AHCCCS
Arizona Health Care Cost Containment System

Arizona's Section 1115 Waiver Demonstration Annual Report

Federal Fiscal Year 2018

October 1, 2017 – September 30, 2018

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I. Introduction

Since its inception, the Arizona Health Care Cost Containment System (AHCCCS), Arizona's single state Medicaid agency, has had the unique distinction of operating a statewide managed care program under the Section 1115 Research and Demonstration Waiver. During its 36 years of operation, the program has proven to be an effective model for the delivery of high quality and cost effective health care services to low income populations. With a model based on competition and member choice, AHCCCS has frequently been a pioneer in testing health care policies and financing strategies, continuously seeking to improve health care outcomes while containing costs.

On September 30, 2016, the Centers for Medicare and Medicaid Services (CMS) approved an extension of Arizona's 1115 Waiver for a five year period from October 1, 2016 to September 30, 2021. Under the new five-year waiver demonstration, the State will continue to modernize its Medicaid program and continue many of the existing authorities that allows AHCCCS to maintain its unique and successful managed care model, use home and community based services for members with long term care needs and other innovations that make AHCCCS one of the most cost effective Medicaid programs in the nation.

Pursuant to the Special Terms and Conditions (STCs), paragraph 41, AHCCCS is required to submit an annual progress report to CMS. The purpose of the annual report is to document accomplishments, project implementation status, quantitative and case study findings, utilization data, and policy and administrative updates related to Arizona's 1115 Waiver Demonstration.

II. Waiver Demonstration Changes

In its effort to reform and modernize the Medicaid program, AHCCCS continues to work with CMS on various waiver amendment requests. Below is a summary of the waiver amendments that have been filed in fiscal years 2018-2019.

AHCCCS Works Waiver Amendment

Arizona Revised Statutes (A.R.S.) 36-2903.09 requires AHCCCS to request an amendment to the current Section 1115 Waiver to allow Arizona to implement a work requirement, additional eligibility verification requirements, and a lifetime limit on coverage for able bodied adult AHCCCS members.[1] Each year, AHCCCS must re-apply to CMS for each element of A.R.S. 36-2903.09 that CMS has not yet approved.

Pursuant to A.R.S. 36-2903.09 and taking into consideration 500 plus comments, AHCCCS submitted a waiver amendment request on December 19, 2017 to CMS seeking authority to implement work requirements and a five-year maximum lifetime benefit limit for able bodied AHCCCS members. This waiver amendment, titled "AHCCCS Works" is designed to provide low-income, able-bodied adults the tools needed to gain and maintain meaningful employment, job training, and education. Able-bodied adults between the ages of 19 and 55 who do not qualify for an exemption will be required to meet the following activities or combination of activities for at least 20 hours per week to qualify for AHCCCS coverage:

- Be employed or actively seek employment;
- Attend school; or

[1] A.R.S. 36-2903.09: http://www.azleg.gov/viewdocument/?docName=http://www.azleg.gov/ars/36/02903-09.htm

- Partake in Employment Support and Development program as defined in the waiver request.

Certain individuals are exempted from the AHCCCS Works requirements, including:

- Those who are at least 55 years old;
- American Indians;
- Pregnant Women and Women up to the end of the month in which the 60th day of post-pregnancy occurs;
- Former Arizona foster youths up to age 26;
- Individuals determined to have a serious mental illness (SMI);
- Individuals currently receiving temporary or permanent long-term disability benefits from a private insurer or from the government;
- Individuals who are determined to be medically frail;
- Full-time high school students who are older than 18 years old;
- Full-time college or graduate students;
- Victims of domestic violence;
- Individuals who are homeless;
- Individuals who have recently been directly impacted by a catastrophic event such as a natural disaster or the death of a family member living in the same household;
- Parents, caretaker relatives, and foster parents; or
- Caregivers of a family member who is enrolled in the Arizona Long Term Care System.

AHCCCS sought broad-based stakeholder feedback regarding the AHCCCS Works waiver amendment in accordance with 42 C.F.R 431.408. In January 2017, over 140 participants attended AHCCCS community forums in Phoenix, Flagstaff, and Tucson, as well as an in-person tribal consultation.[2] In addition, AHCCCS has received more than 500 written public comments, including 14 letters from tribal nations and tribal affiliated organizations.

Prior Quarter Coverage Waiver Amendment

The Arizona Health Care Cost Containment System (AHCCCS) submitted a waiver amendment request on April 6, 2018, to CMS seeking to limit retroactive coverage to the month of application, consistent with Arizona's historical waiver authority prior to January 2014. AHCCCS sought stakeholder feedback regarding the Proposal to Waive Prior Quarter Coverage in accordance with 42 C.F.R 431.408. The Agency conducted public forum meetings on January 18th in Flagstaff, on January 26th in Phoenix, and on January 29th in Tucson. In addition, the waiver amendment was presented at the State Medicaid Advisory Committee (SMAC) meeting on February 7, 2018, and in a tribal consultation meeting on January 11, 2018.

AHCCCS Completed Care Technical Correction Amendment

The Arizona Health Care Cost Containment System (AHCCCS) is submitting a formal request to amend Arizona's Section 1115 Research and Demonstration Waiver. AHCCCS proposes technical amendments to the language of the Special Terms and Conditions to reflect the delivery system changes resulting from the AHCCCS Complete Care managed care contract award.

[2] SB 1092 Waiver Amendment Webpage:
https://www.azahcccs.gov/Resources/Federal/sb1092legislativedirectivewaiverproposal.html

On October 1, 2018, AHCCCS transitioned 1.5 million AHCCCS members into managed care plans called AHCCCS Complete Care plans that provide integrated physical and behavioral health care services. Specifically, the ACC Plans serve AHCCCS Acute Care Program enrollees except for adults determined to have a Serious Mental Illness and foster children enrolled with the Comprehensive Medical and Dental Program (CMDP).

The public has the opportunity to review and submit comments on the proposal posted on the AHCCCS website.[3] All public comments received by December 28, 2018, will be reviewed, considered and included in the final proposal sent to CMS.

III. 1115 Waiver Post Award Forum

Pursuant to STC 10 and 42 CFR 431.420(c), within six months of the 1115 waiver demonstration implementation, and annually thereafter, Arizona is required to host a post award public forum in order to give stakeholders the opportunity to provide meaningful comment on the progress of the demonstration.

AHCCCS hosted community meetings across the state to provide the public with information about its 1115 waiver demonstration program. The Agency hosted three public forum meetings: January 18, 2018 in Phoenix; January 26, 2018 in Tucson; and January 29, 2018 in Flagstaff. AHCCCS presented the details of its demonstration waiver at the Arizona State Medicaid Advisory Committee (SMAC) on February 7, 2018 and at an in-person tribal consultation on January 11, 2018. All the stakeholder meetings had telephonic conference capabilities that ensured statewide accessibility. The Post Award Public Forum presentation slides can be found in Appendix 2. Below is a summary of the key themes that emerged from the post award forums.

Prior Quarter Coverage Waiver

Stakeholders expressed concern that a waiver of Prior Quarter Coverage could increase uncompensated care costs for hospitals, skilled nursing facilities and other health care providers. Some stakeholders are concerned that the proposal to waive Prior Quarter Coverage will shift health care costs, resulting in increased out-of-pocket spending, medical bankruptcies and uncompensated care. Particular concern was expressed in regard to potential disruptions in care for individuals with complex medical conditions. Several stakeholders recommended that AHCCCS conduct an aggressive community education and outreach program in conjunction with the Prior Quarter Coverage waiver request and corresponding policy change.

AHCCCS Works Waiver

Many stakeholders are concerned that imposing a lifetime limit on AHCCCS eligibility could leave members without coverage when the Medicaid safety-net is most needed. Many are concerned that the lifetime limit will undermine access to care for members. Some assert that a lifetime limit is fundamentally inconsistent with the objective of the Medicaid statute. Stakeholders are concerned that the AHCCCS Works reporting requirement will increase costs and administrative burden for the State. Many also expressed concern that these requirements would place undue burden on AHCCCS members with very limited resources and ultimately would result in otherwise eligible members losing Medicaid coverage. Stakeholders also recommended robust monitoring and evaluation of the AHCCCS Works program.

[3] https://www.azahcccs.gov/Resources/Federal/PendingWaivers/ACCTechnicalAmendmentCorrection.html

IMD Waiver

Many stakeholders have urged CMS to approve Arizona's waiver request to provide cost-effective services in IMDs for managed care and fee-for-service members.

IV. Outreach and Innovation Activities

AHCCCS conducts numerous outreach activities across Arizona to educate the community about AHCCCS programs, partnerships, and policy changes. Below is a summary of the Agency's outreach activities in FY 2018.

The Division of Health Care Advocacy and Advancement (DHCAA)

The Division of Health Care Advocacy and Advancement (DHCAA) at AHCCCS is tasked with supporting members, family members and other stakeholders in navigating the Medicaid delivery system. DHCAA has three departments that advocate on behalf of members:

- *The Office of Human Rights (OHR)*—Provides advocacy to individuals determined to have a serious mental illness to help them understand, protect and exercise their rights, facilitate self-advocacy through education and obtain access to behavioral health services in the Arizona Medicaid delivery system. OHR's community engagement and advocacy activities includes, but is not limited to, special assistance home visits, hospital visits, staffing, provider coordination, grievance and appeal matters, Individual Service Planning (ISP) meetings, jail visits, intakes, general outreach and education. In 2017, OHR eliminated the waitlist for special assistance services and currently provides assistance to the largest number of individuals ever. OHR has 2,504 individuals identified as Special Assistance and provides direct advocacy via assignment to 702 members.

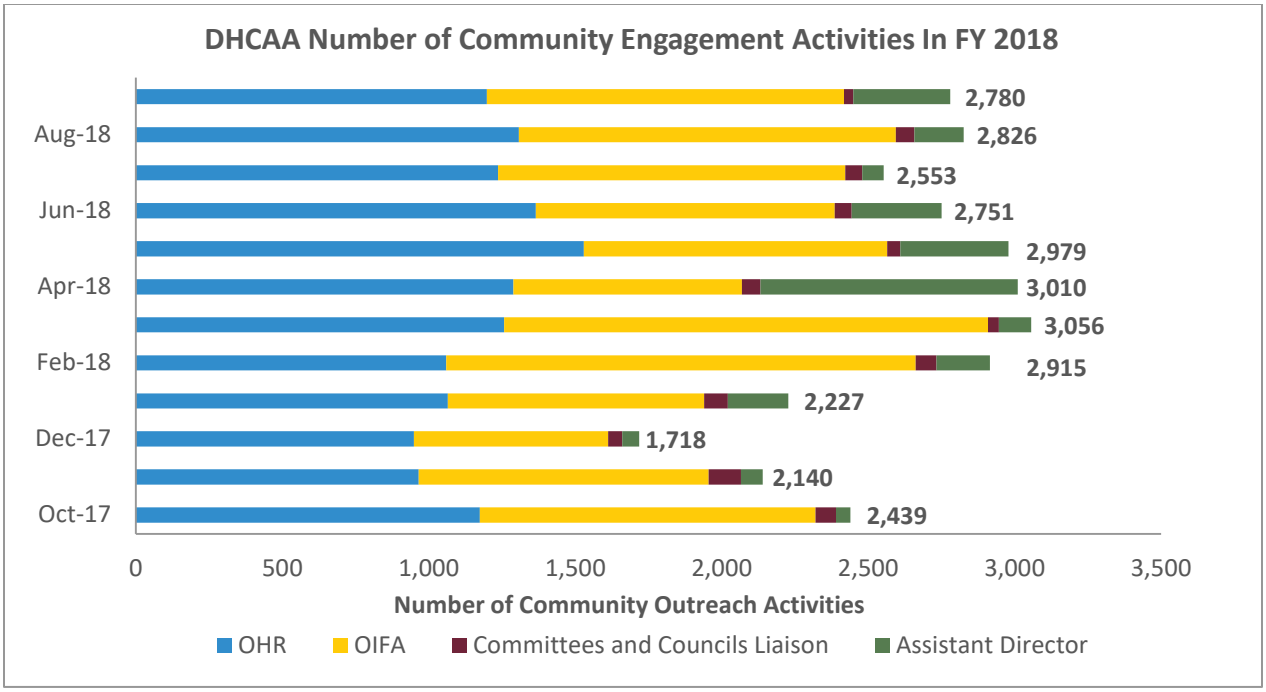
- *The Office of Individuals and Family Affairs (OIFA)*—Promotes recovery, resiliency, and wellness for individuals with mental health and substance abuse challenges. OIFA builds partnerships with individuals, families of choice, youth, communities, organizations and we collaborate with key leadership and community members in the decision making process at all levels of the behavioral health system. OIFA leverages the strategies below to advocate on behalf of members and families:
    - OIFA works to ensure AHCCCS members and their families have direct and meaningful input into the behavioral health system, policies, programs and practices that affect services. This is accomplished by a variety of methods including supporting community advocacy, ensuring peer and family voice is heard at the policy making level, and reviewing documents that are intended to be shared with the stakeholders;
    - OIFA assists and promotes the Peer and Family Career Academy which provides quality continuing education for peer and family support employees by offering classes that enhance and strengthen their skills and knowledge (e.g. forensic, housing, leadership and supervision);
    - OIFA Advisory Council was established to allow members, families, and stakeholders to discuss system issues and advocacy opportunities;
    - One-on-one meetings with members to address system barriers and develop strategies that improve access to Medicaid services; and

- Created one page informational pamphlets to help members and families better understand how to access services.[4]

- *The Committees and Councils Liaison*—Oversees a number of committees and councils that advice AHCCCS on strategic planning, system operations, and policy changes. These councils and committees include:
  - *ALTCS Advisory Council*— Assist the ALTCS Program to develop and monitor a work plan that addresses opportunities for new service innovations or systemic issues impacting ALTCS Members. The Advisory Council consists of ALTCS members and their family/representatives, MCOs, providers, and advocacy agencies. The ALTCS Advisory Council meetings are held quarterly.
  - *Behavioral Health Planning Council*— Advises AHCCCS in planning and implementing a comprehensive community based system of Behavioral Health and Mental Health Services. The Council review plans provided by the State of Arizona and provides suggestions for additions and modifications.[5]
  - *State Medicaid Advisory Committee (SMAC)*—Reviews and advises the Medicaid agency on the operations, programs, and planning for Arizona's Medicaid program, including issues of concern to the community. SMAC meetings are held quarterly. [6]
  - *Autism Advisory*— Committee is charged with articulating a series of recommendations to the State for strengthening the health care system's ability to respond to the needs of AHCCCS members with or at risk for ASD, including those with comorbid diagnoses. The charge included focusing on individuals with varying levels of needs across the spectrum, including those who are able to live on their own and those who may require institutional levels of care, and addressing both the early identification of ASD and the development of person-centered care plans.[7]
  - *Arizona Council of Human Services Providers*— The Council provides a collective voice for members to influence local, state, and federal public policy decisions both legislatively and administratively. Member agencies' ability to provide high quality, evidence based programs is dependent on ensuring adequate funding is available to those who serve our most vulnerable citizens. Council staff establish and maintain strong relationships with elected officials, their staff, and state department staff (DES, DHS, AOC, etc.), and encourage member program staff to do the same on a local level.

The charts below delineate DHCAA's community engagement activities in FY 2018.

[4] https://www.azahcccs.gov/AHCCCS/HealthcareAdvocacy/OIFA.html
[5] Behavioral Health Planning Council: https://www.azahcccs.gov/Resources/Grants/CMHS/
[6] SMAC: https://www.azahcccs.gov/AHCCCS/HealthcareAdvocacy/smac.html
[7] Autism Advisory Council: https://www.azahcccs.gov/shared/asd.html



DHCAA Number of Community Engagement Activities in FY 2018 Table

FY 2018	OHR *(SMI Specific Community Engagement Activities)*	OIFA	Committees & Council Liaison	Assistant Director	Total
October-17	1,174	1,146	70	49	2,439
November-17	965	990	110	75	2,140
December-17	949	663	48	58	1,718
January-18	1,065	875	81	206	2,227
February-18	1,059	1,603	71	182	2,915
March-18	1,257	1,652	37	110	3,056
April-18	1,289	780	63	878	3,010
May-18	1,529	1,036	45	369	2,979
June-18	1,365	1,021	57	308	2,751
July-18	1,236	1,186	58	73	2,553
August-18	1,307	1,287	64	168	2,826
September-18	1,198	1,219	32	331	2,780
Total FY 2018	**14,393**	**13,458**	**736**	**2,807**	**31,394**

The Divisions of Member Services (DMS)

The Division of Member Services (DMS) is responsible for AHCCCS eligibility and for the enrollment of members into health plans. DMS is also responsible for the accuracy of eligibility determinations, including oversight of Medicaid eligibility completed at Department of Economic Security (DES). DMS participated in a variety of outreach activities including:

- *Quarterly Justice Transition Meetings*—DMS provided an overview of ACC enrollment and discussed partnerships/collaborations between AHCCCS and State/County Justice Community Partners.
- *Juvenile Justice Eligibility and Enrollment Meetings*— DMS discussed efforts to improve partnerships and collaborations between AHCCCS and Juvenile State/County Justice Community Partners.
- *DES/AHCCCS Community Partner Review*—DMS provided information on how stakeholders can become community partners in rural areas.
- *HEAplus Kiosk Onboarding Activities*— DMS reviewed kiosk operations at the Durango and MESA justice facilities and disseminated information on how the public can use these kiosks for enrollment.
- *ALTCS Presentations*—Over 283 participants attended meetings across the state regarding ALTCS eligibility and enrollment policies.

AHCCCS Complete Care System Delivery Transformation

On Oct. 1, 2018, AHCCCS streamlined services for 1.5 million members by transitioning them to seven new AHCCCCS Complete Care integrated health care plans. Member outreach and communication planning began in 2017. Across divisions, AHCCCS conducted more than 70 in-person community presentations across the state with members, families, providers and stakeholders, and posted the presentation as a video on the Agency's website.[8] AHCCCS created three videos (English and Spanish) for specific member populations and distributed them to members, providers, and other stakeholder through social media. A number of providers reported using the videos in their offices to educate their AHCCCS patients on the ACC health plans. Nine flyers and Frequently Asked Questions (FAQ) sheets were also created and distributed to stakeholders, with all questions posted on the AHCCCS website.

V. Enrollment Information

Table 1 contains a summary of the number of unduplicated enrollees for FY 2018 (October 1, 2017—September 30, 2018), by population categories. The table also includes the number of voluntarily and involuntary disenrolled members during this period.

Table 1

Population Groups	Number Enrollees	Number Voluntarily Disenrolled-Current Qtr	Number Involuntarily Disenrolled-Current Qtr
Acute AFDC/SOBRA	1,549,720	9,154	980,929
Acute SSI	219,891	693	80,161
Prop 204 Restoration	752,198	2,681	314,921
Adult Expansion	192,139	959	137,220
LTC DD	34,079	150	9,585
LTC EPD	40,708	185	17,400
Non-Waiver	64,272	579	51,828
Total	**2,853,007**	**14,401**	**1,592,044**

[8] ACC webpage content: https://www.azahcccs.gov/AHCCCS/Initiatives/AHCCCSCompleteCare/

Table 2 is a snapshot of the number of current enrollees (as of October 1, 2018) by funding categories as requested by CMS.

Table 2

State Reported Enrollment in the Demonstration (as requested)	Current Enrollees
Title XIX funded State Plan [9]	**1,336,748**
Title XXI funded State Plan [10]	**34,015**
Title XIX funded Expansion[11]	**387,727**
• **Prop 204 Restoration (0-100% FPL)**	310,816
• **Adult Expansion (100% - 133% FPL)**	76,911
Enrollment Current as of	10/1/18

VI. Consumer Issues

In support of the annual report to CMS, presented below is a summary of advocacy issues received in the Office of Client Advocacy (OCA) for FY 2018.

Table 1

Advocacy Issues[12]	Quarter 1 10/01/17-12/31/17	Quarter 2 1/1/18-3/31/18	Quarter 3 4/1/18-6/30/18	Quarter 4 7/1/18-9/30/18	Total
9+Billing Issues • Member reimbursements • Unpaid bills	45	24	25	40	**134**
Cost Sharing • Co-pays • Share of Cost (ALTCS) • Premiums (Kids Care, Medicare)	5	11	3	4	**23**
Covered Services	57	57	61	33	**208**
ALTCS • Resources • Income • Medical	16	15	10	16	**57**

[9] SSI Cash and Related, 1931 Families and Children, 1931 Related, TMA, SOBRA child and pregnant, ALTCS, FTW, QMB, BCCP, SLMB, QI-1

[10] KidsCare

[11] Prop 204 Restoration & Adult Expansion

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

DES • Income • Incorrect determination • Improper referrals	76	124	63	39	**302**
KidsCare • Income • Incorrect determination	5	5	1	0	**11**
SSI/Medical Assistance Only • Income • Not categorically linked	30	40	24	16	**110**
Information • Status of application • Eligibility Criteria • Community Resources • Notification (Did not receive or didn't understand)	168	118	74	162	**522**
Medicare • Medicare Coverage • Medicare Savings Program • Medicare Part D	0	1	10	9	**20**
Prescriptions • Prescription coverage • Prescription denial	64	67	22	24	**177**
Fraud-Referred to Office of Inspector General (OIG)	0	0	0	2	**2**
Quality of Care-Referred to Division of Health Care Management (DHCM)	7	15	11	22	**55**
Total	**473**	**477**	**304**	**367**	**1,621**

Table 2

Issue Originator[13]	Quarter 1 10/01/17-12/31/17	Quarter 2 1/1/18-3/31/18	Quarter 3 4/1/18-6/30/18	Quarter 4 7/1/18-9/30/18	Total
Applicant, Member or Representative	439	401	269	305	**1,414**
CMS	4	4	4	2	**14**
Governor's Office	1	10	22	38	**71**
Ombudsmen/Advocates/Other Agencies…	20	51	9	18	**98**
Senate & House	9	11	0	4	**24**
Total	**473**	**477**	**304**	**367**	**1,621**

[13] This data was compiled from the OCA logs by the OCA Client Advocate and the Member Liaison.

VII. Complaints and Grievances

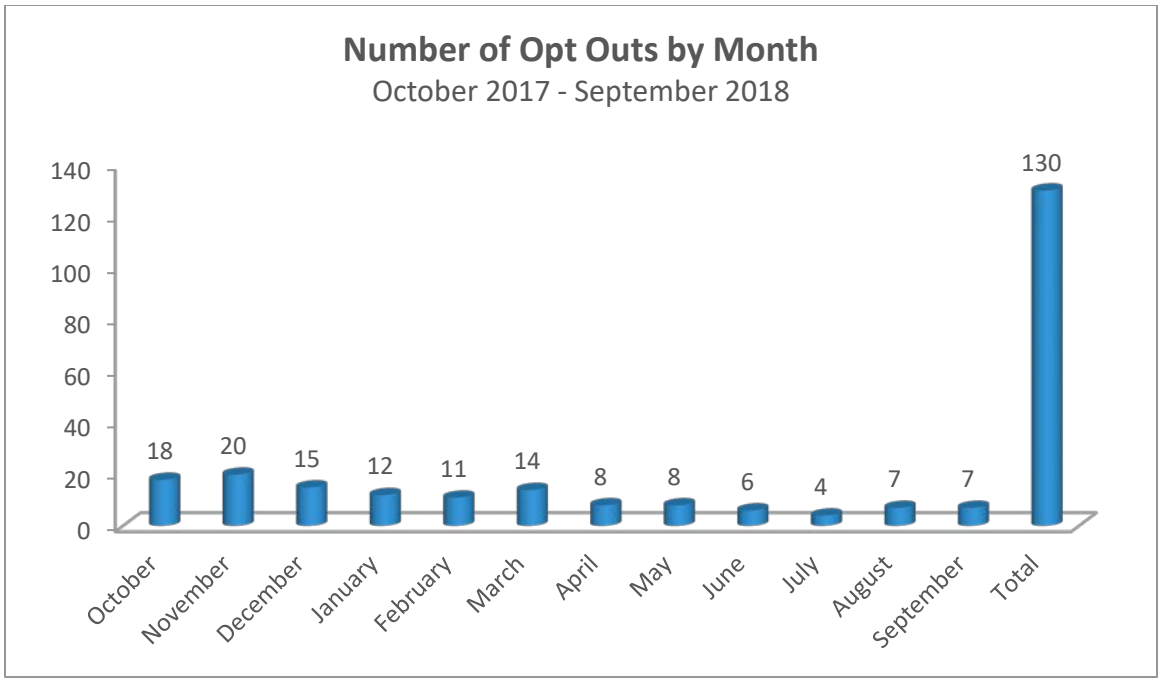
In support of the annual report to CMS, presented below is a summary of the number of complaints and grievances filed on behalf of beneficiaries participating in the SMI and CRS integration projects, broken down by access to care, health plan and provider satisfaction.

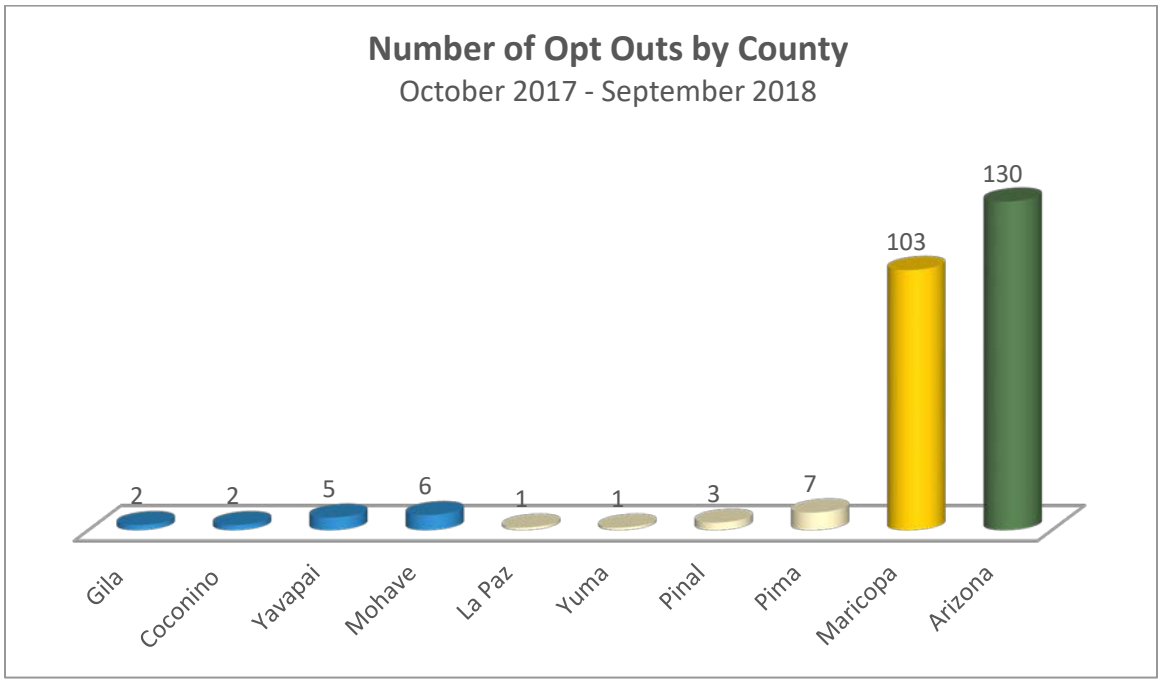
SMI Member Grievances and Complaints	Quarter 1 10/01/17-12/31/17	Quarter 2 1/1/18-3/31/18	Quarter 3 4/1/18-6/30/18	Quarter 4 7/1/18-9/30/18	Total
Access to Care	136	122	137	181	576
Health Plan	297	391	436	230	1,354
Provider Satisfaction	1,363	2,279	1,720	1,698	7,060
Total	**1,796**	**2,792**	**2,293**	**2,109**	**8,990**

CRS Member Grievances and Complaints	Quarter 1 10/01/17-12/31/17	Quarter 2 1/1/18-3/31/18	Quarter 3 4/1/18-6/30/18	Quarter 4 7/1/18-9/30/18	Total
Access to Care	0	0	0	4	4
Health Plan	11	2	3	11	27
Provider Satisfaction	32	40	26	3	101
Total	**43**	**42**	**29**	**18**	**132**

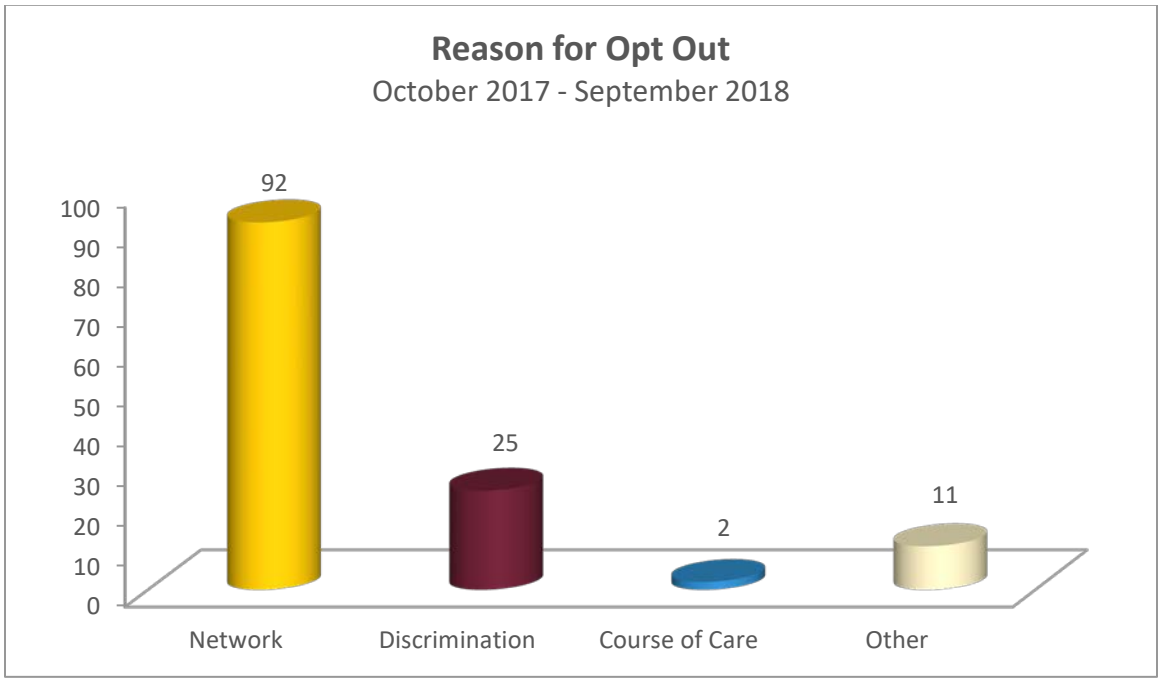
VIII. Individuals with Serious Mental Illness (SMI) Opt-Out for Cause Report

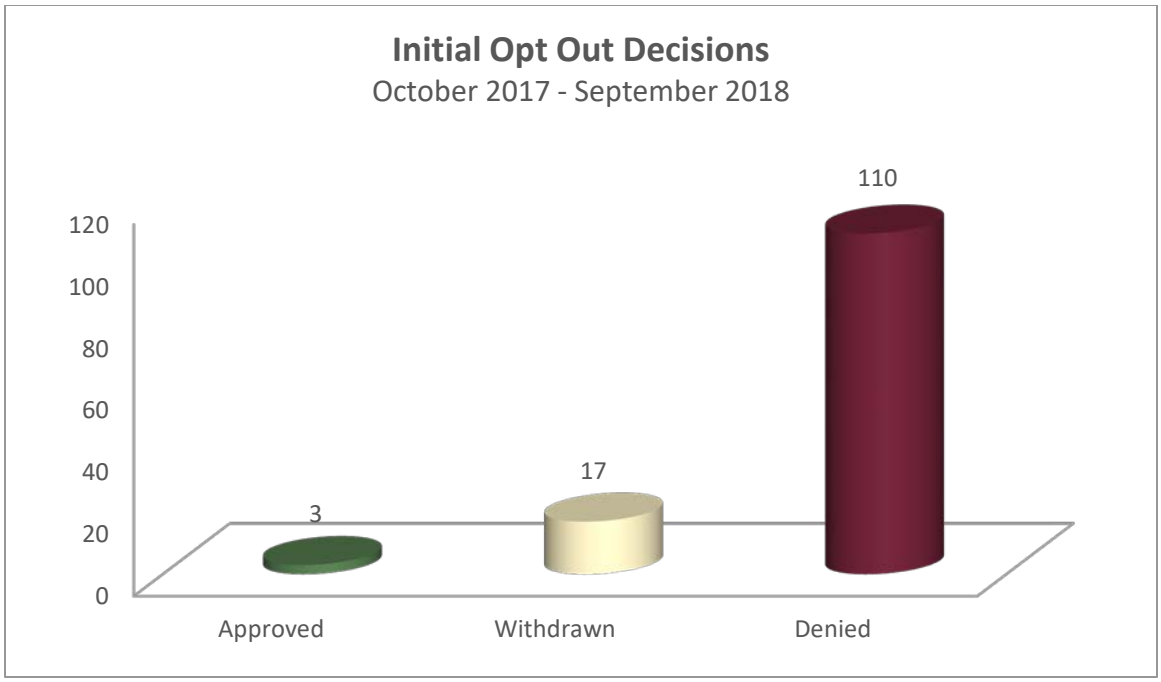
Below is a summary of the opt-out requests filed by individuals with SMI in Maricopa County and Greater Arizona, broken down by months, health plans, counties, reasons for opt-out requests, opt-out outcome, and post-appeal opt-out outcomes.

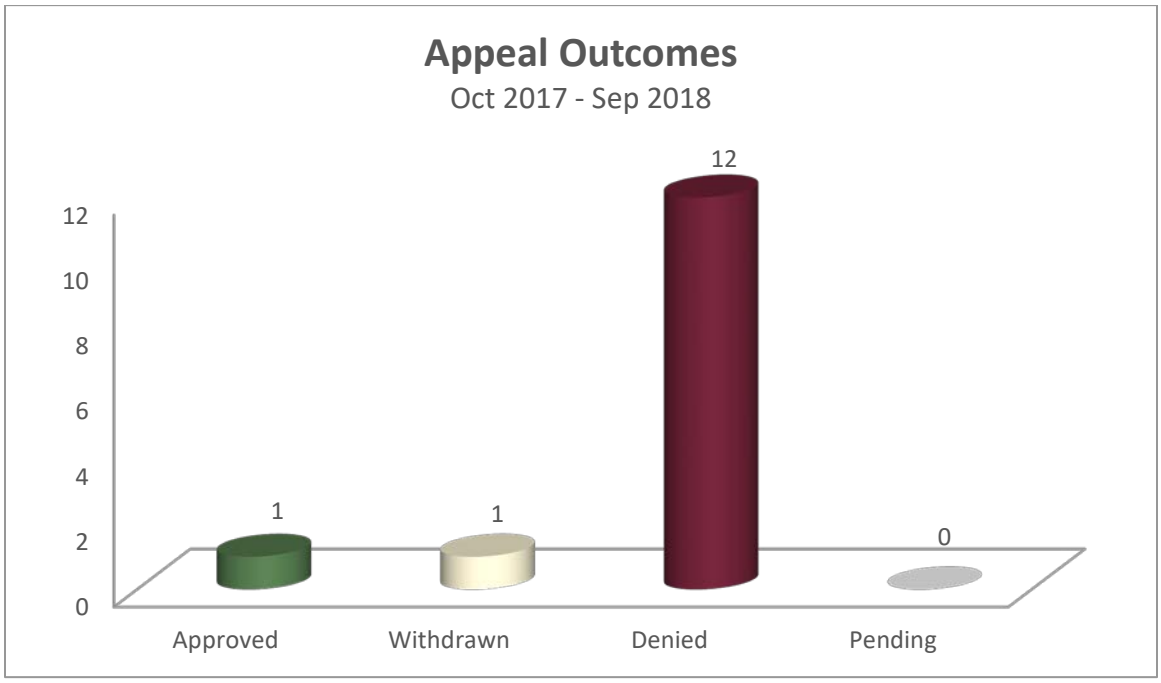

Number of Opt Outs by Month
October 2017 - September 2018
140
120
100
80
60
40
20
0
18
20
15
12
11
14
8
8
6
4
7
7
130
October
November
December
January
February
March
April
May
June
July
August
September
Total

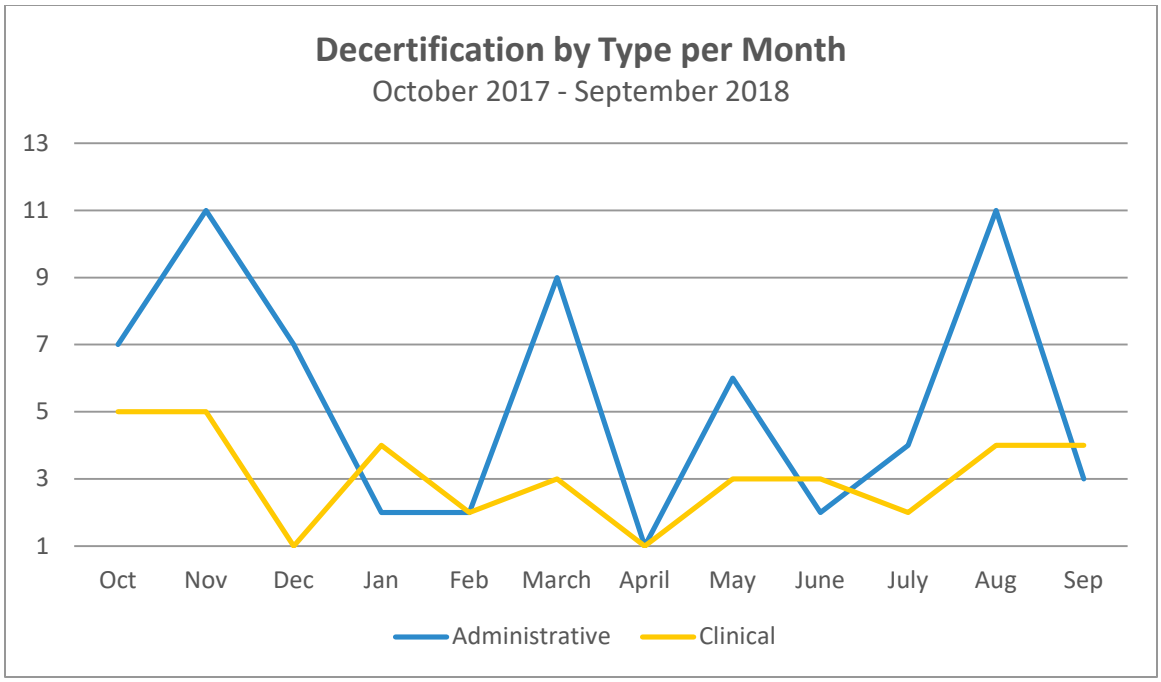

Number of Opt Outs by County
October 2017 - September 2018
2
2
5
6
1
1
3
7
103
130
Gila
Coconino
Yavapai
Mohave
La Paz
Yuma
Pinal
Pima
Maricopa
Arizona

Number of Opt-Out by County /Health Plans: September 2017 - October 2018		
HCIC	Apache	-
HCIC	Coconino	2
HCIC	Gila	2
HCIC	Mohave	6
HCIC	Navajo	-
HCIC	Yavapai	5
HCIC	**Total**	**15**
CIC	Cochise	-
CIC	Graham	-
CIC	Greenlee	-
CIC	La Paz	1
CIC	Pima	7
CIC	Pinal	3
CIC	Santa Cruz	-
CIC	Yuma	1
CIC	**Total**	**12**
MMIC	Maricopa	**103**
Grand Total	**All Counties**	**132**




Initial Opt Out Decisions
October 2017 - September 2018
120
100
80
60
40
20
0
3
17
110
Approved
Withdrawn
Denied


Appeal Outcomes
Oct 2017 - Sep 2018
12
10
8
6
4
2
0
1
1
12
0
Approved
Withdrawn
Denied
Pending



October 2017 – September 2018 Opt Out Request													
	Oct 17	**Nov 17**	**Dec 17**	**Jan 18**	**Feb 18**	**Mar 18**	**Apr 18**	**May 18**	**Jun 18**	**Jul 18**	**Aug 18**	**Sep 18**	**Total**
Admin	7	11	7	2	2	9	1	6	2	4	11	3	**65**
Clinical	5	5	1	4	3	3	1	3	3	2	4	4	**38**

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.

IX. Demonstration Operations and Policies

Legal Update

The Office of Administrative Legal Services (OALS) provides legal counsel to the AHCCCS Administration, is responsible for the Agency rulemaking process, and oversees the Grievance System for the AHCCCS Program. Major components of the Grievance System include: scheduling State Fair Hearings for disputed matters, the informal adjudication of member appeals and provider claim disputes, and the issuance of AHCCCS Hearing Decisions (also referred to as Director's Decisions). AHCCCS Hearing Decisions represent the Agency's final administrative decisions and are issued subsequent to review of the Recommended Decisions made by Administrative Law Judges. The Assistant Director of OALS also serves as the Agency's Privacy Officer with oversight authority over HIPAA and Part II compliance issues.

During the time period of 10/1/17 through 9/30/18, OALS received 17,039 matters which included member appeals, provider claim disputes, ALTCS trust reviews, and eligibility appeals. Of the 17,039 total cases received, 412 were member appeals, 15,090 were provider claim disputes, 328 were ALTCS trust reviews, and 1,209 were eligibility appeals. OALS issued 658 Director's Decisions after State Fair hearings were held. In addition, OALS issued 11,858 informal dispositions of disputes filed with the AHCCCS Administration. In excess of 96% of these disputes were resolved at the informal level, thus obviating the need for State Fair Hearings in these cases.

With regard to major litigation, the following is a summary of the status of major cases involving legal challenges to the AHCCCS Program during this federal fiscal year:

Biggs et al v Brewer and Betlach (Lawsuit to Invalidate Legislation Restoring AHCCCS Coverage, Expanding Eligibility to 133% FPL and Establishing the Hospital Assessment)

On September 12, 2013 the Goldwater Institute, on behalf of various legislators, several citizens who are Arizona residents, and the Director of the Arizona Chapter of Americans for Prosperity, all of whom oppose House Bill 2010 (Laws 2013, 1st Special Session, Chapter 10), filed a lawsuit in Superior Court seeking declaratory and injunctive relief. The lawsuit seeks to overturn Arizona's recent law expanding Medicaid to include persons with incomes up to 133% of the federal poverty guidelines, funded in part through a hospital assessment. The Complaint maintains that the Governor and the Medicaid Director violated the Arizona Constitution by imposing a tax on hospitals through the hospital assessment without obtaining the two thirds majority (supermajority) required by Proposition 108 (which applies to legislation increasing state revenue through taxation) and by violating the Constitution's separation of powers. More specifically, Plaintiffs allege that ARS §36-2901.08 violates Article IX, Section 22 (also referred to as Proposition 108), Article III, and Article IV, Part 1, Section1 of the State Constitution as well as the separation of powers doctrine of the Arizona Constitution. Plaintiffs request that Defendants be enjoined from establishing, administering, or collecting the provider tax and from enforcing ARS §36-2901.08. Attorneys' fees and costs are also requested by Plaintiffs.

On October 2, 2013 Defendants filed a Motion to Dismiss arguing that Plaintiffs lack standing. Plaintiffs filed a Response on October 16, and a Reply was filed on October 28, 2013. Oral argument regarding the Motion to Dismiss, originally scheduled for December 9th, was rescheduled to December 13th, and the Judge took the matter under advisement.

On February 5, 2014, the Superior Court granted Defendants' Motion to Dismiss because Plaintiffs lack standing. The Court dismissed Plaintiffs' Complaint in its entirety. Plaintiffs then appealed to the Court of Appeals on February 11th and subsequently filed a Petition for Special Action on March 4, 2011. On April 22, 2014, the Arizona Court of Appeals, which accepted jurisdiction of the Special Action, reversed the Superior Court decision that the individual legislators lacked standing but affirmed the Superior Court ruling that Plaintiff constituents and taxpayer Jenney lacked standing. On May 14, 2014, the Governor and the AHCCCS Director filed a Petition for Review with the Arizona Supreme Court. Briefs of Amici Curiae were filed on behalf of both Plaintiffs and Defendants. Oral arguments were held before the Arizona Supreme Court on November 6, 2014, and a decision is pending. On December 31, 2014 the Arizona Supreme Court ruled that the Legislature has standing to challenge the constitutionality of the hospital assessment; the matter was remanded to the Superior Court for a determination on the merits of whether or not a two-thirds vote of the Legislature, rather than a majority vote, was required for enactment. The Arizona Supreme Court held that the Superior Court erred in dismissing the action for lack of standing by the Plaintiff Representatives to challenge the validity of the passage of ARS §36-2901.08. Additionally, the Arizona Supreme Court denied Plaintiff Legislators an award attorneys' fees as there has been no determination on the merits.

On behalf of three individuals who are Childless Adults with income under 138% of the federal poverty level, Arizona Center for Law in the Public Interest and the William E Morris Institute for Justice filed a Motion to Intervene as Defendants, alleging that their interests as beneficiaries of the AHCCCS Program are not adequately protected by the existing parties. On April 9 Director Betlach filed a Response to the Motion to Intervene requesting denial of the Motion. On April 21st, Attorneys for Plaintiffs filed a Response to the Motion to Intervene also requesting that the Court deny Applicants' Motion. Intervenor-Defendants filed a Reply on April 21st. The Court granted permissive intervention of the Intervenor- Defendants on April 28, 2015.

Plaintiffs filed a Motion for Summary Judgment on May 15. Defendant Betlach and Intervenor-Defendants also filed Motions for Summary Judgment on May 15 to which Responses and Replies were filed. On August 26, 2015 the Superior Court denied Plaintiffs' Motion for Summary Judgment and granted Motions for Summary Judgment on behalf of the Defendant and the Intervenor-Defendants. Judgment was entered in favor of Defendant Betlach and Intervenor Defendants and against Plaintiffs on September 22, 2015: The Judge determined that lawmakers acted constitutionally when they approved the 2013 assessment to fund the Medicaid Restoration. Rejecting Plaintiffs' assertions, the Judge found that the assessment is not a tax requiring a two-thirds majority vote of the Legislature as maintained by the thirty-six Republican legislators. The Judge concluded that the lawmakers failed to provide evidence establishing that the assessment was a tax. Because the hospitals directly benefit from the assessment, the Judge concluded that the assessment was a fee rather than a tax. Plaintiffs filed Notice of Appeal on October 13, 2015.

Plaintiffs/Appellants filed their Opening Brief on January 19th, and Appellee Betlach filed an Answering Brief on March 7, 2016. An Amicus Brief was also filed by the Arizona Hospital and Healthcare Association on behalf of its 72 members on April 22, 2016 in support of Appellees. On May 11, 2016, the Court of Appeals issued an Order granting oral argument in the normal course of the Court's civil calendar. Oral argument has been scheduled for February 14, 2017.

The Court of Appeals affirmed the decision of the Superior Court and upheld the hospital assessment, ruling that ARS §36-2901.08 creates an assessment that falls within the exception of Article 9, Section

22(C)(2) of the Arizona Constitution. Judge Gerlach declined to award attorney's fees because Appellants did not prevail on appeal. Appellants filed a Petition for Review with the Arizona Supreme Court and oral argument was held on October 26, 2017.

On November 17, 2017, the Arizona Supreme Court issued an Opinion upholding the hospital assessment. The Court held that "the hospital assessment authorized in A.R.S. § 36-2901.08 is not a "tax" for purposes of article 9, section 22 of the Arizona Constitution and it is excepted from the supermajority vote requirement under subsection 22(C)(2) because it is "not prescribed by formula, amount or limit" and is set by the AHCCCS director.

B.K. et al v McKay et al (Formerly Tinsley v McKay-Lawsuit Alleging Violations of Constitutional and Statutory Rights of Foster Care Children)

On February 3, 2015, a class action lawsuit in federal district court was filed against the Directors of the Arizona Department of Child Safety (DCS) and Department of Health Services (ADHS), alleging violations of the constitutional and statutory rights of children in foster care custody of the State of Arizona. Plaintiffs are several children in state foster care custody, suing on behalf of themselves, a general class of children who are or will be placed in such custody, and certain subclasses, to enjoin the directors of DCS and ADHS from continuing to operate the Arizona foster care system in ways that violate Plaintiffs' federal constitutional and statutory rights. Represented by Arizona Center for Law in the Public Interest, Children's Rights, Inc. and Perkins Coie LLP, Plaintiffs allege failures by DCS and ADHS to provide safety and necessary medical and behavioral health care for approximately 17,000 foster children in the custody of the State.

The AHCCCS Administration was not a named defendant. However, because the injunctive and declaratory relief, including imposition of a court monitor, would impair the ability of the AHCCCS Administration to manage the Title XIX program and, in particular, the provision of EPSDT services, AHCCCS filed a Motion to Intervene on May 7, 2015 to add AHCCCS Director Betlach as a defendant on the EPSDT claims. Also on May 7th, Defendants DCS and ADHS jointly moved to dismiss the case on abstention grounds arguing that the federal suit would interfere with state juvenile court proceedings. Plaintiffs filed their Response to Defendants' Motion to Abstain on June 11, 2015, and on June 29th, Defendants filed their Joint Reply. The Court denied Defendants' Motion to Abstain on September 29, 2015. On May 19, 2015, the Plaintiffs responded by not opposing AHCCCS' Motion to Intervene, stating they would amend their complaint to add Director Betlach once the Court grants the motion. The Court granted The Motion to Intervene on June 3, 2015.

Plaintiffs then filed a Second Amended Complaint on June 8, 2015 which includes allegations specific to the AHCCCS Program and the Medicaid subclass. In the Second Amended Complaint, Plaintiffs particularly allege that they have suffered physical and emotional harm and remain at risk of ongoing harm, as a result of Defendants' longstanding failures: (1) to provide adequate health care services to children in state foster care; (2) to conduct timely investigations into reports that children have been abused or neglected while in state care; (3) to provide a minimally adequate number and array of foster homes for children not placed with kin; and (4) to take minimally adequate steps to keep families together after removing children from their homes. A scheduling order was entered on December 21, 2015, and discovery is beginning.

On February 11, 2016, Defendant Betlach filed the First Request for Production of Documents. Plaintiffs' filed Responses on March 14, 2016. The District Court issued an Order for Protection of

Privileged/Confidential Material on March 15, 2016 ordering Defendants to produce redacted information regarding the named Plaintiffs no later than April 1, 2016. The Court also approved, in part, the Parties' Joint Submission of Proposed Protective Order and required the parties to comply with specified requirements concerning the production and handling of information.

After Plaintiffs filed a Motion to Amend the Court's Rule 16 Scheduling Order which was entered December 21, 2015, the Court, on May 12, 2016, extended all outstanding deadlines by 90 days in its First Amended Rule 16 Scheduling Order. On May 13, 2016, the Court approved in part Plaintiffs' Motion for Appointment, approving the appointment of 2 of the 3 individuals volunteering to serve as next friends for the minors. Because of a possible appearance of impropriety with regard to one individual, that one appointment was not approved. The parties were ordered to confer to identify a suitable individual to serve as next friend for the other minors. Expert reports of Marci White, MSW, and of Steven Blatt, MD, both retained by Plaintiffs, were submitted on September 15, 2016. The Plaintiffs filed their Motion for Class Certification on November 29, 2016. The Defendants responded on December 22, 2016.

Plaintiffs' Reply was filed on January 5, 2017. The parties engaged in mediation on May 18th which was unsuccessful. Discovery resumed. On September 30, 2017, the District Court issued an Order granting Plaintiffs' Motion for Class Certification of a General Class and two subclasses consisting of the Non-Kinship Subclass and the Medicaid Subclass. The General Class consists of "all children who are or will be in the legal custody of DCS due to a report or suspicion of abuse or neglect." The Non-Kinship Subclass consists of "all members in the General Class who are not placed in the care of an adult relative or person who has a significant relationship with the child." The Medicaid Subclass is comprised of "all members of the General Class who are entitled to early and periodic screening, diagnostic, and treatment services under the federal Medicaid statute." Additionally, the Court granted Plaintiffs' request to appoint Perkins Coie, the Arizona Center for Law in the Public Interest, and Children's Rights, Inc. as class counsel. Petitions by Defendants to the Ninth Court appealing the ruling will be filed.

On October 16, 2017 Defendants filed a Petition to the Ninth Circuit Court of Appeals challenging the ruling on an immediate interlocutory basis. Plaintiffs filed a Response to the Petitions on October 25, 2017, and the Ninth Circuit granted the Petitions on December 19, 2017. Defendants filed a Motion to Stay the case pending the outcome of the appeal which was denied by the District Court Judge on February 13, 2018. Shortly thereafter, Defendants filed a Motion to Stay with the Ninth Circuit which was granted on February 27, 2018. Events in the district court will not stop while the Ninth Circuit decides the class certification issue. Defendants filed their Joint Opening Brief on April 30th, and on June 29th, Plaintiffs filed their Answering Brief opposing Defendants' appeal of the class certification Order. Meanwhile, Defendants filed a Motion with the Ninth Circuit on June 26, 2018 requesting en banc review of the class certification issue rather than review by the 3 judge panel in light of the importance of the issue. The Ninth Circuit denied the Motion. Oral argument is expected in early 2019.

<u>Darjee and Sanchez Haro v Betlach</u> (Lawsuit Alleging Violation of the Medicaid reasonable promptness requirement at 42 U.S.C. Section 1396a(a)(8), the Medicaid notice requirements at 42 U.S.C. Section 1396a(a)(3), and the due process clause of the Fourteenth Amendment to the U.S. Constitution. Persons Transitioned from Full AHCCCS Coverage to Federal Emergency Services Coverage)

On July 22, 2016, the Morris Institute and the National Health Law Program filed a purported class action in federal district court, naming two AHCCCS recipients, seeking declaratory and injunctive relief

pursuant to 42. U.S.C. Section 1983. The Complaint alleged violations of the Medicaid reasonable promptness requirement at 42 U.S.C. Section 1396a(a)(8), the Medicaid notice requirements at 42 U.S.C. Section 1396a(a)(3), and the due process clause of the Fourteenth Amendment to the U.S. Constitution. The Complaint was filed on behalf of two individuals and a statewide class of persons who were alleged to have been improperly transitioned from full AHCCCS coverage to federal emergency services only coverage. The Motion for Class Certification was filed on July 22, 2016. Plaintiffs subsequently filed a Motion for Preliminary Injunction on July 27, 2016, and Defendant Betlach filed a Motion for Extension of Time to Respond to Motion for Preliminary Injunction and Class Certification. On August 24, 2016 the District Court granted Defendant's Motion to extend time for Defendant to respond to the Complaint and the Motions. However, the Court denied Defendant's Motion to conduct discovery prior to responding to Plaintiffs' Motion for Preliminary Injunction and Motion for Class Certification. On August 29, 2016 Defendant Betlach filed its Motion to Dismiss the Complaint for lack of jurisdiction and failure to state a claim. Plaintiff filed its Response on September 9, 2016. Defendant Betlach filed its Reply on September 19, 2016. On this date, Plaintiffs filed a Reply in Further Support of Motion for Class Certification. Oral argument on all three motions was heard on October 4, 2016. On October 25, 2016, the Magistrate Judge filed his Report and Recommendation that the case be dismissed with prejudice and that the Plaintiffs' other motions all be denied as moot. The Plaintiffs filed an Objection to these recommendations on November 7, 2016. Defendant Betlach filed its Response to Plaintiffs' Objections to the Magistrate's Report and Recommendations. The Plaintiffs were granted leave to file a Reply, which they did on December 19, 2016. Oral argument had been requested but has not yet been scheduled.

The District Court Judge entered two Orders on March 31, 2017: Plaintiffs' Motions for Class Certification and Preliminary Injunction were denied, and Defendant Betlach's Motion to Dismiss was denied. Plaintiffs did not appeal. A Settlement Conference was held on June 19 2017 which was not successful. Plaintiffs' filed a Renewed Motion for Class Certification on September 16, 2017, and Defendant Betlach filed a Response to Motion for Class Certification on September 30, 2017. Plaintiffs filed their Reply on October 12, 2017. Argument was heard on December 14th, and further briefing was completed on January 5, 2018. On November 8, Plaintiffs also filed a Motion to Compel Defendant's Discovery Responses, and Defendant filed its Response to the Motion on November 11, 2017.

The Magistrate Judge, on February 9, 2018, issued a Report and Recommendation, denying Plaintiffs' Renewed Motion for Class Certification on several independent grounds and denying most of Plaintiffs' Motion to Compel further discovery responses. On February 26, 2018, the Plaintiffs filed an Expedited Motion to Stay all discovery pending an appeal of the Magistrate Judge's Recommendation to the District Court Judge. On March 1, 2018, the Magistrate Judge denied Plaintiffs' Expedited Motion to Stay discovery. On March 3, Plaintiffs filed Objections to the Magistrate Judge's Recommendation regarding the Renewed Motion for Class Certification. AHCCCS filed its Response on March 23rd. Meanwhile, on June 1, 2018, AHCCCS filed a Motion for Summary Judgment against the two Plaintiffs. The Plaintiffs then filed a Cross-Motion for Partial Summary Judgment on the notice issues on July 13, 2018, and AHCCCS filed a combined Reply and Response to the Cross-Motion on August 6, 2018. On August 30, 2018, the Plaintiffs filed a Reply regarding the notice issue. Oral argument has not been scheduled. On September 5, 2018, the District Court Judge denied Plaintiffs' Renewed Motion for Class Certification, agreeing with the Magistrate that class certification is not appropriate. In her ruling, the District Court Judge also denied Plaintiffs' request for discovery but ordered AHCCCS to respond to one interrogatory. The District Court Judge ruled that: the Magistrate Judge's Report and Recommendation is accepted and adopted in full; Plaintiffs' Renewed Motion for Class Certification is denied; Plaintiffs' Alternative Motion for Class Discovery is denied, Plaintiffs' Objections to the Magistrate Judge's Denial of Plaintiffs'

Motion to Compel is sustained with respect to Plaintiffs' objection to Plaintiffs" Interrogatory 7 and overruled as to Plaintiffs' Interrogatory Numbers 2, 4, 8-13 and Request for Production Numbers 2-4, 10, 11, 1nd 13. No further appeal has yet been filed.

CMS Disallowance of Medicaid School-Based Administrative Claims

On October 20, 2016, CMS issued its final disallowance of school-based administrative claims that AHCCCS submitted for the period of January 1, 2004-September 30, 2008. CMS disallowed $5,421,711 for failure of the AHCCCS contractor, Maximus, Inc., to retain documentation to support claims in two fiscal quarters and disallowed an additional $6,295,139 because Maximus and AHCCCS used a sampling methodology that was disapproved by CMS. On December 14, 2016, AHCCCS sent a Request for Reconsideration to the Secretary of HHS. By letter dated February 14, 2017, but received by AHCCCS on March 6, 2017, CMS denied AHCCCS' Request for Reconsideration. AHCCCS filed a Notice of Appeal to the Departmental Appeals Board (DAB) on April 3, 2017, and AHCCCS' Opening Brief was filed on May 5, 2017. CMS filed its Response on June 5th, and AHCCCS filed its Reply on June 20, 2017. On October 2nd, 2017, the DAB denied AHCCCS' appeal. AHCCCS filed a Complaint in the U.S. District Court in Phoenix on December 1st to appeal the DAB ruling. On February 8, 2018, the Federal Government filed its Answer. The administrative record was filed on March 30, 2018. AHCCCS filed its Opening Brief on May 11th. The Federal Government filed its Response on June 18th, and AHCCCS filed its Reply on July 9, 2018. A decision has not been issued.

Legislative Update

The Fifty-third Legislature, Second Regular Session adjourned Sine Die on May 4, 2018, after having been in session for 116 days. The information below summarizes legislation and provisions of the SFY 2019 state budget package related to the Agency's operation.

Legislation

HB 2228 – Exempts American Indians and Alaska natives from the provisions outlined under A.R.S. 36-2903.09 (work requirements, 5 year limit, cost sharing).

HB 2235 – Formally recognizes and establishes scope of practice for Dental Health Aide Therapists (DHAT).

- Limits DHATs to practice settings or locations, including mobile units, that are operated or served by FQHCs/FQHC look-alikes, community health centers, a nonprofit dental practice or organization that provides dental care to low-income and underserved individuals, a private dental practice that provides dental care for community health center patients of record.
- Prohibits a DHAT from dispensing or administering a narcotic drug and independently billing for services.
- DHATs may only practice under general supervision pursuant to a written collaborative practice agreement, or direct supervision.

HB 2324 – Recognizes Community Health Workers by requiring ADHS to adopt rules relating to the establishment and administration of a voluntary certification process, including relevant scope of practice, minimum qualifications, and core competencies.

SB 1296 – Requires the state, counties and municipalities to ensure that its communications with persons with disabilities, including online communications and emergency communications, are equally

as effective as its communications with persons without disabilities. The state, counties and municipalities are each required to do the following:

- Provide auxiliary aids and services needed to communicate effectively with persons with communication disabilities.
- Establish a protocol to secure a licensed emergency response interpreter to interpret emergency communications that are presented live to the media for broadcast or delivered through a live online communication, including an official government statement or press conference relating to an emergency situation.

SB 1450 – Renames the various Human Rights Committees to "Independent Oversight Committees" and transfers responsibility for these committees to the Arizona Department of Administration (ADOA), from the Arizona Department of Economic Security (DES), Department of Child Safety (DCS), and AHCCCS.

Opioid Special Session

Laws 2018, First Special Session, Chapter 1–Appropriates $10,000,000 from the state General Fund in FY 2017-2018 to the substance use disorder services fund established by A.R.S. 36-2930.06 for the purpose of providing services for the Non-Title XIX population.

- Monies are not to be used for those eligible under Title XIX or XXI.
- Contractor payments are to be made in accordance with contracts, or in the absence of a contract, at the capped fee schedule rate established by AHCCCS.
- The contractor shall submit expenditure reports monthly for reimbursement of services provided under the agreement.

SFY 2019 Budget Package

Laws 2018, Second Regular Session, Chapter 276 & Laws 2018, Second Regular Session, Chapter 284 includes the following provisions for July 1, 2018, through June 30, 2019:

- $9,943,700 for behavioral health services in schools.
- $100,000 for a Suicide Prevention Coordinator to assist school districts and charter schools in suicide prevention efforts.
- Funds to increase inpatient and outpatient hospital rates by 2.5% in FY 2018-2019 based on hospital performance on established quality measures, in addition to rate adjustments that would otherwise be actuarially determined for FY 2018-2019.
- Monies to increase Skilled Nursing Facility and Assisted Living Facility provider rates by 3% in FY 2018-2019 in addition to rate adjustments that would otherwise be actuarially determined for FY 2018-2019.
- $11,000,000 from the state General Fund and $25,460,100 from DD Medicaid expenditure authority are appropriated in FY 2018-2019 to DES for onetime assistance to address DD provider cost increases resulting from the enactment of Prop 206.
- $2,000,000 is appropriated from the state General Fund in FY 2018-2019 to DES for a onetime increase for state-only room and board expenses funded by DDD.
- $900,000 in savings is generated by eliminating the AHCCCS Hospital Loan Residency Fund (A.R.S 36-2921).
- If a behavioral health inpatient facility, as defined in rule by the Director of DHS, and a contractor or RBHA do not enter into a contract, the reimbursement level for behavioral health services provided on dates of admission on or after July 1, 2018 for that behavioral health inpatient facility is 90% of the capped FFS schedule. This policy applies retroactively to from and after June 30, 2018.

- Laws 2017, Chapter 309, Section 13, as amended by HB 2659 related to increased DSH payments, applies retroactively to June 30, 2017. DSH amount now $113M rather than $108M.
- $300,000 and 12 Full time Employees (FTEs) for the American Indian Health Program staffing and a reduction of $545,000 for the AIHP admin shift.
- Incorporates $2.5M in savings from ending Prior Quarter Coverage as of July, 1 2018.

Program Integrity Update

The Office of Inspector General (OIG) is responsible for and must coordinate activities that promote accountability, integrity, detection of fraud, mismanagement, abuse, and waste in the Arizona Health Care Cost Containment System (AHCCCS). The AHCCCS OIG is a criminal justice agency as defined by Arizona state law.

The Agency increased its commitment of resources during the last decade to implement internal controls throughout the Medicaid System to detect, prevent, and investigate cases of suspected fraud, waste, and abuse.

These are some highlights of OIG's roles and responsibilities:

- OIG is comprised of five sections that accomplish different but interrelated functions as follows:
    - *Provider Registration Section* - The providers are affiliated with managed care organizations (MCOs) in order to provide services; however, the State requires all Medicaid providers to be enrolled through the AHCCCS' Provider Registration Unit (PRU);
    - *Provider Compliance Section* - Performs ongoing investigations of external referrals and internally detected cases through data mining (PI Audits) activities. This section also makes independent referrals to the State MFCU unit and other law enforcement authorities;
    - *Member Compliance Section* - This Section is divided in two subsections. The Member Criminal Investigations Unit and the Fraud Prevention Unit. Each section, with a distinctive role, accomplishes investigations of post and pre enrollment of potential fraud cases involving beneficiaries;
    - *Program Integrity Team* - Tasked with data mining and data audits of post payments. This section also conducts periodic utilization reviews of target providers to identify trends and determine potential fraudulent billing practices; and
    - *Performance Improvement and Audits Section* – This section oversees the Corporate Compliance Program as required by the Federal law and as established in the AHCCCS contract with Managed Care Organizations including the Behavioral Health Authorities (16). The section has two major goals: to conduct performance improvement projects, and to conduct independent provider audits.

In State Fiscal Year (SFY) 2018, the total OIG savings and recoveries for all programs was $53,303,636. OIG continued with projects, initiatives, cases, and joint efforts to proactively combat fraud, waste, and abuse within the AHCCCS program.

Provider Registration Section (PRS)

- 4,453 providers were added to the State Medicaid Program in FY 2018.
- 74,400 total providers are active in AHCCCS.
- The provider registration call center handled 34,140 telephone calls in FY 2018.
- The PRS processed 64,988 documents related to provider applications.
- 321 site visits were completed in FY 2017.

Provider Compliance Section (PCS)

- PCS successfully instituted a Credible Allegation of Fraud suspension against a provider who entered into a fraudulent scheme to bill for services utilizing a provider who had a contract with AHCCCS. The provider has appealed the Credible Allegation of Fraud suspension three separate times and each time OIG, in cooperation through OALS, has successfully proven adherence to the rules for the Credible Allegation of Fraud Suspension.

- The Non-Emergency Medical Transportation (NEMT) project continues to be a proven success with one full time investigator dedicated to this endeavor. FY 2018 has seen successful criminal prosecutions, asset recoupments and restitutions awarded to the State, and civil remedies upheld in various Administrative Law Judges (ALJ) recommendations and the AHCCCS Director's Final Decisions. The statistical accomplishments for this program are as follows:
    - 56 new cases opened;
    - Two of the new cases were presented and accepted for joint criminal investigation;
    - Eight cases closed with recoupments and restitutions totaling $5,999,914.94;
    - Four criminal cases with high media impact; and
    - OIG is expecting prosecutorial results on additional cases coming up within these next months.

- The OIG Self Disclosure Program is designed to work with providers to advance AHCCCS program integrity while concurrently ensuring access to service for members and maintaining a cost effective programs for Arizona's taxpayers. The statistical accomplishments for this program in SFY 2018 are as follows:
    - Received 31 self-disclosures referrals;
    - Achieved $325,891.14 in total recoveries; and
    - Accomplished $1,285,021.21 in program savings.

- Billing under the wrong Provider ID is a common trend found across several provider types. OIG is actively pursues recoupments of overpayments related to wrongful billing. Case examples include, but are not limited to the following:
    - Billing for services performed by the mid-level practitioners by the supervising physician;
    - Billing for services rendered by providers ineligible for payment from the Title XIX program by utilizing another Provider ID number. This includes but is not limited to, services rendered by naturopathic physicians, non-contracted providers, providers with DEA revocations, and providers who have quit employment at various facilities; and
    - Billing for services as though they were Locum Tenens when the requirements to perform these services are not met.

- Coding initiatives have proven to be viable cases and recoveries for PCS as well.
    - J-Codes are combination codes that include the cost and administration of the drug. In effort to identify overpayments to providers, PCS routinely looks for patients who have

a pharmacy claim, office visit, and J-Code combination billing codes. The PCS coding initiative resulted in OIG recovering $400,000.00 from one provider who performed this type of billing pattern;
    - Project 99058 was established off a coding guideline change that no longer allowed this code to be billed separately. PCS has recovered $83,000.00 from several providers who continued to bill AHCCCS using this code after the guideline change. In addition to these recoveries, PCS successfully worked with one AHCCCS health plan to automatically edit claims with the 99058 code to prevent future incorrect payments; and
    - Incorrect coding of proper triage services rendered in a hospital facility led to a recoupment of $450,000.00. Various codes were utilized to determine the difference of what was billed and paid versus what should have been billed and paid.
- Home and Community Based Services (HCBS) is a high risk category of care that has several areas open to fraud, waste, and abuse. Case highlights in this area include, but are not limited to the following:
    - PCS is conducting a joint investigation with a federal agency of a member who is believed to be falsifying a severe cognitive diagnosis (documented in his medical record as being unable to read, write, or function socially) in order to receive various Medicaid services. PCS also investigated a provider who was unable to provide any records to OIG regarding the investigation. In addition to entering into a settlement agreement for $293,000.00, OIG has implemented a Corrective Action Plan against the provider to facilitate compliance of several program integrity areas; and
    - PCS helped coordinate a successful prosecution against a provider who billed for services she never rendered to a member. The member was left unattended and in a vulnerable position as a result of her neglect and fraudulent schemes. This provider was sentenced to 3 years of probation and reported for exclusion from participation by the Attorney General's Office.

Member Compliance Section (MCS)

- MCS conducted an investigation based on an anonymous referral alleging that the AHCCCS member's daughter/authorized representative applied for ALTCS benefits for the member, and failed to report all the member's assets and transfer of those assets. The representative had sold the member's car and mobile home. The transfer amounted to $55,000.00, which the representative deposited into her personal bank account. Had this information been reported, the transfer amount would have disqualified the member from ALTCS. The representative withdrew the member from ALTCS benefits and entered into a Settlement Agreement with AHCCCS and paid the loss of $20,005.46. The closure of benefits caused a savings to the state of $37,933.32.

- MCS conducted a joint investigation with the Department of Economic Security/Office of Special Investigations (DES/OIG) into allegations that an AHCCCS member was not a resident of Arizona. The allegation stated that the member, her children, and nephews were residing in Mexico. It was determined that the member had been residing in Agua Prieta, Sonora, Mexico, from January 1, 2014 through November 30, 2016. On February 23, 2018, the member pleaded guilty to Fraudulent Schemes and Practices, a class five (5) felony. She was sentenced to four (4) months confinement in the Cochise County Jail, placed on supervised probation for 36 months and ordered to pay restitution of $44,140.66 to AHCCCS along with $23,997.00 to DES.

- MCS conducted a joint investigation with DES/OSI, into allegations that the member, her husband, and their children have been residing in Laughlin, Nevada. The investigation determined that the member and her family had been residing in Nevada from July 1, 2014 through October 31, 2016. Rental applications and voluntary statements were obtained from the member and her husband. This time frame of ineligibility caused a loss to the state of $50,551.95, which the members were ordered to pay as restitution to AHCCCS. The member was also sentenced to 96 days confinement in the Mohave County Jail, 80 hours of community service and three years of probation.

- MCS conducted an investigation into an allegation that the AHCCCS member and her husband own several, fully staffed, businesses. The investigation revealed that the members not only owned several businesses, but also used company funds for personal expenses such as purchasing a bulldog for an amount over $2,400, paying their $1,100 monthly rent, purchasing life insurance, paying home utilities, and donating to charity. It was determined that the member and her family fraudulently obtained AHCCCS benefits between 10/1/2010 through 5/31/2014. The members entered into a Settlement Agreement to pay AHCCCS $44,652.11 for the loss caused by the member's fraudulently obtaining medical benefits.

- MCS received a referral from a Maricopa Health Plan auditor alleging that the member was enrolled in both the Maricopa Health Plan in Arizona and the Rocky Mountain Health Plan in Colorado. An investigation was conducted and determined that the member was not a resident of Arizona. This member's ALTCS benefits were terminated, saving the state of Arizona $83,258.16 per year.

- MCS conducted a joint investigation with the Tucson Police Department, Narcotics Alliance Unit and the Attorney General's Office into allegations that an AHCCCS member was involved in an ongoing criminal enterprise. It was determined that the member used multiple bank accounts to launder money that was in excess of income limits for medical benefits. The member was found guilty and ordered to pay restitution of $43,329.02 to AHCCCS for benefits received from 4/1/2015 through 2/28/17. The member was also ordered three years of probation.

- MCS conducted a joint investigation with the Tucson Police Department into allegations that the member and her husband are involved in an ongoing criminal enterprise. The member pled guilty to money laundering and was sentenced to 6 days incarceration in the Pima County Jail. The other member pled guilty to money laundering and was sentenced to three years of prison in the Arizona Department of Corrections. Both members been ordered to pay restitution to AHCCCS in the amount of $62,918.99 for the ineligible time period of 3/1/2013 through 8/31/2016.

Program Integrity Team (PIT)

- The PIT continues to handle high volume data requests from internal and external customers. In SFY 2018, PIT received 55 data requests per month, while maintaining an average turnaround time of two days. The National Association of Medicaid Fraud Control Units (NAMFCU) data requests are invariably more complex and take longer to process, but rarely require an extension to the submission deadline. PIT received over $12.5 million in Global Settlements in SFY 2018.

- In addition to servicing data requests, PIT analysts also conduct investigations and initiate provider self-audits. For SFY 2018, these activities resulted in recoveries of $200,000, program savings over $2 million, and five prosecutions.

- The All-Advance-Medi-Medi referral process was further enhanced to summarize the status of cases on a monthly basis and ensure all referrals are evaluated and entered into the OIG Case Management system. To date these cases have generated $300,000 in recoveries and $400,000 in program savings. However 80 active cases remain and PIT will monitor and report the results.

- Development of the new Case Management system with the AHCCCS Information Services Division (ISD) is in the final stages. PIT has completed the data migration utilities to import the cases from the old system and has begun testing the system. The system is projected to be completed in 2019.

- PIT continues to work closely with LexisNexis to enhance our data analytic activities and identify quality investigation leads. Recent developments include:
    - Pharmacy Summary for analyzing opioid abuse;
    - Upgraded NCCI edit rules for improved Medicaid support;
    - Revised Provider address mapping to identify the likely service location;
    - Enhanced Medical record mapping to support facility investigations; and
    - POI Visualization Tool for more comprehensive provider analysis.

Performance Improvement and Audit Section (PIAS)

- PIAS oversaw the Pharmacy Intelligence Project which led to the creation of PFIT (Pharmaceutical Fraud Intelligence Team) which investigating matters related to opioid and prescription fraud, waste, and abuse. PFIT has been in operation for approximately one year, consisting of four investigators with provider and member fraud experience. The Pharmacy Intelligence Group continues to work closely with local police departments, MFCU, and federal agencies in working joint investigations. Accomplishments include:
    - 113 Referrals Received;
    - 53 Referrals Reviewed;
    - 24 Outbound Referral;
    - 60 Cases Opened;
    - 20 joint cases with MFCU,
    - 17 Lock-down requests;
    - Three Approved lock-downs;
    - 14 Case Management Requests;
    - Six Case Management Request Granted;
    - One Search Warrant Issued;
    - 13 indictments; and
    - One conviction.

- PIAS expanded OIG monthly metrics to track key performance indicators. The new monthly metrics include, but are not limited to (1) two-month comparison charts; (2) individual investigator savings and recovery amounts; and (3) investigator active and suspended case status charts.

- At the end of SFY 2018, OIG Monthly Metrics consisted of a 79 page report with 152 data sets from all sections, Provider Registration, Fraud Prevention, Member Criminal Investigations, Program Integrity, Provider Compliance, Forensic Accounting, Pharmacy Fraud Intelligence, Collections, Audits, and Referrals.

- In SFY 2018, the Collections Team focused on cases that were 60 days or more past due. During that time 862 cases were identified as 60 days or more past due. Additional statistical accomplishments include:
    - $21,694,398.82 Total Collections (On-Time & Past-Due);
    - 1,862 Payments Received (On-Time & Past-Due);
    - 862 60-Day-Past-Due Cases Identified;
    - 207 (24%) 60-Day+ Past-Due Cases Collected; and
    - $564,809.66 Collected from 60-Day-Past-Due Cases.

- In SFY 2018, our Performance Improvement Project Manager completed four SharePoint Applications as part of our Performance Improvement efforts to increase effectiveness and efficiency of our data management. Applications were also maintained for several sections in OIG.

- In SFY 2018 all OIG sections continued to manage their individual Huddle Boards (Tier 1) in the following 10 areas: Provider Registration, Fraud Prevention, Member Criminal Investigations, Program Integrity, Provider Compliance, Forensic Accounting, Collections, OIG Audits, EHR Post-Pay Audits, and Referrals.

- In SFY 2018, the OIG Executive Dashboard (Tier 2 Huddle Board) continued to capture metrics for Provider Compliance, Program Integrity, Collections, Fraud Prevention, Member Criminal Investigations, Provider Registration, Forensic Accounting, EHR Post-Pay Audits, Referrals, Pharmaceutical Fraud Intelligence Team (PFIT), Special Projects, and the Arizona Management System.

- In SFY 2018, the OIG Audit Team completed the following Audits:
    - Two Operational Reviews;
    - 11 Deficit Reduction Act (DRA) Audits;
    - Five Provider Audits;
    - 20 Hospital Presumptive Eligibility (HPE) Deliverable Reviews;
    - 123 Managed Care Organizations (MCOs) Deliverable Reviews; and
    - One FQHC Audit Initiated.

- The EHR Post Pay Audit Team completed the following EHR Post Pay Audits:
    - 68 Eligible Hospitals (EH) Audits;
    - 46 Adapt, Implement, and Upgrade (AIU) Audits;
    - 16 Meaningful Use (MU) Audits;
    - Two Eligible Hospital (EH) Appeals; and
    - $12,919,790.63 in Total Recoupments from Eligible Hospitals and Providers.

- On SFY 2018, CMS issued the Final Report for the Arizona 2017 Medicaid Program Integrity Focused Review and the OIG submitted the Corrective Action Plan to CMS.

State Plan Update

SPA #	Description	Filed	Approved	Eff. Date
Title XIX				
SPA 16-009 General Medical Education 2017	Updates General Medical Education (GME) funding for the service period July 1, 2016 through June 30, 2017 for programs with submitted IGAs.	09/30/2016	11/17/2017	09/30/2016
SPA 17-004 Nursing Facility Rate Update	Updates the State Plan to make changes to NF payments.	09/28/2017	11/08/2017	07/01/2017
SPA 17-005 Disproportionate Share Hospital	Updates the State Plan to transition the Disproportionate Share Hospital program from Arizona's 1115 waiver into the state plan.	09/28/2017	10/23/2017	10/01/2017
SPA 17-008 Adult Emergency Dental and Occupational Therapy	Updates the State Plan to add a benefit for adult emergency dental services and occupational therapy.	12/04/2017	06/18/2018	10/01/2017
SPA 17-009 Share of Cost	Updates the State Plan to make changes to the share of cost deduction by expanding the list of services eligible for a share of cost deduction and adding a reasonable restriction on the period in which the expense occurred.	12/07/2017	02/13/2018	04/01/2018
SPA 17-011 Ambulance Rates	Updates the State Plan to make changes to ambulance rates.	02/11/2017	12/28/2017	10/01/2017
SPA 17-012 LTAC and Rehab Rates	Updates the State Plan to update long term acute care (LTAC) and Rehab rates.	12/11/2017	02/07/2018	10/01/2017
SPA 17-013 Outpatient Hospital Rates	Updates the State Plan to update Outpatient Hospital Rates.	12/11/2017	01/26/2018	10/01/2017

SPA #	Description	Filed	Approved	Eff. Date
SPA 17-014 Other Provider Rates	Updates the State Plan to update the other provider rates.	12/11/2017	01/26/2018	10/01/2017
SPA 17-015 Inpatient Differential Adjusted Payments	Updates the State Plan to establish differential adjusted payments for inpatient care.	12/27/2017	02/08/2018	10/01/2017
SPA 17-016 Integrated Clinic, Physician, Physician's Assistant and Registered Nurse Practitioner Differential Adjusted Payments	Updates the State Plan to establish differential adjusted payments for Integrated Clinic, Physician, Physician's Assistants and Registered Nurse Practitioners.	12/12/2017	02/22/2018	10/01/2017
SPA 17-017 Nursing Facilities Differential Adjusted Payments	Updates the State Plan to establish differential adjusted payments for nursing facilities.	12/12/2017	02/07/2018	10/01/2017
SPA 18-001 Nursing Facilities Rates	Updates nursing facility payments in the State Plan.	02/26/2018	04/03/2018	01/01/2018
SPA 18-002 APR-DRG Rebase	Updates the State Plan to update All Patient Refined Diagnosis Related Group (APR-DRG) reimbursement for inpatient hospital services.	02/26/2018	04/03/2018	01/01/2018
SPA 18-003 IHS/638 Specialty Drugs	Updates the State Plan to update the reimbursement rates for specialty drugs dispensed by IHS/638 facilities.	03/08/2018	06/06/2018	10/01/2018

SPA #	Description	Filed	Approved	Eff. Date
SPA 18-004 Tribal 638 facilities FQHCs	Updates the State Plan to establish an Alternative Payment Methodology (APM) for Tribal 638 facilities that elect to be paid as Federally Qualified Health Centers (FQHCs).	03/12/2018	05/22/2018	04/01/2018
SPA 18-005 Personal Needs Allowance	Updates the State Plan to provide personal needs allowances for income garnished for child support or spousal maintenance.	03/26/2018	04/27/2018	04/01/2018
SPA 18-006 Asset Verification	Updated the State Plan to describe AHCCCS acquisition of an Asset Verification system through the New England States Consortium Systems Organization (NESCO) consortium.	06/07/2018	07/31/2018	05/01/2018
SPA 18-007 DSH Budget Changes	Revises the amounts listed in the State Plan for Disproportionate Share Hospital (DSH) payment pools 4 and 5 pursuant to legislation passed by the Arizona State Legislature.	06/18/2018	07/19/2018	06/01/2018
SPA 18-008 DSH Third Party Payments	Updates the State Plan to exclude third party payments from the Medicaid shortfall calculation.	09/27/2018	Pending	09/30/2018
SPA 18-009 FQHC Alternative Payment Model	Updates the State Plan to update the alternative payment methodology for federally qualified health centers to include quality measures.	09/27/2018	Pending	10/01/2018
SPA 18-010 General Medical Education 2019	Updates General Medical Education (GME) funding for fiscal year 2019.	09/27/2018	Pending	09/30/2018
SPA 18-011 Emergency Medical Services Rates	Updates the Emergency Medical Services (EMS) rate methodology in the State Plan.	10/03/2018	Pending	10/01/2018
Title XXI				
SPA 17-010 Mental Health Parity Regulations	Updates the State Plan to make technical changes and assurances related to Mental Health Parity regulations	12/08/2017	02/16/2018	10/01/2017

X. Quality Assurance/Monitoring Activities

Acute-Care Performance Measures

In 2012, AHCCCS initiated a process to transition its performance measure sets to those included in the CMS Core Measure Sets. AHCCCS incorporated the measures across lines of business in an effort to ensure comparability for access to care and outcomes measures aimed at all populations. These decisions resulted in challenges with developing and implementing some of the measure methodologies. In late 2015, AHCCCS made the choice to further streamline and transition the performance measures to align more closely with measures and populations found in the CMS Core Measure Sets. This transition provided a better opportunity to shift the system towards indicators of health care outcomes, access to care, and patient satisfaction. This transition has also resulted in the ability to compare AHCCCS' rates with those of other states that have implemented the Core Measure Sets.

AHCCCS has updated the performance measure sets for all lines of business. The first substantive changes to the Performance Measure sets occurred in CYE 2014. Since that time, AHCCCS has continued to adjust the measure list across each of the populations served to better align with CMS Core Measure reporting, as well as nationally-recognized measure sets. AHCCCS has also updated the measure sets in the MCO contracts to reflect changes on measures implemented by CMS for the next contract year.

To enhance the capability of its Contractors, AHCCCS provided utilization and encounter data to facilitate the Contractors' planning and implementation efforts for the new performance measures. Availability of this data to the Contractors further supported their ability to sustain/improve continuing measures.

AHCCCS Medicaid and KidsCare rates for CYE 2017 EPSDT Participation and EPSDT Dental Participation are included in Table 2 below. This data is reflective of the information reported to CMS on the annual Form CMS-416 Report. Please note that although KidsCare is not formally reported to CMS via the CMS-416 Report, AHCCCS monitors this population using the same methodology as the Form CMS-416 Report for comparison purposes.

Table 1

Acute-Care Measure	Percentage %					
	Current Rate: Measurement Period CYE 2016	Measurement Period CYE 2015	Relative Percent Change	Statistical Significance	2016 Medicaid National Mean[14]	Minimum Performance Standard
Children's and Adolescents' Access to PCPs, 12 – 24 Months, *Medicaid*	92.1	95.1	-3.1	Yes	94.8	93
Children's and Adolescents' Access to PCPs, 25 Months – 6 Years, *Medicaid*	85.4	87.7	-2/6	Yes	87.1	84
Children's and Adolescents' Access to PCPs, 7 – 11 Years, *Medicaid*	90.6	91.5	-1.0	Yes	89.9	83

[14] National means listed based on Calendar Year 2015 data published by NCQA in it's the State of Health Care Quality 2016.

Children's and Adolescents' Access to PCPs, 12 – 19 Years, *Medicaid*	88.0	89.3	-1.4	Yes	88.5	82
Well-child Visits in the First 15 Months of Life, *Medicaid*	57.7	62.1	-7.1	Yes	61.7	65
Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life, *Medicaid*	61.0	64.6	-5.5	Yes	72.2	66
Adolescent Well-care Visits, *Medicaid*	39.2	39.8	-1.7	Yes	50.6	41
Annual Dental Visits, Medicaid[15]	58.6	63.7	-1.1	Yes	n/a	60
Ambulatory Care: ED Visits, Total	56	59	n/a	n/a	n/a	TBD
Inpatient Utilization: Total Days per 1,000 MM	27.6	30.9	n/a	n/a	n/a	TBD
All-Cause Readmission: Total	11.2	12.1	-7.6	Yes	n/a[2]	TBD
Diabetes Short-Term Complications Admissions	14.3	19.7	n/a	n/a	n/a	TBD
COPD or Asthma in Older Adults Admissions	44.8	54.2	n/a	n/a	n/a	TBD
Heart Failure Admissions	22.4	23	n/a	n/a	n/a	TBD
Asthma in Younger Adults Admissions	6.9	8.5	n/a	n/a	n/a	TBD

n/a = Rate was not measured for the specific reporting period.

Table 2

Acute-Care Measures	Percentage %	
	Current Rate: Measurement Period CYE 2017	Minimum Performance Standard
EPSDT Participation, Medicaid	50.4	68
EPSDT Dental Participation, Medicaid	48.3	46
EPSDT Participation, CHIP	71.2	68
EPSDT Dental Participation, CHIP	48.3	46

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. However, more recently 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

[15] Annual Dental Visits – NCQA has this measure broken down by age group; therefore N/A was utilized as the Medicaid Mean.

care, and patient satisfaction. This transition has also resulted in the ability to compare AHCCCS' rates with those of other states that implement the same or similar measures.

Contractors are required to implement Corrective Action Plans (CAPs) to improve performance when they do not meet the Minimum Performance Standard (MPS) established for any measure. AHCCCS advises Contractors that they may face financial sanctions if their rates do not meet the MPS. Contractors are required to document corrective actions that were already in place for measures that were not meeting the AHCCCS MPS. They are also required to evaluate the effectiveness of those interventions and determine any revisions or implement new activities designed to improve performance. Sanctions have been an ongoing consideration in performance measurement and AHCCCS continues to reserve the right to impose sanctions if Contractor performance does not align with contract expectations.

ALTCS Performance Measures

ALTCS E/PD and DD Contractors are working toward improving the delivery of services and quality of care provided to their members. AHCCCS has a comprehensive system to monitor and improve the timeliness of, access to, and quality of care that Contractors provide to Medicaid members.

During CYE 2018, AHCCCS finalized data from CYE 2016 rates for the ALTCS E/PD Performance Measures.

ALTCS E/PD Measures	Percentage %				
	Measurement Period CYE 2016 (Current Rate)	Measurement Period CYE 2015	Relative Percent Change	Statistical Significance	Minimum Performance Standard
Ambulatory Care: ED Visits	71	68	n/a	n/a	TBD
Inpatient Utilization: Total Days per 1,000 MM	205.8	207.2	n/a	n/a	n/a
All-Cause Readmission: Total	11.7	13.7	n/a	n/a	TBD
Diabetes Short-Term Complications Admissions	19.5	11.6	n/a	n/a	TBD
COPD or Asthma in Older Adults Admissions	88.3	106.2	n/a	n/a	TBD
Heart Failure Admissions	129.3	122.4	n/a	n/a	TBD

n/a = Rate was not measured for the specific reporting period.

During CYE 2018, AHCCCS finalized data from CYE 2016 rates for the ALTCS DD Performance Measures.

ALTCS DD Measures	Percentage %				
	Measurement Period CYE 2016 (Current Rate)	Measurement Period CYE 2015	Relative Percent Change	Statistical Significance	Minimum Performance Standard
Children's and Adolescents' Access to PCPs, 12 – 24 Months	100.0	98.3	1.7	No	93
Children's and Adolescents' Access to PCPs, 25 Months – 6 Years	89.6	90.1	-0.6	No	84
Children's and Adolescents' Access to PCPs, 7 – 11 Years	92.0	91.1	1.0	No	83

Children's and Adolescents' Access to PCPs, 12 – 19 Years	88.5	88.4	0.1	No	82
Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life	51.2	52.1	-1.8	No	66
Adolescent Well-care Visits	43.5	39.8	9.3	Yes	41
Annual Dental Visit	51.9	55.7	-6.9	Yes	60
Ambulatory Care: ED Visits	43	44	n/a	n/a	TBD
Inpatient Utilization: Total Days per 1,000 MM	48.2	53.4	n/a	n/a	n/a
All-Cause Readmission: Total	7.3	9.2	-20.2	No	TBD
Diabetes Short-Term Complications Admissions	4.2	3.2	n/a	n/a	TBD
COPD or Asthma in Older Adults Admissions	9.8	12.0	n/a	n/a	TBD
Heart Failure Admissions	4.8	3.8	n/a	n/a	TBD

n/a = Rate was not measured for the specific reporting period.

AHCCCS requires the Contractor to submit Corrective Action Plans for measures that do not meet the MPS.

These measures provide a standardized way to evaluate Contractor performance in quality management over time. Additionally, most of the above measures are included in the AHCCCS 1115 Waiver Evaluation Plan for the DDD population.

General Mental Health/Substance Abuse (GMH/SA) Performance Measures

General Mental Health/Substance Abuse members receive Behavioral Health services from Regional Behavioral Health Authorities (RBHAs) and AHCCCS evaluates those services in the same manner as physical health services. Data from CYE 2015 as well as CYE 2016 for the General Mental Health/ Substance Abuse (GMH/SA) Performance Measures are included below.

GMH/SA Measures	Percentage %					
	Measurement Period CYE 2016 (Current Rate)	Measurement Period CYE 2015	Relative Percent Change	Statistical Significance	2016 Medicaid National Mean[16]	Minimum Performance Standard
Plan All-Cause Readmission[17]	15.4	21.5	n/a	n/a	n/a	TBD
Inpatient Utilization – Total Days per 1,000 MM	8.5	18.3	n/a	n/a	n/a	TBD
7 Day Follow-Up After Hospitalization for Mental Illness	51.5	46.7	10.4	Yes	45.5	50

[16] National means listed based on Calendar Year 2016 data published by NCQA in it's the *State of Health Care Quality Report*.
[17] Plan All Cause Readmission – NCQA has this measure broken down by age group; therefore, n/a was utilized for the Medicaid Mean as the data reported and the associated MPS relates to the overall total.

30 Day Follow-Up After Hospitalization for Mental Illness	68.9	63.7	8.3	Yes	63.8	70

n/a = Rate/percentage was not measured or reported for the specific reporting period, or rate unable to be calculated based on reporting type.

Serious Mental Illness (SMI) Performance Measures

On April 1, 2014, approximately 17,000 members with Serious Mental Illness in Maricopa County were transitioned to a single plan, Mercy Maricopa Integrated Care, to manage both their behavioral and physical health care needs. On October 1, 2015, this model was launched statewide through Contracts with Health Choice Integrated Care in Northern Arizona and Cenpatico Integrated Care in Southern Arizona. Data from CYE 2015 as well as CYE 2016 for the SMI Measures are included below.

SMI Measures	Percentage %				
	Measurement Period CYE 2016 (Current Rate)	Measurement Period CYE 2015	Relative Percent Change	Statistical Significance	Minimum Performance Standard
Adults' Access to Preventative/Ambulatory Health Services	92.8	94.0	-1.2	Yes	75
Plan All-Cause Readmission	19.6	26.1	n/a	n/a	TBD
Ambulatory Care: ED Visits	132	160	n/a	n/a	TBD
Diabetes Short-Term Complications Admissions	33.9	47.5	n/a	n/a	TBD
COPD or Asthma in Older Adults Admissions	24.7	114.4	n/a	n/a	TBD
Heart Failure Admissions	31.7	32.7	n/a	n/a	TBD
Asthma in Younger Adults Admissions	19.1	21.4	n/a	n/a	TBD
Inpatient Utilization: Total Days per 1,000 MM	332.1	455.9	n/a	n/a	TBD
7 Day Follow-Up After Hospitalization for Mental Illness	74.4	72.8	2.2	No	50
30 Day Follow-Up After Hospitalization for Mental Illness	87.4	85.4	2.4	Yes	70

n/a = Rate/percentage was not measured or reported for the specific reporting period, or rate unable to be calculated based on reporting type.

Performance Improvement Projects

One Performance Improvement Project (PIPs) involving all AHCCCS Contractors was active in CYE 2017.

- Electronic Prescribing – The purpose of this Performance Improvement Project is to increase the number of prescribers electronically prescribing prescriptions and to increase the percentage of prescriptions which are submitted electronically in order to improve patient safety.

AHCCCS Electronic Prescribing Performance Measurement

Line of Business	Percent of Providers who Prescribed at Least One Prescription Electronically	Percent of Prescriptions Prescribed Electronically
Acute		
CYE 2017 (Re-Measurement 2)	73.0	54.9
CYE 2016 (Re-Measurement 1)	69.5	49.5
CYE 2014 (Baseline)	65.1	42.5
ALTCS DD		
CYE 2017 (Re-Measurement 2)	67.4	62.0
CYE 2016 (Re-Measurement 1)	62.8	57.9
CYE 2014 (Baseline)	57	44.5
ALTCS E/PD		
CYE 2017 (Re-Measurement 2)	63.1	33.5
CYE 2016 (Re-Measurement 1)	58.4	28.5
CYE 2014 (Baseline)	49.7	24.6
CMDP		
CYE 2017 (Re-Measurement 2)	60.5	60.7
CYE 2016 (Re-Measurement 1)	55.3	56.6
CYE 2014 (Baseline)	47.7	46.7
CRS		
CYE 2017 (Re-Measurement 2)	61.9	63.6
CYE 2016 (Re-Measurement 1)	58.5	57.3
CYE 2014 (Baseline)	50.8	42.9

XI. Demonstration Implementation Update

AHCCCS Acute Care Program Demonstration

AHCCCS has operated under an 1115 Research and Demonstration Waiver since 1982, when it became the first statewide Medicaid managed care system in the nation. The AHCCCS Acute Care Program (AACP) is a statewide managed care delivery system that provides services for children and pregnant women who qualify for the federal Medicaid Program (Title XIX), as well as childless adults and families. Although most AHCCCS members are required to enroll in contracted health plans, American Indians and Alaska Natives in AACP may choose to receive services through either the contracted health plans or American Indian Health Program (AIHP).

Most AACP enrollees receive integrated physical and behavioral health care services through a single managed care organization (MCO) called an AHCCCS Complete Care (ACC) Plan. AACP members determined to have a SMI receive integrated physical and health services through a geographically designated Regional Behavioral Health Authorities (RBHAs).

On October 1, 2018, AHCCCS transitioned 1.5 million AHCCCS members into the ACC health plans. Specifically, the ACC Plans serve all AHCCCS Acute Care Program enrollees except for adults determined to have a Serious Mental Illness and foster children enrolled with the Comprehensive Medical and Dental Program (CMDP).

The RBHAs retain contracts with AHCCCS for the provision of services for the following populations:

- Adults who have been determined to have a Serious Mental Illness are covered for integrated physical and behavioral health services;
- Children in foster care enrolled with the Comprehensive Medical Dental Program (CMDP) are covered for behavioral health services; and
- Members enrolled with the Department of Economic Security/Division of Developmental Disabilities (DES/DDD) for behavioral health services.

The ACC Contracts were awarded by GSAs, as outlined in the table below.

ACC Managed Care Organization (MCO)	Geographical Service Area (GSA)		
	Central GSA *Maricopa, Gila, Pinal*	**North GSA** *Mohave, Coconino, Apache, Navajo, Yavapai*	**South GSA** *Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, Yuma*
Arizona Complete Health-Complete Care Plan	**X**		**X**
Banner University Family Care	**X**		**X**
Care1st Health Plan	**X**	**X**	
Magellan Complete Care	**X**		
Mercy Care	**X**		
Steward Health Choice Arizona	**X**	**X**	
UnitedHealthcare Community Plan	**X**		**X (Pima County Only)**

Arizona Long Term Care Program (ALTCS) Demonstration

In 1988, six years after the initial program implementation, the original demonstration waiver was substantially amended to allow Arizona to implement a capitated long term care program for the elderly and physically disabled and the developmentally disabled population – the Arizona Long Term Care System (ALTCS). The ALTCS program, administered as a distinct program from the AHCCCS Acute Care program, provides acute, long term care, behavioral health, and HCBS to Medicaid members who are at risk of institutionalization. Program services are provided through contracted prepaid, capitated arrangements with MCOs. ALTCS members who are developmentally disabled are served through the Department of Economic Security (DES), Division of Developmental Disabilities (DDD). The priority of the ALTCS program is to ensure that members are living in the most integrated setting and actively

engaged and participating in community life. Over the past 30 years, ALTCS has achieved remarkable success increasing member placement in HCBS, resulting in significant program savings while also appropriately meeting the needs of members.

In March 2017, AHCCCS awarded contracts for the ALTCS EP/D program which serves more than 26,000 members who are elderly, blind, or disabled and at risk of institutionalization. The ALTCS Contracts were awarded by GSAs, as outlined in the table below. ALTCS Contracts were effective October 1, 2017 for a period of up to seven years.

ALTCS Managed Care Organization (MCO)	**Geographical Service Area (GSA)**		
	Central GSA *Maricopa, Gila, Pinal*	**South GSA** *Mohave, Coconino, Apache, Navajo, Yavapai*	**North GSA** *Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, Yuma*
Banner-University Family Care (B-UFC)	**X**	**X**	
Mercy Care Plan (MCP)	**X**	**X (Pima County Only)**	
UnitedHealthcare Community Plan (UHCCP)	**X**		**X**

Targeted Investments (TI) Program Demonstration

TI Program Background

On January 18, 2017, CMS approved an amendment to Arizona's 1115 Research and Demonstration Waiver authorizing the Targeted Investments (TI) program. 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 Program will provide funding for providers who serve the following populations:

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

The program will make up to $300 million in directed incentive payments to AHCCCS providers who assist the State in promoting the integration of physical and behavioral health care, increasing efficiencies in care delivery, and improving health outcomes. The TI Program will incentivize providers to collaborate on the development of shared clinical and administrative protocols to enable patient care management across provider systems and networks. Incentive payments will be distributed to

participating providers through AHCCCS managed care organizations pursuant to 42 CFR 438.6(c). Providers are expected to meet performance improvement targets in order to receive payments. The table below displays the TI funding by federal fiscal year.

Estimated Annual Funding Distribution for the Targeted Investments Program

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Targeted Investments	$19 m.	$66.5 m.	$85.5 m.	$66.4 m.	$47.5 m.	$285 m.
Administrative Expenses	$1 m.	$3.5 m.	$4.5 m.	$3.5 m.	$2.5 m	$15 m.
Totals	$20 m.	$70 m.	$90 m.	$70 m.	$50 m.	$300 m.

In Demonstration Years 3 through 5, the state must meet the statewide performance measure targets to secure full TI program funding (Appendix 3). If the State does not meet certain performance requirements in a given demonstration year, the TI Program will lose the amount of Designated State Health Program (DSHP) funds specified as "at risk" for that year.

Total Computable DSHP at Risk for Each Demonstration Year

	Year 1	Year 2	Year 3	Year 4	Year 5
Total Computable DSHP	$6,274,400	$21,137,600	$27,177,000	$21,137,600	$15,098,300
Percentage at Risk	0%	0%	10%	15%	20%
Total Amount at Risk	$0	$0	$2,717,700	$3,170,640	$3,019,660

TI Program Updates

Below is a summary of the TI program implementation activities conducted by AHCCCS in FY 2018:

- AHCCCS reviewed over 300 unique applications of behavioral health, hospital, and primary care providers who have applied for the TI Program.[18]
- Established the reporting system for TI program participants to submit attestations of milestone completion, and to upload documents for validation.[19]
- The Agency developed an action plan with Arizona's Health Information Exchange (HIE) to onboard TI participants in order to ensure that they are able to receive admission, discharge, and transfer (ADT) alerts from the HIE by September 30, 2018.
- AHCCCS developed a TI participant orientation module.
- AHCCCS developed and implemented multiple communication avenues for participants, and stakeholders including a detailed and regularly updated Targeted Investments webpage, direct email, a dedicated Targeted Investments email address, and social media post which all together generated media coverage in major news outlets.
- Made Demonstration Year One incentive payments to providers that met the TI program eligibility requirements.

[18] TI Program participation list: https://azahcccs.gov/PlansProviders/TargetedInvestments/TI-participants/
[19] TI program attestation portal: https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2

- Developed and posted 24 education and guidance modules to support TI program participants' efforts to understand and meet milestones.[20]
- Made numerous presentations on the TI program to a range of internal and external stakeholders, explaining the integration and whole person care goals and objectives of the TI program.
- Established an ongoing dialogue between AHCCCS and AHCCCS MCOs to facilitate alignment between the TI program guidance on enhanced provider level integration and the MCOs' provider network integration initiatives, including regular meetings between AHCCCS and MCO medical directors.
- Collaborated with the Arizona Council of Human Services to train behavioral health providers across the state in the Early Childhood Service Intensity Instrument (ECSII). The ECSII is a tool for providers and others involved in the care of young children with emotional, behavioral, and/or developmental needs, and their families, including those children who are experiencing environmental stressors that may put them at risk for such problems. As part of Core Component #5 for Pediatric Behavioral Health Providers, TI participants are required to routinely screen children using ECSII.[21]
- 170 Pediatric primary care provider participants attended training on the screening and impact of adverse child experiences (ACEs) and Trauma-Informed Care and follow-up.
- 2,560 behavioral health provider participated in 79 class sessions on providing trauma-informed care including principles of trauma-informed care, the impact of trauma on relationships and the importance of relationships in helping children heal from trauma, and characteristics of evidence-based trauma-informed practices. [22]
- TI participants were engaged by AHCCCS through electronic and in-person forums, surveys, and webinars including (1) six in person forums for TI participants offered in Phoenix, Tucson, and Cottonwood; (2) six webinars to review the attestation process and the document validation criteria with TI providers with an average of 40 attendees per session[23]; (3) monthly newsletters sent to all the participants which includes pertinent information, tips and reminders, program updates and upcoming due dates; (4) administered surveys to gather feedback from all TI participants that generated over 100 responses[24]; and (5) continued to update the robust TI webpage with resources and communications.
- Five co-located justice clinics that serve AHCCCS members exiting the criminal justice system, became operational with an additional four expected to become operational by October 31, 2018.
- Developed a Peer/Family training curriculum to meet a TI milestone for co-located Justice Clinics that requires training of peer and family support staff. The TI Program Partnered with Maricopa Integrated Health System to develop the first phase of the Peer/Family training curriculum which is being used to train individuals providing Peer/Family services to the justice involved individuals who are served by the TI co-located justice sites.
- Pursuant to STC 57, AHCCCS has submitted the baseline data for the TI program Statewide Focus Population Measures and Targets (Appendix 3).

[20] TI program training and education material: https://azahcccs.gov/PlansProviders/TargetedInvestments/training/
[21] Core Component #5 for Pediatric Behavioral Health Providers: https://www.azahcccs.gov/PlansProviders/Downloads/TI/CoreComponents/The%20Early%20Childhood%20Service%20Intensity%20Instrument%20(ESCII)%20.pdf
[22] TI program Trauma Informed Care training flyer: https://azahcccs.gov/PlansProviders/TargetedInvestments/Training/PediatricBHTraumaInformedCareTraining.pdf
[23] TI program attestation webinar : https://player.vimeo.com/video/284767394
[24] TI program participants survey: https://www.surveymonkey.com/r/L5S57B5

Waiver Evaluation Update

In accordance with STC 59, AHCCCS must submit a draft waiver evaluation design for its 1115 waiver demonstration programs including research questions, hypotheses, and proposed measures for the Acute Care program, ALTCS, and the integration efforts under the RBHAs and CRS plans. In addition, AHCCCS is required by CMS to submit an interim evaluation report and a final evaluation report of the 1115 waiver demonstration by September 30, 2020 and February 12, 2023 respectively.

On May 17, 2017, AHCCCS submitted a draft waiver evaluation design for TI program. The evaluation of the TI program will focus on understanding the impact of the TI projects on:

- Reducing fragmentation that occurs between acute care and behavioral health care including data and information sharing;
- Creating efficiencies in service delivery for members with behavioral health needs including the use of common screening and referral protocols and co-located services; and
- Improving health outcomes for targeted populations.

On June 8, 2017, AHCCCS submitted a draft waiver evaluation design for the Acute Care, ALTCS, Integrated RBHA, and CRS demonstrations. The evaluation design proposes to test a series of hypotheses that will allow Arizona to test its success in achieving the following demonstration goals:

- Providing quality health care to members in a mainstream environment;
- Ensuring access to care for members; and
- Maintaining or improving member satisfaction with care.

In 2018, AHCCCS submitted 1115 Waiver Final Evaluation Report for FY 2011-2016 demonstration period. Furthermore, AHCCCS completed an independent evaluation of the integration of physical and behavioral health services provided to children enrolled in Children's Rehabilitative Services (CRS) program, as well as adults residing in Maricopa County who have been determined to have a Serious Mental Illness (SMI). Pursuant to Arizona's 1115 Waiver STCs, AHCCCS submitted the draft CRS and SMI Integration Evaluation Report to CMS for review.

In FY 2019, AHCCCS will continue to work with CMS to finalize the evaluation designs for the TI program, AHCCCS Complete Care, ALTCS, CMDP, and Integrated RBHA demonstrations.

XII. Notable Achievements

Achievements Noted Above

- AHCCCS successfully defended in court the current statutory structure of the Hospital Assessment funding. The Arizona Supreme Court upheld the AHCCCS Administration's hospital assessment in an Opinion dated November 17, 2017. The Opinion concluded that "the hospital assessment authorized in A.R.S. § 36-2901.08 is not a 'tax' for purposes of article 9, section 22 of the Arizona Constitution and it is excepted from the supermajority vote requirement under subsection 22(C)(2) because it is "not prescribed by formula, amount or limit" and is set by the AHCCCS director."

- In 2018, AHCCCS successfully awarded the ACC RFP and transitioned 1.5 million members on October 1, 2018. The ACC health plans provide integrated physical and behavioral health care services. The ACC Plans serve AHCCCS Acute Care Program enrollees except for adults determined

to have a Serious Mental Illness and foster children enrolled with the Comprehensive Medical and Dental Program (CMDP).

- AHCCCS achieved 98.8% retention rate for TI program participants. AHCCCS has undertaken several initiatives to retain TI participants including regional forums and webinars detailing program requirements, provider surveys, a dedicated email box for provider questions, TI newsletters, weekly messages to participants, bimonthly meeting with MCO Medical Directors, and TI webpage with additional information to providers.

New Items

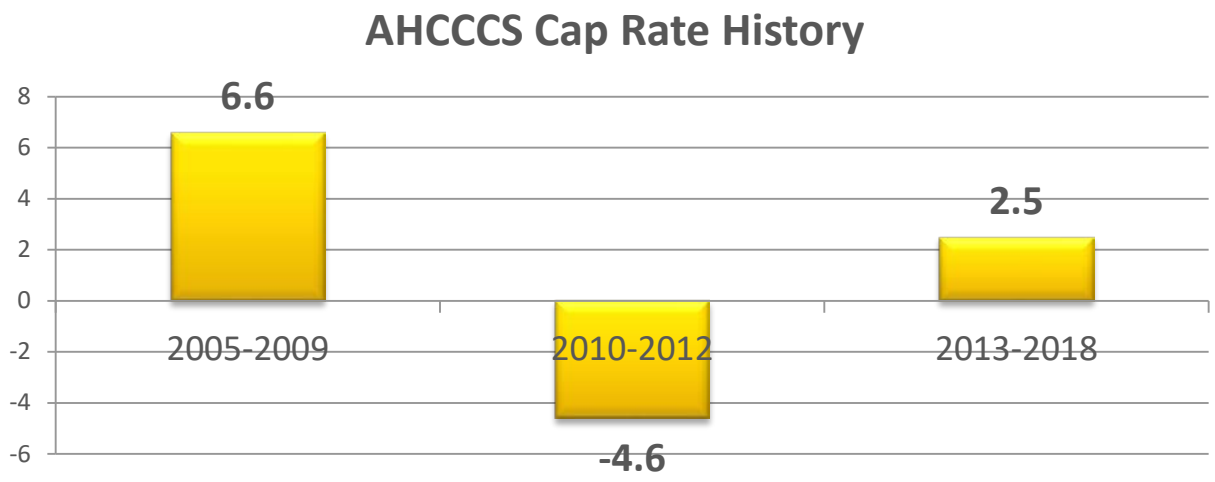
- AHCCCS, the Department of Economic Security (DES), and the Department of Corrections were administrative partners in establishing three Second Chance Centers located in the Lewis and Perryville State Prisons and the Tucson State Prison Complex. The centers, launched in March 2017, equip and prepare inmate with pre-release life and career skills training and meet potential employers. Since the program began, 1,692 inmates have graduated from a Second Chance Center and 808 have had job opportunities upon leaving prison.

- The Agency established new Differential Adjusted Payments (DAP) for hospitals, nursing facilities, and behavioral health providers.[25] For the contracting year October 1, 2018 through September 30, 2019 (CYE 2019), the hospitals, nursing facilities, and behavioral health providers that meet the agency established performance criteria below will qualify for DAP payments:
    - Hospitals that (1) participate in the Network, the state's health information exchange (HIE); (2) hold a Pediatric-Prepared Emergency Care certification; and (3) enter into a care coordination agreement with an IHS or Tribal 638 facility;
    - Nursing Facilities that perform above the Arizona average for long-stay, high-risk residents with Stage II-IV pressure ulcers as reported in the Minimum Data Set (MDS) 3.0; and
    - Behavioral health providers that have contracts in place with AHCCCS Complete Care Contractors and provide services for Fee-For-Service American Indian Health Program (AIHP) enrolled members.

- AHCCCS implemented a $1,000 emergency dental benefit for adult members.

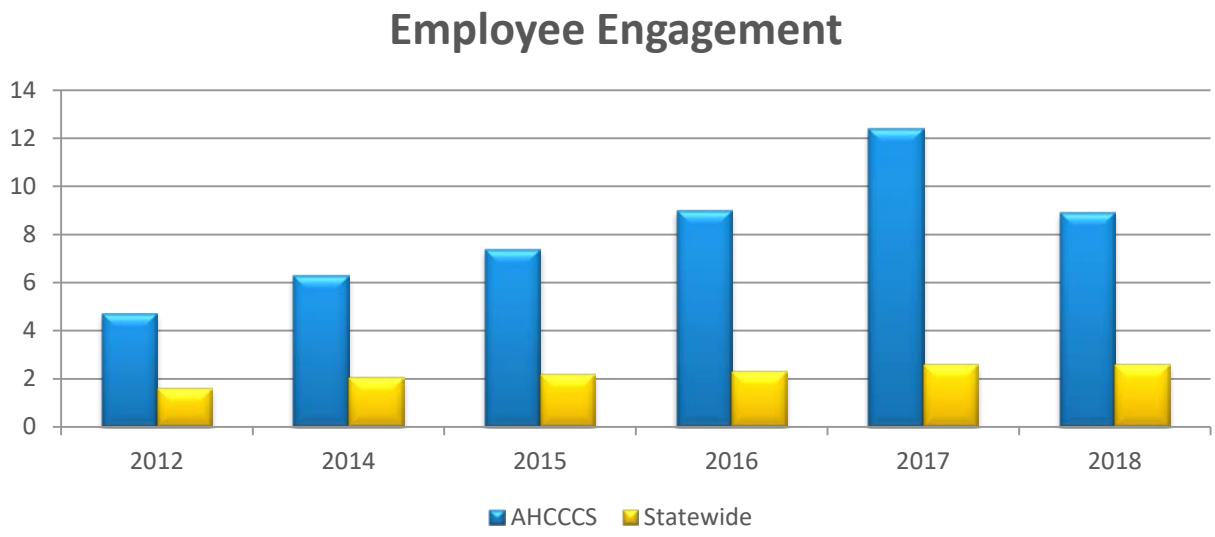
- For Contract Year Ending 2018, AHCCCS experienced a minimal overall weighted average capitation rate increase of 2.9% which continues the overall trend for capitation rate growth of below 3% for the program.

[25] https://www.azahcccs.gov/AHCCCS/Downloads/PublicNotices/rates/DifferentialAdjustedPaymentDAP_20181001.pdf



- AHCCCS has dedicated significant Agency resources to addressing the ongoing opioid epidemic that has occurred in the United States. In collaboration with the Governor and the Department of Health Services, AHCCCS has pursued a number of strategies to leverage limited grant funding and the Medicaid delivery system to expand capacity to services while at the same time establishing protocols to limit the number of prescriptions to opioid naïve members.

- In 2018, AHCCCS continues to have overall employee engagement scores that far exceed the statewide average. AHCCCS has achieved nearly a world class level of employee engagement with 8.9 engaged employees for every 1 disengaged employee in 2018. This is compared to the statewide average of 2.3 engaged employees for every 1 disengaged employee.



APPENDIX 1:
BUDGET NEUTRALITY

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended September 30, 2018

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	DY1-5 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	2,932,352	2,920,036	2,913,896	2,938,635	11,704,919	$ 4,784,751,395	
SSI	835.29	1.06	885.41	69.10%	611.79	487,614	489,048	489,096	491,751	1,957,509	1,197,579,012	
AC [1]			562.08	69.74%	391.97	527,244	430,723	365,132	310,396	1,633,495	640,280,511	
ALTCS-DD	4643.75	1.06	4922.38	67.38%	3316.47	72,510	73,146	73,956	74,810	294,422	976,441,016	
ALTCS-EPD	4503.21	1.052	4737.37	67.50%	3197.93	85,480	85,526	85,748	86,530	343,284	1,097,797,306	
Family Plan Ext [1]		1.058	17.04	90.00%	15.33	12,471	12,424	12,440	12,689	50,024	767,009	
											$ 8,697,616,249	MAP Subtotal
											103,890,985	Add DSH Allotment
											$ 8,801,507,234	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%	423.93	2,911,239	2,890,976	2,902,794	2,918,665	11,623,674	$ 4,927,651,277	
SSI	938.53	67.86%	636.91	494,839	497,245	499,888	503,513	1,995,485	1,270,940,740	
AC [1]	600.79	68.73%	412.94	274,990	248,817	228,204	217,114	969,125	400,188,004	
ALTCS-DD	5217.72	65.83%	3434.66	75,630	76,458	77,272	78,026	307,386	1,055,766,726	
ALTCS-EPD	4983.71	66.01%	3289.97	86,847	86,093	86,321	87,151	346,412	1,139,685,393	
Family Plan Ext [1]	18.42	90.00%	16.58	13,104	13,824	14,187	14,856	55,971	927,946	
									$ 8,795,160,085	MAP Subtotal
									106,384,369	Add DSH Allotment
									$ 8,901,544,454	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	2,891,526	2,839,072	2,955,241	3,112,954	11,798,793	$ 5,391,915,105	
SSI	994.84	69.27%	689.14	506,930	514,698	523,692	530,096	2,075,416	1,430,260,569	
AC [1]	600.51	69.84%	419.42	206,419	87	2	-	206,508	86,613,704	
ALTCS-DD	5530.78	67.35%	3725.09	78,830	79,668	80,657	81,743	320,898	1,195,373,030	
ALTCS-EPD	5242.86	67.53%	3540.31	87,699	87,917	88,759	89,386	353,761	1,252,424,154	
Family Plan Ext [1]	12.99	90.00%	11.69	14,885	-	-	-	14,885	174,071.00	
Expansion State Adults [1]	623.94	85.37%	532.64	-	443,762	623,969	755,331	1,823,062	971,034,448	
									$ 10,327,795,082	MAP Subtotal
									108,086,519	Add DSH Allotment
									$ 10,435,881,601	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%	486.73	3,145,348	3,083,833	3,103,642	3,207,032	12,539,855	$ 6,103,585,727	
SSI	1054.53	70.25%	740.77	537,794	544,665	545,794	546,224	2,174,477	1,610,779,364	
AC	0.00	68.43%	0.00	-	-	-	-	-	-	
ALTCS-DD	5862.63	68.54%	4018.16	82,709	83,804	84,807	85,577	336,897	1,353,707,564	
ALTCS-EPD	5515.49	68.69%	3788.32	90,037	89,909	89,960	90,053	359,959	1,363,641,671	
Family Plan Ext	0.00	90.00%	0.00	-	-	-	-	-	-	
Expansion State Adults	569.32	87.76%	499.61	816,906	834,750	844,222.00	864,233.00	3,360,111	1,678,728,697	
									$ 12,110,443,023	MAP Subtotal
									109,815,903	Add DSH Allotment
									$ 12,220,258,926	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	71.44%	512.13	3,258,890	3,255,778	3,245,802	3,330,068	13,090,538	$ 6,704,115,132	
SSI	1117.81	70.51%	788.20	551,462	554,246	551,367	554,258	2,211,333	1,742,983,543	
AC	0.00	68.66%	0.00	-	-	-	-	-	-	
ALTCS-DD	6214.39	68.96%	4285.72	86,343	87,108	88,220	89,185	350,856	1,503,669,296	
ALTCS-EPD	5802.30	69.10%	4009.42	89,921	89,515	89,675	89,957	359,068	1,439,655,433	
Family Plan Ext	0.00	90.00%	0.00	-	-	-	-	-	-	
Expansion State Adults	567.70	90.70%	514.89	913,697	927,976	929,950	935,710	3,707,333	1,908,850,417	
									$ 13,299,273,822	MAP Subtotal
									110,145,351	Add DSH Allotment
									$ 13,409,419,173	Total BN Limit

	DY6-10 Trend Rate	DY 06 PM/PM			Member Months QE 12/16	QE 3/17	QE 6/17	QE 9/17	Total		
AFDC/SOBRA	1.045	749.11	72.05%	539.72	3,381,966	3,385,607	3,368,329	3,354,840	13,490,742	7,281,283,231	
SSI	1.04	1162.52	70.94%	824.71	555,723	557,530	557,341	558,842	2,229,436	1,838,627,866	
AC		0.00	69.20%	0.00	-	-	-	-	-	-	
ALTCS-DD	1.04	6462.96	69.29%	4478.26	90,164	91,253	92,427	93,386	367,230	1,644,551,144	
ALTCS-EPD	1.037	6016.98	69.45%	4178.89	90,314	90,019	90,414	91,191	361,938	1,512,499,002	
Family Plan Ext		0.00	90.00%	0.00	-	-	-	-	-	-	
Expansion State Adults		602.45	90.84%	547.24	952,746	958,288	958,760	957,645	3,827,439	2,094,542,445	
										$ 14,371,503,689	MAP Subtotal
										111,136,659	Add DSH Allotment
										$ 14,482,640,348	Total BN Limit

	DY 07 PM/PM			Member Months QE 12/17	QE 3/18	QE 6/18	QE 9/18	Total		
AFDC/SOBRA	782.81	72.68%	568.97	3,321,778	3,228,411	3,186,726	3,182,474	12,919,389	$ 7,350,715,623	
SSI	1209.02	71.53%	864.83	562,144	563,526	561,748	558,740	2,246,158	$ 1,942,536,344	
AC	0.00	81.19%	0.00	-	-	-	-	-	$ -	
ALTCS-DD	6721.48	69.93%	4700.47	94,336	95,524	96,902	97,941	384,703	$ 1,808,286,778	
ALTCS-EPD	6239.61	70.07%	4372.24	91,795	91,422	91,922	92,171	367,310	$ 1,605,968,979	
Family Plan Ext	0.00	90.00%	0.00	-	-	-	-	-	$ -	
Expansion State Adults	674.55	91.82%	619.36	955,384	936,451	929,032	933,227	3,754,094	$ 2,325,151,868	
									$ 15,032,659,592	MAP Subtotal
									113,803,939	Add DSH Allotment
									$ 15,146,463,531	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 10/30/2018

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended September 30, 2018

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 2021:	MAP	DSH	Total	AFDC/SOBRA	SSI	AC	ALTCS-DD	ALTCS-EPD	Family Plan	DSH/CAHP	SNCP/DSHP	UNC CARE	MED	Exp St Adults	TIP	TIP-DSHP	Total	VARIANCE
QE 12/11	$ 2,217,697,303	$ 103,890,985	$ 2,321,588,288	$ 502,890,921	$ 191,249,757	$ 175,610,617	$ 151,638,753	$ 164,685,415	$ 167,197	$ -	$ -	$ -	$ 458,635	$ -			$ 1,186,701,295	$ 1,134,886,993
QE 3/12	2,177,962,408	-	2,177,962,408	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	883,189,820
QE 6/12	2,153,168,698	-	2,153,168,698	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	717,896,898
QE 9/12	2,148,787,840	-	2,148,787,840	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	808,134,253
QE 12/12	2,208,593,801	106,384,369	2,314,978,170	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	876,688,787
QE 3/13	2,191,103,448	-	2,191,103,448	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	846,748,192
QE 6/13	2,192,836,894	-	2,192,836,894	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	777,528,349
QE 9/13	2,202,625,942	-	2,202,625,942	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	682,322,897
QE 12/13	2,361,623,357	108,086,519	2,469,709,876	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	964,086,185
QE 3/14	2,496,550,272	-	2,496,550,272	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	1,011,898,897
QE 6/14	2,658,451,086	-	2,658,451,086	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	1,050,426,011
QE 9/14	2,811,170,367	-	2,811,170,367	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	946,596,338
QE 12/14	3,010,888,714	109,815,903	3,120,704,617	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	1,094,352,817
QE 3/15	2,998,866,957	-	2,998,866,957	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	1,245,287,676
QE 6/15	3,018,300,698	-	3,018,300,698	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	1,107,258,452
QE 9/15	3,082,386,654	-	3,082,386,654	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	1,198,323,706
QE 12/15	3,304,676,673	110,145,351	3,414,822,024	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	1,391,857,241
QE 3/16	3,314,280,064	-	3,314,280,064	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	1,367,600,073
QE 6/16	3,313,325,377	-	3,313,325,377	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	1,342,787,374
QE 9/16	3,366,991,708	-	3,366,991,708	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	1,456,479,389
QE 12/16	3,586,211,873	111,136,659	3,697,348,532	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	1,650,532,762
QE 3/17	3,596,344,129	-	3,596,344,129	698,367,817	340,649,746	(91,276)	231,791,677	232,289,659	(72)	4,775,270	-	-	-	533,802,478			2,041,585,299	1,554,758,830
QE 6/17	3,594,029,338	-	3,594,029,338	753,982,845	381,866,177	26,531,976	251,886,540	247,601,051	(70)	112,797,468	27,231,927	269,020		506,442,446			2,308,609,380	1,285,419,958
QE 9/17	3,594,918,349	-	3,594,918,349	678,845,907	344,221,688	(194,349)	242,239,652	246,326,890	(58)	-	-	646,701		499,804,367			2,011,890,798	1,583,027,551
QE 12/17	3,812,646,312	113,803,939	3,926,450,251	701,480,418	358,012,550	8,567,838	257,308,208	250,593,667	(20)	4,267,595	37,995,104	-	-	545,879,873	14,754,469	9,115,704	2,187,975,406	1,738,474,845
QE 3/18	3,731,758,814		3,731,758,814	770,555,544	381,249,547	27,912,368	279,790,181	258,280,283	(2)	2,830,054	-	-	-	544,000,310	(73,171)		2,264,545,114	1,467,213,700
QE 6/18	3,752,945,583		3,752,945,583	680,124,377	363,076,644	(8,697)	194,372,813	250,851,768	(1)	99,454,987	-	-	-	552,217,066	-	-	2,140,088,957	1,612,856,626
QE 9/18	3,735,308,882		3,735,308,882	688,319,576	354,831,919	(454,586)	361,963,935	257,104,150	(377)	2,250,975	-	-		520,261,631	-	-	2,184,277,223	1,551,031,659
	$ 82,634,451,542	$ 763,263,725	$83,397,715,267	$ 18,206,060,476	$8,219,486,648	$1,204,459,639	$5,719,181,717	$5,945,753,976	$ 1,866,414	$766,379,106	$982,643,766	$ 198,000,032	$ 453,960	$ 8,781,966,251	$ 14,681,298	$ 9,115,704	$50,050,048,987	$33,347,666,280

Arizona Health Care Cost Containment System
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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 SEPTEMBER 2021:								
DY 01	$ 8,801,507,234	$ 5,636,154,909	$ 3,165,352,325	35.96%				
DY 02	8,901,544,454	5,839,068,654	3,062,475,800	34.40%				
DY 03	10,435,881,601	6,476,446,668	3,959,434,933	37.94%				
DY 04	12,220,258,926	7,374,367,282	4,845,891,644	39.65%				
DY 05	13,409,419,173	8,034,334,018	5,375,085,155	40.08%				
DY 06	14,482,640,348	8,444,747,841	6,037,892,507	41.69%				
DY 07	15,146,463,531	8,244,929,615	6,901,533,916	45.57%	$ 83,397,715,267	$ 50,050,048,987	$ 33,347,666,280	39.99%
	$ 83,397,715,267	$ 50,050,048,987	$ 33,347,666,280					

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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	07	Total
AC	917,847,899	582,030,474	123,922,054	36,049,882	48,139,177	29,671,597	(575,865)	1,737,085,218
AFDC/SOBRA	3,415,712,842	3,582,413,867	3,539,927,586	3,600,740,525	3,988,085,754	3,919,767,159	3,591,426,657	25,638,074,390
ALTCS-EPD	1,061,686,933	1,166,776,288	1,195,360,110	1,243,689,357	1,264,268,575	1,381,591,269	1,376,092,649	8,689,465,181
ALTCS-DD	939,086,691	1,005,552,529	1,067,544,797	1,170,346,154	1,252,962,694	1,380,802,799	1,547,958,534	8,364,254,198
DSH/CAHP	155,762,651	163,280,200	162,283,023	170,517,535	170,272,775	167,356,270	136,270,924	1,125,743,378
Expansion State Adults	-	-	1,137,259,702	1,909,922,917	2,101,442,025	2,302,507,498	2,325,151,868	9,776,284,010
Family Planning Extension	830,631	1,008,110	190,026	(1,337)	(763)	(342)	(433)	2,025,892
MED	673,818	-	-	-	-	-	-	673,818
SNCP/DSHP	296,636,120	558,334,298	240,250,917	135,561,857	116,750,000	95,000,000	22,500,000	1,465,033,192
SSI	1,349,500,719	1,426,848,072	1,545,557,156	1,738,930,248	1,846,633,567	1,949,062,394	1,875,502,093	11,732,034,249
TIP	-	-	-	-	-	19,438,831	-	19,438,831
TIP - DSHP	-	-	-	-	-	13,165,373	-	13,165,373
Uncomp Care IHS/638	22,866,717	97,192,513	53,888,765	13,437,080	7,647,155	3,208,226	-	198,240,456
Subtotal	8,160,605,021	8,583,436,351	9,066,184,136	10,019,194,218	10,796,200,959	11,261,571,074	10,874,326,427	68,761,518,186
New Adult Group	-	-	108,346,000	308,812,997	444,794,755	505,066,522	442,277,137	1,809,297,411
Total	8,160,605,021	8,583,436,351	9,174,530,136	10,328,007,215	11,240,995,714	11,766,637,596	11,316,603,564	70,570,815,597

Federal Share

Waiver Name	01	02	03	04	05	06	07	Total
AC	640,069,477	400,049,580	86,554,713	24,670,313	33,050,385	20,532,732	(467,561)	1,204,459,639
AFDC/SOBRA	2,385,687,588	2,466,602,711	2,497,529,558	2,572,166,355	2,849,318,109	2,824,296,364	2,610,459,791	18,206,060,476
ALTCS-EPD	716,684,559	770,241,449	807,182,501	854,230,164	873,617,286	959,537,066	964,260,951	5,945,753,976
ALTCS-DD	632,712,981	661,923,939	719,011,976	802,139,221	864,098,810	956,774,063	1,082,520,727	5,719,181,717
DSH/CAHP	104,828,265	107,242,435	109,102,877	116,736,303	117,351,997	115,877,481	95,239,748	766,379,106
Expansion State Adults	-	-	970,884,365	1,676,644,950	1,906,639,217	2,092,224,468	2,135,573,251	8,781,966,251
Family Planning Extension	767,009	927,946	174,071	(1,212)	(689)	(311)	(400)	1,866,414
MED	453,960	-	-	-	-	-	-	453,960
SNCP/DSHP	199,636,108	366,713,968	161,520,692	92,805,648	80,464,100	65,778,000	15,725,250	982,643,766
SSI	932,466,927	968,298,947	1,070,640,085	1,221,568,551	1,302,164,523	1,382,729,757	1,341,617,858	8,219,486,648
TIP	-	-	-	-	-	14,681,298	-	14,681,298
TIP - DSHP	-	-	-	-	-	9,115,704	-	9,115,704
Uncomp Care IHS/638	22,848,035	97,067,679	53,845,830	13,406,989	7,630,280	3,201,219	-	198,000,032
Subtotal	5,636,154,909	5,839,068,654	6,476,446,668	7,374,367,282	8,034,334,018	8,444,747,841	8,244,929,615	50,050,048,987
New Adult Group	-	-	108,346,000	308,804,248	444,338,001	485,976,874	417,793,751	1,765,258,874
Total	5,636,154,909	5,839,068,654	6,584,792,668	7,683,171,530	8,478,672,019	8,930,724,715	8,662,723,366	51,815,307,861

Adjustments to Schedule C Waiver 11-W00275/9

Total Computable

Waiver Name	01	02	03	04	05	06	07	Total
AC	313,572	210,756	87,745	(7)	326	119	2	612,513
AFDC/SOBRA	1,014,881	1,090,143	990,293	5,056,392	4,912,060	4,769,809	4,594,962	22,428,540
SSI	365,158	399,101	398,723	2,391,771	2,371,156	2,374,229	2,957,653	11,257,791
Expansion State Adults	-	-	223,239	3,043,744	3,208,358	3,347,743	2,939,284	12,762,368
ALTCS-DD (Cost Sharing)[1]	-	-	-	-	-	-	-	-
CAHP[2]	(1,693,611)	(1,700,000)	(1,700,000)	(10,491,900)	(10,491,900)	(10,491,900)	(10,491,900)	(47,061,211)
Total	-	-	-	-	-	-	-	-

Federal Share

Waiver Name	01	02	03	04	05	06	07	Total
AC	211,034	138,424	58,991	(5)	225	83	1	408,752
AFDC/SOBRA	683,014	716,006	665,774	3,461,607	3,385,392	3,302,616	3,211,419	15,425,827
SSI	245,752	262,130	268,062	1,637,406	1,634,201	1,643,916	2,067,104	7,758,570
Expansion State Adults	-	-	150,083	2,083,747	2,211,200	2,317,977	2,054,265	8,817,273
ALTCS-DD (Cost Sharing)[1]	-	-	-	-	-	-	-	-
CAHP[2]	(1,139,800)	(1,116,560)	(1,142,910)	(7,182,755)	(7,231,017)	(7,264,592)	(7,332,789)	(32,410,423)
Total	-	-	-	-	-	0	-	0

[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 State should include

[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	07	Total
AC	918,161,471	582,241,230	124,009,799	36,049,875	48,139,503	29,671,716.21	(575,863.21)	1,737,697,731
AFDC/SOBRA	3,416,727,723	3,583,504,010	3,540,917,879	3,605,796,917	3,992,997,814	3,924,536,968	3,596,021,619	25,660,502,930
ALTCS-EPD	1,061,686,933	1,166,776,288	1,195,360,110	1,243,689,357	1,264,268,575	1,381,591,269	1,376,092,649	8,689,465,181
ALTCS-DD	939,086,691	1,005,552,529	1,067,544,797	1,170,346,154	1,252,962,694	1,380,802,799	1,547,958,534	8,364,254,198
DSH/CAHP	154,069,040	161,580,200	160,583,023	160,025,635	159,780,875	156,864,370	125,779,024	1,078,682,167
Expansion State Adults	-	-	1,137,482,941	1,912,966,661	2,104,650,383	2,305,855,241	2,328,091,152	9,789,046,378
Family Planning Extension	830,631	1,008,110	190,026	(1,337)	(763)	(342)	(433)	2,025,892
MED	673,818	-	-	-	-	-	-	673,818
SNCP/DSHP	296,636,120	558,334,298	240,250,917	135,561,857	116,750,000	95,000,000	22,500,000	1,465,033,192
SSI	1,349,865,877	1,427,247,173	1,545,955,879	1,741,322,019	1,849,004,723	1,951,436,623	1,878,459,746	11,743,292,040
TIP	-	-	-	-	-	19,438,831	-	19,438,831
TIP - DSHP	-	-	-	-	-	13,165,373	-	13,165,373
Uncomp Care IHS/638	22,866,717	97,192,513	53,888,765	13,437,080	7,647,155	3,208,226	-	198,240,456
Subtotal	8,160,605,021	8,583,436,351	9,066,184,136	10,019,194,218	10,796,200,959	11,261,571,074	10,874,326,427	68,761,518,186
New Adult Group	-	-	108,346,000	308,812,997	444,794,755	505,066,522	442,277,137	1,809,297,411
Total	8,160,605,021	8,583,436,351	9,174,530,136	10,328,007,215	11,240,995,714	11,766,637,596	11,316,603,564	70,570,815,597

Federal Share

Waiver Name	01	02	03	04	05	06	07	Total
AC	640,280,511	400,188,004	86,613,704	24,670,308	33,050,610	20,532,815	(467,560)	1,204,868,391
AFDC/SOBRA	2,386,370,602	2,467,318,717	2,498,195,332	2,575,627,962	2,852,703,501	2,827,598,980	2,613,671,210	18,221,486,303
ALTCS-EPD	716,684,559	770,241,449	807,182,501	854,230,164	873,617,286	959,537,066	964,260,951	5,945,753,976
ALTCS-DD	632,712,981	661,923,939	719,011,976	802,139,221	864,098,810	956,774,063	1,082,520,727	5,719,181,717
DSH/CAHP	103,688,465	106,125,875	107,959,967	109,553,548	110,120,980	108,612,889	87,906,959	733,968,683
Expansion State Adults	-	-	971,034,448	1,678,728,697	1,908,850,417	2,094,542,445	2,137,627,516	8,790,783,524
Family Planning Extension	767,009	927,946	174,071	(1,212)	(689)	(311)	(400)	1,866,414
MED	453,960	-	-	-	-	-	-	453,960
SNCP/DSHP	199,636,108	366,713,968	161,520,692	92,805,648	80,464,100	65,778,000	15,725,250	982,643,766
SSI	932,712,679	968,561,077	1,070,908,147	1,223,205,957	1,303,798,724	1,384,373,673	1,343,684,962	8,227,245,218
TIP	-	-	-	-	-	14,681,298	-	14,681,298
TIP - DSHP	-	-	-	-	-	9,115,704	-	9,115,704
Uncomp Care IHS/638	22,848,035	97,067,679	53,845,830	13,406,989	7,630,280	3,201,219	-	198,000,032
Subtotal	5,636,154,909	5,839,068,654	6,476,446,668	7,374,367,282	8,034,334,018	8,444,747,841	8,244,929,615	50,050,048,987
New Adult Group	-	-	108,346,000	308,804,248	444,338,001	485,976,874	417,793,751	1,765,258,874
Total	5,636,154,909	5,839,068,654	6,584,792,668	7,683,171,530	8,478,672,019	8,930,724,715	8,662,723,366	51,815,307,861

Calculation of Effective FMAP:

AFDC/SOBRA							
Federal	2,386,370,602	2,467,318,717	2,498,195,332	2,575,627,962	2,852,703,501	2,827,598,980	2,613,671,210
Total	3,416,727,723	3,583,504,010	3,540,917,879	3,605,796,917	3,992,997,814	3,924,536,968	3,596,021,619
Effective FMAP	0.698437451	0.688521266	0.705521963	0.714302003	0.714426512	0.72049238	0.726822997
SSI							
Federal	932,712,679	968,561,077	1,070,908,147	1,223,205,957	1,303,798,724	1,384,373,673	1,343,684,962
Total	1,349,865,877	1,427,247,173	1,545,955,879	1,741,322,019	1,849,004,723	1,951,436,623	1,878,459,746
Effective FMAP	0.690966929	0.678621822	0.692715854	0.702458215	0.705135421	0.709412572	0.715312087
ALTCS-EPD							
Federal	716,684,559	770,241,449	807,182,501	854,230,164	873,617,286	959,537,066	964,260,951
Total	1,061,686,933	1,166,776,288	1,195,360,110	1,243,689,357	1,264,268,575	1,381,591,269	1,376,092,649
Effective FMAP	0.675043214	0.660144928	0.675263039	0.686851712	0.691006091	0.694515873	0.700723859
ALTCS-DD							
Federal	632,712,981	661,923,939	719,011,976	802,139,221	864,098,810	956,774,063	1,082,520,727
Total	939,086,691	1,005,552,529	1,067,544,797	1,170,346,154	1,252,962,694	1,380,802,799	1,547,958,534
Effective FMAP	0.673753538	0.658268882	0.673519255	0.685386301	0.689644484	0.692911445	0.699321528
AC							
Federal	640,280,511	400,188,004	86,613,704	24,670,308	33,050,610	20,532,815	(467,560)
Total	918,161,471	582,241,230	124,009,799	36,049,875	48,139,503	29,671,716	(575,863)
Effective FMAP	0.697350663	0.687323369	0.698442419	0.68433824	0.686559013	0.69199956	0.811928496
Expansion State Adults							
Federal	-	-	971,034,448	1,678,728,697	1,908,850,417	2,094,542,445	2,137,627,516
Total	-	-	1,137,482,941	1,912,966,661	2,104,650,383	2,305,855,241	2,328,091,152
Effective FMAP			0.85366946	0.877552511	0.906967938	0.908358169	0.918188927
New Adult Group							
Federal	-	-	108,346,000	308,804,248	444,338,001	485,976,874	417,793,751
Total	-	-	108,346,000	308,812,997	444,794,755	505,066,522	442,277,137
Effective FMAP			1	0.999971669	0.998973113	0.962203696	0.944642434

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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	2,932,352	487,614	72,510	85,480	527,244	467	12,471		
Quarter Ended March 31, 2012	2,920,036	489,048	73,146	85,526	430,723	-	12,424		
Quarter Ended June 30, 2012	2,913,896	489,096	73,956	85,748	365,132	-	12,440		
Quarter Ended September 30, 2012	2,938,635	491,751	74,810	86,530	310,396	-	12,689		
Quarter Ended December 31, 2012	2,911,239	494,839	75,630	86,847	274,990	-	13,104		
Quarter Ended March 31, 2013	2,890,976	497,245	76,458	86,093	248,817	-	13,824		
Quarter Ended June 30, 2013	2,902,794	499,888	77,272	86,321	228,204	-	14,187		
Quarter Ended September 30, 2013	2,918,665	503,513	78,026	87,151	217,114	-	14,856		
Quarter Ended December 31, 2013	2,891,526	506,930	78,830	87,699	206,419	-	14,885		
Quarter Ended March 31, 2014	2,839,072	514,698	79,668	87,917	87	-	-	443,762	38,983
Quarter Ended June 30, 2014	2,955,241	523,692	80,657	88,759	2	-	-	623,969	86,514
Quarter Ended September 30, 2014	3,112,954	530,096	81,743	89,386	-	-	-	755,331	122,864
Quarter Ended December 31, 2014	3,145,348	537,794	82,709	90,037	-	-	-	816,906	149,731
Quarter Ended March 31, 2015	3,083,833	544,665	83,804	89,909	-	-	-	834,750	191,020
Quarter Ended June 30, 2015	3,103,642	545,794	84,807	89,960	-	-	-	844,222	245,114
Quarter Ended September 30, 2015	3,207,032	546,224	85,577	90,053	-	-	-	864,233	284,690
Quarter Ended December 31, 2015	3,258,890	551,462	86,343	89,921	-	-	-	913,697	312,257
Quarter Ended March 31, 2016	3,255,778	554,246	87,108	89,515	-	-	-	927,976	331,564
Quarter Ended June 30, 2016	3,245,802	551,367	88,220	89,675	-	-	-	929,950	334,080
Quarter Ended September 30, 2016	3,330,068	554,258	89,185	89,957	-	-	-	935,710	325,254
Quarter Ended December 31, 2016	3,381,966	555,723	90,164	90,314	-	-	-	952,746	331,575
Quarter Ended March 31, 2017	3,385,607	557,530	91,253	90,019	-	-	-	958,288	335,535
Quarter Ended June 30, 2017	3,368,329	557,341	92,427	90,414	-	-	-	958,760	338,390
Quarter Ended September 30, 2017	3,354,840	558,842	93,386	91,191	-	-	-	957,645	338,951
Quarter Ended December 31, 2017	3,321,778	562,144	94,336	91,795	-	-	-	955,384	339,114
Quarter Ended March 31, 2018	3,228,411	563,526	95,524	91,422	-	-	-	936,451	328,152
Quarter Ended June 30, 2018	3,186,726	561,748	96,902	91,922				929,032	318,227
Quarter Ended September 30, 2018	3,182,474	558,740	97,941	92,171				933,227	316,386

	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	-	-
Quarter Ended December 31, 2017	-	-
Quarter Ended March 31, 2018	-	-
Quarter Ended June 30, 2018	-	-
Quarter Ended September 30, 2018	-	-

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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	FFY 2018	
Total Allotment	**103,890,985**	**106,384,369**	**108,086,519**	**109,815,903**	**110,145,351**	**111,136,659**	**113,803,939**	**763,263,725**
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				4,775,270				4,775,270
Jun-17		1,152,106		1,483,173	8,005,943	98,523,950		109,165,172
Sep-17								-
Dec-17			13,492			587,709		601,201
Mar-18					2,830,054			2,830,054
Jun-18					631,379	7,250,255	87,906,960	95,788,594
Sep-18						2,250,975		2,250,975
Total Reported to Date	103,688,465	106,125,875	107,959,966	109,553,550	110,120,979	108,612,889	87,906,960	733,968,685
Unused Allotment	**202,520**	**258,494**	**126,553**	**262,353**	**24,372**	**2,523,770**	**25,896,979**	**29,295,040**

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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)

	DY3-5 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	-	38,983	86,514	122,864	248,361	143,686,773

		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%	605.71	149,731	191,020	245,114	284,690	870,555	527,307,542

		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	99.90%	633.55	312,257	331,564	334,080	325,254	1,303,155	825,613,202

	DY6-10 Trend Rate	DY 06 PM/PM			Member Months QE 12/16	QE 3/17	QE 6/17	QE 9/17	Total	
New Adult Group	1.033	655.13	96.22%	630.37	331,575	335,535	338,390	338,951	1,344,451	847,498,767

		DY 07 PM/PM			Member Months QE 12/17	QE 3/18	QE 6/18	QE 9/18	Total	
New Adult Group	1.033	676.75	94.46%	639.29	339,114	328,152	318,227	316,386	1,301,879	832,272,356

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	22,553,225	-	22,553,225	13,870,414	8,682,811
QE 6/14	50,051,810	-	50,051,810	34,313,342	15,738,468
QE 9/14	71,081,739	-	71,081,739	47,984,458	23,097,281
QE 12/14	90,694,196	-	90,694,196	46,004,135	44,690,061
QE 3/15	115,703,530	-	115,703,530	70,387,348	45,316,182
QE 6/15	148,469,035	-	148,469,035	85,319,153	63,149,882
QE 9/15	172,440,781	-	172,440,781	97,948,283	74,492,498
QE 12/15	197,830,267	-	197,830,267	113,800,738	84,029,529
QE 3/16	210,062,207	-	210,062,207	122,290,142	87,772,065
QE 6/16	211,656,218	-	211,656,218	123,158,494	88,497,724
QE 9/16	206,064,510	-	206,064,510	108,777,377	97,287,133
QE 12/16	209,014,240	-	209,014,240	126,789,923	82,224,317
QE 3/17	211,510,497	-	211,510,497	122,882,603	88,627,894
QE 6/17	213,310,197	-	213,310,197	125,355,939	87,954,258
QE 9/17	213,663,834	-	213,663,834	127,776,681	85,887,153
QE 12/17	216,790,660	-	216,790,660	115,394,268	101,396,392
QE 3/18	209,782,812	-	209,782,812	107,961,026	101,821,786
QE 6/18	203,437,904	-	203,437,904	108,718,912	94,718,992
QE 9/18	202,260,979	-	202,260,979	66,525,638	135,735,341
	$ 3,176,378,640	$ -	$ 3,176,378,640	$ 1,765,258,874	$ 1,411,119,766

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	$ 143,686,773	$ 96,168,214	$ 47,518,559	33.07%				
DY 04	527,307,542	299,658,919	227,648,623	43.17%				
DY 05	825,613,202	468,026,751	357,586,451	43.31%				
DY 06	847,498,767	502,805,146	344,693,621	40.67%				
DY 07	832,272,356	398,599,844	433,672,512	52.11%	$ 3,176,378,640	$ 1,765,258,874	$ 1,411,119,766	44.43%
	$ 3,176,378,640	$ 1,765,258,874	$ 1,411,119,766					

Based on CMS-64 certification date of 10/30/2018

APPENDIX 2:
1115 WAIVER
POST AWARD FORUM
PRESENTATION SLIDES

AHCCCS
Arizona Health Care Cost Containment System

AHCCCS Waiver Update & Request to Waive Prior Quarter Coverage

January 2018

What is a Section 1115 Waiver?

- Section 1115 of the Social Security Acts gives states authority to be waived from selected Medicaid requirements in federal law and implement “demonstration projects”
- Purpose: gives states flexibility to design and improve their Medicaid programs
- Two types of authority may be requested:
  - Waiver of provisions of Section 1902
  - Expenditure of federal funds (Section 1903)

Arizona's Section 1115 Waiver

- Arizona has had a 1115 Waiver since 1982
- Latest extension of Arizona's 1115 Waiver approved September 30, 2016 for 5 years: October 1, 2016 – September 30, 2021
- Every FFY, AHCCCS is required to give a Waiver Update
- This update covers 10/1/16 to present

Federal Approval Process

- The Centers for Medicare and Medicaid Services (CMS) is the federal agency responsible for oversight of State Medicaid agencies
- Arizona posts draft waiver and conducts public notice process
- AHCCCS revises and submits waiver to CMS
- AHCCCS must obtain final approval from CMS before implementing
- 1115 Waivers are approved at the discretion of the HHS Secretary

Waiver Update

- Approved Waivers:
  - Targeted Investments
  - Safety Net Care Pool
- Pending Waivers:
  - Institutions for Mental Diseases
  - AHCCCS Works
- Prior Quarter Coverage Waiver Amendment Proposal

Approved Waiver Amendments

Targeted Investments

- On January 18, 2017, CMS approved $300M, 5-year Targeted Investments (TI) Program
- TI Program funds outcomes-based projects aimed at increasing care coordination and integration of physical and behavioral health services for
  - Adults with behavioral health needs;
  - Children with behavioral health needs; and
  - Individuals transitioning from incarceration who are AHCCCS-eligible.

Targeted Investments: Estimated Annual Funding Distribution

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Targeted Investments	$19 m.	$66.5 m.	$85.5 m.	$66.4 m.	$47.5 m.	$285 m.
Administrative Expenses	$1 m.	$3.5 m.	$4.5 m.	$3.5 m.	$2.5 m	$15 m.
Totals	$20 m.	$70 m.	$90 m.	$70 m.	$50 m.	$300 m.

Safety Net Care Pool

- Safety Net Care Pool expenditure authority expired on Dec. 31, 2017
- CMS approved a technical amendment to allow PCH to make claims after 12/31/17 for expenses incurred during 2017
- This does not include a programmatic extension or any additional SNCP funding

Pending Waiver Amendments

Institutions for Mental Diseases Background

- CMS managed care regulations from July 2016 prohibit federal funding for stays in IMDs if the stay is more than 15 days in a calendar month
- Applies to adults aged 21-64
- Effectively restricts Arizona's "in lieu of" authority so that stays in IMDs in lieu of more expensive settings are not reimbursed by the federal government if the stay exceeds 15 days

IMD Waiver Request: Focus on Substance Use Disorders

- On April 12, AHCCCS submitted a waiver requesting that Arizona be exempt from the 15 day limit on federal funding for IMD stays, both for managed care and FFS populations
- CMS has indicated a path forward to exempt stays in IMDs that are related to the treatment of a *substance use disorder* from the 15 day limit
- We are in the midst of negotiations with CMS and expect to receive approval in the near future

AHCCCS Works Waiver

- On December 19, 2017, AHCCCS submitted a request to CMS to implement AHCCCCS Works
- To qualify for AHCCCS coverage, certain able-bodied adults 19-55 who do not qualify for an exemption must, for a total of at least 20 hours per week:
  - Be employed or actively seek employment;
  - Attend school; or
  - Participate in the Employment Support and Development Program.

AHCCCS Works Exemptions, part 1

- Individuals determined to be medically frail
- American Indians
- Pregnant and post-partum women (through the month in which 90th day post partum occurs)
- Individuals receiving temporary or permanent long-term disability benefits (private or government)
- Individuals determined to have a Serious Mental Illness
- Parents, caretakers relatives, and foster parents
- Caregivers of a family member who is enrolled in ALTCS

AHCCCS Works Exemptions, part 2

- Individuals who are homeless
- Individuals who have recently been directly impacted by a catastrophic event (natural disaster or death of a family member living in same household)
- Full time high school, college or graduate students
- Victims of domestic violence
- Former Arizona foster youths up to 26

AHCCCS Works Details

- Job seeking = systematic and sustained effort to obtain work at least 4 different days of the week, and make at least one job contact on each day
- Community service counts toward requirement for those transitioning from justice system, living in an area of high unemployment, or facing a significant barrier to employment

AHCCCS Works Details

- AHCCCS will work with DES to leverage its existing workforce development programs
- Employment Support & Development programs will include:
  - English as a Second Language courses
  - Parenting classes
  - Disease management education
  - Health insurance competency classes
  - Healthy living classes

AHCCCS Works Compliance

- Members subject to requirement who do not qualify for an exemption and fail to meet the requirements will receive a 6-month grace period
- Failure to comply after the grace period will result in a termination of AHCCCS enrollment
- Members may re-enroll once they can demonstrate compliance for at least the past 30 days

AHCCCS Works Population

- AHCCCS has 1.9 million members
- Approximately 400,000 are in the eligibility group that waiver pertains to
  - 43,719 are American Indians
  - 12,912 are determined to have SMI
  - 81,124 are age 55 and over
- Fewer than 269,507 individuals remaining who could be subject to requirements (prior to applying other exemptions)

5 Year Lifetime Limit

- SB 1092: AHCCCS must request approval for a five-year lifetime limit on AHCCCS coverage
- Lifetime limit would apply to able-bodied adult members with same exemptions as for AHCCCS Works
- If approved, it would become effective on waiver approval date
- The following time would not count toward the lifetime limit:
  - Time during which a person received Medicaid benefits prior to waiver approval
  - Time during which an individual is enrolled in AHCCCS and
    - an AHCCCS Works exemption applies; or
    - the individual is complying with the AHCCCS Works requirements

Submitting Comments to CMS on AHCCCS Works Proposal

- Federal public comment period: January 5, 2018 - February 5, 2018
- https://public.medicaid.gov/connect.ti/public.comments/
- Click on AZ, then AHCCCS, then AHCCCS Works

CMS Guidance

- CMS has issued guidance to states on work requirement waivers
- CMS has approved Kentucky's work requirement waiver proposal
- Expect CMS to issue decisions on other states' submittals in near future
- Beginning discussions with CMS on AHCCCS Works
- Evaluating necessary AHCCCS operational changes

Prior Quarter Coverage Waiver Amendment Proposal

Prior Quarter Coverage Proposal

- Currently, Arizona covers enrollees three months prior to the month of application if the enrollee would have been eligible at any point during those months.
- AHCCCS proposes limiting retroactive coverage to the month of application, consistent with AHCCCS policy prior to the Affordable Care Act

Prior Quarter Coverage Proposal Objectives

- This proposal to waive Prior Quarter Coverage promotes the objectives of the Medicaid program by
  - Aligning Medicaid policies with commercial health insurance coverage & pre-ACA policy;
  - Creating efficiencies that ensure Medicaid's sustainability for members over the long term;
  - Encouraging members to obtain and maintain health coverage, even when healthy; and
  - Encouraging members to apply for Medicaid expeditiously when they believe they meet the criteria for eligibility.

The Proposed Retroactive Coverage Example

- On January 1, 2018, Mary receives a routine checkup for her medical condition from a primary care physician (PCP).
- On January 31, 2018, Mary applies for AHCCCS and informs the Agency that she has unpaid medical bills from her PCP visit in January.
- If Mary qualifies for AHCCCS coverage in January, then her AHCCCS eligibility is retroactive to the first day of the month of application—i.e. January 1, 2018.
- If Mary's unpaid medical expenses in January qualify as AHCCCS covered services, then AHCCCS will reimburse Mary's provider for those services.

Prior Quarter Coverage Historical Expenditures

State Fiscal Year (SFY)	Total Expenditures
2014	$19,809
2015	$15,743,139
2016	$21,708,207
2017	$21,347,704
2018 to date*	$11,136,736
Total	**$69,955,595**

* Includes expenditures from July 1, 2017 to November 30, 2017

Waiver Amendment Webpage

- More information about proposed waiver amendment, including proposed waiver applications, public notices, and information about the public comment process, can be found on the AHCCCS website at:
- https://www.azahcccs.gov/Resources/Federal/PendingWaivers/priorquartercoveragewaiveramendment.html

Public Comments

- Comments and questions about the proposed Demonstration application can also be submitted by e-mail to: PublicInput@azahcccs.gov
- Or by mail to: AHCCCS c/o Office of Intergovernmental Relations; 801 E. Jefferson Street, MD 4200, Phoenix, AZ 85034.
- All comments must be received by **February 25, 2018.**

Questions and Comments?

Thank you

AHCCCS
Arizona Health Care Cost Containment System

APPENDIX 3: STATEWIDE FOCUS POPULATION MEASURES AND TARGETS

Child Physical and Behavioral Health Integration Measures			
Year of DSHP	**Proposed Measure**	**Numerator and Denominator Definition**	**Proposed Target**
3	Practice has executed an agreement with AzHeC and routinely receives ADT feeds Baseline: to be measured during Year 1	numerator: An executed agreement with AzHeC and AzHeC confirmation of practice routine receipt of ADT feeds denominator: Pediatric primary care and behavioral health practices participating in the child integration	**Target: 35.77%** Baseline: 20/65= **30.77%** 5 points over baseline
4	Well-child visits in the third, fourth, fifth and sixth years of life for children with a behavioral health diagnosis (HEDIS, modified) Baseline: To be measured during Year 1	numerator: AHCCCS members with a BH diagnosis who are age 3-6 years as of the last calendar day of the measurement year, and are attributed to a -participating primary care provider, who have at least one well-child visit with any PCP during the measurement year.[1] denominator: AHCCCS members with a BH diagnosis who are age 3–6 years as of the last calendar day of the measurement year and are attributed to a participating primary care provider.	**Target: 74.71%** Baseline: 661/909= **72.71%** 2 points over baseline
5	Well-child visits in the third, fourth, fifth and sixth years of life for children with a behavioral health diagnosis (HEDIS, modified) Baseline: To be measured during Year 1	numerator: AHCCCS members with a BH diagnosis who are age 3-6 years as of the last calendar day of the measurement year, and are attributed to a participating primary care provider, who have at least one well-child visit with any PCP during the measurement year. denominator: AHCCCS members with a BH diagnosis who are age 3–6 years as of the last calendar day of the measurement year and are attributed to a participating primary care provider.	**Target: 77.71%** Baseline: 661/909= **72.71%** 5 points over baseline

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

Adult Physical and Behavioral Health Integration Measures			
Year of DSHP	**Proposed Measure**	**Numerator and Denominator Definition**	**Proposed Target**
3	Practice has executed an agreement with AzHeC and routinely receives ADT feeds Baseline: To be measured during Year 1	numerator: An executed agreement with AzHeC and AzHeC confirmation of practice routine receipt of ADT feeds denominator: Adult primary care and behavioral health practices participating in the adult integration	**Target: 32.48%** Baseline: 36/131= **27.48%** 5 points over baseline
4	Follow-up after hospitalization for mental illness (HEDIS, modified[2]) Baseline: To be measured during Year 1	numerator: AHCCCS members 18 years of age and older at any time during the measurement period who had a follow-up visit with a mental health practitioner within 7 days after a denominator-qualifying discharge, including visits that occur on the date of discharge.[3] denominator: Acute hospital discharges of AHCCCS members 18 years of age and older at any time during the measurement period for treatment of selected mental illness diagnoses[4] .	**Target: 52.97%** Baseline: 10,852/ 21,289= **50.97%** 2 points over baseline
5	Follow-up after hospitalization for mental illness (HEDIS, modified) Baseline: Tto be measured during Year 1	numerator: AHCCCS members 18 years of age and older at any time during the measurement period who had a follow-up visit with a mental health practitioner within 7 days after a denominator-qualifying discharge, including visits that occur on the date of discharge. denominator: Acute hospital discharges of AHCCCS members 18 years of age and older at any time during the measurement period for treatment of selected mental illness diagnoses..	**Target: 54.97%** Baseline: 10,852/ 21,289= **50.97%** 4 points over baseline

[2] Modified to apply only to adults, as the HEDIS specifications include those six years and older in the denominator.

[3] The follow-up visit must be with a mental health practitioner as defined by the following NCQA HEDIS value sets: FUH Stand Alone Visits Value Set, (FUH Visits Group 1 Value Set *and* FUH POS Group 1 Value Set), and FUH Visits Group 2 Value Set *and* FUH POS Group 2 Value Set.

[4] A principal diagnosis of mental illness is defined by the NCQA HEDIS Mental Illness Value Set. Inpatient stay is defined by the Inpatient Stay Value Set, but excludes the Nonacute Inpatient Stay Value Set.

Care Coordination Measures for Medicaid Enrolled Released from Criminal Justice Facilities			
Year of DSHP	**Proposed Measure**	**Numerator and Denominator Definition**	**Proposed Target**
3	Practice has executed an agreement with AzHeC and routinely receives ADT feeds Baseline: To be measured during Year 1	numerator: An executed agreement with AzHeC and AzHeC confirmation of practice routine receipt of ADT feeds denominator: Integrated practices participating in the justice transition	100%
4	Adults access to preventive/ambulatory health services (HEDIS, modified[5]) Baseline: To be measured during Year 1	numerator: AHCCCS members age 20-44 years during the measurement period recently released from a criminal justice facility and assigned to a probation or parole office at which a new integrated clinic has been situated who had one or more ambulatory or preventive care visits[6] during the measurement year denominator: AHCCCS members age 20-44 years during the measurement period recently released from a criminal justice facility and assigned to a probation or parole office at which a new integrated clinic has been situated	**Target: 37.71%** Baseline: 5005/14,016= **35.71%** 2 points over baseline
5	Adults access to preventive/ambulatory health services (HEDIS, modified) Baseline: To be measured during Year 1	numerator: AHCCCS members age 20-44 years during the measurement period recently released from a criminal justice facility and assigned to a probation or parole office at which a new integrated clinic has been situated who had one or more ambulatory or preventive care visits during the measurement year denominator: AHCCCS members age 20-44 years during the measurement period recently released from a criminal justice facility and assigned to a probation or parole office at which a new integrated clinic has been situated	**Target: 40.71%** Baseline: 5005/14,016= **35.71%** 5 points over baseline

[5] Modified to apply to only those AHCCCS members recently released from a criminal justice facility at which a new integrated clinic has been situated.

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