June 7, 2016

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

Dear Ms. Woodard:

In accordance with Special Terms and Conditions paragraph 37, enclosed please find the Quarterly Progress Report for January 1, 2016 through March 31, 2016, which also includes the Quarterly Budget Neutrality Tracking Schedule, the Quarterly Quality Initiative and the Arizona Medicaid Administrative Claiming Random Moment Time Study results.

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

Sincerely,

Monica Coury
Assistant Director
AHCCCS Office of Intergovernmental Relations

Enclosure

cc: Brian Zolynas
Hee Young Ansell
Susan Ruiz

AHCCCS Quarterly Report
January 1, 2016 through March 31, 2016

TITLE

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

Section 1115 Quarterly Report
Demonstration Year: 33
Federal Fiscal Quarter: 2nd (January 1, 2016 – March 31, 2016)

INTRODUCTION

As written in Special Terms and Conditions, paragraph 37, the State submits quarterly progress reports to CMS. Quarterly reports inform CMS of significant demonstration activity from the time of approval through completion of the Demonstration.

ENROLLMENT INFORMATION

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

Population Groups	Number Enrollees	Number Voluntarily Disenrolled-Current Qtr	Number Involuntarily Disenrolled-Current Qtr
Acute AFDC/SOBRA	1,274,468	2,077	328,789
Acute SSI	187,350	187	29,840
Prop 204 Restoration	478,356	669	89,067
Adult Expansion	127,452	229	38,823
LTC DD	29,258	35	2,146
LTC EPD	31,206	32	4,264
Non-Waiver	3,330	9	343
Total	**2,131,420**	**3,238**	**493,272**

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

State Reported Enrollment in the Demonstration (as requested)	Current Enrollees
Title XIX funded State Plan [1]	1,330,005
Title XXI funded State Plan [2]	665
Title XIX funded Expansion[3]	86,176
Title XXI funded Expansion [4]	0

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

DSH Funded Expansion	
Other Expansion	
Pharmacy Only	
Family Planning Only[5]	0
Enrollment Current as of	4/1/16

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

State Reported Program Enrollment	Current Enrollees
Agency with Choice Program	2,397

OPERATIONAL/POLICY DEVELOPMENTS/ISSUES

Waiver Update

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

State Plan Update

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

SPA #	Description	Filed	Approved	Eff. Date
Title XIX				
SPA 15-010	DRG Update	12/29/15	3/18/16	10/1/15
SPA 15-009	Rehab and LTAC Hospital Rates	12/29/15	3/16/16	10/1/15
SPA 15-008	NF Assessment Out-of-State Exemption	12/15/15	3/7/16	10/1/15
SPA 16-002	Air Ambulance Rates Update	3/31/16	Pending	1/1/16
SPA 16-002	Hospice Rates Update	3/31/16	Pending	1/1/16
Title XXI				
N/A				

Legislative Update

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

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

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

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

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

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

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

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

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

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

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

The Arizona Legislature adjourned Sine Die on May 7th, 2016.

CONSUMER ISSUES

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

Table 1 **Advocacy Issues**	**January**	**February**	**March**	**Total**
9+Billing Issues • **Member reimbursements** • **Unpaid bills**	18	10	18	**46**
Cost Sharing • **Co-pays** • **Share of Cost (ALTCS)** • **Premiums (Kids Care, Medicare)**	1	3	6	**10**
Covered Services	32	35	65	**132**
Eligibility Issues by Program **Can't get coverage due to :**				

ALTCS • **Resources** • **Income** • **Medical**	9	10	12	**31**
DES • **Income** • **Incorrect determination** • **Improper referrals**	72	89	63	**224**
Kids Care • **Income** • **Incorrect determination**	0	0	0	**0**
SSI/Medical Assistance Only • **Income** • **Not categorically linked**	21	8	8	**37**
Information • **Status of application** • **Eligibility Criteria** • **Community Resources** • **Notification (Did not receive or didn't understand)**	27	32	31	**90**
Medicare • **Medicare Coverage** • **Medicare Savings Program** • **Medicare Part D**	3	8	14	**25**
Prescriptions • **Prescription coverage** • **Prescription denial**	19	48	64	**131**
Issues Referred to other Divisions:				
1.Fraud-Referred to Office of Inspector General (OIG)	0	0	0	**0**
2.Quality of Care-Referred to Division of Health Care Management (DHCM) • **Health Plans/Providers (Caregiver issues, Lack of providers)** • **Services (Equipment, Nursing Homes, Optical and Surgical)**	7	5	1	**13**
Total	**209**	**248**	**282**	**739**

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

Table 2 Issue Originator	January	February	March	Total
Applicant, Member or Representative	160	199	240	599
CMS	4	5	1	10
Governor's Office	0*	0*	0*	0*
Ombudsmen/Advocates/Other Agencies…	40	34	36	110
Senate & House	5	10	5	20
Total	209	248	282	739

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

COMPLAINTS AND GRIEVANCES

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

Member Grievances and Complaints	Jan-16	Feb-16	Mar-16	Total
Access to Care	28	47	25	**100**
Health Plan	113	127	134	**374**
Provider Satisfaction	152	181	238	**571**
Total	293	355	397	**1045**

OPT-OUT FOR CAUSE

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

QUALITY ASSURANCE/MONITORING ACTIVITY:

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

ENCLOSURES/ATTACHMENTS

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

STATE CONTACT(S)

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DATE SUBMITTED TO CMS

June 7, 2016

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Attachment II to the

Section 1115 Quarterly Report

Quality Assurance/Monitoring Activity

Demonstration/Quarter Reporting Period

Demonstration Year: 33

Federal Fiscal Quarter 2/2016 (1/2016 – 3/2016)

Prepared by the Division of Health Care Management
May 2016

Introduction

This report describes the Arizona Health Care Cost Containment System (AHCCCS) quality assurance and monitoring activities that took place during the first quarter of federal fiscal year 2016, as required in STC 37 of the States' Section 115 Wavier. This report also includes updates related to AHCCCS' Quality Assessment and Performance Improvement Strategy, in accordance with the Balanced Budget Act requirements.

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

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

Stakeholder Involvement

The success of AHCCCS can be attributed, in part, to concentrated efforts by the agency to foster partnerships with its sister agencies, contracted managed care organizations (Contractors), providers and the community. During quarter two, AHCCCS continued these ongoing collaborations to improve the delivery of health care and related services to Medicaid recipients and KidsCare members, including those with special health care needs, and to facilitate networking to address common issues and solve problems. Feedback from sister agencies, providers and community organizations are included in the Agency's process for identifying priority areas for quality improvement and the development of new initiatives.

Collaborative Stakeholder Involvement Synopses

During quarter two, AHCCCS participated in several collaborative efforts related to various different quality components. Community and sister agencies that AHCCCS collaborated with during quarter two include:

- *Arizona Department of Health Services (ADHS) Bureau of Tobacco and Chronic Disease* – In collaboration with ADHS, AHCCCS continued monitoring the utilization of, and access to, smoking cessation drugs and nicotine replacement therapy program. AHCCCS members are being encouraged to participate in ADHS' Tobacco Education and Prevention Program (TEPP) smoking cessation support programs such as "ASHLine" and/or counseling, in addition to seeking assistance from their primary care physician. Additional efforts have been focused on the integrated seriously mentally ill (SMI) population in connecting them to smoking cessation and nicotine replacement programs.

AHCCCS also initiated discussions with the ADHS Bureau of Tobacco and Chronic Disease related to intervention strategies for members diagnosed with Alzheimer's or memory issues and those at-risk of Alzheimer's Disease. AHCCCS will implement requirements for its Contractors to utilize education and outreach material provided by ADHS to inform its members about evidence based prevention and treatment options for individuals diagnosed or at-risk for the conditions. In addition, will share information about upcoming ADHS sponsored educational and Continuing Medical Education events for providers.

- *Arizona Department of Health Services (ADHS) Bureau of USDA Nutrition Programs* – AHCCCS works with ADHS Bureau of USDA Nutrition Programs for many initiatives ranging from Contractor education to Women, Infants and Children (WIC) promotion and obesity issues. The nutrition coordinators present the most up-to-date information, at the AHCCCS Contractor Quarterly meetings.

- *Arizona Department of Health Services (ADHS) Immunization Program* – Vaccine for Children (VFC) program– Ongoing collaboration with the ADHS help ensure efficient and effective administration and oversight of the federal Vaccines for Children (VFC) program. The VFC program representatives provide education to Contractors, regular notification to AHCCCS regarding vaccine-related trends and issues, and updates regarding the Arizona State immunization Information System (ASIIS) which is an immunization registry that can capture immunization data on individuals within the state.

- *Arizona Department of Health Services (ADHS) Office of Environmental Health – Targeted Lead Screening*– The Centers for Medicare and Medicaid Services (CMS) has approved the Agency to implement a targeted approach to lead screening based on data obtained and analyzed by ADHS. The targeted policy is based on a three-pronged approach that takes into account high risk zip codes, Arizona Health Care Cost Containment System (AHCCCS) enrollment, and individual risk assessment. The AHCCCS Policy change effective April 2015 requires all children living in a high risk zip code, as identified by the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning, must have a blood lead test at 12 and 24 months of age. Children between 36 and 72 months of age must receive a screening blood lead test, if they have not been previously screened for lead poisoning. Children living outside of the targeted high-risk zip codes must receive an individual risk assessment according to the AHCCCS periodicity schedule (when the child is 6, 9, 12, 18, and 24 months of age and then annually through age 6 years), with appropriate follow-up action taken for those children who are determined to be at high risk based on criteria included within the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning.

AHCCCS reviews and analyzes quarterly reports submitted by AHCCCS Contractors which includes information on members who received a blood lead test, members who received verbal lead screen as well as those who had an elevated blood lead level (EBLL). The Contractors track and monitor this information and provide appropriate follow up when needed. ADHS continues with ongoing community surveillance efforts and outreach for those children with EBLLs, AHCCCS remains committed to evaluating performance using CMS-416 data and results of intermittent auditing efforts to ensure children with EBLLs are screened and identified appropriately.

Collaborative efforts between ADHS and AHCCCS remain ongoing.

- *Arizona Early Intervention Program* – The Arizona Early Intervention Program (AzEIP), Arizona's IDEA Part C program, is administered by the Department of Economic Security (DES). Maternal and Child Health (MCH) staff in the Clinical Quality Management (CQM) unit at AHCCCS work with AzEIP to facilitate early intervention services for children under three years of age who are enrolled with AHCCCS Contractors. These services are closely monitored to ensure timely access to availability of services to members. AHCCCS and AzEIP continue to collaborate and meet regularly to ensure members receive care in a timely manner.

- *Arizona Head Start Association* – The Arizona Head Start and Early Head start programs provide education, development, health, nutrition and family support services to qualifying families. The Arizona Head Start grantees including the City of Phoenix, Maricopa County, Chicanos Por La Causa and Southwest Human Development continue to host community meetings on a quarterly basis. The meetings are attended by families participating with the Head Start program along with AHCCCS and the AHCCCS Contractor MCH/EPSDT Coordinators.

- *Task Force on Prevention of Prenatal Exposure to Alcohol and other Drugs* – The task force is comprised of representatives from various agencies. The Task force works towards increasing awareness and addressing concerns in the community regarding fetal alcohol spectrum disorders. AHCCCS attends the monthly meetings and regaularly participate in discussions on solutions to reduce prenatal exposure to alcohol and other drugs. The strategic Plan has been finalized by the Task Force and members are meeting regularly to work on the goals and objectives.

- *Arizona Medical Association and the Arizona Chapter of the American Academy of Pediatrics* – AHCCCS collaborates with the Arizona Medical Association (ArMA) and the Arizona Chapter of the American Academy of Pediatrics (AAP) in a number of ways, from development and review of assessment tools to data sharing and support of system enhancements for providers, such as Electronic Health Record (EHR) Incentive Program.

- The Arizona Partnership for Immunization (TAPI) – During the quarter, CQM staff attended subcommittee meetings for community awareness, provider issues and adult immunizations. TAPI regularly communicates immunization trends and best practices with AHCCCS and its Contractors. TAPI's Providers Awareness and Adult and Community Awareness committee continue to focus on long-term projects such as updating the TAPI website with the most current information for providers, parents and the community at large.

- *Arizona Perinatal Trust* – The Arizona Perinatal Trust (APT) oversees voluntary certification of hospitals for the appropriate level of perinatal care according to established guidelines and conducts site visits for initial certification and recertification. Since AHCCCS covers approximately half the births in Arizona, the site reviews give the Agency a better look at the hospitals that provide care to pregnant women and newborns, from normal labor and delivery to neonatal intensive care. Details of the site visit review are kept confidential and are not shared with the public. However, site visit reviews do allow opportunities for collaboration among health care professionals to learn about innovative practices hospitals have implemented as well as sharing of best practice policies, guidelines, etc. which is encouraged at the site visits. AHCCCS continues to support APT and participate in site visits regularly.

- *Healthy Mothers, Healthy Babies* – The Healthy Mothers, health Babies Maricopa County Coalition is focused on improving maternal child health outcomes in the Maryvale community. AHCCCS supports the Coalition through assisting in educating communities about AHCCCS-covered services for women and children and the initiation of prenatal care. The Coalition meetings have been suspended until further notice.

- *Arizona Health-E Connection/Arizona Regional Extension Center* – Arizona Health-E Connection (AzHeC) is a public-private community agency geared towards promotion of, and provider support for, electronic health record integration into the healthcare system. AzHeC is a key partner with AHCCCS in promoting the use of health information technology (HIT) as well as Arizona's Health Information Exchange (HIE). As a subset of AzHeC, the Arizona Regional Extension Center (REC) provides technical assistance and support to Medicare and Medicaid eligible professionals who are working to adopt, implement or upgrade (AIU) an electronic health record (EHR) in their practice and/or achieve Meaningful Use in order to receive monetary payments through state (Medicaid) and national (Medicare) EHR Incentive Programs. The long term goal is to be able to use this technology for quality improvement purposes and to improve outcomes for AHCCCS members. A first step in utilizing electronic health records is being taken

through the Childhood Obesity Learning Collaborative where Federally Qualified Health Center E.H.R. data will be utilized to collect data for the initiative.

AzHeC is the umbrella company for the Health Information Network of Arizona (HINAz), which is responsible for building the state's largest electronic health information exchange (HIE) site. HINAz partners with a multitude of community partners and stakeholders, including AHCCCS, in order to make the HIE a successful reality. To date, approximately 35 health systems (representing 55% of covered lives in AZ) have signed agreements with HINAz to share health information in the HIE. Additionally, HINAz has formed a partnership opportunity with the Behavioral health Information Network of Arizona (BHINAz) to ensure coordination of care between physical and behavioral health providers. During the quarter, HINAz continued to onboard Managed Care Organizations and hospitals. A fully operating HIE opened in April, 2015 with many planned enhancements scheduled through 2016.

- *Arizona Diabetes Steering Committee* – The Diabetes Steering Committee is responsible for increasing adherence to evidence based guidelines, guiding efforts to improve state policy and implementing the Chronic Disease Self-Management Program to improve quality of life and outcomes for Arizona citizens diagnosed with diabetes. AHCCCS is a member of the Steering Committee as well as the Diabetes Coalition and works to align Medicaid policy with statewide efforts. AHCCCS continues to collaborate and encourage the participation of its Contractors in the Diabetes Coalition.

- *Injury Prevention Advisory Council* – Arizona's injury statistics exceed the national average. In response, the Arizona Department of health Services (ADHS) entered into a cooperative agreement with the Centers for Disease Control (CDC) in September 2000 to develop systematic injury surveillance and control process. ADHS formed an internal work group with representatives from the divisions of Public Health Services, Assurance and Licensure Services, and Behavioral Health services. An AHCCCS representative also participates in this counsel in order to provide opportunities to implement change and interventions in the Medicaid program to prevent injuries. The work group, with input from leaders in the field of injury control met to develop the Arizona Injury Surveillance and Prevention Plan, 2001-2005, 2006-2010, and 2012-2016. Along with development of the plan the Injury Prevention Advisory Council provides recommendations to ADHS on injury priorities, reviews progress in implementation, assists in problem solving, participates in revision and evaluation of the plan, and acts as a liaison between external agencies and ADHS.

- *Arizona Newborn Screening Advisory Committee* – The Newborn Screening Advisory Committee is established to provide recommendations and advice to the Arizona Department of Health services regarding tests that should be included in the Newborn Screening panel. The committee recommended the 29 disorders, including hearing loss, of the core panel of the Uniform Screening Panel from the HHS Secretary's Advisory Committee on Heritable Disorders in Newborns and Children. Any recommendation of a test to be added to the panel must be accompanied by a cost-benefit analysis. The committee is chaired by the Director of the Department of health Services and meets at least annually. The Director appoints the members of the committee to include: seven physicians representing the medical specialties of endocrinology, pediatrics, neonatology, family practice, otology and obstetrics; a neonatal nurse practitioner; an audiologist; a representative of an agency that provides services under part C of the Individuals with Disabilities Education Act; at least one parent of a child with a hearing loss or a congenital disorder; a representative from the insurance industry familiar with health care reimbursement issues; the director of the AHCCCS or the director's designee; and a representative of the hospital or health care industry.

- *Behavioral Health Children's Executive Committee (ACEC)* – In 2002, the child-serving agencies of Arizona signed a Memorandum of Understanding (MOU) calling for the formation of the Arizona Children's Executive Committee (ACEC). The signers of the MOU include the Arizona Department of Health Services, the Arizona Department of Economic security, AHCCCS, the Arizona Department of Juvenile Corrections the Arizona Department of Education, and the Administration of the Courts. ACEC brings together multiple state and government agencies, community advocacy organizations, and family members of children/youth with behavioral health needs to collectively ensure that behavioral health services are being provided to children and families according to the Arizona Vision and 12 Principles. ACEC strives to create and implement a successful system of behavioral health care in Arizona by serving as a state-level link for local, county, tribal and regional teams. ACEC includes four sub-committees comprised of committee participants, family members and other representatives from state agencies, behavioral health authorities and family-run organizations including Family Involvement, Clinical/substance Abuse, Training, and Information sharing.

- *Arizona Chapter of the American Academy Pediatrics* – The Arizona Chapter of the American Academy of Pediatrics (AzAAP) was initially founded to play a vital role in child-oriented public health initiatives. AzAAPs membership boasts more than 900 pediatric and allied health professionals supporting and championing key child health programs, services and issues from all regions of the state. Efforts include early childhood literacy, fighting childhood obesity, ensuring that all Arizona's children have the best health care available to them by providing the highest quality of continuing

education to the professionals who care for them. AHCCCS works closely with the AzAAP seeking stakeholder input regarding its EPSDT program. The AzAAP has been a consistent partner with AHCCCS in developing and implementing developmental screening tools and guidelines, fluoride varnish in primary care offices, ensuring the AHCCCS EPSDT policies and forms reflect best practices and current recommendations and in communicating the needs of children that are served in the Arizona communities. The AzAAP is working with AHCCCS and the Arizona Association of Health Plans to maintain a list and links to developmental tool training opportunities as well as training for primary care providers on the application of fluoride varnish during EPSDT visits.

- *First Things First Health Advisory Committee* – A child's most important developmental years are those leading up to kindergarten. First Things First is committed to helping Arizona kids, ages five and younger, receive the quality education, healthcare and family support they need to arrive at school healthy and ready to succeed. The purpose of the First Things First Health Advisory Committee is to provide health content expertise and to make recommendations to the First Things First Board Policy and Program Committee regarding children's healthy development. AHCCCS services on this committee for the purpose of aligning children's health care initiatives, identifying opportunities for AHCCCS to inform other represented organizations regarding AHCCCS covered services, policies and procedures, and to ensure best practices promoted by First Things First are incorporated when possible into AHCCCS program requirements.

- *Build Arizona Health Committee* – The Build Arizona Steering Committee is comprised of both public and private sector early childhood leaders. Representatives are from government agencies, business, the child care community and higher education. The steering committee also includes five workgroups, Communications, Early Learning, Professional Development, Health and early Grade success. These workgroups include an even broader range of state, community and early childhood leaders in Arizona. Arizona is one of the newest Build Initiative partner states. The Build Arizona Steering Committee and workgroups are creating work plans focused on supporting early grade success. Their overall goal is to reframe early care and education from birth to age eight (0-8) as critical component of the overall education system and policy framework. AHCCCS is a member of the health Committee and has provided information and updates on the comprehensive nature of the AHCCCS EPSDT program. AHCCCS' values align with Build's goal of supporting expanded access to comprehensive screening and services to include social, emotional, physical and cognitive assessments for children. A current focus of Build is on the Public Health home visitation initiatives of which AHCCCS also is a statewide partner. There were no meetings of the Build Arizona Steering Committee during this quarter.

- *Strong Families Interagency Leadership Team (IALT)* – the Strong Families Interagency Leadership Team (IALT) was established as a result of the MIECHV grant, which ensures high-risk families have access to home visitation services in Arizona. The IALT is composed of various stakeholders in the community and some of the represented agencies include the Department of Economic security, Department of Education, Department of health Services and AHCCCS. The purpose of the leadership team is to discuss strategy for building a statewide home visiting system. Additionally, this team oversees the implementation of the MIECHV grant and any decisions that need to be made regarding home visitation practices. The role of AHCCCS is to provide input and support around the implementation efforts of a home visiting system in our state.

Developing and Implementing Projects to Improve the Delivery System

Serious Mental Illness (SMI) Integration

In December 2014, AHCCCS sought and received, from CMS, approval to amend the state's current 1115 wavier. This amendment allowed for the integration of physical and behavioral health services for individuals living with Serious Mental Illness (SMI) in Greater Arizona requiring the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) to serve as the only managed care plan for both acute and behavioral health conditions. The objective of this integration project is to reduce the fragmentation of care that this population currently experience as they navigate the multiple systems of care in order to receive their physical and behavioral health services. The demonstration will test the effect of integrating behavioral and physical health services for this population by measuring the improvements in health outcomes as compared to the state's current structure.

AHCCCS also sought to at least maintain alignment for Medicare/Medicaid enrollees (formerly referenced as "dual eligible") with SMI who are currently enrolled in acute care health plans that are also Special Needs Plans (SNPs) by requiring the ADHS/DBHS subcontractor to become a Medicare Dual Special Needs Plan (D-SNP) and passively enrolling those Medicare/Medicaid enrollees into the D-SNP. These changes allow that state to improve care coordination and health outcomes for individuals with SMI Greater Arizona, increase the ability for ADHS/DBHS to collect and analyze data to better assess the health needs of their members, streamline the current fragmented health care delivery system, reduce cost by decreasing hospital utilizations and promote sharing of information between physical and behavioral health providers to work as a team and manage treatment designed to address an individual's whole health needs. AHCCCS and ADHS/DBHS implemented the SMI Integrated RBHAs statewide on October 1, 2015. AHCCCS receives quarterly reports specific to the SMI Integration from the RBHAs.

Children's Rehabilitative Services (CRS) Integration

AHCCCS sought and received, from CMS, approval to amend the state's current 1115 wavier. This amendment allows for the state to create one singe, statewide integrated CRS Managed Care Organization (MCO) that will serve as the only managed care plan for acute care enrollees with a CRS-qualifying condition.

This change allows the state to improve care coordination for children with special health care needs, increase ability of the integrated CRS MCO to collect and analyze data to better assess the health needs of their members, streamline the current fragmented health care delivery system, improve health outcomes and promote sharing of information between CRS, acute and behavioral health providers.

Agency with Choice

On January 1, 2013, AHCCCS implemented and instituted a new member-directed option, Agency with Choice. The option is available to Arizona Long Term Care System (ALTCS) members who reside in their own home. A member or the member's Individual Representative (IR) may choose to participate in the Agency with Choice option. Under the option, the provider agency and the member/IR enter into a formal partnership agreement. The provider agency serves as the legal employer of the Direct Care Worker and the member/IR serves as the day-to-day managing employer. Agency with Choice presents an opportunity for members interested in directing their own care who would also like the support offered by a provider agency. For provider agencies, the new option affords them an opportunity to support members in directing their own care.

During CYE 2012, AHCCCS worked in collaboration with a Development and Implementation Council comprised of ALTCS members, providers, community stakeholders and contractors. The Council's primary function was to provide input on programmatic changes AHCCCS needed to make in order to implement the new Agency with Choice member-directed option, including policy and form changes. The Council continues to meet on a regular basis; however, the role has now expanded to that of an ALTCS Advisory Council that discusses all issues and opportunities related to improving care and health outcomes for ALTCS members.

In CYE 2013, the primary focus was on supporting contractors to educate members/IRs about all the available service model options including member-directed options. While Contractors monitor the delivery and quality of services on a routine basis, in CYE 2014, AHCCCS prioritized the development of tools for the purpose of assessment members support needs for directing their care under this option. The following are examples of those monitoring tools.

- Developed a Case Manager refresher training to ensure Case Managers are able to support members/IRs to make informed choices about electing member-directed options.

- Developed tools to educate Case Managers on how to assess whether or not a member/IR is fulfilling their respective roles and responsibilities and how to determine the need for additional support
- Developed a provider assessment tool that helps providers and Contractors assess whether or not a provider agency is fulfilling its respective roles and responsibilities and whether or not additional technical assistance is required.

In CYE 2015, AHCCCS planned to work in collaboration with Contractors to implement the use of these specific tools, but implementation was postponed to CYE 2016 to align with other program development activities.

In CYE 2015, there was a 10.5% increase of member's electing this option from the previous year.

Direct Care Workforce Development

Significant activities continue regarding the growing challenges related to ensuring the establishment of an adequate direct care (caregiver) workforce. The foundation for current activities began in March of 2004 when former Governor Napolitano formed the Citizens' Workgroup on the Long Term Care Workforce. The purpose of the Workgroup was to study the issue of the direct care workforce and provide recommendations regarding potential strategies to improve the workforce.

In an effort to address the recommendations outlined in a report issued by the Workgroup in April 2005, AHCCCS, the Department of Economic Security and the Department of Health Services funded and created a Direct Care Workforce Specialist position in 2007 to provide coordination for direct care workforce initiatives, including recruitment and retention, training, and raising the qualifications of direct care professionals in Arizona. Since 2007, the Workforce Specialist has coordinated the activity of the Direct Care Workforce Committee (DCWC), which has established training and competency standards for all in-home caregivers (housekeeping, personal care and attendant care).

Beginning October 1, 2012, AHCCCS formally incorporated the competency standards, training curriculum and testing protocol into its service specifications for attendant care, personal care and housekeeping. All in-home care givers are now required to pass standardized examinations based upon the competency standards established by the Committee in order to provide care to ALTCS members in their homes.

In CYE 2013, AHCCCS and Contractors initiated audits of the Approved Direct Care Worker Training and Testing Programs to ensure the programs were in compliance with AHCCCS standards pertaining to the training and testing of Direct Care Workers. Additionally, AHCCCS developed and implemented an online database to serve as a tool to support the portability or transferability of Direct Care Worker testing records from one employer to another

employer. The online database also serves a secondary purpose to assist in monitoring compliance with the AHCCCS Direct Care Worker training and testing initiative.

In CY 2015, AHCCCS created online computer-based training (CBT) modules to support users to learn how to set up the accounts and enter and access data within the online database. The CBT modules have proven to be an effective technical assistance tool for users. Additionally, AHCCCS and the MCOs formally incorporated the utilization of the online database into monitoring and auditing tools for both Direct Care Service Agencies and Approved Direct Care Worker Training and Testing Programs. Priorities related to revisions to the standardized curriculum, development of alternate standardized competency tests and requirements for Direct Care Workers providing respite services to pass the competency tests in order to provide care to ALTCS members continue to be identified for future implementation, as well as utilization of the online database to crosscheck Direct Care Workers with Medicare and Medicaid exclusions lists.

AHCCCS continues to explore options internally with the Office of Clinical Quality Management to identify quality of care measures that may be utilized to assess the impact of the new competency and training standards on the quality of care received by members including measures pertaining to member satisfaction, hospitalization re-admittance (in-patient, emergency room visits, etc.) and incident reports.

Arizona Association of Health Plans (AzAHP)

The Arizona Association of Health Plans (AzAHP) is an Association comprised of most health plans that contract with AHCCCS for Medicaid business. The Association led an effort, with the support of AHCCCS, in selecting and implementing a credential verification organization (CVO) that would be utilized by all AHCCCS Contractors. The purpose of moving this initiative forward was to reduce the burden of submission of applications, documents and attestations on providers that are contracted with multiple Medicaid health plans. The credentialing process for primary source verification was implemented in the first quarter of this fiscal year. This process has reduced inefficiencies with different Contractors credentialing the same panel of physicians. AHCCCS requested that the Association expand these efforts to include behavioral health credentialing and tracking of provider training in developmental screening tools and primary care physician application of fluoride varnish.

Emergency Medical Services (EMS): Treat and Refer Innitiaive

AHCCCS began the process of looking at treatment deferrals with the City of Mesa EMS teams a year or more ago. One of the primary concerns that the team identified was that many times, members do not need to be taken to an emergency department for treatment; however, that was the only mechanism for payment that the EMS teams had when they were called out. From those insightful discussions, AHCCCS took the opportunity to explore a broad-based approach to EMS care and is currently working on opening code sets to allow EMS crews to treat and release members as appropriate and bill for those evaluations versus having to bill for transport and have

the member incur an emergency department fee also. It is expected that EMS teams will use their training to complete a thorough assessment of the member and make the best decision for care while limiting burden and unnecessary treatment of the member. If a member needs emergent services, the member will be expeditiously transported; however, if the member is ok, the EMS teams can make recommendations for home care and timely follow-up with PCPs.

Qualifying as a Treat and Refer provider is open state-wide for EMS entities. If EMS entities qualify to be recognized as a Treat and Refer entity, they are eligible to register as an AHCCCS provider. If they meet the criteria for registering as a Medicaid provider, they can be reimbursed for treat and refer services as detailed in the protocols that have been established. Qualifying providers will receive one year of recognition and must requalify to continue with recognition. Qualifying providers are required to meet data submission requirements that will be monitored closely to ensure appropriate level of care is performed. If providers are unable to meet data submission requirements, they lose their treat and refer recognition.

We met with CMS on May 2nd and was well received. A state plan amendment will be submitted soon for CMS review.

Proposed Model:

- AHCCCS to create new provider type specifically for treat and refer
- AHCCCS to identify scope of services assigned to this provider type
- AHCCCS to determine rate for this provider type (different from ambulance providers)
- Similar to “Premier Status” but focused on Treat and Refer
- DHS to develop training requirements to qualify
- Data submission by provider required
- Provider must meet specific performance measures to qualify
- Each jurisdiction would be required to have their Medical Director review referrals
- Provider required to demonstrate continuous process improvement
- Implement new process (October, 2016)

Identifying Priority Areas for Improvement

AHCCCS has established an objective, systematic process for identifying priority areas for improvement. This process involves a review of data from both internal and external sources, while also taking into account such factors as the prevalence of a particular condition and population affected, the resources required by both AHCCCS and Contractors to conduct studies and effect improvement, and whether the areas currently are priorities of CMS or state leadership and/or can be combined with existing initiatives. Of importance is whether initiatives focused on the topic area are actionable and would result in improved quality improvement, member

satisfaction and system efficiencies. Contractor input is also sought in prioritizing areas for improvement.

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

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

Establishing Realistic Outcome-Based Performance Measures

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

AHCCCS has developed new performance measure sets for all lines of business. Additional measures have been added to contracts for all lines of business, these measures largely include preventative measures for adults such as; Adults Access to Care, Breast Cancer Screening and Cervical Cancer screening. The new measures and related Minimum Performance Standards/Goals became effective on October 1, 2015 which aligns with the start of a new contract period for all lines of business. The AHCCCS decision to transition to a new measure set was partially driven by a desire to align with measures sets such as the CHIPRA Core Measure Set, the Adult Core Measure Set, Meaningful Use, and others measure sets being implemented by CMS. AHCCCS has also updated the measure sets with contracts to reflect changes on measures implemented by CMS for the current contract year.

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

which include greatest need for members, system ability to impact/improve results, alignment with national measure sets, and comparability across lines of business.

The health care system is evolving in relation to measuring quality. It is in a transitional phase in that what has existed as data sources and methodologies will no longer be enough. Yet, the systems, data sources and processes to fully achieve the next level in clinical outcomes and satisfaction measures are not yet fully developed or implemented such as electronic health records, health information exchange data and information that will be available through public health connectivity. Transitioning the AHCCCS measure sets is anticipated to support the adoption of electronic health records and use of the health information exchange which will, in turn, result in efficiencies and data/information that will transform care practices, improve individual patient outcomes and population health management, improve patient satisfaction with the care experience, increase efficiencies and reduce health care costs.

CYE 2014 Performance Measure Crosswalk

Measures	Acute	ALTCS E/PD	GMS/SA	SMI	CMDP	CRS	DDD		HEDIS	CMS Adult Core Measures	CHIPRA Core Measures
ADULT MEASURES											
Inpatient Utilization	X	X	X	X	X	X	X		X		
ED Utilization	X	X	X	X	X	X	X		X		
Hospital Readmission	X	X	X	X			X			X	
Follow-Up After Hospitalization for Mental Health, 7 Days		X	X	X						X	
Follow-Up After Hospitalization for Mental Health, 30 Days		X	X	X						X	
Adults' Access to Preventive/Ambulatory Health Services	X	X		X			X		X		
Breast Cancer Screening	X			X			X			X	
Cervical Cancer Screening	X			X			X			X	

Chlamydia Screening in Women	X			X			X		X	
Colorectal Screening	X			X				X		
CDC - HbA1c Testing	X	X		X			X		X	
CDC - HbA1c Poor Control (>9.0%)	X	X		X			X		X	
CDC - Eye Exam	X	X		X			X	X		
Flu Shots for Adults, Ages 18 and Older*	X	X		X			X		X	
Diabetes Admissions, Short-Term Complications	X	X		X			X		X	
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	X	X		X			X		X	
Asthma in Younger Adults Admissions	X			X			X		X	
Heart Failure Admission Rate	X	X		X			X		X	
Timeliness of Prenatal Care: Prenatal Care Visit in the First Trimester or Within 42 days of Enrollment	X			X						X
Timeliness of Prenatal Care: Postpartum Care Rate	X			X					X	
Mental Health Utilization	X	X	X	X		X		X		
Use of Opioids From Multiple Providers at High Dosage in Persons Without Cancer	X	X	X	X	X	X	X		X	
Screening for Clinical Depression and Follow-Up Plan		X							X	
Annual Monitoring for Patients on Persistent Medications: Combo Rate		X		X			X		X	

Advance Directives		X									
Access to Behavioral Health Professional Services, 7 Days			X	X							
Access to Behavioral Health Professional Services, 23 Days			X	X							
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication				X						X	
CHILDRENS MEASURES											
Children's Access to PCPs, by age: ***12-24 mo.***	X				X	X	X				X
Children's Access to PCPs, by age: ***25 mo.- 6 yrs.***	X				X	X	X				X
Children's Access to PCPs, by age: ***7 - 11 yrs.***	X				X	X	X				X
Children's Access to PCPs, by age: ***12 - 19 yrs.***	X				X	X	X				X
Well-Child Visits: ***15 mo.***	X					X					X
Well-Child Visits: ***3 - 6 yrs.***	X				X	X	X				X
Adolescent Well-Child Visits: ***12–21 yrs.***	X				X	X	X				X
Children's Dental Visits (ages 2-21)	X				X (2-18 yrs)	X	X				X
Weight Assessment and counseling - Body Mass Index (BMI) Assessment for Children/Adolescents	X	X	X		X	X	X				X
EPSDT Participation	X	X (18-21 yrs)	X	X (18-21 yrs)	X	X	X				
Percentage of Eligibiles Who Received Preventive Dental Services	X	X			X	X	X				
SEAL: Dental Sealants for Children Ages 6-9 at Elevated Caries Risk	X	X			X	X	X				X
Developmental Screening in the First Three Years of Life	X	X			X	X	X				X
Human Papillomavirus Vaccine for Female Adolescents	X				X	X	X				X

Use of Multiple Concurrent Antipsychotics in Children and Adolescents			X		X						X
Childhood Immunization Status											
DTaP	X				X	X	X				X
IPV	X				X	X	X				X
MMR	X				X	X	X				X
Hib	X				X	X	X				X
HBV	X				X	X	X				X
VZV	X				X	X	X				X
PCV	X				X	X	X				X
Hep A	X				X	X	X				X
Rotavirus	X				X	X	X				X
Influenza	X				X	X	X				X
Combination 3 (4:3:1:3:3:1:4)	X				X	X	X				X
Immunizations for Adolescents											
Adolescent Meningococcal	X				X	X	X				X
Adolescent Tdap	X				X	X	X				X
Combination 1	X				X	X	X				X

Identifying, Collecting and Assessing Relevant Data

Performance Measures

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

Contractors have been provided the data to enhance their planning and implementation efforts related to the new performance measures as well as the sustaining/improving continuing measures. Some of these efforts will include new work groups, new reporting mechanisms, increased opportunities for technical assistance, a more transparent reporting process with plans for proactive reporting prior to the end of the measurement period so that Contractors can make

necessary adjustments/final pushes and payment reform initiatives that align with performance measure thresholds.

Performance Improvement Projects

Providing Incentives for Excellence and Imposing Sanctions for Poor Performance

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

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

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

Performance Improvement Projects (PIPs)

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

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

Providers e-Prescribing to Members Aged 0-64

Line of Business	Percent of Providers who prescribed at least one prescription electronically

Acute	**52.44%**
ALTCS E/PD	**43.36%**
ALTCS DDD	**57.11%**
CRS	**50.60%**
Behavioral Health – non-integrated	**48.20%**
Behavioral Health - integrated	**47.24%**
CMDP	**47.31%**

Providers e-Prescribing to Members Aged 65+

Line of Business	Percent of Providers who prescribed at least one prescription electronically
Acute	**56.56%**
ALTCS E/PD	**44.60%**
ALTCS DDD	**59.63%**
Behavioral Health – non-integrated	**56.72%**
Behavioral Health - integrated	**55.84%**

New Prescriptions e-Prescribed to Members Aged 0-64

Line of Business	Percent of prescriptions prescribed electronically
Acute	**42.06%**
ALTCS E/PD	**23.17%**
ALTCS DDD	**44.69%**
CRS	**43.04%**
Behavioral Health – non-integrated	**31.81%**
Behavioral Health - integrated	**33.86%**
CMDP	**46.70%**

New Prescriptions e-Prescribed to Members Aged 65+

Line of Business	Percent of prescriptions prescribed electronically
Acute	**56.02%**
ALTCS E/PD	**24.02%**
ALTCS DDD	**37.95%**
Behavioral Health – non-integrated	**29.87%**
Behavioral Health - integrated	**45.31%**

The first target for improvement is a statistically significant increase in rates from the baseline measurement. The first remeasurement will be reflective of CYE 2017.

Additional PIPs that are currently under development include the following:

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

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

Including Medical Quality Assessment and Performance Improvement Requirements in AHCCCS Contracts

Contracts with health plans are reviewed to ensure that they include all federally required elements prior to renewal. As noted above, revisions were incorporated into contracts to continue incentivizing improvement in performance.

Regular Monitoring and Evaluating of Contractor Compliance and Performance

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

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

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

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

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

- *Review and analysis of program-specific Performance Measures and Performance Improvement Projects* - AHCCCS considers a Performance Improvement Project (PIP) as a planned process of data gathering, evaluation, and analysis to determine interventions or activities that are anticipated to have a positive outcome. PIPs are designed to improve the quality of care and service delivery and usually last at least four years. While Contractors may select and implement their own PIPs to address problems specific to their plans, AHCCCS mandates other program-wide PIPs in which Contractors must participate, and monitors performance until each Contractor meet requirements for demonstrable and sustained improvement.

Another method by which AHCCCS monitors the quality and appropriateness of care provided to members is through Performance Measures. Contractors submit encounter data to AHCCCS,

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

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

Maintaining an Information system that Supports Initial and Ongoing Operations

The AHCCCS Data Decision Support (ADDS) system provides greater flexibility and timeliness in monitoring a broad spectrum of data, including that supports ongoing operations and review of quality management and performance improvement activities. Enhancements have been made to the ADDS function that generates Performance Measure data. The system is used to support performance monitoring, as well as provide data through specific queries to guide new quality initiatives. In addition, AHCCCS has an ongoing process of reviewing and updating its programming for collecting and analyzing Performance Measures according to HEDIS-like specifications through the ADDS data warehouse. Measures are validated against historical data, as well as individual recipient and service records in PMMIS, to ensure accuracy and reliability of data.

Reviewing, Revising and Beginning New Projects in any given Area of Quality Strategy

Review and revision of the components of the Quality Strategy is an ongoing process for AHCCCS. The Quality Strategy is aligned with federal Medicaid Managed Care requirements, including the CMS toolkit, and links to other significant documents, including annual External Quality Review reports, the AHCCCS Five Year Strategic Plan, AHCCCS E-Health Initiative, managed care contracts and other Agency reports. The Quality Strategy was last revised in July 2012 and received approval from the State Medicaid Advisory Committee in October 2012. Ahead of the anticipated release of the Final Rule for Medicaid Managed Care, AHCCCS has suspended the Quality Strategy revisions until final guidance is available. Due to the numerous implications for the Quality Strategy, AHCCCS has opted for a comprehensive review of the Strategy once the new requirements are known, in order to eliminate duplication of effort.

Wavier Evaluation Planning

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

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

Independent Waiver Evaluation Timeline:

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

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

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

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

Active Participants

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

Staff Pool	January – March 2016
Administrative	3,226
Direct Service	3,145
Personal Care	4,716

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

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

Return Rate

Cost Pool	Moments Generated	Valid Response	Return Rate
Administrative	3,200	3,107	97.09%
Direct Service	3,400	3,259	95.85%
Personal Care	3,500	3,132	89.49%

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

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

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

	FFY 2012 PM/PM	Trend Rate	DY 01 PM/PM	Effective FMAP	Federal Share PM/PM	Member Months QE 12/11	QE 3/12	QE 6/12	QE 9/12	Total	Federal Share Budget Neutrality Limit	
AFDC/SOBRA	556.34	1.052	585.28	69.84%	408.78	2,932,642	2,920,345	2,914,216	2,938,965	11,706,168	$ 4,785,268,539	
SSI	835.29	1.06	885.41	69.10%	611.78	487,500	488,912	488,925	491,549	1,956,886	1,197,192,694	
AC [1]			562.10	69.74%	391.98	527,244	430,723	365,132	310,396	1,633,495	640,302,062	
ALTCS-DD	4643.75	1.06	4922.38	67.38%	3316.47	72,528	73,164	73,974	74,829	294,495	976,683,118	
ALTCS-EPD	4503.21	1.052	4737.37	67.50%	3197.92	85,451	85,497	85,721	86,503	343,172	1,097,437,831	
Family Plan Ext [1]		1.058	17.04	90.00%	15.33	12,471	12,424	12,440	12,689	50,024	767,009	
											$ 8,697,651,253	MAP Subtotal
											103,890,985	Add DSH Allotment
											$ 8,801,542,238	Total BN Limit

	DY 02 PM/PM			Member Months QE 12/12	QE 3/13	QE 6/13	QE 9/13	Total		
AFDC/SOBRA	615.71	68.85%	423.92	2,911,626	2,891,396	2,903,258	2,919,185	11,625,465	$ 4,928,233,167	
SSI	938.53	67.86%	636.89	494,615	496,974	499,543	503,039	1,994,171	1,270,076,904	
AC [1]	601.42	68.73%	413.37	274,990	248,817	228,204	217,114	969,125	400,604,553	
ALTCS-DD	5217.72	65.83%	3434.67	75,648	76,477	77,293	78,047	307,465	1,056,040,588	
ALTCS-EPD	4983.71	66.02%	3290.02	86,820	86,065	86,291	87,121	346,297	1,139,322,440	
Family Plan Ext [1]	18.42	90.00%	16.58	13,104	13,824	14,187	14,856	55,971	927,946	
									$ 8,795,205,598	MAP Subtotal
									106,384,369	Add DSH Allotment
									$ 8,901,589,967	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	70.57%	457.09	2,892,129	2,839,858	2,956,309	3,114,391	11,802,687	$ 5,394,907,536	
SSI	994.84	69.28%	689.20	506,301	513,523	521,992	527,784	2,069,600	1,426,369,115	
AC [1]	605.20	69.85%	422.70	206,419	87	2	-	206,508	87,291,883	
ALTCS-DD	5530.78	67.35%	3725.18	78,855	79,695	80,684	81,770	321,004	1,195,798,184	
ALTCS-EPD	5242.86	67.53%	3540.53	87,664	87,881	88,722	89,345	353,612	1,251,972,244	
Family Plan Ext [1]	13.39	90.00%	12.05	14,885	-	-	-	14,885	179,426.00	
Expansion State Adults [1]	643.61	85.32%	549.10	-	444,482	625,121	756,994	1,826,597	1,002,977,504	
									$ 10,359,495,892	MAP Subtotal
									107,980,135	Add DSH Allotment
									$ 10,467,476,027	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	71.41%	486.58	3,146,974	3,086,105	3,106,937	3,212,278	12,552,294	$ 6,107,714,586	
SSI	1054.53	70.23%	740.59	534,911	541,107	541,410	540,540	2,157,968	1,598,168,600	
AC	0.00	68.41%	0.00	-	-	-	-	-	-	
ALTCS-DD	5862.63	68.54%	4018.31	82,735	83,839	84,845	85,622	337,041	1,354,335,154	
ALTCS-EPD	5515.49	68.68%	3788.03	89,995	89,864	89,914	89,991	359,764	1,362,798,060	
Family Plan Ext	0.00	90.00%	0.00	-	-	-	-	-	-	
Expansion State Adults	588.31	87.69%	515.92	818,854	837,153	847,551.00	868,740.00	3,372,298	1,739,829,881	
									$ 12,162,846,281	MAP Subtotal
									109,707,817	Add DSH Allotment
									$ 12,272,554,098	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	70.85%	507.89	3,265,463	3,251,815			6,517,278	$ 3,310,091,993	
SSI	1117.81	70.13%	783.94	543,185	542,300			1,085,485	850,957,588	
AC	0.00	70.08%	0.00	-	-			-	-	
ALTCS-DD	6214.39	68.96%	4285.56	86,350	86,788			173,138	741,993,275	
ALTCS-EPD	5802.30	69.01%	4004.26	89,684	87,753			177,437	710,503,591	
Family Plan Ext	0.00	90.00%	0.00	-	-			-	-	
Expansion State Adults	532.21	89.71%	477.46	919,879	932,600			1,852,479	884,477,619	
									$ 6,498,024,065	MAP Subtotal
									110,036,940	Add DSH Allotment
									$ 6,608,061,005	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 3/31/2016

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

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

	Budget Neutrality Limit - Federal Share			Expenditures from CMS-64 - Federal Share												
WAIVER PERIOD OCTOBER 1, 2011 THROUGH SEPTEMBER 30, 2016:	MAP	DSH	Total	AFDC/SOBRA	SSI	AC	ALTCS-DD	ALTCS-EPD	Family Plan	DSH/CAHP	SNCP/DSHP	UNC CARE	MED	Exp St Adults	Total	VARIANCE
QE 12/11	$ 2,217,720,051	$ 103,890,985	$ 2,321,611,036	$ 502,890,921	$ 191,249,757	$ 175,610,617	$ 151,638,753	$ 164,685,415	$ 167,197	$ -	$ -	$ -	$ 458,635	$ -	$ 1,186,701,295	$ 1,134,909,741
QE 3/12	2,177,978,180	-	2,177,978,180	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	883,205,592
QE 6/12	2,153,173,080	-	2,153,173,080	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	717,901,280
QE 9/12	2,148,779,943	-	2,148,779,943	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	808,126,356
QE 12/12	2,208,659,762	106,384,369	2,315,044,131	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	876,754,748
QE 3/13	2,191,142,608	-	2,191,142,608	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	846,787,352
QE 6/13	2,192,838,808	-	2,192,838,808	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	777,530,263
QE 9/13	2,202,564,420	-	2,202,564,420	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	682,261,375
QE 12/13	2,362,469,830	107,980,135	2,470,449,965	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	964,826,274
QE 3/14	2,504,118,525	-	2,504,118,525	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	1,019,467,150
QE 6/14	2,668,998,170	-	2,668,998,170	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	1,060,973,095
QE 9/14	2,823,909,367	-	2,823,909,367	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	959,335,338
QE 12/14	3,023,229,579	109,707,817	3,132,937,396	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	1,106,585,596
QE 3/15	3,011,581,308	-	3,011,581,308	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	1,258,002,027
QE 6/15	3,031,538,512	-	3,031,538,512	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	1,120,496,266
QE 9/15	3,096,496,882	-	3,096,496,882	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	1,212,433,934
QE 12/15	3,252,715,515	-	3,252,715,515	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	1,229,750,732
QE 3/16	3,245,308,550	110,036,940	3,355,345,490	648,184,948	306,551,003	(1,729,262)	213,667,327	223,755,826	(1)	20,729,076	43,581,049	3,093,001	-	482,768,728	1,940,601,695	1,414,743,795
QE 6/16		-	-												-	-
QE 9/16		-	-												-	-
	$ 46,513,223,090	$ 538,000,246	$ 47,051,223,336	$ 11,236,290,020	$ 4,744,962,868	$ 1,141,324,023	$ 3,237,434,539	$ 3,541,306,188	$ 1,873,168	$ 430,282,169	$ 829,532,905	$ 189,701,285	$ 453,960	$ 3,623,971,297	$ 28,977,132,422	$ 18,074,090,914

Last Updated: 5/3/2016

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

III. SUMMARY BY DEMONSTRATION YEAR

	Federal Share of Budget Neutrality Limit	Federal Share of Waiver Costs on CMS-64	Annual Variance	As % of Annual Budget Neutrality Limit	Cumulative Federal Share of Budget Neutrality Limit	Cumulative Federal Share of Waiver Costs on CMS-64	Cumulative Federal Share Variance	As % of Cumulative Budget Neutrality Limit
WAIVER PERIOD OCTOBER 1, 2011 THROUGH SEPTEMBER 30, 2016								
DY 01	$ 8,801,542,238	$ 5,636,740,734	$ 3,164,801,504	35.96%				
DY 02	8,901,589,967	5,847,766,643	3,053,823,324	34.31%				
DY 03	10,467,476,027	6,501,446,304	3,966,029,723	37.89%				
DY 04	12,272,554,098	7,377,220,432	4,895,333,666	39.89%				
DY 05	6,608,061,005	3,613,958,309	2,994,102,696	45.31%	$ 47,051,223,336	$ 28,977,132,422	$ 18,074,090,914	38.41%
	$ 47,051,223,336	$ 28,977,132,422	$ 18,074,090,914					

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

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

Schedule C Waiver 11-W00275/9

Total Computable

Waiver Name	01	02	03	04	05	Total
AC	917,873,228	582,641,947	124,890,894	19,811,713	(28,099)	1,645,189,683
AFDC/SOBRA	3,415,795,264	3,586,548,727	3,542,219,785	3,599,472,430	1,850,319,895	15,994,356,101
ALTCS-EPD	1,062,184,808	1,167,097,458	1,185,581,103	1,241,251,898	580,633,815	5,236,749,082
ALTCS-DD	939,086,691	1,005,678,145	1,067,625,094	1,170,211,844	611,283,493	4,793,885,267
DSH/CAHP	155,762,651	163,516,194	161,993,800	154,152,100	5,245,950	640,670,695
Expansion State Adults	-	-	1,175,387,547	1,980,922,342	984,338,245	4,140,648,134
Family Planning Extension	830,631	1,008,110	195,976	(1,337)	(1)	2,033,379
MED	673,818	-	-	-	-	673,818
SNCP/DSHP	296,636,120	564,951,230	240,250,917	119,071,612	22,924,710	1,243,834,589
SSI	1,349,749,974	1,427,933,003	1,540,913,999	1,709,275,345	820,361,519	6,848,233,840
Uncomp Care IHS/638	22,866,717	97,192,513	53,888,765	13,437,080	2,538,353	189,923,428
Subtotal	8,161,459,902	8,596,567,327	9,092,947,880	10,007,605,027	4,877,617,880	40,736,198,016
New Adult Group	-	-	108,400,435	306,903,621	216,613,957	631,918,013
Total	8,161,459,902	8,596,567,327	9,201,348,315	10,314,508,648	5,094,231,837	41,368,116,029

Federal Share

Waiver Name	01	02	03	04	05	Total
AC	640,091,028	400,466,129	87,232,892	13,553,662	(19,688)	1,141,324,023
AFDC/SOBRA	2,385,748,434	2,469,360,749	2,499,708,905	2,570,449,051	1,311,022,881	11,236,290,020
ALTCS-EPD	717,019,792	770,463,878	800,627,442	852,490,379	400,704,697	3,541,306,188
ALTCS-DD	632,712,981	662,008,210	719,084,275	802,076,171	421,552,902	3,237,434,539
DSH/CAHP	104,828,265	107,397,436	108,908,432	105,532,527	3,615,509	430,282,169
Expansion State Adults	-	-	1,002,827,421	1,737,746,134	883,397,742	3,623,971,297
Family Planning Extension	767,009	927,946	179,426	(1,212)	(1)	1,873,168
MED	453,960	-	-	-	-	453,960
SNCP/DSHP	199,636,108	371,059,969	161,520,692	81,516,426	15,799,710	829,532,905
SSI	932,635,122	969,014,647	1,067,510,989	1,200,450,305	575,351,805	4,744,962,868
Uncomp Care IHS/638	22,848,035	97,067,679	53,845,830	13,406,989	2,532,752	189,701,285
Subtotal	5,636,740,734	5,847,766,643	6,501,446,304	7,377,220,432	3,613,958,309	28,977,132,422
New Adult Group	-	-	108,400,435	306,903,621	216,613,957	631,918,013
Total	5,636,740,734	5,847,766,643	6,609,846,739	7,684,124,053	3,830,572,266	29,609,050,435

Adjustments to Schedule C Waiver 11-W00275/9

Total Computable

Waiver Name	01	02	03	04	05	Total
AC	313,572	210,756	87,745	(7)	253	612,319
AFDC/SOBRA	1,014,881	1,090,143	990,293	5,056,392	2,507,421	10,659,130
SSI	365,158	399,101	398,723	2,391,771	1,171,421	4,726,174
Expansion State Adults	-	-	223,239	3,043,744	1,566,856	4,833,839
ALTCS-DD (Cost Sharing)[1]	-	-	-	-	-	-
CAHP[2]	(1,693,611)	(1,700,000)	(1,700,000)	(10,491,900)	(5,245,950)	(20,831,461)
Total	-	-	-	-	0	0

Federal Share

Waiver Name	01	02	03	04	05	Total
AC	211,034	138,424	58,991	(5)	174	408,618
AFDC/SOBRA	683,014	716,006	665,774	3,461,607	1,728,114	7,254,515
SSI	245,752	262,130	268,062	1,637,406	807,344	3,220,694
Expansion State Adults	-	-	150,083	2,083,747	1,079,877	3,313,707
ALTCS-DD (Cost Sharing)[1]	-	-	-	-	-	-
CAHP[2]	(1,139,800)	(1,116,560)	(1,142,910)	(7,182,755)	(3,615,509)	(14,197,534)
Total	-	-	-	-	-	-

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

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

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

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

Revised Schedule C Waiver 11-W00275/9

Total Computable

Waiver Name	01	02	03	04	05	Total
AC	918,186,800	582,852,703	124,978,639	19,811,706	(27,846)	1,645,802,002
AFDC/SOBRA	3,416,810,145	3,587,638,870	3,543,210,078	3,604,528,822	1,852,827,316	16,005,015,231
ALTCS-EPD	1,062,184,808	1,167,097,458	1,185,581,103	1,241,251,898	580,633,815	5,236,749,082
ALTCS-DD	939,086,691	1,005,678,145	1,067,625,094	1,170,211,844	611,283,493	4,793,885,267
DSH/CAHP	154,069,040	161,816,194	160,293,800	143,660,200	-	619,839,234
Expansion State Adults	-	-	1,175,610,786	1,983,966,086	985,905,101	4,145,481,973
Family Planning Extension	830,631	1,008,110	195,976	(1,337)	(1)	2,033,379
MED	673,818	-	-	-	-	673,818
SNCP/DSHP	296,636,120	564,951,230	240,250,917	119,071,612	22,924,710	1,243,834,589
SSI	1,350,115,132	1,428,332,104	1,541,312,722	1,711,667,116	821,532,940	6,852,960,014
Uncomp Care IHS/638	22,866,717	97,192,513	53,888,765	13,437,080	2,538,353	189,923,428
Subtotal	8,161,459,902	8,596,567,327	9,092,947,880	10,007,605,027	4,877,617,880	40,736,198,016
New Adult Group	-	-	108,400,435	306,903,621	216,613,957	631,918,013
Total	8,161,459,902	8,596,567,327	9,201,348,315	10,314,508,648	5,094,231,837	41,368,116,029

Federal Share

Waiver Name	01	02	03	04	05	Total
AC	640,302,062	400,604,553	87,291,883	13,553,657	(19,514)	1,141,732,641
AFDC/SOBRA	2,386,431,448	2,470,076,755	2,500,374,679	2,573,910,658	1,312,750,995	11,243,544,535
ALTCS-EPD	717,019,792	770,463,878	800,627,442	852,490,379	400,704,697	3,541,306,188
ALTCS-DD	632,712,981	662,008,210	719,084,275	802,076,171	421,552,902	3,237,434,539
DSH/CAHP	103,688,465	106,280,876	107,765,522	98,349,772	0	416,084,635
Expansion State Adults	-	-	1,002,977,504	1,739,829,881	884,477,619	3,627,285,004
Family Planning Extension	767,009	927,946	179,426	(1,212)	(1)	1,873,168
MED	453,960	-	-	-	-	453,960
SNCP/DSHP	199,636,108	371,059,969	161,520,692	81,516,426	15,799,710	829,532,905
SSI	932,880,874	969,276,777	1,067,779,051	1,202,087,711	576,159,149	4,748,183,562
Uncomp Care IHS/638	22,848,035	97,067,679	53,845,830	13,406,989	2,532,752	189,701,285
Subtotal	5,636,740,734	5,847,766,643	6,501,446,304	7,377,220,432	3,613,958,309	28,977,132,422
New Adult Group	-	-	108,400,435	306,903,621	216,613,957	631,918,013
Total	5,636,740,734	5,847,766,643	6,609,846,739	7,684,124,053	3,830,572,266	29,609,050,435

Calculation of Effective FMAP:

AFDC/SOBRA					
Federal	2,386,431,448	2,470,076,755	2,500,374,679	2,573,910,658	1,312,750,995
Total	3,416,810,145	3,587,638,870	3,543,210,078	3,604,528,822	1,852,827,316
Effective FMAP	0.698438411	0.688496486	0.705680618	0.71407687	0.708512328
SSI					
Federal	932,880,874	969,276,777	1,067,779,051	1,202,087,711	576,159,149
Total	1,350,115,132	1,428,332,104	1,541,312,722	1,711,667,116	821,532,940
Effective FMAP	0.690963942	0.678607429	0.692772489	0.702290591	0.701322029
ALTCS-EPD					
Federal	717,019,792	770,463,878	800,627,442	852,490,379	400,704,697
Total	1,062,184,808	1,167,097,458	1,185,581,103	1,241,251,898	580,633,815
Effective FMAP	0.675042409	0.660153848	0.675303815	0.686798852	0.690116019
ALTCS-DD					
Federal	632,712,981	662,008,210	719,084,275	802,076,171	421,552,902
Total	939,086,691	1,005,678,145	1,067,625,094	1,170,211,844	611,283,493
Effective FMAP	0.673753538	0.658270455	0.673536318	0.685411086	0.689619312
AC					
Federal	640,302,062	400,604,553	87,291,883	13,553,657	(19,514)
Total	918,186,800	582,852,703	124,978,639	19,811,706	(27,846)
Effective FMAP	0.697354898	0.687316969	0.698454421	0.684123669	0.700769542
Expansion State Adults					
Federal	-	-	1,002,977,504	1,739,829,881	884,477,619
Total	-	-	1,175,610,786	1,983,966,086	985,905,101
Effective FMAP			0.853154391	0.876945374	0.89712247
New Adult Group					
Federal	-	-	108,400,435	306,903,621	216,613,957
Total	-	-	108,400,435	306,903,621	216,613,957
Effective FMAP			1	1	1

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

V. Budget Neutrality Member Months and Cost Sharing Premium Collections

Budget Neutrality Member Months:	AFDC/SOBRA	SSI	ALTCS-DD	ALTCS-EPD	AC	MED	Family Plan Ext	Expan St Adults	New Adult Group
Quarter Ended December 31, 2011	2,932,642	487,500	72,528	85,451	527,244	467	12,471		
Quarter Ended March 31, 2012	2,920,345	488,912	73,164	85,497	430,723	-	12,424		
Quarter Ended June 30, 2012	2,914,216	488,925	73,974	85,721	365,132	-	12,440		
Quarter Ended September 30, 2012	2,938,965	491,549	74,829	86,503	310,396	-	12,689		
Quarter Ended December 31, 2012	2,911,626	494,615	75,648	86,820	274,990	-	13,104		
Quarter Ended March 31, 2013	2,891,396	496,974	76,477	86,065	248,817	-	13,824		
Quarter Ended June 30, 2013	2,903,258	499,543	77,293	86,291	228,204	-	14,187		
Quarter Ended September 30, 2013	2,919,185	503,039	78,047	87,121	217,114	-	14,856		
Quarter Ended December 31, 2013	2,892,129	506,301	78,855	87,664	206,419	-	14,885		
Quarter Ended March 31, 2014	2,839,858	513,523	79,695	87,881	87	-	-	444,482	39,040
Quarter Ended June 30, 2014	2,956,309	521,992	80,684	88,722	2	-	-	625,121	86,627
Quarter Ended September 30, 2014	3,114,391	527,784	81,770	89,345	-	-	-	756,994	123,013
Quarter Ended December 31, 2014	3,146,974	534,911	82,735	89,995	-	-	-	818,854	149,841
Quarter Ended March 31, 2015	3,086,105	541,107	83,839	89,864	-	-	-	837,153	191,217
Quarter Ended June 30, 2015	3,106,937	541,410	84,845	89,914	-	-	-	847,551	245,371
Quarter Ended September 30, 2015	3,212,278	540,540	85,622	89,991	-	-	-	868,740	285,006
Quarter Ended December 31, 2015	3,265,463	543,185	86,350	89,684	-	-	-	919,879	312,453
Quarter Ended March 31, 2016	3,251,815	542,300	86,788	87,753	-	-	-	932,600	329,873
Quarter Ended June 30, 2016									
Quarter Ended September 30, 2016									

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

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

VI. Allocation of Disproportionate Share Hospital Payments

Federal Share

	FFY 2012	FFY 2013	FFY 2014	FFY 2015	FFY 2016	
Total Allotment	**103,890,985**	**106,384,369**	**107,980,135**	**109,707,817**	**110,036,940**	**538,000,246**
Reported in QE						
Dec-11	-	-	-	-	-	-
Mar-12	-	-	-	-	-	-
Jun-12	78,996,800	-	-	-	-	78,996,800
Sep-12	6,248,670	-	-	-	-	6,248,670
Dec-12	11,346,623	-	-	-	-	11,346,623
Mar-13	309,515	-	-	-	-	309,515
Jun-13	1,022,914	77,733,987	-	-	-	78,756,901
Sep-13	-	-	-	-	-	-
Dec-13	-	6,098,257	-	-	-	6,098,257
Mar-14	2,505,265	-	-	-	-	2,505,265
Jun-14	-	4,725,871	-	-	-	4,725,871
Sep-14	3,258,682	-	79,568,453	-	-	82,827,135
Dec-14	-	-	6,222,002	-	-	6,222,002
Mar-15	-	1,474,261	-	-	-	1,474,261
Jun-15	-	16,248,501	(219,987)	92,024,206	-	108,052,719
Sep-15	-	-	1,465,978	-	-	1,465,978
Dec-15	(4)			6,325,567		6,325,563
Mar-16			20,729,076			
Jun-16						
Sep-16						
Total Reported to Date	103,688,465	106,280,876	107,765,522	98,349,773	-	395,355,560
Unused Allotment	**202,520**	**103,493**	**214,613**	**11,358,044**	**110,036,940**	**142,644,686**

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

VII. BUDGET NEUTRALITY TRACKING SCHEDULE -- NEW ADULT GROUP

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

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

	Trend Rate	DY 03 PM/PM	Effective FMAP	Federal Share PM/PM	Member Months QE 12/13	QE 3/14	QE 6/14	QE 9/14	Total	Federal Share Budget Neutrality Limit
New Adult Group		578.54	100.00%	578.54	-	39,040	86,627	123,013	248,680	143,871,327

	Trend Rate	DY 04 PM/PM	Effective FMAP	Federal Share PM/PM	Member Months QE 12/14	QE 3/15	QE 6/15	QE 9/15	Total	Federal Share Budget Neutrality Limit
New Adult Group	1.047	605.73	100.00%	605.73	149,841	191,217	245,371	285,006	871,435	527,855,525

	Trend Rate	DY 05 PM/PM	Effective FMAP	Federal Share PM/PM	Member Months QE 12/15	QE 3/16	QE 6/16	QE 9/16	Total	Federal Share Budget Neutrality Limit
New Adult Group	1.047	634.20	100.00%	634.20	312,453	329,873			642,326	407,363,634

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	22,586,202	-	22,586,202	13,870,414	8,715,788
QE 6/14	50,117,185	-	50,117,185	34,313,342	15,803,843
QE 9/14	71,167,941	-	71,167,941	47,984,458	23,183,483
QE 12/14	90,763,396	-	90,763,396	46,004,135	44,759,261
QE 3/15	115,826,137	-	115,826,137	70,387,348	45,438,789
QE 6/15	148,628,914	-	148,628,914	85,319,153	63,309,761
QE 9/15	172,637,078	-	172,637,078	97,948,283	74,688,795
QE 12/15	198,157,928	-	198,157,928	113,800,738	84,357,190
QE 3/16	209,205,706	-	209,205,706	122,290,142	86,915,564
QE 6/16					
QE 9/16					
	$ 1,079,090,486	$ -	$ 1,079,090,486	$ 631,918,013	$ 447,172,473

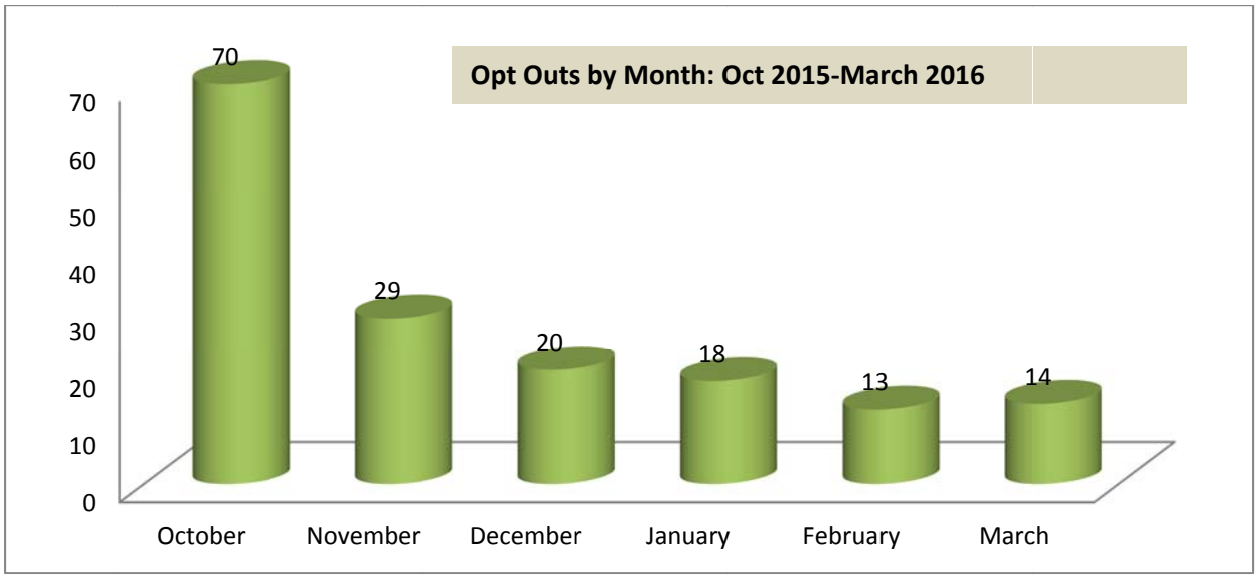
III. SUMMARY BY DEMONSTRATION YEAR

	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	$ 143,871,327	$ 96,168,214	$ 47,703,113	33.16%				
DY 04	527,855,525	299,658,919	228,196,606	43.23%				
DY 05	407,363,634	236,090,880	171,272,754	42.04%	$ 1,079,090,486	$ 631,918,013	$ 447,172,473	41.44%
	$ 1,079,090,486	$ 631,918,013	$ 447,172,473					

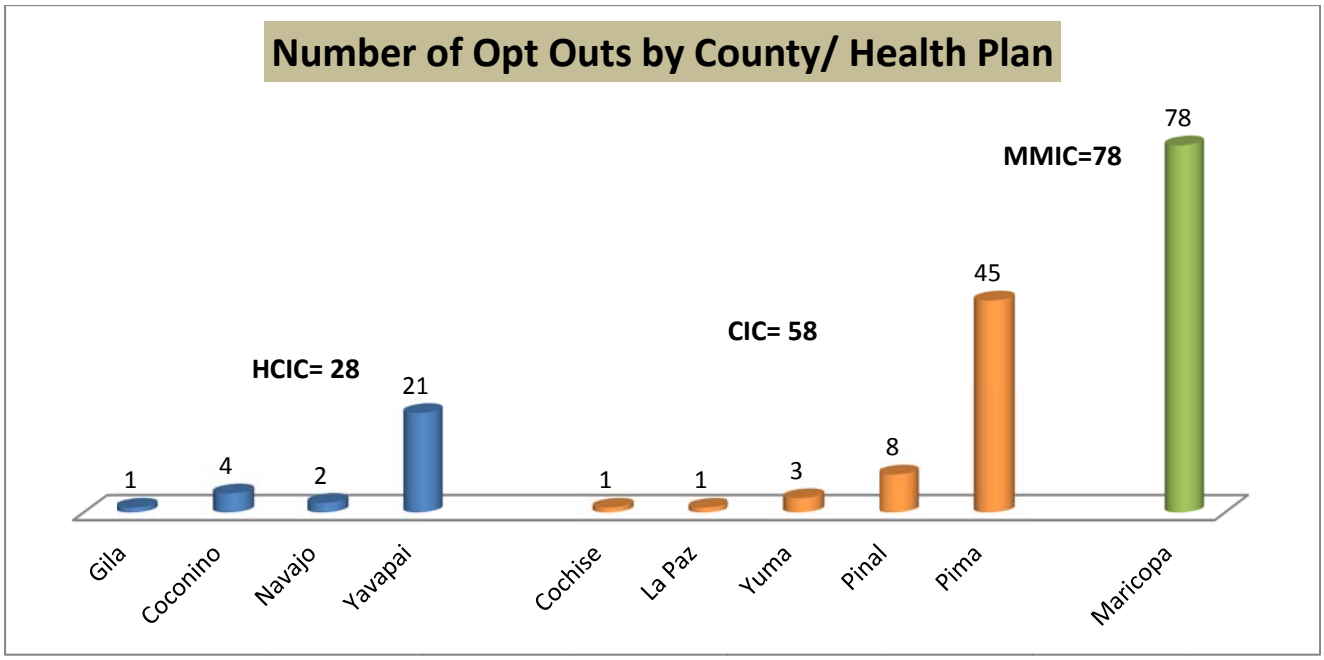
Based on CMS-64 certification date of 3/31/2016

OPT-OUT FOR CAUSE

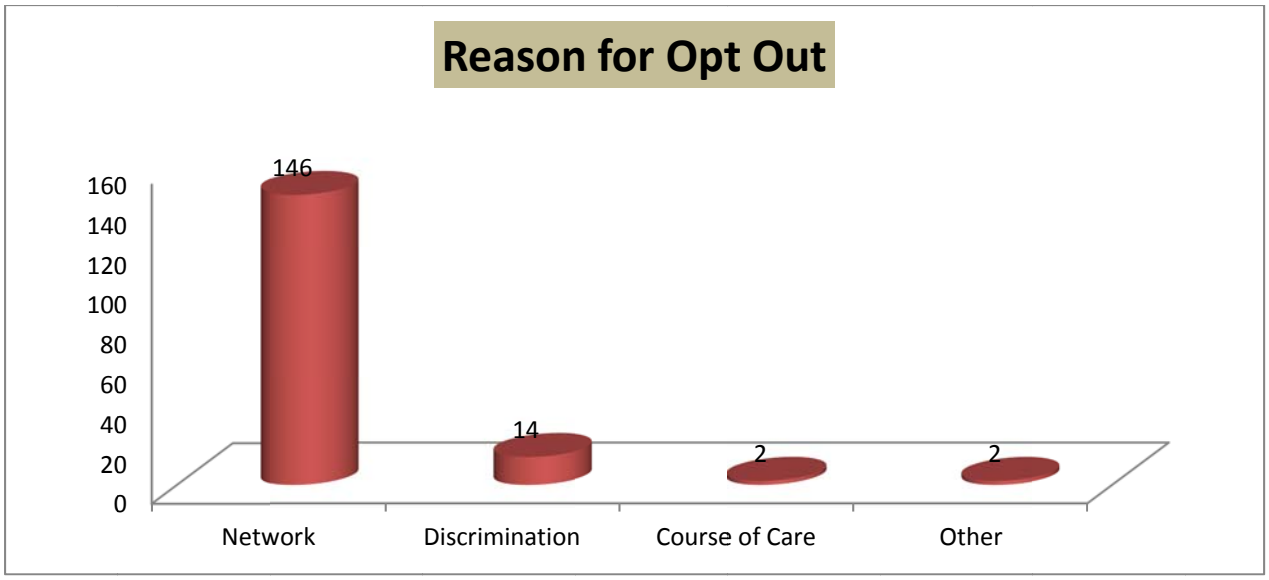
OPT Out Requests:



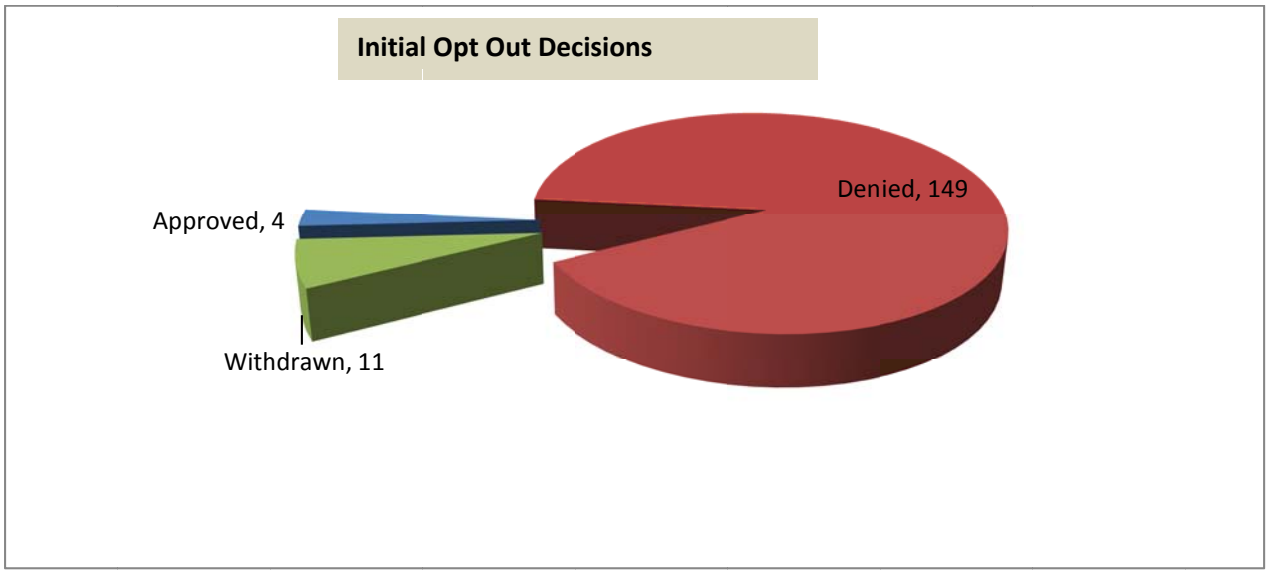
Oct 2015 - March 2016 Opt Out Request						
October	**November**	**December**	**January**	**February**	**March**	**Total**
70	29	20	18	13	14	**164**



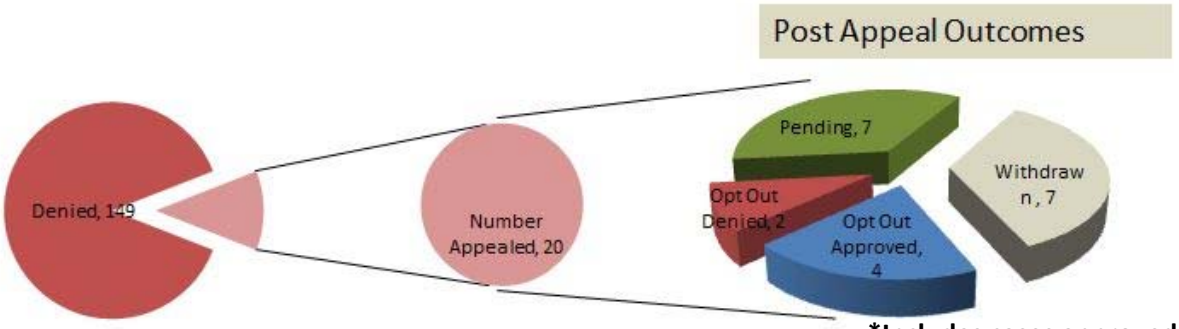
Oct 2015 -March 2016 Opt Out Request			
Counties	**Health Choice Integrated Care (HCIC)**	**Cenpatico Integrated Care (CIC)**	**Mercy Maricopa Integrated Care (MMIC)**
Apache	-		
Coconino	4		
Gila	1		
Mohave	-		
Navajo	2		
Yavapai	21		
Cochise		1	
Graham		-	
Greenlee		-	
La Paz		1	
Pinal		8	
Pima		45	
Yuma		3	
Maricopa			78



Oct 2015 -March 2016 Opt Out Request			
Network	**Discrimination**	**Course of Care**	**Other**
146	**14**	**2**	**2**



Oct 15- March 2016 Opt Out Decisions		
Denied	**Withdraw**	**Approved**
149	11	4



***Includes cases approved by the ADHS following a denial through the fair hearing process**

Oct 15- March 2016 Post Appeal Opt Out Outcomes	
Pending	7
Withdraw	7
Denied	2
Approved	4