

August 31, 2015

Jessica Woodard  
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Dear Ms. Woodard:

In accordance with Special Terms and Conditions paragraph 37, enclosed please find the Quarterly Progress Report for April 1<sup>st</sup>, 2015 through June 30<sup>th</sup>, 2015, 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 Christopher Vinyard at (602) 417- 4034.

Sincerely,



Monica Coury  
Assistant Director  
AHCCCS Office of Intergovernmental Relations

Enclosure

cc: Brian Zolynas  
Hee Young Ansell  
Susan Ruiz

**AHCCCS Quarterly Report**  
**April 1, 2015 through June 30, 2015**

**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: 3rd (April 1, 2015 – June 30, 2015)

**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**

Population Groups	Number Enrollees	Number Voluntarily Disenrolled-Current Qtr	Number Involuntarily Disenrolled-Current Qtr
<b>Acute AFDC/SOBRA</b>	1,236,604	1,551	397,555
<b>Acute SSI</b>	186,707	170	41,253
<b>Prop 204 Restoration</b>	418,701	564	63,293
<b>Adult Expansion</b>	96,165	147	22,809
<b>LTC DD</b>	28,546	30	1,975
<b>LTC EPD</b>	31,425	40	4,143
<b>Non-Waiver</b>	3,177	2	459
<b>Total</b>	2,001,325	2,504	531,487

State Reported Enrollment in the Demonstration (as requested)	Current Enrollees
<b>Title XIX funded State Plan</b> <sup>1</sup>	1,290,537
<b>Title XXI funded State Plan</b> <sup>2</sup>	1,005
<b>Title XIX funded Expansion</b> <sup>3</sup>	65,420
<b>Title XXI funded Expansion</b> <sup>4</sup>	0
<b>DSH Funded Expansion</b>	
<b>Other Expansion</b>	
<b>Pharmacy Only</b>	
<b>Family Planning Only</b> <sup>5</sup>	0
<b>Enrollment Current as of</b>	7/1/15

<sup>1</sup> SSI, 1931 Families and Children, 1931 Related, TMA, SOBRA child and pregnant, ALTCS, FTW, QMB, BCCP, SLMB, QI-1

<sup>2</sup> KidsCare

<sup>3</sup> MI/MN

<sup>4</sup> AHCCCS for Parents

<sup>5</sup> Represents point-in-time enrollment as of 1/1/15

**OPERATIONAL/POLICY DEVELOPMENTS/ISSUES**

Waiver Update

No waiver updates were submitted during the reporting period.

State Plan Update

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

SPA #	Description	Filed	Approved	Eff. Date
<b>Title XIX</b>				
15-004	Ambulance Rates	6/1/15	pending	10/1/15
15-003	Orthotics	4/28/15	5/28/15	8/1/15
15-002	Nursing Facility Assessment	3/19/15	4/21/15	1/1/15
15-001	Supplemental Drug Rebates	2/5/15	5/28/15	1/1/15
14-013-D	Nursing Facility Rates	10/31/14	5/14/15	10/1/14
14-013-C	Other Provider Rates	10/31/14	5/15/15	10/1/14
14-013-B	Outpatient Rates	10/31/14	4/29/15	10/1/14
14-013-A	Freestanding Psychiatric Hospital Rates	10/31/14	4/8/15	10/1/14
<b>Title XXI</b>				
N/A				

Legislative Update

During the 52<sup>nd</sup> Legislature, First Regular Session, SB 1475 (health; budget reconciliation; 2015-2016) was enacted and included a provider rate reduction up to an aggregate of five percent for most healthcare providers between October 1, 2015 through September 30, 2016. The proposed rate reductions excluded developmental disability and home and community based healthcare providers. The Legislature also authorized the agency to account for changes in utilization that were less than the amounts appropriated, as long as the fiscal impact of final decisions on provider rates did not exceed the amount appropriated for capitation rates for fiscal year 2015-2016.

On April 1, the agency opened up a public comment period seeking feedback on the impact a potential 5% rate reduction could have on providers. The agency reviewed comments submitted from 145 different providers and associations representing thousands of providers statewide. Based on the data and information provided through these public comments, along with lower than forecasted utilization and other available funding, AHCCCS has, working with the Governor's Office, determined that no provider rate reductions are required at this time.

SB 1257 (behavioral health; transfer; AHCCCS) makes necessary statutory changes to effectuate the transfer of behavioral health services from ADHS to AHCCCS. The Division of Behavioral Health Services (DBHS) and AHCCCS have been partners in an effort to improve care for Arizonans receiving behavioral health services. As such, AHCCCS continues to make strides in effectuating the changes outlined in 1257. This includes the recent completion of Phase 1:

developing the new organization. AHCCCS is now entering Phase 2 of the process, which includes transitioning over 90% of the 112 staff from BHS over the next six months.

**CONSUMER ISSUES**

In support of the quarterly report to CMS, presented below is a summary of advocacy issues received in the Office of Client Advocacy (OCA) for the quarter April 2015 – June 2015.

Tables summarizing quarter April 2015 - June 2015  
Office of Client Advocacy (OCA) issues and their frequency:

<b>Table 1 Advocacy Issues</b>	<b>October</b>	<b>November</b>	<b>December</b>	<b>Total</b>
<b><u>9+Billing Issues</u></b>	9	10	7	26
<ul style="list-style-type: none"> <li>• Member reimbursements</li> <li>• Unpaid bills</li> </ul>				
<b><u>Cost Sharing</u></b>	2	0	1	3
<ul style="list-style-type: none"> <li>• Co-pays</li> <li>• Share of Cost (ALTCS)</li> <li>• Premiums (Kids Care, Medicare)</li> </ul>				
<b><u>Covered Services</u></b>	10	14	17	41
<b><u>Eligibility Issues by Program</u></b>				
<b>Can't get coverage due to :</b>				
<b>ALTCS</b>				
<ul style="list-style-type: none"> <li>• Resources</li> <li>• Income</li> <li>• Medical</li> </ul>	15	9	3	27
<b>DES</b>				
<ul style="list-style-type: none"> <li>• Income</li> <li>• Incorrect determination</li> <li>• Improper referrals</li> </ul>	145	121	131	397
<b>Kids Care</b>				
<ul style="list-style-type: none"> <li>• Income</li> <li>• Incorrect determination</li> </ul>	1	1	0	2
<b>SSI/Medical Assistance Only</b>				
<ul style="list-style-type: none"> <li>• Income</li> <li>• Not categorically linked</li> </ul>	38	35	26	99
<b><u>Information</u></b>				
<ul style="list-style-type: none"> <li>• Status of application</li> <li>• Eligibility Criteria</li> <li>• Community Resources</li> <li>• Notification (Did not receive or didn't understand)</li> </ul>	37	31	23	91
<b><u>Medicare</u></b>				

<ul style="list-style-type: none"> <li>• Medicare Coverage</li> <li>• Medicare Savings Program</li> <li>• Medicare Part D</li> </ul>	12	9	11	32
<b>Prescriptions</b>				
<ul style="list-style-type: none"> <li>• Prescription coverage</li> <li>• Prescription denial</li> </ul>	11	6	15	32
<b>Issues Referred to other Divisions:</b>				
<b>1.Fraud-Referred to Office of Inspector General (OIG)</b>	0	0	0	0
<b>2.Quality of Care-Referred to Division of Health Care Management (DHCM)</b>	4	4	4	12
<ul style="list-style-type: none"> <li>• Health Plans/Providers (Caregiver issues, Lack of providers)</li> <li>• Services (Equipment, Nursing Homes, Optical and Surgical)</li> </ul>				
<b>Total</b>	<b>284</b>	<b>240</b>	<b>238</b>	<b>762</b>

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

Table 2 Issue Originator	April	May	June	Total
Applicant, Member or Representative	211	179	184	574
CMS	3	2	2	7
Governor's Office	15	8	14	37
Ombudsmen/Advocates/Other Agencies...	49	49	27	125
Senate & House	6	2	11	19
<b>Total</b>	<b>284</b>	<b>240</b>	<b>238</b>	<b>762</b>

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

## COMPLAINTS AND GRIEVANCES

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

Member Grievances and Complaints	Apr-15	May-15	Jun-15	Total
Access to Care	25	29	40	94

<b>Health Plan</b>	45	58	89	192
<b>Provider Satisfaction</b>	114	131	124	369
<b>Total</b>	184	218	253	<b>655</b>

**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, and the Arizona Medicaid Administrative Claiming (MAC) Random Moment Time Study (RMTS) results.

**STATE CONTACT(S)**

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**DATE SUBMITTED TO CMS**

August 31, 2015

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM**

***Attachment II to the  
Section 1115 Quarterly Report***

***Quality Assurance/Monitoring Activity***

**Demonstration/Quarter Reporting Period**

Demonstration Year: 33

Federal Fiscal Quarter 3/2015 (04/2015 – 06/2015)

Prepared by the Division of Health Care Management  
August 2015

## Introduction

This report described the Arizona Health Care Cost Containment System (AHCCCS) quality assurance and monitoring activities that took place during the third quarter of federal fiscal year 2015, 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, including services received from the Arizona Department of health services (ADHS) through benefit carve outs. 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 within the community. During quarter three, AHCCCS continued these ongoing collaborations to improve the delivery of health care and related services to Medicaid recipients and KidsCare members, including those with special health care needs, and to facilitate networking to address common issues and solve problems. Feedback from sister agencies, providers and community organizations are included in the Agency's process for identifying priority areas for quality improvement and the development of new initiatives.

### *Collaborative Stakeholder Involvement Synopses*

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

- *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. The nutrition coordinators present the most up to date information, at the AHCCCS Contractor Quarterly meetings. New WIC foods that became available on April 1, 2015 and formula changes and cash vouchers will become effective on October 1, 2015.
- *Arizona Department of Health Services (ADHS) Immunization 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). ASIIS staff also provides monthly data sharing regarding AHCCCS members receiving immunizations and ongoing collaboration regarding Stage 1 and Stage 2 Meaningful Use (MU) public health requirements. The most recent update from the immunization program is the addition of two new Meningococcal vaccines to the VFC program as well as the addition of HPV-9 vaccine.
- *Arizona Department of Health Services (ADHS) Office of Environmental Health* – 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 the ADHS. 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
- *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 works 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 added language to the contract to enforce that all Contractors must reimburse all AHCCCS AzEIP registered providers whether or not they contracted with the AHCCCS Contractor. Individual Family Service Plan (IFSP) services must be reviewed for medical necessity prior to reimbursement. In addition, the AzEIP program has updated its vendor agreement to require that the provider accept the AHCCCS fee-for-service rate for services rendered to AHCCCS members. It is anticipated that this will increase the utilization of developmental services across the two programs.

- 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. AHCCCS meets with Head Start leadership at least quarterly to discuss enrollment and coordination of care barriers and successes. Arizona Head Start grantees including the City of Phoenix, Maricopa County, Chicanos Por La Causa and Southwest Human Development continue hosting community meetings on a quarterly basis. The meetings are attended by families participating with the Head Start program and the AHCCCS and EPSDT Coordinators from AHCCCS contractors.
- Task Force on Prevention of Prenatal Exposure to alcohol and other Drugs – This 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. 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. During this quarter AHCCCS continued discussions related to increasing use of developmental screening tools, the primary care enhanced payment structure, and care and services delivered to members with a diagnosis of autism.
- The Arizona Partnership for Immunization (TAPI) – During the quarter, CQM staff attended TAPI Steering Committee meetings and 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. In addition to the website, TAPI vaccination handouts have been updated with new color and formats. TAPI has launched a new Teen Vaccination Campaign (Tdap, Meningococcal and HPV vaccines) targeting provider education as well as parent and teen outreach. The parent focused campaign is *Protect Me with 3* – reminding parents that their kids still need them to protect them and help with healthy decisions. The Teen campaign is *Take Control* and addresses the vaccines that teens need to have to keep healthy as they begin to take control of their lives such as – off to college, driving and even health decisions. Posters, flyers and reminder recall postcards are available on their Free Materials page.

- *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. The current areas of focus for APT include elective C-Sections and inductions prior to 30 weeks gestation, infant and parental immunizations (pertussis), and promoting coordination of care with Medicaid Contractors. 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. Currently, per the group leader, the Coalition meetings have been suspended until further notice
- *South Phoenix Healthy Start Community Consortium* – The South Phoenix Healthy Start Consortium aims to connect organizations and to educate members on current programs and initiatives occurring the community. Additionally, it provides networking opportunities to allow for better collaborative efforts between agencies. AHCCCS continues to attend these meetings and supports the Consortium.
- *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.

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 the next six to twelve months.

- *Strong Families* – The Strong Families Workgroup is responsible for developing and implementing a statewide plan for home visiting programs in Arizona. AHCCCS members benefit from home visiting programs when identification and referrals are made by AHCCCS Contractors. AHCCCS continues to be a strong referral source to the home visiting programs with the anticipated results of improved birth outcomes for mothers and babies.
- *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 of 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 Medical Association, Maternal and Child Health Subcommittee (ArMA MCHC)* – The ArMA Maternal and Child Health Care (MCHC) Committee meets three times annually at ArMA Headquarters. Comprised of physicians and health care professionals, this committee discusses medical issues related to women and children’s health in our state. The committee is intended to be the arena in which ArMA’s maternal and child health professionals have the opportunity to champion issues that need attention and evoke positive changes for physicians and their patients. Additionally, the Committee serves as a forum and meeting point for state entities such as AHCCCS, ASIIS, and various offices at ADHS. The AHCCCS Quality Administrator is a member of the Committee and brings information and program updates to the Committee for discussion.
- *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.
- *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. AHCCCS attends these meetings monthly and also shares home visiting updates with AHCCCS Contractors.

## 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 waiver. This amendment allowed for the integration of physical and behavioral health services for individuals living with Serious Mental Illness (SM)I 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 RBHA on April 1, 2014. AHCCCS receives quarterly reports specific to the SMI Integration from DBHS. This report provides additional insight as to the progress and status of services and outreach provided to the population since implementation in April 2014. It also includes self-reported rates by DBHS, on select performance measures, which includes an analysis and narrative of the data and efforts to improve their performance.

#### *Children's Rehabilitative Services (CRS) Integration*

AHCCCS sought and received, from CMS, approval to amend the state's current 1115 waiver. This amendment allows for the state to create one single, 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.

#### *Targeted Lead Screening Policy*

The Arizona Department of Health Services (ADHS) has developed a Targeted Screening Policy focused on geographic testing for children who are at higher risk of lead poisoning. 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. While ADHS has implemented targeted screening since 2003, the policy included universal screening for all children covered by AHCCCS in accordance with the CMS requirements. This policy has recently been revised through a collaborative effort between ADHS and AHCCCS to reflect the support of CMS as issued in an Information Bulletin (released March 30, 2012) recommending a targeted screening approach for children eligible for and enrolled in Medicaid Early Periodic Screening, Diagnostic and Treatment (EPSDT) services for States where less than 12 percent of children have lead poisoning and where 27 percent or fewer of houses were built before 1950. Arizona meets the requirements to pursue a targeted screening approach. While ADHS remains committed to preventing new cases of childhood lead poisoning from occurring, a combined effort with AHCCCS mandating member outreach and education related to the risks and prevention of lead poisoning in children support the new efforts currently under way. During the quarter, AHCCCS obtained approval from the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) to implement a targeted approach for blood lead testing of EPSDT aged members.

#### *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. During the quarter, AzAHP and AHCCCS reached an agreement for more efficient medical records reviews (MRRs). The new process is being implemented and both parties are looking forward to seeing the results of the streamlined efforts.

### Developing/Assessing the Quality and Relevance of Care/Services for Members

#### *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 quarter three, one initiative continued for specific Contractor involvement and improvement, increasing oral health participation 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.

- CMS Oral Health Initiative – Based on the CMS directives of improving preventative oral health care by 10 percent and increasing dental sealants on permanent molars of 6-9 year olds by 10 percent, AHCCCS formed a collaborative workgroup to drive these improvements across the state. All AHCCCS Contractors have agreed to share data and implement interventions relevant to this initiative; all Contractors have joined the workgroup that is driving the intensive planning efforts related to these directives. During quarter three AHCCCS and the Contractors collaboratively developed objectives for reaching State Goal two in order to submit to the Centers for Health Care Strategies (CHCS) as part of the Oral Health Learning Collaborative.

During quarter three, AHCCCS continued efforts to improve postpartum care. Arizona was one of eleven states selected for an initiative focusing on maternal and infant health.

- The Center for Medicaid and CHIP Services (CMCS) Maternal and Infant Health Initiative: Improving Postpartum Care Action Learning Series - The AHCCCS CQM Unit continues to meet regularly to move the efforts of this project forward. AHCCCS is collaborating with the pilot site, which is a provider office, and also obtaining insight from Contractor representatives on how to improve postpartum care and family planning discussions for AHCCCS members. For this quarter, interventions continued to be implemented at the pilot site. Additionally, we were able to collect our final results to see the impact of our efforts as well as discuss the challenges/barriers encountered with this rapid cycle project. The results will be shared with CMS in early July.

#### *Requesting Grant Funding Opportunities*

The demonstration grant for Testing Experience and Functional Assessment Tools in Community-Based Long-Term Services and Supports, known as TEFT, is designed to test quality measurement tools and demonstrate e-health in Medicaid long term care services and supports. The TEFT grant funding was awarded on April 1, 2014 and will conclude on March 31, 2018, with year one designated to plan and complete work plans outlining all components, which will map the implementation phase for Years two through four. AHCCCS was initially awarded \$343,000 for the first year and will be eligible to receive a non-competitive grant award up to a total of \$3.5 million for years two through four.

The purpose of the TEFT grant is to support States in furthering adult quality measurement activities under section 2701 of the Patient Protection and Affordable Care Act. The TEFT grant advances the development of two national, rigorously tested tools that can be used across all beneficiaries using Community-Based Long Term Services and Supports (CB-LTSS), an area in need of national measures. Additionally, the grant offers funding and technical support to demonstrate the use of a Personal Health Record (PHR) and test new electronic standards for interoperability among long term services and supports data.

During this quarter CMS awarded AHCCCS \$427,000 in TEFT grant funding for the second year. AHCCCS submitted an additional request for carryover funding for all unused Year One funds in the amount of \$215,112.

AHCCCS has continued to gather information by participating in weekly teleconferences with the Office of the National Coordinator for the Electronic Long Term Services and Supports (e-LTSS) Initiative and plans to participate in Truven's Community of Practice teleconferences for state grantees to discuss the Experience of Care Survey and Health Information Technology components of the grant. Lewin, the CMS contracted grant evaluator, released the final site visit report which AHCCCS reviewed and recommended changes to content as well as the data integration score. THE AHCCCS TEFT team attended the Long Term Post Acute Care Health Information Technology Summit in Baltimore, MD in June. They were able to touch base with grant leadership and fellow grantees as well as attend an array of educational sessions focusing on health care innovations and the use of technology in the long term care setting.

In the next quarter, AHCCCS plans to continue working on the Electronic Long Term Services and Supports (e-LTSS) Plan piloting requirements and guides with the Office of the National Coordinator. They will also begin finalizing the Functional Assessment Standardized Items (FASI) Tool, formally known as the CARE Tool and assist Truven with Round One piloting requirements.

### *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, 2014 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 next 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.

### Identifying, Collecting and Assessing Relevant Data

#### *Data Exchange*

AHCCCS continues a quarterly data-sharing process with Contractors that began in Quality Improvement (QI) in 2014, this process facilitates the sharing of claim and encounter data with all AHCCCS Contractors regarding the members that were assigned to their care. The purpose of this process is to eliminate any "blind spots" for services provided to members shared by multiple programs. Contractors are required to use this information to develop short and long term strategies to improve care coordination for their members. The most recent quarter of data was provided to all Contractors in April 2015.

#### *Performance Measures*

AHCCCS has implemented several efforts over the past two 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 for the CYE 13 and CYE 14 measurement periods. 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.

**Acute-Care Performance Measures  
Measurement Period 10/01/12-09/30/13**

<b>Measures</b>	<b>CYE 13 Performance (10/01/12-09/30/13)</b>	<b>CYE 12 Performance (10/01/11-09/30/12)</b>	<b>Relative Percent Change From Previous Year</b>	<b>Statistical Significance</b>
Access to PCPs:				
12-24 months	97.4%	97.0%	0.4%	0.001
25 mo. - 6 years	89.2%	87.7%	1.7%	<0.001
7-11 years	91.4%	89.9%	1.7%	<0.001
12-19 years	89.4%	87.7%	2.0%	<0.001
Well Child Visits, 6+ by 15 mo.	68.4%	67.8%	0.8%	0.042
Well Child Visits, 3-6 years	65.5%	66.8%	-1.9%	<0.001
Adolescent Well Visits	39.7%	38.0%	4.3%	<0.001
Dental Visits (Ages 2 to 21)	59.9	61.8%	-3.0%	<0.001
EPSDT Participation	62.3	65.7%	-5.3%	<0.001

In order to address the issue stated above as well as meet the technological demands of transitioning to a new performance measure set, AHCCCS made the decision to identify and contract with a vendor that is capable and interested in partnering to develop and implement measures from the CMS Core and other measures sets in addition to maintaining the traditional HEDIS measures. Although there are several vendors qualified to develop the required measures, AHCCCS sought a vendor that was interested in partnering to develop, maintain and continue to these activities with national decisions on measure sets for Medicaid. AHCCCS has signed a contract with Optum/Lewin Group as the program's vendor for maintaining and calculating the AHCCCS Performance Measure results. During this quarter AHCCCS continued running and validating preliminary data for measures within contract.

### 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. For ALTCS EPD a minimum of five percent of the value of total payments under all contracts executed with health care providers must be governed by shared-savings arrangements with the following limitations.

At least five percent of total Acute Care service payments under all contracts executed for such services must be governed by shared-savings arrangements for the measurement year. At least five percent of total Long Term Care (LTC) service payments under all contracts executed for such services must be governed by shared-savings arrangements for the measurement year.

### *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 was collected, validated and released to Contractors during this quarter.

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*) 2015.
- 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*) 2015.

### *Sharing Best Practices*

AHCCCS makes a point to acknowledge best practices (and worst practices) and share those practices with other Contractors when appropriate. In addition, AHCCCS regularly reviews national projects and interventions that could potentially be replicated in Arizona in order to drive quality improvement. AHCCCS also participates in many learning collaboratives with

other states, national agencies and CMS, which allows for gathering and sharing of best practices. Examples of these collaborations include:

- Regional, All-State, and Community of Practice calls and webinars related to implementation and oversight of Meaningful Use
- OTAG calls with CMS
- QTAG calls with CMS
- CMS Oral Health Technical Assistance Calls
- CHCS Oral Health Learning Collaborative

### 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 DBHS (with regards to the SMI integration) 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. DBHS is also required to submit a quarterly report for general mental health. 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. CQM staff responded to Contractors with requests for clarification or additional information.

- 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. AHCCCS is preparing a series of PIP “kick-off” meetings to discuss potential upcoming PIPs. These meetings will focus on areas, services or populations in need of 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.

As mentioned previously, AHCCCS has selected a vendor that can accommodate both national measures such as HEDIS and Core Measure sets as well as “home-grown” measures that AHCCCS determined to be beneficial to the populations served. AHCCCS has continues testing and validating 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

In preparation for the forthcoming 1115 Waiver Evaluation Process, detailed tracking forms were developed to outline all needed data, responsible parties, and timelines. These activities are being overseen by the Clinical Quality Management (CQM) Unit at AHCCCS. Planning meetings were held with everyone responsible for data collection to ensure that there were no gaps in the evaluation process.

Planning regarding the many different independent evaluation components was addressed during the quarter. It has been determined that HSAG (AHCCCS’ EQRO) will take the lead on many of the independent evaluations. The scope of work and other details related to these processes will be outlined by the end of March. CQM will be the point of contact for AHCCCS as HSAG begins the evaluation process.

During Q3, internal monitoring meetings were held to ensure that all baseline data is collected, that independent evaluation components are moving as they should, and that the detailed evaluation plan was scoped and put out as a Task Order in order to procure a vendor to complete

the actual independent evaluation work. CQM will be the primary point of contact for these efforts; however, representatives from the Director's Office, Intergovernmental Relations, Office of Business Intelligence, Administrative Legal Services, and many units within DHCM will be involved also.

Arizona Health Care Cost Containment System (AHCCCS)  
Quarterly Random Moment Time Study Report  
April 2015 – June 2015

The April through June 2015 quarter for the Medicaid School Based Claiming (MSBC) program Random Moment Time Study (RMTS) was completed successfully with the administrative, direct service, and personal care time study cost pools.

***Active Participants***

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

Staff Pool	April – June 2015
Administrative	3,386
Direct Service	3,176
Personal Care	4,536

The table below demonstrates the administrative, direct service, and personal care time study achieved the 85% return rate in the April to June 2015 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	3,106	97.06%
Direct Service	3,400	3,290	96.76%
Personal Care	3,500	3,163	90.37%

**Arizona Health Care Cost Containment System  
Medicaid Section 1115 Demonstration Number 11-W00275/9  
Budget Neutrality Tracking Report  
For the Period Ended June 30, 2015**

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				Total	Federal Share Budget Neutrality Limit
						QE 12/11	QE 3/12	QE 6/12	QE 9/12		
AFDC/SOBRA	556.34	1.052	585.28	69.84%	408.77	2,932,703	2,920,419	2,914,306	2,939,080	11,706,508	\$ 4,785,225,430
SSI	835.29	1.06	885.41	69.10%	611.78	487,377	488,773	488,763	491,356	1,956,269	1,196,799,660
AC <sup>1</sup>			562.52	69.73%	392.27	527,244	430,723	365,132	310,396	1,633,495	640,771,586
ALTCS-DD	4643.75	1.06	4922.38	67.38%	3316.47	72,536	73,173	73,983	74,838	294,530	976,799,587
ALTCS-EPD	4503.21	1.052	4737.37	67.50%	3197.93	85,445	85,491	85,715	86,498	343,149	1,097,366,716
Family Plan Ext <sup>1</sup>		1.058	17.04	90.00%	15.33	12,471	12,424	12,440	12,689	50,024	767,009
											\$ 8,697,729,988
											103,890,985
											\$ 8,801,620,973
											MAP Subtotal
											Add DSH Allotment
											Total BN Limit

	DY 02 PM/PM					Member Months				Total	
						QE 12/12	QE 3/13	QE 6/13	QE 9/13		
AFDC/SOBRA	615.71	68.82%	423.73	2,911,765	2,891,602	2,903,567	2,919,601	11,626,535	\$ 4,926,514,524		
SSI	938.53	67.85%	636.76	494,368	496,608	499,016	502,336	1,992,328	1,268,635,478		
AC <sup>1</sup>	603.99	68.72%	415.05	274,990	248,817	228,204	217,114	969,125	402,235,449		
ALTCS-DD	5217.72	65.83%	3434.60	75,657	76,486	77,302	78,056	307,501	1,056,143,038		
ALTCS-EPD	4983.71	66.02%	3290.10	86,817	86,061	86,288	87,118	346,284	1,139,307,817		
Family Plan Ext <sup>1</sup>	18.42	90.00%	16.58	13,104	13,824	14,187	14,856	55,971	927,972		
									\$ 8,793,764,277		
									106,384,369		
									\$ 8,900,148,646		
									MAP Subtotal		
									Add DSH Allotment		
									Total BN Limit		

	DY 03 PM/PM					Member Months				Total	
						QE 12/13	QE 3/14	QE 6/14	QE 9/14		
AFDC/SOBRA	647.73	70.54%	456.89	2,892,486	2,840,141	2,956,650	3,114,999	11,804,276	\$ 5,393,284,777		
SSI	994.84	69.27%	689.14	505,493	512,262	520,335	525,663	2,063,753	1,422,224,566		
AC <sup>1</sup>	556.27	70.07%	389.77	206,419	87	2	-	206,508	80,491,111		
ALTCS-DD	5530.78	67.35%	3724.86	78,866	79,704	80,693	81,782	321,045	1,195,846,334		
ALTCS-EPD	5242.86	67.52%	3540.18	87,656	87,875	88,716	89,338	353,585	1,251,755,824		
Family Plan Ext <sup>1</sup>	13.39	90.00%	12.05	14,885	-	-	-	14,885	179,426.00		
Expansion State Adults <sup>1</sup>	641.49	85.30%	547.19	-	444,900	626,034	758,233	1,829,167	1,000,908,920		
									\$ 10,344,690,957		
									107,980,135		
									\$ 10,452,671,092		
									MAP Subtotal		
									Add DSH Allotment		
									Total BN Limit		

	DY 04 PM/PM					Member Months				Total	
						QE 12/14	QE 3/15	QE 6/15	QE 9/15		
AFDC/SOBRA	681.41	71.12%	484.59	3,147,835	3,089,093	3,126,401	-	9,363,329	\$ 4,537,405,004		
SSI	1054.53	70.09%	739.07	531,886	536,626	534,372	-	1,602,884	1,184,648,046		
AC	0.00	70.12%	0.00	-	-	-	-	-	-		
ALTCS-DD	5862.63	68.54%	4018.11	82,746	83,800	84,464	-	251,010	1,008,586,055		
ALTCS-EPD	5515.49	68.63%	3785.40	89,948	89,637	88,178	-	267,763	1,013,588,963		
Family Plan Ext	0.00	90.00%	0.00	-	-	-	-	-	-		
Expansion State Adults	557.50	87.29%	486.62	820,255	838,551	847,346.00	-	2,506,152	1,219,532,073		
									\$ 8,963,760,141		
									109,707,817		
									\$ 9,073,467,958		
									MAP Subtotal		
									Add DSH Allotment		
									Total BN Limit		

	DY 05 PM/PM					Member Months				Total	
						QE 12/15	QE 3/16	QE 6/16	QE 9/16		
AFDC/SOBRA	716.85									\$ -	
SSI	1117.81									-	
AC	0.00									-	
ALTCS-DD	6214.39									-	
ALTCS-EPD	5802.30									-	
Family Plan Ext	0.00									-	
Expansion State Adults	0.00									-	
										\$ -	
										-	
										\$ -	
										MAP Subtotal	
										Add DSH Allotment	
										Total BN Limit	

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

Based on CMS-64 certification date of 6/30/2015

**Arizona Health Care Cost Containment System  
 Medicaid Section 1115 Demonstration Number 11-W00275/9  
 Budget Neutrality Tracking Report  
 For the Period Ended June 30, 2015**

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	\$ 2,217,779,838	\$ 103,890,985	\$ 2,321,670,823	\$ 502,890,921	\$ 191,249,757	\$ 175,610,617	\$ 151,638,753	\$ 164,685,415	\$ 167,197	\$ -	\$ -	\$ -	\$ 458,635	\$ -	\$ 1,186,701,295	\$ 1,134,969,528
QE 3/12	2,178,009,246	-	2,178,009,246	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	883,236,658
QE 6/12	2,153,177,860	-	2,153,177,860	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	717,906,060
QE 9/12	2,148,763,043	-	2,148,763,043	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	808,109,456
QE 12/12	2,208,436,605	106,384,369	2,314,820,974	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	876,531,591
QE 3/13	2,190,828,076	-	2,190,828,076	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	846,472,820
QE 6/13	2,192,431,403	-	2,192,431,403	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	777,122,858
QE 9/13	2,202,068,193	-	2,202,068,193	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	681,765,148
QE 12/13	2,354,631,576	107,980,135	2,462,611,711	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	956,988,020
QE 3/14	2,502,121,693	-	2,502,121,693	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	1,017,470,318
QE 6/14	2,666,660,699	-	2,666,660,699	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	1,058,635,624
QE 9/14	2,821,276,989	-	2,821,276,989	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	956,702,960
QE 12/14	2,990,641,845	-	2,990,641,845	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	964,290,045
QE 3/15	2,977,640,025	-	2,977,640,025	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	1,224,060,744
QE 6/15	2,995,478,271	109,707,817	3,105,186,088	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	1,194,143,842
QE 9/15	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
QE 12/15	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
QE 3/16	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
QE 6/16	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
QE 9/16	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
<b>\$36,799,945,364</b>	<b>\$427,963,306</b>	<b>\$37,227,908,670</b>	<b>\$9,181,739,791</b>	<b>\$3,797,587,560</b>	<b>\$1,122,691,565</b>	<b>\$2,539,712,871</b>	<b>\$2,884,344,319</b>	<b>\$1,873,195</b>	<b>\$398,146,043</b>	<b>\$800,650,796</b>	<b>\$184,095,733</b>	<b>\$453,960</b>	<b>\$2,218,207,163</b>	<b>\$23,129,502,996</b>	<b>\$14,098,405,674</b>	

Last Updated: 8/17/2015

**Arizona Health Care Cost Containment System  
Medicaid Section 1115 Demonstration Number 11-W00275/9  
Budget Neutrality Tracking Report  
For the Period Ended June 30, 2015**

III. SUMMARY BY DEMONSTRATION YEAR

	<u>Federal Share of Budget Neutrality Limit</u>	<u>Federal Share of Waiver Costs on CMS-64</u>	<u>Annual Variance</u>	<u>As % of Annual Budget Neutrality Limit</u>	<u>Cumulative Federal Share of Budget Neutrality Limit</u>	<u>Cumulative Federal Share of Waiver Costs on CMS-64</u>	<u>Cumulative Federal Share Variance</u>	<u>As % of Cumulative Budget Neutrality Limit</u>
WAIVER PERIOD OCTOBER 1, 2011 THROUGH SEPTEMBER 30, 2016								
DY 01	\$ 8,801,620,973	\$ 5,640,374,200	\$ 3,161,246,773	35.92%				
DY 02	8,900,148,646	5,870,222,293	3,029,926,353	34.04%				
DY 03	10,452,671,092	6,424,757,966	4,027,913,126	38.53%				
DY 04	9,073,467,958	5,194,148,537	3,879,319,421	42.75%	\$ 37,227,908,670	\$ 23,129,502,996	\$ 14,098,405,674	37.87%
DY 05			-					
	<u>\$ 37,227,908,670</u>	<u>\$ 23,129,502,996</u>	<u>\$ 14,098,405,674</u>					

**Arizona Health Care Cost Containment System  
 Medicaid Section 1115 Demonstration Number 11-W00275/9  
 Budget Neutrality Tracking Report  
 For the Period Ended June 30, 2015**

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

**Schedule C Waiver 11-W00275/9**

Waiver Name	<u>Total Computable</u>					Total
	01	02	03	04	05	
AC	918,559,186	585,129,194	114,785,660	(567,771)		1,617,906,269
AFDC/SOBRA	3,419,536,085	3,597,470,247	3,499,008,816	2,600,553,534		13,116,568,682
ALTCS-EPD	1,062,341,665	1,161,666,528	1,184,748,363	874,710,100		4,283,466,656
ALTCS-DD	939,104,875	1,005,623,212	1,067,219,508	767,869,711		3,779,817,306
DSH/CAHP	155,762,657	163,516,194	128,980,184	144,912,300		593,171,335
Expansion State Adults	-	-	1,173,175,998	1,394,138,174		2,567,314,172
Family Planning Extension	830,631	1,008,149	195,976	(1,337)		2,033,419
MED	673,818	-	-	-		673,818
SNCP/DSHP	296,636,120	587,330,859	240,250,917	78,491,216		1,202,709,112
SSI	1,350,523,194	1,433,118,983	1,522,578,907	1,194,743,784		5,500,964,868
<u>Uncomp Care IHS/638</u>	<u>22,866,717</u>	<u>97,192,513</u>	<u>53,595,408</u>	<u>10,650,714</u>		<u>184,305,352</u>
Subtotal	8,166,834,948	8,632,055,879	8,984,539,737	7,065,500,425	-	32,848,930,989
New Adult Group	-	-	107,318,854	190,559,996		297,878,850
Total	8,166,834,948	8,632,055,879	9,091,858,591	7,256,060,421	-	33,146,809,839

Waiver Name	<u>Federal Share</u>					Total
	01	02	03	04	05	
AC	640,560,552	402,097,025	80,432,120	(398,132)		1,122,691,565
AFDC/SOBRA	2,388,270,259	2,475,788,219	2,468,140,458	1,849,540,855		9,181,739,791
ALTCS-EPD	717,127,270	766,897,575	799,987,871	600,331,603		2,884,344,319
ALTCS-DD	632,725,487	661,958,763	718,748,240	526,280,381		2,539,712,871
DSH/CAHP	104,828,269	107,397,436	86,713,378	99,206,960		398,146,043
Expansion State Adults	-	-	1,000,758,837	1,217,448,326		2,218,207,163
Family Planning Extension	767,009	927,972	179,426	(1,212)		1,873,195
MED	453,960	-	-	-		453,960
SNCP/DSHP	199,636,108	385,758,909	161,520,692	53,735,087		800,650,796
SSI	933,157,251	972,328,715	1,054,723,788	837,377,806		3,797,587,560
<u>Uncomp Care IHS/638</u>	<u>22,848,035</u>	<u>97,067,679</u>	<u>53,553,156</u>	<u>10,626,863</u>		<u>184,095,733</u>
Subtotal	5,640,374,200	5,870,222,293	6,424,757,966	5,194,148,537	-	23,129,502,996
New Adult Group	-	-	107,318,854	190,559,996		297,878,850
Total	5,640,374,200	5,870,222,293	6,532,076,820	5,384,708,533	-	23,427,381,846

**Adjustments to Schedule C Waiver 11-W00275/9**

Waiver Name	<u>Total Computable</u>					Total
	01	02	03	04	05	
AC	313,572	210,756	87,745	(7)	-	612,066
AFDC/SOBRA	1,014,881	1,090,143	990,293	5,056,392	-	8,151,709
SSI	365,158	399,101	398,723	2,391,771	-	3,554,753
Expansion State Adults	-	-	223,239	3,043,744	-	3,266,983
ALTCS-DD (Cost Sharing) <sup>1</sup>	-	-	-	-	-	-
CAHP <sup>2</sup>	(1,693,611)	(1,700,000)	(1,700,000)	(10,491,900)	-	(15,585,511)
Total	-	-	-	-	-	-

Waiver Name	<u>Federal Share</u>					Total
	01	02	03	04	05	
AC	211,034	138,424	58,991	(5)	-	408,444
AFDC/SOBRA	683,014	716,006	665,774	3,461,607	-	5,526,401
SSI	245,752	262,130	268,062	1,637,406	-	2,413,350
Expansion State Adults	-	-	150,083	2,083,747	-	2,233,830
ALTCS-DD (Cost Sharing) <sup>1</sup>	-	-	-	-	-	-
CAHP <sup>2</sup>	(1,139,800)	(1,116,560)	(1,142,910)	(7,182,755)	-	(10,582,025)
Total	-	-	-	-	-	-

<sup>1</sup> The CMS 1115 Waiver, Special Term and Condition 42.d requires that premiums collected by the State shall be reported on Form CMS-64

<sup>2</sup> 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  
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IV. Schedule C as Adjusted for Manual Entries and Waiver PMPM Groupings

**Revised Schedule C Waiver 11-W00275/9**

Waiver Name	<u>Total Computable</u>					Total
	01	02	03	04	05	
AC	918,872,758	585,339,950	114,873,405	(567,778)	-	1,618,518,335
AFDC/SOBRA	3,420,550,966	3,598,560,390	3,499,999,109	2,605,609,926	-	13,124,720,391
ALTCS-EPD	1,062,341,665	1,161,666,528	1,184,748,363	874,710,100	-	4,283,466,656
ALTCS-DD	939,104,875	1,005,623,212	1,067,219,508	767,869,711	-	3,779,817,306
DSH/CAHP	154,069,046	161,816,194	127,280,184	134,420,400	-	577,585,824
Expansion State Adults	-	-	1,173,399,237	1,397,181,918	-	2,570,581,155
Family Planning Extension	830,631	1,008,149	195,976	(1,337)	-	2,033,419
MED	673,818	-	-	-	-	673,818
SNCP/DSHP	296,636,120	587,330,859	240,250,917	78,491,216	-	1,202,709,112
SSI	1,350,888,352	1,433,518,084	1,522,977,630	1,197,135,555	-	5,504,519,621
Uncomp Care IHS/638	22,866,717	97,192,513	53,595,408	10,650,714	-	184,305,352
Subtotal	8,166,834,948	8,632,055,879	8,984,539,737	7,065,500,425	-	32,848,930,989
New Adult Group	-	-	107,318,854	190,559,996	-	297,878,850
Total	8,166,834,948	8,632,055,879	9,091,858,591	7,256,060,421	-	33,146,809,839

**Federal Share**

Waiver Name	<u>Federal Share</u>					Total
	01	02	03	04	05	
AC	640,771,586	402,235,449	80,491,111	(398,137)	-	1,123,100,009
AFDC/SOBRA	2,388,953,273	2,476,504,225	2,468,806,232	1,853,002,462	-	9,187,266,192
ALTCS-EPD	717,127,270	766,897,575	799,987,871	600,331,603	-	2,884,344,319
ALTCS-DD	632,725,487	661,958,763	718,748,240	526,280,381	-	2,539,712,871
DSH/CAHP	103,688,469	106,280,876	85,570,468	92,024,205	-	387,564,018
Expansion State Adults	-	-	1,000,908,920	1,219,532,073	-	2,220,440,993
Family Planning Extension	767,009	927,972	179,426	(1,212)	-	1,873,195
MED	453,960	-	-	-	-	453,960
SNCP/DSHP	199,636,108	385,758,909	161,520,692	53,735,087	-	800,650,796
SSI	933,403,003	972,590,845	1,054,991,850	839,015,212	-	3,800,000,910
Uncomp Care IHS/638	22,848,035	97,067,679	53,553,156	10,626,863	-	184,095,733
Subtotal	5,640,374,200	5,870,222,293	6,424,757,966	5,194,148,537	-	23,129,502,996
New Adult Group	-	-	107,318,854	190,559,996	-	297,878,850
Total	5,640,374,200	5,870,222,293	6,532,076,820	5,384,708,533	-	23,427,381,846

**Calculation of Effective FMAP:**

<b>AFDC/SOBRA</b>						
Federal	2,388,953,273	2,476,504,225	2,468,806,232	1,853,002,462	-	
Total	3,420,550,966	3,598,560,390	3,499,999,109	2,605,609,926	-	
Effective FMAP	0.698411834	0.688193043	0.705373389	0.711158813		
<b>SSI</b>						
Federal	933,403,003	972,590,845	1,054,991,850	839,015,212	-	
Total	1,350,888,352	1,433,518,084	1,522,977,630	1,197,135,555	-	
Effective FMAP	0.690954957	0.678464301	0.692716577	0.700852304		
<b>ALTCS-EPD</b>						
Federal	717,127,270	766,897,575	799,987,871	600,331,603	-	
Total	1,062,341,665	1,161,666,528	1,184,748,363	874,710,100	-	
Effective FMAP	0.675043909	0.660170158	0.675238638	0.686320648		
<b>ALTCS-DD</b>						
Federal	632,725,487	661,958,763	718,748,240	526,280,381	-	
Total	939,104,875	1,005,623,212	1,067,219,508	767,869,711	-	
Effective FMAP	0.673753809	0.658257243	0.673477419	0.685377185		
<b>AC</b>						
Federal	640,771,586	402,235,449	80,491,111	(398,137)	-	
Total	918,872,758	585,339,950	114,873,405	(567,778)	-	
Effective FMAP	0.697345286	0.687182635	0.700694047	0.701219491		
<b>Expansion State Adults</b>						
Federal	-	-	1,000,908,920	1,219,532,073	-	
Total	-	-	1,173,399,237	1,397,181,918	-	
Effective FMAP			0.852999464	0.872851314		
<b>New Adult Group</b>						
Federal	-	-	107,318,854	190,559,996	-	
Total	-	-	107,318,854	190,559,996	-	
Effective FMAP			1	1		

**Arizona Health Care Cost Containment System  
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For the Period Ended June 30, 2015**

V. Budget Neutrality Member Months and Cost Sharing Premium Collections

<b>Budget Neutrality Member Months:</b>	<b>AFDC/SOBRA</b>	<b>SSI</b>	<b>ALTCS-DD</b>	<b>ALTCS-EPD</b>	<b>AC</b>	<b>MED</b>	<b>Family Plan Ext</b>	<b>Expan St Adults</b>	<b>New Adult Group</b>
Quarter Ended December 31, 2011	2,932,703	487,377	72,536	85,445	527,244	467	12,471		
Quarter Ended March 31, 2012	2,920,419	488,773	73,173	85,491	430,723	-	12,424		
Quarter Ended June 30, 2012	2,914,306	488,763	73,983	85,715	365,132	-	12,440		
Quarter Ended September 30, 2012	2,939,080	491,356	74,838	86,498	310,396	-	12,689		
Quarter Ended December 31, 2012	2,911,765	494,368	75,657	86,817	274,990	-	13,104		
Quarter Ended March 31, 2013	2,891,602	496,608	76,486	86,061	248,817	-	13,824		
Quarter Ended June 30, 2013	2,903,567	499,016	77,302	86,288	228,204	-	14,187		
Quarter Ended September 30, 2013	2,919,601	502,336	78,056	87,118	217,114	-	14,856		
Quarter Ended December 31, 2013	2,892,486	505,493	78,866	87,656	206,419	-	14,885		
Quarter Ended March 31, 2014	2,840,141	512,262	79,704	87,875	87	-	-	444,900	38,762
Quarter Ended June 30, 2014	2,956,650	520,335	80,693	88,716	2	-	-	626,034	86,295
Quarter Ended September 30, 2014	3,114,999	525,663	81,782	89,338	-	-	-	758,233	122,669
Quarter Ended December 31, 2014	3,147,835	531,886	82,746	89,948	-	-	-	820,255	149,346
Quarter Ended March 31, 2015	3,089,093	536,626	83,800	89,637	-	-	-	838,551	190,412
Quarter Ended June 30, 2015	3,126,401	534,372	84,464	88,178	-	-	-	847,346	242,323
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									

**ALTCS Developmentally Disabled**

<b>Cost Sharing Premium Collections:</b>	<b>Total Computable</b>	<b>Federal Share</b>
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  
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VI. Allocation of Disproportionate Share Hospital Payments

**Federal Share**

	<u>FFY 2012</u>	<u>FFY 2013</u>	<u>FFY 2014</u>	<u>FFY 2015</u>	<u>FFY 2016</u>	
<b>Total Allotment</b>	<b>103,890,985</b>	<b>106,384,369</b>	<b>107,980,135</b>	<b>109,707,817</b>		<b>427,963,306</b>
Reported in <u>QE</u>						
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						
Dec-15						
Mar-16						
Jun-16						
Sep-16						
<b>Total Reported to Date</b>	<b>103,688,469</b>	<b>106,280,876</b>	<b>85,570,468</b>	<b>92,024,206</b>	<b>-</b>	<b>387,564,019</b>
<b>Unused Allotment</b>	<b>202,516</b>	<b>103,493</b>	<b>22,409,667</b>	<b>17,683,611</b>	<b>-</b>	<b>40,399,287</b>

**Arizona Health Care Cost Containment System  
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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 PMPM	Member Months				Total	Federal Share Budget Neutrality Limit
					QE 12/13	QE 3/14	QE 6/14	QE 9/14		
New Adult Group		578.54	100.00%	578.54	-	38,762	86,295	122,669	247,726	143,319,400

  

	Trend Rate	DY 04 PM/PM	Effective FMAP	Federal Share PMPM	Member Months				Total	Federal Share Budget Neutrality Limit
					QE 12/14	QE 3/15	QE 6/15	QE 9/15		
New Adult Group	1.047	605.73	100.00%	605.73	149,346	190,412.00	242,323.00		582,081	352,584,727

  

	Trend Rate	DY 05 PM/PM	Effective FMAP	Federal Share PMPM	Member Months				Total	Federal Share Budget Neutrality Limit
					QE 12/15	QE 3/16	QE 6/16	QE 9/16		
New Adult Group	1.047	634.20							-	-

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

	Budget Neutrality Limit - Federal Share			Expenditures		VARIANCE
	MAP	DSH	Total	New Adult Grp		
QE 12/13	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
QE 3/14	22,425,367	-	22,425,367	13,870,414		8,554,953
QE 6/14	49,925,109	-	49,925,109	34,313,342		15,611,767
QE 9/14	70,968,923	-	70,968,923	47,984,458		22,984,465
QE 12/14	90,463,559	-	90,463,559	46,004,135		44,459,424
QE 3/15	115,338,524	-	115,338,524	70,387,348		44,951,176
QE 6/15	146,782,645	-	146,782,645	85,319,153		61,463,492
QE 9/15						
QE 12/15						
QE 3/16						
QE 6/16						
QE 9/16						
	<u>\$ 495,904,127</u>	<u>\$ -</u>	<u>\$ 495,904,127</u>	<u>\$ 297,878,850</u>		<u>\$ 198,025,277</u>

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	\$ 143,319,400	\$ 96,168,214	\$ 47,151,186	32.90%				
DY 04	352,584,727	201,710,636	150,874,091	42.79%	\$ 495,904,127	\$ 297,878,850	\$ 198,025,277	39.93%
DY 05								
	<u>\$ 495,904,127</u>	<u>\$ 297,878,850</u>	<u>\$ 198,025,277</u>					

Based on CMS-64 certification date of 6/30/2015