AHCCCS
Arizona Health Care Cost Containment System

***Our first care is your health care***
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

**Janice K. Brewer, Governor**
**Thomas J. Betlach, Director**

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May 30, 2014

Wakina Scott
Project Officer, Division of State Demonstrations, Waivers & Managed Care
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Dear Ms. Scott:

In accordance with Special Terms and Conditions paragraph 36, enclosed please find the Quarterly Progress Report for January 1st, 2014 through March 31st, 2014, 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: Cheryl Young
Hee Young Ansell
Susan Ruiz

# AHCCCS Quarterly Report
# January 1, 2014 through March 31, 2014

## TITLE

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

Section 1115 Quarterly Report
Demonstration Year: 32
Federal Fiscal Quarter: 2nd (January 1, 2014 – March 31, 2014)

## INTRODUCTION

As written in Special Terms and Conditions, paragraph 36, 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 |
|---|---|---|---|
| **Acute AFDC/SOBRA** | 1,126,279 | 1,056 | 433,983 |
| **Acute SSI** | 173,791 | 88 | 20,326 |
| **Acute AC/MED** | 0 | 0 | 0 |
| **Acute Adult** | 210,545 | 169 | 36,036 |
| **Family Planning** | 0 | 0 | 0 |
| **LTC DD** | 26,774 | 32 | 2,370 |
| **LTC EPD** | 30,382 | 43 | 3,858 |
| **Non-Waiver** | 227,485 | 184 | 49,543 |
| **TOTAL** | **1,795,256** | **1,572** | **546,116** |

| State Reported Enrollment in the Demonstration (as requested) | Current Enrollees |
|---|---|
| **Title XIX funded State Plan** [1] | 1,148,260 |
| **Title XXI funded State Plan** [2] | 2,098 |
| **Title XIX funded Expansion** [3] | 14,000 |
| **Title XXI funded Expansion** [4] | 0 |
| **DSH Funded Expansion** | |
| **Other Expansion** | |
| **Pharmacy Only** | |
| **Family Planning Only** [5] | 0 |
| **Enrollment Current as of** | 4/1/14 |

[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
[5] Represents point-in-time enrollment as of 12/31/12

## Outreach/Innovative Activities:

AHCCCS has recently implemented a new outreach initiative, Promising Practices, designed specifically to encourage rural and urban tribal communities, Indian Health Services, tribally owned or operated 638 facilities and others to share programs that have had a positive impact on tribal communities in one of the following four areas: prevention and chronic disease management, elder services and long term care, care coordination and behavioral health.

While heart disease, stroke, cancer, diabetes, and asthma are a few examples of some of the most common chronic diseases, the goal of Prevention is to avoid chronic disease in the first place. Once someone has been diagnosed, Chronic Disease Management aims to lessen the severity and improve the health-related quality and duration of the individual's life.

Since Arizona has been a leader in providing home and community based services to elders and individuals with physical or cognitive disabilities, we are able to keep people out of institutions, which provides for better quality of life for our members. This is achieved through the Arizona Long Term Care System (ALTCS) Tribal Case Management Program which provides acute care, behavioral health, long term care, and case management services. These services are offered to American Indian ALTCS members at risk of institutionalization who reside on a tribal reservation.

Moreover, one of the greatest challenges with health care today is that providers do not talk to one another. A primary care provider, for instance, may have no idea that their patient has gone to the Emergency Department five times in the last few months. This is health care but not a system of care and as such, impacts the quality of care received. Care coordination is about building a team approach to health care by connecting providers to each other, their patients and the community. By providing health care in a coordinated fashion, we can improve outcomes and reduce health related disparities

Lastly, behavioral health services include evaluation and treatment and support services for individuals with mental illness and/or substance abuse.

Additional information on these four specific areas of promising practices can be found at the AHCCCS American Indian Health webpage located at http://www.azahcccs.gov/tribal/.

## Operational/Policy Developments/Issues:

*Waiver Update*

On February 11th, 2014 AHCCCS submitted a Cost Sharing Proposal Draft at the direction of the Arizona State Legislature to impose mandatory cost sharing on the Expansion population (100%-133%). The proposed mandatory cost sharing will include a premium of not more than two percent of the person's household income, a copayment of two hundred dollars for nonemergency use of an emergency room if the person is not admitted to the hospital and a copayment of two hundred dollars for nonemergency use of an emergency room if there is a community health center, rural health center or urgent care center within twenty miles of the hospital. Public comments were accepted through March 14th, 2014.

On February 20th, 2014 AHCCCS proposed to expand integrated health care service delivery by allowing the Greater Arizona RBHAs to provide physical and behavioral health care services to individuals with Serious Mental Illness in order to maximize care coordination statewide. Public comments were accepted through March 24th, 2014.

Lastly, during the quarter AHCCCS has requested authority to support a Medical Home Program for the FFS population receiving services at Indian Health Services and 638 facilities.

*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** | | | | |
| 14-001 | ADHS Licensure Changes | 1/10/14 | Pending | 1/1/14 |
| 14-002 | Coverage for over-the-counter or non-prescription medication | 1/29/14 | 2/24/14 | 1/1/14 |
| 14-003 | Medically Preferred Treatment Options | 1/31/14 | Pending | TBD |
| 14-004 | Therapies | 2/20/14 | Pending | 1/1/14 |
| 14-005 | Medicaid Administration | 3/11/14 | Pending | 1/1/14 |
| 14-006 | Alternative Benefit Plan (ABP) | 3/17/14 | 4/1/14 | 1/1/14 |
| 14-007 | Barbiturates, Benzodiazepines and Tobacco Cessation | 3/17/14 | 4/15/14 | 1/1/14 |
| 14-008 | Presumptive Eligibility | 3/28/14 | Pending | 1/1/14 |
| **Title XXI** | | | | |

There were no Title XXI State Plan Amendments submitted during the quarter

*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 2007, SB 1124 and HB 2367.

HB2007 (developmental disability services; service providers) extends the mandatory monitoring period for day program facilities that serve developmentally disabled members from six months to one year if granted deemed status by the Department of Economic Security. The bill was signed by the Governor on 4/22/14.

SB1124 (controlled substances prescription monitoring program), signed by the Governor on 4/22/14, was updated to allow prescribers to reference the controlled substances database before issuing a new prescription for a controlled substance. The bill also allows a prescriber's "delegate", specifically a licensed healthcare professional who is employed in the office of or in a hospital setting with the prescriber, to reference the database.

Lastly, HB2367 (AHCCCS; annual waiver submittals) sought to require the agency to annually apply for a waiver that, if granted, would implement a work requirement for all able-bodied

adults receiving Medicaid services, restrict benefits for able-bodied adults to a lifetime limit of five years and develop and impose meaningful copayments to deter both nonemergency use of emergency departments and the use of ambulance services for nonemergency transportation or when it is not medically necessary. HB2367 was vetoed by the Governor on 4/22/14.

The Legislature adjourned sine die on 4/24/14.

**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 2014-March 2014.

Tables summarizing quarter January 2014-March 2014
Office of Client Advocacy (OCA) issues and their frequency:

| Table 1 **Advocacy Issues** | **January** | **February** | **March** | **Total** |
|---|---|---|---|---|
| **Billing Issues** | **10** | **21** | **10** | **41** |
| • **Member reimbursements** | | | | |
| • **Unpaid bills** | | | | |
| **Cost Sharing** | **9** | **0** | **9** | **18** |
| • **Co-pays** | | | | |
| • **Share of Cost (ALTCS)** | | | | |
| • **Premiums (Kids Care, Medicare)** | | | | |
| | **9** | **8** | **19** | **36** |
| **Covered Services** | | | | |
| **Eligibility Issues by Program** | | | | |
| **Can't get coverage due to :** | **14** | **10** | **8** | **32** |
| **ALTCS** | | | | |
| • **Resources** | | | | |
| • **Income** | | | | |
| • **Medical** | **137** | **151** | **150** | **438** |
| **DES** | | | | |
| • **Income** | | | | |
| • **Incorrect determination** | | | | |
| • **Improper referrals** | **32** | **9** | **2** | **43** |
| **Kids Care** | | | | |
| • **Income** | | | | |
| • **Incorrect determination** | | | | |
| **SSI/Medical Assistance Only** | **22** | **16** | **27** | **65** |
| • **Income** | | | | |
| • **Not categorically linked** | | | | |
| **Information** | **97** | **85** | **93** | **275** |

| | | | | |
|---|---|---|---|---|
| • **Status of application**<br>• **Eligibility Criteria**<br>• **Community Resources**<br>• **Notification (Did not receive or didn't understand)** | | | | |
| **Medicare** | **3** | **1** | **2** | **6** |
| • **Medicare Coverage**<br>• **Medicare Savings Program**<br>• **Medicare Part D** | | | | |
| **Prescriptions** | **29** | **24** | **28** | **81** |
| • **Prescription coverage**<br>• **Prescription denial** | | | | |
| **Issues Referred to other Divisions:** | **0** | **0** | **0** | **0** |
| **1.Fraud-Referred to Office of Inspector General (OIG)** | | | | |
| | **5** | **1** | **2** | **8** |
| **2.Quality of Care-Referred to Division of Health Care Management (DHCM)**<br>• **Health Plans/Providers *(*Caregiver issues, Lack of providers)**<br>• **Services *(*Equipment, Nursing Homes, Optical and Surgical)** | | | | |
| **Total** | **367** | **326** | **350** | **1043** |

**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** | **230** | **224** | **273** | **727** |
| **CMS** | **46** | **25** | **18** | **89** |
| **Governor's Office** | **46** | **39** | **18** | **103** |
| **Ombudsmen/Advocates/Other Agencies…** | **20** | **24** | **33** | **77** |
| **Senate & House** | **25** | **14** | **8** | **47** |
| **Total** | **367** | **326** | **350** | **1043** |

**Note: This data was compiled from the OCA logs completed by the OCA Client Advocate and 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 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|
| Access to Care | 1 | 1 | 0 |
| Health Plan | 0 | 1 | 4 |
| Provider Satisfaction | 17 | 12 | 6 |

**Note: This table only includes CRS data, as the SMI integration did not become effective until 4/1/14**

**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.

**Innovative Activities:**

*Health-e-Arizona Plus: Plan C*

Arizona made a determination that it could not safely convert all of the data from its legacy systems into the new Health-e-Arizona Plus system before October 1, 2013. Therefore the state implemented its Plan C mitigation strategy. One exception to Plan C is Children's Rehabilitative Services (CRS). Health-e-Arizona Plus was implemented on 9/23/13 for CRS. The CRS implementation did not require a data conversion.

Plan C includes implementation of Health-e-Arizona Plus in three steps.

*Step 1:*

On October 19, 2013, implemented Health-e-Arizona Plus for consumers and consumer assisters. Exercised new policies and processes for MAGI, Medicaid Expansion and Account transfer to the FFM.

*Step 2:*

Converted ACE data into Health-e-Arizona Plus in November 2013. AHCCCS staff began using the Health-e-Arizona Plus system for aged blind disabled programs (ABD), Medicare Savings Programs and CHIP.

*Step 3:*

DES staff began using the Health-e-Arizona Plus system in December 2013. Health-e-Arizona Plus is completely rolled out for Phase I when all DES staff are using the system for Medicaid, SNAP and TANF.

**Enclosures/Attachments:**

Attached you will find the Budget Neutrality Tracking Schedule and the Quality Assurance/Monitoring Activities, including the CRS update for the quarter. Beginning during the October- December, 2010 quarter, AHCCCS will submit quarterly summary reports for the

Arizona Medicaid Administrative Claiming (MAC) Random Moment Time Study (RMTS) results as part of the ongoing quarterly reporting by AHCCCS to CMS.

**State Contact(s):**

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**Date Submitted to CMS:**

May 30, 2014


Arizona Health Care Cost Containment System

# Attachment II to the
# *SECTION 1115 QUARTERLY REPORT*

## *QUALITY ASSURANCE/MONITORING ACTIVITY*

**Demonstration/Quarter Reporting Period**
Demonstration Year: 32
Federal Fiscal Quarter: 2/2014 (01/14-03/14)

Prepared by the Division of Health Care Management
May 2014

## INTRODUCTION

This report describes the Arizona Health Care Cost Containment System (AHCCS) quality assurance/monitoring activities that took place during the quarter, as required in STC 37 of the State's Section 1115 Waiver. This report also includes updates related to AHCCCS's Quality Assessment and Performance Improvement Strategy, in accordance with Balanced Budget Act (BBA) 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 focuses 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 State's progress and activities under each of the components of the 1115 Waiver and AHCCCS Quality Strategy.

### Facilitating Stakeholder Input

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 the quarter, 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 is included in the Agency's process for identifying priority areas for quality improvement and the development of new initiatives.

*Collaborative Stakeholder Involvement Highlights*

During the quarter, AHCCCS participated in several collaborative efforts related to many different quality components. These opportunities are discussed in detail below, along with the benefits of each:

1. *Group:* **Arizona Perinatal Trust**
   *Topic:* Initiative Planning and Collaborative Partnerships
   *Stakeholders*: Representatives from AHCCCS, Arizona Department of Health Services (ADHS), high risk Obstetricians and the Arizona Perinatal Trust
   *Benefits:*

   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, from normal labor and delivery to neonatal intensive care. The current areas of focus for APT include elective C-Sections and inductions prior to 39 weeks gestation, infant and parental immunizations

(pertussis), and promoting coordination of care with the Medicaid Contractors. AHCCCS participated in the 2013 Arizona Perinatal Trust Perinatal Conference, providing an AHCCCS update for attendees related to Maternal and Child Health aspects including; addition of children and adult core measures, lead efforts and policy reviews.

2. *Group:* **South Phoenix Healthy Start**
   *Topic:* Reducing infant mortality
   *Stakeholders*: Representatives from AHCCCS, Arizona Department of Health Services (ADHS), Arizona Department of Public Health, Community Social Service agencies.

   *Benefits:* The South Phoenix Healthy Start Consortium aims to connect organizations and to educate members on current programs and initiatives occurring in the community. Additionally, it provides networking opportunities to allow for better collaborative efforts between agencies.

3. *Group:* **Arizona and Maricopa County Asthma Coalitions**
   *Topic:* Support optimal health outcomes for members with asthma
   *Stakeholders*: Representatives from AHCCCS, Arizona Department of Health Services (ADHS) and Department of Economic Security, Community agencies and organizations and health care groups

   *Benefits:* AHCCCS participates in regular meetings of these coalitions to identify and provide to Contractors quality improvement resources that can be used to support optimal health outcomes among members with asthma and other respiratory diseases.

In addition to the three groups highlighted above, there were many other collaborative stakeholder processes during the quarter. Community and sister agencies that AHCCCS collaborated with during the quarter 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 the "ASHLine" and/or counseling, in addition to seeking assistance from their Primary Care Physician.

- *Arizona Department of Health Services' Bureau of USDA Nutrition Programs* - AHCCCS works with the Arizona Department of Health Services **(**ADHS) Bureau of USDA Nutrition Programs for many initiatives ranging from Contractor education to WIC promotion. During this quarter's presentation AHCCCS Contractors were informed of the following changes: starting April 1, 2014 Similac Advance and Enfamil Prosobee will be the only standard contract formulas offered by WIC; most participants will be transitioned to these formulas. Also, medical documentation continues to be an option for those

children with special needs who do not meet criteria for AHCCCS coverage. All Arizona providers were informed via letter of the formula changes

- *Arizona Department of Health Services Immunization Program* - Ongoing collaboration with the ADHS helps ensure efficient and effective administration and oversight of the federal Vaccines for Children (VFC) Program. VFC Program representatives provide education to Contractors, regular notifications 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 public health requirements.

- *Arizona Department of Health Services Office of Environmental Health (ADHS)* - AHCCCS and several Contractors participate in the Arizona Childhood Lead Poisoning Elimination Coalition to develop strategies to increase testing of children who are enrolled in AHCCCS or who live in areas with the highest risk of lead poisoning due to the prevalence of older housing, industries that use/produce lead, and the use of lead-containing pottery or folk medicines. During this quarter AHCCCS worked with ADHS on updating the state's blood lead testing plan that supports a targeted lead screening and testing program for the Medicaid program. AHCCCS continues worked with ADHS and the Arizona Chapter of the Academy of Pediatrics to submit a proposal to CMS which would allow the Agency to implement a targeted approach to lead screening based on data obtained and analyzed by the ADHS.

- *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 and availability of services to members. During this quarter a well-attended meeting for AHCCCS MCH Coordinators and AzEIP Intervention Providers continued efforts to strengthen the relationships between AzEIP Early Intervention Programs and AHCCCS MCH Coordinators. During the meeting a new referral form was unveiled. Topics covered in the latest AzEIP newsletter include Contract Updates, no shows and cancellations, the AzEIP website, central referral, what to expect when in AzEIP, I-Teams updates, and AzEIP shining stars.

- *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 the 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 AHCCCS EPSDT Coordinators.

- *Fetal Alcohol Spectrum Disorder Task Force* – The Fetal Alcohol Spectrum Disorder 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. This quarter, the focus was on developing objectives and strategies towards the Task Force's Strategic Plan.

- *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 the Electronic Health Record (her) Incentive Program. During this quarter AHCCCS continued discussions on payment reform opportunities, medical home initiatives, fluoride varnish application by primary care providers, dental homes, developmental screening updates, and AHCCCS initiatives related to 39 week gestation.

- *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 Provider Awareness and Adult and Community Awareness committees 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. .

- *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 39 weeks gestation, infant and parental immunizations (pertussis), and promoting coordination of care with the Medicaid Contractors.

- *Arizona Dementia Coalition* - This partnership is specifically related to reducing the use of antipsychotics for dementia patients who receive care in nursing facilities. The group discusses barriers and interventions and to date has approximately 50 nursing facilities across the state signed up to participate in this work. AHCCCS and its Contractors provide aggregate de-identified data related to this initiative and work with stakeholders to develop effective interventions.

- *Healthy Mothers, Healthy Babies - The Healthy Mothers, Healthy 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.

- *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 in the community. Additionally, it provides networking opportunities to allow for better collaborative efforts between agencies.

- *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. During the quarter, AzHeC merged with the Health Information Network of Arizona (HINAz). It was found that stakeholders across the state desired a streamlined approach to all elements of HIT and HIE, so AzHeC now serves as the umbrella agency for these initiatives.

  HINAz 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 20 health systems have signed agreements with HINAz to share health information in the HIE. Partners include one of the state's largest hospital systems – Banner Health, SureScripts, and SonoraQuest Laboratories as well as many other regional providers. Additionally, HINAz is exploring a partnership opportunity with the Behavioral Health Information Network of Arizona (BHINAz) to ensure coordination of care between physical and behavioral health providers.

- *Arizona American Indian Oral Health Coalition* – The Coalition's focus is to promote oral health care and oral health education to American Indians both on and off the reservations. The Coalition held the Statewide Executive Oral Health meeting on Thursday February 13, 2014 at the Arizona Dental Association. This meeting served as the "Kick Off" for the incoming Statewide Executive Committee for the purpose of establishing a foundation of leadership that will take Arizona to the next level while unifying oral health champions in 2014..

- *Strong Families Workgroup* – 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 health 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.

- *ADHS Rule Stakeholder groups* -- The Arizona Department of Health Services (ADHS) Licensing Services recognize the interconnectivity of an individual's physical health and behavioral health and the importance to assist and promote whole body healthcare for all Arizonans." As part of this process the rule packet for all medical licensing and behavioral health facilities were opened for revision about 18 months ago. The rules initially would be open until July, 2013. ADHS received an extension until April, 2014 for Long Term Care and Assisted Living rule packages to incorporate rules related to the integration of physical and behavioral health. The main emphasis of this rule packet was to align physical health and behavioral health services to reflect the current integration of health care in Arizona. AHCCCS has been an active participant in this process attending all the stakeholder group meetings as well as meeting individually with ADHS leadership to convey Medicaid's position on key elements.

- *Injury Prevention Advisory Counsel* - 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 a 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, 2002-2005, 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 Arizona Health Care Cost Containment System (AHCCCS) or the director's designee; and a representative of the hospital or health care industry. The Advisory Committee is currently reviewing adding up to three additional tests to the newborn screening panel including CCHD and SCID.

- *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 of 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. AzAAP's 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 children are immunized against infectious diseases, and guaranteeing that 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.

- *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 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 serves 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 a 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.

- *Strong Families Inter-Agency 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 the Arizona Health Care Cost Containment System (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 which Improve the Health Care Delivery System

*Serious Mentally Illness (SMI) Integration*

AHCCCS sought and received, from CMS, approval to amend the state's current 1115 wavier. This amendment allows for the integration of physical and behavioral health services for a select population by 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 for AHCCCS acute care enrollees with Serious Mental Illness (SMI) in Maricopa County.

This request 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. This changes allows the state to improve care coordination and health outcomes for individuals with SMI in Maricopa County, 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 are moving forward with implementation of the SMI Integrated RBHA with an effective date of April 1, 2014.

*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. In CYE 2014, AHCCCS will prioritize activities to monitor the progress and quality of the initiative in collaboration with the stakeholders and Contractors. These monitoring activities are prioritized to be developed during the third quarter of CYE 2014.

- Develop and implement a case manager refresher training to ensure case managers are able to support members/IRs to make informed choices about electing member-directed options. Additionally, developing tools to educate case managers on how to assess whether or not the member/IR is fulfilling their respective roles and responsibilities and whether or not additional support is required.

- Develop and implement 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.

- Development of performance indicators for Contractors

*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. Conversely, AHCCCS is working 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.

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*Targeted Lead Screening Policy*

The Arizona Department of Health Services (ADHS) has developed a Targeted Screening Policy based on geographic testing for children who are at higher risk of lead poisoning, which 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, will support such efforts currently under way.

*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 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 has asked the Association to further 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. Discussions with the Association are also under way to determine if a similar process could be used for medical record review processes of primary care providers, obstetricians, dental providers and high volume specialists (50 or more Medicaid cases in a year). The Association anticipates conducting a review of the CVO as well as the results of the process after a year of full implementation to determine the accuracy of the process, efficiencies gained and any resulting cost savings.

## Developing and Assessing the Quality and Appropriateness 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 quality improvement, member satisfaction and system efficiencies. Contractor input also is sought in prioritizing areas for improvement.

During the quarter, two initiatives continued for specific Contractor involvement and improvement: increasing oral health participation for the EPSDT population and prenatal care. Both topics are being promoted through AHCCCS/Contractor collaborative workgroups, with external stakeholders also being invited to participate.

- CMS Oral Health Initiative – Based on the CMS directives of improving preventive 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; many Contractors also joined the workgroup that is driving the intensive planning efforts related to these directives. During this quarter the workgroup discussed utilization rates by county and age groups in order to identify priority areas.

- AHCCCS Prenatal Workgroup- This Workgroup's focus is on improving timeliness of prenatal care and encouraging Contractors to look at reducing elective deliveries prior to 39 weeks gestation. All acute-care contractors have representatives participating in this group, which is aimed to increase good birth outcomes and enhance data related to pregnancies and deliveries. Additionally, this group will discuss best practices for driving birth outcomes, reducing early elective C-sections and inductions, and increasing postpartum follow-up care.

  Contractors have also participated in a mini-study to evaluate early, elective deliveries. Contractors have submitted data collection tools and AHCCCS is in the process of reviewing the data. This will help AHCCCS better understand provider practices and delivery trends in Arizona.

*Requested 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. During this quarter AHCCCS was selected to receive the demonstration grant and was awarded $343,000.00 for the first year which begins April 1, 2014. The duration of the project is four years; one year is awarded for the planning phase and up to three years for implementation will follow.

AHCCCS has identified two CB-LTSS program sub-groups, the elderly/physically disabled and the developmentally disabled populations, to participate in an experience survey and functional status assessment. AHCCCS and the CMS Technical Assistance partner, Truven, will investigate the use of

the survey tool to create a systemic way to measure functional status within the CB-LTSS population across members residing in multiple residential placements. The grant also includes taking a coordinated approach to integrating the personal health record initiative with the existing agency health information strategy. AHCCCS also plans to work with CMS and their consultants to develop and test relevant standards for e-LTSS records. During the next quarter AHCCCS will develop a work plan to submit to CMS for approval. Continued funding into the implementation phase is dependent on approval of the submitted work plan. If approved the work plan will serve as the strategic and implementation plan for the Arizona TEFT Grant.

*Home and Community Based Monitoring Tool*

AHCCCS requires ALTCS contractors to develop and implement a collaborative process to coordinate the routine quality monitoring and oversight of nursing home and certain home and community based providers such as assisted living and group home providers. Many of these providers contract with more than one ALTCS contractor. By coordinating the monitoring and review processes there is significant reduction in the burden to the providers for the on-site visits. In addition, Contractors have developed a uniform tool for the review activities which has resulted in consistencies in the review and in the findings. AHCCCS worked in partnership with the ALTCS Contractors to develop the alternative residential audit tool which includes review standards for resident's rights, medical records, service/care plan, advanced directives, medication administration, staff and physical plant. Testing of this tool began in the previous quarter and continued into the current quarter. AHCCCS and its ALTCS Contractors will review the effectiveness of the tool and will revise as needed. Full implementation is expected during the fourth quarter of the fiscal year. It is expected that this collaborative effort will result in standardized oversight processes of facilities, reduction in provider burden, and increased efficiency among the Contractors.

*Establishing Realistic Outcome-Based Performance Measures*

AHCCCS has developed new performance measure sets for all lines of business. The new measures and related Minimum Performance Standards/Goals became effective on October 1, 2013 which aligns with the start of the new five-year contract period for Acute-Care plans and the newly integrated Children's Rehabilitative Services (CRS) and Seriously Mentally Ill (SMI) plans. 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 is currently working to update the measure sets 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.

*Identifying, Collecting and Assessing Relevant Data*

<u>Data Exchange</u>

AHCCCS began a data-sharing process with Contractors in QI that facilitated the sharing of claims 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 should use this information to develop short and long term strategies to improve care coordination for their members. Three years of historical data was

provided to several lines of business and current ongoing data will be provided to all lines of business at least quarterly, including the CRS- and SMI-integrated Contractors.

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 utilized its External Quality Review Organization to perform the measurement calculations for the CYE 12 measurement period. AHCCCS has finalized the contract with an external vendor to support future performance measurements. Optum, the selected vendor has the capability and willingness to work with AHCCCS in developing and implementing current and future quality, utilization and access to care measures implemented by CMS.

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 10/01/11-09/30/12**

| Measures | CYE 12 Performance (10/01/11-09/30/12) | CYE 11 Performance (10/01/10-09/30/11) | Relative Percent Change From Previous Year | Statistical Significance |
|---|---|---|---|---|
| Access to PCPs: | | | | |
| 12-24 months | 97.0% | 96.8% | 0.2% | 0.163 |
| 25 mo. - 6 years | 87.7% | 86.9% | 0.8% | **<0.001** |
| 7-11 years | 89.9% | 89.3% | 6.9% | **<0.001** |
| 12-19 years | 87.7% | 87.2% | 3.9% | **0.002** |
| Well Child Visits, 6+ by 15 mo. | 67.8% | 70.2% | -3.4% | **<0.001** |
| Well Child Visits, 3-6 years | 66.8% | 64.5% | 3.5% | **<0.001** |
| Adolescent Well Visits | 38.0% | 35.2% | 8.0% | **<0.001** |
| Dental Visits (Ages 2 to 21) | 61.8% | 62.9% | -1.7% | **<0.001** |
| EPSDT Participation | 65.7% | 63.6% | -4.1% | **<0.001** |

**KidsCare Performance Measures**
**Measurement Period 10/01/11-09/30/12**

| Measures | CYE 12 Performance (10/01/11-09/30/12) | CYE 11 Performance (10/01/10-09/30/11) | Relative Percent Change From Previous Year | Statistical Significance |
|---|---|---|---|---|
| Access to PCPs: | | | | |
| 12-24 months | 100% | 100% | 0.0% | 1.000 |
| 25 mo. - 6 years | 93.9% | 93.4% | 0.6% | **0.527** |
| 7-11 years | 95.9% | 95.3% | 0.6% | **0.205** |
| 12-19 years | 94.0% | 93.8% | 0.3% | **0.553** |
| Well Child Visits, 6+ by 15 mo. | N/A | N/A | N/A | N/A |
| Well Child Visits, 3-6 years | 76.6% | 72.7% | 5.4% | **0.025** |
| Adolescent Well Visits | 55.1% | 50.6% | 8.2% | **<0.001** |
| Dental Visits (Ages 2 to 21) | 77.9% | 78.1% | -0.3% | **0.644** |
| EPSDT Participation | 77.3% | 63.9% | 20.9% | **<0.001** |

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. Going forward, AHCCCS has made the decision to transition to measures found in the CMS measures 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.

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.

AHCCCS recognized the opportunity to develop and implement the CMS core and proposed measure sets. The implementation of ICD-10, 5010 as well as the timing of the Request for

Proposal for the Acute-care line of business further established a prime opportunity to implement the performance measure change process.

In order to 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 Optum worked cohesively with AHCCCS to develop methodologies for AHCCCS specific measures meant to improve the quality of life for Arizona residents. In the next quarter AHCCCS and Optum will have a technical assistance meeting with Contractors regarding technical specifications for CHIPRA and adult core measures, HEDIS measures and AHCCCS specific measures within their contracts.

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.

For FFY14, 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.

A competitive approach is utilized whereby Contractor scores on six quality measures established by the AHCCCS Clinical Quality Management Department are used to redistribute a 1% capitation withhold pool based on Contractor's ranking on the selected measures.

Also, a minimum of 5 percent of the value of total payments under all contracts executed with health care providers must be governed by shared-savings arrangements for the measurement year in order for a Contractor to qualify for a withhold distribution payment.

*PIPs*
AHCCCS has a number of Performance Improvement Projects under way with Contractors, which are designed to improve enrollee health outcomes and/or satisfaction. Recent activity related to data collection and analysis for these projects includes:

- **Coordination of Care (Acute Contractors and ADHS Division of Behavioral Health Services):** The purpose of this Performance Improvement Project is to improve coordination

of care provided to AHCCCS members who are receiving both medical and behavioral health services through the exchange of opiate and benzodiazepine prescribing and other clinical information between medical and behavioral health providers, in order to reduce morbidity and/or mortality among these members. A coordination of care work group, consisting of AHCCCS, ADHS Division of Behavioral Health Services (DBHS), Acute care Contractors and Regional Behavioral Health Authorities (RBHA, contracted with DBHS to provide behavioral health services) meet regularly to develop best practices. During the quarter, the work group met to develop and agree on a prescriber introduction letter and a prescriber notification of coordination of care issues. The work group also Confirmed dose risk stratifications and began discussions on outreach and advocacy.

AHCCCS completed an analysis of the data from the baseline measurement period for this PIP. Overall, of the members included in this PIP, 8.6 percent of members were admitted into an acute inpatient setting and 30.2 percent of members had an Emergency Department visit during the measurement period. Both admissions and ED visits must have had a primary or secondary diagnosis of chronic pain, substance abuse, anxiety, and/or depression. Lastly 0.13 percent of members died accidentally, 0.05 percent died from suicide and 0.05 percent died from reasons unknown during the measurement period. AHCCCS has provided baseline data from this study to all Contractors, who will further analyze their data and identify interventions to decrease their rates of ED visits and admissions as well as the deaths of their members.

Through this PIP, all Contractors are expected to decrease the number of members visiting and being admitted into the ED as well reducing the number of deaths related medication issues. A Contractor will show improvement when:

- It meets or exceeds the next highest threshold above its baseline rate
- It narrows the gap between its baseline rate and the next highest threshold by at least 10 percent, or
- It maintains a rate above the highest threshold, if its baseline rate already exceeds that level.

A data analysis is expected for re-measurement in the fall of 2014.

- **All Cause Readmissions –** The purpose of this Performance Improvement Project (PIP) is to decrease the rate of inpatient readmissions among AHCCCS members within 30 days of a previous discharge, in order to improve quality of life, promote patient-centered care, and reduce unnecessary health care utilization and costs. During the previous quarter, AHCCCS completed an analysis of the data from the baseline measurement period for this PIP. This PIP includes all AHCCCS lines of business; Acute, Long Term Care and KidsCare. Overall, of the members included in this PIP 14.84 percent of members were readmitted into an inpatient setting following a discharge within 30 days. AHCCCS has provided baseline data from this study to all Contractors, who will further analyze their data and identify interventions to decrease their rates of readmissions.

  Through this PIP, all Contractors are expected to decrease the number of members being readmitted into an inpatient setting within 30 days of a previous discharge. A Contractor will show improvement when:

- It meets or exceeds the next highest threshold above its baseline rate
- It narrows the gap between its baseline rate and the next highest threshold by at least 10 percent, or
- It maintains a rate above the highest threshold, if its baseline rate already exceeds that level.

A data analysis is expected for re-measurement in the fall of 2014.

- 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. AHCCCS has completed the methodology for this PIP and expects to put it out for Contractor comments within the next quarter. The baseline measurement period for this PIP will be CYE 2014.

*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 and CMS, which allows for gathering and sharing of best practices. Examples of these collaborations include:

- CMS Data Analytics in conjunction with other states and Mathematica
- 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. An OR for three

Contractors were completed during this quarter, with remaining Contractor ORs are scheduled throughout CYE 2014; however, planning began for Readiness Assessments following the award of the Acute-CRS RFP. The Readiness Assessment is similar in nature to the OR process in ensuring that Contractors can effectively meet the requirements set forth in contract.

- *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 Acute and ALTCS 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. CQM staff responded to Contractors with requests for clarification or additional information. It should be noted that similar templates have been developed and are being utilized for all lines of business including the CRS and SMI populations in order to ensure that members are receiving timely and appropriate care. The new template, which incorporates all the new Core measures for all lines of business, was utilized this quarter by Contractors.

    - Annual Plans; QM/QI, EPSDT and Dental – AHCCCS requires all lines of business to submit an annual plan which address details of the Contractors methods for achieve 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* - During the quarter**,** AHCCCS selected a vendor as a result of an Request for Proposal (RFP). The vendors contracts are anticipated to begin 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 in previously, AHCCCS has selected a vender 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 begun planning and implementation processes.

**Reviewing, Revising and Beginning New Projects in Any Given Area of the 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. During this quarter AHCCCS continues the processes of updating the Quality Strategy. A cross-functional team representing all Divisions of AHCCCS was developed to review and revise the strategy and meetings have been held to discuss the progress of the report. A draft report is expected in Q3, with a completed approval date in Q4.

Arizona Health Care Cost Containment System (AHCCCS)
Quarterly Random Moment Time Study Report
January 2014 – March 2014

The January through March 2014 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 2014 |
|---|---|
| Administrative | 3,390 |
| Direct Service | 3,025 |
| Personal Care | 4,388 |

The table below demonstrates the administrative, direct service, and personal care time study achieved the 85% return rate in the January to March 2014 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 | 3,117 | 97.41% |
| Direct Service | 3,400 | 3,274 | 96.29% |
| Personal Care | 3,500 | 3,166 | 90.46% |

**Arizona Health Care Cost Containment System**
**Medicaid Section 1115 Demonstration Number 11-W00275/9**
**Budget Neutrality Tracking Report**
**For the Period Ended March 31, 2014**

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% | 408.77 | 2,933,014 | 2,920,816 | 2,914,814 | 2,939,706 | 11,708,350 | $ 4,786,073,926 | |
| SSI | 835.29 | 1.06 | 885.41 | 69.09% | 611.73 | 486,874 | 488,035 | 487,742 | 490,088 | 1,952,739 | 1,194,548,333 | |
| AC [1] | | | 560.29 | 69.77% | 390.89 | 527,477 | 431,045 | 365,558 | 310,880 | 1,634,960 | 639,086,396 | |
| ALTCS-DD | 4643.75 | 1.06 | 4922.38 | 67.38% | 3316.51 | 72,537 | 73,176 | 73,988 | 74,845 | 294,546 | 976,865,901 | |
| ALTCS-EPD | 4503.21 | 1.052 | 4737.37 | 67.51% | 3198.11 | 85,428 | 85,469 | 85,692 | 86,470 | 343,059 | 1,097,139,577 | |
| Family Plan Ext [1] | | 1.058 | 17.04 | 90.00% | 15.33 | 12,471 | 12,424 | 12,440 | 12,689 | 50,024 | 767,009.00 | |
| | | | | | | | | | | | $ 8,694,481,142 | MAP Subtotal |
| | | | | | | | | | | | 103,890,985 | Add DSH Allotment |
| | | | | | | | | | | | $ 8,798,372,127 | 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 | 68.60% | 422.37 | 2,912,435 | 2,892,401 | 2,904,408 | 2,920,339 | 11,629,583 | $ 4,911,968,409 | |
| SSI | 938.53 | 67.75% | 635.87 | 492,796 | 494,767 | 496,881 | 499,575 | 1,984,019 | 1,261,572,244 | |
| AC [1] | 575.81 | 68.72% | 395.70 | 275,521 | 249,369 | 228,836 | 217,914 | 971,640 | 384,479,377 | |
| ALTCS-DD | 5217.72 | 65.80% | 3433.00 | 75,666 | 76,501 | 77,315 | 78,071 | 307,553 | 1,055,829,879 | |
| ALTCS-EPD | 4983.71 | 65.98% | 3288.49 | 86,787 | 86,025 | 86,253 | 87,071 | 346,136 | 1,138,263,076 | |
| Family Plan Ext [1] | 18.40 | 90.00% | 16.56 | 13,104 | 13,824 | 14,187 | 14,856 | 55,971 | 926,910.00 | |
| | | | | | | | | | $ 8,753,039,895 | MAP Subtotal |
| | | | | | | | | | 106,384,369 | Add DSH Allotment |
| | | | | | | | | | $ 8,859,424,264 | 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 | 69.53% | 450.37 | 2,891,329 | 2,824,456 | | | 5,715,785 | $ 2,574,205,241 | |
| SSI | 994.84 | 68.80% | 684.47 | 501,250 | 501,726 | | | 1,002,976 | 686,508,396 | |
| AC [1] | 500.54 | 70.19% | 351.31 | 207,490 | 91 | | | 207,581 | 72,925,291 | |
| ALTCS-DD | 5530.78 | 67.28% | 3721.05 | 78,859 | 79,382 | | | 158,241 | 588,822,848 | |
| ALTCS-EPD | 5242.86 | 67.37% | 3532.11 | 87,526 | 86,239 | | | 173,765 | 613,756,703 | |
| Family Plan Ext [1] | 14.16 | 90.00% | 12.74 | 14,885 | - | | | 14,885 | 189,685.00 | |
| Expansion State Adults [1] | 626.45 | 84.47% | 529.19 | - | 438,174 | | | 438,174 | 231,876,797.00 | |
| | | | | | | | | | $ 4,768,284,961 | MAP Subtotal |
| | | | | | | | | | 107,980,135 | Add DSH Allotment |
| | | | | | | | | | $ 4,876,265,096 | 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 | | | | | - | $ - | |
| SSI | 1054.53 | | | | | - | - | |
| AC | 0.00 | | | | | - | - | |
| ALTCS-DD | 5862.63 | | | | | - | - | |
| ALTCS-EPD | 5515.49 | | | | | - | - | |
| Family Plan Ext | 14.98 | | | | | - | - | |
| Expansion State Adults | 0.00 | | | | | - | - | |
| | | | | | | | $ - | MAP Subtotal |
| | | | | | | | - | Add DSH Allotment |
| | | | | | | | $ - | 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 | | | | | - | $ - | |
| SSI | 1117.81 | | | | | - | - | |
| AC | 0.00 | | | | | - | - | |
| ALTCS-DD | 6214.39 | | | | | - | - | |
| ALTCS-EPD | 5802.30 | | | | | - | - | |
| Family Plan Ext | 15.85 | | | | | - | - | |
| Expansion State Adults | 0.00 | | | | | - | - | |
| | | | | | | | $ - | MAP Subtotal |
| | | | | | | | - | Add DSH Allotment |
| | | | | | | | $ - | 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 4/30/2014

**Arizona Health Care Cost Containment System**
**Medicaid Section 1115 Demonstration Number 11-W00275/9**
**Budget Neutrality Tracking Report**
**For the Period Ended March 31, 2014**

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

| | Budget Neutrality Limit - Federal Share | | | Expenditures from CMS-64, Schedule B - 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 | $ 2,216,929,935 | $ 103,890,985 | $ 2,320,820,920 | $ 502,890,921 | $ 191,249,757 | $ 175,610,617 | $ 151,638,753 | $ 164,685,415 | $ 167,197 | $ - | $ - | $ - | $458,635 | $ - | $ 1,186,701,295 | $ 1,134,119,625 |
| QE 3/12 | 2,177,209,457 | - | 2,177,209,457 | 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 | 882,436,869 |
| QE 6/12 | 2,152,385,100 | - | 2,152,385,100 | 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 | 717,113,300 |
| QE 9/12 | 2,147,956,649 | - | 2,147,956,649 | 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 | 807,303,062 |
| QE 12/12 | 2,197,873,559 | 106,384,369 | 2,304,257,928 | 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 | 865,968,545 |
| QE 3/13 | 2,180,689,393 | - | 2,180,689,393 | 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 | 836,334,137 |
| QE 6/13 | 2,182,530,305 | - | 2,182,530,305 | 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 | 767,221,760 |
| QE 9/13 | 2,191,946,639 | - | 2,191,946,639 | 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 | 671,643,594 |
| QE 12/13 | 2,320,925,275 | - | 2,320,925,275 | 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 | 815,301,584 |
| QE 3/14 | 2,447,359,687 | 107,980,135 | 2,555,339,822 | 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 | 1,070,688,447 |
| QE 6/14 | | - | - | | | | | | | | | | | | - | - |
| QE 9/14 | | - | - | | | | | | | | | | | | - | - |
| QE 12/14 | | - | - | | | | | | | | | | | | - | - |
| QE 3/15 | | - | - | | | | | | | | | | | | - | - |
| QE 6/15 | | - | - | | | | | | | | | | | | - | - |
| QE 9/15 | | - | - | | | | | | | | | | | | - | - |
| QE 12/15 | | - | - | | | | | | | | | | | | - | - |
| QE 3/16 | | - | - | | | | | | | | | | | | - | - |
| QE 6/16 | | - | - | | | | | | | | | | | | - | - |
| QE 9/16 | | - | - | | | | | | | | | | | | - | - |
| | $ 22,215,805,998 | $ 318,255,489 | $ 22,534,061,487 | $ 5,865,512,696 | $ 2,314,580,109 | $ 1,096,082,689 | $ 1,639,716,084 | $ 1,845,742,124 | $ 1,883,604 | $ 187,089,846 | $ 627,701,611 | $ 155,291,045 | $453,960 | $ 231,876,797 | $ 13,965,930,565 | $ 8,568,130,922 |

Last Updated: 5/22/2014

**Arizona Health Care Cost Containment System**
**Medicaid Section 1115 Demonstration Number 11-W00275/9**
**Budget Neutrality Tracking Report**
**For the Period Ended March 31, 2014**

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 | $ 8,798,372,127 | $ 5,632,347,025 | $ 3,166,025,102 | 35.98% | | | | |
| DY 02 | 8,859,424,264 | 5,662,895,988 | 3,196,528,276 | 36.08% | | | | |
| DY 03 | 4,876,265,096 | 2,670,687,552 | 2,205,577,544 | 45.23% | $ 22,534,061,487 | $ 13,965,930,565 | $ 8,568,130,922 | 38.02% |
| DY 04 | | | - | | | | | |
| DY 05 | | | - | | | | | |
| | $ 22,534,061,487 | $ 13,965,930,565 | $ 8,568,130,922 | | | | | |

**Arizona Health Care Cost Containment System**
**Medicaid Section 1115 Demonstration Number 11-W00275/9**
**Budget Neutrality Tracking Report**
**For the Period Ended March 31, 2014**

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 | 915,737,545 | 559,272,037 | 103,815,331 | | | 1,578,824,913 |
| AFDC/SOBRA | 3,423,419,377 | 3,474,600,047 | 1,569,002,135 | | | 8,467,021,559 |
| ALTCS-EPD | 1,059,294,624 | 1,150,359,209 | 551,539,703 | | | 2,761,193,536 |
| ALTCS-DD | 939,159,398 | 1,002,376,336 | 516,403,668 | | | 2,457,939,402 |
| DSH/CAHP | 150,920,633 | 129,337,400 | 850,000 | | | 281,108,033 |
| Expansion State Adults | - | - | 274,493,508 | | | 274,493,508 |
| Family Planning Extension | 830,631 | 1,007,080 | 207,657 | | | 2,045,368 |
| MED | 673,818 | - | - | | | 673,818 |
| New Adult Group | - | - | 13,870,414 | | | 13,870,414 |
| SNCP/DSHP | 287,152,017 | 536,091,563 | 122,480,090 | | | 945,723,670 |
| SSI | 1,354,262,256 | 1,389,466,755 | 635,910,749 | | | 3,379,639,760 |
| Uncomp Care IHS/638 | 22,866,717 | 97,192,513 | 35,403,179 | | | 155,462,409 |
| Total | 8,154,317,016 | 8,339,702,940 | 3,823,976,434 | - | - | 20,317,996,390 |

**Federal Share**

| Waiver Name | 01 | 02 | 03 | 04 | 05 | Total |
|---|---|---|---|---|---|---|
| AC | 638,875,362 | 384,340,953 | 72,866,374 | | | 1,096,082,689 |
| AFDC/SOBRA | 2,391,030,144 | 2,383,542,246 | 1,090,940,306 | | | 5,865,512,696 |
| ALTCS-EPD | 715,109,931 | 759,060,842 | 371,571,351 | | | 1,845,742,124 |
| ALTCS-DD | 632,770,805 | 659,514,311 | 347,430,968 | | | 1,639,716,084 |
| DSH/CAHP | 101,569,587 | 84,948,804 | 571,455 | | | 187,089,846 |
| Expansion State Adults | - | - | 231,876,797 | | | 231,876,797 |
| Family Planning Extension | 767,009 | 926,910 | 189,685 | | | 1,883,604 |
| MED | 453,960 | - | - | | | 453,960 |
| New Adult Group | - | - | 13,870,414 | | | 13,870,414 |
| SNCP/DSHP | 193,253,307 | 352,104,939 | 82,343,365 | | | 627,701,611 |
| SSI | 935,668,885 | 941,389,304 | 437,521,920 | | | 2,314,580,109 |
| Uncomp Care IHS/638 | 22,848,035 | 97,067,679 | 35,375,331 | | | 155,291,045 |
| Total | 5,632,347,025 | 5,662,895,988 | 2,684,557,966 | - | - | 13,979,800,979 |

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

**Total Computable**

| Waiver Name | 01 | 02 | 03 | 04 | 05 | Total |
|---|---|---|---|---|---|---|
| AC | 313,572 | 210,756 | 87,635 | - | - | 611,963 |
| AFDC/SOBRA | 1,014,881 | 1,090,143 | 556,240 | - | - | 2,661,264 |
| SSI | 365,158 | 399,101 | 206,125 | - | - | 970,384 |
| ALTCS-DD (Cost Sharing)[1] | - | - | - | - | - | - |
| CAHP[2] | (1,693,611) | (1,700,000) | (850,000) | - | - | (4,243,611) |
| Total | - | - | - | - | - | - |

**Federal Share**

| Waiver Name | 01 | 02 | 03 | 04 | 05 | Total |
|---|---|---|---|---|---|---|
| AC | 211,034 | 138,424 | 58,917 | - | - | 408,375 |
| AFDC/SOBRA | 683,014 | 716,006 | 373,960 | - | - | 1,772,980 |
| SSI | 245,752 | 262,130 | 138,578 | - | - | 646,460 |
| ALTCS-DD (Cost Sharing)[1] | - | - | - | - | - | - |
| CAHP[2] | (1,139,800) | (1,116,560) | (571,455) | - | - | (2,827,815) |
| Total | - | - | - | - | - | - |

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

[2] The Critical Access Hospital Payment (CAHP) waiver expenditures are included in the AFDC\SOBRA and SSI 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, SSI and AC/MED 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, 2014**

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 | 916,051,117 | 559,482,793 | 103,902,966 | - | - | 1,579,436,876 |
| AFDC/SOBRA | 3,424,434,258 | 3,475,690,190 | 1,569,558,375 | - | - | 8,469,682,823 |
| ALTCS-EPD | 1,059,294,624 | 1,150,359,209 | 551,539,703 | - | - | 2,761,193,536 |
| ALTCS-DD | 939,159,398 | 1,002,376,336 | 516,403,668 | - | - | 2,457,939,402 |
| DSH/CAHP | 149,227,022 | 127,637,400 | - | - | - | 276,864,422 |
| Expansion State Adults | - | - | 274,493,508 | - | - | 274,493,508 |
| Family Planning Extension | 830,631 | 1,007,080 | 207,657 | - | - | 2,045,368 |
| MED | 673,818 | - | - | - | - | 673,818 |
| New Adult Group | - | - | 13,870,414 | - | - | 13,870,414 |
| SNCP/DSHP | 287,152,017 | 536,091,563 | 122,480,090 | - | - | 945,723,670 |
| SSI | 1,354,627,414 | 1,389,865,856 | 636,116,874 | - | - | 3,380,610,144 |
| Uncomp Care IHS/638 | 22,866,717 | 97,192,513 | 35,403,179 | - | - | 155,462,409 |
| Total | 8,154,317,016 | 8,339,702,940 | 3,823,976,434 | - | - | 20,317,996,390 |

**Federal Share**

| Waiver Name | 01 | 02 | 03 | 04 | 05 | Total |
|---|---|---|---|---|---|---|
| AC | 639,086,396 | 384,479,377 | 72,925,291 | - | - | 1,096,491,064 |
| AFDC/SOBRA | 2,391,713,158 | 2,384,258,252 | 1,091,314,266 | - | - | 5,867,285,676 |
| ALTCS-EPD | 715,109,931 | 759,060,842 | 371,571,351 | - | - | 1,845,742,124 |
| ALTCS-DD | 632,770,805 | 659,514,311 | 347,430,968 | - | - | 1,639,716,084 |
| DSH/CAHP | 100,429,787 | 83,832,244 | - | - | - | 184,262,031 |
| Expansion State Adults | - | - | 231,876,797 | - | - | 231,876,797 |
| Family Planning Extension | 767,009 | 926,910 | 189,685 | - | - | 1,883,604 |
| MED | 453,960 | - | - | - | - | 453,960 |
| New Adult Group | - | - | 13,870,414 | - | - | 13,870,414 |
| SNCP/DSHP | 193,253,307 | 352,104,939 | 82,343,365 | - | - | 627,701,611 |
| SSI | 935,914,637 | 941,651,434 | 437,660,498 | - | - | 2,315,226,569 |
| Uncomp Care IHS/638 | 22,848,035 | 97,067,679 | 35,375,331 | - | - | 155,291,045 |
| Total | 5,632,347,025 | 5,662,895,988 | 2,684,557,966 | - | - | 13,979,800,979 |

**Calculation of Effective FMAP:**

| | | | | | |
|---|---|---|---|---|---|
| AFDC/SOBRA | | | | | |
| Federal | 2,391,713,158 | 2,384,258,252 | 1,091,314,266 | - | - |
| Total | 3,424,434,258 | 3,475,690,190 | 1,569,558,375 | - | - |
| Effective FMAP | 0.698425777 | 0.685981236 | 0.695300209 | | |
| SSI | | | | | |
| Federal | 935,914,637 | 941,651,434 | 437,660,498 | - | - |
| Total | 1,354,627,414 | 1,389,865,856 | 636,116,874 | - | - |
| Effective FMAP | 0.690901887 | 0.677512459 | 0.688019004 | | |
| ALTCS-EPD | | | | | |
| Federal | 715,109,931 | 759,060,842 | 371,571,351 | - | - |
| Total | 1,059,294,624 | 1,150,359,209 | 551,539,703 | - | - |
| Effective FMAP | 0.675081243 | 0.659846799 | 0.673698283 | | |
| ALTCS-DD | | | | | |
| Federal | 632,770,805 | 659,514,311 | 347,430,968 | - | - |
| Total | 939,159,398 | 1,002,376,336 | 516,403,668 | - | - |
| Effective FMAP | 0.673762948 | 0.657950799 | 0.672789505 | | |
| AC | | | | | |
| Federal | 639,086,396 | 384,479,377 | 72,925,291 | - | - |
| Total | 916,051,117 | 559,482,793 | 103,902,966 | - | - |
| Effective FMAP | 0.69765364 | 0.687205008 | 0.70185957 | | |
| Expansion State Adults | | | | | |
| Federal | - | - | 231,876,797 | - | - |
| Total | - | - | 274,493,508 | - | - |
| Effective FMAP | | | 0.844744193 | | |
| New Adult Group | | | | | |
| Federal | - | - | 13,870,414 | - | - |
| Total | - | - | 13,870,414 | - | - |
| Effective FMAP | | | 1 | | |

**Arizona Health Care Cost Containment System**
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V. Budget Neutrality Member Months and Cost Sharing Premium Collections

| Budget Neutrality Member Months: | AFDC/SOBRA | SSI | ALTCS-DD | ALTCS-EPD | AC | MED | Family Plan Ext | Expan St Adults | New Adult Group |
|---|---|---|---|---|---|---|---|---|---|
| Quarter Ended December 31, 2011 | 2,933,014 | 486,874 | 72,537 | 85,428 | 527,477 | 467 | 12,471 | | |
| Quarter Ended March 31, 2012 | 2,920,816 | 488,035 | 73,176 | 85,469 | 431,045 | - | 12,424 | | |
| Quarter Ended June 30, 2012 | 2,914,814 | 487,742 | 73,988 | 85,692 | 365,558 | - | 12,440 | | |
| Quarter Ended September 30, 2012 | 2,939,706 | 490,088 | 74,845 | 86,470 | 310,880 | - | 12,689 | | |
| Quarter Ended December 31, 2012 | 2,912,435 | 492,796 | 75,666 | 86,787 | 275,521 | - | 13,104 | | |
| Quarter Ended March 31, 2013 | 2,892,401 | 494,767 | 76,501 | 86,025 | 249,369 | - | 13,824 | | |
| Quarter Ended June 30, 2013 | 2,904,408 | 496,881 | 77,315 | 86,253 | 228,836 | - | 14,187 | | |
| Quarter Ended September 30, 2013 | 2,920,339 | 499,575 | 78,071 | 87,071 | 217,914 | - | 14,856 | | |
| Quarter Ended December 31, 2013 | 2,891,329 | 501,250 | 78,859 | 87,526 | 207,490 | - | 14,885 | | |
| Quarter Ended March 31, 2014 | 2,824,456 | 501,726 | 79,382 | 86,239 | 91 | - | - | 438,174 | 19,591 |
| 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 | | | | | | | | | |

| | 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 | | |

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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** | | | **318,255,489** |
| 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 | | | | | | |
| Sep-14 | | | | | | |
| Dec-14 | | | | | | |
| Mar-15 | | | | | | |
| Jun-15 | | | | | | |
| Sep-15 | | | | | | |
| Dec-15 | | | | | | |
| Mar-16 | | | | | | |
| Jun-16 | | | | | | |
| Sep-16 | | | | | | |
| Total Reported to Date | 100,429,787 | 83,832,244 | - | - | - | 184,262,031 |
| **Unused Allotment** | **3,461,198** | **22,552,125** | **107,980,135** | **-** | **-** | **133,993,458** |

**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 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 | - | 19,591 | | | 19,591 | 11,334,177 |

| | | DY 04 PM/PM | Member Months QE 12/14 | QE 3/15 | QE 6/15 | QE 9/15 | Total | |
|---|---|---|---|---|---|---|---|---|
| New Adult Group | 1.047 | 605.73 | | | | | - | - |

| | | DY 05 PM/PM | Member Months QE 12/15 | QE 3/16 | QE 6/16 | QE 9/16 | Total | |
|---|---|---|---|---|---|---|---|---|
| New Adult Group | 1.047 | 634.20 | | | | | - | - |

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

| | Budget Neutrality Limit - Federal Share | | | Expenditures | |
|---|---|---|---|---|---|
| | MAP | DSH | Total | New Adult Grp | VARIANCE |
| QE 12/13 | $ - | $ - | $ - | $ - | $ - |
| QE 3/14 | 11,334,177 | - | 11,334,177 | 13,870,414 | (2,536,237) |
| QE 6/14 | | | | | |
| QE 9/14 | | | | | |
| QE 12/14 | | | | | |
| QE 3/15 | | | | | |
| QE 6/15 | | | | | |
| QE 9/15 | | | | | |
| QE 12/15 | | | | | |
| QE 3/16 | | | | | |
| QE 6/16 | | | | | |
| QE 9/16 | | | | | |
| | $ 11,334,177 | $ - | $ 11,334,177 | $ 13,870,414 | $ (2,536,237) |

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 | $ 11,334,177 | $ 13,870,414 | $ (2,536,237) | -22.38% | $ 11,334,177 | $ 13,870,414 | $ (2,536,237) | -22.38% |
| DY 04 | | | | | | | | |
| DY 05 | | | | | | | | |
| | $ 11,334,177 | $ 13,870,414 | $ (2,536,237) | | | | | |

Based on CMS-64 certification date of 4/30/2014