AHCCCS Annual Report
Federal Fiscal Year 2016
October 1, 2015 - September 30, 2016

TITLE

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

Section 1115 Quarterly Report
Demonstration Year: 34

INTRODUCTION

As written in Special Terms and Conditions, paragraph 41, 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 2016

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 2016, CMS approved Arizona's request to extend its Medicaid demonstration, entitled "Arizona Health Care Cost Containment System (AHCCCS)". On September 30, 2016, CMS approved the new Waiver for a 5-year period from October 1, 2016 to September 30, 2021. The Waiver allows AHCCCS to continue many of the existing waiver authorities to maintain current efficiencies and flexibilities and includes new authorities designed to modernize Medicaid.

New Authorities:

Arizona received CMS approval to implement the AHCCCS CARE program—Choice Accountability Responsibility Engagement (CARE). AHCCCS CARE is designed to engage the adult members with incomes over 100% of the Federal Poverty Level (FPL) to improve health literacy and prepare for a transition into private health coverage. Under this initiative, the state may require that members pay monthly contributions in amounts not more than two percent of household income and utilization-based copayment-like charges on a limited set of services, subject to Medicaid's aggregate cap of five percent of household income.

Arizona also received approval through the passage of SB 1507 (discussed below) to add a new $1000 per year/per member dental benefit for ALTCS members.

Extension of Previous Authorities:

Specifically, the Waiver permits Arizona to continue to administer:

- Mandatory managed care delivery system for mandatory and optional Medicaid state plan populations
- Home and community based services for people in the long term care program (ALTCS)
- Administrative simplifications that reduce the inefficiencies in eligibility
- Integrated health plans for persons with serious mental illness and children with special healthcare needs
- Safety Net Care Pool (SNCP) payments to Phoenix Children's Hospital through 2017

Technical Amendments:

CMS has also revised the special terms and conditions (STCs) and waiver and expenditure authorities to update certain requirements in accordance with CMS policy and to remove authorities that are obsolete or expired, including:

- The authorities that restrict individuals from disenrolling from managed care without cause have been time limited to align with new managed care regulations. Effective October 1, 2017, beneficiaries will be allowed 90 days to change managed care plans without cause.
- The waiver of retroactive eligibility under section 1902(a)(34) of the Act that expired on December 31, 2013 has been removed.
- Shift authority of the Disproportionate Share Hospital (DSH) Funding from the Waiver to the State Plan, effective October 1, 2018.
- Waiver was also updated to reflect the merger between the Arizona Department of Health Services Division of Behavioral Health Services and AHCCCS

Outstanding Issues:

Arizona continues to work with CMS on the American Indian Medical Home proposal coverage of traditional healing services.

ENROLLMENT INFORMATION

Table 1 contains a summary of the number of unduplicated enrollees for FFY 2016 (October 1, 2015-September 30, 2016), by population categories. The table also includes the number of voluntarily and involuntary disenrolled members during this period.

Population Groups	Number Enrollees to Date	Number Voluntarily Disenrolled-Current FFY Ending 9/30/16	Number Involuntarily Disenrolled-Current FFY Ending 9/30/16
Acute AFDC/SOBRA	1,578,041	9,388	1,020,480
Acute SSI	216,167	753	94,804
Prop 204 Restoration	698,696	2,903	322,297
Adult Expansion	190,877	886	132,993
LTC DD	30,897	135	8,014
LTC EPD	38,583	149	16,071
Non-Waiver	9,553	38	5,550
Total	**2,762,814**	**14,252**	**1,600,209**

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

State Reported Enrollment in the Demonstration (as requested)	Current Enrollees
Title XIX funded State Plan [1]	1,380,391
Title XXI funded State Plan [2]	5,911
Title XIX funded Expansion [3]	80,693
Title XXI funded Expansion [4]	0
DSH Funded Expansion	
Other Expansion	
Pharmacy Only	
Family Planning Only [5]	0
Enrollment Current as of	10/1/16

OUTREACH/INNOVATION ACTIVITIES

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

[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 4/1/16

OPERATIONAL/POLICY DEVELOPMENTS/ISSUES

Legislative Update

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

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

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

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

SB 1283 (controlled substances prescription monitoring program) requires a medical practitioner before prescribing an opioid analgesic or benzodiazepine controlled substance listed in schedule II, III or IV for a patient to obtain a patient utilization report regarding the patient for the preceding twelve months from the program's central database tracking system at the beginning of each new course of treatment, and reference the database at least quarterly while that prescription remains a part of the treatment. Exceptions to the requirements of the bill include a patient

receiving hospice care or palliative care for a serious or chronic illness; a patient receiving care for cancer, a cancer-related illness or condition or dialysis treatment; a medical practitioner will administer the controlled substance; a patient is receiving the controlled substance during the course of inpatient or residential treatment in a hospital, nursing care facility, assisted living facility, correctional facility or mental health facility; a medical practitioner is prescribing the controlled substance to the patient for no more than a ten-day period for an invasive medical or dental procedure or a medical or dental procedure that results in acute pain to the patient; a medical practitioner is prescribing no more than a five-day prescription and has reviewed the program's central database tracking system for that patient within the last thirty days, and the system shows that no other prescriber has prescribed a controlled substance in the preceding thirty-day period; and medical practitioner that uses electronic medical records that integrate data from the controlled substances prescription monitoring program. SB 1283 was signed by the Governor on 5/12/16 and effectuated 8/6/16.

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

SB 1442 (mental health services; information disclosure) would modify the requirements for health care providers or entities to allow the disclosure of confidential health care records to relatives, close personal friends or any other person identified by the patient as otherwise authorized or required by state or federal law. SB 1442 was signed by the Governor on 5/17/16 and effectuated 8/6/16.

SB 1507 (ALTCS; dental services) would expand the list of services that are required to be provided by the Arizona Long-Term Care System (ALTCS) program contractors to ALTCS members to include dental services in an annual amount of not more than $1,000 per member. The legislation is consistent with the Governor's FY 2017 Budget Recommendation and is estimated to have a GF cost of $1.4 million for the Elderly and Physically Disabled (EPD) program, and $1.2 million for the Developmentally Disabled (DD) program. Although SB 1507 was not signed by the Governor, the ALTCS dental benefit was included as part of the overall budget, and eventually approved as part of the 1115 Waiver, effective 10/1/16.

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

State Plan Update

The following State Plan Amendments (SPA) were submitted to CMS during FFY 2016:

Title XIX				
SPA #	**Description**	**Filed**	**Approved**	**Eff. Date**
SPA 15-007	Updates DRG for the DCI and transition adjustment factors as of October 1, 2015.	10/7/15	11/3/15	10/1/15
SPA 15-008	Updates the State Plan to exempt out of state nursing facilities from receiving supplemental	12/15/15	3/7/16	10/1/15

	payments.			
SPA 15-009	Updates the State Plan to describe payments to long term acute care and rehabilitation hospitals.	12/29/15	3/16/16	10/1/15
SPA 15-010	Updates the State Plan to revise DRG.	12/29/15	3/18/16	10/1/15
SPA 16-001	Updates the State Plan to revise Hospice Rates.	3/31/16	9/7/16	3/31/16
SPA 16-002	Updates the State Plan to revise Air Ambulance Rates.	3/31/16	Pending	1/1/16
SPA 16-003	Updates the State Plan to expand the types of vaccines and immunizations administered by pharmacists for AHCCCS members consistent with ARS §32-1974.	5/12/16	7/13/16	7/1/16
SPA 16-004	Updates the State Plan to add services provided by a podiatrist as an Other Licensed Practitioner.	7/21/16	9/29/16	8/6/16
SPA 16-005	Updates the State Plan to revise the assessment amounts for Nursing Facility supplemental funding.	8/25/16	Pending	1/1/17
SPA 16-006	Updates the State Plan to add to describe community paramedicine, otherwise referred to as Treat and Refer.	8/26/16	10/24/16	10/1/16
SPA 16-007	Updates the State Plan to include Freestanding Hospital-based Emergency Departments as a reimbursable provider under outpatient hospital services.	8/30/16	Pending	1/1/17
SPA 16-008	Updates the State Plan to revise the effective date of rates to long term acute care and rehabilitation hospitals.	8/31/16	Pending	10/1/16
SPA 16-009	Updates GME funding for the service period July 1, 2016 through June 30, 2017 for programs with submitted IGAs.	9/30/16	Pending	9/30/16
Title XXI				
SPA #	**Description**	**Filed**	**Approved**	**Eff. Date**
SPA 16-017	Updates the State Plan to change the premium lock	5/27/16	7/22/16	7/26/16

	out period from 90 days to 2 months.			

COMBATING FRAUD

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

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

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

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

  - *Provider Registration Section* - The providers are affiliated with 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.

In State Fiscal Year (SFY) 2016, the total OIG savings and recoveries for all programs was $40,794,688. The OIG continued with projects, initiatives, cases, and joint efforts to proactively combat fraud, waste, and abuse within the AHCCCS program:

Provider Registration Section (PRS):

- 8,966 providers were added to the State Medicaid Program in FY 2016
- 68,090 total providers are active in AHCCCS
- The Provider Registration Call Center handled 40,097 telephone calls in FY 2016
- The Provider Registration Section processed 88,462 documents related to provider applications
- 199 site visits were completed

Provider Compliance Section (PCS):

- Ten pending cases from CMS regarding Excluded Providers
    - CMS estimated value $3,594,229.46. The investigation is verifying the loss to the program.
- The Non-Emergency Medical Transportation (NEMT) Project continues to be a proven success with one full time investigator dedicated to this endeavor. FY2016 has seen successful criminal prosecutions, asset forfeiture awards to the State, and civil remedies upheld in various Administrative Law Judges (ALJ) recommendations and the AHCCCS Director's Final Decisions. The statistical accomplishments for this program are as follows:

    - 37 New cases opened
    - 39 cases closed resulting in $5,905,741.40 in recoveries
    - $652,338.96 in forfeiture funds awarded to the state
    - Six successful criminal prosecutions with high media impact.

    - Additional pleas and sentencing pending Indictments:

        - Arizona One 2013-0595

    - Civil Remedies:

        - Mercy Trans Group, LLC; wherein a decision was upheld that AHCCCS was able to impose a CMP of $854,000.00 in penalties and $67,749.52 in assessments, and that it "…was reasonable and in accord with applicable law…"

        - Valley Care & Enrichment Services and Valley Care Medical Transportation; wherein a decision was upheld that AHCCCS appropriately followed the rules and provisions regarding suspension of payment for a Credible Allegation of Fraud for both of these providers

- Sunflower Transportation; wherein a decision was upheld that Sunflower was appropriately terminated from the network

- Home and Community Based Services is a high risk category of care that has several areas open to fraud, waste, and abuse. Case highlights in this area include, but are not limited to the following:

  - The PCS conducted a joint investigation with the AGO, Medicaid Fraud Control Unit (MFCU) of an individual who was not a contracted provider but conspired with family members to fraudulently bill Medicaid. The case merged two related cases, after the HCFA developed information indicating that the subject had knowledge of that his wife and her daughter were turning in false timesheets for the AHCCCS funded respite care of the daughter's son. Records revealed the subject received money from his wife, as well as he paid money to her. The subject was convicted of Facilitation to Commit Trafficking in Stolen Property and was sentenced to one year in prison. The wife and daughter both plead guilty for their roles in the fraudulent schemes.

  - The PCS investigated a subject who was qualified to receive AHCCCS benefits, including in-home caregiving services. However, the subject stole the identity of an actual caregiver and began billing AHCCCS, using the victim's identity, and claiming that the victim had provided personal home care to her. The subject created various documents using the subject's own address, using the victim's name, and forging the victim's signature. The subject was able to get the victim's "pay card" which was in subject's possession. The subject entered into a guilty plea to Amended Count 2: Theft (C6F). Stork was sentenced to three years' probation and was ordered to complete 200 hours of community restitution, and to pay court fees and assessments totaling $2,420.00, restitution to the AHCCCS in the amount of $6,732.00, and investigative costs to MFCU in the amount of $500.00.

  - The PCS investigated a subject who was an in-home paid caregiver for her elderly mother. The subject was employed by Instant Care, which had a contract with AHCCCS under which subject was paid to provide care for her mother. An investigation by Instant Care determined the subject continued to bill for services after her mother's death. When confronted by Instant Care the subject told the caller that her mother was still alive and in fact was sitting right next to her and invited the caller from Instant Care to come to her home to see for herself. The subject then provided the Instant Care employee the address to an empty lot. When the subject was interviewed she claimed that she did not know how the fraudulent claims were submitted and denied telling Instant Care that her mother was still alive when they had called her. The subject was convicted and sentenced to: One year of prison; placed on four years' supervised probation; ordered to pay $2,419.04 restitution to Instant Care of Arizona; and ordered to pay $1,000.00 investigative costs.

- Excluded Providers are prohibited from participating in the Medicaid program as a result of various exclusions, sanctions, or revocations. During SFY 16, $101,622.97 was

recovered for monies paid out for excluded providers. Case examples include, but are not limited to the following:

- On subject was working at Assured Care during her exclusion. Assured Care attempted to appeal the results of the excluded individual they employed claiming her identity was stolen. However, no proof was provided of the stolen identity and the case was eventually concluded. Assured Care paid AHCCCS back $20,826.70 for services rendered by an excluded party.

- G & B Adult Foster Care was owned by a subject. The subject was excluded for his participation in signing a document attesting that an individual signed a will assigning property over to another party, albeit the signing occurred after the individual was deceased. Due to his exclusion, the subject was not allowed to participate in the Medicaid program, albeit as an owner of a company. This case was settled for $10,500.00, G & B Adult Foster Care was terminated, and all AHCCCS members were moved to other providers.

- A preliminary investigation is being conducted of a provider. When this occurs, the state Medicaid agencies are required to terminate a provider's billing privileges or deny its enrollment if Medicare, another State Medicaid agency, or CHIP agency has terminated the provider and appeal rights are exhausted or expired. As a result of a Medicare Revocation, OIG has identified a provider who was not eligible for participation in the Medicaid program during the time period of said revocation. The preliminary amount identified is $3,008,961.78. This is still an active and ongoing investigation.

- Best Practices identified by the OIG, PCS, includes, but is not limited to the following:

- During SFY 2016, the OIG has instituted within settlement agreements to seek providers to voluntary agree to self-report themselves as excluded. When providers seek to negotiate lower settlement numbers during the offers to compromise, because they are stating that they are leaving the country, the OIG has countered back and included a stipulation of agreement to be excluded. This allows OIG to report that these providers are excluded from participation in the State's network. Reports of excluded providers are shared state to state and with HHS OIG. The result has been to deter and prevent the providers from jumping to another state to commit the same fraudulent scheme, due to the shared reporting.

- The OIG established a Forensic Accounting Unit (FAU) as a best practice for reviewing information of providers who counter that they are financially unable to make payment of the various overpayments and/or civil monetary penalties they are beholden to. The FAU has been able to bring forward a level of review that was previously not accessible. Their reviews have been utilized in a few different cases. One example is a provider who stated they didn't have the money to pay. A review performed by the FAU showed the provider was claiming large salaries from the business and recommended that a review of the

personal income tax would be beneficial in further determining the culpability of the potential bankruptcy statements claimed by the provider.

Member Compliance Section (MCS):

- The MCS worked a joint investigation with DES, Food Stamps. The AHCCCS member falsified her residency on her food stamps and AHCCCS applications claiming she lived in Kingman and Bullhead City, AZ when she actually lived in Laughlin Nevada. She was indicted on several counts of fraud, theft and unlawful use of food stamps. The DES had a loss of $10,218.00 and AHCCCS had a loss of **$29,020.099**. She was arrested on April 24th in Nevada. The member had since pled guilty and was ordered to pay full restitution to AHCCCS and DES.

- The MCS conducted an investigation of an AHCCCS member who falsified their household composition on their application. The initial allegation was that the member is married, but failed to report the spouse as living in the home, and failed to report the spouse's income. The case was solved using social media. Upon contact by MCIU, the member requested to enter into a repayment agreement. At the same time the AHCCCS Investigator found a "Go Fund Me Account" for help with the payment of rent. The member was seeking donations of approximately $4000. Later, the account was changed to "God Has a Reason for Everything." The member has earned $220 through "Go Fund Me." The member voluntarily shut down the account. The member agreed to make a repayment of **$23,308.20**.

- The MCS successfully concluded a case where the AHCCCS member drove a Mercedes and failed to list the spouse's business and income on the application. This case made the local news, as the member was indicted on 10 felony charges and accused of falsifying her income. The member received in excess of $70,000 in state medical benefits. The member and spouse operated a vehicle restoration business, lived in a large home, and drove expensive vehicles: Nissan 350Z; and a Mercedes. The member also owned a Recreational Vehicle, two boats, and three additional vehicles. The member was indicted on fraud, theft, and forgery. The member pled guilty to several Felonies and was ordered to pay restitution in the amount of $71,640.60. The member was also sentenced to five months in county jail, and three years of probation.

- The MCS investigated a case involving an AHCCCS member whose spouse owns three race horses. One of the race horses recently won a race valued at $80,000.00. The investigation revealed the member had numerous vehicles, trailers, all-terrain vehicles, livestock, as well as additional horses. The investigation revealed the member's spouse earned money for racing and training horses, and employed at a local business. The member failed to state this income on the AHCCCS application. During the interview, the member admitted she did not report the household's entire income, voluntarily sought to withdraw from AHCCCS, and agreed to pay AHCCCS **$23,431.06**.

- The MCS worked a joint case with the Drug Enforcement Administration (DEA) where an AHCCCS member had several bank accounts that reflected many unexplained cash deposits. The investigation revealed member and their family were involved in an ongoing criminal and drug enterprise. The investigation received The member pled guilty to theft, and was sentenced to a total of three and one half years in prison, five years' probation, and was ordered to pay restitution in the amount of $**47,974.15**.

- The MCS worked a joint investigation with DEA and the State of Arizona's Attorney General's Border Crimes Unit. The investigation involved a member and their significant other being associated to a large drug trafficking and money laundering organization. As a result of this investigation, in 2016, the organization was dismantled. The investigation also determined that other members of the group were on AHCCCS benefits. The member was sentenced to 9.75 years in prison. The significant other was sentenced to three years in prison. The member was ordered to pay restitution in the amount of **$11,710.32**.

Program Integrity Team (PIT):

- Developed a process for identifying high quality (validated) referrals from the Medi-Medi program. Those referrals are reviewed and are integrated into the cases of existing OIG investigations. If a Medi-Medi referral does not already support a current OIG Investigation, then the cases are entered in the OIG SMART case management system. The information is then evaluated for viability within the Medicaid program.

    - One example is a PIT case involving two physicians. The improper billing case resulted in a recovery of $40,000 from one doctor; and a settlement of $210,000 from the second doctor.

- Consisting of a team of five data analysts and subject matter experts, is handling a high volume of ad hoc requests from the PCS and the MCS of approximately 40 to 50 per month, while maintaining a mean turnaround time of two days, with a median and mode of one day for all ad hoc requests. This is to say that in most instances, investigators receive ad hoc results in one day; however, more complex ad hoc requests can take a few days longer. In 2016, the PIT ad hoc data and random sample methodology was verified and accepted during a large PCS court case.

- Working jointly with the AHCCCS, Information Systems Division (ISD) has been developing a new Case Management software system. The new system is in the final stages of approval, and ISD has already started on development implementation, anticipated to occur in approximately six months.

- Working closely with the AGO's Medicaid Fraud Control Unit (MFCU), meeting every two weeks to develop innovative investigation strategies to fight fraud, waste, and abuse. One joint project already implemented will expose Primary Care Physicians (PCPs) billing for services not rendered via the use of fictitious AHCCCS ID Cards.

- Continues to work closely with LexisNexis to develop meaningful and actionable reports especially in the area of Drug Diversion. Currently, there are several new DEA reports available in LexisNexis. Some of the data mining results have been shared with the MFCU and other reports will be incorporated into the OIG Pharmacy Intelligence Project. PIT Staff have also worked with LexisNexis in developing a "Provider of Interest" rating for providers, which incorporates variables specifically identified by the PIT to be meaningful to AHCCCS OIG investigations. The PIT is also working with LexisNexis in testing business mapping software that would provide insights into suspect provider business associates to facilitate investigations.

- Identified, and is currently evaluating two different open source Geo software packages for potential use in the future by all investigators to create visual patterns of recipient and provider locations regarding their claims activity.

Performance Improvement and Audit Section (PIAS):

- Leads the Pharmacy Intelligence Project related to the creation of a Pharmacy Fraud, Opioid Abuse, and Prescription Abuse Task Force. The task force has been in operation for approximately six months, consisting of members from each of OIG's five sections. The task force works closely with local policer departments, MFCU, and federal agencies in working joint investigations. The statistical accomplishment include: 139 Referrals; 96 Referrals Reviewed; 7 Cases Opened; One joint case with MFCU, with a second case pending for acceptance as a criminal case.

- Expanded OIG monthly metrics to include, but not limited to, the following: Case Processing Time; Aged Cases; Active Cases by Allegation and by Investigator.

- Newly formed Collections Team has met their goal of collecting 10% of all cases, identified as 60 days or more past due, every month the last four out of six months.

- Completed 10 SharePoint Applications; and three pending SharePoint applications as part of our Performance Improvement efforts to increase effectiveness and efficiency of our data management.

- Ten OIG Huddle Boards developed, with weekly meetings held by the appropriate units.

- Established an Executive Dashboard for overview of progress.

- Fully implemented OIG Audit Team. The team completed the following Audits: Post Pay Audits; Operational Reviews, seven; Deficit Reduction Act, 17; Provider Audits, five; Hospital Presumptive Eligibility Audits, three3; and an ongoing review of the continuous submission of Deliverables by the Managed Care Organizations.

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, 2016, 58,608 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 it was implemented on November 1, 1998.

Arizona's income threshold is set at 200% of the federal poverty level 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% 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.

In 2016, Governor Doug Ducey signed SB 1457, restoring KidsCare coverage to children in households between 133% and 200% Federal Poverty Limit. Application for KidsCare was accepted beginning July 26, 2016 for coverage effective September 1, 2016.

As of October 1, 2016, there were 5,911 children enrolled in the KidsCare Program.

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 FFY 2016.

Table 1 **Advocacy Issues**	**Quarter 1 10/01/15-12/31/15**	**Quarter 2 1/1/16-3/31/16**	**Quarter 3 4/1/16-6/30/16**	**Quarter 4 7/1/16-9/30/16**	**Total**
9+Billing Issues • **Member reimbursements** • **Unpaid bills**	9	46	67	96	**218**
Cost Sharing • **Co-pays** • **Share of Cost (ALTCS)** • **Premiums (Kids Care, Medicare)**	6	10	12	12	**40**
Covered Services	15	132	132	88	**367**
Eligibility Issues by Program **Can't get coverage due to :** **ALTCS** • **Resources** • **Income** • **Medical**	21	31	28	15	**95**
DES	361	224	241	260	**1,086**

• **Income** • **Incorrect determination** • **Improper referrals**					
Kids Care	1	0	0	9	**10**
• **Income** • **Incorrect determination**					
SSI/Medical Assistance Only	49	37	27	30	**143**
• **Income** • **Not categorically linked**					
Information	92	90	129	252	**563**
• **Status of application** • **Eligibility Criteria** • **Community Resources** • **Notification (Did not receive or didn't understand)**					
Medicare	17	25	25	5	**72**
• **Medicare Coverage** • **Medicare Savings Program** • **Medicare Part D**					
Prescriptions	28	131	134	67	**360**
• **Prescription coverage** • **Prescription denial**					
Issues Referred to other Divisions:					

1.Fraud-Referred to Office of Inspector General (OIG)	0	0	0	0	**0**
2.Quality of Care-Referred to Division of Health Care Management (DHCM) • **Health Plans/Providers (Caregiver issues, Lack of providers)** • **Services** **(Equipment, Nursing Homes, Optical and Surgical)**	14	13	30	28	**85**
Total	**613**	**739**	**825**	**862**	**3,039**

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	Quarter 1 10/01/15-12/31/15	Quarter 2 1/1/16-3/31/16	Quarter 3 4/1/16-6/30/16	Quarter 4 7/1/16-9/30/16	Total
Applicant, Member or Representative	473	599	705	675	2,452
CMS	10	10	6	10	36
Governor's Office	4	0*	0*	0*	4
Ombudsmen/Advocates/Other Agencies…	103	110	100	160	473
Senate & House	23	20	14	17	74
Total	**613**	**739**	**825**	**862**	**3,039**

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

COMPLAINTS AND GRIEVANCES

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

SMI Member Grievances and Complaints	Quarter 1 10/01/15-12/31/15	Quarter 2 1/1/16-3/31/16	Quarter 3 4/1/16-6/30/16	Quarter 4 7/1/16-9/30/16	Total

Access to Care	108	100	71	98	**377**
Health Plan	314	373	384	276	**1,347**
Provider Satisfaction	481	542	585	756	**2,364**
Total	903	1015	1,040	1,130	**4,088**

CRS Member Grievances and Complaints	Quarter 1 10/01/15-12/31/15	Quarter 2 1/1/16-3/31/16	Quarter 3 4/1/16-6/30/16	Quarter 4 7/1/16-9/30/16	Total
Access to Care	0	0	0	0	**0**
Health Plan	0	1	6	3	**10**
Provider Satisfaction	23	29	17	34	**103**
Total	23	30	23	37	**113**

SMI OPT-OUT FOR CAUSE

See attachment 1 for a summary of the opt-out requests filed by individuals with SMI in Maricopa County and Greater Arizona, broken down by months, health plans, counties, reasons for opt-out requests, opt-out outcome, and post-appeal opt-out outcomes.

QUALITY ASSURANCE/MONITORING ACTIVITY

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 has resulted in the ability to compare AHCCCS' rates with those of other states who have implemented the Core measure sets.

AHCCCS has updated the performance measure sets for all lines of business. The new measures and related Minimum Performance Standards 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.

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 to ensure the most meaningful performance measures were selected for each population served. 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 currently utilizing its External Quality Review Organization to perform the measurement calculations.

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.

AHCCCS Medicaid and KidsCare rates for EPSDT Participation and EPSDT Dental Participation, for CYE 2015, 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 2014*	Measurement period CYE 2013	Measurement period CYE 2012	2014 Medicaid national mean[1]	Minimum Performance Standard
Medicaid Rates for Children					
Children's and Adolescents' Access to PCPs, 12 – 24 Months, *Medicaid*	97.1	97.4	97.0	95.5	93
Children's and Adolescents' Access to PCPs, 25 Months – 6 Years, *Medicaid*	88.5	89.2	87.7	87.8	84
Children's and Adolescents' Access to PCPs, 7 – 11 Years, *Medicaid*	92.4	91.4	89.9	91.0	83
Children's and Adolescents' Access to PCPs, 12 – 19 Years, *Medicaid*	90.1	89.4	87.7	89.3	82
Well-child Visits in the First 15 Months of Life, *Medicaid*	71.4	67.9	67.8	58.9	65
Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life, *Medicaid*	64.9	65.5	66.8	71.9	66
Adolescent Well-care Visits, *Medicaid*	40.7	39.7	38.0	50.0	41
Annual Dental Visits, Medicaid	63.5	59.2	61.8	n/a	60

Timeliness of Prenatal Care	n/a	n/a	n/a	82.4	80
Postpartum Care	n/a	n/a	n/a	61.8	64
Appropriate Medications for Asthma	80.6	79.6	n/a	n/a	86
Diabetes Care: HbA1c Testing	n/a	71.2	n/a	86.3	77
Diabetes Care: LDL-C Screening	n/a	65.7	n/a	n/a	70
Diabetes Care: Eye Exams	n/a	42.2	n/a	54.4	49
Ambulatory Care: ED Visits, Total	56	57	n/a	n/a	TBD
Inpatient Utilization: Total Discharges per 1,000 MM	8	11	n/a	n/a	TBD
Inpatient Utilization: Total, Average Length of Stay	3.8	3.1	n/a	n/a	TBD
All-Cause Readmission: Total	13.6	11.7	n/a	n/a	TBD
Diabetes Short-Term Complications Admissions	225	244.4	n/a	n/a	TBD
COPD or Asthma in Older Adults Admissions	875.7	1152.9	n/a	n/a	TBD
Heart Failure Admissions	290.9	278.4	n/a	n/a	TBD
Asthma in Younger Adults Admissions	104.2	119.5	n/a	n/a	TBD

* Draft Data
[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 2015	Measurement period CYE 2014	Measurement period CYE 2013	Measurement period CYE 2012	2014 Medicaid national mean	Minimum Performance Standard
Medicaid Rates, CMS 416						
EPSDT Participation, *Medicaid*	51.5	54	60.6	65.7	n/a	68
EPSDT Dental Participation, *Medicaid*	46.6	44.6	45.5	44.1	n/a	46
CHIP Rates, CMS 416*						
EPSDT Participation, *CHIP*	51.9	57	60.6	65.7	n/a	68
EPSDT Dental Participation, *Medicaid*	55.0	21.8	39.8	59.1	n/a	46

N/A – A rate was not measured for the specific reporting period.
* Due to the CHIP program being closed, there has been a significant decrease in this population as only those members who maintained eligibility after the Program closure were allowed to continue on with the Program.

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 thus far, not fully developed or implemented (e.g. electronic health records, health information exchange data, information 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.

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 2016, AHCCCS finalized data from CYE 2014 as well as ran the CYE 2015 rates for 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 2015	Measurement period CYE 2014	Measurement period CYE 2013	2014 Medicaid national mean	Minimum Performance Standard
EPSDT Participation	37.9	38	42.4	n/a	68
EPSDT Dental Participation	38.9	33.4	40.4	n/a	46

ALTCS E/PD Measures	(%)				
	Current Rate	Measurement	Measurement	2014 Medicaid	Minimum

	Measurement period CYE 2014	period CYE 2013	period CYE 2012	national mean[1]	Performance Standard
7 Day Follow-Up After Hospitalization for Mental Illness	17.96	n/a	n/a	n/a	50
30 Day Follow-Up After Hospitalization for Mental Illness	32.34	n/a	n/a	n/a	70
Diabetes Care: HbA1c Testing	n/a	n/a	n/a	86.3	83
Diabetes Care: LDL-C Screening	n/a	n/a	n/a	n/a	75
Diabetes Care: Eye Exams	n/a	n/a	n/a	54.4	60
Ambulatory Care: ED Visits	63	n/a	n/a	n/a	TBD
Inpatient Utilization: Total Discharges per 1,000 MM	185.4	n/a	n/a	n/a	TBD
Inpatient Utilization: Total, Average Length of Stay	5.6	n/a	n/a	n/a	TBD
All-Cause Readmission: Total	15.5	n/a	n/a	n/a	TBD
Diabetes Short-Term Complications Admissions	170.62	n/a	n/a	n/a	TBD
COPD or Asthma in Older Adults Admissions	1329.92	n/a	n/a	n/a	TBD
Heart Failure Admissions	1156.45	n/a	n/a	n/a	TBD
Asthma in Younger Adults	212.8	n/a	n/a	n/a	TBD

ALTCS DDD Measures	(%)				
	Current Rate Measurement period CYE 2014	Measurement period CYE 2013	Measurement period CYE 2012	2014 Medicaid national mean[1]	Minimum Performance Standard
Children's and Adolescents' Access to PCPs, 12 – 24 Months	93.4	98.6	93.7	96.0	93
Children's and Adolescents' Access to PCPs, 25 Months – 6 Years	86.5	88.1	86.3	88.3	84
Children's and Adolescents' Access to PCPs, 7 – 11 Years	90.1	89.5	87.9	89.9	83
Children's and Adolescents' Access to PCPs, 12 – 19 Years	87.3	85.9	85.2	88.4	82
Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life	47.9	48.8	51.5	72.0	66
Adolescent Well-care Visits	35.7	35.1	35.4	49.7	41
Annual Dental Visit	52.8	49.38	n/a	n/a	60
Diabetes Care: HbA1c Testing	n/a	61.3	n/a	86.3	77
Diabetes Care: LDL-C Screening	n/a	57.7	n/a	n/a	70

Diabetes Care: Eye Exams	n/a	36.3	n/a	54.4	49
Ambulatory Care: ED Visits	41	43	n/a	n/a	TBD
Inpatient Utilization: Total Discharges per 1,000 MM	46.5	9.3	n/a	n/a	TBD
Inpatient Utilization: Total, Average Length of Stay	5.6	5.6	n/a	n/a	TBD
All-Cause Readmission: Total	11.5	10.1	n/a	n/a	TBD
Diabetes Short-Term Complications Admissions	63.7	67.1	n/a	n/a	TBD
COPD or Asthma in Older Adults Admissions	99.5	281.6	n/a	n/a	TBD
Heart Failure Admissions	47.8	75.5	n/a	n/a	TBD
Asthma in Younger Adults	70.3	74.9	n/a	n/a	TBD

ALTCS DDD Measure	(%)				
	Current Rate Measurement period CYE 2015	Measurement period CYE 2014	Measurement period CYE 2013	2014 Medicaid national mean	Minimum Performance Standard
EPSDT Participation	39.3	37	45	n/a	68
EPSDT Dental Participation	45.1	43.5	40.8	n/a	46

[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 2016

- 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

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 10/1/15 through 9/30/16, OALS received 10815 matters which included member appeals, provider claim disputes, ALTCS trust reviews, and eligibility appeals. Of the 10815 total cases received, 361 were member appeals, 8824 were provider claim disputes, 216 were ALTCS trust reviews, and 1414 were eligibility appeals. OALS issued 726 Director's Decisions after State Fair hearings were held. In addition, OALS issued 9655 informal dispositions of disputes filed with the AHCCCS Administration. In excess of 97% of these disputes were resolved at the informal level, thus obviating the need for State Fair Hearings in these cases.

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

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

On September 12, 2013, the Goldwater Institute, on behalf of various legislators, several citizens who are Arizona residents, and the Director of the Arizona Chapter of Americans for Prosperity, all of whom oppose House Bill 2010 (Laws 2013, 1st Special Session, Chapter 10), filed a lawsuit in Superior Court seeking declaratory and injunctive relief. The lawsuit seeks to overturn Arizona's recent law expanding Medicaid to include persons with incomes up to 133% of the federal poverty guidelines, funded in part through a hospital assessment. The Complaint maintains that the Governor and the Medicaid Director violated the Arizona Constitution by

imposing a tax on hospitals through the hospital assessment without obtaining the two thirds majority (supermajority) required by Proposition 108 (which applies to legislation increasing state revenue through taxation) and by violating the Constitution's separation of powers. More specifically, Plaintiffs allege that ARS §36-2901.08 violates Article IX, Section 22 (also referred to as Proposition 108), Article III, and Article IV, Part 1, Section1 of the State Constitution as well as the separation of powers doctrine of the Arizona Constitution. Plaintiffs request that Defendants be enjoined from establishing, administering, or collecting the provider tax and from enforcing ARS §36-2901.08. Attorneys' fees and costs are also requested by Plaintiffs.

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

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

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

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

The AHCCCS Administration was not a named defendant. However, because the injunctive and declaratory relief, including imposition of a court monitor, would impair the ability of the AHCCCS Administration to manage the Title XIX program and, in particular, the provision of EPSDT services, AHCCCS filed a Motion to Intervene on May 7, 2015 to add AHCCCS Director Betlach as a defendant on the EPSDT claims. Also on May 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**.**

On February 11, 2016, Defendant Betlach filed the First Request for Production of Documents. Plaintiffs' filed Responses on March 14, 2016. The District Court issued an Order for Protection of Privileged/Confidential Material on March 15, 2016, ordering Defendants to produce redacted information regarding the named Plaintiffs no later than April 1, 2016. The Court also approved, in part, the Parties' Joint Submission of Proposed Protective Order and required the parties tom comply with specified requirements concerning the production and handling of information.

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

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

On July 22, 2016, the Morris Institute and the National Health Law Program filed a purported class action in federal district court, naming two AHCCCS recipients, seeking declaratory and injunctive relief pursuant to 42. U.S.C. Section 1983. The Complaint alleged violations of the Medicaid reasonable promptness requirement at 42 U.S.C. Section 1396a(a)(8), the Medicaid notice requirements at 42 U.S.C. Section 1396a(a)(3), and the due process clause of the Fourteenth Amendment to the U.S. Constitution. The Complaint was filed on behalf of two individuals and a statewide class of persons who were alleged to have been improperly transitioned from full AHCCCS coverage to federal emergency services only coverage. The Motion for Class Certification was filed on July 22, 2016. Plaintiffs subsequently filed a Motion for Preliminary Injunction on July 27, 2016, and Defendant Betlach filed a Motion for Extension of Time to Respond to Motion for Preliminary Injunction and Class Certification. On August 24, 2016 the District Court granted Defendant's Motion to extend time for Defendant to respond to the Complaint and the Motions. However, the Court denied Defendant's Motion to conduct discovery prior to responding to Plaintiffs' Motion for Preliminary Injunction and Motion for Class Certification. On August 29, 2016, Defendant Betlach filed its Motion to Dismiss the Complaint for lack of jurisdiction and failure to state a claim. Plaintiff filed its Response on

September 9, 2016. Defendant Betlach filed its Reply on September 19, 2016. On this date, Plaintiffs filed a Reply in Further Support of Motion for Class Certification. Oral argument on all three motions was heard on October 4, 2016. On October 25, 2016, the Magistrate Judge filed his Report and Recommendation that the case be dismissed with prejudice and that the Plaintiffs' other motions all be denied as moot. The Plaintiffs filed an Objection to these recommendations on November 7, 2016. Defendant Betlach filed its Response to Plaintiffs' Objections to the Magistrate's Report and Recommendations. The Plaintiffs were granted leave to file a Reply, which they did on December 19, 2016. Oral argument has been requested but has not yet been scheduled.

ACCOMPLISHMENTS IN FFY 2016

AHCCCS has successfully obtained approval for a new 1115 demonstration waiver. Included in the new waiver is the innovative new AHCCCS CARE program which contains the AHCCCS CARE account, Healthy Living Targets, and AHCCCS Works to connect members to employment opportunities. The waiver approval also includes an extension of existing authorities, such as mandatory managed care and use of home and community based services for members with long-term care needs, as well as a new $1,000 dental benefit for long term care members on ALTCS.

AHCCCS was ranked number one nationally among state Medicaid programs for its individuals with developmental disabilities program in the 2016 United Cerebral Palsy Report.

In 2016, AHCCCS successfully completed the merger with the Department of Behavioral Health Services. This merger has allowed for an increased focus on whole person health, reduce stigma, and enhanced service delivery for all members.

AHCCCS has been committed to helping foster families and in 2016 implemented Jacob's Law, (HB 2442). Through this implementation AHCCCS has simplified access to needed behavioral health services, created monitoring systems to ensure timely access to services, and engaged with foster families throughout the process.

As a culmination of the work done by the ASD Advisory Committee, AHCCCS released a report with recommendations to strengthen the health care system's ability to respond to the needs of members with or at risk for ASD, including those with comorbid diagnoses.

AHCCCS released a comprehensive report on Behavioral Health Needs of Children involved with the Department of Child Safety: Psychotropic Prescribing Update. This report analyzed psychotropic prescribing among children in Arizona's foster care system. The report sets a baseline for ongoing monitoring of prescribing tends for youth involved in the foster care system.

Reopened enrollment for the KidsCare program providing high quality healthcare coverage for working families and meet the health care needs of Arizona's children.

Restored podiatry services provided by a licensed podiatrist and provided a $1000 dental benefit to members in the ALTCS program.

Expanded the external contract for determinations for persons with Serious Mental Illness to all Arizona counties (from Maricopa only) to assure consistency and fairness in the determination process.

Expanded the use of the online eligibility determination system to include all DES Medicaid determinations. This has previously been used in the community as well as at AHCCCS – we rolled out to all DES offices.

Worked with DCS to establish a Justice System Transition program which allows eligible individuals to be enrolled with AHCCCS immediately upon release.

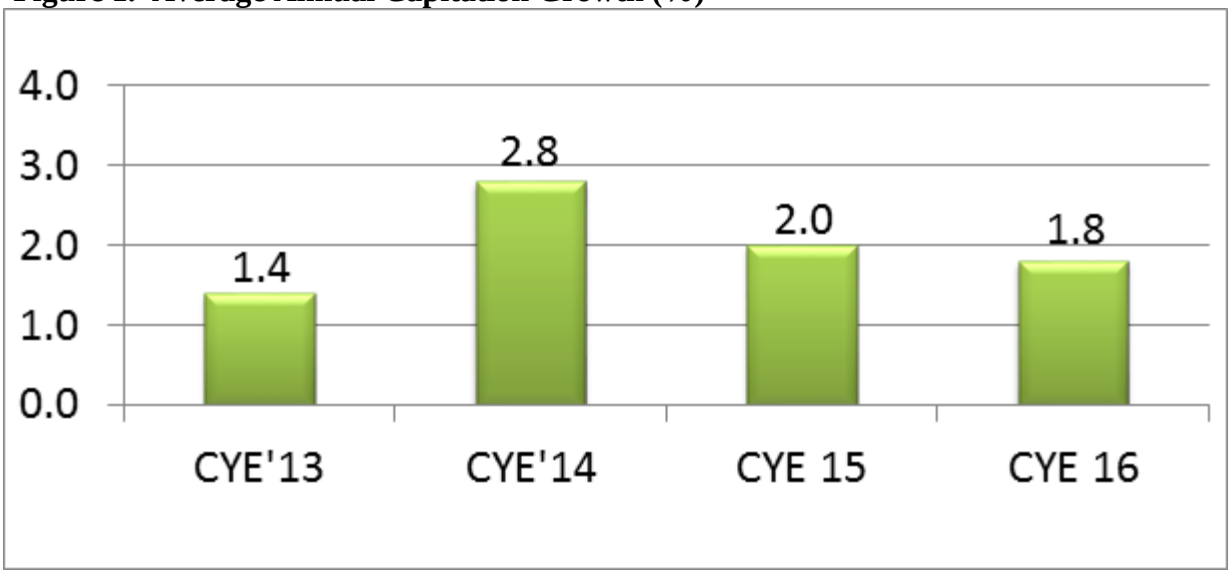
AHCCCS now provides integrated services for 80,000 dual eligible members.

In 2016, as a result of the DBHS merger, AHCCCS was able to streamline the requirements for TRBHA organizations creating an opportunity to integrate services and work more closely with Tribes on the delivery and coordination of services.

AHCCCS has implemented the Greater Arizona RBHAs and provides fully integrated care for members with SMI.

In 2016, AHCCCS experienced a minimal capitation rate increase of 1.8%. This was a decline of 1 full percentage point from CYE14. This decrease occurred despite an increase in the AHCCCS population, restoration of benefits, and long term investments. AHCCCS will continue to pursue long term strategies which focus on value to continue this trend of bending the cost curve.

Figure 1. Average Annual Capitation Growth (%)



Care delivery and payment reform efforts continued to focus on transitioning from paying for the volume of care to the value of care provided. Contracted managed care organizations (MCO's) were incentivized to have an increased percentage of their provider payments in value based arrangements, where payments are related quality outcomes. AHCCCS established internal systems that support the MCOs' use of payment models other the traditional fee for service model. MCOs were contractually incentivized to increase the proportion of electronic prescriptions written by their provider network, a safer and more accurate method. To address provider care fragmentation faced by members, plans were developed with input from a wide range of stakeholders for advancing integrated behavioral – physical health delivery models for adults, children, American Indians, and justice involved individuals.

Program Integrity - AHCCCS met the vast majority of the Program Integrity goals established in its annual plan. The Agency worked with prosecutors successfully on 39 different cases resulting in 62 convictions - a program record. AHCCCS realized over $1 billion as a result of coordination of benefits, third party recoveries, and OIG activities, and began pursuing the ability to leverage private sector expertise on data analyses.

Health Information Technology – AHCCCS has registered, validated and paid 5,190 eligible professionals and 76 acute care and critical access hospitals since the program opened in July, 2011 - the payments total over $658 million. AHCCCS continues to serve on the Health-E Connection Board, the Health Information Network of Arizona (HINAZ) Board, and the Network Leadership Council. In July 2016, AHCCCS became an official participant in the network when our Division of Fee-for-service management began receiving information from the network about its patient population. In November 2016, AHCCCS sought funding from CMS for non-eligible Medicaid providers, not currently part of the EHR Incentive Program, to receive a subsidy for joining the state level health information exchange (HIE).

AHCCCS preserved access to care for our members by avoiding a 5% provider rate reduction.

AHCCCS continued to pursue an improved partnership with Arizona tribes while continuing to engage in strategies that improve the health system for tribal members. AHCCCS conducted 8 tribal consultation meetings in 2016.

The AHCCCS 2016 employee survey indicated a strong positive feeling among staff. A total of 97% of staff value members of their team; 96% believe in the AHCCCS mission; 90% understand clearly what is expected from them; and 87% are proud to be an AHCCCS employee. In addition, AHCCCS has achieved a world class level of employee engagement with 9 engaged employees for every 1 disengaged employee. This is compared to the statewide average of 2.3 engaged employees for every 1 disengaged employee.

ENCLOSURES/ATTACHMENTS

Attached you will find the SMI Opt-Out for Cause data and Budget Neutrality Tracking Schedule.

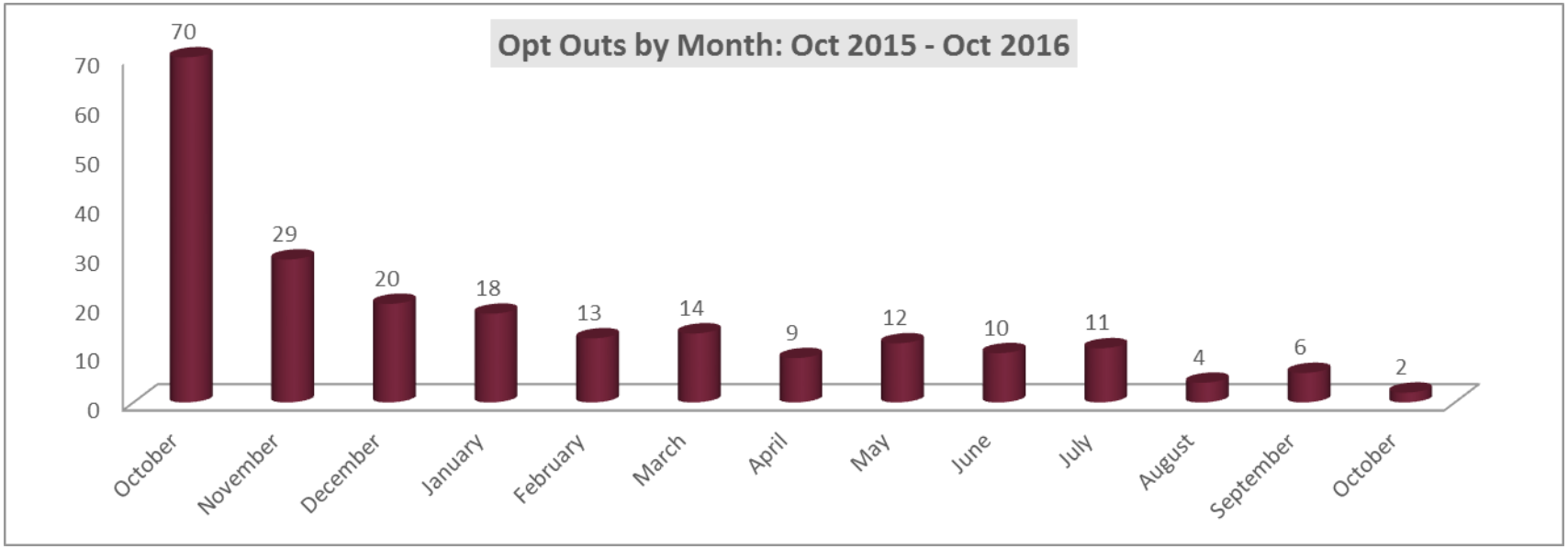
STATE CONTACT(S)

Mohamed Arif
801 E. Jefferson St., MD- 4200
Phoenix, AZ 85034
(602) 417-4573

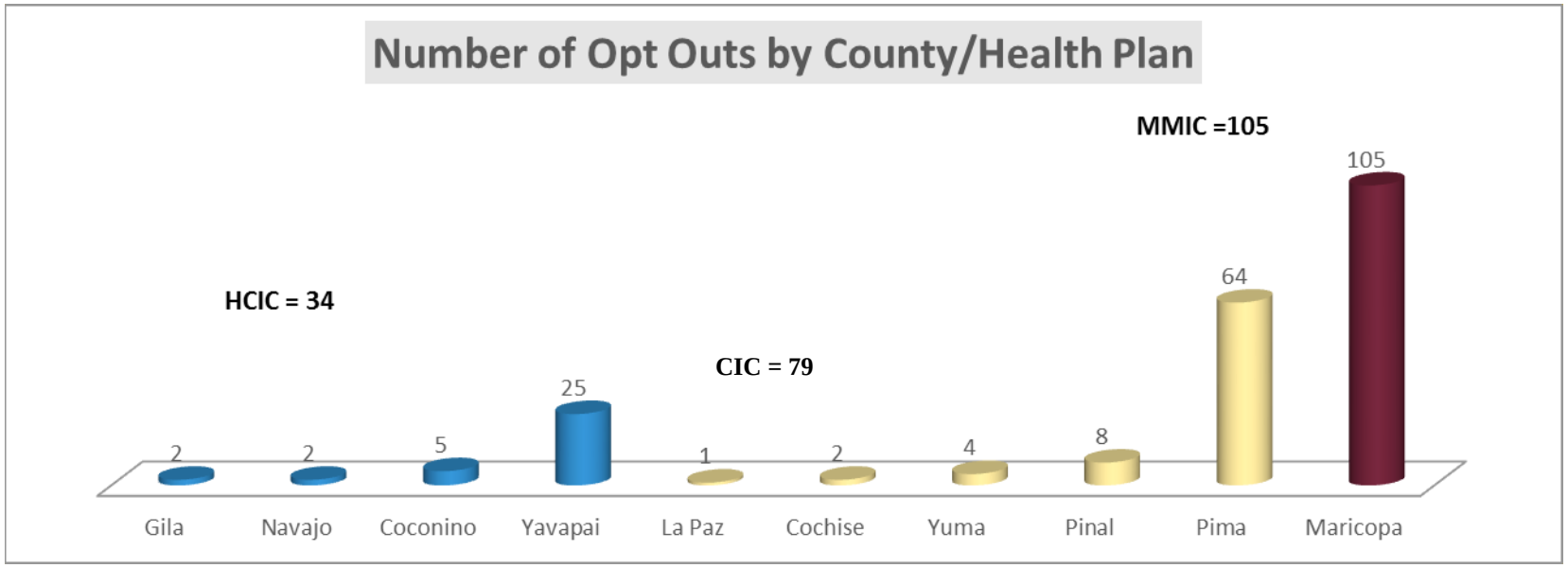
DATE SUBMITTED TO CMS

January 31, 2017

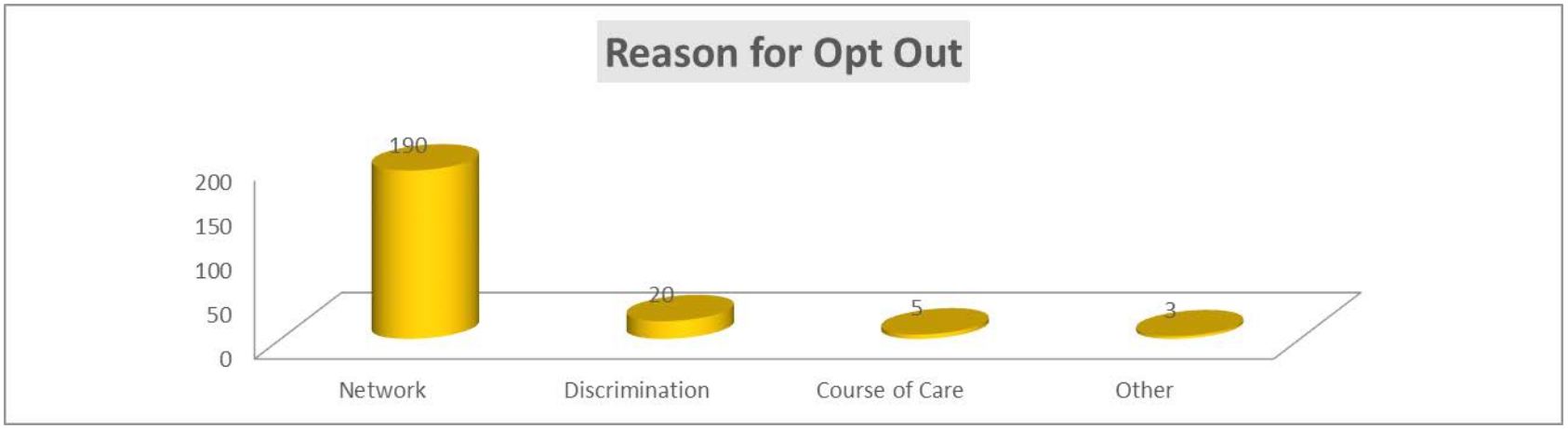
Attachment 1: Opt-Out for Cause Report



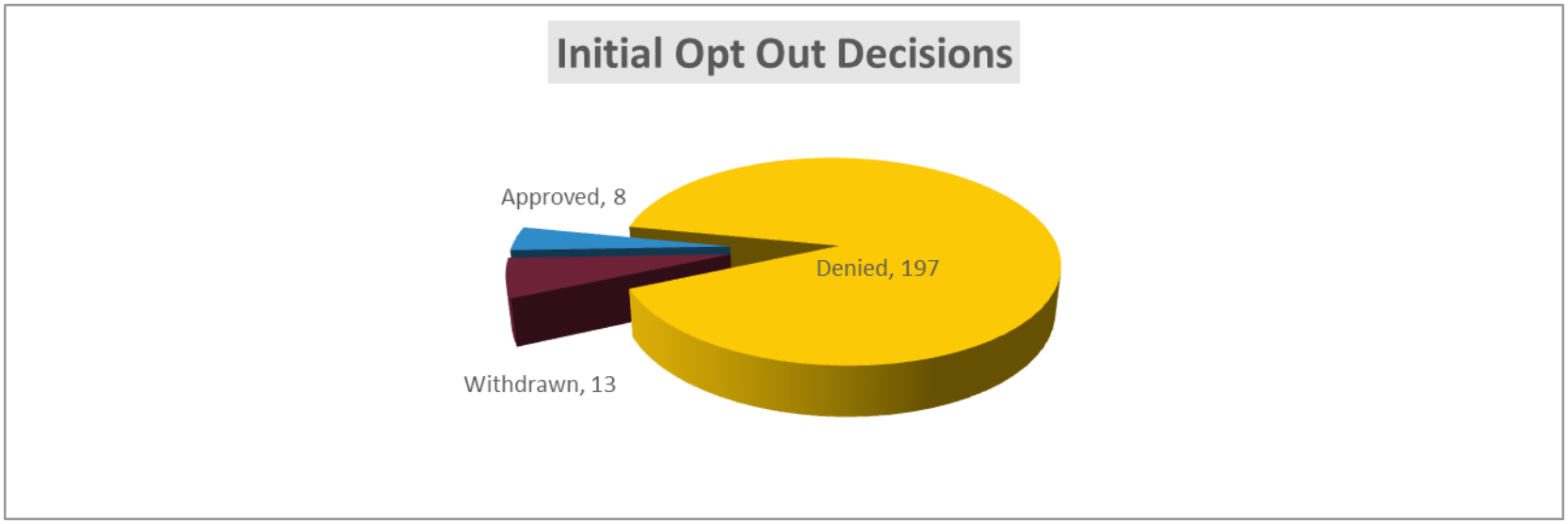
October 2015 – October 2016 Opt Out Request												
Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
70	29	20	18	13	14	9	12	10	11	4	6	2



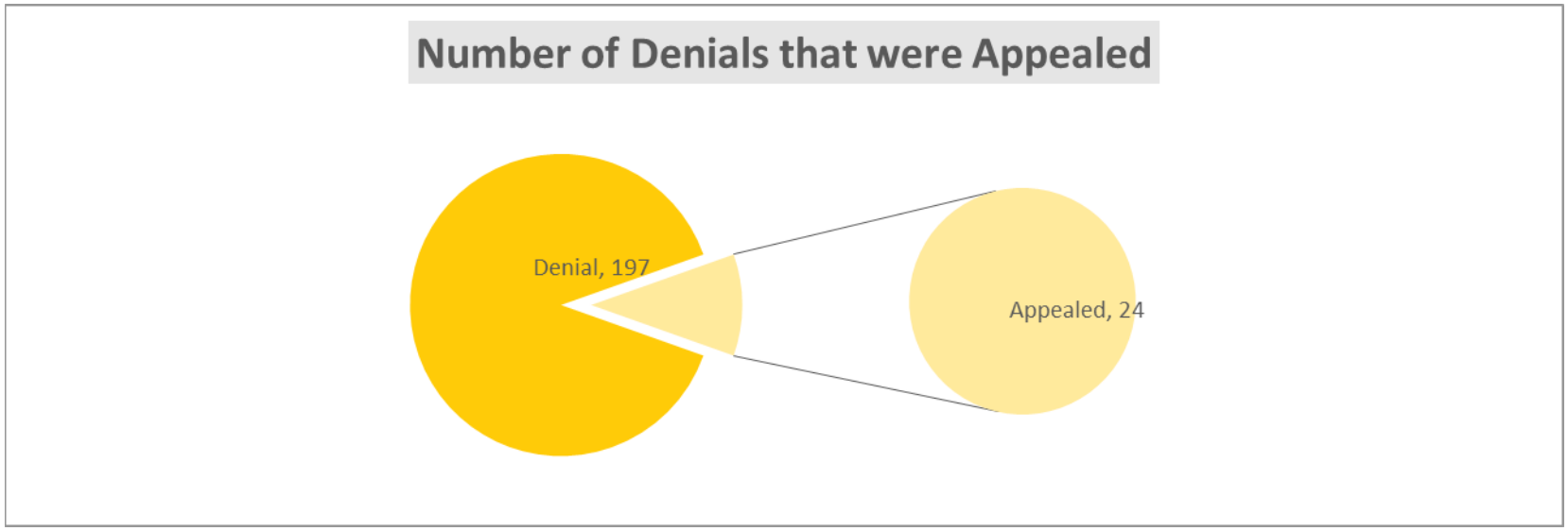
Number of Opt-Out by County /Health Plans: October 2015 – October 2016		
HCIC	Gila	2
HCIC	Navajo	2
HCIC	Coconino	4
HCIC	Yavapai	25
HCIC	**Total**	**33**
CIC	La Paz	1
CIC	Cochise	2
CIC	Yuma	4
CIC	Pinal	8
CIC	Pima	64
CIC	**Total**	**79**
MMIC	Maricopa	**105**
Grand Total	**All Counties**	**217**



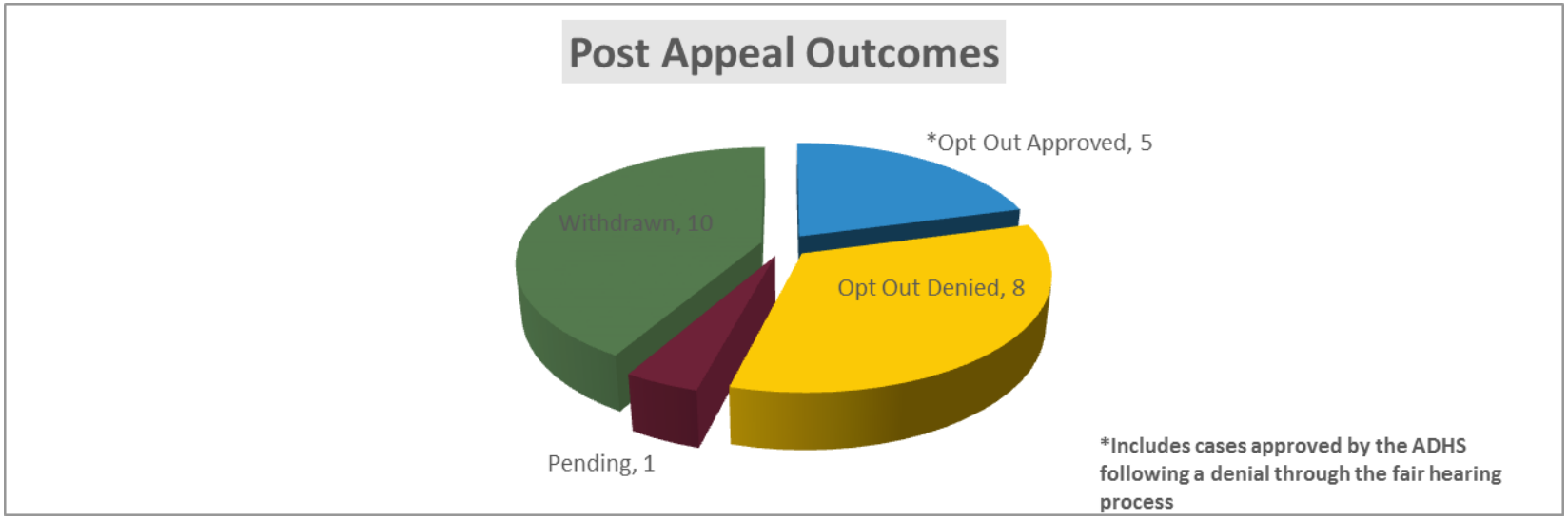
Network	Discrimination	Other	Course of Care
190	20	5	3



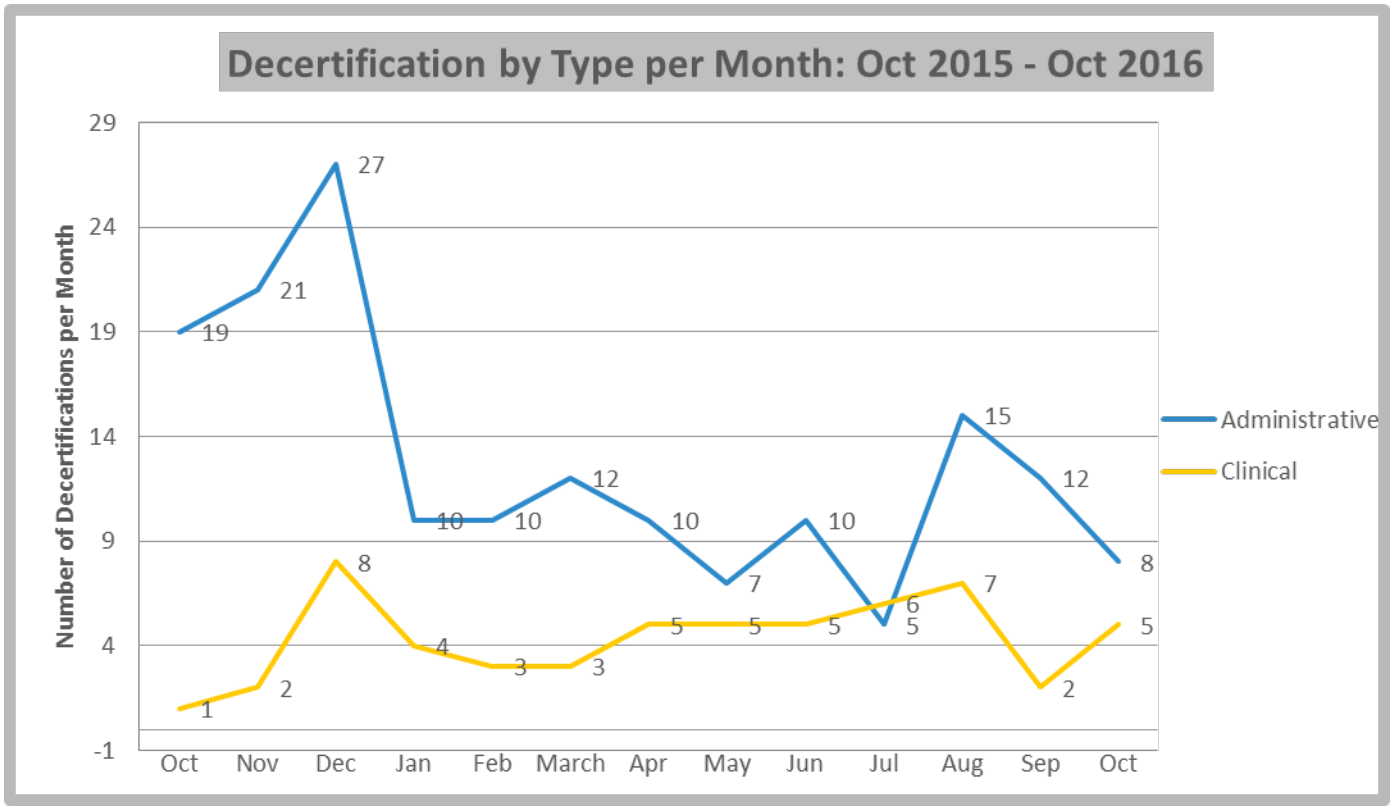
October 2015- October 2016 Opt Out Decisions			
Denied	**Withdraw**	**Approved**	**Pending**
197	13	8	0



Out of the 197 denied Opt Out requests only 24 applicants appealed the decision.



Oct 15- Oct. 2016 Post Appeal Opt Out Outcomes	
Pending	1
Withdrawn	10
Denied	8
Approved	5



Decertification by Type per Month: October 2015 – October 2016: Administrative												
Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
19	21	27	10	10	12	10	7	10	5	15	12	8

Decertification by Type per Month: October 2015 – October 2016: Clinic												
Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
1	2	8	4	3	3	5	5	5	6	7	2	5

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended September 30, 2016

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

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

	FFY 2012 PM/PM	Trend Rate	DY 01 PM/PM	Effective FMAP	Federal Share PM/PM	Member Months QE 12/11	QE 3/12	QE 6/12	QE 9/12	Total	Federal Share Budget Neutrality Limit	
AFDC/SOBRA	556.34	1.052	585.28	69.84%	408.78	2,932,580	2,920,267	2,914,143	2,938,884	11,705,874	$ 4,785,148,101	
SSI	835.29	1.06	885.41	69.10%	611.79	487,537	488,958	488,982	491,618	1,957,095	1,197,326,382	
AC [1]			562.09	69.74%	391.98	527,244	430,723	365,132	310,396	1,633,495	640,294,778	
ALTCS-DD	4643.75	1.06	4922.38	67.38%	3316.47	72,516	73,152	73,964	74,820	294,452	976,540,510	
ALTCS-EPD	4503.21	1.052	4737.37	67.50%	3197.92	85,463	85,509	85,731	86,512	343,215	1,097,575,816	
Family Plan Ext [1]		1.058	17.04	90.00%	15.33	12,471	12,424	12,440	12,689	50,024	767,009	
											$ 8,697,652,596	MAP Subtotal
											103,890,985	Add DSH Allotment
											$ 8,801,543,581	Total BN Limit

	DY 02 PM/PM			Member Months QE 12/12	QE 3/13	QE 6/13	QE 9/13	Total		
AFDC/SOBRA	615.71	68.85%	423.92	2,911,537	2,891,297	2,903,136	2,919,037	11,625,007	$ 4,928,030,394	
SSI	938.53	67.86%	636.90	494,688	497,059	499,682	503,271	1,994,700	1,270,424,581	
AC [1]	601.22	68.73%	413.22	274,990	248,817	228,204	217,114	969,125	400,463,799	
ALTCS-DD	5217.72	65.83%	3434.66	75,639	76,467	77,281	78,035	307,422	1,055,890,768	
ALTCS-EPD	4983.71	66.01%	3289.97	86,829	86,075	86,303	87,133	346,340	1,139,447,775	
Family Plan Ext [1]	18.42	90.00%	16.58	13,104	13,824	14,187	14,856	55,971	927,946	
									$ 8,795,185,263	MAP Subtotal
									106,384,369	Add DSH Allotment
									$ 8,901,569,632	Total BN Limit

	DY 03 PM/PM			Member Months QE 12/13	QE 3/14	QE 6/14	QE 9/14	Total		
AFDC/SOBRA	647.73	70.55%	456.98	2,891,942	2,839,568	2,955,939	3,113,908	11,801,357	$ 5,392,933,564	
SSI	994.84	69.27%	689.09	506,596	514,059	522,679	528,599	2,071,933	1,427,749,720	
AC [1]	596.43	69.87%	416.71	206,419	87	2	-	206,508	86,053,697	
ALTCS-DD	5530.78	67.35%	3725.10	78,841	79,683	80,672	81,760	320,956	1,195,594,176	
ALTCS-EPD	5242.86	67.53%	3540.31	87,679	87,893	88,734	89,357	353,663	1,252,077,823	
Family Plan Ext [1]	13.39	90.00%	12.05	14,885	-	-	-	14,885	179,426.00	
Expansion State Adults [1]	625.80	85.36%	534.21	-	444,156	624,670	756,405	1,825,231	975,057,294	
									$ 10,329,645,700	MAP Subtotal
									107,980,135	Add DSH Allotment
									$ 10,437,625,835	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	71.44%	486.80	3,146,645	3,085,624	3,106,356	3,211,097	12,549,722	$ 6,109,143,929	
SSI	1054.53	70.25%	740.77	535,890	542,278	542,786	542,648	2,163,602	1,602,738,498	
AC	0.00	68.41%	0.00	-	-	-	-	-	-	
ALTCS-DD	5862.63	68.54%	4018.24	82,728	83,830	84,836	85,612	337,006	1,354,169,858	
ALTCS-EPD	5515.49	68.68%	3788.29	90,010	89,879	89,927	90,014	359,830	1,363,139,038	
Family Plan Ext	0.00	90.00%	0.00	-	-	-	-	-	-	
Expansion State Adults	584.97	87.73%	513.21	818,297	836,535	846,708.00	867,410.00	3,368,950	1,728,981,507	
									$ 12,158,172,831	MAP Subtotal
									109,707,817	Add DSH Allotment
									$ 12,267,880,648	Total BN Limit

	DY 05 PM/PM			Member Months QE 12/15	QE 3/16	QE 6/16	QE 9/16	Total		
AFDC/SOBRA	716.85	71.30%	511.14	3,264,186	3,260,263	3,243,573	3,323,731	13,091,753	$ 6,691,774,460	
SSI	1117.81	70.43%	787.23	547,068	548,498	543,203	542,927	2,181,696	1,717,499,025	
AC	0.00	88.99%	0.00	-	-	-	-	-	-	
ALTCS-DD	6214.39	68.96%	4285.21	86,377	87,136	88,209	88,862	350,584	1,502,326,395	
ALTCS-EPD	5802.30	69.05%	4006.76	89,870	89,427	89,389	88,128	356,814	1,429,668,392	
Family Plan Ext	0.00	90.00%	0.00	-	-	-		-	-	
Expansion State Adults	550.99	90.61%	499.26	917,644	931,657	931,132	935,676	3,716,109	1,855,322,694	
									$ 13,196,590,966	MAP Subtotal
									110,036,940	Add DSH Allotment
									$ 13,306,627,906	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 9/30/2016

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended September 30, 2016

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

	Budget Neutrality Limit - Federal Share			Expenditures from CMS-64 - Federal Share												
WAIVER PERIOD OCTOBER 1, 2011 THROUGH SEPTEMBER 30, 2016:	MAP	DSH	Total	AFDC/SOBRA	SSI	AC	ALTCS-DD	ALTCS-EPD	Family Plan	DSH/CAHP	SNCP/DSHP	UNC CARE	MED	Exp St Adults	Total	VARIANCE
QE 12/11	$ 2,217,715,074	$ 103,890,985	$ 2,321,606,059	$ 502,890,921	$ 191,249,757	$ 175,610,617	$ 151,638,753	$ 164,685,415	$ 167,197	$ -	$ -	$ -	$ 458,635	$ -	$ 1,186,701,295	$ 1,134,904,764
QE 3/12	2,177,972,603	-	2,177,972,603	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	883,200,015
QE 6/12	2,153,176,807	-	2,153,176,807	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	717,905,007
QE 9/12	2,148,788,112	-	2,148,788,112	579,782,505	222,428,252	118,032,081	205,664,611	175,615,524	201,702	6,248,670	14,312,682	18,367,266	294	-	1,340,653,587	808,134,525
QE 12/12	2,208,623,226	106,384,369	2,315,007,595	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	876,718,212
QE 3/13	2,191,113,190	-	2,191,113,190	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	846,757,934
QE 6/13	2,192,836,725	-	2,192,836,725	588,378,705	241,298,377	88,125,077	102,142,130	187,310,029	227,668	78,756,901	111,555,510	17,514,148	-	-	1,415,308,545	777,528,180
QE 9/13	2,202,612,122	-	2,202,612,122	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	682,309,077
QE 12/13	2,360,935,864	107,980,135	2,468,915,999	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	963,292,308
QE 3/14	2,497,152,016	-	2,497,152,016	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	1,012,500,641
QE 6/14	2,659,329,256	-	2,659,329,256	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	1,051,304,181
QE 9/14	2,812,228,564	-	2,812,228,564	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	947,654,535
QE 12/14	3,022,107,716	109,707,817	3,131,815,533	768,767,395	322,908,117	24,114,620	197,157,685	209,877,907	254	9,813,379	78,963,846	3,397,109	-	411,351,488	2,026,351,800	1,105,463,733
QE 3/15	3,010,426,818	-	3,010,426,818	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	1,256,847,537
QE 6/15	3,030,340,445	-	3,030,340,445	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	1,119,298,199
QE 9/15	3,095,297,852	-	3,095,297,852	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	1,211,234,904
QE 12/15	3,287,517,604	-	3,287,517,604	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	1,264,552,821
QE 3/16	3,295,111,804	-	3,295,111,804	648,184,948	312,291,893	(1,729,262)	213,667,327	224,085,947	(1)	20,729,076	43,581,049	3,093,001	-	482,776,013	1,946,679,991	1,348,431,813
QE 6/16	3,286,596,078	-	3,286,596,078	634,709,981	301,905,309	(1,180,414)	215,370,099	223,597,734	(3)	106,020,956	48,305,720	2,494,969		439,313,652	1,970,538,003	1,316,058,075
QE 9/16	3,327,365,481	110,036,940	3,437,402,421	669,689,230	311,948,359	(750,198)	221,278,330	214,057,429	(685)	504,237	-	2,161,386		491,624,231	1,910,512,319	1,526,890,102
	$ 53,177,247,357	$ 538,000,246	$ 53,715,247,603	$ 12,540,689,231	$ 5,364,557,426	$ 1,139,393,411	$ 3,674,082,968	$ 3,979,291,472	$ 1,872,480	$ 536,807,362	$ 877,838,625	$ 194,357,640	$ 453,960	$ 4,554,916,465	$ 32,864,261,040	$ 20,850,986,563

Last Updated: 11/28/2016

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III. SUMMARY BY DEMONSTRATION YEAR

	Federal Share of Budget Neutrality Limit	Federal Share of Waiver Costs on CMS-64	Annual Variance	As % of Annual Budget Neutrality Limit	Cumulative Federal Share of Budget Neutrality Limit	Cumulative Federal Share of Waiver Costs on CMS-64	Cumulative Federal Share Variance	As % of Cumulative Budget Neutrality Limit
WAIVER PERIOD OCTOBER 1, 2011 THROUGH SEPTEMBER 30, 2016								
DY 01	$ 8,801,543,581	$ 5,636,517,001	$ 3,165,026,580	35.96%				
DY 02	8,901,569,632	5,842,627,726	3,058,941,906	34.36%				
DY 03	10,437,625,835	6,482,283,323	3,955,342,512	37.90%				
DY 04	12,267,880,648	7,378,295,466	4,889,585,182	39.86%				
DY 05	13,306,627,906	7,524,537,524	5,782,090,382	43.45%	$ 53,715,247,603	$ 32,864,261,040	$ 20,850,986,563	38.82%
	$ 53,715,247,603	$ 32,864,261,040	$ 20,850,986,563					

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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	917,864,400	582,446,683	123,080,530	19,811,523	(633,793)	1,642,569,343
AFDC/SOBRA	3,415,777,246	3,585,644,616	3,542,968,926	3,593,250,018	3,673,489,744	17,811,130,550
ALTCS-EPD	1,062,033,693	1,167,492,540	1,195,922,455	1,246,554,641	1,198,914,984	5,870,918,313
ALTCS-DD	939,086,691	1,005,553,251	1,067,558,046	1,170,247,785	1,244,752,067	5,427,197,840
DSH/CAHP	155,762,651	163,493,529	162,262,955	160,980,915	152,785,300	795,285,350
Expansion State Adults	-	-	1,142,003,496	1,967,693,477	2,044,343,440	5,154,040,413
Family Planning Extension	830,631	1,008,110	195,976	(1,337)	(763)	2,032,617
MED	673,818	-	-	-	-	673,818
SNCP/DSHP	296,636,120	558,334,298	240,250,917	119,071,612	99,320,126	1,313,613,073
SSI	1,349,595,732	1,427,660,328	1,545,554,386	1,718,608,975	1,683,019,595	7,724,439,016
Uncomp Care IHS/638	22,866,717	97,192,513	53,888,765	13,437,080	7,205,006	194,590,081
Subtotal	8,161,127,699	8,588,825,868	9,073,686,452	10,009,654,689	10,103,195,706	45,936,490,414
New Adult Group	-	-	108,395,983	302,658,393	452,799,508	863,853,884
Total	8,161,127,699	8,588,825,868	9,182,082,435	10,312,313,082	10,555,995,214	46,800,344,298

Federal Share

Waiver Name	01	02	03	04	05	Total
AC	640,083,744	400,325,375	85,994,706	13,553,532	(563,946)	1,139,393,411
AFDC/SOBRA	2,385,735,722	2,468,733,953	2,499,604,236	2,567,133,806	2,619,481,514	12,540,689,231
ALTCS-EPD	716,918,093	770,713,779	807,562,631	856,189,434	827,907,535	3,979,291,472
ALTCS-DD	632,712,981	661,924,661	719,023,961	802,086,202	858,335,163	3,674,082,968
DSH/CAHP	104,828,265	107,382,550	109,089,385	110,207,533	105,299,629	536,807,362
Expansion State Adults	-	-	974,907,211	1,726,897,760	1,853,111,494	4,554,916,465
Family Planning Extension	767,009	927,946	179,426	(1,212)	(689)	1,872,480
MED	453,960	-	-	-	-	453,960
SNCP/DSHP	199,636,108	366,713,968	161,520,692	81,516,426	68,451,431	877,838,625
SSI	932,533,084	968,837,815	1,070,555,245	1,207,304,996	1,185,326,286	5,364,557,426
Uncomp Care IHS/638	22,848,035	97,067,679	53,845,830	13,406,989	7,189,107	194,357,640
Subtotal	5,636,517,001	5,842,627,726	6,482,283,323	7,378,295,466	7,524,537,524	32,864,261,040
New Adult Group	-	-	108,395,983	302,658,393	452,799,508	863,853,884
Total	5,636,517,001	5,842,627,726	6,590,679,306	7,680,953,859	7,977,337,032	33,728,114,924

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)	326	612,392
AFDC/SOBRA	1,014,881	1,090,143	990,293	5,056,392	4,912,060	13,063,769
SSI	365,158	399,101	398,723	2,391,771	2,371,156	5,925,909
Expansion State Adults	-	-	223,239	3,043,744	3,208,358	6,475,341
ALTCS-DD (Cost Sharing)[1]	-	-	-	-	-	-
CAHP[2]	(1,693,611)	(1,700,000)	(1,700,000)	(10,491,900)	(10,491,900)	(26,077,411)
Total	-	-	-	-	-	-

Federal Share

Waiver Name	01	02	03	04	05	Total
AC	211,034	138,424	58,991	(5)	225	408,669
AFDC/SOBRA	683,014	716,006	665,774	3,461,607	3,385,392	8,911,793
SSI	245,752	262,130	268,062	1,637,406	1,634,201	4,047,551
Expansion State Adults	-	-	150,083	2,083,747	2,211,200	4,445,030
ALTCS-DD (Cost Sharing)[1]	-	-	-	-	-	-
CAHP[2]	(1,139,800)	(1,116,560)	(1,142,910)	(7,182,755)	(7,231,017)	(17,813,042)
Total	-	-	-	-	-	-

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

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

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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	918,177,972	582,657,439	123,168,275	19,811,516	(633,467)	1,643,181,735
AFDC/SOBRA	3,416,792,127	3,586,734,759	3,543,959,219	3,598,306,410	3,678,401,804	17,824,194,319
ALTCS-EPD	1,062,033,693	1,167,492,540	1,195,922,455	1,246,554,641	1,198,914,984	5,870,918,313
ALTCS-DD	939,086,691	1,005,553,251	1,067,558,046	1,170,247,785	1,244,752,067	5,427,197,840
DSH/CAHP	154,069,040	161,793,529	160,562,955	150,489,015	142,293,400	769,207,939
Expansion State Adults	-	-	1,142,226,735	1,970,737,221	2,047,551,798	5,160,515,754
Family Planning Extension	830,631	1,008,110	195,976	(1,337)	(763)	2,032,617
MED	673,818	-	-	-	-	673,818
SNCP/DSHP	296,636,120	558,334,298	240,250,917	119,071,612	99,320,126	1,313,613,073
SSI	1,349,960,890	1,428,059,429	1,545,953,109	1,721,000,746	1,685,390,751	7,730,364,925
Uncomp Care IHS/638	22,866,717	97,192,513	53,888,765	13,437,080	7,205,006	194,590,081
Subtotal	8,161,127,699	8,588,825,868	9,073,686,452	10,009,654,689	10,103,195,706	45,936,490,414
New Adult Group	-	-	108,395,983	302,658,393	452,799,508	863,853,884
Total	8,161,127,699	8,588,825,868	9,182,082,435	10,312,313,082	10,555,995,214	46,800,344,298

Federal Share

Waiver Name	01	02	03	04	05	Total
AC	640,294,778	400,463,799	86,053,697	13,553,527	(563,721)	1,139,802,080
AFDC/SOBRA	2,386,418,736	2,469,449,959	2,500,270,010	2,570,595,413	2,622,866,906	12,549,601,024
ALTCS-EPD	716,918,093	770,713,779	807,562,631	856,189,434	827,907,535	3,979,291,472
ALTCS-DD	632,712,981	661,924,661	719,023,961	802,086,202	858,335,163	3,674,082,968
DSH/CAHP	103,688,465	106,265,990	107,946,475	103,024,778	98,068,612	518,994,320
Expansion State Adults	-	-	975,057,294	1,728,981,507	1,855,322,694	4,559,361,495
Family Planning Extension	767,009	927,946	179,426	(1,212)	(689)	1,872,480
MED	453,960	-	-	-	-	453,960
SNCP/DSHP	199,636,108	366,713,968	161,520,692	81,516,426	68,451,431	877,838,625
SSI	932,778,836	969,099,945	1,070,823,307	1,208,942,402	1,186,960,487	5,368,604,977
Uncomp Care IHS/638	22,848,035	97,067,679	53,845,830	13,406,989	7,189,107	194,357,640
Subtotal	5,636,517,001	5,842,627,726	6,482,283,323	7,378,295,466	7,524,537,524	32,864,261,040
New Adult Group	-	-	108,395,983	302,658,393	452,799,508	863,853,884
Total	5,636,517,001	5,842,627,726	6,590,679,306	7,680,953,859	7,977,337,032	33,728,114,924

Calculation of Effective FMAP:

AFDC/SOBRA					
Federal	2,386,418,736	2,469,449,959	2,500,270,010	2,570,595,413	2,622,866,906
Total	3,416,792,127	3,586,734,759	3,543,959,219	3,598,306,410	3,678,401,804
Effective FMAP	0.698438374	0.688495282	0.705501913	0.71439036	0.713045242
SSI					
Federal	932,778,836	969,099,945	1,070,823,307	1,208,942,402	1,186,960,487
Total	1,349,960,890	1,428,059,429	1,545,953,109	1,721,000,746	1,685,390,751
Effective FMAP	0.690967304	0.678613176	0.692662216	0.702464775	0.70426427
ALTCS-EPD					
Federal	716,918,093	770,713,779	807,562,631	856,189,434	827,907,535
Total	1,062,033,693	1,167,492,540	1,195,922,455	1,246,554,641	1,198,914,984
Effective FMAP	0.675042701	0.6601445	0.675263373	0.686844688	0.690547325
ALTCS-DD					
Federal	632,712,981	661,924,661	719,023,961	802,086,202	858,335,163
Total	939,086,691	1,005,553,251	1,067,558,046	1,170,247,785	1,244,752,067
Effective FMAP	0.673753538	0.658269127	0.673522122	0.685398607	0.689563155
AC					
Federal	640,294,778	400,463,799	86,053,697	13,553,527	(563,721)
Total	918,177,972	582,657,439	123,168,275	19,811,516	(633,467)
Effective FMAP	0.697353669	0.687305734	0.698667713	0.684123668	0.889898405
Expansion State Adults					
Federal	-	-	975,057,294	1,728,981,507	1,855,322,694
Total	-	-	1,142,226,735	1,970,737,221	2,047,551,798
Effective FMAP			0.853646009	0.877327271	0.906117587
New Adult Group					
Federal	-	-	108,395,983	302,658,393	452,799,508
Total	-	-	108,395,983	302,658,393	452,799,508
Effective FMAP			1	1	1

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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	2,932,580	487,537	72,516	85,463	527,244	467	12,471		
Quarter Ended March 31, 2012	2,920,267	488,958	73,152	85,509	430,723	-	12,424		
Quarter Ended June 30, 2012	2,914,143	488,982	73,964	85,731	365,132	-	12,440		
Quarter Ended September 30, 2012	2,938,884	491,618	74,820	86,512	310,396	-	12,689		
Quarter Ended December 31, 2012	2,911,537	494,688	75,639	86,829	274,990	-	13,104		
Quarter Ended March 31, 2013	2,891,297	497,059	76,467	86,075	248,817	-	13,824		
Quarter Ended June 30, 2013	2,903,136	499,682	77,281	86,303	228,204	-	14,187		
Quarter Ended September 30, 2013	2,919,037	503,271	78,035	87,133	217,114	-	14,856		
Quarter Ended December 31, 2013	2,891,942	506,596	78,841	87,679	206,419	-	14,885		
Quarter Ended March 31, 2014	2,839,568	514,059	79,683	87,893	87	-	-	444,156	39,019
Quarter Ended June 30, 2014	2,955,939	522,679	80,672	88,734	2	-	-	624,670	86,577
Quarter Ended September 30, 2014	3,113,908	528,599	81,760	89,357	-	-	-	756,405	122,955
Quarter Ended December 31, 2014	3,146,645	535,890	82,728	90,010	-	-	-	818,297	149,858
Quarter Ended March 31, 2015	3,085,624	542,278	83,830	89,879	-	-	-	836,535	191,236
Quarter Ended June 30, 2015	3,106,356	542,786	84,836	89,927	-	-	-	846,708	245,366
Quarter Ended September 30, 2015	3,211,097	542,648	85,612	90,014	-	-	-	867,410	285,007
Quarter Ended December 31, 2015	3,264,186	547,068	86,377	89,870	-	-	-	917,644	312,525
Quarter Ended March 31, 2016	3,260,263	548,498	87,136	89,427	-	-	-	931,657	331,353
Quarter Ended June 30, 2016	3,243,573	543,203	88,209	89,389	-	-	-	931,132	332,522
Quarter Ended September 30, 2016	3,323,731	542,927	88,862	88,128				935,676	322,124

	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			20,729,076			20,729,076
Jun-16		(14,886)	180,953	4,170,769	98,068,611	102,405,447
Sep-16				504,238		504,238
Total Reported to Date	103,688,465	106,265,990	107,946,475	103,024,780	98,068,611	518,994,320
Unused Allotment	**202,520**	**118,379**	**33,660**	**6,683,037**	**11,968,329**	**19,005,926**

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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	-	39,019	86,577	122,955	248,551	143,796,696

	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	149,858	191,236	245,366	285,007	871,467	527,874,909

	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	312,525	331,353	332,522	322,124	1,298,524	823,524,901

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	22,574,052	-	22,574,052	13,870,414	8,703,638
QE 6/14	50,088,258	-	50,088,258	34,313,342	15,774,916
QE 9/14	71,134,386	-	71,134,386	47,984,458	23,149,928
QE 12/14	90,773,693	-	90,773,693	46,004,135	44,769,558
QE 3/15	115,837,646	-	115,837,646	70,387,348	45,450,298
QE 6/15	148,625,886	-	148,625,886	85,319,153	63,306,733
QE 9/15	172,637,683	-	172,637,683	97,948,283	74,689,400
QE 12/15	198,203,591	-	198,203,591	113,800,738	84,402,853
QE 3/16	210,144,323	-	210,144,323	122,290,142	87,854,181
QE 6/16	210,885,703	-	210,885,703	123,158,494	87,727,209
QE 9/16	204,291,284	-	204,291,284	108,777,377	95,513,907
	$ 1,495,196,505	$ -	$ 1,495,196,505	$ 863,853,884	$ 631,342,621

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	$ 143,796,696	$ 96,168,214	$ 47,628,482	33.12%				
DY 04	527,874,909	299,658,919	228,215,990	43.23%				
DY 05	823,524,901	468,026,751	355,498,150	43.17%	$ 1,495,196,505	$ 863,853,884	$ 631,342,621	42.22%
	$ 1,495,196,505	$ 863,853,884	$ 631,342,621					

Based on CMS-64 certification date of 9/30/2016