AHCCCS
Arizona Health Care Cost Containment System

Arizona's Section 1115 Waiver Demonstration
Annual Report
Federal Fiscal Year 2017
October 1, 2016 – September 30, 2017

Table of Contents

I. Introduction

Since its inception, the Arizona Health Care Cost Containment System (AHCCCS), Arizona's single state Medicaid agency, has had the unique distinction of operating a statewide managed care program under the Section 1115 Research and Demonstration Waiver. During its 35 years of operation, the program has proven to be an effective model for the delivery of high quality and cost effective health care services to low income populations. With a model based on competition and member choice, AHCCCS has frequently been a pioneer in testing health care policies and financing strategies, continuously seeking to improve health care outcomes while containing costs.

On September 30, 2016, the Centers for Medicare and Medicaid Services (CMS) approved an extension of Arizona's 1115 Waiver for a five year period from October 1, 2016 to September 30, 2021. Under the new five-year waiver demonstration, the State will continue to modernize its Medicaid program and continue many of the existing authorities that allows AHCCCS to maintain its unique and successful managed care model, use home and community based services for members with long term care needs and other innovations that make AHCCCS one of the most cost effective Medicaid programs in the nation.

Pursuant to the Special Terms and Conditions (STCs), paragraph 41, AHCCCS is required to submit an annual progress report to CMS. The purpose of the annual report is to document accomplishments, project implementation status, quantitative and case study findings, utilization data, and policy and administrative updates related to Arizona's 1115 Waiver Demonstration.

II. Waiver Demonstration Changes

In its effort to reform and modernize the Medicaid program, AHCCCS continues to work with CMS on various waiver amendment requests. Below is a summary of the waiver amendments that have been filed and/or approved in 2017.

Targeted Investments Program
On January 18, 2017, the Centers for Medicare and Medicaid Services (CMS) approved Arizona's request to implement the Targeted Investments (TI) Program to support the state's ongoing efforts to integrate the health care delivery system for AHCCCS members. The TI Program will fund time-limited, outcomes-based projects aimed at building the necessary infrastructure to create and sustain integrated, high-performing health care delivery systems that improve care coordination and drive better health and financial outcomes for some of the most complex and costly AHCCCS populations. The TI projects will serve (1) adults with behavioral health needs; (2) children with behavioral health needs, including children with or at risk for Autism Spectrum Disorder (ASD), and children engaged in the child welfare system; and (3) individuals transitioning from incarceration who are AHCCCS-eligible.

AHCCCS Works Waiver Amendment
Arizona Revised Statutes (A.R.S.) 36-2903.09 requires AHCCCS to request an amendment to the current Section 1115 Waiver to allow Arizona to implement a work requirement, additional eligibility verification requirements, and a lifetime limit on coverage for able bodied adult AHCCCS members. [1] Each year, AHCCCS must re-apply to CMS for each element of A.R.S. 36-2903.09 that CMS has not yet approved.

[1] A.R.S. 36-2903.09: http://www.azleg.gov/viewdocument/?docName=http://www.azleg.gov/ars/36/02903-09.htm

Pursuant to A.R.S. 36-2903.09 and taking into consideration 500 plus comments, AHCCCS submitted a waiver amendment request on December 19, 2017 to CMS seeking authority to implement work requirements and a five-year maximum lifetime benefit limit for able bodied AHCCCS members. This waiver amendment, titled "AHCCCS Works" is designed to provide low-income, able-bodied adults the tools needed to gain and maintain meaningful employment, job training, and education. Able-bodied adults between the ages of 19 and 55 who do not qualify for an exemption will be required to meet the following activities or combination of activities for at least 20 hours per week to qualify for AHCCCS coverage:

- Be employed or actively seek employment;
- Attend school; or
- Partake in Employment Support and Development program as defined in the waiver request.

Certain individuals are exempted from the AHCCCS Works requirements, including:

- Those who are at least 55 years old;
- American Indians;
- Pregnant Women and Women up to the end of the month in which the 90th day of post-pregnancy occurs;
- Former Arizona foster youths up to age 26;
- Individuals determined to have a serious mental illness (SMI);
- Individuals currently receiving temporary or permanent long-term disability benefits from a private insurer or from the government;
- Individuals who are determined to be medically frail;
- Full-time high school students who are older than 18 years old;
- Full-time college or graduate students;
- Victims of domestic violence;
- Individuals who are homeless;
- Individuals who have recently been directly impacted by a catastrophic event such as a natural disaster or the death of a family member living in the same household;
- Parents, caretaker relatives, and foster parents; or
- Caregivers of a family member who is enrolled in the Arizona Long Term Care System.

AHCCCS sought broad-based stakeholder feedback regarding the AHCCCS Works waiver amendment in accordance with 42 C.F.R 431.408. In January 2017, over 140 participants attended AHCCCS community forums in Phoenix, Flagstaff, and Tucson, as well as an in-person tribal consultation.[2] In addition, AHCCCS has received more than 500 written public comments, including 14 letters from tribal nations and tribal affiliated organizations.

Institution for Mental Disease (IMD) Waiver Amendment

On April 12, 2017, AHCCCS submitted to CMS a request for a waiver from restrictions on federal funding for services provided to Medicaid beneficiaries aged 21-64 who receive inpatient services in an Institution for Mental Disease (IMD), regardless of delivery system. With this approval, AHCCCS would maintain and enhance beneficiary access to behavioral health services. In addition, a waiver of the IMD

[2] SB 1092 Waiver Amendment Webpage:
https://www.azahcccs.gov/Resources/Federal/sb1092legislativedirectivewaiverproposal.html

exclusion would allow psychiatric facilities (i.e., hospitals, nursing facilities, or other institutions of more than 16 beds that are primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services) to be able to continue to provide reimbursable services to all AHCCCS members.

On June 2, 2017, CMS indicated that currently there is only a path forward for an IMD waiver for individuals with substance use disorder (SUD) needs, as part of a comprehensive state substance use disorder strategy. As a result, AHCCCS has submitted a document that includes a comprehensive overview of Arizona's SUD delivery strategy and a description of how Arizona is meeting the six milestones specified by CMS in its State Medicaid Director Letter (SMD) #17-003.

AHCCCS anticipates receiving CMS's approval for the SUD IMD waiver amendment request in 2018.

Phoenix Children's Hospital (PCH) Safety Net Care Pool (SNCP) Technical Amendment Correction
On July 25, 2017, AHCCCS submitted a technical amendment correction to the language of the Special Terms and Conditions (STC 32 and Attachment E) to allow Arizona to claim federal financial participation (FFP) for payments to Phoenix Children's Hospital (PCH) made after December 31, 2017, that are based on uncompensated care costs incurred by PCH during calendar year 2017, to the extent that the aggregate payments based on uncompensated care for calendar year 2017 do not exceed $90 million (total computable). The technical clarifications do not amend the total cap on SNCP funds that are available to PCH or otherwise substantively amend the SNCP program.

The PCH SNCP technical amendment correction was approved by CMS on December 29, 2017.

III. 1115 Waiver Post Award Forum

Pursuant to STC 10 and 42 CFR 431.420(c), within six months of the 1115 waiver demonstration implementation, and annually thereafter, Arizona is required to host a post award public forum in order to give stakeholders the opportunity to provide meaningful comment on the progress of the demonstration.

AHCCCS hosted community meetings across the state to provide the public with information about its 1115 waiver demonstration program. The Agency hosted three public forum meetings: January 17, 2017 in Phoenix; January 27, 2017 in Tucson; and January 30, 2017 in Flagstaff. AHCCCS presented the details of its demonstration waiver at the Arizona State Medicaid Advisory Committee (SMAC) on November 16, 2017, and at an in-person tribal consultation on January 18, 2017. All the stakeholder meetings had telephonic conference capabilities that ensured statewide accessibility. The Post Award Public Forum presentation slides can be found in Appendix 2.

IV. Enrollment Information

Table 1 contains a summary of the number of unduplicated enrollees for FY 2017 (October 1, 2016—September 30, 2017), by population categories. The table also includes the number of voluntarily and involuntary disenrolled members during this period.

Table 1

Population Groups	Number Enrollees	Number Voluntarily Disenrolled-Current Qtr	Number Involuntarily Disenrolled-Current Qtr
Acute AFDC/SOBRA	1,571,809	10,149	908,593
Acute SSI	217,994	970	95,376
Prop 204 Restoration	729,190	2,994	309,534
Adult Expansion	191,575	1,227	129,018
LTC DD	32,349	131	7,676
LTC EPD	39,203	168	15,492
Non-Waiver	45,375	882	35,813
Total	**2,827,495**	**16,521**	**1,501,502**

Table 2 is a snapshot of the number of current enrollees (as of October 1, 2017) by funding categories as requested by CMS.

Table 2

State Reported Enrollment in the Demonstration (as requested)	Current Enrollees
Title XIX funded State Plan [3]	**1,377,569**
Title XXI funded State Plan [4]	**23,199**
Title XIX funded Expansion[5]	**400,326**
• **Prop 204 Restoration (0-100% FPL)**	82,512
• **Adult Expansion (100% - 133% FPL)**	317,814
Enrollment Current as of	10/1/17

V. Consumer Issues

In support of the annual report to CMS, presented below is a summary of advocacy issues received in the Office of Client Advocacy (OCA) for FY 2017.

Table 1

Advocacy Issues[6]	Quarter 1 10/01/16-12/31/16	Quarter 2 1/1/17-3/31/17	Quarter 3 4/1/17-6/30/17	Quarter 4 7/1/17-9/30/17	Total
9+Billing Issues • Member reimbursements	83	68	40	55	**246**

[3] SSI Cash and Related, 1931 Families and Children, 1931 Related, TMA, SOBRA child and pregnant, ALTCS, FTW, QMB, BCCP, SLMB, QI-1

[4] KidsCare

[5] Prop 204 Restoration & Adult Expansion

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

• Unpaid bills					
Cost Sharing • Co-pays • Share of Cost (ALTCS) • Premiums (Kids Care, Medicare)	11	10	17	7	**45**
Covered Services	86	66	90	58	**300**
ALTCS • Resources • Income • Medical	8	13	15	21	**57**
DES • Income • Incorrect determination • Improper referrals	195	236	187	206	**824**
KidsCare • Income • Incorrect determination	4	5	5	5	**19**
SSI/Medical Assistance Only • Income • Not categorically linked	30	39	36	62	**167**
Information • Status of application • Eligibility Criteria • Community Resources • Notification (Did not receive or didn't understand)	268	377	386	387	**1,418**
Medicare • Medicare Coverage • Medicare Savings Program • Medicare Part D	8	5	3	1	**17**
Prescriptions • Prescription coverage • Prescription denial	74	80	72	73	**299**
Fraud-Referred to Office of Inspector General (OIG)	0	0	0	0	**0**
Quality of Care-Referred to Division of Health Care Management (DHCM)	19	25	37	38	**119**
Total	**786**	**924**	**888**	**913**	**3,511**

Table 2

Issue Originator	Quarter 1 10/01/16-12/31/16	Quarter 2 1/1/17-3/31/17	Quarter 3 4/1/17-6/30/17	Quarter 4 7/1/17-9/30/17	Total
Applicant, Member or Representative	670	735	726	779	**2,910**
CMS	9	11	11	10	**41**
Governor's Office	9	38	46	34	**127**
Ombudsmen/Advocates/Other Agencies…	90	125	92	70	**377**
Senate & House	8	15	13	20	**56**
Total	**786**	**924**	**888**	**913**	**3,511**

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

VI. Complaints and Grievances

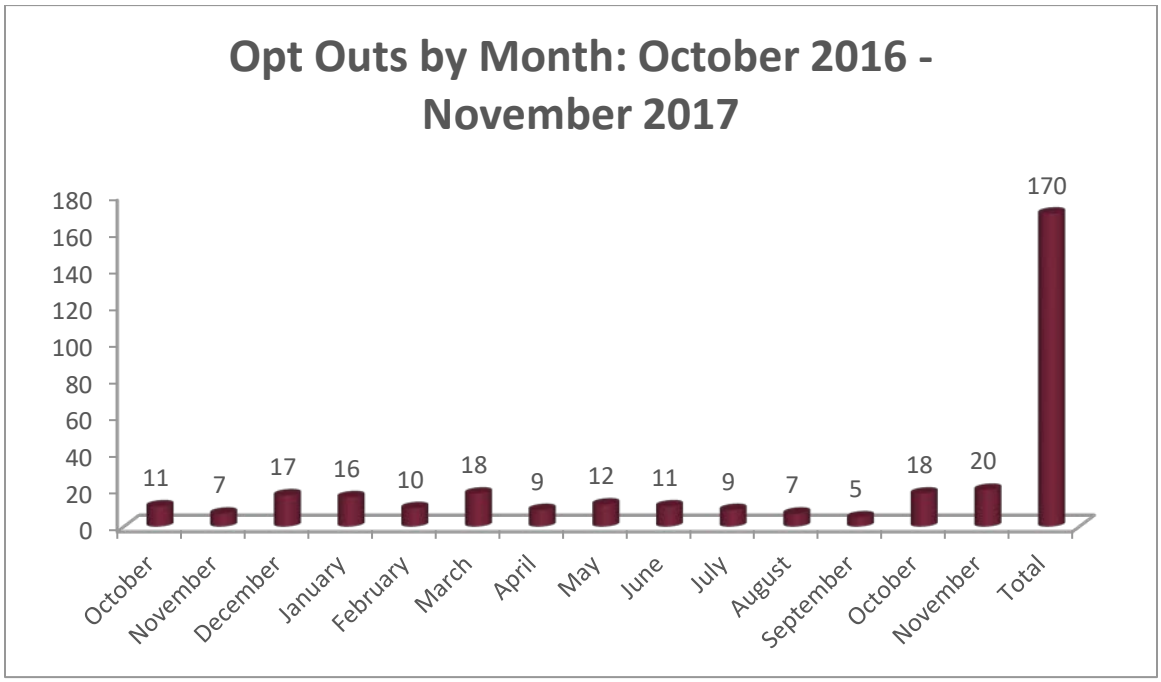
In support of the annual report to CMS, presented below is a summary of the number of complaints and grievances filed on behalf of beneficiaries participating in the SMI and CRS integration projects, broken down by access to care, health plan and provider satisfaction.

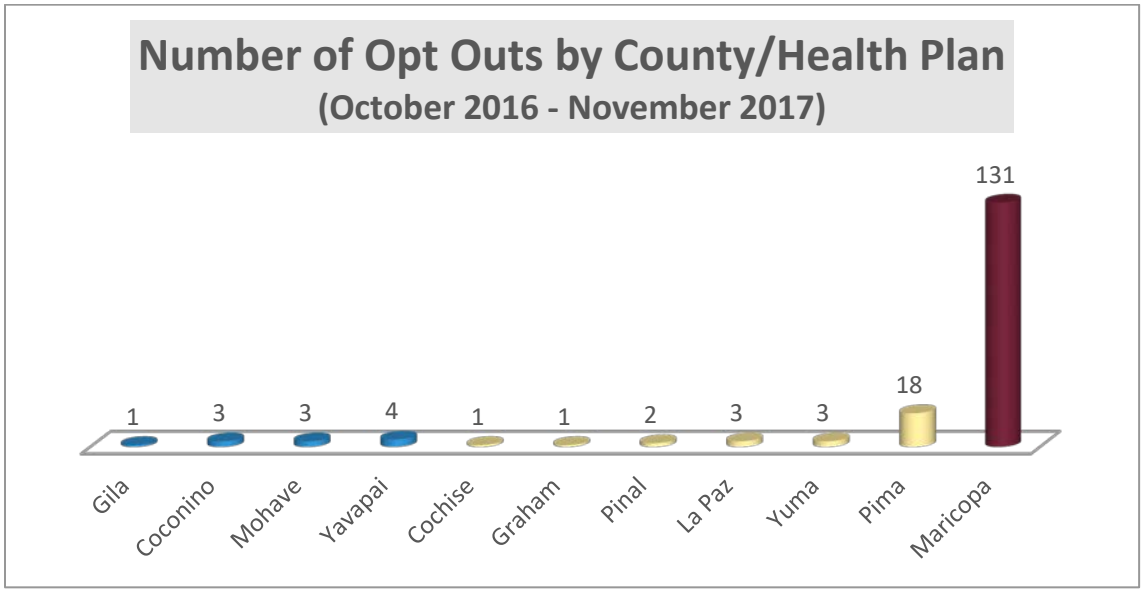
SMI Member Grievances and Complaints	Quarter 1 10/01/16-12/31/16	Quarter 2 1/1/17-3/31/17	Quarter 3 4/1/17-6/30/17	Quarter 4 7/1/17-9/30/17	Total
Access to Care	138	129	138	114	**519**
Health Plan	380	350	276	236	**1,242**
Provider Satisfaction	964	1,041	1,171	1,272	**4,448**
Total	**1,482**	**1,520**	**1,585**	**1,622**	**6,209**

CRS Member Grievances and Complaints	Quarter 1 10/01/16-12/31/16	Quarter 2 1/1/17-3/31/17	Quarter 3 4/1/17-6/30/17	Quarter 4 7/1/17-9/30/17	Total
Access to Care	0	0	0	0	**0**
Health Plan	10	7	8	3	**28**
Provider Satisfaction	19	26	30	29	**104**
Total	**29**	**33**	**38**	**32**	**132**

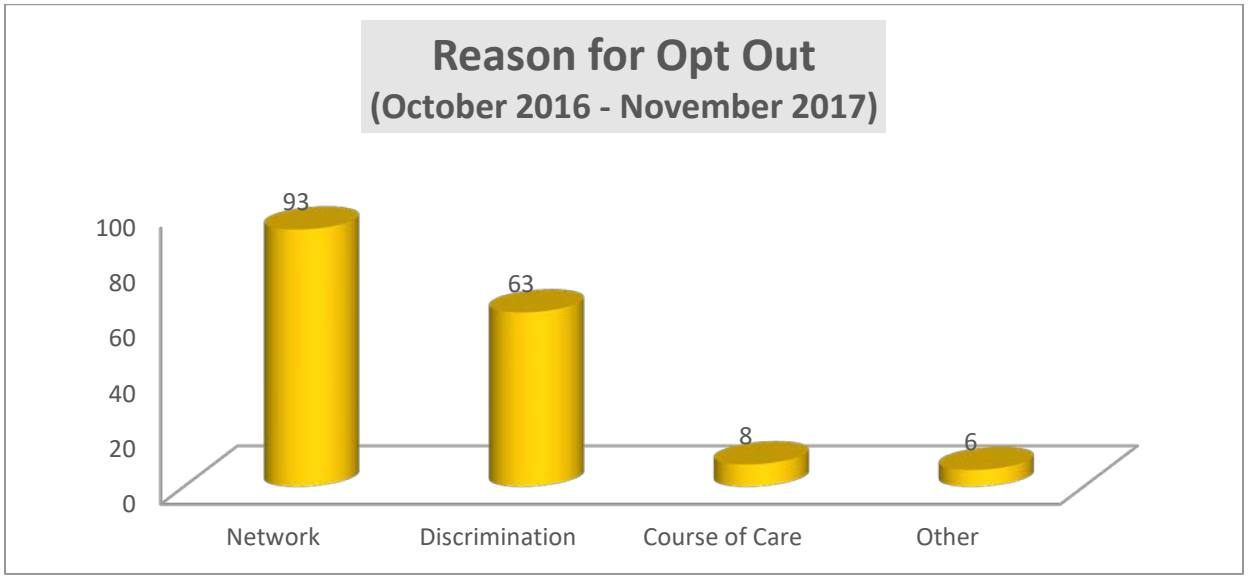
VII. Individuals with Serious Mental Illness (SMI) Opt-Out for Cause Report

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

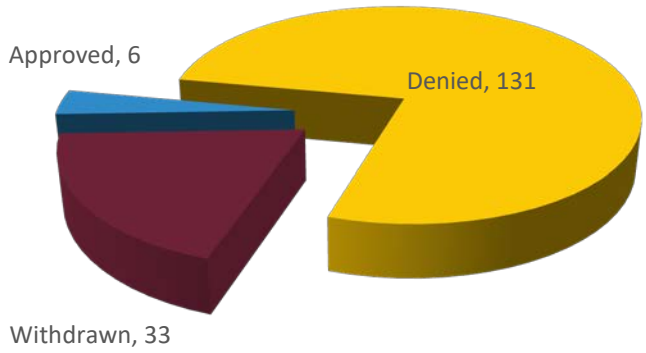




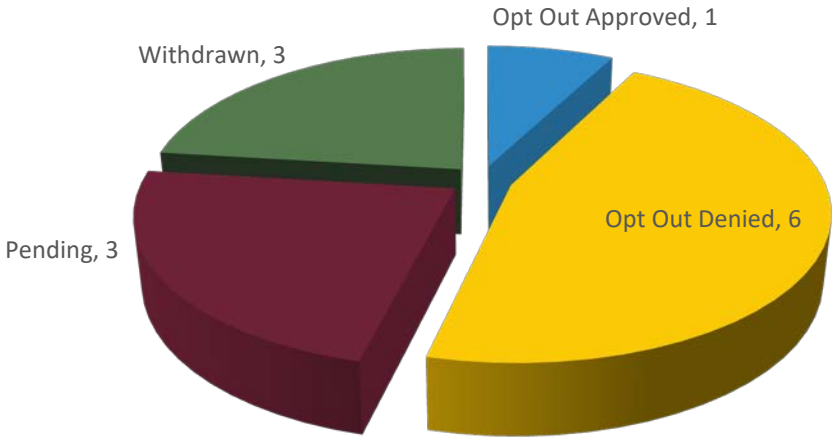
Number of Opt-Out by County /Health Plans: October 2016 - November 2017		
HCIC	Apache	
HCIC	Coconino	3
HCIC	Gila	1
HCIC	Mohave	3
HCIC	Navajo	
HCIC	Yavapai	4
HCIC	**Total**	**11**
CIC	Cochise	1
CIC	Graham	1
CIC	Greenlee	
CIC	La Paz	3
CIC	Pima	18
CIC	Pinal	2
CIC	Santa Cruz	
CIC	Yuma	3
CIC	**Total**	**28**
MMIC	Maricopa	**131**
Grand Total	**All Counties**	**170**



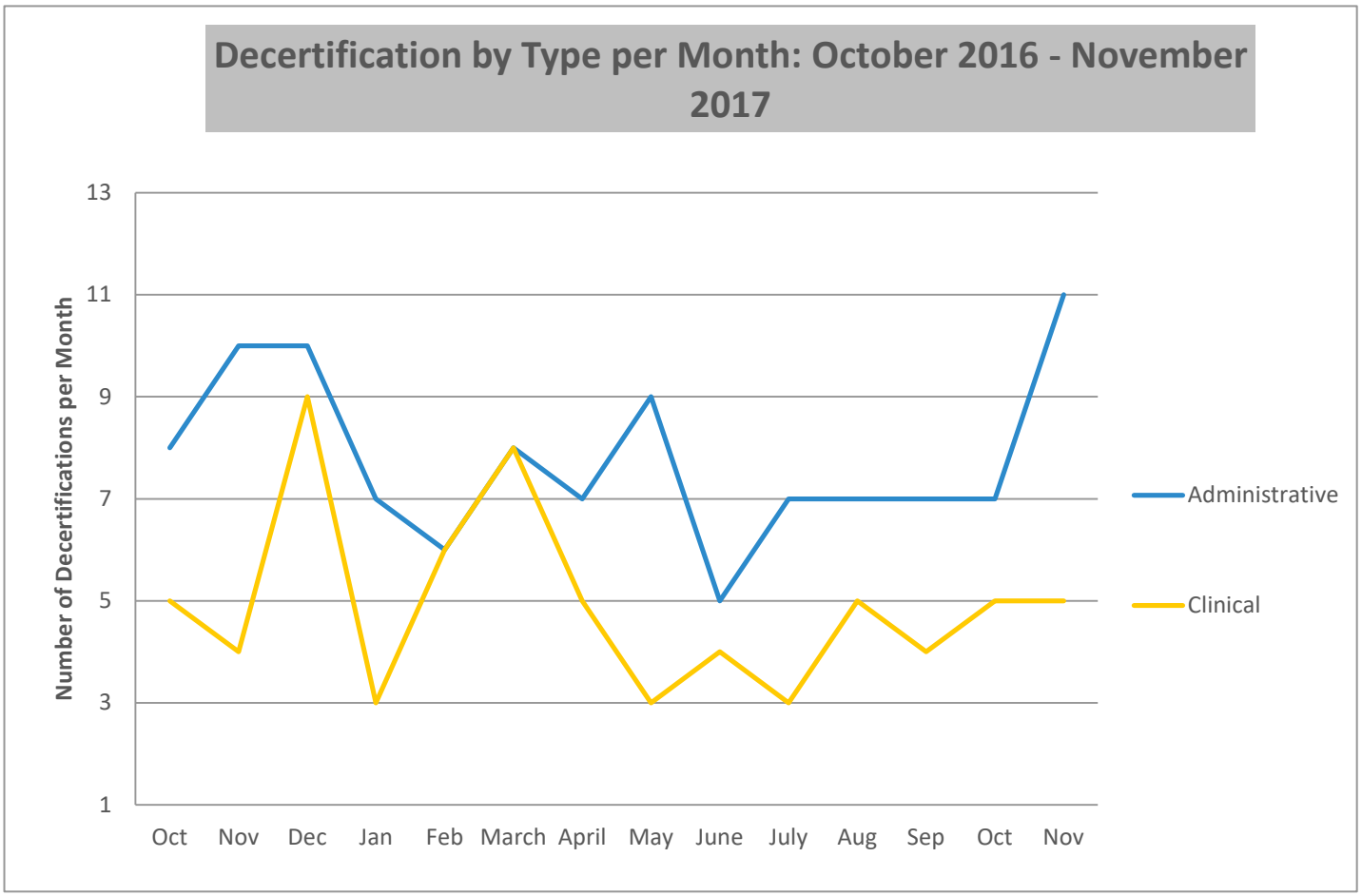
Initial Opt Out Decisions
(October 2016 - November 2017)



Appeal Outcomes
(October 2016 - November 2017)



Note: Number of appeals is based on those who requested an appeal within the timeframe



October 2016 - November 2017 Opt Out Request														
	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17
Admin	8	10	10	7	6	8	7	9	5	7	7	7	7	11
Clinical	5	4	9	3	6	8	5	3	4	3	5	4	5	5

Note:

There are two established mechanisms for changing an individual's designation and service eligibility as Seriously Mentally Ill (SMI) as follows:

- Clinical decertification. Eligibility for SMI services is based upon a clinical determination involving whether a person meets a designated set of qualifying diagnostic and functional criteria. Clinical decertification involves a review of the criteria to establish whether or not an individual continues to meet SMI criteria. If a clinical review finds that a person no longer meets the established criteria, the person's SMI eligibility is removed. In this case the person will be eligible for behavioral health services under the general mental health (GMH) program category. These determinations are made by CRN.

- Administrative decertification. This process is an administrative option that allows for an individual to elect to change their behavioral health category from SMI to GMH. This process is available to individuals who have a designation of SMI in the system but have not received behavioral health services for two or more years. This process is facilitated by AHCCCS.

VIII. Demonstration Operations and Policies

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 (Health Insurance Portability and Accountability Act of 1996) compliance issues.

During the time period of October 1, 2016 through September 30, 2017, OALS received 13,086 matters which included member appeals, provider claim disputes, ALTCS trust reviews, and eligibility appeals. Of the 13,086 total cases received, 405 were member appeals, 11,456 were provider claim disputes, 146 were ALTCS trust reviews, and 1,079 were eligibility appeals. OALS issued 652 Director's Decisions after State Fair hearings were held. In addition, OALS issued 12,874 informal dispositions of disputes filed with the AHCCCS Administration. In excess of 97 percent 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, 2014. 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. 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 9th Director Betlach filed a Response to the Motion to Intervene requesting denial of the Motion. On April 21st 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.

The Court of Appeals affirmed the decision of the Superior Court and upheld the hospital assessment, ruling that ARS §36-2901.08 creates an assessment that falls within the exception of Article 9, Section 22(C)(2) of the Arizona Constitution. Judge Gerlach declined to award attorney's fees because Appellants did not prevail on appeal. Appellants filed a Petition for Review with the Arizona Supreme Court and oral argument was held on October 26, 2017.

The Arizona Supreme Court upheld the AHCCCS Administration's hospital assessment in an Opinion dated November 17, 2017. The Opinion concluded that "the hospital assessment authorized in A.R.S. § 36-2901.08 is not a "tax" for purposes of article 9, section 22 of the Arizona Constitution and it is excepted from the supermajority vote requirement under subsection 22(C)(2) because it is "not prescribed by formula, amount or limit" and is set by the AHCCCS director."

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 to 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.

Plaintiffs' Reply was filed on January 5, 2017. The parties engaged in mediation on May 18 which was unsuccessful. Discovery resumed. On September 30, 2017, the District Court issued an Order granting Plaintiffs' Motion for Class Certification of a General Class and two subclasses consisting of the Non-Kinship Subclass and the Medicaid Subclass. The General Class consists of "all children who are or will be in the legal custody of DCS due to a report or suspicion of abuse or neglect." The Non-Kinship Subclass consists of "all members in the General Class who are not placed in the care of an adult relative or person who has a significant relationship with the child." The Medicaid Subclass is comprised of "all members of the General Class who are entitled to early and periodic screening, diagnostic, and treatment services under the federal Medicaid statute." Additionally, the Court granted Plaintiffs' request to appoint Perkins Coie, the Arizona Center for Law in the Public Interest, and Children's Rights, Inc. as class counsel. Petitions by Defendants to the Ninth Court appealing the ruling will be filed.

<u>Darjee and Sanchez Haro v Betlach</u> (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 had been requested but has not yet been scheduled.

The District Court Judge entered two Orders on March 31, 2017: Plaintiffs' Motions for Class Certification and Preliminary Injunction were denied, and Defendant Betlach's Motion to Dismiss was denied. Plaintiffs did not appeal. A Settlement Conference was held on June 19 2017 which was not successful. Plaintiffs' filed a Renewed Motion for Class Certification on September 15, 2017, and Defendant Betlach filed a Response to Motion for Class Certification on September 30, 2017. On November 8, Plaintiffs also file a Motion to Compel Defendant's Discovery Responses, and Defendant filed its Response to the Motion on November 11, 2017.

Legislative Update

AHCCCS proposed and advocated on behalf of one piece of legislation during the 2017 legislative session: House Bill (HB) 2084 (tribal courts; involuntary commitment orders). HB 2084 allows mental health treatment facilities outside of tribal service areas to admit tribal members for court-ordered treatment, pending the filing and domestication of a tribal court's involuntary commitment order in a Superior Court. In order to comply with the provisions of HB 2084, the tribal court's order for involuntary treatment must be filed by the close of business the next day the Superior Court is open following admission of the member. If the order is not filed in accordance with HB 2084, the member must be discharged back to the jurisdiction of the tribal court. HB 2084 was signed by the Governor on 3/29/17.

In addition to HB 2084, the legislature introduced a number of bills related to the Agency's operations, including HB 2442, SB 1030, SB 1440 and SB 1522.

HB 2442 (AHCCCS; dental care; pregnant women) would have required AHCCCS to add to the list of covered services dental services up to $1,000 annually for a person who is at least twenty-one years of age and in any stage of pregnancy. HB 2442 was unsuccessful in fulfilling the legislative process.

SB 1030 (AHCCCS; covered services; occupational therapy) would have required AHCCCS to add to the list of covered services occupational therapy in an outpatient setting. Historically, occupational therapy has only been a covered service for adults in an inpatient setting. The General Fund cost associated with adding this service was estimated to range from $113,000 to $272,000. Although this legislation did not fulfill the legislative process, this policy was successfully added to the approved budget and has become

law. In FY 2018, AHCCCS submitted a state plan amendment to cover occupational therapy for adult members in an outpatient setting.

SB 1440 (AHCCCS; clinical oversight committee) requires the AHCCCS Director to establish an internal clinical oversight review committee to review clinical data specific to agency initiatives and populations, including data on behavioral health services for persons receiving behavioral health services. The committee is required to 1) meet at least once every three months; 2) review clinical data specific to populations and initiatives being undertaken by the Administration; 3) analyze and review clinical quality performance metrics that are indicative of overall system performance and make recommendations on metrics that may enhance system performance, clinical outcomes and member experience; 4) advise the Director on challenges, successes and data trends and identify potential service delivery improvements; and 5) for behavioral health services, solicit additional information and perspectives related to the clinical data or clinical quality performance metrics reviewed by the committee from patients, patient advocates and other informed parties. Lastly, on or before 2/1/18 and by February 1 of each year thereafter, AHCCCS must provide a summary report of topics reviewed by the committee in the preceding year and any recommendations relating to quality performance metrics stemming from the committee's activities. SB 1440 was signed by the Governor on 4/26/17.

SB 1522 (budget; general appropriation act; 2017-2018) contained appropriations for state agencies and programs. Specific to the AHCCCS Administration, the budget included the following items:

1. Covered benefits expanded to include:
    a. Adult emergency dental benefit up to $1,000 annually;
    b. Occupational Therapy for adults in an outpatient setting;
2. 5 FTEs funded related to the opioid epidemic. The positions will be dedicated to identifying needs for member interventions and opportunities to prevent provider waste due to drug abuse; and
3. Funding related to the Proposition 206 minimum wage increases.

The Arizona Legislature adjourned Sine Die on May 10th, 2017; and general effective date is August 9, 2017.

Program Integrity Update

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 managed care organizations (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) 2017, the total OIG savings and recoveries for all programs was $32,299,180. OIG continued with projects, initiatives, cases, and joint efforts to proactively combat fraud, waste, and abuse within the AHCCCS program.

Provider Registration Section (PRS)

- 10,731 providers were added to the State Medicaid Program in FY 2017
- 74,947 total providers are active in AHCCCS
- The provider registration call center handled 47,589 telephone calls in FY 2017
- The PRS processed 64,793 documents related to provider applications
- 321 site visits were completed in FY 2017

Provider Compliance Section (PCS)

- The PCS worked on 10 pending cases from CMS regarding Excluded Providers.
    - CMS estimated the value of the loss to be $3,594,229.46. Cases are still pending final outcomes through the appropriate appeal processes and legal resolutions.

- The Non-Emergency Medical Transportation (NEMT) project continues to be a proven success with one full time investigator dedicated to this endeavor. FY 2017 has seen successful criminal prosecutions, asset recoupments and restitutions awarded 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:
    - 29 new cases opened
    - Eight of the new cases were presented and accepted for joint criminal investigation
    - 13 cases closed with recoupments and restitutions totaling $4,424,119.96
    - Three criminal cases with high media impact

- OIG is expecting prosecutorial results on additional cases coming up within these next months

- OIG has rigorous program integrity protocols to safeguard against Opioid and Pharmacy Fraud at both the provider and member level. In SFY 2017, PCS has achieved the following accomplishments:

  - 106 open cases related to Provider Opioid and Pharmacy Fraud
    - Out of the 106 open cases, thirty-three have been referred to Law Enforcement.
      - 28 to the Medicaid Fraud Control Unit in the Attorney General's Office
      - 4 to the US Drug Enforcement Administration (DEA)
      - 1 to the FBI
    - Notable cases included
      - Case 2016-1233
        - OIG successfully recovered $593,587 as result of this investigation.
      - Case 2016-1403
        - OIG successfully recovered $400,000 as a result of this investigation.

  - 79 open cases related to Member Opioid and Pharmacy Fraud

  - The AHCCCS OIG Pharmacy Initiative has implemented a variety of tools to mitigate fraud, waste and abuse as it relates to opioid prescriptions.
    - OIG has implemented a pharmacy "lock-down" program to promote safe use of controlled substances for members. An in-depth clinical review of pharmacy claims and the Controlled Substance Prescription Monitoring Program (CSPMP) are used to determine if the member meets the approved lock-down criteria. If the member meets the criteria, both the prescriber and member are notified of the decision to lock the member to a specific pharmacy. The Pharmacy Fraud Investigative Team (PFIT) has referred fifty (50) members to the lock-down program. As of SFY 2017, 13 members have been verified and officially enrolled in the lock-down program.
    - OIG is utilizing data from CSPMP to detect overprescribing, diversion, and fraud related to prescription of the controlled substances. Specifically, OIG has leveraged CSPMP to identify and review Arizona's top prescribers of controlled substance. As of SFY 2017, there are nine active investigations on providers listed on this top prescriber list. Five out of these nine cases are joint investigations with law enforcement.
    - OIG has also spent time tracking and comparing various referrals from a multitude of sources in order to identify any AHCCCS provider or member connections. This third initiative has led to a joint investigation with MFCU on a potential pharmaceutical fraud schemes.
    - OIG has recently hired both a licensed pharmacist and a pharmacy technician to combat fraud, waste and abuse.
    - Recently, PIT has aligned efforts with a federal task force on a joint case pending with the US Attorney's Office (USAO). Additional coordinated efforts have led to

the AGO's Consumer Division filing a lawsuit against a provider for illegally prescribing medications to AHCCCS members.

- Billing under the wrong Provider ID is a common trend found across several provider types. OIG actively pursues recoupments of overpayments related to wrongful billing. Case examples include, but are not limited to the following:
    - A provider that is currently being investigated billed under the wrong provider ID and also entered into a written agreement to allow an entity to use the provider's ID number to bill for services that were not rendered by the provider. OIG suspended payments to this entity and consequently entered in appeals process with the provider before the Administrative Law Judge (ALJ). The opposing counsel raised an argument stating that "AHCCCS OIG had no authority to impose any suspensions of payments due to; a believed violation of the 10th amendment, that federal regulations authorizing the suspension of payments exceed the scope of the PPACA, and that Arizona is specifically excluded from suspension of payments due to a failure to enact implementing legislation or regulations to do so." The ALJ recommendation found that "….this Tribunal….lacks the authority to make any administrative recommendations or orders on matters reaching beyond the purview of state administrative agencies and conflicts between federal laws and state sovereignty." As such, OIG is currently awaiting a finalized Director's Decision and potential further appeal.

- Home and Community Based Services (HCBS) 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:
    - OIG is conducting a joint investigation with a federal agency of a member who is believed to be falsifying a severe cognitive diagnosis (documented in his medical record as being unable to read, write, or function socially) in order to receive various Medicaid services.

    - OIG investigated a member who stole her caretaker's identity by claiming services were rendered and forging the caretaker's name. The member was qualified to receive AHCCCS benefits, including in-home caregiving services. On November 24, 2015, it was reported that the member 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 member created various documents forging the victim's signature. One such document allowed payment for caregiving services, allegedly provided by the victim, to be submitted to a pay card. The pay card was in the member's possession due to the fraudulent documentation submitted. As a result of this scheme, the member obtained through fraud more than $10,000 in AHCCCS funds. The member was sentenced to 3 years of probation, 200 hours of community service, and ordered to pay back restitution.

- Best Practices Identified by OIG PCU
    - Integration of various aspects of Pharmacy Fraud with the PFIT
        - Several areas of pharmacy cross over into member abuse and inappropriate provider billing practices. OIG's integrated oversight amongst its differing teams have worked and gained significant ground in identifying methods for actions on both realms.

- Integration with OIG collection unit to facilitate complete recoveries of monies due.
  - This effort is an ongoing streamline of information between both units to ensure all dollars are recouped from providers who owe balance to OIG.

- Continued outreach into the provider community
  - Recently OIG participated in an open forum presentation joint with AGO/MFCU, HHS OIG, and FBI on "How to Communicate with Regulators". The results of this presentation have created a presence of working with OIG to combat fraud, waste and abuse while also giving education to the provider community.

Member Compliance Section (MCS)

- The MCS conducted a joint investigation with DES/OIG into allegations that an AHCCCS member was part of a criminal enterprise profiting from illegal activities. It was determined that the member failed to report his correct income. The member pled guilty to Money Laundering and was sentenced to seven years of probation. Under the member's plea agreement, he forfeited seven bank accounts, seven vehicles, and nine properties in Cochise County. From the forfeitures, restitution in the amount of $38,414.00 was paid to AHCCCS.

- The MCS conducted a joint investigation with the Arizona Attorney General's Office. Allegations were that the member and her husband failed to report their correct income and committed abuse of Power of Attorney against the parents of the member's husband. They spent the victims' money for their own personal benefit which included the purchase of a home for the member's parents, a new pool, and home renovations. The members were sentenced to 2.5 years imprisonment for the wife and two years' imprisonment for the husband; both sentenced to four years of probation and ordered to pay AHCCCS $39,834.91 restitution. The husband's benefits were also terminated causing a $60,855.48 savings to AHCCCS.

- The MCS conducted a joint investigation with the Drug Enforcement Agency (DEA) into allegations that an AHCCCS member was part of an ongoing criminal enterprise and had unreported income that would impact her household's eligibility. It was determined that the member failed to report her correct income to AHCCCS and was laundering money through multiple unreported bank accounts. The member pled guilty to Facilitation to Commit Money Laundering and was sentenced to six months imprisonment, seven years of probation and ordered to pay AHCCCS $33,719.28 restitution.

- The MCS conducted an investigation into an AHCCCS member and her husband after they appeared on the television show "Dateline." The investigation revealed that the member failed to report that her husband was living with her and they were running a daycare out of their home. The member was found guilty and sentenced to three years of probation and ordered to pay AHCCCS $20,588.21 restitution.

- The MCS conducted an investigation after receiving a referral alleging that the member and his wife were operating a successful business in Sun City and collecting professional fees from another company while collecting Unemployment Insurance, Food Stamps, and AHCCCS medical benefits. The investigation found that the members failed to report their correct income. The couple pled guilty and was sentenced to one year of probation each and ordered to pay AHCCCS $46,593.48 restitution.

- The MCS conducted an investigation into allegations that an AHCCCS member failed to disclose her true income. This member was found to have been employed by an AHCCCS provider for a timeframe of four years. Had the member reported her income she would have been ineligible for benefits. The member entered into a settlement agreement with AHCCCS to repay the loss of $15,000.

- The MCS conducted a joint investigation with DES/OIG. The AHCCCS member and his children were residing in Mexico with the member's wife who had been deported. They received benefits between December 2009 and October 2015. The member pled guilty to Fraudulent Schemes and Practices. He was sentenced to three years of probation, ordered to serve 150 days in the county jail, up to 200 community restitution hours and ordered to pay AHCCCS $27,645.95 restitution.

Program Integrity Team (PIT)

- The PIT continues to handle high volume data requests from internal and external customers. In SFY 2017, PIT received 60 and 70 data requests per month, while maintaining an average turnaround time of two days. The National Association of Medicaid Fraud Control Units (NAMFCU) data requests are invariably more complex and take longer to process, but rarely require an extension to the submission deadline. PIT received over $2.3 million in Global Settlements in SFY 2017.

- In addition to servicing data requests, PIT analysts also conduct investigations and initiate provider self-audits. For SFY 2017, these activities resulted in recoveries of $766,000, program savings over $4 million, asset forfeitures of $214,000, and two prosecutions.

- The Medi-Medi referral process was further enhanced to summarize the status of cases on a monthly basis and ensure all referrals are evaluated and entered into the OIG Case Management system. Two PCS investigators are now dedicated to processing these cases.

- Development of the new Case Management system with the AHCCCS Information Services Division (ISD) is in the final stages. PIT is currently preparing test plans and tuning data migration utilities to import the cases from the old system. An aggressive year-end implementation date has been set.

- PIT continues to work closely with LexisNexis to enhance our data analytic activities and identify quality investigation leads. Recent developments include DEA Class II Summaries by prescriber/dispenser/patient, Pharmacy Report Cards based on potential FWA and risk factors, and a Provider Trend utility that can monitor the impact of a self-audit. A Relationship Mapping tool that connects providers via business/financial association is another product we may be considering.

Performance Improvement and Audit Section (PIAS)

- PIAS oversaw the Pharmacy Intelligence Project which led to the creation of PFIT which investigating matters related to opioid and prescription fraud, waste, and abuse. The PFIT has been in operation for approximately six months, consisting of investigators with provider and member fraud experience. The Pharmacy Intelligence Group continues to work closely with local

police departments, MFCU, and federal agencies in working joint investigations. The statistical accomplishment include:

- 303 Referrals Received;
- 215 Referrals Reviewed;
- One Outbound Referral;
- 34 Cases Opened;
- Five joint cases with MFCU,
- 50 Lock-down requests;
- 13 Approved lock-downs;
- 2 Search Warrants Issued; and
- One indictment.

- PIAS expanded OIG monthly metrics to track key performance indicators. The new monthly metrics include, but are not limited to (1) Case Processing Time; (2) Aged Cases; and (3) Active Cases by Allegation and by Investigator. At the end of SFY 2017 OIG Monthly Metrics consisted of a 61 page report with 118 data sets from all sections, Provider Registration; Fraud Prevention; Member Criminal Investigations; Program Integrity; Provider Compliance; Forensic Accounting; Pharmacy Fraud Intelligence; Collections; Audits; and Referrals.

- In SFY 2017, the newly formed Collections Team focused on cases that were 60 days or more past due. During that time 1,189 cases were 60 days or more past due. As result of the Collections Team's effort, 182 cases were collected on time which resulted in a total of $962,925.79 in collections.

- In SFY 2017, our Performance Improvement Project Manager completed 10 SharePoint Applications as part of our Performance Improvement efforts to increase effectiveness and efficiency of our data management. Applications were developed for several sections in OIG.

- In SFY 2017 all OIG sections continued to manage their individual Huddle Boards (Tier 1) in the following 10 areas: Provider Registration; Fraud Prevention; Member Criminal Investigations; Program Integrity; Provider Compliance; Forensic Accounting; Collections; OIG Audits; EHR Post-Pay Audits; and Referrals.

- Established an Executive Dashboard for overview of progress. In SFY 2017, the OIG Executive Dashboard (Tier 2 Huddle Board) was expanded to capture metrics for Forensic Accounting; EHR Post-Pay Audits; Referrals; Pharmacy Fraud Intelligence Team (PFIT); and Special Projects.

- In SFY 2017, the OIG Audit Team completed the following Audits:
  - Six Operational Reviews
  - 17 Deficit Reduction Act (DRA) Audits
  - Eight Provider Audits
  - 22 Hospital Presumptive Eligibility (HPE) Deliverable Reviews
  - 104 Managed Care Organizations (MCOs) Deliverable Reviews

- The EHR Post Pay Audit Team completed the following EHR Post Pay Audits:
  - 25 Eligible Hospitals (EH) Audits

- 55 Adapt, Implement, and Upgrade (AIU) Audits
- 22 Adapt and Implement
- Upgrade and Meaningful Use (AIU & MU) Audits
- 13- IHS Adapt, Implement, and Upgrade (IHS-AIU) Audits

- In SFY 2017, the CMS 2012 Medicaid Program Integrity Review Corrective Action Plan was approved and the review was closed.

- In SFY 2017, the CMS 2017 Medicaid Program Integrity Focused Review was conducted on-site by the CMS Review Team.

State Plan Update

SPA #	Description	Filed	Approved	Eff. Date
Title XIX				
SPA 15-004	Updates Ambulance Rates in the State Plan.	6/01/2015	1/30/2017	10/01/2015
SPA 15-005-B	Updates rates for outpatient services as of October 1, 2015.	8/26/2016	11/15/2016	10/01/2015
SPA 15-005-C	Updates rates for other provider services as of October 1, 2015.	8/26/2015	4/06/2017	10/01/2015
SPA 15-005-D	Updates reimbursement rates for Nursing Facilities the period October 1, 2015 to September 30, 2016 and permanently removes the automatic inflation factor beginning October 1, 2015.	8/27/2015	10/04/2016	10/01/2015
SPA 15-006	Updates funding for GME programs for the service period July 1, 2015, through June 30, 2016 for programs with submitted IGAs.	9/30/2015	4/11/2017	9/30/2015
SPA 16-002	Updates the State Plan to revise Air Ambulance Rates.	3/31/2016	4/06/2017	1/01/2016
SPA 16-005	Updates the State Plan to revise the assessment amounts for Nursing Facility supplemental funding	8/25/2016	4/11/2017	1/01/2017
SPA 16-006	Updates the State Plan to add to describe community paramedicine, otherwise referred to as Treat and Refer.	8/26/2016	10/24/2016	10/01/2016

SPA #	Description	Filed	Approved	Eff. Date
SPA 16-007	Updates the State Plan to include Freestanding Hospital-based Emergency Departments as a reimbursable provider under outpatient hospital services.	8/30/2016	11/15/2016	1/01/2017
SPA 16-008	Updates the State Plan to revise the effective date of rates to long term acute care and rehabilitation hospitals.	8/31/2016	3/30/17	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.	9/30/2016	Pending	9/30/2016
SPA 16-010-A	Updates rates for freestanding psychiatric hospitals for the period beginning October 1, 2016.	10/14/2016	12/08/2016	10/01/2016
SPA 16-010-B	Updates the State Plan to make changes to outpatient hospital rates.	12/30/2016	3/23/2017	10/01/2016
SPA 16-010-C	Updates the State Plan to make changes to other provider rates.	12/30/2016	6/02/2017	10/01/2016
SPA 16-010-D	Updates reimbursement for Nursing Facilities rates for the period beginning October 1, 2016.	10/20/2016	11/01/2016	10/01/2016
SPA 16-010-E	Updates the State Plan to make changes to ambulance and air ambulance rates.	12/30/2016	5/12/2017	10/01/2016
SPA 16-011	Updates the State Plan to add podiatrist services under the other licensed practitioner benefit.	9/20/2016	11/29/2016	8/06/2016
SPA 16-012-A	Updates the State Plan to include Value Based Purchasing (VBP) differential adjusted payment for Hospitals providing inpatient hospital services.	12/30/2016	06/08/2017	10/01/2016
SPA 16-012-B	Updates the State Plan to include Value Based Purchasing (VBP) differential adjusted payment for hospitals providing outpatient hospital services and providers registered with AHCCCS as integrated clinics.	12/30/2016	06/08/2017	10/01/2016

SPA #	Description	Filed	Approved	Eff. Date
SPA 16-012-C	Updates the State Plan to include Value Based Purchasing (VBP) differential adjusted payment for nursing facilities.	12/30/2016	3/23/2017	10/01/2016
SPA 16-013	Updates the State Plan to make changes to DRG payments.	12/30/2016	06/12/2017	10/01/2016
SPA 17-001	Updates the State Plan to make changes to NF payments.	03/29/2017	06/15/2017	01/01/2017
SPA 17-002	Updates the State Plan to make changes to the DRG pediatric policy adjustor.	03/29/2017	06/22/2017	01/01/2017
SPA 17-003	Adds the American Indian Medical Home program in the State Plan.	04/12/2017	06/14/2017	07/01/2017
Title XXI				
None				

IX. Quality Assurance/Monitoring Activities

Acute-Care Performance Measures

In 2012, AHCCCS initiated a process to transition its performance measure sets to measures included in the 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 provided 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 who have implemented the Core Measure Sets.

AHCCCS has updated the performance measure sets for all lines of business. The first substantive changes to the Performance Measure sets occurred in CYE 2014. Since that time, AHCCCS has continued to adjust the measure list across each of the populations served to better align with CMS Core Measure reporting as well as nationally-recognized measure sets. AHCCCS has also updated the measure sets in the MCO 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 or continuing work groups, new reporting mechanisms, and increased opportunities for technical assistance.

AHCCCS Medicaid and KidsCare rates for EPSDT Participation and EPSDT Dental Participation, for CYE 2016, are included in the tables below. This data is reflective of the information reported to CMS on the annual CMS-416 Report. Please note that while KidsCare is not formally reported to CMS via the CMS-416 Report; AHCCCS monitors this population using the same methodology as the CMS-416 Report for comparability purposes.

Acute-Care Measure	Percentage %					
	Current Rate: Measurement Period CYE 2015[1]	Measurement Period CYE 2014	Relative Percent Change	Statistical Significance	2015 Medicaid National Mean[2]	Minimum Performance Standard
Children's and Adolescents' Access to PCPs, 12 – 24 Months, *Medicaid*	95.1	97.1	-2.1	yes	94.7	93
Children's and Adolescents' Access to PCPs, 25 Months – 6 Years, *Medicaid*	87.6	88.5	-1.0	yes	87.2	84
Children's and Adolescents' Access to PCPs, 7 – 11 Years, *Medicaid*	91.5	92.4	-1.0	yes	90.2	83
Children's and Adolescents' Access to PCPs, 12 – 19 Years, *Medicaid*	89.2	90.1	-1.0	yes	88.6	82
Well-child Visits in the First 15 Months of Life, *Medicaid*	61.6	71.5	-13.9	yes	59.3	65
Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life, *Medicaid*	64.2	64.9	-1.2	yes	71.3	66
Adolescent Well-care Visits, *Medicaid*	39.4	40.7	-3.3	yes	48.9	41
Annual Dental Visits, Medicaid*	62.8	63.5	-1.1	yes	n/a	60*
Ambulatory Care: ED Visits, Total	59	56.2	n/a	n/a	n/a	TBD
Inpatient Utilization: Total Days per 1,000 MM	30.9	30.6	n/a	n/a	n/a	TBD
All-Cause Readmission: Total	11.5	13.6	-15.4	yes	n/a	TBD
Diabetes Short-Term Complications Admissions**	19.6	224.9	n/a	n/a	n/a	TBD
COPD or Asthma in Older Adults Admissions**	54.3	876.2	n/a	n/a	n/a	TBD

Heart Failure Admissions**	23.1	290.9	n/a	n/a	n/a	TBD
Asthma in Younger Adults Admissions**	8.5	104.3	n/a	n/a	n/a	TBD

[1] Reported rates reflective of draft rates for Contract Year Ending (CYE 2015)
[2] National means listed based on Calendar Year 2015 data published by NCQA in it's the *State of Health Care Quality 2016*.
[n/a] Rate was not measured for the specific reporting period.
* Annual Dental Visits – NCQA has this measure broken down by age group; therefore N/A was utilized as the Medicaid Mean.
** PQI Measures – Variation from CYE 2014 to CYE 2015 rates due to a change in calculations to reflect the rate per 100,000 member months starting CYE 2015

Acute-Care Measure	Percentage %					
	Current Rate: Measurement Period CYE 2016	Measurement Period CYE 2015	Relative Percent Change	Statistical Significance	2015 Medicaid National Mean	Minimum Performance Standard
EPSDT Participation, Medicaid	48.3	51.5	-6.2	yes	n/a	68
EPSDT Dental Participation, Medicaid	42.7	46.2	-7.7	yes	n/a	46
EPSDT Participation, CHIP*	n/a	51.9	n/a	n/a	n/a	68
EPSDT Dental Participation, CHIP	56.8	54.6	4.1	no	n/a	46

[n/a] Rate was not measured for the specific reporting period.
* During the reporting period, the CHIP program was frozen and there were not sufficient members to report on the data.

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 Contractors 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 (MPS) established for any measure. AHCCCS advises Contractors that they may face financial sanctions if their rates do not meet MPS. 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 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 and quality improvement 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 2017, AHCCCS finalized data from CYE 2014 as well as ran the CYE 2015 rates. 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 and DDD Contractors are working toward improving the delivery of services and quality of care provided to their members. AHCCCS has a comprehensive system to monitor and improve the timeliness of, access to, and quality of care that Contractors provide to Medicaid members.

ALTCS E/PD Measures	Percentage %					
	Current Rate Measurement Period CYE 2015[1]	Measurement Period CYE 2014	Relative Percent Change	Statistical Significance	2015 Medicaid National Mean[2]	Minimum Performance Standard
7 Day Follow-Up After Hospitalization for Mental Illness	40.6	18.0	125.5	yes	n/a	50
30 Day Follow-Up After Hospitalization for Mental Illness	72.9	32.3	125.7	yes	n/a	70
Ambulatory Care: ED Visits	68	63	n/a	n/a	n/a	TBD
Inpatient Utilization: Total Days per 1,000 MM	206.9	185.4	n/a	n/a	n/a	n/a
All-Cause Readmission: Total	13.8	15.5	-10.9	yes	n/a	TBD
Diabetes Short-Term Complications Admissions**	11.5	170.6	n/a	n/a	n/a	TBD
COPD or Asthma in Older Adults Admissions**	106.1	1330	n/a	n/a	n/a	TBD
Heart Failure Admissions**	122.3	1152.8	n/a	n/a	n/a	TBD
Asthma in Younger Adults**	n/a	212.8	n/a	n/a	n/a	TBD

[1] Reported rates reflective of draft rates for Contract Year Ending (CYE 2015)

[2] National means listed based on Calendar Year 2015 data published by NCQA in it's the *State of Health Care Quality 2016*.

n/a Rate was not measured for the specific reporting period.

** PQI Measures – Variation from CYE 2014 to CYE 2015 rates due to a change in calculations to reflect the rate per 100,000 member months starting CYE 2015

ALTCS E/PD Measures	Percentage %					
	Current Rate Measurement period CYE 2016	Measurement period CYE 2015	Relative Percent Change	Statistical Significance	2015 Medicaid National Mean	Minimum Performance Standard

EPSDT Participation	41.6	37.9	9.8	no	n/a	68
EPSDT Dental Participation	36.3	38.9	-6.7	no	n/a	46

During CYE 2017, AHCCCS finalized data from CYE 2014 as well as ran the CYE 2015 rates for the DDD Performance.

ALTCS DDD Measures	Percentage %					
	Current Rate Measurement period CYE 2015[1]	Measurement Period CYE 2014	Relative Percent Change	Statistical Significance	2015 Medicaid National Mean[2]	Minimum Performance Standard
Children's and Adolescents' Access to PCPs, 12 – 24 Months	98.3	93.4	5.3	no	94.7	93
Children's and Adolescents' Access to PCPs, 25 Months – 6 Years	90.1	86.6	4.0	yes	87.2	84
Children's and Adolescents' Access to PCPs, 7 – 11 Years	91.1	90.1	1.1	no	90.2	83
Children's and Adolescents' Access to PCPs, 12 – 19 Years	88.4	87.3	1.2	no	88.6	82
Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life	51.8	48.0	3.4	yes	71.3	66
Adolescent Well-care Visits	39.7	35.8	4.1	yes	48.9	41
Annual Dental Visit*	55.4	52.9	4.9	yes	n/a	60*
Ambulatory Care: ED Visits	44	41.3	n/a	n/a	n/a	TBD
Inpatient Utilization: Total Days per 1,000 MM	53.3	46.6	n/a	n/a	n/a	n/a
All-Cause Readmission: Total	11.8	11.5	3.0	no	n/a	TBD
Diabetes Short-Term Complications Admissions**	3.2	63.7	n/a	n/a	n/a	TBD
COPD or Asthma in Older Adults Admissions**	12.0	99.5	n/a	n/a	n/a	TBD
Heart Failure Admissions**	3.8	47.8	n/a	n/a	n/a	TBD
Asthma in Younger Adults**	n/a	70.3	n/a	n/a	n/a	TBD

[1] Reported rates reflective of draft rates for Contract Year Ending (CYE 2015)

[2] National means listed based on Calendar Year 2015 data published by NCQA in it's the *State of Health Care Quality 2016*.

[n/a] Rate was not measured for the specific reporting period.

* Annual Dental Visits – NCQA has this measure broken down by age group; therefore N/A was utilized as the Medicaid Mean.

** PQI Measures – Variation from CYE 2014 to CYE 2015 rates due to a change in calculations to reflect the rate per 100,000 member months starting CYE 2015.

ALTCS DDD Measures	Percentage %					
	Current Rate Measurement period CYE 2016	Measurement Period CYE 2015	Relative Percent Change	Statistical Significance	2015 Medicaid National Mean	Minimum Performance Standard
EPSDT Participation	40.1	39.3	2.1	no	n/a	68

EPSDT Dental Participation	41.3	45.1	-8.4	yes	n/a	46

AHCCCS requires the Contractor to submit Corrective Action Plans for measures that do not meet the MPS.

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.

General Mental Health/Substance Abuse (GMH/SA) Performance Measures

General Mental Health/Substance Abuse members receive Behavioral Health services from the Regional Behavioral Health Authorities (RBHAs) and AHCCCS evaluates those services in the same manner as physical health services. Data from CYE 2014 as well as CYE 2015 for the General Mental Health/Substance Abuse Performance Measures are included below.

General Mental Health/Substance Abuse Measures	Percentage %					
	Current Rate: Measurement period CYE 2015[1]	Measurement period CYE 2014	Relative Percent Change	Statistical Significance	2015 Medicaid National Mean[2]	Minimum Performance Standard
Plan All-Cause Readmission	21.5	22.4	-3.9	no	n/a	TBD
Inpatient Utilization – Total Days per 1,000 MM	18.3	n/a	n/a	n/a	n/a	TBD

[1] Reported rates reflective of draft rates for Contract Year Ending (CYE 2015)

[2] National means listed based on Calendar Year 2015 data published by NCQA in it's the *State of Health Care Quality 2016*.

[n/a] Rate was not measured for the specific reporting period.

Serious Mental Illness (SMI) Performance Measures

On April 1, 2014, approximately 17,000 members with Serious Mental Illness in Maricopa County were transitioned to a single plan, Mercy Maricopa Integrated Care, to manage both their behavioral and physical health care needs. On October 1, 2015, this model will be launched statewide through contracts with Health Choice Integrated Care in Northern Arizona and Cenpatico Integrated Care in Southern Arizona. Data from CYE 2014 as well as CYE 2015 for the SMI Measures are included below.

SMI Measures	Percentage %					
	Current Rate: Measurement Period CYE 2015[1]	Measurement Period CYE 2014	Relative Percent Change	Statistical Significance	2015 Medicaid National Mean[2]	Minimum Performance Standard
Cervical Cancer Screening	21.9	n/a	n/a	n/a	55.8	64
Plan All-Cause Readmission	26.1	n/a	n/a	n/a	n/a	TBD
Ambulatory Care: ED Visits	160	142	n/a	n/a	n/a	TBD
Diabetes Short-Term Complications Admissions**	44.1	466	n/a	n/a	n/a	TBD
COPD or Asthma in Older Adults Admissions**	114.4	1,003	n/a	n/a	n/a	TBD
Heart Failure Admissions**	32.7	216	n/a	n/a	n/a	TBD
Asthma in Younger Adults Admissions**	21.5	242	n/a	n/a	n/a	TBD

Inpatient Utilization: Total Days per 1,000 MM	456.5	n/a	n/a	n/a	n/a	TBD

[1] Reported rates reflective of draft rates for Contract Year Ending (CYE 2015)
[2] National means listed based on Calendar Year 2015 data published by NCQA in it's the *State of Health Care Quality 2016*.
[n/a] Rate was not measured for the specific reporting period.

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.

AHCCCS Electronic Prescribing Performance Measurement

Line of Business	Percent of Providers who prescribed at least one prescription electronically	Percent of prescriptions prescribed electronically
Acute		
2016 (Re-Measurement 1)	69.5	49.5
2014 (Baseline)	65.1	42.5
ALTCS DD		
2016 (Re-Measurement 1)	62.8	57.9
2014 (Baseline)	57	44.5
ALTCS E/PD		
2016 (Re-Measurement 1)	58.4	28.5
2014 (Baseline)	49.7	24.6
CMDP		
2016 (Re-Measurement 1)	55.3	56.6
2014 (Baseline)	47.7	46.7
CRS		
2016 (Re-Measurement 1)	58.5	57.3
2014 (Baseline)	50.8	42.9

X. Demonstration Implementation Update

AHCCCS Acute Care Program Demonstration

AHCCCS has operated under an 1115 Research and Demonstration Waiver since 1982, when it became the first statewide Medicaid managed care system in the nation. The AHCCCS Acute Care Program is a statewide, managed care system that delivers acute care services through eight prepaid, capitated health plans, known as Managed Care Organizations.

The Acute Care program includes services for children and pregnant women who qualify for the federal Medicaid Program (Title XIX), as well as childless adults and families. Although most AHCCCS members are required to enroll in contracted health plans, American Indians and Alaska Natives in the Acute Care program may choose to receive services through either the contracted health plans or American Indian Health Program (AIHP). The Acute Care program also includes behavioral health benefits largely administered through Regional Behavioral Health Authorities (RBHAs) that manage the full physical and

behavioral health benefit for persons with a serious mental illness (SMI). All AHCCCS acute MCOs also must be Dual Eligible Special Needs Plans (D-SNPs) to serve members who are eligible for both Medicaid and Medicare.

On November 2, 2017, AHCCCS released a Request for Proposal (RFP) for the "AHCCCS Complete Care" program, which will integrate physical and behavioral health care contracts under managed care plans for the Acute Care program members. Integrating physical and behavioral healthcare contracts will drive several strategic, innovative health care initiatives forward. With these contracts, AHCCCS strives to improve payment systems, encourage participation in electronic health record sharing, reward providers for positive health outcomes, provide coordinated care to inmates as they leave the justice system, impact services for foster children and those diagnosed with Autism Spectrum Disorder, and create more access to treatment for opioid and heroin-addicted patients

Specifically, the AHCCCS Complete Care RFP is soliciting participation of MCOs that will replace Acute and Children Rehabilitative Services (CRS) Contractors serving the following Title XIX/XXI populations and services:

- Adults who are not determined to have a Serious Mental Illness who are covered for general mental health and/or substance needs for integrated physical and behavioral health services.

- All children except for foster children enrolled with the Comprehensive Medical Dental Program (CMDP) members for integrated physical and behavioral health services. Children served by the MCOs include but are not limited to: children with CRS conditions, children determined to be Seriously Emotionally Disturbed (SED) and children at risk or diagnosed with Autism Spectrum Disorder (ASD).

The AHCCCS Complete Care RFP proposals are due on January 25, 2018, and multiple contracts will be awarded on or before March 8, 2018 in the three Geographic Services Areas (GSAs) that comprise all fifteen Arizona counties. Implementation is scheduled for October 1, 2018.

Arizona Long Term Care Program (ALTCS) Demonstration

In 1988, six years after the initial program implementation, the original demonstration waiver was substantially amended to allow Arizona to implement a capitated long term care program for the elderly and physically disabled and the developmentally disabled population – the Arizona Long Term Care System (ALTCS). The ALTCS program, administered as a distinct program from the AHCCCS Acute Care program, provides acute, long term care, behavioral health, and HCBS to Medicaid members who are at risk of institutionalization. Program services are provided through contracted prepaid, capitated arrangements with MCOs. ALTCS members who are developmentally disabled are served through the Department of Economic Security (DES), Division of Developmental Disabilities (DDD). The priority of the ALTCS program is to ensure that members are living in the most integrated setting and actively engaged and participating in community life. Over the past 28 years, ALTCS has achieved remarkable success increasing member placement in HCBS, resulting in significant program savings while also appropriately meeting the needs of members.

In March 2017, AHCCCS awarded contracts for the Arizona Long Term Care System (ALTCS) program for individuals who are elderly and/or have a physical disability (EPD). UnitedHealthcare Community Plan (UHCCP), Mercy Care Plan (MCP), and Banner-University Family Care (B-UFC) will serve more than

26,000 members who are elderly, blind, or disabled and at risk of institutionalization. The ALTCS contracts are awarded by the GSAs listed in the table below. Contracts are effective October 1, 2017, and will run for up to seven years.

ALTCS Managed Care Organization (MCO)	**Geographical Service Area (GSA)**		
	Central GSA *Maricopa, Gila, Pinal*	**South GSA** *Mohave, Coconino, Apache, Navajo, Yavapai*	**North GSA** *Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, Yuma*
Banner-University Family Care (B-UFC)	X	X	
Mercy Care Plan (MCP)	X	X (Pima County Only)	
UnitedHealthcare Community Plan (UHCCP)	X		X

Targeted Investments (TI) Program Demonstration

TI Program Background

On January 18, 2017, CMS approved an amendment to Arizona's 1115 Research and Demonstration Waiver authorizing the Targeted Investments (TI) program. The TI Program will fund time-limited, outcomes-based projects aimed at building the necessary infrastructure to create and sustain integrated, high-performing health care delivery systems that improve care coordination and drive better health and financial outcomes for some of the most complex and costly AHCCCS populations. The TI Program will provide funding for providers who serve the following populations:

- Adults with behavioral health needs;
- Children with behavioral health needs, including children with or at risk for Autism Spectrum Disorder, and children engaged in the child welfare system; and
- Individuals transitioning from incarceration.

The program will make up to $300 million in directed incentive payments to AHCCCS providers who assist the State in promoting the integration of physical and behavioral health care, increasing efficiencies in care delivery, and improving health outcomes. The TI Program will incentivize providers to collaborate on the development of shared clinical and administrative protocols to enable patient care management across provider systems and networks. Incentive payments will be distributed to participating providers through AHCCCS managed care organizations pursuant to 42 CFR 438.6(c). Providers are expected to meet performance improvement targets in order to receive payments. The table below displays the TI funding by federal fiscal year.

Estimated Annual Funding Distribution for the Targeted Investments Program

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Targeted Investments	$19 m.	$66.5 m.	$85.5 m.	$66.4 m.	$47.5 m.	$285 m.
Administrative Expenses	$1 m.	$3.5 m.	$4.5 m.	$3.5 m.	$2.5 m	$15 m.
Totals	$20 m.	$70 m.	$90 m.	$70 m.	$50 m.	$300 m.

In Demonstration Years 3 through 5, the state must meet the statewide performance measure targets to secure full TI program funding (Appendix 3). If the State does not meet certain performance requirements in a given demonstration year, the TI Program will lose the amount of Designated State Health Program (DSHP) funds specified as "at risk" for that year.

Total Computable DSHP at Risk for Each Demonstration Year

	Year 1	Year 2	Year 3	Year 4	Year 5
Total Computable DSHP	$6,274,400	$21,137,600	$27,177,000	$21,137,600	$15,098,300
Percentage at Risk	0%	0%	10%	15%	20%
Total Amount at Risk	$0	$0	$2,717,700	$3,170,640	$3,019,660

TI Program Updates

Below is a summary of the TI program implementation activities conducted by AHCCCS from January 18, 2017 through September 30, 2017:

- AHCCCS has worked closely with CMS to finalize the Designated State Health Programs (DSHP) protocol.
- AHCCCS developed the specific projects, milestones, and the associated requirements for the TI program focus areas: (1) adult physical health and behavioral integration; (2) children physical health and behavioral health integration; and (3) care coordination for individuals transitioning from incarceration who are AHCCCS-eligible.
- The Agency developed the attribution modeling to determine the basis for payment allocation to participating providers. AHCCCS worked in collaboration with a broad range of stakeholders including provider organizations and AHCCCS health plans to develop the TI program core project components and the associated milestones (for TI demonstration years 2 and 3). This activity also included developing the TI participant incentive payment model including attribution funds flow among provider types and areas of concentration.
- AHCCCS convened a statewide stakeholder forum to disseminate information regarding the TI program objectives, requirements, incentive payments, and application process. Approximately 300 individuals representing behavioral health providers, physical health providers, RBHAs, and Medicaid acute care plans attended this meeting (in-person and via webinar).
- AHCCCS launched the online application platform for behavioral health, hospital, and primary care providers interested to participate in the TI Program. Over 300 unique practices and organizations submitted applications to participate in the Program.
- AHCCCS initiated the review and validation process of the TI Program participation applications.

- The Agency launched the TI Program webpage as part of the public communication plan, as means to provide resources to Program applicants, and a dedicated email inbox to respond to stakeholder questions about the program.[7]
- AHCCCS submitted a draft evaluation design of TI program demonstration on May 17, 2017. The AHCCCS team is working closely with CMS to finalize the details of the evaluation design document.
- Pursuant to STC 57, AHCCCS has submitted the baseline data for the TI program Statewide Focus Population Measures and Targets (Appendix 3).

Waiver Evaluation Update

In accordance with STC 59, AHCCCS must submit a draft waiver evaluation design for its 1115 waiver demonstration programs including research questions, hypotheses, and proposed measures for the Acute Care program, ALTCS, and the integration efforts under the RBHAs and CRS plans. In addition, AHCCCS is required by CMS to submit an interim evaluation report and a final evaluation report of the 1115 waiver demonstration by September 30, 2020 and February 12, 2023 respectively.

On May 17, 2017, AHCCCS submitted a draft waiver evaluation design for TI program. The evaluation of the TI program will focus on understanding the impact of the TI projects on:

- Reducing fragmentation that occurs between acute care and behavioral health care including data and information sharing;
- Creating efficiencies in service delivery for members with behavioral health needs including the use of common screening and referral protocols and co-located services; and
- Improving health outcomes for targeted populations.

On June 8, 2017, AHCCCS submitted a draft waiver evaluation design for the Acute Care, ALTCS, Integrated RBHA, and CRS demonstrations. The evaluation design proposes to test a series of hypotheses that will allow Arizona to test its success in achieving the following demonstration goals:

- Providing quality health care to members in a mainstream environment;
- Ensuring access to care for members; and
- Maintaining or improving member satisfaction with care.

In FY 2018, AHCCCS will continue to work with CMS to finalize the evaluation designs for the TI program, Acute Care, ALTCS, Integrated RBHA, and CRS demonstrations.

XI. Notable Achievements

Achievements Noted Above

- AHCCCS successfully defended in court the current statutory structure of the Hospital Assessment funding. The Arizona Supreme Court upheld the AHCCCS Administration's hospital assessment in an Opinion dated November 17, 2017. The Opinion concluded that "the hospital assessment authorized in A.R.S. § 36-2901.08 is not a 'tax' for purposes of article 9, section 22 of the Arizona Constitution and it is excepted from the supermajority vote requirement under

[7] https://www.azahcccs.gov/PlansProviders/TargetedInvestments/

subsection 22(C)(2) because it is "not prescribed by formula, amount or limit" and is set by the AHCCCS director."

- The Agency received approval and began implementing the Targeted Investments program, helping facilitate integration at approximately 500 provider sites across the state. The TI Program is AHCCCS' strategy to provide financial incentives to eligible AHCCCS providers to develop systems for integrated care.

- In 2017, AHCCCS successfully awarded the ALTCS RFP and transitioned over 9,000 members on October 1, 2017. Banner-University Family Care, Mercy Care Plan, and UnitedHealthcare Community Plan have been selected to provide integrated acute, behavioral health, and long term services and supports to over 26,000 AHCCCS members who are elderly (65 and over), blind, or disabled and at risk of institutionalization.

- In 2017, AHCCCS completed an RFI, held public meetings and released the largest procurement in the history of Arizona for AHCCCS Complete Care. The Complete Care program will integrate physical and behavioral health care contracts under managed care plans for the majority of the 1.9 million AHCCCS members.

New Items

- AHCCCS received approval from CMS to begin the American Indian Medical Home (AIMH) program. The AIMH program supports Primary Care Case Management (PCCM), diabetes education, care coordination, and promotes participation in the state Health Information Exchange (HIE), for American Indian/Alaska Native (AI/AN) members enrolled in AIHP. Beginning October 1, 2017, AHCCCS registered IHS/638 facilities who meet registration criteria to participate as an AIMH will become eligible for per member per month payments, based on the level of AIMH services the facility provides to empaneled members.

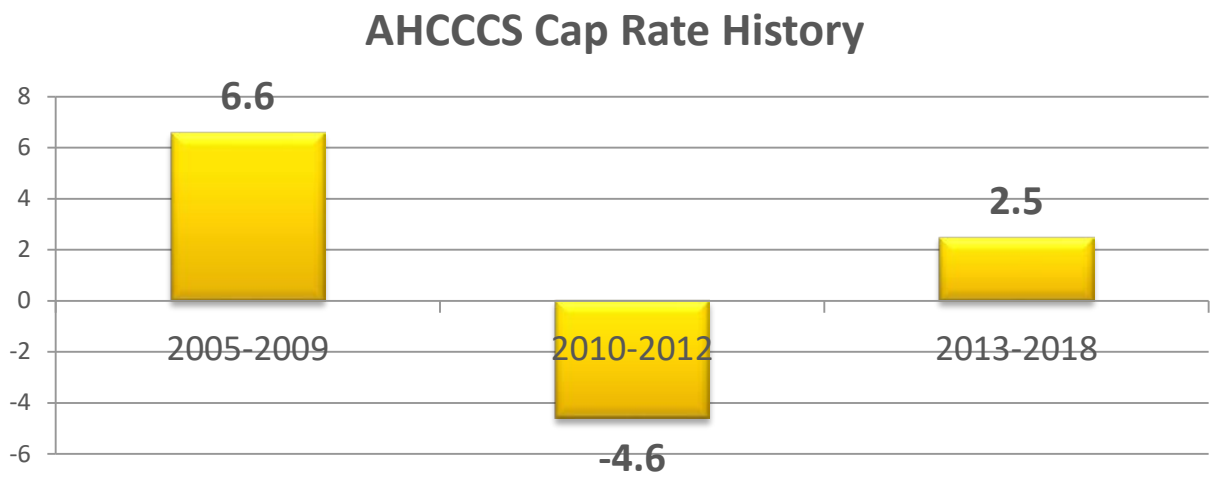
- The Agency established new Value Based Payment (VBP) strategies for Nursing Facilities (NFs) and providers who utilize E-prescriptions.

- AHCCCS completed a rebase of the APR-DRG methodology, better aligning inpatient reimbursement with current data.

- AHCCCS increased the funding for physicians who are affiliated with Graduate Medical Education (GME) by $40 million.

- The Agency implemented a new reimbursement methodology for Free-Standing Emergency Departments.

- For Contract Year Ending 2018, AHCCCS experienced a minimal overall weighted average capitation rate increase of 2.9% which continues the overall trend for capitation rate growth of below 3% for the program.



- The Office of Human Rights eliminated the waitlist for special assistance services and currently provides assistance to the largest number of individuals ever. The Office of Human has 2,504 individuals identified as Special Assistance and provides direct advocacy via assignment to 702 members.

- Cross–agency collaboration between AHCCCS, Department of Correction (DOC) and County justice partners resulted in over six thousand incarcerated individuals becoming eligible for AHCCCS prior to release.

- AHCCCS transitioned approximately 130,000 acute members as part of the closure of Phoenix Health Plan and Maricopa Health Plan.

- AHCCCS began registering Board Certified Behavior Analyst (BCBA) providers.

- The Agency expanded access to Hepatitis C medication while lowering the overall drug costs.

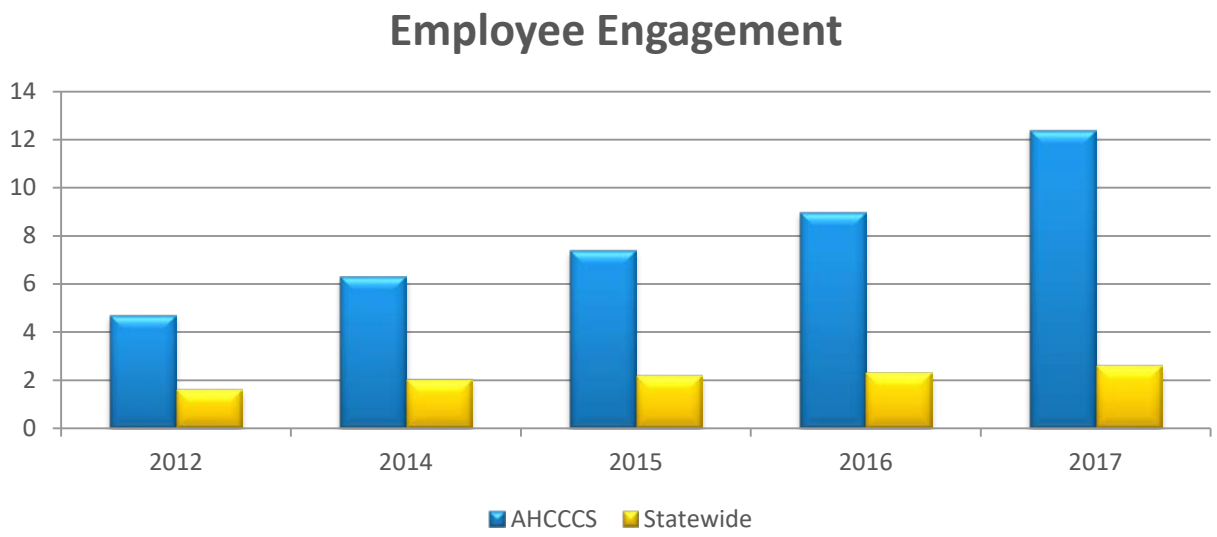
- AHCCCS has implemented a new Assessment Policy and streamlined demographic reporting to reduce provider and member administrative burdens.

- AHCCCS has dedicated significant agency resources to address the ongoing opioid epidemic that has occurred in the United States. In collaboration with the Governor and the Department of Health Services, AHCCCS has pursued a number of strategies to leverage limited grant funding and the Medicaid delivery system to expand capacity to services while at the same time establishing protocols to limit the number of prescriptions to opioid naïve members.

- AHCCCS has hosted four quarterly Tribal Consultation meetings which saw the largest turnout in AHCCCS history.

- In 2017, AHCCCS continues to have overall employee engagement scores that far exceeded the statewide average. The AHCCCS 2017 employee engagement survey indicated a strong positive feeling among staff. A total of 97% of staff value members of their team; 97% believe in the

AHCCCS mission; and 94% recognize fellow employees for work well done. In addition, AHCCCS has achieved a world class level of employee engagement with 12.4 engaged employees for every 1 disengaged employee. This is compared to the statewide average of 2.3 engaged employees for every 1 disengaged employee.



APPENDIX 1:
BUDGET NEUTRALITY

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended September 30, 2017

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

WAIVER PERIOD OCTOBER 1, 2011 THROUGH SEPTEMBER 2021:

	FFY 2012 PM/PM	DY1-5 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	2,932,510	2,920,199	2,914,080	2,938,811	11,705,600	$ 4,785,029,638	
SSI	835.29	1.06	885.41	69.10%	611.79	487,591	489,024	489,056	491,705	1,957,376	1,197,497,581	
AC [1]			562.09	69.74%	391.97	527,244	430,723	365,132	310,396	1,633,495	640,283,961	
ALTCS-DD	4643.75	1.06	4922.38	67.38%	3316.47	72,519	73,155	73,965	74,820	294,459	976,563,725	
ALTCS-EPD	4503.21	1.052	4737.37	67.50%	3197.93	85,460	85,506	85,730	86,512	343,208	1,097,554,228	
Family Plan Ext [1]		1.058	17.04	90.00%	15.33	12,471	12,424	12,440	12,689	50,024	767,009	
											$ 8,697,696,143	MAP Subtotal
											103,890,985	Add DSH Allotment
											$ 8,801,587,128	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%	423.93	2,911,442	2,891,192	2,903,029	2,918,910	11,624,573	$ 4,928,016,803	
SSI	938.53	67.86%	636.91	494,793	497,190	499,819	503,447	1,995,249	1,270,793,448	
AC [1]	600.80	68.73%	412.94	274,990	248,817	228,204	217,114	969,125	400,194,481	
ALTCS-DD	5217.72	65.83%	3434.66	75,639	76,467	77,281	78,035	307,422	1,055,890,374	
ALTCS-EPD	4983.71	66.01%	3289.98	86,829	86,075	86,303	87,133	346,340	1,139,450,235	
Family Plan Ext [1]	18.42	90.00%	16.58	13,104	13,824	14,187	14,856	55,971	927,946	
									$ 8,795,273,287	MAP Subtotal
									106,384,369	Add DSH Allotment
									$ 8,901,657,656	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%	456.99	2,891,763	2,839,342	2,955,581	3,113,393	11,800,079	$ 5,392,500,173	
SSI	994.84	69.27%	689.13	506,860	514,564	523,506	529,799	2,074,729	1,429,763,172	
AC [1]	600.56	69.84%	419.45	206,419	87	2	-	206,508	86,620,322	
ALTCS-DD	5530.78	67.35%	3725.09	78,841	79,683	80,672	81,758	320,954	1,195,581,666	
ALTCS-EPD	5242.86	67.53%	3540.32	87,679	87,893	88,734	89,362	353,668	1,252,096,959	
Family Plan Ext [1]	12.99	90.00%	11.69	14,885	-	-	-	14,885	174,071.00	
Expansion State Adults [1]	624.01	85.37%	532.70	-	443,847	624,103	755,543	1,823,493	971,375,076	
									$ 10,328,111,438	MAP Subtotal
									108,086,519	Add DSH Allotment
									$ 10,436,197,957	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%	486.77	3,145,932	3,084,693	3,104,991	3,209,034	12,544,650	$ 6,106,357,697	
SSI	1054.53	70.24%	740.75	537,346	543,950	544,675	544,701	2,170,672	1,607,931,319	
AC	0.00	68.43%	0.00	-	-	-	-	-	-	
ALTCS-DD	5862.63	68.54%	4018.16	82,725	83,826	84,827	85,603	336,981	1,354,045,077	
ALTCS-EPD	5515.49	68.68%	3788.31	90,012	89,878	89,930	90,018	359,838	1,363,179,215	
Family Plan Ext	0.00	90.00%	0.00	-	-	-	-	-	-	
Expansion State Adults	569.95	87.76%	500.16	817,223	835,272	845,124.00	865,504.00	3,363,123	1,682,107,571	
									$ 12,113,620,878	MAP Subtotal
									109,815,903	Add DSH Allotment
									$ 12,223,436,781	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	71.55%	512.89	3,261,498	3,258,413	3,246,906	3,331,594	13,098,411	$ 6,718,105,614	
SSI	1117.81	70.57%	788.89	549,592	552,070	548,929	551,512	2,202,103	1,737,221,089	
AC	0.00	68.48%	0.00	-	-	-	-	-	-	
ALTCS-DD	6214.39	68.96%	4285.72	86,368	87,129	88,236	89,201	350,934	1,504,003,499	
ALTCS-EPD	5802.30	69.10%	4009.42	89,881	89,458	89,610	89,890	358,839	1,438,735,473	
Family Plan Ext	0.00	90.00%	0.00	-	-	-	-	-	-	
Expansion State Adults	573.68	90.71%	520.36	915,333	929,666	931,186	937,206	3,713,391	1,932,303,643	
									$ 13,330,369,318	MAP Subtotal
									110,145,351	Add DSH Allotment
									$ 13,440,514,669	Total BN Limit

	DY6-10 Trend Rate	DY 06 PM/PM			Member Months QE 12/16	QE 3/17	QE 6/17	QE 9/17	Total		
AFDC/SOBRA	1.045	749.11	71.95%	538.96	3,382,815	3,386,731	3,369,171	3,349,764	13,488,481	7,269,817,985	
SSI	1.04	1162.52	70.90%	824.21	552,447	553,552	551,946	550,778	2,208,723	1,820,453,125	
AC		0.00	71.19%	0.00	-	-	-	-	-	-	
ALTCS-DD	1.04	6462.96	69.28%	4477.65	90,176	91,261	92,414	93,025	366,876	1,642,742,163	
ALTCS-EPD	1.037	6016.98	69.39%	4175.29	90,246	89,935	90,151	89,419	359,751	1,502,065,934	
Family Plan Ext		0.00	90.00%	0.00	-	-	-	-	-	-	
Expansion State Adults		586.16	90.77%	532.04	954,385	960,388	961,511	959,123	3,835,407	2,040,584,088	
										$ 14,275,663,295	MAP Subtotal
										111,136,659	Add DSH Allotment
										$ 14,386,799,954	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 9/30/2017

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended September 30, 2017

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	$ 2,217,714,764	$ 103,890,985	$ 2,321,605,749	$ 502,890,921	$ 191,249,757	$ 175,610,617	$ 151,638,753	$ 164,685,415	$ 167,197	$ -	$ -	$ -	$ 458,635	$ -	$ 1,186,701,295	$ 1,134,904,454
QE 3/12	2,177,981,097	-	2,177,981,097	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	883,208,509
QE 6/12	2,153,192,440	-	2,153,192,440	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	717,920,640
QE 9/12	2,148,807,842	-	2,148,807,842	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	808,154,255
QE 12/12	2,208,621,367	106,384,369	2,315,005,736	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	876,716,353
QE 3/13	2,191,130,645	-	2,191,130,645	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	846,775,389
QE 6/13	2,192,863,081	-	2,192,863,081	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	777,554,536
QE 9/13	2,202,658,193	-	2,202,658,193	596,611,333	237,327,560	84,327,037	230,955,206	190,188,088	228,524	558,280	144,169,561	35,937,456	-	-	1,520,303,045	682,355,148
QE 12/13	2,361,654,230	108,086,519	2,469,740,749	623,051,060	253,112,363	84,773,209	180,587,089	208,608,187	221,957	6,098,257	128,610,551	20,561,018	-	-	1,505,623,691	964,117,058
QE 3/14	2,496,618,479	-	2,496,618,479	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	1,011,967,104
QE 6/14	2,658,548,857	-	2,658,548,857	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	1,050,523,782
QE 9/14	2,811,289,872	-	2,811,289,872	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	946,715,843
QE 12/14	3,011,526,003	109,815,903	3,121,341,906	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	1,094,990,106
QE 3/15	2,999,552,430	-	2,999,552,430	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	1,245,973,149
QE 6/15	3,019,116,705	-	3,019,116,705	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	1,108,074,459
QE 9/15	3,083,425,739	-	3,083,425,739	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	1,199,362,791
QE 12/15	3,313,196,445	110,145,351	3,423,341,796	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	1,400,377,013
QE 3/16	3,322,592,818	-	3,322,592,818	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	1,375,912,827
QE 6/16	3,320,357,697	-	3,320,357,697	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	1,349,819,694
QE 9/16	3,374,222,358	-	3,374,222,358	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	1,463,710,039
QE 12/16	3,566,900,903	-	3,566,900,903	693,694,761	331,020,951	2,802,954	225,745,743	223,415,036	(5,466)	3,195,395	39,578,110	2,726,671	-	524,641,615	2,046,815,770	1,520,085,133
QE 3/17	3,576,675,803	-	3,576,675,803	698,367,817	340,649,746	(91,276)	231,791,677	232,289,659	(72)	4,775,270	-	-	-	533,802,478	2,041,585,299	1,535,090,504
QE 6/17	3,572,549,969	-	3,572,549,969	753,982,845	381,866,177	26,531,976	251,886,540	247,601,051	(70)	112,797,468	27,231,927	269,020		506,442,446	2,308,609,380	1,263,940,589
QE 9/17	3,559,536,620	111,136,659	3,670,673,279	678,845,907	344,221,688	(194,349)	242,239,652	246,326,890	(58)	-	-	646,701		499,804,367	2,011,890,798	1,658,782,481
	$ 67,540,734,360	$ 649,459,786	$ 68,190,194,146	$ 15,365,580,561	$ 6,762,315,988	$ 1,168,442,716	$ 4,625,746,580	$ 4,928,924,108	$ 1,866,814	$ 657,575,495	$ 944,648,662	$ 198,000,032	$ 453,960	$ 6,619,607,371	$ 41,273,162,287	$ 26,917,031,859

Last Updated: 11/7/2017

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended September 30, 2017

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 DECEMBER, 2016								
DY 01	$ 8,801,587,128	$ 5,636,249,551	$ 3,165,337,577	35.96%				
DY 02	8,901,657,656	5,839,464,172	3,062,193,484	34.40%				
DY 03	10,436,197,957	6,476,708,825	3,959,489,132	37.94%				
DY 04	12,223,436,781	7,369,177,050	4,854,259,731	39.71%				
DY 05	13,440,514,669	7,987,283,961	5,453,230,708	40.57%				
DY 06	14,386,799,954	7,964,278,728	6,422,521,226	44.64%	$ 68,190,194,146	$ 41,273,162,287	$ 26,917,031,859	39.47%
	$ 68,190,194,146	$ 41,273,162,287	$ 26,917,031,859					

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended September 30, 2017

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	06	Total
AC	917,852,454	582,039,990	123,931,899	32,933,115	28,695,229	(609,341)	1,684,843,346
AFDC/SOBRA	3,415,744,880	3,582,736,918	3,540,045,447	3,595,162,559	3,927,844,358	3,664,453,098	21,725,987,260
ALTCS-EPD	1,061,777,856	1,166,995,182	1,195,519,885	1,244,829,021	1,265,151,485	1,304,566,950	7,238,840,379
ALTCS-DD	939,086,691	1,005,552,529	1,067,544,854	1,170,355,497	1,253,427,062	1,364,765,657	6,800,732,290
DSH/CAHP	155,762,651	163,280,200	162,262,955	170,517,535	165,250,384	152,785,300	969,859,025
Expansion State Adults	-	-	1,137,650,457	1,913,752,306	2,127,098,250	2,244,797,462	7,423,298,475
Family Planning Extension	830,631	1,008,110	190,026	(1,337)	(763)	(342)	2,026,325
MED	673,818	-	-	-	-	-	673,818
SNCP/DSHP	296,636,120	558,334,298	240,250,917	135,561,857	116,750,000	62,836,722	1,410,369,914
SSI	1,349,511,688	1,426,887,053	1,545,203,664	1,734,090,361	1,822,773,086	1,814,545,863	9,693,011,715
Uncomp Care IHS/638	22,866,717	97,192,513	53,888,765	13,437,080	7,647,155	3,208,226	198,240,456
Subtotal	8,160,743,506	8,584,026,793	9,066,488,869	10,010,637,994	10,714,636,246	10,611,349,595	57,147,883,003
New Adult Group	-	-	108,354,982	309,242,873	482,159,857	485,532,920	1,385,290,632
Total	8,160,743,506	8,584,026,793	9,174,843,851	10,319,880,867	11,196,796,103	11,096,882,515	58,533,173,635

Federal Share

Waiver Name	01	02	03	04	05	06	Total
AC	640,072,927	400,056,057	86,561,331	22,536,574	19,649,616	(433,789)	1,168,442,716
AFDC/SOBRA	2,385,709,896	2,466,817,333	2,497,611,498	2,568,366,508	2,810,451,092	2,636,624,234	15,365,580,561
ALTCS-EPD	716,745,913	770,387,114	807,291,715	855,010,392	874,226,287	905,262,687	4,928,924,108
ALTCS-DD	632,712,981	661,923,939	719,012,033	802,145,617	864,419,011	945,532,999	4,625,746,580
DSH/CAHP	104,828,265	107,242,435	109,089,385	116,736,303	113,890,565	105,788,542	657,575,495
Expansion State Adults	-	-	971,224,993	1,680,023,824	1,930,092,443	2,038,266,111	6,619,607,371
Family Planning Extension	767,009	927,946	174,071	(1,212)	(689)	(311)	1,866,814
MED	453,960	-	-	-	-	-	453,960
SNCP/DSHP	199,636,108	366,713,968	161,520,692	92,805,648	80,464,100	43,508,146	944,648,662
SSI	932,474,457	968,327,701	1,070,377,277	1,218,146,407	1,286,461,256	1,286,528,890	6,762,315,988
Uncomp Care IHS/638	22,848,035	97,067,679	53,845,830	13,406,989	7,630,280	3,201,219	198,000,032
Subtotal	5,636,249,551	5,839,464,172	6,476,708,825	7,369,177,050	7,987,283,961	7,964,278,728	41,273,162,287
New Adult Group	-	-	108,354,982	309,235,568	481,730,714	467,337,766	1,366,659,030
Total	5,636,249,551	5,839,464,172	6,585,063,807	7,678,412,618	8,469,014,675	8,431,616,494	42,639,821,317

Adjustments to Schedule C Waiver 11-W00275/9

Total Computable

Waiver Name	01	02	03	04	05	06	Total
AC	313,572	210,756	87,745	(7)	326	119	612,511
AFDC/SOBRA	1,014,881	1,090,143	990,293	5,056,392	4,912,060	4,769,809	17,833,578
SSI	365,158	399,101	398,723	2,391,771	2,371,156	2,374,229	8,300,138
Expansion State Adults	-	-	223,239	3,043,744	3,208,358	3,347,743	9,823,084
ALTCS-DD (Cost Sharing)[1]	-	-	-	-	-	-	-
CAHP[2]	(1,693,611)	(1,700,000)	(1,700,000)	(10,491,900)	(10,491,900)	(10,491,900)	(36,569,311)
Total	-	-	-	-	-	-	-

Federal Share

Waiver Name	01	02	03	04	05	06	Total
AC	211,034	138,424	58,991	(5)	225	83	408,751
AFDC/SOBRA	683,014	716,006	665,774	3,461,607	3,385,392	3,302,616	12,214,409
SSI	245,752	262,130	268,062	1,637,406	1,634,201	1,643,916	5,691,467
Expansion State Adults	-	-	150,083	2,083,747	2,211,200	2,317,977	6,763,008
ALTCS-DD (Cost Sharing)[1]	-	-	-	-	-	-	-
CAHP[2]	(1,139,800)	(1,116,560)	(1,142,910)	(7,182,755)	(7,231,017)	(7,264,592)	(25,077,634)
Total	-	-	-	-	-	0	0

[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 Sheet line 9,D.

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

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended September 30, 2017

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	06	Total
AC	918,166,026	582,250,746	124,019,644	32,933,108	28,695,555	(609,221.79)	1,685,455,857
AFDC/SOBRA	3,416,759,761	3,583,827,061	3,541,035,740	3,600,218,951	3,932,756,418	3,669,222,907	21,743,820,838
ALTCS-EPD	1,061,777,856	1,166,995,182	1,195,519,885	1,244,829,021	1,265,151,485	1,304,566,950	7,238,840,379
ALTCS-DD	939,086,691	1,005,552,529	1,067,544,854	1,170,355,497	1,253,427,062	1,364,765,657	6,800,732,290
DSH/CAHP	154,069,040	161,580,200	160,562,955	160,025,635	154,758,484	142,293,400	933,289,714
Expansion State Adults	-	-	1,137,873,696	1,916,796,050	2,130,306,608	2,248,145,205	7,433,121,559
Family Planning Extension	830,631	1,008,110	190,026	(1,337)	(763)	(342)	2,026,325
MED	673,818	-	-	-	-	-	673,818
SNCP/DSHP	296,636,120	558,334,298	240,250,917	135,561,857	116,750,000	62,836,722	1,410,369,914
SSI	1,349,876,846	1,427,286,154	1,545,602,387	1,736,482,132	1,825,144,242	1,816,920,092	9,701,311,853
Uncomp Care IHS/638	22,866,717	97,192,513	53,888,765	13,437,080	7,647,155	3,208,226	198,240,456
Subtotal	8,160,743,506	8,584,026,793	9,066,488,869	10,010,637,994	10,714,636,246	10,611,349,595	57,147,883,003
New Adult Group	-	-	108,354,982	309,242,873	482,159,857	485,532,920	1,385,290,632
Total	8,160,743,506	8,584,026,793	9,174,843,851	10,319,880,867	11,196,796,103	11,096,882,515	58,533,173,635

Federal Share

Waiver Name	01	02	03	04	05	06	Total
AC	640,283,961	400,194,481	86,620,322	22,536,569	19,649,841	(433,706)	1,168,851,467
AFDC/SOBRA	2,386,392,910	2,467,533,339	2,498,277,272	2,571,828,115	2,813,836,484	2,639,926,850	15,377,794,970
ALTCS-EPD	716,745,913	770,387,114	807,291,715	855,010,392	874,226,287	905,262,687	4,928,924,108
ALTCS-DD	632,712,981	661,923,939	719,012,033	802,145,617	864,419,011	945,532,999	4,625,746,580
DSH/CAHP	103,688,465	106,125,875	107,946,475	109,553,548	106,659,548	98,523,950	632,497,861
Expansion State Adults	-	-	971,375,076	1,682,107,571	1,932,303,643	2,040,584,088	6,626,370,379
Family Planning Extension	767,009	927,946	174,071	(1,212)	(689)	(311)	1,866,814
MED	453,960	-	-	-	-	-	453,960
SNCP/DSHP	199,636,108	366,713,968	161,520,692	92,805,648	80,464,100	43,508,146	944,648,662
SSI	932,720,209	968,589,831	1,070,645,339	1,219,783,813	1,288,095,457	1,288,172,806	6,768,007,455
Uncomp Care IHS/638	22,848,035	97,067,679	53,845,830	13,406,989	7,630,280	3,201,219	198,000,032
Subtotal	5,636,249,551	5,839,464,172	6,476,708,825	7,369,177,050	7,987,283,961	7,964,278,728	41,273,162,287
New Adult Group	-	-	108,354,982	309,235,568	481,730,714	467,337,766	1,366,659,030
Total	5,636,249,551	5,839,464,172	6,585,063,807	7,678,412,618	8,469,014,675	8,431,616,494	42,639,821,317

Calculation of Effective FMAP:

AFDC/SOBRA						
Federal	2,386,392,910	2,467,533,339	2,498,277,272	2,571,828,115	2,813,836,484	2,639,926,850
Total	3,416,759,761	3,583,827,061	3,541,035,740	3,600,218,951	3,932,756,418	3,669,222,907
Effective FMAP	0.698437431	0.688519088	0.70552162	0.714353252	0.7154871	0.719478461
SSI						
Federal	932,720,209	968,589,831	1,070,645,339	1,219,783,813	1,288,095,457	1,288,172,806
Total	1,349,876,846	1,427,286,154	1,545,602,387	1,736,482,132	1,825,144,242	1,816,920,092
Effective FMAP	0.690966892	0.678623434	0.692704248	0.702445358	0.70574995	0.708987045
ALTCS-EPD						
Federal	716,745,913	770,387,114	807,291,715	855,010,392	874,226,287	905,262,687
Total	1,061,777,856	1,166,995,182	1,195,519,885	1,244,829,021	1,265,151,485	1,304,566,950
Effective FMAP	0.675043192	0.660145925	0.675264147	0.686849662	0.691005225	0.693918152
ALTCS-DD						
Federal	632,712,981	661,923,939	719,012,033	802,145,617	864,419,011	945,532,999
Total	939,086,691	1,005,552,529	1,067,544,854	1,170,355,497	1,253,427,062	1,364,765,657
Effective FMAP	0.673753538	0.658268882	0.673519272	0.685386294	0.689644445	0.692817111
AC						
Federal	640,283,961	400,194,481	86,620,322	22,536,569	19,649,841	(433,706)
Total	918,166,026	582,250,746	124,019,644	32,933,108	28,695,555	(609,222)
Effective FMAP	0.697350961	0.68732326	0.698440337	0.684313457	0.684769494	0.71190236
Expansion State Adults						
Federal	-	-	971,375,076	1,682,107,571	1,932,303,643	2,040,584,088
Total	-	-	1,137,873,696	1,916,796,050	2,130,306,608	2,248,145,205
Effective FMAP			0.853675658	0.877562102	0.907054241	0.907674506
New Adult Group						
Federal	-	-	108,354,982	309,235,568	481,730,714	467,337,766
Total	-	-	108,354,982	309,242,873	482,159,857	485,532,920
Effective FMAP			1	0.999976378	0.999109957	0.962525396

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended September 30, 2017

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	2,932,510	487,591	72,519	85,460	527,244	467	12,471		
Quarter Ended March 31, 2012	2,920,199	489,024	73,155	85,506	430,723	-	12,424		
Quarter Ended June 30, 2012	2,914,080	489,056	73,965	85,730	365,132	-	12,440		
Quarter Ended September 30, 2012	2,938,811	491,705	74,820	86,512	310,396	-	12,689		
Quarter Ended December 31, 2012	2,911,442	494,793	75,639	86,829	274,990	-	13,104		
Quarter Ended March 31, 2013	2,891,192	497,190	76,467	86,075	248,817	-	13,824		
Quarter Ended June 30, 2013	2,903,029	499,819	77,281	86,303	228,204	-	14,187		
Quarter Ended September 30, 2013	2,918,910	503,447	78,035	87,133	217,114	-	14,856		
Quarter Ended December 31, 2013	2,891,763	506,860	78,841	87,679	206,419	-	14,885		
Quarter Ended March 31, 2014	2,839,342	514,564	79,683	87,893	87	-	-	443,847	39,000
Quarter Ended June 30, 2014	2,955,581	523,506	80,672	88,734	2	-	-	624,103	86,536
Quarter Ended September 30, 2014	3,113,393	529,799	81,758	89,362	-	-	-	755,543	122,897
Quarter Ended December 31, 2014	3,145,932	537,346	82,725	90,012	-	-	-	817,223	149,789
Quarter Ended March 31, 2015	3,084,693	543,950	83,826	89,878	-	-	-	835,272	191,116
Quarter Ended June 30, 2015	3,104,991	544,675	84,827	89,930	-	-	-	845,124	245,232
Quarter Ended September 30, 2015	3,209,034	544,701	85,603	90,018	-	-	-	865,504	284,851
Quarter Ended December 31, 2015	3,261,498	549,592	86,368	89,881	-	-	-	915,333	312,463
Quarter Ended March 31, 2016	3,258,413	552,070	87,129	89,458	-	-	-	929,666	331,687
Quarter Ended June 30, 2016	3,246,906	548,929	88,236	89,610	-	-	-	931,186	333,967
Quarter Ended September 30, 2016	3,331,594	551,512	89,201	89,890	-	-	-	937,206	325,153
Quarter Ended December 31, 2016	3,382,815	552,447	90,176	90,246	-	-	-	954,385	331,196
Quarter Ended March 31, 2017	3,386,731	553,552	91,261	89,935	-	-	-	960,388	335,113
Quarter Ended June 30, 2017	3,369,171	551,946	92,414	90,151				961,511	337,732
Quarter Ended September 30, 2017	3,349,764	550,778	93,025	89,419				959,123	336,867

	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	-	-
Quarter Ended December 31, 2016	-	-
Quarter Ended March 31, 2017	-	-
Quarter Ended June 30, 2017	-	-
Quarter Ended September 30, 2017	-	-

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended September 30, 2017

VI. Allocation of Disproportionate Share Hospital Payments

Federal Share

	FFY 2012	FFY 2013	FFY 2014	FFY 2015	FFY 2016	FFY 2017	
Total Allotment	**103,890,985**	**106,384,369**	**108,086,519**	**109,815,903**	**110,145,351**	**111,136,659**	**649,459,786**
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
Dec-16		(1,292,221)		270,327	584,993		(436,900)
Mar-17				4,775,270			4,775,270
Jun-17		1,152,106		1,483,173	8,005,943	98,523,950	109,165,172
Sep-17							-
Dec-17							-
Total Reported to Date	103,688,465	106,125,875	107,946,475	109,553,550	106,659,547	98,523,950	632,497,862
Unused Allotment	**202,520**	**258,494**	**140,044**	**262,353**	**3,485,804**	**12,612,709**	**16,961,924**

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended September 30, 2017

VII. BUDGET NEUTRALITY TRACKING SCHEDULE -- NEW ADULT GROUP

WAIVER PERIOD JANUARY 1, 2014 THROUGH SEPTEMBER 30, 2021:

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

	DY3-5 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	-	39,000	86,536	122,897	248,433	143,728,428

		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%	605.72	149,789	191,116	245,232	284,851	870,988	527,572,300

		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	99.91%	633.64	312,463	331,687	333,967	325,153	1,303,270	825,799,166

	DY6-10 Trend Rate	DY 06 PM/PM			Member Months QE 12/16	QE 3/17	QE 6/17	QE 9/17	Total	
New Adult Group	1.033	655.13	96.25% QE 12/16	630.58	331,196				331,196	208,845,132
			95.00% QE 9/17	622.37		335,113	337,732	336,867	1,009,712	628,417,396
										837,262,528

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	22,563,060	-	22,563,060	13,870,414	8,692,646
QE 6/14	50,064,537	-	50,064,537	34,313,342	15,751,195
QE 9/14	71,100,830	-	71,100,830	47,984,458	23,116,372
QE 12/14	90,729,754	-	90,729,754	46,004,135	44,725,619
QE 3/15	115,762,224	-	115,762,224	70,387,348	45,374,876
QE 6/15	148,541,209	-	148,541,209	85,319,153	63,222,056
QE 9/15	172,539,113	-	172,539,113	97,948,283	74,590,830
QE 12/15	197,987,896	-	197,987,896	113,800,738	84,187,158
QE 3/16	210,168,920	-	210,168,920	122,290,142	87,878,778
QE 6/16	211,613,611	-	211,613,611	123,158,494	88,455,117
QE 9/16	206,028,740	-	206,028,740	108,777,377	97,251,363
QE 12/16	208,845,132	-	208,845,132	126,789,923	82,055,209
QE 3/17	208,565,253	-	208,565,253	122,882,603	85,682,650
QE 6/17	210,195,248	-	210,195,248	125,355,939	84,839,309
QE 9/17	209,656,895	-	209,656,895	127,776,681	81,880,214
	$ 2,334,362,423	$ -	$ 2,334,362,423	$ 1,366,659,030	$ 967,703,393

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	$ 143,728,428	$ 96,168,214	$ 47,560,214	33.09%				
DY 04	527,572,300	299,658,919	227,913,381	43.20%				
DY 05	825,799,166	468,026,751	357,772,415	43.32%				
DY 06	837,262,528	502,805,146	334,457,382	39.95%	$ 2,334,362,423	$ 1,366,659,030	$ 967,703,393	41.45%
	$ 2,334,362,423	$ 1,366,659,030	$ 967,703,393					

Based on CMS-64 certification date of 6/30/2017

APPENDIX 2:
1115 WAIVER
POST AWARD FORUM
PRESENTATION SLIDES

AHCCCS
Arizona Health Care Cost Containment System

AHCCCS Waiver Update and SB 1092 Directive

Arizona's Section 1115 Demonstration Waiver

AHCCCS Today

- Largest Insurer in the State of Arizona
- $12.0 billion program
- Mandatory Managed Care; Public-Private Partnership
- Integrated delivery system–over 66,000 providers
- Covers two-thirds of nursing facility days
- Covers nearly as many adults as traditionally eligible populations, such as pregnant women, children, elderly, persons with disabilities

Section 1115 Defined

- Section 1115 of the Social Security Acts gives states authority to be waived from selected Medicaid requirements in federal law
- Two types of authority may be requested:
  - Waiver of provisions of Section 1902
  - Expenditure of federal funds under Section 1903
- Arizona's waiver is a 5 year contract

Waiver Structure

- Federal authorities are granted to the State and detailed through three major sections:
  1. Waiver List
  2. Expenditure Authority List
  3. Special Terms and Conditions
- Additional Attachments provide more detail on various programs and guidelines

Federal Process

- The Centers for Medicare and Medicaid Services (CMS) is the federal agency responsible for oversight of State Medicaid agencies
- Arizona obtained final approval from CMS
- The Office of Management and Budget and the Department of Health and Human Services also review waiver proposals
- 1115 Waivers are approved at the discretion of the HHS Secretary

Arizona's 1115 Waiver

- Arizona's waiver expired September 30, 2016
- Arizona submitted its letter of intent to apply for a new Demonstration September 30, 2015
- Extension of Arizona's 1115 waiver was approved September 30, 2016 for 5 years: October 1, 2016 – September 30, 2021

Waiver Update

- DSRIP and AI Medical Home
- Traditional Healing
- SB 1092

New Authorities: The AHCCCS CARE Program

The AHCCCS CARE Program

- Required participation: Adults over 100% FPL in the New Adult Group
- Exceptions:
  - Persons with Serious Mental Illness
  - American Indian/Alaska Native
  - Medically Frail
  - Short-term hardship exemptions for members experiencing out-of-pocket expense

The AHCCCS CARE Program

AHCCCS CARE
CHOICE • ACCOUNTABILITY
RESPONSIBILITY • ENGAGEMENT

- Voluntary participation:
  - Adults over 100% FPL otherwise exempted
  - Adults at or below 100% FPL
- Co-Insurance:
  - Up to 3% of annual household income
  - Members make monthly AHCCCS CARE payments reflecting co-insurance for services already obtained
  - Co-insurance goes to AHCCCS as cost offset

Strategic Co-Insurance

AHCCCS CARE
CHOICE • ACCOUNTABILITY
RESPONSIBILITY • ENGAGEMENT

No Co-Insurance

- Preventive Services
- Wellness
- Chronic illness
- Persons with Serious Mental Illness
- Services obtained at your Primary Care Physician or OB-GYN

Co-Insurance Required

- Opioids, except cancer and terminal illness ($4)
- Non-Emergency use of ED ($8)
- Specialist services without PCP referral ($5-10)
- Brand name drugs when generic available unless physician determines generic ineffective ($4)

AHCCCS CARE Premiums

- Members make monthly AHCCCS CARE premium payment
- Set at 2% of household income or $25, whichever is lesser
- Premiums serve as contributions into member's AHCCCS CARE Account – funds belong to members in good standing

Penalty for Failure to Pay

- Members have a two month grace period to make premium payments
- Failure to pay results in disenrollment
- There is no lockout period
- Members may re-enroll at any time

The AHCCCS CARE Account

- Functions like a flexible spending account
- Employers and the Philanthropic community can make AHCCCS CARE Account contributions
- Members must be in good standing to be eligible for the AHCCCS CARE Account by
  - Making timely co-insurance and premium payments
  - Meeting a Healthy Arizona target
- Members in good standing can use funds for non-covered services or to offset copays

AHCCCS Works

- Supporting Work Opportunities:
  - All AHCCCS CARE members will be enrolled in Arizona Department of Economic Security (DES) AZ Job Connection program, part of the DES Arizona @ Work initiative
- AHCCCS eligibility is not conditioned upon participating in AHCCCS Works
- **AHCCCS CARE Account balance is returned to members that transition out of AHCCCS and into private coverage**

AHCCCS Care Implementation

- Significant policy discussion at federal level surrounding future of Affordable Care Act and Medicaid Expansion
- Implementation on AHCCCS Care provisions on hold until federal policy decisions resolved
- AHCCCS will provide public notice of implementation activities

New Authorities: ALTCS Dental

ALTCS Dental

- Adult dental benefit for ALTCS members
- Limit is up to $1,000 per year per member
- Effective October 1, 2016
- Members receive the benefit through their ALTCS health plan and can talk to their case manager for more information

Extensions and Amendments

Extensions of Existing Authorities

- Mandatory managed care
- Statewide integrated CRS program
- Integrated RBHAs providing behavioral and physical health for members with SMI
- HCBS for ALTCS members
- Statewide DDD and CMDP programs
- Spouses as paid caregivers in ALTCS
- Higher ALTCS income threshold (300% FBR)

Extensions of Existing Authorities

- Payments to IHS and Tribal 638 facilities for emergency dental to adults
- Direct payment to IHS and Tribal 638 facilities by AHCCCS for MCO enrolled AI/AN rather than requiring MCO payment
- Critical Access Hospital payments
- Case management for behavioral health

Amendments to Existing Authorities

- Phase down of Safety Net Care Pool for PCH; program sunsets Dec. 31, 2017
- Amendments reflecting merger with DBHS
- DSH to move to State Plan in one year (not a substantive change to methodology)

HCBS Implementation

- HCBS Assessment and Transition plan to comply with Final Rule released by CMS 1-16-14
- Rule defined what qualifies as HCBS setting
- Arizona largely complies; modest changes
- HCBS program lives in 1115 Waiver; thus, Assessment and Transition Plan are part of this broader process
- Because of specificity to this topic, see http://www.azahcccs.gov/hcbs/default.aspx

Other Pending Items

For Amendment Requests and New Authorities

Pending Items – New Requests

- Delivery System Reform Incentive Payment (DSRIP)
- American Indian Medical Home
- Traditional Healing
- AHCCCS in active discussion with CMS on these pending items

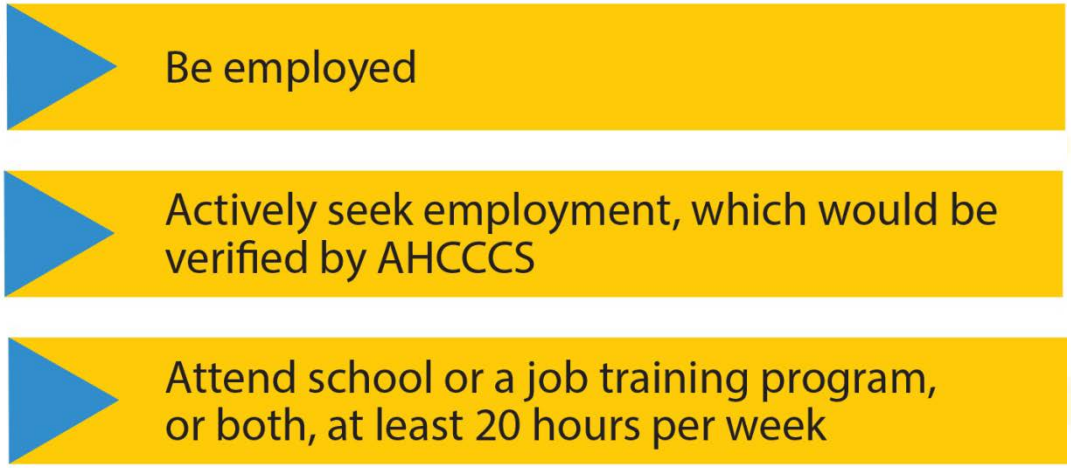
SB 1092 Overview

The Requirements: SB 1092

- SB 1092 requires AHCCCS to request from CMS by March 30 of each year only the waivers or amendments to the current Section 1115 Waiver that have not been approved and are not in effect
- Similar authorities were requested as part of the October 1, 2016 waiver and were not approved

The Requirements: SB 1092

- All able-bodied adult* members are required to meet one of the following employment criteria to qualify for AHCCCS:



*Able-bodied adults are individuals who are at least 19 years of age, and are physically and mentally capable of working.

SB 1092 Work Requirement – Exemptions

- Exemption for individuals meeting any of the following
  - Is at least 19 years of age but is still attending high school as a full-time student
  - Is the sole caregiver of a family member who is under 6 years of age
  - Is currently receiving temporary or permanent long-term disability benefits from a private insurer or the government
  - Has been determined to be physically or mentally unfit for employment by a health care professional in accordance with rules adopted by the agency

SB 1092 Lifetime Limit

- Limit lifetime enrollment to five years
  - Begins on effective date of waiver change
  - Does not include time during which person is
    - Pregnant
    - Sole caregiver of family member under 6
    - Receiving long-term disability benefits
    - At least 19 and still attending high school full time
    - Employed full time, meets AHCCCS income eligibility
    - Enrolled before age 19
    - Former foster child under 26 years of age
- Applies to adults age 19 and older “physically and mentally capable of working”
- No exemption for American Indian Members

SB 1092 Other

- Develop cost sharing requirements to deter:
  - Use of ambulance services for non-emergency transportation when not medically necessary
- Requires persons to verify compliance with work requirements monthly
- One year ban for making false statements regarding compliance with work requirements or knowingly failing to report change in income

Estimated impact

- Current potentially-affected population with enrollment over 5 years: 242,000
  - Number could be lower because AHCCCS does not currently collect data to allow us to identify the following excluded periods of enrollment:
    - Long-term disability benefits
    - Employed full-time
    - Sole caregiver of child under age 6
  - Number could be higher because current figure does not account for recent enrollment growth
- Working on data run for impact of work requirement

Questions and Public Comments

Waiver Amendment Webpage

- More information about the proposed waiver amendment, including the proposed waiver application and the full public notice and public input process, can be found on the AHCCCS website at:
- https://azahcccs.gov/Resources/Federal/sb1092legislativedirectivewaiverproposal.html

Public Comments

- Comments and questions about the proposed Demonstration application can also be submitted by e-mail to: PublicInput@azahcccs.gov
- Or by mail to: AHCCCS c/o Office of Intergovernmental Relations; 801 E. Jefferson Street, MD 4200, Phoenix, AZ 85034.
- All comments must be received by **February 28, 2017.**

Thank You.

AHCCCS
Arizona Health Care Cost Containment System

APPENDIX 3: STATEWIDE FOCUS POPULATION MEASURES AND TARGETS

Child Physical and Behavioral Health Integration Measures			
Year of DSHP	**Proposed Measure**	**Numerator and Denominator Definition**	**Proposed Target**
3	Practice has executed an agreement with AzHeC and routinely receives ADT feeds Baseline: to be measured during Year 1	numerator: An executed agreement with AzHeC and AzHeC confirmation of practice routine receipt of ADT feeds denominator: Pediatric primary care and behavioral health practices participating in the child integration	**Target: 35.77%** Baseline: 20/65= **30.77%** 5 points over baseline
4	Well-child visits in the third, fourth, fifth and sixth years of life for children with a behavioral health diagnosis (HEDIS, modified) Baseline: To be measured during Year 1	numerator: AHCCCS members with a BH diagnosis who are age 3-6 years as of the last calendar day of the measurement year, and are attributed to a -participating primary care provider, who have at least one well-child visit with any PCP during the measurement year.[1] denominator: AHCCCS members with a BH diagnosis who are age 3–6 years as of the last calendar day of the measurement year and are attributed to a participating primary care provider.	**Target: 74.71%** Baseline: 661/909= **72.71%** 2 points over baseline
5	Well-child visits in the third, fourth, fifth and sixth years of life for children with a behavioral health diagnosis (HEDIS, modified) Baseline: To be measured during Year 1	numerator: AHCCCS members with a BH diagnosis who are age 3-6 years as of the last calendar day of the measurement year, and are attributed to a participating primary care provider, who have at least one well-child visit with any PCP during the measurement year. denominator: AHCCCS members with a BH diagnosis who are age 3–6 years as of the last calendar day of the measurement year and are attributed to a participating primary care provider.	**Target: 77.71%** Baseline: 661/909= **72.71%** 5 points over baseline

[1] Well-care visit as defined in the HEDIS 2017 Well-Care Value Set. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child or be within the Targeted Investment provider entity.

Adult Physical and Behavioral Health Integration Measures			
Year of DSHP	**Proposed Measure**	**Numerator and Denominator Definition**	**Proposed Target**
3	Practice has executed an agreement with AzHeC and routinely receives ADT feeds Baseline: To be measured during Year 1	numerator: An executed agreement with AzHeC and AzHeC confirmation of practice routine receipt of ADT feeds denominator: Adult primary care and behavioral health practices participating in the adult integration	**Target: 32.48%** Baseline: 36/131= **27.48%** 5 points over baseline
4	Follow-up after hospitalization for mental illness (HEDIS, modified[2]) Baseline: To be measured during Year 1	numerator: AHCCCS members 18 years of age and older at any time during the measurement period who had a follow-up visit with a mental health practitioner within 7 days after a denominator-qualifying discharge, including visits that occur on the date of discharge.[3] denominator: Acute hospital discharges of AHCCCS members 18 years of age and older at any time during the measurement period for treatment of selected mental illness diagnoses[4] .	**Target: 52.97%** Baseline: 10,852/ 21,289= **50.97%** 2 points over baseline
5	Follow-up after hospitalization for mental illness (HEDIS, modified) Baseline: Tto be measured during Year 1	numerator: AHCCCS members 18 years of age and older at any time during the measurement period who had a follow-up visit with a mental health practitioner within 7 days after a denominator-qualifying discharge, including visits that occur on the date of discharge. denominator: Acute hospital discharges of AHCCCS members 18 years of age and older at any time during the measurement period for treatment of selected mental illness diagnoses..	**Target: 54.97%** Baseline: 10,852/ 21,289= **50.97%** 4 points over baseline

[2] Modified to apply only to adults, as the HEDIS specifications include those six years and older in the denominator.

[3] The follow-up visit must be with a mental health practitioner as defined by the following NCQA HEDIS value sets: FUH Stand Alone Visits Value Set, (FUH Visits Group 1 Value Set *and* FUH POS Group 1 Value Set), and FUH Visits Group 2 Value Set *and* FUH POS Group 2 Value Set.

[4] A principal diagnosis of mental illness is defined by the NCQA HEDIS Mental Illness Value Set. Inpatient stay is defined by the Inpatient Stay Value Set, but excludes the Nonacute Inpatient Stay Value Set.

Care Coordination Measures for Medicaid Enrolled Released from Criminal Justice Facilities			
Year of DSHP	**Proposed Measure**	**Numerator and Denominator Definition**	**Proposed Target**
3	Practice has executed an agreement with AzHeC and routinely receives ADT feeds Baseline: To be measured during Year 1	numerator: An executed agreement with AzHeC and AzHeC confirmation of practice routine receipt of ADT feeds denominator: Integrated practices participating in the justice transition	100%
4	Adults access to preventive/ambulatory health services (HEDIS, modified[5]) Baseline: To be measured during Year 1	numerator: AHCCCS members age 20-44 years during the measurement period recently released from a criminal justice facility and assigned to a probation or parole office at which a new integrated clinic has been situated who had one or more ambulatory or preventive care visits[6] during the measurement year denominator: AHCCCS members age 20-44 years during the measurement period recently released from a criminal justice facility and assigned to a probation or parole office at which a new integrated clinic has been situated	**Target: 37.71%** Baseline: 5005/14,016= **35.71%** 2 points over baseline
5	Adults access to preventive/ambulatory health services (HEDIS, modified) Baseline: To be measured during Year 1	numerator: AHCCCS members age 20-44 years during the measurement period recently released from a criminal justice facility and assigned to a probation or parole office at which a new integrated clinic has been situated who had one or more ambulatory or preventive care visits during the measurement year denominator: AHCCCS members age 20-44 years during the measurement period recently released from a criminal justice facility and assigned to a probation or parole office at which a new integrated clinic has been situated	**Target: 40.71%** Baseline: 5005/14,016= **35.71%** 5 points over baseline

[5] Modified to apply to only those AHCCCS members recently released from a criminal justice facility at which a new integrated clinic has been situated.

[6] Visits defined by the following NCQA HEDIS measure sets: Ambulatory Visits Value Set and Other Ambulatory Visits Value Set.