	543,208	84,833	89,924	-	-	-	846,272	245,323
Quarter Ended September 30, 2015	3,210,136	543,083	85,609	90,011	-	-	-	866,855	284,962
Quarter Ended December 31, 2015	3,262,759	547,594	86,374	89,870	-	-	-	916,929	312,529
Quarter Ended March 31, 2016	3,258,784	549,525	87,134	89,437	-	-	-	930,756	331,445
Quarter Ended June 30, 2016	3,243,535	545,185	88,241	89,553	-	-	-	930,461	332,906
Quarter Ended September 30, 2016	3,328,741	545,963	89,188	89,635	-	-	-	937,173	323,962
Quarter Ended December 31, 2016	3,374,625	544,399	89,747	88,447	-	-	-	952,823	328,446
Quarter Ended March 31, 2017									
Quarter Ended June 30, 2017									
Quarter Ended September 30, 2017									

	ALTCS Developmentally Disabled	
Cost Sharing Premium Collections:	Total Computable	Federal Share
Quarter Ended December 31, 2011	-	-
Quarter Ended March 31, 2012	-	-
Quarter Ended June 30, 2012	-	-
Quarter Ended September 30, 2012	-	-
Quarter Ended December 31, 2012	-	-
Quarter Ended March 31, 2013	-	-
Quarter Ended June 30, 2013	-	-
Quarter Ended September 30, 2013	-	-
Quarter Ended December 31, 2013	-	-
Quarter Ended March 31, 2014	-	-
Quarter Ended June 30, 2014	-	-
Quarter Ended September 30, 2014	-	-
Quarter Ended December 31, 2014	-	-
Quarter Ended March 31, 2015	-	-
Quarter Ended June 30, 2015	-	-
Quarter Ended September 30, 2015	-	-
Quarter Ended December 31, 2015	-	-
Quarter Ended March 31, 2016	-	-
Quarter Ended June 30, 2016	-	-
Quarter Ended September 30, 2016	-	-
Quarter Ended December 31, 2016	-	-
Quarter Ended March 31, 2017	-	-
Quarter Ended June 30, 2017	-	-
Quarter Ended September 30, 2017	-	-

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VI. Allocation of Disproportionate Share Hospital Payments

Federal Share

	FFY 2012	FFY 2013	FFY 2014	FFY 2015	FFY 2016	FFY 2017	
Total Allotment	**103,890,985**	**106,384,369**	**108,086,519**	**109,707,817**	**110,036,940**	**111,027,272**	**649,133,902**
Reported in QE							
Dec-11	-	-	-	-	-		-
Mar-12	-	-	-	-	-		-
Jun-12	78,996,800	-	-	-	-		78,996,800
Sep-12	6,248,670	-	-	-	-		6,248,670
Dec-12	11,346,623	-	-	-	-		11,346,623
Mar-13	309,515	-	-	-	-		309,515
Jun-13	1,022,914	77,733,987	-	-	-		78,756,901
Sep-13	-	-	-	-	-		-
Dec-13	-	6,098,257	-	-	-		6,098,257
Mar-14	2,505,265	-	-	-	-		2,505,265
Jun-14	-	4,725,871	-	-	-		4,725,871
Sep-14	3,258,682	-	79,568,453	-	-		82,827,135
Dec-14	-	-	6,222,002	-	-		6,222,002
Mar-15	-	1,474,261	-	-	-		1,474,261
Jun-15	-	16,248,501	(219,987)	92,024,206	-		108,052,719
Sep-15	-	-	1,465,978	-	-		1,465,978
Dec-15	(4)			6,325,567			6,325,563
Mar-16			20,729,076				20,729,076
Jun-16		(14,886)	180,953	4,170,769	98,068,611		102,405,447
Sep-16				504,238			504,238
Dec-16		(1,292,221)		270,327	584,993		(436,900)
Mar-17							-
Jun-17							-
Sep-17							-
Dec-17							-
Total Reported to Date	103,688,465	104,973,769	107,946,475	103,295,107	98,653,604	-	518,557,420
Unused Allotment	**202,520**	**1,410,600**	**140,044**	**6,412,710**	**11,383,336**	**111,027,272**	**130,576,482**

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VII. BUDGET NEUTRALITY TRACKING SCHEDULE -- NEW ADULT GROUP

WAIVER PERIOD JANUARY 1, 2014 THROUGH SEPTEMBER 30, 2021:

I. CALCULATION OF BUDGET NEUTRALITY LIMIT BY DEMONSTRATION YEAR (WITHOUT WAIVER CEILING FEDERAL SHARE)

	Trend Rate	DY 03 PM/PM	Effective FMAP	Federal Share PM/PM	Member Months QE 12/13	QE 3/14	QE 6/14	QE 9/14	Total	Federal Share Budget Neutrality Limit
New Adult Group		578.54	100.00%	578.54	-	39,013	86,566	122,942	248,521	143,779,339

	Trend Rate	DY 04 PM/PM			Member Months QE 12/14	QE 3/15	QE 6/15	QE 9/15	Total	
New Adult Group	1.047	605.73	100.00%	605.73	149,849	191,212	245,323	284,962	871,346	527,801,615

	Trend Rate	DY 05 PM/PM			Member Months QE 12/15	QE 3/16	QE 6/16	QE 9/16	Total	
New Adult Group	1.047	634.20	100.00%	634.20	312,529	331,445	332,906	323,962	1,300,842	824,994,978

	Trend Rate	DY 06 PM/PM			Member Months QE 12/16	QE 3/17	QE 6/17	QE 9/17	Total	
New Adult Group	1.047	664.01	100.00%	664.01	328,446	-	-	-	328,446	218,090,834

II. WAIVER COSTS AND VARIANCE FROM BUDGET NEUTRALITY LIMIT - BY QUARTER, BY DATE OF PAYMENT

	Budget Neutrality Limit - Federal Share MAP	DSH	Total	Expenditures New Adult Grp	VARIANCE
QE 12/13	$ -	$ -	$ -	$ -	$ -
QE 3/14	22,570,581	-	22,570,581	13,870,414	8,700,167
QE 6/14	50,081,894	-	50,081,894	34,313,342	15,768,552
QE 9/14	71,126,865	-	71,126,865	47,984,458	23,142,407
QE 12/14	90,768,242	-	90,768,242	46,004,135	44,764,107
QE 3/15	115,823,109	-	115,823,109	70,387,348	45,435,761
QE 6/15	148,599,839	-	148,599,839	85,319,153	63,280,686
QE 9/15	172,610,426	-	172,610,426	97,948,283	74,662,143
QE 12/15	198,206,128	-	198,206,128	113,800,738	84,405,390
QE 3/16	210,202,669	-	210,202,669	122,290,142	87,912,527
QE 6/16	211,129,236	-	211,129,236	123,158,494	87,970,742
QE 9/16	205,456,945	-	205,456,945	108,777,377	96,679,568
QE 12/16	218,090,834	-	218,090,834	126,789,923	91,300,911
QE 3/17		-	-		-
QE 6/17		-	-		-
QE 9/17		-	-		-
	$ 1,714,666,767	$ -	$ 1,714,666,767	$ 990,643,807	$ 724,022,960

III. SUMMARY BY DEMONSTRATION YEAR

	Federal Share of Budget Neutrality Limit	Federal Share of Waiver Costs on CMS-64	Annual Variance	As % of Annual Budget Neutrality Limit	Cumulative Federal Share of Budget Neutrality Limit	Cumulative Federal Share of Waiver Costs on CMS-64	Cumulative Federal Share Variance	As % of Cumulative Budget Neutrality Limit
DY 03	$ 143,779,339	$ 96,168,214	$ 47,611,125	33.11%				
DY 04	527,801,615	299,658,919	228,142,696	43.23%				
DY 05	824,994,978	468,026,751	356,968,227	43.27%				
DY 06	218,090,834	126,789,923	91,300,911	41.86%	$ 1,714,666,767	$ 990,643,807	$ 724,022,960	42.23%
	$ 1,714,666,767	$ 990,643,807	$ 724,022,960					

Based on CMS-64 certification date of 12/31/2016