August 31, 2016

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 37, enclosed please find the Quarterly Progress Report for April 1, 2016 through June 30, 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,

Monica Coury
Assistant Director
AHCCCS Office of Intergovernmental Relations

Enclosure

cc: Brian Zolynas
Hee Young Ansell
Susan Ruiz

AHCCCS Quarterly Report
April 1, 2016 through June 30, 2016

TITLE

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

Section 1115 Quarterly Report
Demonstration Year: 33
Federal Fiscal Quarter: 3nd (April 1, 2016 – June 30, 2016)

INTRODUCTION

As written in Special Terms and Conditions, paragraph 37, 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 April 2016-June 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	1,271,955	2,706	300,601
Acute SSI	188,366	190	27,429
Prop 204 Restoration	487,856	810	75,099
Adult Expansion	126,925	192	31,900
LTC DD	29,662	22	2,999
LTC EPD	31,439	35	4,790
Non-Waiver	2,357	2	255
Total	**2,138,560**	**3,957**	**443,073**

Table 2 is a snapshot of the number of current enrollees (as of July 1, 2016) by funding categories as requested by CMS.

State Reported Enrollment in the Demonstration (as requested)	Current Enrollees
Title XIX funded State Plan [1]	1,349,935
Title XXI funded State Plan [2]	549
Title XIX funded Expansion [3]	80,265
Title XXI funded Expansion [4]	0

[1] SSI, 1931 Families and Children, 1931 Related, TMA, SOBRA child and pregnant, ALTCS, FTW, QMB, BCCP, SLMB, QI-1
[2] KidsCare
[3] MI/MN
[4] AHCCCS for Parents

DSH Funded Expansion	
Other Expansion	
Pharmacy Only	
Family Planning Only[5]	0
Enrollment Current as of	7/1/16

Table 3 represents number of members who received services through the Agency with Choice program[6] for the quarter April 2016 – June 2016.

State Reported Program Enrollment	Current Enrollees
Agency with Choice Program	2,208

OPERATIONAL/POLICY DEVELOPMENTS/ISSUES

Waiver Update

AHCCCS submitted the 1115 Waiver application on September 30, 2015. We are continuing our negotiations with CMS on issues related to our waiver proposal.

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 16-003	Vaccines and Immunizations	5/12/16		7/1/16
Title XXI				
SPA 16-017	Change the premium lock out period from 90 days to 2 months	5/27/16		7/26/16
SPA 16-016	Remove the enrollment cap on the KidsCare program	5/23/16		7/26/16

Legislative Update

AHCCCS did not propose or advocate on behalf of any legislation. Instead, the legislature introduced a number of bills that would have impacted the agency, including HB 2309, HB 2357, HB 2442, SB 1283, SB 1305, SB 1442, and SB 1507.

[5] Represents point-in-time enrollment as of 4/1/16

[6] Under the Agency with Choice option, the provider agency and the member/IR enter into a co-employment agreement. The provider agency serves as the legal employer of the Direct Care Worker (DCW) and the member/IR serves as the day-to-day managing employer of the DCW.

HB 2309 (children's health insurance program) restores the CHIP (KidsCare) program. The bill would have required AHCCCS to submit to CMS a State Plan Amendment (SPA) within five days of enactment to resume enrollment in the program. Although the bill did not successfully make its way through the legislative process, proponents were successful in amending SB 1457 (eligibility; empowerment scholarships; health insurance), which included the same restoration language.

HB 2357 (AHCCCS; podiatry services) adds podiatry services performed by a Podiatrist to the list of covered services for members who are at least 21 years of age. It was estimated that the restoration of these services would result in a General Fund (GF) obligation of $214,200. Similar to HB 2309, HB 2357 was unsuccessful in making its way through the legislative process. Instead, restoration of podiatry services performed by a Podiatrist was included as part of the FY 2017 budget.

HB 2442 (behavioral health; urgent need; children) was an emergency measure that was signed and effectuated by Governor Ducey on March 24, 2016. First, the bill requires that an out-of-home-placement shall receive immediately on placement of the child from the Department of Child Safety (DCS) an updated complete placement packet that includes: 1) The child's RBHA designated point of contact; 2) AHCCCS customer service line; 3) A list of AHCCCS registered providers; and 4) Information regarding the out-of-home placement's rights. Second, if it is determined the foster or adoptive child is in need of behavioral health services, and the child is eligible for either Title XIX or Title XXI services, the out-of-home placement or adoptive parent may directly contact the RBHA for a screening and evaluation. Third, on completion of the initial evaluation, the out-of-home placement or adoptive parents shall call the RBHA designated point of contact and the AHCCCS customer service line if services are not received within twenty-one days to document the failure to receive services. If there is a failure to receive services, the out-of-home placement or adoptive parents may access services directly from any AHCCCS registered provider regardless of whether the provider is contracted with the RBHA and the provider must submit claims to the RBHA and accept the lesser of one hundred thirty percent of the AHCCCS fee schedule. Lastly, if the foster child moves into a different county because of the location of the child's out-of-home placement, the child's out-of-home placement may choose to have the child continue any current treatment in the previous county, or seek any new or additional treatment for the child in the out-of-home placement's county of residence.

SB 1283 (controlled substances prescription monitoring program) requires a medical practitioner before prescribing an opioid analgesic or benzodiazepine controlled substance listed in schedule II, III or IV for a patient to obtain a patient utilization report regarding the patient for the preceding twelve months from the program's central database tracking system at the beginning of each new course of treatment, and reference the database at least quarterly while that prescription remains a part of the treatment. Exceptions to the requirements of the bill include a patient receiving hospice care or palliative care for a serious or chronic illness, a patient receiving care for cancer, a cancer-related illness or condition or dialysis treatment, a medical practitioner will administer the controlled substance, a patient is receiving the controlled substance during the course of inpatient or residential treatment in a hospital, nursing care facility, assisted living facility, correctional facility or mental health facility, a medical practitioner is prescribing the controlled substance to the patient for no more than a ten-day period for an invasive medical or dental procedure or a medical or dental procedure that results in acute pain to the patient, a

medical practitioner is prescribing no more than a five-day prescription and has reviewed the program's central database tracking system for that patient within the last thirty days, and the system shows that no other prescriber has prescribed a controlled substance in the preceding thirty-day period, and medical practitioner that uses electronic medical records that integrate data from the controlled substances prescription monitoring program.

SB 1305 (AHCCCS; covered services) expands the list of services available to the adult population by including Occupational Therapy in an outpatient setting. The GF costs associated with this service has been estimated to range from $113,300 to $271,900. SB 1305 was unsuccessful in making its way through the legislative process.

SB 1442 (mental health services; information disclosure) modifies the requirements for health care providers or entities to allow the disclosure of confidential health care records to relatives, close personal friends or any other person identified by the patient as otherwise authorized or required by state or federal law.

SB 1507 (ALTCS; dental services) expands the list of services that are required to be provided by the Arizona Long-Term Care System (ALTCS) program contractors to ALTCS members to include dental services in an annual amount of not more than $1,000 per member. The legislation is consistent with the Governor's FY 2017 Budget Recommendation and is estimated to have a GF cost of $1.4 million for the Elderly and Physically Disabled (EPD) program, and $1.2 million for the Developmentally Disabled (DD) program.

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 April 2016 – June 2016.

Table 1 **Advocacy Issues**	**April**	**May**	**June**	**Total**
9+Billing Issues • **Member reimbursements** • **Unpaid bills**	12	25	30	**67**
Cost Sharing • **Co-pays** • **Share of Cost (ALTCS)** • **Premiums (Kids Care, Medicare)**	2	5	5	**12**
Covered Services	36	49	47	**132**
Eligibility Issues by Program **Can't get coverage due to :**				

ALTCS • **Resources** • **Income** • **Medical**	9	9	10	**28**
DES • **Income** • **Incorrect determination** • **Improper referrals**	85	99	57	**241**
Kids Care • **Income** • **Incorrect determination**	0	0	0	**0**
SSI/Medical Assistance Only • **Income** • **Not categorically linked**	13	12	2	**27**
Information • **Status of application** • **Eligibility Criteria** • **Community Resources** • **Notification (Did not receive or didn't understand)**	51	28	50	**129**
Medicare • **Medicare Coverage** • **Medicare Savings Program** • **Medicare Part D**	12	5	8	**25**
Prescriptions • **Prescription coverage** • **Prescription denial**	60	44	30	**134**
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) • **Health Plans/Providers *(*Caregiver issues, Lack of providers)** • **Services *(*Equipment, Nursing Homes, Optical and Surgical)**	7	11	12	**30**
Total	287	287	251	**825**

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**	**April**	**May**	**June**	**Total**
Applicant, Member or Representative	237	255	213	705
CMS	3	2	1	6
Governor's Office	0	0	0	0
Ombudsmen/Advocates/Other Agencies…	41	25	34	100
Senate & House	6	5	3	14
Total	**287**	**287**	**251**	**825**

Note: This data was compiled from the OCA logs from the OCA Client Advocate and the Member Liaison.
***Governor's staff now sending through Ombudsmen office**

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	Apr-16	May-16	Jun-16	**Total**
Access to Care	21	25	25	**71**
Health Plan	130	120	134	**384**
Provider Satisfaction	210	189	186	**585**
Total	361	334	345	**1,040**

CRS Member Grievances and Complaints	Apr-16	May-16	Jun-16	**Total**
Access to Care	0	0	0	**0**
Health Plan	2	2	2	**6**
Provider Satisfaction	8	8	1	**17**
Total	10	10	3	**23**

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)

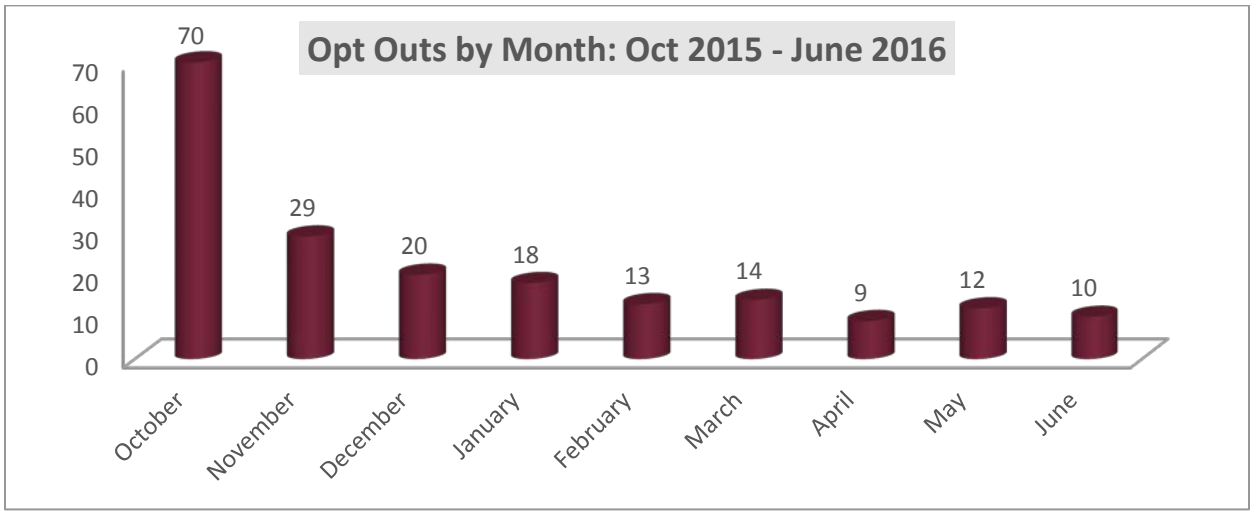
STATE CONTACT(S)

Monica Coury
801 E. Jefferson St., MD- 4200
Phoenix, AZ 85034
(602) 417-4534

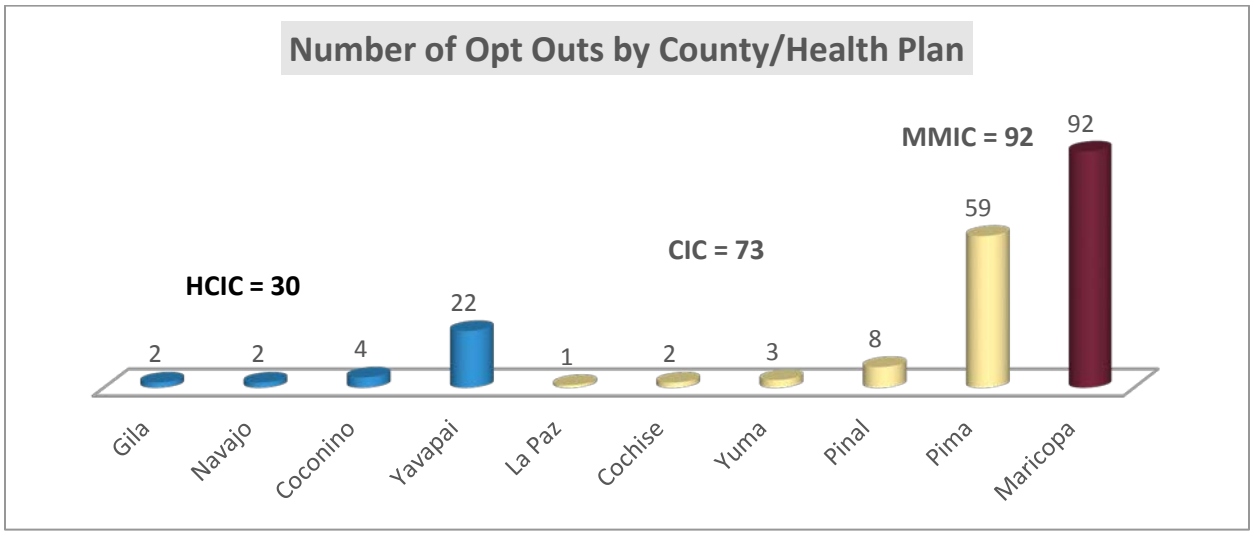
DATE SUBMITTED TO CMS

August 31, 2016

Attachment 1: Opt-Out for Cause Report



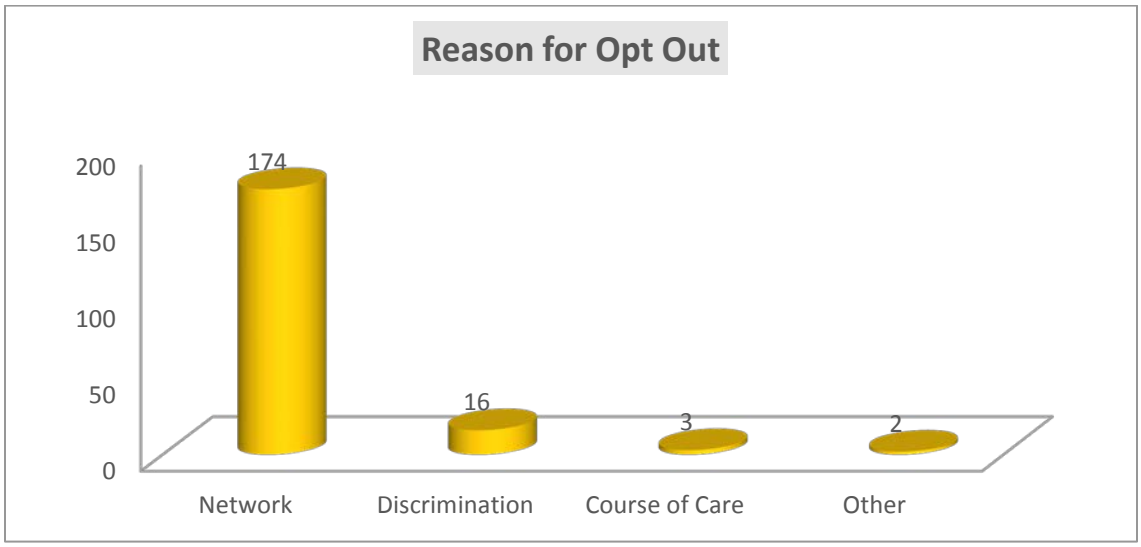
Oct 2015 - June 2016 Opt Out Request								
Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
70	29	20	18	13	14	9	12	10



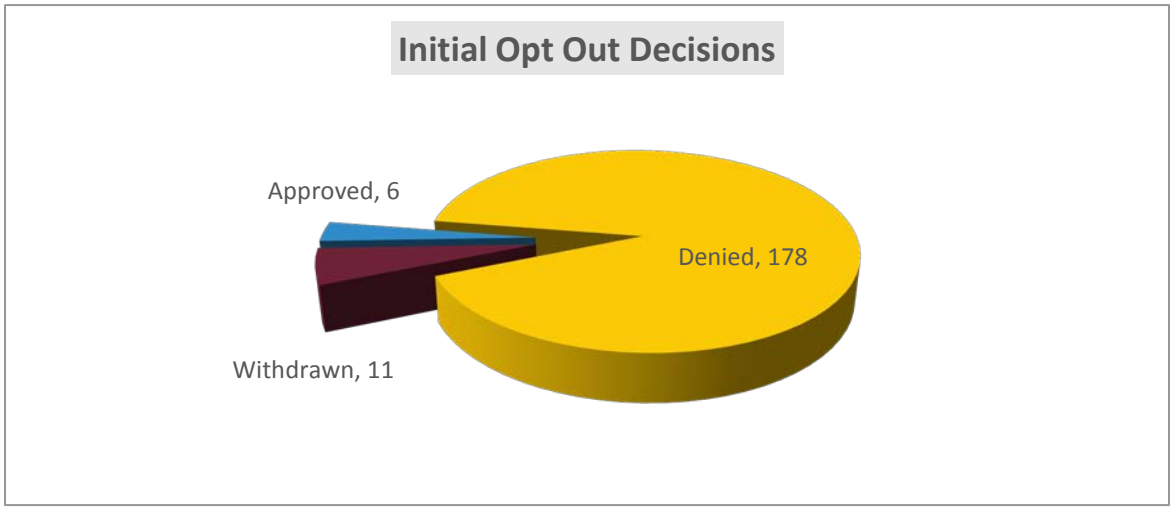
Number of Opt-Out by County /Health Plans: Oct. 2015 - June 2016		
HCIC	Gila	2
HCIC	Navajo	2
HCIC	Coconino	4
HCIC	Yavapai	22
HCIC	**Total**	**30**
CIC	La Paz	1
CIC	Cochise	2

Attachment 1: Opt-Out for Cause Report

CIC	Yuma	3
CIC	Pinal	8
CIC	Pima	59
CIC	**Total**	**73**
MMIC	Maricopa	**92**
Grand Total	**All Counties**	**195**

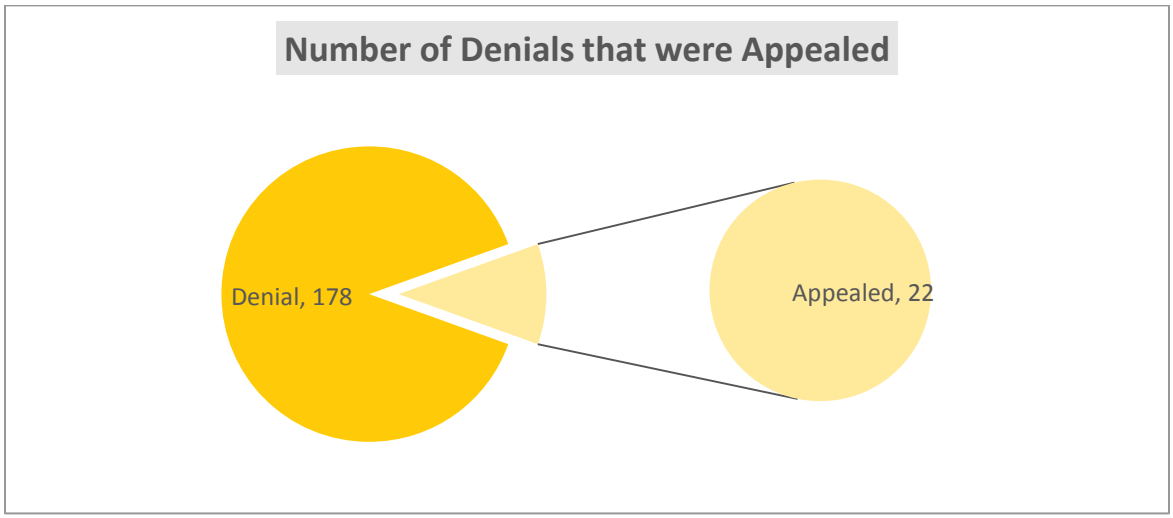


Network	Discrimination	Other	Course of Care
174	**16**	**3**	**2**

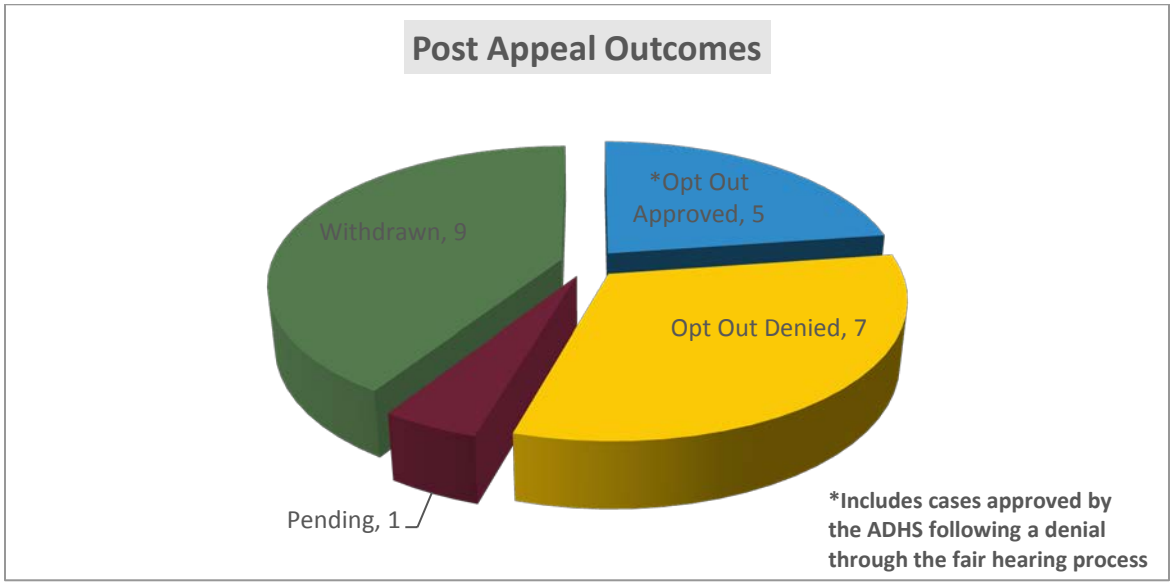


Oct 15- June 2016 Opt Out Decisions			
Denied	**Withdraw**	**Approved**	**Pending**
178	11	6	0

Attachment 1: Opt-Out for Cause Report



Out of the 178 denied Opt Out request only 22 appealed the decision.



Oct 15- Jan 2016 Post Appeal Opt Out Outcomes	
Pending	1
Withdrawn	9
Denied	7
Approved	5

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Attachment II to the

Section 1115 Quarterly Report

Quality Assurance/Monitoring Activity

Demonstration/Quarter Reporting Period

Demonstration Year: 33

Federal Fiscal Quarter 3/2016 (4/2016 – 6/2016)

Prepared by the Division of Health Care Management
August 2016

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 115 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 States' 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 (Contractors), providers and the community. During quarter three, 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, and to facilitate networking to address common issues and solve problems. 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.

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 Commitee*
ADHS Bureau of USDA Nutrition Programs	*Health Mothers/Healthy Babies*
ADHS Immunization Program and Vaccines for Children Program	*Arizona Health-E Connenction/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 that the Quality, MCH, and EPSDT teams are involved in.

Developing and Implementing Projects to Improve the Delivery System

Administrative Simplification

As part of the Fiscal Year 2015 Arizona Budget Session, it was announced that the Division of Behavioral Health Services (DBHS) would be merging with AHCCCS, with the process finalizing on July 1, 2016. Efforts to integrate the two organizations began in April 2015. The AHCCCS/DBHS clinical teams were some of the first to integrate, with the CQM and MCH/EPSDT teams completing staff integration in September 2015. Since that time, numerous benefits have been experienced and staff have actively engaged with educating each other on their areas of expertise (physical health vs. behavioral health). Projects and initiatives are viewed through an enhanced lens of whole person health and are made stronger by the team collaboration and perspective.

Additionally, the Agency has taken the opportunity to evaluate all units and divisions and break down silos if any were found. One of the best benefits to the CQM and MCH/EPSDT teams are the new opportunities to work closely with the Customer Service, Medical Management, and Client Advocate units at the Agency. All teams have taken time to clearly define their scopes and areas of expertise, resulting in increased efficiency and enhanced collaboration for responding to member concerns. The teams have had face-to-face meetings and now regularly interact to make sure that members needs and concerns with Contractors and providers are addressed consistently.

Integration Efforts

The CQM and MCH/EPSDT teams continue to monitor Contractor activies to ensure that integrated plans are providing for all needs of members, whether they be physical, behavioral, or special health care needs. There are quarterly deliverable that are reviewed to ensure that care and services are being delivered as expected (e.g. EPSDT visits for members aged 18 to 20 and enrolled in the Serious Mental Illness (SMI) - integrated plans). The teams also look for opportunities to highlight best practices from these plans; when identified, the Contractor is asked to present at quarterly all-Contractor meetings to share their work and outcomes. Additionally, resources are brought in to the Quarterly meetings that enhance knowledge around whole-person health as well as how Contractors can build collaborative efforts in those instances where members are receiving care and services from multiple entities.

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 as it offers a singe point of contact for the Contracotrs and promotes consistentcy across the system. The Association works closely with AHCCCS to discuss Contractor concerns, barriers, and challenges to the efforts they are asked to undertake, but 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 the prevalence of a particular condition and population affected, the resources required by both AHCCCS and Contractors to conduct studies and effect improvement, and whether the areas currently are priorities of CMS or state leadership and/or can be combined with existing initiatives. Of importance is whether initiatives focused on the topic area are actionable and would result in improved quality improvement, member satisfaction and system efficiencies. Contractor input is also sought in prioritizing areas for improvement.

During this quarter, one initiative continued for specific Contractor involvement and improvement, decreasing childhood obesity for the EPSDT population. This topic is being promoted through an AHCCCS/Contractor collaborative workgroup, with external stakeholders also being invited to participate to give presentations on community efforts.

- Innovations in Childhood Obesity – AHCCCS was selected by CHCS to participate in this initiative, AHCCCS formed a collaborative workgroup to drive these improvements across the state. AHCCCS has selected an FQHC to work in partnership with to collect data and implement interventions relevant to this initiative; AHCCCS Contractors have joined the workgroup that is driving the intensive planning efforts related to these directives. During quarter three AHCCCS and the selected FQHC finalized methods for collecting data which is being generated by the FQHC to share with both AHCCCS and participating Contractors.

Establishing Realistic Outcome-Based Performance Measures

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 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 been added to 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 will become effective on October 1, 2016 which aligns with the start of a new contract period 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 others measure sets being implemented by CMS. AHCCCS has also updated the measure sets with contracts to reflect changes on measures implemented by CMS for the current contract year.

It is AHCCCS' goal to continue to develop and implement additional Core measures as the data sources become valid and reliable. Initial measures were chosen based on a number of criteria,

which include greatest need for members, 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 what has existed as data sources and methodologies will no longer be enough. Yet, 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 such as electronic health records, health information exchange data and information that will be available through public health connectivity. Transitioning the AHCCCS measure sets is anticipated to support the adoption of electronic health records and use of the health information exchange which will, in turn, result in efficiencies and data/information that will transform care practices, improve individual patient outcomes and population health management, improve patient satisfaction with the care experience, increase efficiencies and reduce health care costs.

CYE 2017 Performance Measure Crosswalk

Measures	Acute	ALTCS E/PD	GMS/SA	SMI	CMDP	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	
Follow-Up After Hospitalization for Mental Health, 30 Days		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 at High Dosage in Persons Without Cancer	X	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									
Access to Behavioral Health Professional Services, 7 Days			X	X		X					
Access to Behavioral Health Professional Services, 23 Days			X specific to DDD and aggregate reporting	X		X					
Access to Behavioral Health Professional Services, 21 Days			X specific to CMDP reporting		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 Eligibiles 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 (4:3:1:3:3:1:4)	X				X	X	X				X
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

* This measure will be Core-like

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 that was identified was the possibility that the information system and data analytic staff resources were reduced which would not allow the level of review and validation of performance measure programming necessary to ensure the validity and accuracy of Performance Measures. 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 the sustaining/improving continuing measures. Some of these efforts will include new work groups, new reporting mechanisms, increased opportunities for technical assistance, a more transparent reporting process with plans for proactive reporting prior to the end of the measurement period so that Contractors can 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 has 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 EDP 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.

- Opioid Mis- and Over-Prescribing and CSPMP Database Utilization - The purpose of this PIP is to increase the number of prescribers registered and accessing the Board of Pharmacy Controlled Substance Prescription Monitoring Program (CSPMP) Database and to reduce the number of unexpected deaths and adverse outcomes related to opioid over- and mis-prescribing. There will be two measurements for this PIP. The first will focus on the number of prescribers that have registered with the CSPMP database and have logged on to (actively use) the database. The second measure will focus on the utilization rate of the CSPMP database prior to prescribing opioids to AHCCCS members. The baseline measurement will be reflective of Contract Year Ending (CYE; *federal fiscal year*) 2016.

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 opportunites.

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 were received and reviewed during the quarter.

    - 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 as well as their claims and encounters and 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

Durning the quarter, the final Managed Care regulations were released. There were notable changes as well as new requirements for the Quality Strategy. AHCCCS will be working to implement the new Rule and developing a revised Quality Strategy that is reflective of the requirements. 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. Work on the Quality Strategy is expected to begin in Quarter 4 of 2016.

Wavier Evaluation Planning

The AHCCCS Office of Intergovernmental Relations is responsible for coordinating the waiver evaluation process and is working in close collaboration with the Division of Health Care Management as well as other key areas within the agency.

The Waiver Evaluation Manager serves as the project lead and primary contact person for the CMS waiver evaluation project. The Waiver Evaluation Manager will be supported in this effort by the Office of Intergovernmental Relations Team. The Waiver Evaluation Manager is working closely with qualified staff in the Division of Health Care Management, including Clinical Quality Management staff who have extensive experience in conducting program evaluations, performance improvement initiatives, and quality improvement processes, including developing the study design, data collection and analysis and the reporting of findings. Other Divisions and AHCCCS staff are also involved in the waiver evaluation processes including the Office of the Director (OOD), Division of Member Services (DMS), Division of Business and Finance (DBF), Office of Business Intelligence (OBI), and the Information Services Division (ISD).

Independent Waiver Evaluation Timeline:

Quarters	Task Completed	Notes
Quarter 4 July-September 2015	**CRS and SMI Integration- Independent Evaluation Components** - Procured contract with Mercer as the independent evaluator for CRS and SMI integration demonstrations.	
Quarter 1 October-December 2015	**CRS and SMI Integration- Independent Evaluation Components** - Meetings were held with Mercer to establish a detailed method for evaluating the CRS and SMI integration demonstrations. - Organized internal planning meetings with AHCCCS staff responsible for data collection to ensure that there are no gaps in the evaluation process. **Other Independent Waiver Evaluation Components** - Determined HSAG (AHCCCS' EQRO) as the lead entity to conduct the independent validation of AHCCCS performance measures utilized for the waiver evaluation components.	

Quarters	Task Completed	Notes
Quarter 2 January-March 2016	**CRS and SMI Integration- Independent Evaluation** - Mercer acquired CRS and SMI data files including baseline data from AHCCCS, and starts data validation process. **Other Independent Waiver Evaluation Components** - Meetings were held with AHCCCS staff to develop project work plan and discuss timelines for deliverables.	**CRS and SMI Integration- Independent Evaluation** During this quarter AHCCCS and Mercer encountered several challenges with SMI and CRS data files. Mercer requested additional data files from AHCCCS. As result of this request, the timeline for completing the evaluation was moved back.
Quarter 3 April-June 2016	**CRS and SMI Integration- Independent Evaluation Components** - Conduct internal meetings with AHCCCS to review the data. - Mercer received additional data files from AHCCCS. **Other Independent Waiver Evaluation Components** - Obtained baseline and re-measurement data for the specified performance measures listed in the independent evaluation. - Started drafting the independent waiver evaluation report.	
Below are activities that are projected to occur in the upcoming quarters:		
Quarter 4 July-September 2016	**CRS and SMI Integration- Independent Evaluation Components** - Mercer completes data validation and analysis **Other Independent Waiver Evaluation Components** - Review and finalize independent waiver evaluation reports. - Submit final report to CMS	
Quarter 1 (FFY 2017) October-December 2016	**CRS and SMI Integration- Independent Evaluation Components** - Mercer submits the draft of the Independent evaluation report to AHCCCS - AHCCCS reviews the independent evaluation report draft, and submits the final draft to CMS	

Arizona Health Care Cost Containment System (AHCCCS)
Quarterly Random Moment Time Study Report
April 2016 – June 2016

The April through June 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	April - June 2016
Administrative	3,206
Direct Service	3,208
Personal Care	4,747

The table below demonstrates the administrative, direct service, and personal care time study achieved the 85% return rate in the April to June 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	3,114	97.31%
Direct Service	3,400	3,303	97.15%
Personal Care	3,500	3,179	90.83%

Attachment 4:
Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended June 30, 2016

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

WAIVER PERIOD OCTOBER 1, 2011 THROUGH SEPTEMBER 30, 2016:

	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	2,932,612	2,920,298	2,914,170	2,938,914	11,705,994	$ 4,785,196,877	
SSI	835.29	1.06	885.41	69.10%	611.79	487,522	488,940	488,957	491,591	1,957,010	1,197,272,905	
AC [1]			562.10	69.74%	391.98	527,244	430,723	365,132	310,396	1,633,495	640,301,673	
ALTCS-DD	4643.75	1.06	4922.38	67.38%	3316.47	72,525	73,161	73,971	74,826	294,483	976,643,321	
ALTCS-EPD	4503.21	1.052	4737.37	67.50%	3197.92	85,452	85,497	85,721	86,503	343,173	1,097,441,034	
Family Plan Ext [1]		1.058	17.04	90.00%	15.33	12,471	12,424	12,440	12,689	50,024	767,009	
											$ 8,697,622,818	MAP Subtotal
											103,890,985	Add DSH Allotment
											$ 8,801,513,803	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	2,911,571	2,891,338	2,903,188	2,919,097	11,625,194	$ 4,928,114,907	
SSI	938.53	67.86%	636.90	494,663	497,031	499,639	503,190	1,994,523	1,270,309,041	
AC [1]	601.40	68.73%	413.35	274,990	248,817	228,204	217,114	969,125	400,587,368	
ALTCS-DD	5217.72	65.83%	3434.67	75,645	76,473	77,287	78,041	307,446	1,055,975,076	
ALTCS-EPD	4983.71	66.02%	3290.01	86,820	86,066	86,294	87,124	346,304	1,139,343,098	
Family Plan Ext [1]	18.42	90.00%	16.58	13,104	13,824	14,187	14,856	55,971	927,946	
									$ 8,795,257,436	MAP Subtotal
									106,384,369	Add DSH Allotment
									$ 8,901,641,805	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	70.58%	457.18	2,892,027	2,839,692	2,956,084	3,114,091	11,801,894	$ 5,395,577,593	
SSI	994.84	69.28%	689.24	506,478	513,824	522,370	528,225	2,070,897	1,427,343,594	
AC [1]	596.85	69.88%	417.08	206,419	87	2	-	206,508	86,131,202	
ALTCS-DD	5530.78	67.35%	3725.17	78,847	79,686	80,675	81,763	320,971	1,195,673,034	
ALTCS-EPD	5242.86	67.53%	3540.39	87,670	87,887	88,728	89,351	353,636	1,252,007,993	
Family Plan Ext [1]	13.39	90.00%	12.05	14,885	-	-	-	14,885	179,426.00	
Expansion State Adults [1]	622.16	85.37%	531.17	-	444,295	624,885	756,693	1,825,873	969,844,722	
									$ 10,326,757,565	MAP Subtotal
									107,980,135	Add DSH Allotment
									$ 10,434,737,700	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	71.44%	486.81	3,146,769	3,085,762	3,106,479	3,211,423	12,550,433	$ 6,109,636,290	
SSI	1054.53	70.25%	740.76	535,478	541,798	542,226	541,861	2,161,363	1,601,056,119	
AC	0.00	68.41%	0.00	-	-	-	-	-	-	
ALTCS-DD	5862.63	68.54%	4018.28	82,731	83,833	84,839	85,615	337,018	1,354,231,596	
ALTCS-EPD	5515.49	68.68%	3788.25	90,001	89,870	89,918	90,010	359,799	1,363,009,671	
Family Plan Ext	0.00	90.00%	0.00	-	-	-	-	-	-	
Expansion State Adults	583.96	87.73%	512.30	818,580	836,825	847,040.00	867,873.00	3,370,318	1,726,602,275	
									$ 12,154,535,950	MAP Subtotal
									109,707,817	Add DSH Allotment
									$ 12,264,243,767	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	71.10%	509.70	3,264,705	3,258,820	3,233,208		9,756,733	$ 4,972,974,963	
SSI	1117.81	70.30%	785.84	545,786	545,931	539,360		1,631,077	1,281,758,047	
AC	0.00	71.66%	0.00	-	-	-		-	-	
ALTCS-DD	6214.39	68.97%	4285.92	86,378	87,100	87,913		261,391	1,120,300,228	
ALTCS-EPD	5802.30	69.06%	4006.98	89,858	89,287	88,024		267,169	1,070,540,637	
Family Plan Ext	0.00	90.00%	0.00	-	-	-		-	-	
Expansion State Adults	546.29	90.28%	493.20	918,394	932,555	929,443		2,780,392	1,371,290,267	
									$ 9,816,864,142	MAP Subtotal
									110,036,940	Add DSH Allotment
									$ 9,926,901,082	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 6/30/2016

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended June 30, 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	$ 2,217,715,321	$ 103,890,985	$ 2,321,606,306	$ 502,890,921	$ 191,249,757	$ 175,610,617	$ 151,638,753	$ 164,685,415	$ 167,197	$ -	$ -	$ -	$ 458,635	$ -	$ 1,186,701,295	$ 1,134,905,011
QE 3/12	2,177,967,000	-	2,177,967,000	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	883,194,412
QE 6/12	2,153,164,771	-	2,153,164,771	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	717,892,971
QE 9/12	2,148,775,726	-	2,148,775,726	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	808,122,139
QE 12/12	2,208,652,305	106,384,369	2,315,036,674	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	876,747,291
QE 3/13	2,191,139,952	-	2,191,139,952	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	846,784,696
QE 6/13	2,192,855,984	-	2,192,855,984	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	777,547,439
QE 9/13	2,202,609,195	-	2,202,609,195	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	682,306,150
QE 12/13	2,361,636,436	107,980,135	2,469,616,571	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	963,992,880
QE 3/14	2,496,424,735	-	2,496,424,735	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	1,011,773,360
QE 6/14	2,658,076,728	-	2,658,076,728	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	1,050,051,653
QE 9/14	2,810,619,666	-	2,810,619,666	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	946,045,637
QE 12/14	3,021,268,804	109,707,817	3,130,976,621	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	1,104,624,821
QE 3/15	3,009,530,528	-	3,009,530,528	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	1,255,951,247
QE 6/15	3,029,390,083	-	3,029,390,083	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	1,118,347,837
QE 9/15	3,094,346,535	-	3,094,346,535	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	1,210,283,587
QE 12/15	3,276,127,782	-	3,276,127,782	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	1,253,162,999
QE 3/16	3,281,032,820	-	3,281,032,820	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	1,334,352,829
QE 6/16	3,259,703,540	110,036,940	3,369,740,480	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	1,399,202,477
QE 9/16		-	-												-	-
	$ 49,791,037,911	$ 538,000,246	$ 50,329,038,157	$ 11,871,000,001	$ 5,052,609,067	$ 1,140,143,609	$ 3,452,804,638	$ 3,765,234,043	$ 1,873,165	$ 536,303,125	$ 877,838,625	$ 192,196,254	$ 453,960	$ 4,063,292,234	$ 30,953,748,721	$ 19,375,289,436

Last Updated: 8/15/2016

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended June 30, 2016

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 SEPTEMBER 30, 2016								
DY 01	$ 8,801,513,803	$ 5,636,628,460	$ 3,164,885,343	35.96%				
DY 02	8,901,641,805	5,843,699,204	3,057,942,601	34.35%				
DY 03	10,434,737,700	6,463,297,402	3,971,440,298	38.06%				
DY 04	12,264,243,767	7,368,907,159	4,895,336,608	39.92%				
DY 05	9,926,901,082	5,641,216,496	4,285,684,586	43.17%	$ 50,329,038,157	$ 30,953,748,721	$ 19,375,289,436	38.50%
	$ 50,329,038,157	$ 30,953,748,721	$ 19,375,289,436					

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended June 30, 2016

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	Total
AC	917,872,804	582,623,717	123,166,560	19,811,713	(30,498)	1,643,444,296
AFDC/SOBRA	3,415,789,172	3,586,504,387	3,527,885,273	3,588,002,500	2,759,820,419	16,878,001,751
ALTCS-EPD	1,062,183,658	1,167,575,274	1,196,152,014	1,245,896,337	889,062,620	5,560,869,903
ALTCS-DD	939,086,691	1,005,675,270	1,067,615,389	1,170,344,447	923,401,517	5,106,123,314
DSH/CAHP	155,762,651	163,493,529	162,262,955	160,244,372	152,785,300	794,548,807
Expansion State Adults	-	-	1,135,769,554	1,965,092,226	1,515,683,326	4,616,545,106
Family Planning Extension	830,631	1,008,110	195,976	(1,337)	(4)	2,033,376
MED	673,818	-	-	-	-	673,818
SNCP/DSHP	296,636,120	558,334,298	240,250,917	119,071,612	99,320,126	1,313,613,073
SSI	1,349,590,806	1,427,969,861	1,538,667,090	1,715,172,037	1,251,913,442	7,283,313,236
Uncomp Care IHS/638	22,866,717	97,192,513	53,888,765	13,437,080	5,038,840	192,423,915
Subtotal	8,161,293,068	8,590,376,959	9,045,854,493	9,997,070,987	7,596,995,088	43,391,590,595
New Adult Group	-	-	108,395,848	308,940,231	337,740,428	755,076,507
Total	8,161,293,068	8,590,376,959	9,154,250,341	10,306,011,218	7,934,735,516	44,146,667,102

Federal Share

Waiver Name	01	02	03	04	05	Total
AC	640,090,639	400,448,944	86,072,211	13,553,662	(21,847)	1,140,143,609
AFDC/SOBRA	2,385,743,913	2,469,328,528	2,490,069,960	2,563,446,475	1,962,411,125	11,871,000,001
ALTCS-EPD	717,019,019	770,777,705	807,734,262	855,729,791	613,973,266	3,765,234,043
ALTCS-DD	632,712,981	662,006,159	719,076,404	802,160,462	636,848,632	3,452,804,638
DSH/CAHP	104,828,265	107,382,550	109,089,385	109,703,296	105,299,629	536,303,125
Expansion State Adults	-	-	969,694,639	1,724,518,528	1,369,079,067	4,063,292,234
Family Planning Extension	767,009	927,946	179,426	(1,212)	(4)	1,873,165
MED	453,960	-	-	-	-	453,960
SNCP/DSHP	199,636,108	366,713,968	161,520,692	81,516,426	68,451,431	877,838,625
SSI	932,528,531	969,045,725	1,066,014,593	1,204,872,742	880,147,476	5,052,609,067
Uncomp Care IHS/638	22,848,035	97,067,679	53,845,830	13,406,989	5,027,721	192,196,254
Subtotal	5,636,628,460	5,843,699,204	6,463,297,402	7,368,907,159	5,641,216,496	30,953,748,721
New Adult Group	-	-	108,395,848	308,940,231	337,740,428	755,076,507
Total	5,636,628,460	5,843,699,204	6,571,693,250	7,677,847,390	5,978,956,924	31,708,825,228

Adjustments to Schedule C Waiver 11-W00275/9

Total Computable

Waiver Name	01	02	03	04	05	Total
AC	313,572	210,756	87,745	(7)	326	612,392
AFDC/SOBRA	1,014,881	1,090,143	990,293	5,056,392	4,912,060	13,063,769
SSI	365,158	399,101	398,723	2,391,771	2,371,156	5,925,909
Expansion State Adults	-	-	223,239	3,043,744	3,208,358	6,475,341
ALTCS-DD (Cost Sharing)[1]	-	-	-	-	-	-
CAHP[2]	(1,693,611)	(1,700,000)	(1,700,000)	(10,491,900)	(10,491,900)	(26,077,411)
Total	-	-	-	-	-	-

Federal Share

Waiver Name	01	02	03	04	05	Total
AC	211,034	138,424	58,991	(5)	225	408,669
AFDC/SOBRA	683,014	716,006	665,774	3,461,607	3,385,392	8,911,793
SSI	245,752	262,130	268,062	1,637,406	1,634,201	4,047,551
Expansion State Adults	-	-	150,083	2,083,747	2,211,200	4,445,030
ALTCS-DD (Cost Sharing)[1]	-	-	-	-	-	-
CAHP[2]	(1,139,800)	(1,116,560)	(1,142,910)	(7,182,755)	(7,231,017)	(17,813,042)
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

[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.

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended June 30, 2016

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	Total
AC	918,186,376	582,834,473	123,254,305	19,811,706	(30,172)	1,644,056,688
AFDC/SOBRA	3,416,804,053	3,587,594,530	3,528,875,566	3,593,058,892	2,764,732,479	16,891,065,520
ALTCS-EPD	1,062,183,658	1,167,575,274	1,196,152,014	1,245,896,337	889,062,620	5,560,869,903
ALTCS-DD	939,086,691	1,005,675,270	1,067,615,389	1,170,344,447	923,401,517	5,106,123,314
DSH/CAHP	154,069,040	161,793,529	160,562,955	149,752,472	142,293,400	768,471,396
Expansion State Adults	-	-	1,135,992,793	1,968,135,970	1,518,891,684	4,623,020,447
Family Planning Extension	830,631	1,008,110	195,976	(1,337)	(4)	2,033,376
MED	673,818	-	-	-	-	673,818
SNCP/DSHP	296,636,120	558,334,298	240,250,917	119,071,612	99,320,126	1,313,613,073
SSI	1,349,955,964	1,428,368,962	1,539,065,813	1,717,563,808	1,254,284,598	7,289,239,145
Uncomp Care IHS/638	22,866,717	97,192,513	53,888,765	13,437,080	5,038,840	192,423,915
Subtotal	8,161,293,068	8,590,376,959	9,045,854,493	9,997,070,987	7,596,995,088	43,391,590,595
New Adult Group	-	-	108,395,848	308,940,231	337,740,428	755,076,507
Total	8,161,293,068	8,590,376,959	9,154,250,341	10,306,011,218	7,934,735,516	44,146,667,102

Federal Share

Waiver Name	01	02	03	04	05	Total
AC	640,301,673	400,587,368	86,131,202	13,553,657	(21,622)	1,140,552,278
AFDC/SOBRA	2,386,426,927	2,470,044,534	2,490,735,734	2,566,908,082	1,965,796,517	11,879,911,794
ALTCS-EPD	717,019,019	770,777,705	807,734,262	855,729,791	613,973,266	3,765,234,043
ALTCS-DD	632,712,981	662,006,159	719,076,404	802,160,462	636,848,632	3,452,804,638
DSH/CAHP	103,688,465	106,265,990	107,946,475	102,520,541	98,068,612	518,490,083
Expansion State Adults	-	-	969,844,722	1,726,602,275	1,371,290,267	4,067,737,264
Family Planning Extension	767,009	927,946	179,426	(1,212)	(4)	1,873,165
MED	453,960	-	-	-	-	453,960
SNCP/DSHP	199,636,108	366,713,968	161,520,692	81,516,426	68,451,431	877,838,625
SSI	932,774,283	969,307,855	1,066,282,655	1,206,510,148	881,781,677	5,056,656,618
Uncomp Care IHS/638	22,848,035	97,067,679	53,845,830	13,406,989	5,027,721	192,196,254
Subtotal	5,636,628,460	5,843,699,204	6,463,297,402	7,368,907,159	5,641,216,496	30,953,748,721
New Adult Group	-	-	108,395,848	308,940,231	337,740,428	755,076,507
Total	5,636,628,460	5,843,699,204	6,571,693,250	7,677,847,390	5,978,956,924	31,708,825,228

Calculation of Effective FMAP:

AFDC/SOBRA					
Federal	2,386,426,927	2,470,044,534	2,490,735,734	2,566,908,082	1,965,796,517
Total	3,416,804,053	3,587,594,530	3,528,875,566	3,593,058,892	2,764,732,479
Effective FMAP	0.698438333	0.688496014	0.705815688	0.714407461	0.711025943
SSI					
Federal	932,774,283	969,307,855	1,066,282,655	1,206,510,148	881,781,677
Total	1,349,955,964	1,428,368,962	1,539,065,813	1,717,563,808	1,254,284,598
Effective FMAP	0.690966452	0.678611676	0.692811604	0.702454338	0.70301563
ALTCS-EPD					
Federal	717,019,019	770,777,705	807,734,262	855,729,791	613,973,266
Total	1,062,183,658	1,167,575,274	1,196,152,014	1,245,896,337	889,062,620
Effective FMAP	0.675042412	0.660152473	0.675277266	0.686838676	0.690584951
ALTCS-DD					
Federal	632,712,981	662,006,159	719,076,404	802,160,462	636,848,632
Total	939,086,691	1,005,675,270	1,067,615,389	1,170,344,447	923,401,517
Effective FMAP	0.673753538	0.658270297	0.673535068	0.68540545	0.689676831
AC					
Federal	640,301,673	400,587,368	86,131,202	13,553,657	(21,622)
Total	918,186,376	582,834,473	123,254,305	19,811,706	(30,172)
Effective FMAP	0.697354796	0.687308981	0.698808873	0.684123669	0.716634943
Expansion State Adults					
Federal	-	-	969,844,722	1,726,602,275	1,371,290,267
Total	-	-	1,135,992,793	1,968,135,970	1,518,891,684
Effective FMAP			0.853741967	0.877277943	0.902822948
New Adult Group					
Federal	-	-	108,395,848	308,940,231	337,740,428
Total	-	-	108,395,848	308,940,231	337,740,428
Effective FMAP			1	1	1

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended June 30, 2016

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	2,932,612	487,522	72,525	85,452	527,244	467	12,471		
Quarter Ended March 31, 2012	2,920,298	488,940	73,161	85,497	430,723	-	12,424		
Quarter Ended June 30, 2012	2,914,170	488,957	73,971	85,721	365,132	-	12,440		
Quarter Ended September 30, 2012	2,938,914	491,591	74,826	86,503	310,396	-	12,689		
Quarter Ended December 31, 2012	2,911,571	494,663	75,645	86,820	274,990	-	13,104		
Quarter Ended March 31, 2013	2,891,338	497,031	76,473	86,066	248,817	-	13,824		
Quarter Ended June 30, 2013	2,903,188	499,639	77,287	86,294	228,204	-	14,187		
Quarter Ended September 30, 2013	2,919,097	503,190	78,041	87,124	217,114	-	14,856		
Quarter Ended December 31, 2013	2,892,027	506,478	78,847	87,670	206,419	-	14,885		
Quarter Ended March 31, 2014	2,839,692	513,824	79,686	87,887	87	-	-	444,295	39,025
Quarter Ended June 30, 2014	2,956,084	522,370	80,675	88,728	2	-	-	624,885	86,597
Quarter Ended September 30, 2014	3,114,091	528,225	81,763	89,351	-	-	-	756,693	122,976
Quarter Ended December 31, 2014	3,146,769	535,478	82,731	90,001	-	-	-	818,580	149,864
Quarter Ended March 31, 2015	3,085,762	541,798	83,833	89,870	-	-	-	836,825	191,240
Quarter Ended June 30, 2015	3,106,479	542,226	84,839	89,918	-	-	-	847,040	245,357
Quarter Ended September 30, 2015	3,211,423	541,861	85,615	90,010	-	-	-	867,873	284,997
Quarter Ended December 31, 2015	3,264,705	545,786	86,378	89,858	-	-	-	918,394	312,498
Quarter Ended March 31, 2016	3,258,820	545,931	87,100	89,287	-	-	-	932,555	330,936
Quarter Ended June 30, 2016	3,233,208	539,360	87,913	88,024	-	-	-	929,443	330,484
Quarter Ended September 30, 2016									

	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		

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended June 30, 2016

VI. Allocation of Disproportionate Share Hospital Payments

Federal Share

	FFY 2012	FFY 2013	FFY 2014	FFY 2015	FFY 2016	
Total Allotment	**103,890,985**	**106,384,369**	**107,980,135**	**109,707,817**	**110,036,940**	**538,000,246**
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						
Total Reported to Date	103,688,465	106,265,990	107,946,475	102,520,542	98,068,611	518,490,082
Unused Allotment	**202,520**	**118,379**	**33,660**	**7,187,275**	**11,968,329**	**19,510,164**

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended June 30, 2016

VII. BUDGET NEUTRALITY TRACKING SCHEDULE -- NEW ADULT GROUP

WAIVER PERIOD JANUARY 1, 2014 THROUGH SEPTEMBER 30, 2016:

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	-	39,025	86,597	122,976	248,598	143,823,887

	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	149,864	191,240	245,357	284,997	871,458	527,869,457

	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	312,498	330,936	330,484		973,918	617,659,531

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	22,577,524	-	22,577,524	13,870,414	8,707,110
QE 6/14	50,099,828	-	50,099,828	34,313,342	15,786,486
QE 9/14	71,146,535	-	71,146,535	47,984,458	23,162,077
QE 12/14	90,777,328	-	90,777,328	46,004,135	44,773,193
QE 3/15	115,840,069	-	115,840,069	70,387,348	45,452,721
QE 6/15	148,620,434	-	148,620,434	85,319,153	63,301,281
QE 9/15	172,631,626	-	172,631,626	97,948,283	74,683,343
QE 12/15	198,186,467	-	198,186,467	113,800,738	84,385,729
QE 3/16	209,879,861	-	209,879,861	122,290,142	87,589,719
QE 6/16	209,593,202	-	209,593,202	123,158,494	86,434,708
QE 9/16					
	$ 1,289,352,875	$ -	$ 1,289,352,875	$ 755,076,507	$ 534,276,368

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	$ 143,823,887	$ 96,168,214	$ 47,655,673	33.13%				
DY 04	527,869,457	299,658,919	228,210,538	43.23%				
DY 05	617,659,531	359,249,374	258,410,157	41.84%	$ 1,289,352,875	$ 755,076,507	$ 534,276,368	41.44%
	$ 1,289,352,875	$ 755,076,507	$ 534,276,368					

Based on CMS-64 certification date of 6/30/2016