AHCCCS Annual Report
Federal Fiscal Year 2015
October 1, 2014- September 30, 2015

Title

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

Section 1115 Annual Report

Demonstration Year: 33

Introduction:

As written in Special Term and Condition paragraph 38, the State submits the following draft Annual report to CMS. The purpose of the annual report is to document accomplishments, project status, quantitative and case study findings, utilization data, the status of the collection and verification of encounter data and policy and administrative difficulties in the operation of the Acute Care, and Arizona Long Term Care System (ALTCS) components of the Demonstration.

Brief History:

AHCCCS was created to defray the cost of indigent health care. Prior to 1982, Arizona was the only state in the nation that had declined federal Medicaid funds for low-income women, children, aged, blind, and the disabled. In 1980, the counties turned to the Arizona Legislature for help. The Legislature responded and passed legislation in 1981 that created the Arizona Health Care Cost Containment System (AHCCCS). On October 1, 1982, AHCCCS became the first statewide Medicaid managed care system in the nation. From the beginning of the program back in 1982, AHCCCS has operated under an 1115 Research and Demonstration waiver granted by the Department of Health and Human Services. Since that time, a number of waiver extensions have been approved by the Centers for Medicare and Medicaid Services.

Waiver Changes FFY 2015:

The 1115 Waiver allows states to initiate innovative projects in their Medicaid programs. Arizona's 1115 Waiver allows AHCCCS to run its unique and successful managed care model. Specifically, the 1115 Waiver exempts Arizona from certain provisions of the Social Security Act and includes expenditure authority to allow reimbursement for costs that would not otherwise be matchable by the Federal government, so long as they are budget neutral.

During FFY 2015, a number of changes were made to Arizona's 1115 Waiver. More information is provided below.

On December 15, 2014, CMS approved the expansion of the Integrated Regional Behavioral Health Authorities statewide, together with a proposal to extend the Safety Net Care Pool for Phoenix Children's Hospital until December 31, 2015. This proposal also extends uncompensated care payments to IHS and 638 facilities through December

31, 2015. CMS approved the proposal to reimburse for the full array of services to women found to be eligibile under the Hospital Presumptive Eligibility Program.

AHCCCS continues to work with CMS on its request to use federal matching funds for services provided by Tuba City Regional Health Care for inmates of the Navajo Detention Center and to charge premiums to individuals with income above 100% FPL.
CMS did not approve Arizona's request to require $200 co-pays for non-emergency use of the emergency room for individuals with income above 100% FPL.

On September 30, 2015, AHCCCS formally submitted the request to apply for a new Section 1115 Research and Demonstration Waiver that would build upon past successes and employ new strategies for member engagement. The Waiver application covers the period of 10/1/16 through 9/30/21.

The State's proposal reflects the changing face of Medicaid. Traditionally, Medicaid was designed to serve children, pregnant women, the elderly, and individuals with disabilities. Today, AHCCCS serves nearly as many adults as it does Arizonans enrolled in the traditional eligibility categories. Although AHCCCS has developed strategies around member engagement, wellness, disease management, supported employment and housing and other opportunities for traditional eligibility categories, the same cannot be said for adults. Accordingly, new strategies must be developed to engage the adult membership. Some of these strategies include:

1. Giving Meaning to Personal Responsibility
    a. *Strategic Copays*: This new look at copayments is designed to direct care to the right setting at the right time. Copayments will not be collected at the point of service, but instead will be billed retrospectively.
    b. *Putting Premiums to Work*: The Arizona Legislature passed SB 1475 that would require premiums for the adult population not to exceed 2% of annual household income. This measure combines personal responsibility with purpose and provides opportunity to allow members to use their premium dollars for non-covered services like dental care and vision.

2. The AHCCCS CARE Account
    a. *Members*: Members will receive a quarterly invoice that shows how much they owe for copayments and premiums. Members make monthly payments into their AHCCCS CARE account. Copayments are used to offset program costs. Premium payments are monies that can be withdrawn by members for non-covered services. As long as members are timely with their payments, meet one Healthy Arizona target, and participate in AHCCCS works, they can withdraw funds from their CARE account.
    b. *Business Sector*: The AHCCCS CARE program also offers a new opportunity to engage the business sector. Many employers rely on Medicaid as the source of their employees' health insurance. The CARE account provides those employers with an opportunity to more directly invest in the health of their workforce.
3. Healthy Arizona
    a. *Education*: The primary goal is to educate members about proactive measures they can take to stay healthy. Meeting the Healthy Arizona target can be as simple as getting your flu shot or mammogram.

b. *Engagement*: It is also important to set higher goals and engage employers and the philanthropic community to partner with the State. Everyone shares similar goals to achieve a healthier citizenry. So, for members who meet targets, such as tobacco cessation goals, opportunities will be created for additional support to be provided into members' CARE accounts by charitable organizations who also may share similar goals.

4. AHCCCS Works
    a. *SB 1092*: The Arizona Legislature passed SB 1092 to condition AHCCCS eligibility upon acquiring work. The AHCCCS Works program taps into the spirit of SB 1092 by taking that first step – connecting AHCCCS members to work opportunities. Participation in AHCCCS Works is not a condition of AHCCCS eligibility, nor is there a requirement that the member actually find employment. Rather, participating in AHCCCS Works is a connection to employment supports.

Additional aspects of the waiver request include proposals for system reform through the Delivery System Reform Incentive Payment (DSRIP) program; uncompensated care payments for Indian Health Services and tribally operated 638 facilities; supporting a medical home model that incorporates traditional healing practices for our American Indian/Alaska Native members; transitioning to the new Home and Community Based Services settings standards; phasing out of the Safety Net Care Pool to smarter and more sustainable models that support Phoenix Children's Hospital; and changes that reflect recent transitions within Arizona's Medicaid system.

Needless to say, the fact that Arizona's Waiver is an evolving document is critical. Healthcare is changing at a rate that far outpaces government's ability to keep up through statutes and regulations. The Waiver affords a tool through which states can more nimbly support innovations like AHCCCS CARE to better serve members and their families and allow decision-making at the local level.

Enrollment Information:

Population Groups (as hard-coded in the CMS 64)	Number Enrollees to Date	Number Voluntarily Disenrolled-FFY Ending 9/30/15	Number Involuntarily Disenrolled-FFY Ending 9/30/15
Acute AFDC/SOBRA	1,270,061	2,562	378,455
SSI	186,142	180	32,475
Prop 204 Restoration	438,129	767	62,843
Adult Expansion	108,474	260	25,098
LTC DD	28,818	26	1,746
LTC EPD	31,438	41	3,786
Eligibility Non Waiver	2,189	7	253
TOTAL	2,065,251	3,843	504,656

State Reported Enrollment in the Demonstration (as requested)	Current Enrollees
Title XIX funded State Plan	1,330,472
Title XXI funded State Plan	882
Title XIX funded Expansion	73,265
Title XXI funded Expansion	0
DSH Funded Expansion	
Other Expansion	
Pharmacy Only	
Family Planning Only	0
Enrollment Current as of	10/1/15

Outreach/Innovative Activities:

During this Fiscal Year, AHCCCS lacked the resources to provide education and partnership activities in the community.

Operational/Policy Developments/Issues:

Legislative Update

While AHCCCS proposed only one bill during the 2015 Legislative Session, HB 2102 (children; chronic illness; physical disability), a number of bills were enacted that directly impact the program.

HB 2102 transfers the statutory provisions relating to the administration of the Children's Rehabilitative Services (CRS) program from the Department of Health Services (DHS) to AHCCCS. There are no fiscal or programmatic impacts as a result of this legislation. The Governor signed HB 2102 on April 6, 2015.

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

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

SB 1092 (AHCCCS; annual waiver submittals) requires AHCCCS, by March 30 of each year, to apply for waivers or amendments to the current section 1115 waiver to allow Arizona to institute a work requirement for all "able-bodied" "adults", place a lifetime limit of five years of benefits on able-bodied adults except in specified conditions, and

develop and impose meaningful cost-sharing requirements to deter the nonemergency use of emergency departments and the use of ambulance services for nonemergency transportation or when it is not medically necessary. In any year, AHCCCS is required to apply for only the waivers or amendments to the current 1115 Waiver that have not been approved and are not in effect. The Governor signed SB 1092 on March 6, 2015.

SB 1032 (AHCCCS; contractors; prescription monitoring) requires contractors to intervene if an AHCCCS member has 10 or more prescriptions for controlled substances within a 3-month period, and are required to monitor prescriptions that are being filled by members and intervene with both the prescriber and the member when excessive amounts of controlled substances are used. The Governor signed SB 1032 on March 23, 2015.

SB 1034 (AHCCCS; emergency services, case management) requires contractors to intervene if an AHCCCS member inappropriately seeks care at a hospital emergency department four times or more in a six-month period in order to educate the member regarding the proper use of emergency services. The Governor signed SB 1034 on March 23, 2015.

SB 1136 (nursing facility assessment; continuation) extends the repeal date to October 1, 2023, for the assessment on health care items and services provided by nursing facilities, which are used for supplemental payments to nursing facilities for covered Medicaid expenditures. Furthermore, subject to approval by the Centers for Medicare and Medicaid Services (CMS), a nursing facility located outside of Arizona cannot receive payments for quarterly nursing facility adjustments. The Governor signed SB 1136 on March 23, 2015.

Lastly, SB 1257 (behavioral health; transfer; AHCCCS) made statutory changes that effectuated the transfer of behavioral health services from the DHS to AHCCCS. The Division of Behavioral Health Services (DBHS) and AHCCCS have been partners in an effort to improve care for Arizonans receiving behavioral health services. As such, AHCCCS continues to make strides in effectuating the changes outlined in SB 1257, which will be finalized on July 1, 2016. The Governor signed SB 1257 on April 6, 2015.

The legislature adjourned Sine Die on 4/3/15.

State Plan Update

The following State Plan Amendments (SPA) were submitted to CMS during FFY 2015:

SPA 15-006 – Graduate Medical Education 2016 (submitted 9/30/15)
Updates funding for GME programs for the service period July 1, 2015, through June 30, 2016 for programs with submitted IGAs.

SPA 15-005-D – Nursing Facility Rates (submitted 8/27/15)
Updates reimbursement rates for Nursing Facilities the period October 1, 2015 to September 30, 2016 and permanently removes the automatic inflation factor beginning October 1, 2015.

SPA 15-005-C – Other Provider Rates (submitted 8/26/15)
Updates rates for other provider services as of October 1, 2015.

SPA 15-005-B – Outpatient Rates (submitted 8/26/15)
Updates rates for outpatient services as of October 1, 2015.

SPA 15-005-A – Freestanding Psychiatric Hospital Rates (submitted 8/26/15)
Updates the rates for freestanding psychiatric hospitals as of October 1, 2015.

SPA 15-004 - Ambulance Rates (submitted 6/1/15)
Updates Ambulance Rates in the State Plan.

SPA 15-003 – Orthotics (submitted 4/28/15; approved 5/28/15)
Updates the State Plan to reflect updates to the orthotic benefit.

SPA 15-002 – Nursing Facility Assessment (submitted 3/19/15; approved 4/21/15)
Updates the Nursing Facility assessment dollar amounts in State Plan.

SPA 15-001 – Supplemental Drug Rebates (submitted 2/5/15; approved 5/28/15)
Updates the State Plan to include supplemental drug rebates effective January 1, 2015.

SPA 14-014 – ABP Cost-Sharing (submitted 11/31/14; resubmitted 12/13/14)
Updates the State Plan to include cost-sharing for individuals with income over 100% FPL.

SPA 14-013-D – Nursing Facility Rates (submitted 10/31/14; approved 5/14/15)
Updates reimbursement rates for Nursing Facilities for the period October 1, 2014 to September 30, 2015.

SPA 14-013-C – Other Provider Rates (submitted 10/31/14; approved 5/15/15)
Updates reimbursement rates for other providers for the period October 1, 2014 to September 30, 2015.

SPA 14-013-B – Outpatient Rates (submitted 10/31/14; approved 4/29/15)
Continues current outpatient hospital reimbursement rates for the period October 1, 2014 to September 30, 2015.

SPA 14-013-A – Freestanding Psychiatric Hospital Rates (submitted 10/31/14; approved 4/8/15)
Continues rates for freestanding psychiatric hospitals for the period October 1, 2014 to September 30, 2015.

Combating Fraud

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

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

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

- OIG is comprised of five sections that accomplish different but interrelated functions as follows:

    - *Provider Registration Section* - The providers are affiliated with MCOs in order to provide services; however, the State requires all Medicaid providers to be enrolled through the AHCCCS' Provider Registration Unit (PRU).

    - *Provider Compliance Section* - Performs ongoing investigations of external referrals and internally detected cases through data mining (PI Audits) activities. This section also makes independent referrals to the State MFCU unit and other law enforcement authorities.

    - *Member Compliance Section* - This Section is divided in two subsections. The Member Criminal Investigations Unit and the Fraud Prevention Unit. Each section, with a distinctive role, accomplishes investigations of post and pre enrollment of potential fraud cases involving beneficiaries.

    - *Program Integrity Team* - Tasked with data mining and data audits of post payments. This section also conducts periodic utilization reviews of target providers to identify trends and determine potential fraudulent billing practices.

    - Performance Improvement and Audits Section – This section oversees the Corporate Compliance Program as required by the Federal law and as established in the AHCCCS contract with Managed Care Organizations including the Behavioral Health Authorities (16). The section has two major goals: to conduct performance improvement projects, and to conduct independent provider audits.

OIG PROJECT UPDATES

Provider Compliance Section

<u>The OIG Non-Emergency Medical Transportation (NEMT) Project</u> – OIG has continued the project for the NEMT related investigations after the risk assessment based on utilization patterns as well as allegations. Some of these cases have identified with credible allegations of fraud resulting in those providers either being terminated from participation in the Medicaid program or an imposition of payment suspension with millions in savings, recoupments and restitutions for the State.

NEMT Cases Update:

- SFY 2015 (7/1/2014 through 06/30/2015)

    - 85 Open NEMT cases.

        - 24 joint cases with Law Enforcement, some of which have indictments pending (20 with FBI, 2 with MFCU & 2 with Homeland Defense)

        - 28 new NEMT case opened during this fiscal year

        - 2 cases with Credible Allegation of Fraud suspensions

            - 4 NEMT providers were terminated

        - 10 cases closed for a total recovery of $54,198.16

- Several NEMT case investigations reached CMP conclusions outside SFY 2015

The OIG Excluded Providers Project- Excluded providers are generated as a result of the monthly sanction report review –OIG has devoted more resources to investigate cases in which a provider or a person under the ownership list has been excluded from federal and other state's participation. OIG is investigating potential recoveries based on the claims or encounters for services provided by those excluded individuals who own entities. More than 42 cases have been investigated since the inception of this project.

Excluded Providers Update:

- SFY 2015 (7/1/2014 through 06/30/2015)
  - 14 new excluded provider cases opened
    - 20 cases closed for no fraud found
    - 4 cases still Active and Open
    - The recoveries as a result of these investigations totaled $221,672.47

The following are some examples of provider fraud cases:

- A habilitation provider related case billing for services not rendered. The investigation concluded that the services were billed from a caregiver not residing in Arizona. It was determined that there were 3 subjects involved in the scheme. The case recoveries included $10,055.03 in overpayments, recouped from the entity payments were made to. Additionally, OIG assessed 3 civil monetary penalties issued to the subjects that caused these fraudulent claims to be submitted.

- A dental investigation determined that the practice was inappropriately billing under the incorrect provider ID, did not maintain medical records in patient files, and the rendering provider signatures/initials were missing from the treatment notes on file. As a result, AHCCCS/OIG was able to reach a settlement with the provider in the amount of $100,000.

The following is the OIG summary for the SFY 2015 corresponding to investigation recoveries and savings for the Provider Compliance Section:

Provider Compliance Section *	
Recoveries, Savings, and Costs	**FYTD**
Recoveries	$1,719,100.42
Adjustment to Recoveries	*-$41,059.52*
Investigative Costs Recovered	$56,165.65
Program Savings	
• BETH reported savings of $3,335.02 while an additional savings of $8,945,252.16 was	$ 8,948,587.18

determined for SFY15	
TOTAL	**$10,682,793.73**

Member Compliance Section

The Member Compliance Joint Task Force - Tucson is comprised of the Office of Inspector General, the Office of Attorney General- Special Investigations, Drug Enforcement Agency (DEA) and Arizona Border Crimes and Control. Special investigators work jointly on cases involving criminal enterprise, drug trafficking and money laundering. Individuals involved in these crimes have been identified as also receiving State Medicaid under false pretenses. The Arizona Attorney General's office and AHCCCS OIG have several cases pending prosecution and are preparing for prosecution for failure to disclose income obtained through criminal activity.

- Since the inception of this joint work, 13 cases have been submitted for prosecution.
- 4 of those cases have been sentenced totaling $191,101.99 in savings and recoveries. It is expected that AHCCCS will receive an approximate of $162,530.22 in restitution and assets forfeitures on the remaining 9 cases.
- The initial task force consisted of two Member Compliance investigators working on referrals from the numerous agencies. Due to the preliminary success of the joint efforts, OIG has placed a full-time Member Compliance investigator within the Attorney General's Special Investigations Unit under a Memorandum of Understanding (MOU) to focus all efforts on these criminal enterprises.

Case Example: AHCCCS received a referral from the joint task force Drug Enforcement Agency (DEA) alleging that a subject was involved in an illegal enterprise involving money laundering. Through an investigation it was discovered that the subject was receiving deposits into several accounts that were not included on her AHCCCS eligibility application. During the time period of June 1, 2011 through March 1, 2014, over $70,000 was deposited into the subject's accounts. The case is currently pending prosecution. The loss to the agency is $$20,982.77.
OIG Member Compliance and The Fraud Prevention Unit have identified two additional initiatives in a proactive effort to combat fraud, waste, and abuse within the AHCCCS program.

- The Fraud Prevention Unit (FPU) Pregnancy Project:

OIG, FPU, experienced a significant decrease in the number of referrals sent by eligibility workers and other referring entities, during SFY 2015 due to the implementation of a new online eligibility system -Health-e- Arizona Plus.

This decrease is a direct result of more members moving away from face-to-face applications, and applying online. FPU has worked to identify indicators of fraud based on historical data and eligibility criteria in order to investigate members who may enroll online fraudulently.

The Pregnancy project involves, auditing the online system to identify pregnant women who have reported no source of income and no spouse or father in the home. Historical data has shown this to be a high risk area. The initial audit yielded over 14,000 potential individuals. Further narrowing of the criteria drastically reduced this number. Both the Phoenix and Tucson FPU teams are currently conducting an investigation pilot of these referrals. OIG estimates that the

project will yield a 42% increase in savings to the AHCCSS program of approximately 10 million dollars.

- Pharmacy and Drug Diversion Referrals:

The second initiative involves pharmacy and drug diversion referrals. The Member Compliance unit is working jointly with the Provider Compliance unit to identify drug diversion cases that involve members, providers and pain clinics that have been identified as having a high propensity for fraud, waste and abuse. We will be working closely with managed care contracted plans and their compliance officers. This initiative is in its infancy and an update will be available as the year progresses.

The following is the OIG summary for the SFY 2015 corresponding to investigations recoveries, and savings for the Member Compliance Section:

Member Compliance Section	
Criminal Investigations Unit **	**FYTD**
Recoveries	$776,598.15
Investigative Costs Recovered	$35,526.26
Program Savings	$780,514.94
Residency Verification Savings	$46,371.58
Social Security Cost Savings	$13,121.72
SUB-TOTAL	$1,652,132.65
**Based on Member Case Type	
Fraud Prevention Unit	
Program Savings	$17,622,747.00
Residency Verification Savings	$0.00
SUB-TOTAL	*$17,622,747.00*
DES/OSI	
Program Savings	$6,935,295.04
TOTAL MEMBER RECOVERIES & SAVINGS	**$26,210,174.69**

Arizona Long Term Care Program (ALTCS):

In 1987, Arizona passed legislation to establish ALTCS for the delivery of long term care services. ALTCS was implemented on December 19, 1988, for the developmentally disabled (DD) population. The long term care program for the elderly or physically disabled (EPD) population was implemented on January 1, 1989.

The ALTCS program provides a complete array of acute medical care services, behavioral health care, long term care and case management services to individuals at risk of institutionalization (individuals who are elderly, physically disabled, and / or developmentally disabled). The program emphasizes delivery of care in the member's own home or alternative residential settings. Like the Acute Care program, members of all ages who are not American Indians with an "on-reservation status" receive their care through contracted ALTCS plans referred to as “Contractors.” All members with developmental disabilities are enrolled with the Arizona Department of Economic Security (DES), Division

of Developmental Disabilities (DDD). Tribal members who are physically disabled or elderly with an "on-reservation" status are enrolled in the ALTCS fee-for-service program. They are provided case management with from one of eight American Indian case management organizations. Seven are Tribal operated and one is a non-profit American Indian organization. Tribal members with developmental disabilities are served through the DES/DDD. Once enrolled in the ALTCS, the member has a choice of available case managers and primary care providers who coordinate care and act as gatekeepers. In 2011, AHCCCS awarded new contracts to the following 4 EPD Program Contractors: Evercare Select, SCAN Long Term Care, Mercy Care Plan, and Bridgeway Health Solutions. SCAN Long Term Care was awarded a capped enrollment contract and subsequently terminated their contract as of May 1, 2012. As of October 1, 2015, 57,513 members were enrolled in ALTCS.

Programs under Title XXI:

The Title XXI State Children's Health Insurance Program (CHIP), which is referred to in Arizona as KidsCare, provides affordable insurance coverage for low-income children. In May 1998, the Arizona Legislature authorized the implementation of a stand-alone Title XXI SCHIP program, and was implemented on November 1, 1998.

Arizona's income threshold is set at 200% FPL with no resource test for this population. A screening and referral process is used to determine whether a child is eligible for Medicaid (Title XIX) prior to a determination of eligibility for KidsCare. The program maximizes federal contributions, realizing a federal contribution of almost $3 for every $1 spent by the state. With the exception of Native American children, who may elect to receive their care through IHS, children enrolled in KidsCare are assigned to managed-care health plans already established with AHCCCS. Children enrolled in KidsCare presently receive the full array of services offered to children enrolled with Medicaid.

As a result of the budget shortfall, the KidsCare program was capped on January 1, 2010. All applicants for KidsCare were placed on a waiting list. On April 6, 2012, CMS approved a Waiver Amendment, which included funding for KidsCare II. KidsCare II was a temporary program to provide coverage to a limited number of children who were on the KidsCare wait list, with incomes up to 200% of the federal poverty level (FPL), and who meet other eligibility requirements. Authority to administer the KidsCare II program expired on February 1, 2014. Of the 37,000 children who were enrolled in KidsCare II, 23,000 were transitioned to Medicaid under the expanded eligibility limit from the Affordable Care Act of 133% FPL, while the enrollment information for the remaining 14,000 children was submitted to the Marketplace. These families were notified of their enrollment changes and given the opportunity to create accounts on the Marketplace.

As of October 1, 2015, there were 882 children enrolled in the KidsCare Program.

The Employer-Sponsored Insurance (ESI) Program was phased-out on January 1, 2014.

Family Planning Extension Program (FPEP):

Waiver authority for FPEP expired on December 31, 2013. Women previously eligible for coverage under this program are now eligible for coverage on the Marketplace, or have been transition to Medicaid if their incomes are below 133% FPL.

Consumer Issues:

In support of the Annual report to CMS, presented below is a summary of complaint issues received in OCA for October 2014 – September 2015:

Complaint Issues and Their Frequency

Table 1 **Advocacy Issues**	**10/01/14-12/31/14**	**1/1/15-3/31/15**	**4/1/15-6/30/15**	**7/1/15-9/30/15**	**Total**
Billing Issues	**51**	**36**	**26**	**30**	**143**
• **Member reimbursements**					
• **Unpaid bills**					
Cost Sharing	**8**	**1**	**3**	**3**	**15**
• **Co-pays**					
• **Share of Cost (ALTCS)**					
• **Premiums (Kids Care, Medicare)**	**33**	**48**	**41**	**27**	**149**
Covered Services					
Eligibility Issues by Program	**28**	**29**	**27**	**25**	**109**
Can't get coverage due to :					
ALTCS					
• **Resources**					
• **Income**	**872**	**628**	**397**	**488**	**2385**
• **Medical**					
DES					
• **Income**	**1**	**0**	**2**	**2**	**5**
• **Incorrect determination**					
• **Improper referrals**	**143**	**137**	**99**	**108**	**487**
Kids Care					
• **Income**					
• **Incorrect determination**	**166**	**242**	**91**	**71**	**570**
SSI/Medical Assistance Only					
• **Income**					
• **Not categorically linked**					
Information	**31**	**24**	**32**	**18**	**105**

• **Status of application** • **Eligibility Criteria** • **Community Resources** • **Notification (Did not receive or didn't understand)**					
	58	**37**	**32**	**25**	**152**
Medicare • **Medicare Coverage** • **Medicare Savings Program** • **Medicare Part D**					
	0	**0**	**0**	**1**	**1**
Prescriptions • **Prescription coverage** • **Prescription denial**					
	13	**8**	**12**	**17**	**50**
Issues Referred to other Divisions: **1.Fraud-Referred to Office of Inspector General (OIG)** **2.Quality of Care-Referred to Division of Health Care Management (DHCM)** • **Health Plans/Providers (Caregiver issues, Lack of providers)** • **Services (Equipment, Nursing Homes, Optical and Surgical)**					
Total	**1404**	**1190**	**762**	**815**	**4171**

Quality Assurance/Monitoring Activity:

See the attached quality assurance monitoring activity report.

Legal Update:

The Office of Administrative Legal Services (OALS) provides legal counsel to the AHCCCS Administration, is responsible for the Agency rulemaking process, and oversees the Grievance System for the AHCCCS Program. Major components of the Grievance System include: scheduling State Fair Hearings for disputed matters, the informal adjudication of member appeals and provider claim disputes, and the issuance of

AHCCCS Hearing Decisions (also referred to as Director's Decisions). AHCCCS Hearing Decisions represent the Agency's final administrative decisions and are issued subsequent to review of the Recommended Decisions made by Administrative Law Judges. The Assistant Director of OALS also serves as the Agency's Privacy Officer with oversight authority over HIPAA compliance issues.

During the time period of 10/1/14 through 9/30/15 OALS received 9099 matters which included member appeals, provider claim disputes, ALTCS trust reviews and eligibility appeals. Of the 9099 total cases received, 383 were member appeals, 6932 were provider claim disputes, 227 were ALTCS trust reviews, and 1557 were eligibility appeals. OALS issued 688 Director's Decisions after State Fair hearings were held. In addition, OALS issued 5571 informal dispositions of disputes filed with the AHCCCS Administration. More than 97.7% of these disputes were resolved at the informal level, thus alleviating the need for State Fair Hearings in these cases.

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

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

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

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

On February 5, 2014, the Superior Court granted Defendants' Motion to Dismiss because Plaintiffs lack standing. The Court dismissed Plaintiffs' Complaint in its entirety. Plaintiffs then appealed to the Court of Appeals on February 11 and subsequently filed a Petition for Special Action on March 4, 2011. On April 22, 2014, the Arizona Court of

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

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

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

Tinsley et al v McKay et al (Lawsuit Alleging Violations of Constitutional and Statutory Rights of Foster Care Children)

On February 3, 2015 a class action lawsuit in federal district court was filed against the Directors of the Arizona Department of Child Safety (DCS) and Department of Health Services (ADHS), alleging violations of the constitutional and statutory rights of children in foster care custody of the State of Arizona. Plaintiffs are several children in state

foster care custody, suing on behalf of themselves, a general class of children who are or will be placed in such custody, and certain subclasses, to enjoin the directors of DCS and ADHS from continuing to operate the Arizona foster care system in ways that violate Plaintiffs' federal constitutional and statutory rights. Represented by Arizona Center for Law in the Public Interest, Children's Rights, Inc. and Perkins Coie LLP, Plaintiffs allege failures by DCS and ADHS to provide safety and necessary medical and behavioral health care for approximately 17,000 foster children in the custody of the State.

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

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

Accomplishments in 2015:

This past year, AHCCCS completed quite a few major accomplishments and implementations toward building a more cohesive and effective health care system in Arizona by reducing fragmentation, structuring provider reimbursements to incentivize quality outcomes, leveraging health information technology and working with private sector partners to further innovation to the greatest extent.

BHS Merger – AHCCCS made a significant step forward on how behavioral health services are delivered in the broader healthcare system by bringing the behavioral health administrative expertise into the broader AHCCCS administration. As a result, more informed decisions can be made regarding not only the delivery of behavioral health, but all AHCCCS services, since behavioral health is such a critical part of one's overall health. Arizona is also setting the pace nationally- prior to this past year, only 4 states

had behavioral health services as part of their Medicaid program. Since moving in this direction, a number of other states are looking to do something similar.
During this past year, the merger took a lot of hard work. There was a lot of significant work that went into drafting the legislation, educating policy-makers and communicating with stakeholders.

New Integrated RBHAs were implemented in 14 counties in Arizona on October 1st. This implementation creates an integrated plan structure statewide now for over 36,000 individuals with serious mental illness. On that same date, the general mental health and substance abuse behavioral health services for 80,000 dual eligible were transitioned to integrated contractors (AHCCCS acute plans) so that for many of these members all Medicare and Medicaid services are now provided by the same plan. Finally on October 1st we transitioned to a single statewide vendor that conducts all of the SMI determinations.

Systems – DBF and many other divisions worked to stand up a new accounting and procurement system on July 1st. This replaced the State's 20+ year old accounting system. After a couple of delays by the federal government, ICD-10 was finally implemented. We transitioned all of the Medicaid determinations and DES offices from the DES legacy system into HEAplus, which has processed over 4 million applications since going live in late 2013. We also processed over 300,000 renewals automatically based on electronic data that was available significantly streamlining the redetermination process. This past year we also had to program and distribute new 1095 forms to AHCCCS members.

Other Projects – In 2015 AHCCCS accomplished a number of other important projects. We transitioned to a new PBM for the fee-for-service program. We continued to make tremendous success in working with our contracted health plans on moving towards more value based purchasing for Medicaid services. We sent CMS over 30 pages of comments and concerns on proposed managed care regulations and worked closely with the National Association of Medicaid Directors on their 55 page letter that identified 109 recommendations. We promulgated new CRS rules.

We were able to work with the Governor's Office to avoid having to institute a 5% across the board reductions of provider rates after receiving over 140 comments from stakeholders expressing concerns. We completed work on a couple of Lean projects to improve operations in DMS and OIG and have started to see visual management boards spring up in various parts of the organization. We implemented new payment requirements of the plans to FQHCs to better reflect the total cost of care. We worked with a number of stakeholders to improve care coordination efforts for American Indians. We partnered with a number of individuals and organizations to develop recommendations on how to improve the delivery system for individuals with autism. We drafted recommendations for the legislature to consider on how to potentially improve services for children in foster care.

AHCCCS also continually undergoes a number of audits and review by federal partners. The Payment Error Rate Measurement (PERM) program reviews all states over the course of a three-year period. CMS and their third party vendors just completed their

work for Arizona and FFY 2014. The national average for the 17 states in this cycle was 9.8%. Arizona came in with an error rate of 1.23%.

Finally, because of all the great work by AHCCCS staff we had a number of different opportunities over this past year to educate, inform and highlight the AHCCCS success story to a wide range of healthcare policy audiences. Over this past year, the AHCCCS director had the opportunity to present to over 4,000 different individuals outside the State of Arizona and thousands more people in our State. Groups like congressional staff, the National Association of State Budget Officers, The National Academy for State Health Policy, Medicaid Evidence Based Decision Project, The National Association of Medicaid Directors, the National Association of Latino Elected Officials, The National Council for Behavioral Health, MediCal Medicaid Leadership Academy, Medicaid Health Plans of America, Texas Waiver Summit and the Congressional Panel of Healthcare Policy Advisors all heard about the great work going on in Arizona.

State Contact(s):

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Date Submitted to CMS:

March 1, 2016

Quality Assurance/Monitoring Activity:

Acute-care Performance Measures

In 2012, AHCCCS initiated a process to transition its performance measure sets to measures included in the Centers for Medicare and Medicaid Services (CMS) Core Measure Sets. AHCCCS incorporated the measures across lines of business in an effort to ensure comparability of access to care and outcomes measures for all populations. These decisions resulted in challenges in developing and implementing some of the measure methodologies. In late 2015, AHCCCS made the decision to further streamline and transition the performance measures to align more closely with the measures and populations found in the CMS Core measure sets. The transition will provide a better opportunity to shift the system towards indicators of health care outcomes, access to care, and patient satisfaction. This transition will also result in the ability to compare AHCCCS' rates with those of other states as the measure sets are implemented.

AHCCCS has updated the performance measure sets for all lines of business. The new measures and related Minimum Performance Standards/Goals became effective during CYE 2014. The AHCCCS decision to transition to a new measure set was partially driven by a desire to align with measures sets such as the CHIPRA Core Measure Set, the Adult Core Measure Set, Meaningful Use, and others measure sets being implemented by CMS. AHCCCS has also updated the measure sets in Contractor contracts to reflect changes on measures implemented by CMS for the next contract year.

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 risks. One risk that was identified was the possibility that the information system and data analytic staff resources were reduced which would not allow the level of review and validation of performance measure programming necessary to ensure the validity and accuracy of Performance Measures. To address this concern, the Agency is utilizing its External Quality Review Organization to perform the measurement calculations going forward.

Contractors have been provided utilization or encounter data to enhance their planning and implementation efforts related to the new performance measures as well as to support their ability to sustain/improve continuing measures. Some of these efforts will include new work groups, new reporting mechanisms, increased opportunities for technical assistance, and a more transparent reporting process with Contractors for proactive reporting prior to the end of the measurement period. This will allow Contractors to make necessary adjustments/final pushes and to develop payment reform initiatives that align with performance measure thresholds.

Data will be provided for the CYE 2014 reporting period as it becomes available from the External Quality Review Organization within quarterly reports or as part of the CYE 2016 Annual Report.

AHCCCS Medicaid and KidsCare rates for EPSDT Participation and EPSDT Dental Participation, for CYE 2014, are included. This data is reflective of the information reported to CMS on the annual 416 Report. Please note that while KidsCare is not formally reported to CMS via the 416; AHCCCS monitors this population using the same methodology as the 416 for comparability purposes.

Acute-Care Measure	(%)						
	Current Rate: Measurement period CYE 2013	Measurement period CYE 2012	Measurement period CYE 2011	Measurement period CYE 2010	2014 Medicaid national mean[1]	Minimum Performance Standard	AHCCCS Goal
Medicaid Rates- Children							
Children's and Adolescents' Access to PCPs, 12 – 24 Months, *Medicaid*	97.4	97.0	96.8	87.0	95.5	93	97
Children's and Adolescents' Access to PCPs, 25 Months – 6 Years, *Medicaid*	89.2	87.7	86.9	84.1	87.8	84	90
Children's and Adolescents' Access to PCPs, 7 – 11 Years, *Medicaid*	91.4	89.9	89.3	83.5	91.0	83	90
Children's and Adolescents' Access to PCPs, 12 – 19 Years, *Medicaid*	89.4	87.7	87.2	83.9	89.3	82	90
Well-child Visits in the First 15 Months of Life, *Medicaid*	67.9	67.8	70.0	64.1	58.9	65	90
Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life, *Medicaid*	65.5	66.8	64.5	67.7	71.9	66	80
Adolescent Well-care Visits, *Medicaid*	39.7	38.0	35.2	42.1	50.0	41	50
Annual Dental Visits, Medicaid	59.2	61.8	62.9	64.7	n/a	60	75
Timeliness of Prenatal Care	57.9	n/a	80.2	78.1	82.4	80	90
Postpartum Care	22.8	n/a	n/a	n/a	61.8	64	90
Appropriate Medications for Asthma	79.6	n/a	94.8	96.3	n/a	86	93
Diabetes Care: HbA1c Testing	71.2	n/a	69.9	66.7	86.3	77	89
Diabetes Care: LDL-C Screening	65.7	n/a	65.1	63.6	n/a	70	91
Diabetes Care: Eye Exams	42.2	n/a	29.3	30.5	54.4	49	68
Ambulatory Care: ED Visits, Total	57	n/a	n/a	n/a	n/a	TBD	TBD
Inpatient Utilization: Total Discharges per 1,000 MM	11	n/a	n/a	n/a	n/a	TBD	TBD
Inpatient Utilization: Total, Average Length of Stay	3.1						
All-Cause Readmission: Total	11.7	n/a	n/a	n/a	n/a	TBD	TBD
Diabetes Short-Term Complications Admissions	244.4	n/a	n/a	n/a	n/a	TBD	TBD
COPD or Asthma in Older Adults Admissions	1152.9	n/a	n/a	n/a	n/a	TBD	TBD
Heart Failure Admissions	278.4	n/a	n/a	n/a	n/a	TBD	TBD
Asthma in Younger Adults Admissions	119.5	n/a	n/a	n/a	n/a	TBD	TBD

[1]These national means are based on calendar year 2014 data published by NCQA in it's the *State of Health Care Quality 2015*.
N/A – A rate was not measured for the specific reporting period.

Acute-Care Measure	(%)						
	Current Rate: Measurement period CYE 2014	Measurement period CYE 2013	Measurement period CYE 2012	Measurement period CYE 2011	2014 Medicaid national mean	Minimum Performance Standard	AHCCCS Goal
Medicaid Rates- Children							
EPSDT Participation, *Medicaid*	54	60.6	65.7	63.6	n/a	68	80
EPSDT Dental Participation, *Medicaid*	44.6	45.5	44.1	n/a	n/a	46	54
KidsCare- Children							
EPSDT Participation, *Medicaid*	57	60.6	65.7	63.6	n/a	68	80
EPSDT Dental Participation, *Medicaid*	21.8	39.8	59.1	n/a	n/a	46	54

N/A – A rate was not measured for the specific reporting period.

AHCCCS has long been a leader in developing, implementing and holding Contractors accountable to performance measure goals. AHCCCS developed and implemented HEDIS-*like* measures, before HEDIS existed. AHCCCS' consistency in performance expectations has resulted in many performance measures performing at a rate close to the NCQA HEDIS national Medicaid mean. For AHCCCS, the HEDIS-*like* measures have been a reasonable indicator of health care accessibility, availability and quality. AHCCCS has transitioned to measures found in the CMS Core measure sets that provide a better opportunity to shift the system towards indicators of health care outcomes, access to care, and patient satisfaction. This transition has also resulted 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 supports 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 continues to develop opportunities to work with its providers and in some cases directly with providers to utilize the electronic health record capabilities for quality improvement opportunities.

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

The performance measures provide a standardized way to evaluate Contractor performance in quality management over time. Many of the above measures are quality indicators identified in the AHCCCS 1115 Waiver Evaluation Plan for the Acute-care Program.

ALTCS Performance Measures

During CYE 2015, AHCCCS reviewed data from CYE 2014 on two EPSDT-related rates: EPSDT Participation and EPSDT Dental Participation. The EPSDT Participation rate for ALTCS E/PD Contractors is relatively low; however, the rate is likely underreported because physically disabled members qualify for AHCCCS based on functional status rather than income alone and may be covered by another payer; thus encounters for well-child services may have been covered by another insurer.

ALTCS E/PD Measure	(%)						
	Current Rate Measurement period CYE 2014	Measurement period CYE 2013	Measurement period CYE 2012	Measurement period CYE 2011	2013 Medicaid national mean	Minimum Performance Standard	AHCCCS Goal
EPSDT Participation	38	42.4	32.3	41.1	n/a	68	80
EPSDT Dental Participation	33.4	40.4	44.1	n/a	n/a	46	56

AHCCCS requires corrective action plans (CAPs) according to contract requirements, and will require new or revised CAPs based on the current measurement. Contractors also will be required to evaluate existing interventions to improve performance.

ALTCS DDD Measures	(%)						
	Measurement period CYE 2013	Measurement period CYE 2012	Measurement period CYE 2011	Measurement period CYE 2010	Most recent Medicaid national mean[1]	Minimum Performance Standard	AHCCCS Goal
Children's and Adolescents' Access to PCPs, 12 – 24 Months	98.6	93.7	94.3	91.4	96.0	93	97
Children's and Adolescents' Access to PCPs, 25 Months – 6 Years	88.1	86.3	86.0	87.0	88.3	84	97
Children's and Adolescents' Access to PCPs, 7 – 11 Years	89.5	87.9	84.4	83.1	89.9	83	97
Children's and Adolescents' Access to PCPs, 12 – 19 Years	85.9	85.2	82.9	82.3	88.4	82	97
Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life	48.8	51.5	50.1	52.2	72.0	66	80
Adolescent Well-care Visits	35.1	35.4	37.5	38.5	49.7	41	50
Annual Dental Visit	49.38	n/a	n/a	n/a	n/a	60	75
Diabetes Care: HbA1c Testing	61.3	n/a	n/a	n/a	86.3	77	89
Diabetes Care: LDL-C Screening	57.7	n/a	n/a	n/a	n/a	70	91

Diabetes Care: Eye Exams	36.3	n/a	n/a	n/a	54.4	49	68
Ambulatory Care: ED Visits	43	n/a	n/a	n/a		TBD	TBD
Inpatient Utilization: Total Discharges per 1,000 MM	9.3	n/a	n/a	n/a	n/a	TBD	TBD
Inpatient Utilization: Total, Average Length of Stay	5.6	n/a	n/a	n/a	n/a	TBD	TBD
All-Cause Readmission: Total	10.1	n/a	n/a	n/a	n/a	TBD	TBD
Diabetes Short-Term Complications Admissions	67.1	n/a	n/a	n/a	n/a	TBD	TBD
COPD or Asthma in Older Adults Admissions	281.6	n/a	n/a	n/a	n/a	TBD	TBD
Heart Failure Admissions	75.5	n/a	n/a	n/a	n/a	TBD	TBD
Asthma in Younger Adults	74.9	n/a	n/a	n/a	n/a	TBD	TBD
ALTCS DDD Measures, con'.t	**(%)**						
	Current Rate Measurement period CYE 2014	**Measurement period CYE 2013**	**Measurement period CYE 2012**	**Measurement period CYE 2011**	**Most recent Medicaid national mean**	**Minimum Performance Standard**	**AHCCCS Goal**
EPSDT Participation	37	45	48.1	50.4	n/a	68	80
EPSDT Dental Participation	43.5	40.8	37.0	n/a	n/a	46	54

[1]These national means are based on calendar year 2014 data published by NCQA in it's the *State of Health Care Quality 2015*.
N/A – A rate was not measured for the specific reporting period.

AHCCCS requires the Contractor to submit Corrective Action Plans for measures that do not meet the MPS. These measures will be evaluated for CAP submission once data becomes available.

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

Performance Improvement Projects
One Performance Improvement Project (PIPs) involving all AHCCCS Contractors was active in CYE 2015.

- Electronic Prescribing – The purpose of this Performance Improvement Project is to increase the number of prescribers electronically prescribing prescriptions and to increase the percentage of prescriptions which are submitted electronically in order to improve patient safety. This PIP included the following AHCCCS lines of business; Acute, Long Term Care and KidsCare.

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

Acute	52.8	42.4
KidsCare	51.7	49.7
ALTCS	43.8	23.7
CMDP	47.3	46.7
CRS	50.5	43.0

Waiver Evaluation Progress

In preparation for the upcoming 115 Wavier Evaluation, regular meetings have been held since March 2015 with all parties responsible for data collection to ensure that there are no gaps in the evaluation process. These meetings also ensure that all baseline data is collected, that independent evaluation components are moving as they should and that the detailed evaluation plan will be submitted timely to CMS as the end of March 2016. An external vendor has been obtained to collect data specific to the SMI and CRS integrated plans. Several in-person and telephonic meetings have been held with the vendor since the fall of 2015 to ensure all requirements of the evaluation are met and detailed data, with respect to HIPPA requirements, are provided to the vendor for validation and reporting.

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended December 31, 2015

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

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

	FFY 2012 PM/PM	Trend Rate	DY 01 PM/PM	Effective FMAP	Federal Share PM/PM	Member Months 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	2,932,677	2,920,373	2,914,243	2,939,001	11,706,294	$ 4,785,134,687	
SSI	835.29	1.06	885.41	69.10%	611.78	487,460	488,874	488,885	491,507	1,956,726	1,197,081,736	
AC [1]			562.51	69.73%	392.26	527,244	430,723	365,132	310,396	1,633,495	640,752,606	
ALTCS-DD	4643.75	1.06	4922.38	67.38%	3316.47	72,531	73,167	73,977	74,832	294,507	976,723,169	
ALTCS-EPD	4503.21	1.052	4737.37	67.50%	3197.93	85,448	85,494	85,718	86,500	343,160	1,097,401,224	
Family Plan Ext [1]		1.058	17.04	90.00%	15.33	12,471	12,424	12,440	12,689	50,024	767,009	
											$ 8,697,860,431	MAP Subtotal
											103,890,985	Add DSH Allotment
											$ 8,801,751,416	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	68.84%	423.87	2,911,670	2,891,438	2,903,324	2,919,303	11,625,735	$ 4,927,807,178	
SSI	938.53	67.86%	636.87	494,556	496,908	499,435	502,851	1,993,750	1,269,757,263	
AC [1]	602.08	68.73%	413.80	274,990	248,817	228,204	217,114	969,125	401,023,223	
ALTCS-DD	5217.72	65.83%	3434.68	75,651	76,480	77,296	78,050	307,477	1,056,085,566	
ALTCS-EPD	4983.71	66.02%	3290.02	86,817	86,061	86,288	87,118	346,284	1,139,282,213	
Family Plan Ext [1]	18.42	90.00%	16.58	13,104	13,824	14,187	14,856	55,971	927,946	
									$ 8,794,883,390	MAP Subtotal
									106,384,369	Add DSH Allotment
									$ 8,901,267,759	Total BN Limit

	DY 03 PM/PM			Member Months QE 12/13	QE 3/14	QE 6/14	QE 9/14	Total		
AFDC/SOBRA	647.73	70.57%	457.12	2,892,273	2,840,075	2,956,533	3,114,659	11,803,540	$ 5,395,611,891	
SSI	994.84	69.28%	689.21	506,083	513,181	521,556	527,247	2,068,067	1,425,335,817	
AC [1]	594.75	69.89%	415.68	206,419	87	2	-	206,508	85,842,259	
ALTCS-DD	5530.78	67.35%	3725.21	78,858	79,698	80,687	81,776	321,019	1,195,864,302	
ALTCS-EPD	5242.86	67.53%	3540.52	87,660	87,878	88,719	89,338	353,595	1,251,911,859	
Family Plan Ext [1]	13.39	90.00%	12.05	14,885	-	-	-	14,885	179,426.00	
Expansion State Adults [1]	643.88	85.31%	549.32	-	444,633	625,378	757,354	1,827,365	1,003,800,983	
									$ 10,358,546,536	MAP Subtotal
									107,980,135	Add DSH Allotment
									$ 10,466,526,671	Total BN Limit

	DY 04 PM/PM			Member Months QE 12/14	QE 3/15	QE 6/15	QE 9/15	Total		
AFDC/SOBRA	681.41	71.36%	486.27	3,147,233	3,086,553	3,107,945	3,214,254	12,555,985	$ 6,105,555,994	
SSI	1054.53	70.21%	740.34	534,222	540,300	540,273	538,605	2,153,400	1,594,254,838	
AC	0.00	68.42%	0.00	-	-	-	-	-	-	
ALTCS-DD	5862.63	68.54%	4018.50	82,741	83,845	84,851	85,602	337,039	1,354,391,898	
ALTCS-EPD	5515.49	68.68%	3787.86	89,987	89,853	89,887	89,780	359,507	1,361,761,116	
Family Plan Ext	0.00	90.00%	0.00	-	-	-	-	-	-	
Expansion State Adults	584.01	87.65%	511.86	819,231	837,533	848,185.00	869,729.00	3,374,678	1,727,372,147	
									$ 12,143,335,993	MAP Subtotal
									109,707,817	Add DSH Allotment
									$ 12,253,043,810	Total BN Limit

	DY 05 PM/PM			Member Months QE 12/15	QE 3/16	QE 6/16	QE 9/16	Total		
AFDC/SOBRA	716.85	70.44%	504.94	3,265,454				3,265,454	$ 1,648,857,837	
SSI	1117.81	69.97%	782.18	540,039				540,039	422,407,634	
AC	0.00	177.32%	0.00	-				-	-	
ALTCS-DD	6214.39	68.94%	4284.10	86,070				86,070	368,732,551	
ALTCS-EPD	5802.30	68.96%	4001.24	88,337				88,337	353,457,669	
Family Plan Ext	0.00	90.00%	0.00	-				-	-	
Expansion State Adults	510.77	88.02%	449.58	919,394				919,394	413,343,146	
									$ 3,206,798,836	MAP Subtotal
									110,036,940	Add DSH Allotment
									$ 3,316,835,776	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 12/31/2015

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended December 31, 2015

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

	Budget Neutrality Limit - Federal Share			Expenditures from CMS-64 - Federal Share												
WAIVER PERIOD OCTOBER 1, 2011 THROUGH SEPTEMBER 30, 2016:	MAP	DSH	Total	AFDC/SOBRA	SSI	AC	ALTCS-DD	ALTCS-EPD	Family Plan	DSH/CAHP	SNCP/DSHP	UNC CARE	MED	Exp St Adults	Total	VARIANCE
QE 12/11	$ 2,217,806,475	$ 103,890,985	$ 2,321,697,460	$ 502,890,921	$ 191,249,757	$ 175,610,617	$ 151,638,753	$ 164,685,415	$ 167,197	$ -	$ -	$ -	$ 458,635	$ -	$ 1,186,701,295	$ 1,134,996,165
QE 3/12	2,178,036,530	-	2,178,036,530	577,297,998	217,984,093	165,596,401	156,526,315	176,620,644	179,167	572,050	-	-	(4,080)	-	1,294,772,588	883,263,942
QE 6/12	2,153,211,805	-	2,153,211,805	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	717,940,005
QE 9/12	2,148,805,622	-	2,148,805,622	579,782,505	222,428,252	118,032,081	205,664,611	175,615,524	201,702	6,248,670	14,312,682	18,367,266	294	-	1,340,653,587	808,152,035
QE 12/12	2,208,613,501	106,384,369	2,314,997,870	617,247,020	242,322,491	118,103,369	159,452,070	179,452,256	230,267	11,346,623	95,263,307	14,871,980	-	-	1,438,289,383	876,708,487
QE 3/13	2,191,077,329	-	2,191,077,329	589,464,629	239,092,492	96,180,297	163,937,798	192,970,394	257,756	867,795	32,840,000	28,744,095	-	-	1,344,355,256	846,722,073
QE 6/13	2,192,750,731	-	2,192,750,731	588,378,705	241,298,377	88,125,077	102,142,130	187,310,029	227,668	78,756,901	111,555,510	17,514,148	-	-	1,415,308,545	777,442,186
QE 9/13	2,202,441,829	-	2,202,441,829	596,611,333	237,327,560	84,327,037	230,955,206	190,188,088	228,524	558,280	144,169,561	35,937,456	-	-	1,520,303,045	682,138,784
QE 12/13	2,361,018,627	107,980,135	2,468,998,762	623,051,060	253,112,363	84,773,209	180,587,089	208,608,187	221,957	6,098,257	128,610,551	20,561,018	-	-	1,505,623,691	963,375,071
QE 3/14	2,504,246,547	-	2,504,246,547	609,066,404	242,247,737	19,448,214	172,865,678	191,271,321	(15,809)	3,076,720	-	14,814,313	-	231,876,797	1,484,651,375	1,019,595,172
QE 6/14	2,669,166,375	-	2,669,166,375	584,523,581	274,963,993	(3,697,277)	132,811,366	206,922,285	(9,314)	4,725,871	46,518,282	17,460,925	-	343,805,363	1,608,025,075	1,061,141,300
QE 9/14	2,824,114,987	-	2,824,114,987	642,058,425	286,491,486	1,044,222	234,971,144	202,325,318	735	83,398,590	14,595,643	716,900	-	398,971,566	1,864,574,029	959,540,958
QE 12/14	3,018,588,470	-	3,018,588,470	768,767,395	322,908,117	24,114,620	197,157,685	209,877,907	254	9,813,379	78,963,846	3,397,109	-	411,351,488	2,026,351,800	992,236,670
QE 3/15	3,006,878,586	-	3,006,878,586	643,924,687	297,141,870	3,771,216	198,833,968	208,709,812	(475)	1,474,261	-	2,362,678	-	397,361,264	1,753,579,281	1,253,299,305
QE 6/15	3,026,884,574	-	3,026,884,574	676,953,007	301,501,985	1,376,095	136,222,624	210,766,873	(1,609)	111,644,096	32,871,414	4,867,076	-	434,840,685	1,911,042,246	1,115,842,328
QE 9/15	3,090,984,363	109,707,817	3,200,692,180	660,928,120	297,720,765	(1,214,417)	269,436,928	218,219,020	(26)	1,465,978	(14,698,940)	2,512,551	-	449,692,969	1,884,062,948	1,316,629,232
QE 12/15	3,206,798,836	110,036,940	3,316,835,776	745,437,161	343,103,540	21,576,137	214,617,413	214,987,023	-	9,941,072	-	-	-	473,302,437	2,022,964,783	1,293,870,993
QE 3/16		-	-												-	-
QE 6/16		-	-												-	-
QE 9/16		-	-												-	-
	$ 43,201,425,187	$ 538,000,246	$ 43,739,425,433	$ 10,588,105,072	$ 4,438,411,865	$ 1,143,053,285	$ 3,023,767,212	$ 3,317,550,362	$ 1,873,169	$ 409,553,093	$ 785,951,856	$ 186,608,284	$ 453,960	$ 3,141,202,569	$ 27,036,530,727	$ 16,702,894,706

Last Updated: 2/22/2016

Arizona Health Care Cost Containment System
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For the Period Ended December 31, 2015

III. SUMMARY BY DEMONSTRATION YEAR

	Federal Share of Budget Neutrality Limit	Federal Share of Waiver Costs on CMS-64	Annual Variance	As % of Annual Budget Neutrality Limit	Cumulative Federal Share of Budget Neutrality Limit	Cumulative Federal Share of Waiver Costs on CMS-64	Cumulative Federal Share Variance	As % of Cumulative Budget Neutrality Limit
WAIVER PERIOD OCTOBER 1, 2011 THROUGH SEPTEMBER 30, 2016								
DY 01	$ 8,801,751,416	$ 5,640,336,512	$ 3,161,414,904	35.92%				
DY 02	8,901,267,759	5,855,202,469	3,046,065,290	34.22%				
DY 03	10,466,526,671	6,475,699,284	3,990,827,388	38.13%				
DY 04	12,253,043,810	7,306,743,217	4,946,300,593	40.37%				
DY 05	3,316,835,776	1,758,549,245	1,558,286,531	46.98%	$ 43,739,425,433	$ 27,036,530,727	$ 16,702,894,706	38.19%
	$ 43,739,425,433	$ 27,036,530,727	$ 16,702,894,706					

Arizona Health Care Cost Containment System
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IV. Schedule C as Adjusted for Manual Entries and Waiver PMPM Groupings

Schedule C Waiver 11-W00275/9

Total Computable

Waiver Name	01	02	03	04	05	Total
AC	918,542,684	583,275,788	122,732,703	23,157,122	(314)	1,647,707,983
AFDC/SOBRA	3,419,432,563	3,595,115,221	3,538,203,719	3,588,049,243	947,247,510	15,088,048,256
ALTCS-EPD	1,062,226,028	1,167,166,800	1,185,733,410	1,221,547,390	276,019,218	4,912,692,846
ALTCS-DD	939,087,470	1,005,689,202	1,067,647,940	1,170,035,215	301,626,170	4,484,085,997
DSH/CAHP	155,762,651	163,516,194	131,160,726	154,152,100	5,245,950	609,837,621
Expansion State Adults	-	-	1,176,371,988	1,967,813,979	468,027,541	3,612,213,508
Family Planning Extension	830,631	1,008,110	195,976	(1,337)	-	2,033,380
MED	673,818	-	-	-	-	673,818
SNCP/DSHP	296,636,120	564,951,230	240,250,917	78,491,216	-	1,180,329,483
SSI	1,350,731,018	1,429,956,135	1,538,673,303	1,697,327,347	396,016,024	6,412,703,827
Uncomp Care IHS/638	22,866,717	97,192,513	53,595,408	13,168,904	-	186,823,542
Subtotal	8,166,789,700	8,607,871,193	9,054,566,090	9,913,741,179	2,394,182,099	38,137,150,261
New Adult Group	-	-	108,284,627	301,292,299	100,050,945	509,627,871
Total	8,166,789,700	8,607,871,193	9,162,850,717	10,215,033,478	2,494,233,044	38,646,778,132

Federal Share

Waiver Name	01	02	03	04	05	Total
AC	640,541,572	400,884,799	85,783,268	15,843,929	(283)	1,143,053,285
AFDC/SOBRA	2,388,196,327	2,474,987,233	2,497,020,410	2,560,631,256	667,269,846	10,588,105,072
ALTCS-EPD	717,048,773	770,511,374	800,730,170	838,918,276	190,341,769	3,317,550,362
ALTCS-DD	632,713,670	662,017,847	719,105,820	801,993,467	207,936,408	3,023,767,212
DSH/CAHP	104,828,265	107,397,436	88,179,356	105,532,527	3,615,509	409,553,093
Expansion State Adults	-	-	1,003,650,900	1,725,288,400	412,263,269	3,141,202,569
Family Planning Extension	767,009	927,946	179,426	(1,212)	-	1,873,169
MED	453,960	-	-	-	-	453,960
SNCP/DSHP	199,636,108	371,059,969	161,520,692	53,735,087	-	785,951,856
SSI	933,302,793	970,348,186	1,065,976,086	1,191,662,073	277,122,727	4,438,411,865
Uncomp Care IHS/638	22,848,035	97,067,679	53,553,156	13,139,414	-	186,608,284
Subtotal	5,640,336,512	5,855,202,469	6,475,699,284	7,306,743,217	1,758,549,245	27,036,530,727
New Adult Group	-	-	108,284,627	301,292,299	100,050,945	509,627,871
Total	5,640,336,512	5,855,202,469	6,583,983,911	7,608,035,516	1,858,600,190	27,546,158,598

Adjustments to Schedule C Waiver 11-W00275/9

Total Computable

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

Federal Share

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

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

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

Arizona Health Care Cost Containment System
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Budget Neutrality Tracking Report
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IV. Schedule C as Adjusted for Manual Entries and Waiver PMPM Groupings

Revised Schedule C Waiver 11-W00275/9

Total Computable

Waiver Name	01	02	03	04	05	Total
AC	918,856,256	583,486,544	122,820,448	23,157,115	(61)	1,648,320,302
AFDC/SOBRA	3,420,447,444	3,596,205,364	3,539,194,012	3,593,105,635	949,754,931	15,098,707,386
ALTCS-EPD	1,062,226,028	1,167,166,800	1,185,733,410	1,221,547,390	276,019,218	4,912,692,846
ALTCS-DD	939,087,470	1,005,689,202	1,067,647,940	1,170,035,215	301,626,170	4,484,085,997
DSH/CAHP	154,069,040	161,816,194	129,460,726	143,660,200	-	589,006,160
Expansion State Adults	-	-	1,176,595,227	1,970,857,723	469,594,397	3,617,047,347
Family Planning Extension	830,631	1,008,110	195,976	(1,337)	-	2,033,380
MED	673,818	-	-	-	-	673,818
SNCP/DSHP	296,636,120	564,951,230	240,250,917	78,491,216	-	1,180,329,483
SSI	1,351,096,176	1,430,355,236	1,539,072,026	1,699,719,118	397,187,445	6,417,430,001
Uncomp Care IHS/638	22,866,717	97,192,513	53,595,408	13,168,904	-	186,823,542
Subtotal	8,166,789,700	8,607,871,193	9,054,566,090	9,913,741,179	2,394,182,099	38,137,150,261
New Adult Group	-	-	108,284,627	301,292,299	100,050,945	509,627,871
Total	8,166,789,700	8,607,871,193	9,162,850,717	10,215,033,478	2,494,233,044	38,646,778,132

Federal Share

Waiver Name	01	02	03	04	05	Total
AC	640,752,606	401,023,223	85,842,259	15,843,924	(109)	1,143,461,903
AFDC/SOBRA	2,388,879,341	2,475,703,239	2,497,686,184	2,564,092,863	668,997,960	10,595,359,587
ALTCS-EPD	717,048,773	770,511,374	800,730,170	838,918,276	190,341,769	3,317,550,362
ALTCS-DD	632,713,670	662,017,847	719,105,820	801,993,467	207,936,408	3,023,767,212
DSH/CAHP	103,688,465	106,280,876	87,036,446	98,349,772	0	395,355,559
Expansion State Adults	-	-	1,003,800,983	1,727,372,147	413,343,146	3,144,516,276
Family Planning Extension	767,009	927,946	179,426	(1,212)	-	1,873,169
MED	453,960	-	-	-	-	453,960
SNCP/DSHP	199,636,108	371,059,969	161,520,692	53,735,087	-	785,951,856
SSI	933,548,545	970,610,316	1,066,244,148	1,193,299,479	277,930,071	4,441,632,559
Uncomp Care IHS/638	22,848,035	97,067,679	53,553,156	13,139,414	-	186,608,284
Subtotal	5,640,336,512	5,855,202,469	6,475,699,284	7,306,743,217	1,758,549,245	27,036,530,727
New Adult Group	-	-	108,284,627	301,292,299	100,050,945	509,627,871
Total	5,640,336,512	5,855,202,469	6,583,983,911	7,608,035,516	1,858,600,190	27,546,158,598

Calculation of Effective FMAP:

AFDC/SOBRA					
Federal	2,388,879,341	2,475,703,239	2,497,686,184	2,564,092,863	668,997,960
Total	3,420,447,444	3,596,205,364	3,539,194,012	3,593,105,635	949,754,931
Effective FMAP	0.698411357	0.688420985	0.705721748	0.713614662	0.704390089
SSI					
Federal	933,548,545	970,610,316	1,066,244,148	1,193,299,479	277,930,071
Total	1,351,096,176	1,430,355,236	1,539,072,026	1,699,719,118	397,187,445
Effective FMAP	0.690956396	0.678579902	0.692783788	0.702056867	0.699745357
ALTCS-EPD					
Federal	717,048,773	770,511,374	800,730,170	838,918,276	190,341,769
Total	1,062,226,028	1,167,166,800	1,185,733,410	1,221,547,390	276,019,218
Effective FMAP	0.675043497	0.660155321	0.675303709	0.686766869	0.689596074
ALTCS-DD					
Federal	632,713,670	662,017,847	719,105,820	801,993,467	207,936,408
Total	939,087,470	1,005,689,202	1,067,647,940	1,170,035,215	301,626,170
Effective FMAP	0.673753713	0.6582728	0.673542085	0.685443871	0.689384505
AC					
Federal	640,752,606	401,023,223	85,842,259	15,843,924	(109)
Total	918,856,256	583,486,544	122,820,448	23,157,115	(61)
Effective FMAP	0.697337153	0.687287868	0.698924816	0.684192483	1.773237832
Expansion State Adults					
Federal	-	-	1,003,800,983	1,727,372,147	413,343,146
Total	-	-	1,176,595,227	1,970,857,723	469,594,397
Effective FMAP			0.853140451	0.876457051	0.880213113
New Adult Group					
Federal	-	-	108,284,627	301,292,299	100,050,945
Total	-	-	108,284,627	301,292,299	100,050,945
Effective FMAP			1	1	1

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

Budget Neutrality Member Months:	AFDC/SOBRA	SSI	ALTCS-DD	ALTCS-EPD	AC	MED	Family Plan Ext	Expan St Adults	New Adult Group
Quarter Ended December 31, 2011	2,932,677	487,460	72,531	85,448	527,244	467	12,471		
Quarter Ended March 31, 2012	2,920,373	488,874	73,167	85,494	430,723	-	12,424		
Quarter Ended June 30, 2012	2,914,243	488,885	73,977	85,718	365,132	-	12,440		
Quarter Ended September 30, 2012	2,939,001	491,507	74,832	86,500	310,396	-	12,689		
Quarter Ended December 31, 2012	2,911,670	494,556	75,651	86,817	274,990	-	13,104		
Quarter Ended March 31, 2013	2,891,438	496,908	76,480	86,061	248,817	-	13,824		
Quarter Ended June 30, 2013	2,903,324	499,435	77,296	86,288	228,204	-	14,187		
Quarter Ended September 30, 2013	2,919,303	502,851	78,050	87,118	217,114	-	14,856		
Quarter Ended December 31, 2013	2,892,273	506,083	78,858	87,660	206,419	-	14,885		
Quarter Ended March 31, 2014	2,840,075	513,181	79,698	87,878	87	-	-	444,633	39,044
Quarter Ended June 30, 2014	2,956,533	521,556	80,687	88,719	2	-	-	625,378	86,649
Quarter Ended September 30, 2014	3,114,659	527,247	81,776	89,338	-	-	-	757,354	123,035
Quarter Ended December 31, 2014	3,147,233	534,222	82,741	89,987	-	-	-	819,231	149,837
Quarter Ended March 31, 2015	3,086,553	540,300	83,845	89,853	-	-	-	837,533	191,269
Quarter Ended June 30, 2015	3,107,945	540,273	84,851	89,887	-	-	-	848,185	245,439
Quarter Ended September 30, 2015	3,214,254	538,605	85,602	89,780	-	-	-	869,729	285,075
Quarter Ended December 31, 2015	3,265,454	540,039	86,070	88,337	-	-	-	919,394	311,510
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**	**109,707,817**	**110,036,940**	**538,000,246**
Reported in QE						
Dec-11	-	-	-	-	-	-
Mar-12	-	-	-	-	-	-
Jun-12	78,996,800	-	-	-	-	78,996,800
Sep-12	6,248,670	-	-	-	-	6,248,670
Dec-12	11,346,623	-	-	-	-	11,346,623
Mar-13	309,515	-	-	-	-	309,515
Jun-13	1,022,914	77,733,987	-	-	-	78,756,901
Sep-13	-	-	-	-	-	-
Dec-13	-	6,098,257	-	-	-	6,098,257
Mar-14	2,505,265	-	-	-	-	2,505,265
Jun-14	-	4,725,871	-	-	-	4,725,871
Sep-14	3,258,682	-	79,568,453	-	-	82,827,135
Dec-14	-	-	6,222,002	-	-	6,222,002
Mar-15	-	1,474,261	-	-	-	1,474,261
Jun-15	-	16,248,501	(219,987)	92,024,206	-	108,052,719
Sep-15	-	-	1,465,978	-	-	1,465,978
Dec-15	(4)			6,325,567		6,325,563
Mar-16						
Jun-16						
Sep-16						
Total Reported to Date	103,688,465	106,280,876	87,036,446	98,349,773	-	395,355,560
Unused Allotment	**202,520**	**103,493**	**20,943,689**	**11,358,044**	**110,036,940**	**142,644,686**

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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	-	39,044	86,649	123,035	248,728	143,899,097

	Trend Rate	DY 04 PM/PM			Member Months QE 12/14	QE 3/15	QE 6/15	QE 9/15	Total	
New Adult Group	1.047	605.73	100.00%	605.73	149,837	191,269.00	245,439.00	285,075.00	871,620	527,967,585

	Trend Rate	DY 05 PM/PM			Member Months QE 12/15	QE 3/16	QE 6/16	QE 9/16	Total	
New Adult Group	1.047	634.20	100.00%	634.20	311,510				311,510	197,559,877

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

	Budget Neutrality Limit - Federal Share MAP	DSH	Total	Expenditures New Adult Grp	VARIANCE
QE 12/13	$ -	$ -	$ -	$ -	$ -
QE 3/14	22,588,516	-	22,588,516	13,870,414	8,718,102
QE 6/14	50,129,912	-	50,129,912	34,313,342	15,816,570
QE 9/14	71,180,669	-	71,180,669	47,984,458	23,196,211
QE 12/14	90,760,973	-	90,760,973	46,004,135	44,756,838
QE 3/15	115,857,635	-	115,857,635	70,387,348	45,470,287
QE 6/15	148,670,104	-	148,670,104	85,319,153	63,350,951
QE 9/15	172,678,873	-	172,678,873	97,948,283	74,730,590
QE 12/15	197,559,877		197,559,877	113,800,738	83,759,139
QE 3/16					
QE 6/16					
QE 9/16					
	$ 869,426,560	$ -	$ 869,426,560	$ 509,627,871	$ 359,798,689

III. SUMMARY BY DEMONSTRATION YEAR

	Federal Share of Budget Neutrality Limit	Federal Share of Waiver Costs on CMS-64	Annual Variance	As % of Annual Budget Neutrality Limit	Cumulative Federal Share of Budget Neutrality Limit	Cumulative Federal Share of Waiver Costs on CMS-64	Cumulative Federal Share Variance	As % of Cumulative Budget Neutrality Limit
DY 03	$ 143,899,097	$ 96,168,214	$ 47,730,883	33.17%				
DY 04	527,967,585	299,658,919	228,308,666	43.24%				
DY 05	197,559,877	113,800,738	83,759,139	42.40%	$ 869,426,560	$ 509,627,871	$ 359,798,689	41.38%
	$ 869,426,560	$ 509,627,871	$ 359,798,689					

Based on CMS-64 certification date of 12/31/2015