AHCCCS
Arizona Health Care Cost Containment System

Douglas A. Ducey, Governor
Thomas J. Betlach, Director

September 1, 2017

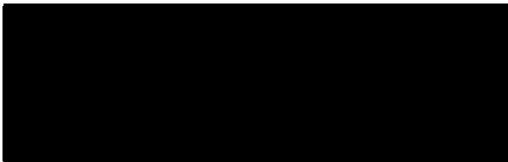
Jessica Woodard
Project Officer, Division of State Demonstrations, Waivers & Managed Care
Center for Medicaid, CHIP and Survey & Certification
Centers for Medicare and Medicaid Services
Mailstop: S2-01-16
7500 Security Blvd.
Baltimore, Maryland 21244-1850

Dear Ms. Woodard:

In accordance with Special Terms and Conditions paragraph 41, enclosed please find the Quarterly Progress Report for April 1, 2017 through June 30, 2017, which also includes the Quarterly Budget Neutrality Tracking Schedule, the Quarterly Quality Initiative, and the Arizona Medicaid Administrative Claiming Random Moment Time Study results.

If you have any questions about the enclosed report, please contact Mohamed Arif at (602) 417- 4573.

Sincerely,



Elizabeth Lorenz
Assistant Director
AHCCCS Office of Intergovernmental Relations

Enclosure

cc: Brian Zolynas
Hee Young Ansell
Susan Ruiz

AHCCCS Quarterly Report
April 1, 2017 – June 30, 2017

TITLE

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

Section 1115 Quarterly Report
Demonstration Year: 34
Federal Fiscal Quarter: 3rd (April 1, 2017 – June 30, 2017)

INTRODUCTION

As written in Special Terms and Conditions, paragraph 41, the State submits quarterly progress reports to CMS. Quarterly reports inform CMS of significant demonstration activity from the time of approval through completion of the Demonstration.

ENROLLMENT INFORMATION

Table 1 contains a summary of the number of unduplicated enrollees for quarter April 1, 2017 – June 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	1,223,081	2,705	259,355
Acute SSI	190,026	132	25,748
Prop 204 Restoration	519,388	782	75,531
Adult Expansion	127,916	225	31,055
LTC DD	31,020	30	2,255
LTC EPD	31,430	40	3,871
Non-Waiver	27,665	159	10,967
Total	**2,150,526**	**4,073**	**408,782**

Table 2 is a snapshot of the number of current enrollees (as of July 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 [1]	1,381,347
Title XXI funded State Plan [2]	21,050

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

State Reported Enrollment in the Demonstration (as requested)	Current Enrollees
Title XIX funded Expansion[3]	**399,363**
• Prop 204 Restoration (0-100% FPL)	82,228
• Adult Expansion (100% - 133% FPL)	317,135
Enrollment Current as of	7/1/17

OPERATIONAL/POLICY DEVELOPMENTS/ISSUES

Waiver Update

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 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, the Centers for Medicare and Medicaid Services (CMS) has indicated that currently there is only a path forward for an IMD waiver for individuals with substance use disorder needs, as part of a comprehensive state substance use disorder (SUD) strategy. AHCCCS will move forward with the submitting such comprehensive strategy, and will comply with the IMD provisions of the managed care regulations for individuals with non-SUD behavioral health conditions.

Targeted Investment Program Update

Below is a summary of the TI program implementation activities conducted by AHCCCS from April 1, 2017 through June 30, 2017:

- 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.
- Drafting of a TI managed care organization (MCO) payment policy and contract language was also initiated during this quarter, as was ongoing consultation with the State Health Information Exchange (Health Current) on data exchange and sharing expectations for TI participants.
- On June 9, 2017, AHCCCS convened a statewide stakeholder forum to disseminate information regarding the TI program objectives, requirements, incentive payments, and

[3] Prop 204 Restoration & Adult Expansion

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).

- On June 15, 2017, AHCCCS launched the online application platform for providers interested to participate in the TI Program. In addition, the Agency launched the TI program webpage as part of the public communication plan, as well as a dedicated email inbox to respond to stakeholder questions about the program.[4]
- 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.

State Plan Update

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

SPA #	Description	Filed	Approved	Eff. Date
Title XIX				
SPA 15-005-C Other Provider Rates	Updates rates for other provider services as of October 1, 2015.	08/26/2015	04/06/2017	10/01/2015
SPA 15-006 Graduate Medical Education 2016	Updates funding for GME programs for the service period July 1, 2015, through June 30, 2016 for programs with submitted IGAs.	09/30/2015	04/11/2017	09/30/2015
SPA 16-002 Air Ambulance Rates Update	Updates the State Plan to revise Air Ambulance Rates.	03/31/2016	04/06/2017	01/01/2016
SPA 16-005 NF Provider Assessment	Updates the State Plan to revise the assessment amounts for Nursing Facility supplemental funding.	08/25/2016	04/11/2017	01/01/2017
SPA 16-010-E Ambulance and Air Ambulance Rates	Updates the State Plan to make changes to ambulance and air ambulance rates.	12/30/2016	05/12/2017	10/01/2016
SPA 16-012-A Inpatient Hospitals Value Based	Updates the State Plan to include Value Based Purchasing (VBP) differential adjusted	12/30/2016	06/08/2017	10/01/2016

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

SPA #	Description	Filed	Approved	Eff. Date
Purchasing (VBP) differential adjusted payment	payment for Hospitals providing inpatient hospital services.			
SPA 16-012-B Outpatient Services Value Based Purchasing (VBP) differential adjusted payment	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 16-013 DRG Updates	Updates the State Plan to make changes to DRG payments.	12/30/2016	06/12/2017	10/01/2016
SPA 17-001 Prop 206 NF Rate Update	Updates the State Plan to make changes to NF payments.	03/29/2017	06/15/2017	01/01/2017
SPA 17-002 DRG Pediatric Policy Adjustor	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 American Indian Medical Home	Adds the American Indian Medical Home program in the State Plan.	04/12/2017	06/14/2017	07/01/2017
Title XXI				
None				

Legislative Update

AHCCCS proposed and advocated on behalf of one piece of legislation during the 2017 legislative session: 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 that would have impacted the agency, 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 is estimated to range from $113,000 to $272,000. Although this legislation did not fulfill the legislative process, it was successfully added to the approved budget.

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, whom 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) contains 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.

CONSUMER ISSUES

In support of the quarterly report to CMS, presented below is a summary of advocacy issues received in the Office of Client Advocacy (OCA) for the quarter April 1, 2017 – June 30, 2017.

Table 1 Advocacy Issues	Apr.	May	Jun.	Total
9+Billing Issues • Member reimbursements • Unpaid bills	14	15	11	40
Cost Sharing • Co-pays • Share of Cost (ALTCS) • Premiums (Kids Care, Medicare)	3	6	8	17
Covered Services	26	19	45	90
Eligibility Issues by Program Can't get coverage due to :				
ALTCS • Resources • Income • Medical	1	5	9	15
DES • Income • Incorrect determination • Improper referrals	74	45	68	187
Kids Care • Income • Incorrect determination	2	3	0	5
SSI/Medical Assistance Only • Income • Not categorically linked	11	11	14	36
Information • Status of application • Eligibility Criteria • Community Resources • Notification (Did not receive or didn't understand)	116	118	152	386
Medicare • Medicare Coverage	1	1	1	3

• Medicare Savings Program • Medicare Part D				
Prescriptions • Prescription coverage • Prescription denial	23	27	22	72
Issues Referred to other Divisions:	0	0	0	0
1.Fraud-Referred to Office of Inspector General (OIG)				
2.Quality of Care-Referred to Division of Health Care Management (DHCM) • Health Plans/Providers (Caregiver issues, Lack of providers) • Services (Equipment, Nursing Homes, Optical and Surgical)	15	11	11	37
Total	**286**	**261**	**341**	**888**

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

Table 2 **Issue Originator**	**Apr.**	**May**	**Jun.**	**Total**
Applicant, Member or Representative	219	225	282	726
CMS	4	2	5	11
Governor's Office	17	8	21	46
Ombudsmen/Advocates/Other Agencies…	41	24	27	92
Senate & House	5	2	6	13
Total	**286**	**261**	**341**	**888**

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

COMPLAINTS AND GRIEVANCES

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

SMI Member Grievances and Complaints	Apr-17	May-17	Jun-17	**Total**

Access to Care	49	44	45	138
Health Plan	100	93	83	276
Provider Satisfaction	374	368	429	1171
Total	523	505	557	**1585**

CRS Member Grievances and Complaints	Apr-17	May-17	Jun-17	Total
Access to Care	0	0	0	**0**
Health Plan	3	2	3	8
Provider Satisfaction	8	10	12	30
Total	**11**	**12**	**15**	**38**

OPT-OUT FOR CAUSE

Attached 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.

QUALITY ASSURANCE/MONITORING ACTIVITY:

Attached is a description of AHCCCS' Quality Assurance/Monitoring Activities during the quarter. The attachment also includes updates on implementation of the AHCCCS Quality Assessment and Performance Improvement Strategy, in accordance with Balanced Budget Act (BBA) requirements.

ENCLOSURES/ATTACHMENTS

Attached you will find the SMI opt-out for cause data (Attachment 1), Quality Assurance/Monitoring Activities including the CRS update for the quarter (Attachment 2), Arizona Medicaid Administrative Claiming (MAC) Random Moment Time Study (RMTS) results (Attachment 3), and the Budget Neutrality Tracking Schedule (Attachment 4)

STATE CONTACT(S)

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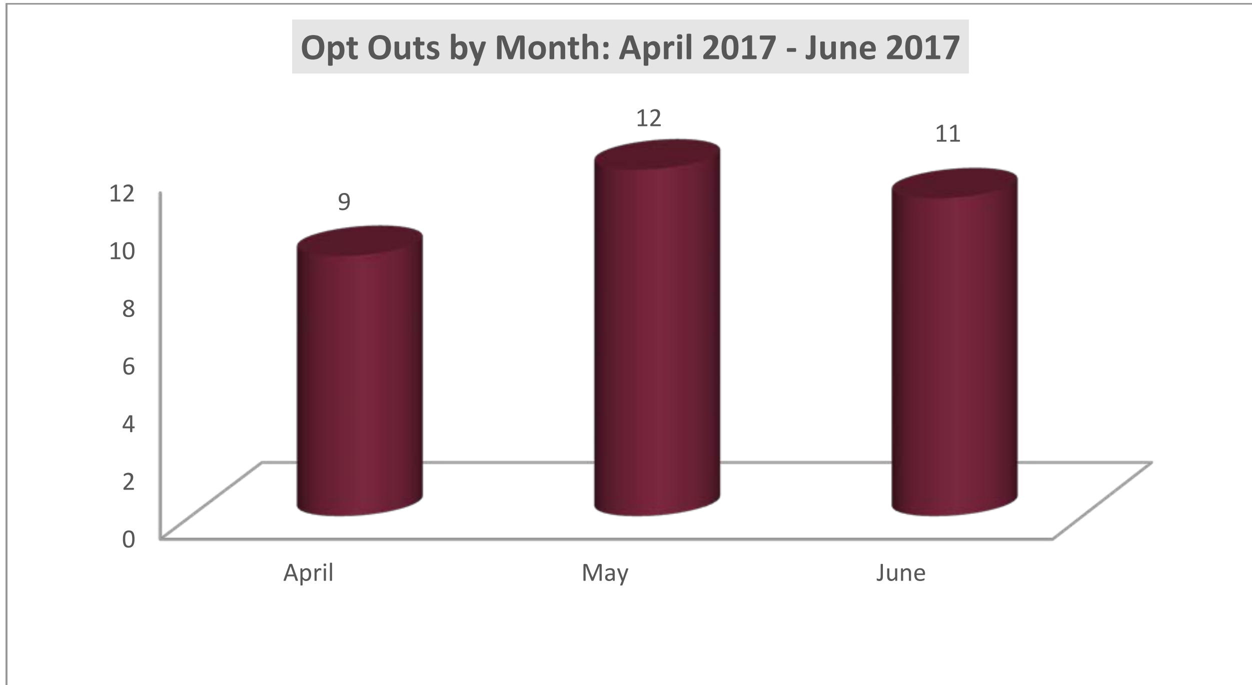
(602) 417-4534

DATE SUBMITTED TO CMS

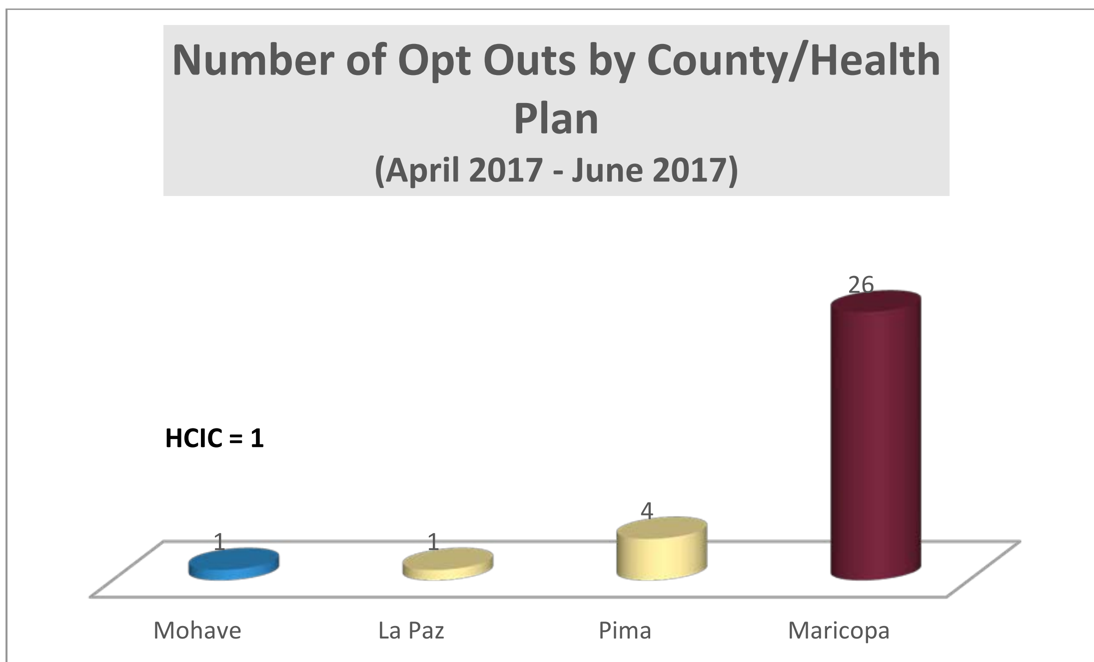
September 1, 2017

AHCCCS
Arizona Health Care Cost Containment System

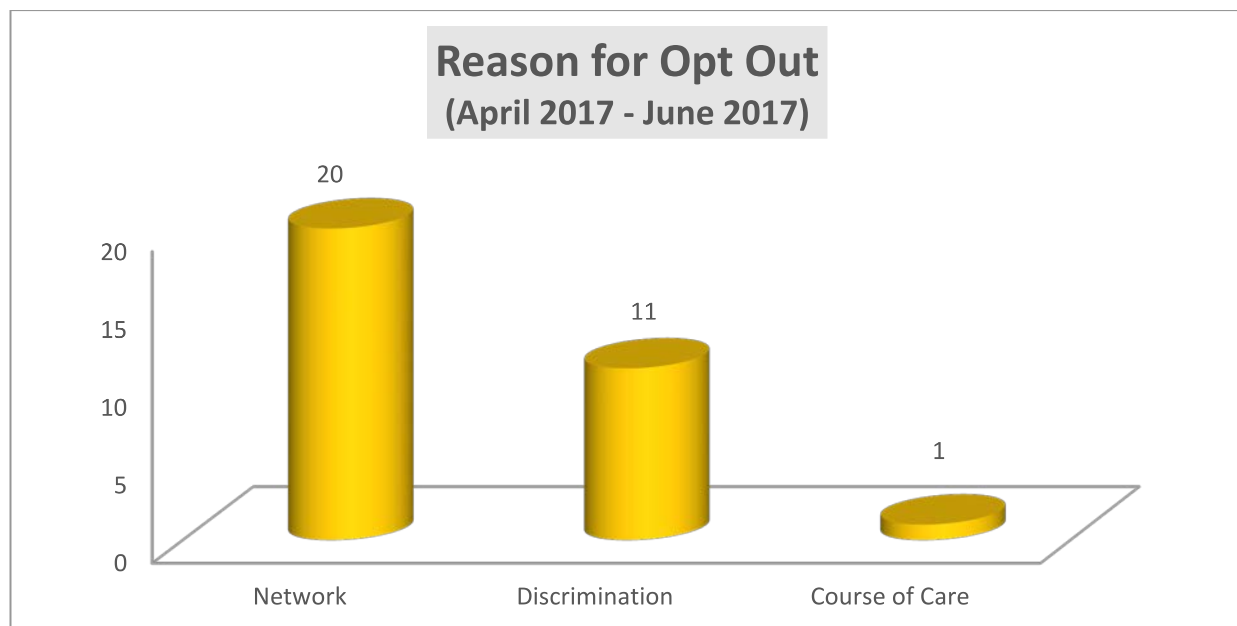
Attachment 1: SMI Opt-Out for Cause Report



April – June 2017 Opt-Out Request		
April 2017	May 2017	June 2017
9	12	11

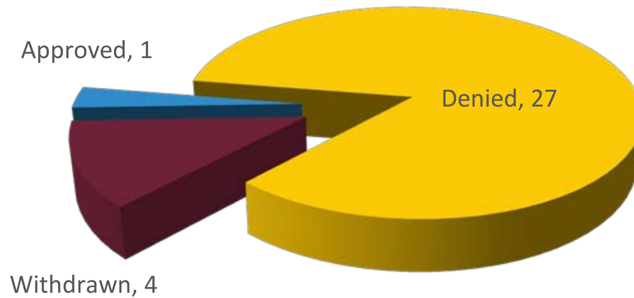


Number of Opt-Out by County /Health Plans: April 2017 – June 2017		
HCIC	Gila	-
HCIC	Navajo	-
HCIC	Coconino	-
HCIC	Yavapai	-
HCIC	Mohave	1
HCIC	**Total**	**1**
CIC	La Paz	1
CIC	Cochise	-
CIC	Graham	-
CIC	Yuma	-
CIC	Pinal	-
CIC	Pima	4
CIC	**Total**	**5**
MMIC	Maricopa	**26**
Grand Total	**All Counties**	**32**



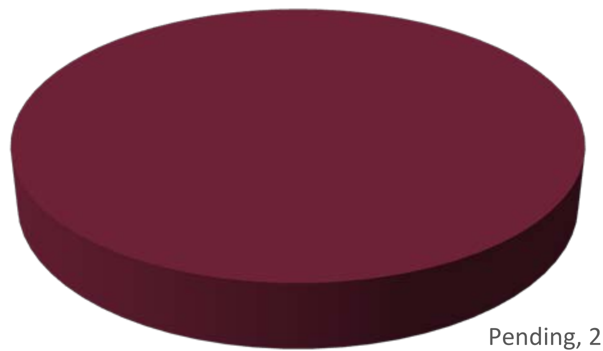
Network	Discrimination	Course of Care	Other
20	**11**	**1**	**0**

Initial Opt Out Decisions
(April 2017 - June 2017)

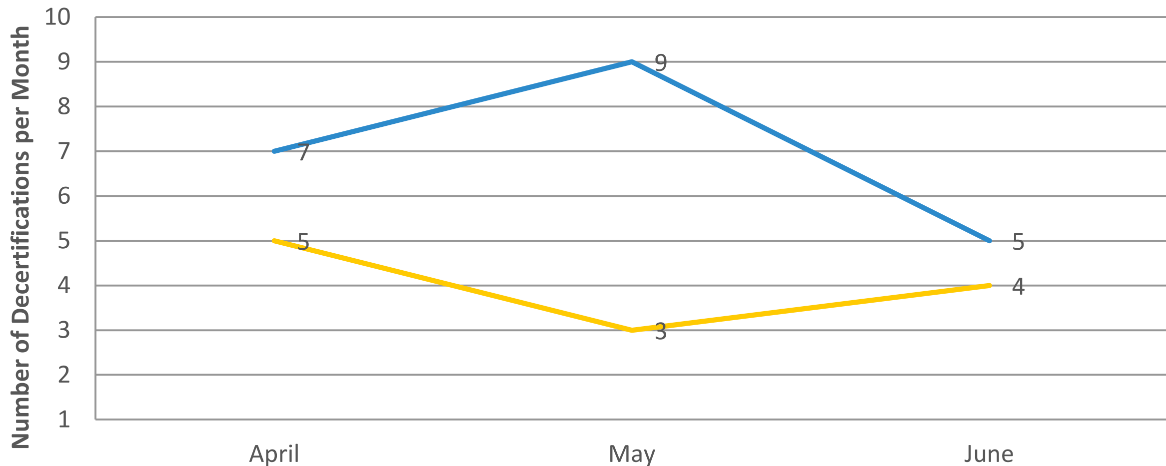


April 2017- June 2017 Opt Out Decisions			
Denied	**Withdraw**	**Approved**	**Pending**
27	4	1	0

Appeal Outcomes
(April 2017 - June 2017)



April 2017-June 2017 Post Appeal Opt Out Outcomes	
Pending	2
Withdrawn	0
Denied	0
Approved	0



January – March 2017 Opt-Out Request			
	January 2017	February 2017	March 2017
Admin	7	9	5
Clinical	5	3	4

Note:

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

- 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.
- 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.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Attachment II to the
Section 1115 Quarterly Report

Quality Assurance/Monitoring Activity

Demonstration/Quarter Reporting Period

Demonstration Year: 34

Federal Fiscal Quarter 3/2017 (4/1/17 – 6/30/17)

Prepared by the Division of Health Care Management
July, 2017

Introduction

This report describes the Arizona Health Care Cost Containment System (AHCCCS) quality assurance and monitoring activities that took place during the third quarter of federal fiscal year 2017, as required in STC 41 of the States' Section 1115 Wavier. This report also includes updates related to AHCCCS' Quality Assessment and Performance Improvement Strategy, in accordance with the Balanced Budget Act requirements.

The AHCCCS Division of Health Care Management (DHCM) is responsible for directly overseeing the quality of health care services provided to its members enrolled with managed care organizations. DHCM is also responsible for the administrative and financial functions of the contracted health plans (Contractors). DHCM, in conjunction with other AHCCCS Divisions, sister agencies and community partners, continually focuses on the provision of "comprehensive, quality health care for those in need", as delineated in the Agency mission.

DHCM is the division that houses the Quality Management (QM), Quality Improvement (QI), and Maternal and Child Health /Early and Periodic Screening, Diagnostic and Treatment (MCH/EPSDT) Units. Those two units are the primary driver of efforts outlined in the Quality Strategy and the teams closely collaborate to ensure thoughtful processes for members, stakeholders, policies, and improvement activities.

The following sections provide an update on the State's progress and activities under each of the components of the 1115 Wavier and AHCCCS Quality Strategy.

Stakeholder Involvement

The success of AHCCCS can be attributed, in part, to concentrated efforts by the agency to foster partnerships with its sister agencies, contracted Managed Care Organizations (MCOs – also referred to as "Contractors"), providers, and the community. During the first quarter of CYE 2017, AHCCCS continued these ongoing collaborations to improve the delivery of health care and related services to Medicaid recipients and KidsCare members, including those with special health care needs. AHCCCS also continued to address common issues and solve problems through ongoing networking activities. Feedback from sister agencies, providers and community organizations are included in the Agency's process for identifying priority areas for quality improvement and the development of new initiatives. AHCCCS has also made a concentrated effort to include member and stakeholder feedback in most facets of Agency operations, including Policy Committee, quarterly meetings, new advisory councils, and specialty workgroups (e.g. Autism and Foster Care).

Collaborative Stakeholders

The AHCCCS QM and MCH/EPSDT teams partner with a number of stakeholders, including but not limited to:

Arizona Department of Health Services (ADHS) Bureau of Tobacco and Chronic Disease	*Attorney General's Health Care Committee*
ADHS Bureau of USDA Nutrition Programs	*Healthy Mothers/Healthy Babies*
ADHS Immunization Program and Vaccines for Children Program	*Arizona Health-E Connection/Health Information Network of Arizona*
ADHS Office of Environmental Health – Targeted Lead Screening	*Arizona Diabetes Steering Committee*
Arizona Early Intervention Program (AzEIP)	*Injury Prevention Advisory Council*
Arizona Head Start Association	*Arizona Newborn Screening Advisory Committee*
Task Force on Prevention of Prenatal Exposure to Alcohol and other Drugs	*First Things First*
Arizona Medical Association	*Arizona Women, Infants, And Children Program*
Arizona Chapter of the American Academy of Pediatrics	*Strong Families*
The Arizona Partnership for Immunization (TAPI)	*ADHS Emergency Preparedness Office*
Arizona Perinatal Trust	*National Alliance on Mental Illness (NAMI) Arizona*
ADHS/HSAG Statewide Workgroup on Psychiatric Inpatient Readmissions	*ADHS Cancer Prevention and Control Office*

Innovative Practices

AHCCCS is continually reviewing opportunities to improve the effectiveness of Arizona's health care delivery system as well as methods to promote optimized health for members, transparency, and efficiency. There are teams throughout the Agency that promote innovation for both internal and external processes. Below are some of the efforts in which the QM, QI, and MCH/EPSDT teams are involved.

Developing and Implementing Projects to Improve the Delivery System

Administrative Simplification

Following successful efforts around Administrative Simplification, the Clinical team has since taken on several new initiatives to enhance the knowledge and understanding of behavioral health care. The Medical Management (MM) Unit, which regularly partners with the QM and MCH/EPSDT units, added a Behavioral Health Coordinator to support efforts for the Clinical team as a whole. The addition of a Behavioral Health Coordinator enhances the ability for clinical considerations, service delivery, program and contract development to encompass a holistic approach in all aspects of care. AHCCCS continues to hire additional behavioral health expertise within its workforce.

Within the QM, QI, and MCH/EPSDT units, other activities designed to enhance integration have involved utilization of performance and quality measurement activities that provide a greater focus on specific aspects of integrated care. Highlights include:

- Required tracking of performance on frequency of diabetic screening for individuals with schizophrenia or bipolar disorder;
- Tracking performance on prenatal and postnatal timeliness of care with supplemental training to contracted health plan staff, relative to physical and behavioral health aspects of perinatal mood disorders; and
- Implementation of regular community-based meetings open to AHCCCS membership with a focus on enhancing member/stakeholder involvement and investment in performance and quality improvement activities for physical and behavioral health care.

Integration Efforts

Integration efforts are ongoing at AHCCCS, as demonstrated by newly awarded ALTCS/EPD contracts. Contracts were awarded to three MCOs throughout Arizona to administrator Arizona's integrated long term care system; implementation date is set for October 1st, 2017. Contracts were awarded based on the bidder's proposed approaches for care and treatment of ALTCS/EPD individuals using a fully integrated care perspective at both the systemic and direct care levels (e.g. use of health homes, electronic health records, coordinated case management, collaboration between behavioral and physical health). An additional expectation is centered on their ability to demonstrate a more thorough understanding and use of Arizona's long-standing model of behavioral health service delivery, in conjunction with traditional ALTCS physical health care activities. Although Arizona's ALTCS model has historically provided integrated care that included behavioral health treatment, emphasis was added to promote greater use of Arizona's behavioral health model, particularly with regard to individuals who have been determined to have a serious mental illness (SMI).

Behavioral Health Learning Opportunities

With the advent of Administrative Simplification, AHCCCS recognized the need to provide learning opportunities for staff that lacked behavioral health experience and expertise, due to the historical hiring requirements for medically trained personnel. As such, since July 1, 2016, AHCCCS began to offer formal meetings and informal workshops/lunch-hour trainings to ensure staff had opportunities to increase behavioral health system knowledge. Internal behavioral health subject matter experts, licensed behavioral health practitioners and community professionals have been procured to offer training on topics such as infant/toddler mental health, trauma informed care, perinatal mood disorders and adult system of care processes for individuals with general mental health needs and serious mental illnesses.

To further enhance integration efforts, and facilitate quality of care reviews utilizing a behavioral health perspective, QM has scheduled additional Behavioral Health "Lunch and Learn" trainings for QM and QOC staff in particular, with attendance open to other departments based on department need. Topics include:

- Regulatory requirements for individuals determined to have a serious mental illness (SMI) versus general mental health and/or substance abuse needs (GMHSA);
- Grant-based housing for individuals with SMI;
- Short term behavioral health residential services;
- Crisis process and requirements;
- Diagnostic categories/symptoms;
- Best and Evidence-practice clinical approaches for adults and children; and
- Mental Health Awareness.

Community Initiatives

AHCCCS Opioid Initiative: The overarching goal of this initiative is to reduce the prevalence of Opioid Use Disorders and opioid-related overdose deaths. The initiative approach includes developing and supporting state, regional, and local level collaborations and service enhancements to develop and implement best practices to comprehensively address the full continuum of care related to opioid misuse, abuse and dependency. Strategies include:

1. Increasing access to Naloxone through community-based education and distribution, as well as a co-prescribing campaign for individuals receiving opioid prescriptions in excess of 90 morphine equivalent daily doses and combinations of opioids and benzodiazepines;
2. Increasing access to and participation and retention in Medication Assisted Treatment;
3. Reducing the number of opioid-naïve members unnecessarily started on opioid treatment; and
4. Promoting best practices and improving care process models for chronic pain and high-risk members.

The Opioid State Targeted Response grant will enhance community-based prevention activities and treatment activities that will include 24/7 access to care points in "hotspot" areas throughout the state; increasing the availability of peer supports; providing additional care coordination efforts among high risk and priority populations; and adding recovery supports.

The Quality Caregiver Initiative (QCI): The objective of the QCI is to improve relationship-based, trauma-informed service supports for foster, kinship and adoptive parents by identifying a matrix of evidence-based intervention programs that are developmentally appropriate and span the continuum of service intensity needs from basic trauma trainings to brief intervention to intensive in-home services. In doing so, the goal is provide the right services and the right time to the family unit as a mechanism to decrease disruptions, increase permanency and ultimately, the social and emotional outcomes of the children in the child welfare system. The collaborative consists of several state agencies, behavioral health providers and experts in infant-toddler mental health, child development, family systems and trauma-informed care. The group is

currently reviewing the matrix of options and identifying training needs, provider capacity and ways to integrate with developmental screening and referral processes from pediatrics and other acute care settings.

Arizona Association of Health Plans (AzAHP)

The Arizona Association of Health Plans (AzAHP) is an Association comprised of most health plans that contract with AHCCCS for Medicaid business. The Association led an effort, with the support of AHCCCS, in selecting and implementing a credentialing verification organization (CVO) that would be utilized by all AHCCCS Contractors. The purpose of moving this initiative forward was to reduce the burden of submission of applications, documents and attestations on providers that are contracted with multiple Medicaid health plans. The credentialing process for primary source verification was implemented in the first quarter of this fiscal year.

The Association is a welcome partner for AHCCCS because it offers a singe point of contact for the Contractors and promotes consistency across the system. The Association works closely with AHCCCS to discuss Contractor concerns, barriers, and challenges to the efforts they are asked to undertake. It also provides valuable feedback for consideration as the direct link to the care and services being provided. AHCCCS utilizes the Association to provide stakeholder insight and to collaborate and promote new initiatives.

Identifying Priority Areas for Improvement

AHCCCS has established an objective, systematic process for identifying priority areas for improvement. This process involves a review of data from both internal and external sources, while also taking into account such factors as: (1) the prevalence of a particular condition and population affected, (2) the resources required by both AHCCCS and its Contractors to conduct studies and effect improvement, (3) whether the areas currently are priorities of CMS or state leadership and/or can be combined with existing initiatives, and (4) whether CMS priorities can be combined with current initiatives. Of importance is whether initiatives focused on the topic area are actionable and have the potential to result in improved quality improvement, member satisfaction and system efficiencies. Contractor input is also sought in prioritizing areas for improvement.

During the second quarter, one ongoing initiative was finalized, while two others continue.

1. First, a multi-year childhood obesity initiative was finalized. This longitudinal initiative focused on a cohort of children between two to five years of age with a Body Mass Index (BMI) of 85% or more. The study cohort was scattered across multiple contracted health plans and all were receiving services in an urban Federal Qualified Health Center (FQHC). The goal was to examine preliminary findings for prevalence of obesity in

children of this age, and to examine the potential effectiveness of behavioral health intervention strategies.

2. Second, our initiative on behavioral health care for children in the foster care system continues. Development of these metrics focused on children served under Comprehensive Medical and Dental Plan (CMDP), Arizona's health plan for children in Arizona's Foster Care system. AHCCCS' goal for these measures is to identify whether access and timeliness standards are met, as well as overall utilization trends for CMDP children needing behavioral health care.

3. Third, we continue to update tools that provide best practice strategies for infants and toddlers, including psychotropic prescribing, and early childhood mental health intervention and trauma informed care. The focus of the documents is on the most current prescribing practices and psychotherapeutic approaches during early childhood, with the recommendation that psychotherapeutic approaches be the preferred method of treatment prior to implementation of psychopharmacologic intervention.

Establishing Realistic Outcome-Based Performance Measures

AHCCCS has long been a leader in developing, implementing and holding Contractors accountable to performance measure goals. AHCCCS developed and implemented HEDIS-*like* measures before HEDIS existed. AHCCCS' consistency in performance expectations has resulted in many performance measures performing at a rate close to the NCQA HEDIS national Medicaid mean. For AHCCCS, the HEDIS-*like* measures have been a reasonable indicator of health care accessibility, availability and quality. AHCCCS has transitioned to measures found in the CMS Core measure sets that provide a better opportunity to shift the system towards indicators of standardized health care outcomes, access to care, and patient satisfaction. This transition will also result in the ability to compare AHCCCS' rates with those of other states as the measure sets are implemented.

AHCCCS has developed new performance measure sets for all lines of business. Additional measures have also been incorporated into contracts for all lines of business. These measures include behavioral health measures for adults such as: "Follow-up After Hospitalization for Mental Illness", "Mental Health Utilization" and "Use of Opioids at High Dosage". The new measures and related Minimum Performance Standards/Goals became effective October 1, 2016. This date aligned with the new contract begin date for all lines of business. The AHCCCS decision to transition to a new measure set was partially driven by a desire to align with measures sets, such as the CHIPRA Core Measure Set, the Adult Core Measure Set, Meaningful Use, and other measure sets being implemented by CMS. AHCCCS has also aligned the measure sets with contracts to reflect changes on measures implemented by CMS for the current contract year.

It is AHCCCS' goal to continue development and implementation of additional Core measures as the data sources become valid and reliable. Initial measures were chosen based on a number of criteria that included member needs, system ability to impact/improve results, alignment with national measure sets, and comparability across lines of business.

The health care system is evolving in relation to measuring quality. It is in a transitional phase in that the data sources and methodologies that previously existed will no longer be enough. The systems, data sources and processes to fully achieve the next level in clinical outcomes and satisfaction measures are not yet fully developed or implemented. Informatics, such as electronic health records, health information exchanges plus data and information available through public health connectivity, are yet to become fully available. Transitioning the AHCCCS measure sets is anticipated to support the adoption of electronic health records and use of the health information exchanges. This will in turn, result in efficiencies and data/information designed to achieve the following:

1. transform care practices;
2. continue evolution to fully integrated care across all statewide systems;
3. improve individual patient outcomes;
4. guide population health management;
5. improve patient satisfaction with the care experience;
6. increase efficiencies; and
7. reduce health care costs.

CYE2017 Performance Measures are provided below:

CYE 2017 Performance Measure Crosswalk

MEASURES "R" denotes "Reserve" Status	Acute	ALTCS/EPD	CMDP	CRS	DDD	GMH/SA	SMI	HEDIS	CMS Adult Core Measures	CMS Children's Core Measures
Timeliness of Prenatal Care: Prenatal Care Visit in the First Trimester or Within 42 days of Enrollment	x						x			x
Timeliness of Prenatal Care: Postpartum Care Rate	x						x		x	
Mental Health Utilization	*R*	x		x		x	x	x		
Use of Opioids From Multiple Providers	*R*	x			x	x	x		x	
Screening for Clinical Depression and Folow-up Plan		*R*							x	
Annual Monitoring for Patients on Persistent Medications: Combo Rate		*R*			*R*		*R*		x	
Advance Directives	x	x								
Access to Behavioral Health Services (7 days) - TABLED								AHCCCS		
Access to Behavioral Health Services (21 Days for CRS/23 days for other) - TABLED										
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medication							*R*		x	
Children's Access to PCPs, by age: **12-24 mo.**	x		x	x	x					x
Children's Access to PCPs, by age: **25 mo to 6 yrs.**	x		x	x	x					x

MEASURES "R" denotes "Reserve" Status	Acute	ALTCS/EPD	CMDP	CRS	DDD	GMH/SA	SMI	HEDIS	CMS Adult Core Measures	CMS Children's Core Measures
Children's Access to PCPs, by age: **7 - 11 yrs.**	x		x	x	x					x
Children's Access to PCPs, by age: **12 - 19 yrs.**	x		x	x	x					x
Well-Child Visits: **15 mo.**	x		x	x						x
Well-Child Visits: **3 - 6 yrs.**	x		x	x	x					x
Adolescent Well-Child Visits: **12 - 21 yrs.**	x		x	x	x					x
Children's Dental Visits: **(ages 2-21)**	x		x	x	x					x
Weight Assessment and counseling - Body Mass Index (BMI) Assessment for Chldredolescents	x	x	*R*	x	*R*					x
EPSDT Participation	*R*	*R*	*R*	x	*R*		*R*			x
Percentage of Eligibles Who Received Preventive Dental	x	x	x	x	x				x	
SEAL: Dental Sealants for Children Ages 6-9 at Elevated Caries Risk	x	x	x	x	x					x
Developmental Screening in the First Three Years of Life	*R*	*R*	*R*	x	*R*					x
Human Papillomavirus Vaccine for Female Adolescents	x		x	x	x					x
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	x		x	x		x				x

MEASURES "R" denotes "Reserve" Status	Acute	ALTCS/EPD	CMDP	CRS	DDD	GMH/SA	SMI	HEDIS	CMS Adult Core Measures	CMS Children's Core Measures
Childhood Immunization Status										
DTaP	x		x	x	x					x
IPV	x		x	x	x					x
MMR	x		x	x	x					x
Hib	x		x	x	x					x
HBV	x		x	x	x					x
VAV	x		x	x	x					x
PCV	x		x	x	x					x
Hep A	x		x	x	x					x
Rotavirus	x		x	x	x					x
Influenza	x		x	x	x					x
Combination 3 (4:3:1:3:3:1:4)	x		x	x	x					x
Immunization for Adolescents										
Adolescent Meningococcal	x		x	x	x					x
Adolescent Tdap/Td	x		x	x	x					x
Combination 1	x		x	x	x					x

Identifying, Collecting and Assessing Relevant Data

Performance Measures

AHCCCS has implemented several efforts over the past few years in preparation for the performance measure transition described above. First and foremost, the Agency undertook extensive internal planning efforts, including evaluation of new requirements, future goals and desired capabilities, as well as barrier identification and associated risk. One risk identified, was the possibility that the reduction of information system and data analytic staff resources would not allow the level of review and validation of performance measure programming necessary to ensure the validity and accuracy of Performance Measurement activities. To address this concern, the Agency is utilizing its External Quality Review Organization to perform the measurement calculations. AHCCCS has finalized the contract with an external vendor to support future performance measurements.

Contractors have been provided the data to enhance their planning and implementation efforts related to the new performance measures, as well as sustaining and improving continuing measures. Some of these efforts will include new work groups, new reporting mechanisms, increased opportunities for technical assistance, and a more transparent reporting process with plans for proactive reporting prior to the end of the measurement period. Such efforts should facilitate the Contractors' ability to make necessary adjustments/final pushes and payment reform initiatives that align with performance measure thresholds.

Performance Improvement Projects

Providing Incentives for Excellence and Imposing Sanctions for Poor Performance

AHCCCS regularly monitors Contractors to ensure compliance with contractually-mandated performance measures. Contracts outline Minimum Performance Standards (MPS) that the Contractor must meet and Goals that the Contractor should strive to achieve. Those measures are evaluated to determine what regulatory actions should be taken. At a minimum, measures that fail to meet the MPS will require a Corrective Action Plan. Additional actions could include mandatory technical assistance, Notices to Cure, and financial sanctions.

Re-evaluation/Re-development of Performance Measures

AHCCCS has implemented a payment reform initiative (PRI) for the Acute Care population that is designed to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, and those related to child and adolescent health. This PRI process will be performed annually on a contract year basis. Starting with FFY15, AHCCCS also implemented a payment reform initiative for the ALTCS EPD population as well. The EPD Quality Measures target ED Utilization, Readmissions, Diabetes Management and Flu Shots.

The Acute Care requirement of total payments under all contracts executed with health care providers governed by shared-savings arrangements, increases to 10 percent in FFY15. For ALTCS EPD a minimum of five percent of the value of total payments under all EPD contracts executed (1.5% for D-SNP contracts) with health care providers must be governed by shared-savings arrangements.

Performance Improvement Projects (PIPs)

AHCCCS has a Performance Improvement Project (PIP) under way with Contractors for all lines of business, which is designed to improve enrollee health outcomes and satisfaction.

- E-Prescribing - The purposes of this PIP is to increase the number of prescribers electronically prescribing at least one prescription and increase the percentage of prescriptions which are submitted electronically, in order to improve patient safety. The baseline measurement period for this PIP is Contract Year Ending (CYE; federal fiscal year) 2014. Baseline data has been collected, validated and released to Contractors. Efforts are currently underway to collect and validate data for remeasurement year 1. Additionally, there are two Contractors for which CYE 2016 will serve as their baseline measurement period, with efforts underway to collect and validate this data as well.

- Developmental Screening - The purpose of the Developmental Screening PIP is to increase the number of early life screenings for members at 9-, 18-, and 24-months of age to ensure that developmental delays are identified early and referred for appropriate

follow-up and treatment. The PIP measure will focus on the number of children who receive a developmental screening at the appropriate age intervals versus the total number of children in each age group. Although not formally tied to the PIP measurement, AHCCCS will be evaluating whether or not follow-up appointments are scheduled and maintained for any concerns identified through the screening process. Additionally, AHCCCS will monitor the care coordination process and Contractor oversight of the screening and referral processes. The baseline measurement will be reflective of Contract Year Ending (CYE) 2016. Efforts are currently underway to collect and validate data for remeasurement year one (1).

Including Medical Quality Assessment and Performance Improvement Requirements in AHCCCS Contracts

Contracts with health plans are reviewed at least annually to ensure that they include all federally required elements prior to renewal. In addition, contracts are reviewed for clarity and for opportunities to strengthen expectations and/or promote new opportunities. AHCCCS has begun efforts to identify Performance Improvement Projects targeted to begin CYE 2018.

Regular Monitoring and Evaluating of Contractor Compliance and Performance

AHCCCS monitors and evaluates access to care, organizational structure and operations, clinical and non-clinical quality measurement and performance improvement outcomes through the following methods.

- *On-site Operational Reviews* - Operational and Financial Reviews (ORs) are used by AHCCCS to evaluate Contractor compliance related to access/availability and quality of services, including implementation of policies and procedures and progress toward plans of correction to improve quality of care and service for members.

- *Review and analysis of periodic reports* - A number of contract deliverables are used to monitor and evaluate Contractor compliance and performance. AHCCCS reviews, provides feedback and approves these reports as appropriate.

    - Quarterly EPSDT and Adult Monitoring Reports - AHCCCS requires CRS, Acute, ALTCS and RBHA Contractors to submit quarterly EPSDT and Adult Monitoring Reports demonstrating their efforts to sustain or improve annual performance rates for all contractually mandated performance measure as well as their efforts to inform families/caregivers and providers of EPSDT/Adult services. AHCCCS has developed a template for Contractors to report data on member and provider outreach, as well as Contractor rates for various EPSDT and adult services. The template prompts Contractors to evaluate the effectiveness of activities, including care coordination,

follow up and new or revised interventions to improve quality and access to care. These reports are received and reviewed on a quarterly basis.

- Annual Plans - QM/QI, EPSDT, MCH and Dental – AHCCCS requires all lines of business to submit an annual plan which will address details of the Contractors methods for achieving optimal outcomes for their members. A separate report is submitted for Quality Management and Improvement (QM/QI).

- Integrated Care Reports - For those plans (e.g. Integrated RBHAs) that currently follow an integrated model, distinct Integrated Care reports are required. These reports focus on the quality and quantity of coordination and integration activities.

- *Review and analysis of program-specific Performance Measures and Performance Improvement Projects* - AHCCCS considers a Performance Improvement Project (PIP) as a planned process of data gathering, evaluation, and analysis to determine interventions or activities that are anticipated to have a positive outcome. PIPs are designed to improve the quality of care and service delivery and usually last at least four years. While Contractors may select and implement their own PIPs to address problems specific to their plans, AHCCCS mandates other program-wide PIPs in which Contractors must participate, and monitors performance until each Contractor meet requirements for demonstrable and sustained improvement.

Another method by which AHCCCS monitors the quality and appropriateness of care provided to members is through Performance Measures. Contractors submit encounter data to AHCCCS, which measures each plan's performance and evaluates its compliance in meeting contractual performance standards for specific health care services. Under their contracts with AHCCCS, Contractors are required to improve their rates for Performance Measures and achieve specific goals for each. AHCCCS requires corrective action plans from Contractors that do not meet the Minimum Performance Standard, or that show a statistically significant decline in their rates. Contractors also could face significant financial sanctions if they do not improve performance to a level that meets or exceeds the minimum standard.

Maintaining an Information System that Supports Initial and Ongoing Operations

AHCCCS maintains a robust information system—the Prepaid Medical Management Information System (PMMIS)—that documents all members, their claims and encounter data, plus many other data points. PMMIS data feeds into the AHCCCS Data Warehouse, which is the centralized system, used for data analytics. There is a newly formed Data Integrity team that supports maintaining valid, accurate, and reliable data; this team is made up of data users and

system experts from across the Agency and meets at least quarterly to discuss any issues or opportunities around the data and systems. AHCCCS has focused on building data expertise within every division of the Agency, promoting data analytics as the cornerstone of operations and monitoring/oversite activities.

Reviewing and Revising the Quality Strategy

AHCCCS continues its efforts to implement the new Managed Care Rule through revisions of the Agency's Quality Strategy. The focus of revisions is to create a cohesive reflection of numerous efforts underway around integrated care, increased member satisfaction, and improvement of clinical outcomes. QM will be leading a cross-functional Agency team to draft a practical Quality Strategy that brings together the requirements of the Rule as well as the mission, vision, and operational goals of the Agency.

Attachment 3: Arizona Health Care Cost Containment System (AHCCCS)
Quarterly Random Moment Time Study Report
April 2017 – June 2017

The April through June 2017 quarter for the Medicaid School Based Claiming (MSBC) program Random Moment Time Study (RMTS) was completed successfully with the administrative, direct service, and personal care time study cost pools.

Active Participants

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

Staff Pool	April - June 2017
Administrative	3,118
Direct Service	3,324
Personal Care	5,133

The table below demonstrates the administrative, direct service, and personal care time study achieved the 85% return rate in the April to June 2017 quarter.

The return rate reflects number of responses received divided by the total number of moments generated per quarter.

Return Rate

Cost Pool	Moments Generated	Valid Response	Return Rate
Administrative	3,200	3,137	98.03%
Direct Service	3,400	3,304	97.18%
Personal Care	3,500	3,236	92.46%

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended June 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	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	2,932,519	2,920,210	2,914,090	2,938,820	11,705,639	$ 4,785,045,218	
SSI	835.29	1.06	885.41	69.10%	611.79	487,575	489,003	489,032	491,682	1,957,292	1,197,446,143	
AC [1]			562.09	69.74%	391.97	527,244	430,723	365,132	310,396	1,633,495	640,284,571	
ALTCS-DD	4643.75	1.06	4922.38	67.38%	3316.47	72,516	73,152	73,962	74,817	294,447	976,523,928	
ALTCS-EPD	4503.21	1.052	4737.37	67.50%	3197.93	85,463	85,509	85,733	86,515	343,220	1,097,592,096	
Family Plan Ext [1]		1.058	17.04	90.00%	15.33	12,471	12,424	12,440	12,689	50,024	767,009	
											$ 8,697,658,965	MAP Subtotal
											103,890,985	Add DSH Allotment
											$ 8,801,549,950	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	2,911,453	2,891,209	2,903,049	2,918,929	11,624,640	$ 4,928,028,889	
SSI	938.53	67.86%	636.91	494,769	497,163	499,785	503,412	1,995,129	1,270,714,908	
AC [1]	600.80	68.73%	412.94	274,990	248,817	228,204	217,114	969,125	400,195,127	
ALTCS-DD	5217.72	65.83%	3434.66	75,636	76,464	77,278	78,032	307,410	1,055,849,158	
ALTCS-EPD	4983.71	66.01%	3289.98	86,832	86,078	86,306	87,136	346,352	1,139,489,635	
Family Plan Ext [1]	18.42	90.00%	16.58	13,104	13,824	14,187	14,856	55,971	927,946	
									$ 8,795,205,663	MAP Subtotal
									106,384,369	Add DSH Allotment
									$ 8,901,590,032	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	2,891,787	2,839,380	2,955,633	3,113,481	11,800,281	$ 5,392,604,277	
SSI	994.84	69.27%	689.13	506,815	514,492	523,373	529,552	2,074,232	1,429,415,214	
AC [1]	600.58	69.84%	419.47	206,419	87	2	-	206,508	86,623,815	
ALTCS-DD	5530.78	67.35%	3725.09	78,838	79,680	80,669	81,755	320,942	1,195,536,965	
ALTCS-EPD	5242.86	67.53%	3540.32	87,682	87,896	88,737	89,362	353,677	1,252,128,784	
Family Plan Ext [1]	12.99	90.00%	11.69	14,885	-	-	-	14,885	174,071.00	
Expansion State Adults [1]	624.02	85.37%	532.72	-	443,881	624,197	755,729	1,823,807	971,572,266	
									$ 10,328,055,392	MAP Subtotal
									108,086,519	Add DSH Allotment
									$ 10,436,141,911	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	71.43%	486.71	3,146,071	3,084,870	3,105,241	3,209,379	12,545,561	$ 6,106,096,292	
SSI	1054.53	70.24%	740.74	536,979	543,518	544,167	544,139	2,168,803	1,606,515,197	
AC	0.00	68.43%	0.00	-	-	-	-	-	-	
ALTCS-DD	5862.63	68.54%	4018.16	82,722	83,824	84,827	85,603	336,976	1,354,024,944	
ALTCS-EPD	5515.49	68.68%	3788.31	90,012	89,877	89,929	90,018	359,836	1,363,171,363	
Family Plan Ext	0.00	90.00%	0.00	-	-	-	-	-	-	
Expansion State Adults	574.70	87.75%	504.31	817,491	835,585	845,518.00	865,954.00	3,364,548	1,696,776,104	
									$ 12,126,583,901	MAP Subtotal
									109,707,817	Add DSH Allotment
									$ 12,236,291,718	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	71.54%	512.83	3,261,940	3,258,834	3,246,962	3,331,829	13,099,565	$ 6,717,906,613	
SSI	1117.81	70.56%	788.77	548,924	551,332	548,071	550,466	2,198,793	1,734,335,239	
AC	0.00	68.48%	0.00	-	-	-	-	-	-	
ALTCS-DD	6214.39	68.96%	4285.69	86,368	87,129	88,236	89,204	350,937	1,504,005,721	
ALTCS-EPD	5802.30	69.10%	4009.12	89,878	89,452	89,595	89,873	358,798	1,438,463,827	
Family Plan Ext	0.00	90.00%	0.00	-	-	-	-	-	-	
Expansion State Adults	576.62	90.70%	523.00	915,853	930,172	931,613	937,705	3,715,343	1,943,129,152	
									$ 13,337,840,553	MAP Subtotal
									110,036,940	Add DSH Allotment
									$ 13,447,877,493	Total BN Limit

	DY 06 PM/PM			Member Months QE 12/16	QE 3/17	QE 6/17	QE 9/17	Total		
AFDC/SOBRA	754.12	71.76%	541.18	3,383,220	3,387,102	3,363,042		10,133,364	5,483,949,811	
SSI	1184.87	70.77%	838.49	550,973	551,275	548,394		1,650,642	1,384,051,526	
AC	0.00	71.81%	0.00	-	-	-		-	-	
ALTCS-DD	6587.25	69.27%	4562.97	90,179	91,237	92,101		273,517	1,248,051,111	
ALTCS-EPD	6104.02	69.34%	4232.49	90,223	89,588	88,721		268,532	1,136,557,920	
Family Plan Ext	0.00	90.00%	0.00	-	-	-		-	-	
Expansion State Adults	580.18	90.76%	526.60	955,089	961,412	960,592		2,877,093	1,515,088,489	
									$ 10,767,698,857	MAP Subtotal
									111,027,272	Add DSH Allotment
									$ 10,878,726,129	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 6/30/2017

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

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

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

	Budget Neutrality Limit - Federal Share			Expenditures from CMS-64 - Federal Share												
	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	$ 2,217,708,266	$ 103,890,985	$ 2,321,599,251	$ 502,890,921	$ 191,249,757	$ 175,610,617	$ 151,638,753	$ 164,685,415	$ 167,197	$ -	$ -	$ -	$ 458,635	$ -	$ 1,186,701,295	$ 1,134,897,956
QE 3/12	2,177,972,323	-	2,177,972,323	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	883,199,735
QE 6/12	2,153,181,397	-	2,153,181,397	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	717,909,597
QE 9/12	2,148,796,979	-	2,148,796,979	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	808,143,392
QE 12/12	2,208,605,864	106,384,369	2,314,990,233	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	876,700,850
QE 3/13	2,191,115,783	-	2,191,115,783	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	846,760,527
QE 6/13	2,192,844,999	-	2,192,844,999	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	777,536,454
QE 9/13	2,202,639,017	-	2,202,639,017	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	682,335,972
QE 12/13	2,361,638,671	108,086,519	2,469,725,190	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	964,101,499
QE 3/14	2,496,612,543	-	2,496,612,543	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	1,011,961,168
QE 6/14	2,658,542,293	-	2,658,542,293	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	1,050,517,218
QE 9/14	2,811,261,886	-	2,811,261,886	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	946,687,857
QE 12/14	3,014,649,993	109,707,817	3,124,357,810	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	1,098,006,010
QE 3/15	3,002,747,900	-	3,002,747,900	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	1,249,168,619
QE 6/15	3,022,380,009	-	3,022,380,009	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	1,111,337,763
QE 9/15	3,086,805,999	-	3,086,805,999	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	1,202,743,051
QE 12/15	3,315,277,904	110,036,940	3,425,314,844	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	1,402,350,061
QE 3/16	3,324,626,769	-	3,324,626,769	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	1,377,946,778
QE 6/16	3,322,037,434	-	3,322,037,434	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	1,351,499,431
QE 9/16	3,375,898,445	-	3,375,898,445	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	1,465,386,126
QE 12/16	3,589,215,559	-	3,589,215,559	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	1,542,399,789
QE 3/17	3,597,039,350	-	3,597,039,350	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	1,555,454,051
QE 6/17	3,581,443,948	111,027,272	3,692,471,220	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	1,383,861,840
QE 9/17			-												-	-
	$ 64,053,043,330	$ 649,133,902	$ 64,702,177,232	$ 14,686,734,654	$ 6,418,094,300	$ 1,168,637,065	$ 4,383,506,928	$ 4,682,597,218	$ 1,866,872	$ 657,575,495	$ 944,648,662	$ 197,353,331	$ 453,960	$ 6,119,803,004	$ 39,261,271,489	$ 25,440,905,743

Last Updated: 8/1/2017

Arizona Health Care Cost Containment System
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III. SUMMARY BY DEMONSTRATION YEAR

	Federal Share of Budget Neutrality Limit	Federal Share of Waiver Costs on CMS-64	Annual Variance	As % of Annual Budget Neutrality Limit	Cumulative Federal Share of Budget Neutrality Limit	Cumulative Federal Share of Waiver Costs on CMS-64	Cumulative Federal Share Variance	As % of Cumulative Budget Neutrality Limit
WAIVER PERIOD OCTOBER 1, 2011 THROUGH DECEMBER, 2016								
DY 01	$ 8,801,549,950	$ 5,636,365,085	$ 3,165,184,865	35.96%				
DY 02	8,901,590,032	5,839,686,223	3,061,903,809	34.40%				
DY 03	10,436,141,911	6,476,861,562	3,959,280,349	37.94%				
DY 04	12,236,291,718	7,391,302,422	4,844,989,296	39.60%				
DY 05	13,447,877,493	7,984,651,612	5,463,225,881	40.63%				
DY 06	10,878,726,129	5,932,404,585	4,946,321,544	45.47%	$ 64,702,177,232	$ 39,261,271,489	$ 25,440,905,743	39.32%
	$ 64,702,177,232	$ 39,261,271,489	$ 25,440,905,743					

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

Schedule C Waiver 11-W00275/9

Total Computable

Waiver Name	01	02	03	04	05	06	Total
AC	917,853,361	582,040,636	123,936,290	32,933,169	28,695,229	(340,094)	1,685,118,591
AFDC/SOBRA	3,415,751,961	3,582,994,522	3,540,155,640	3,606,256,898	3,924,446,922	2,720,828,470	20,790,434,413
ALTCS-EPD	1,061,940,357	1,167,011,339	1,195,528,242	1,244,890,085	1,261,769,353	953,528,486	6,884,667,862
ALTCS-DD	939,086,691	1,005,552,529	1,067,544,854	1,170,386,428	1,252,457,466	1,016,239,125	6,451,267,093
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	-	-	1,137,871,988	1,930,577,313	2,139,129,229	1,665,897,396	6,873,475,926
Family Planning Extension	830,631	1,008,110	190,026	(1,337)	(763)	(280)	2,026,387
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	1,349,512,893	1,426,950,723	1,545,012,120	1,733,791,929	1,812,264,435	1,342,754,039	9,210,286,139
Uncomp Care IHS/638	22,866,717	97,192,513	53,888,765	13,437,080	7,647,155	2,560,109	197,592,339
Subtotal	8,160,915,200	8,584,364,870	9,066,641,797	10,038,350,957	10,708,409,410	7,917,089,273	54,475,771,507
New Adult Group	-	-	108,363,046	303,800,112	481,887,787	357,307,714	1,251,358,659
Total	8,160,915,200	8,584,364,870	9,175,004,843	10,342,151,069	11,190,297,197	8,274,396,987	55,727,130,166

Federal Share

Waiver Name	01	02	03	04	05	06	Total
AC	640,073,537	400,056,703	86,564,824	22,536,611	19,649,616	(244,226)	1,168,637,065
AFDC/SOBRA	2,385,714,661	2,466,986,527	2,497,694,705	2,575,994,028	2,807,689,330	1,952,655,403	14,686,734,654
ALTCS-EPD	716,855,277	770,397,726	807,297,334	855,052,161	871,824,208	661,170,512	4,682,597,218
ALTCS-DD	632,712,981	661,923,939	719,012,033	802,166,792	863,744,227	703,946,956	4,383,506,928
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	-	-	971,422,183	1,694,692,357	1,940,917,952	1,512,770,512	6,119,803,004
Family Planning Extension	767,009	927,946	174,071	(1,212)	(689)	(253)	1,866,872
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	932,475,252	968,369,300	1,070,240,505	1,217,912,745	1,278,842,023	950,254,475	6,418,094,300
Uncomp Care IHS/638	22,848,035	97,067,679	53,845,830	13,406,989	7,630,280	2,554,518	197,353,331
Subtotal	5,636,365,085	5,839,686,223	6,476,861,562	7,391,302,422	7,984,651,612	5,932,404,585	39,261,271,489
New Adult Group	-	-	108,363,046	303,792,807	481,495,491	345,231,005	1,238,882,349
Total	5,636,365,085	5,839,686,223	6,585,224,608	7,695,095,229	8,466,147,103	6,277,635,590	40,500,153,838

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.

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

Revised Schedule C Waiver 11-W00275/9

Total Computable

Waiver Name	01	02	03	04	05	06	Total
AC	918,166,933	582,251,392	124,024,035	32,933,162	28,695,555	(339,974.79)	1,685,731,102
AFDC/SOBRA	3,416,766,842	3,584,084,665	3,541,145,933	3,611,313,290	3,929,358,982	2,725,598,279	20,808,267,991
ALTCS-EPD	1,061,940,357	1,167,011,339	1,195,528,242	1,244,890,085	1,261,769,353	953,528,486	6,884,667,862
ALTCS-DD	939,086,691	1,005,552,529	1,067,544,854	1,170,386,428	1,252,457,466	1,016,239,125	6,451,267,093
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	-	-	1,138,095,227	1,933,621,057	2,142,337,587	1,669,245,139	6,883,299,010
Family Planning Extension	830,631	1,008,110	190,026	(1,337)	(763)	(280)	2,026,387
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	1,349,878,051	1,427,349,824	1,545,410,843	1,736,183,700	1,814,635,591	1,345,128,268	9,218,586,277
Uncomp Care IHS/638	22,866,717	97,192,513	53,888,765	13,437,080	7,647,155	2,560,109	197,592,339
Subtotal	8,160,915,200	8,584,364,870	9,066,641,797	10,038,350,957	10,708,409,410	7,917,089,273	54,475,771,507
New Adult Group	-	-	108,363,046	303,800,112	481,887,787	357,307,714	1,251,358,659
Total	8,160,915,200	8,584,364,870	9,175,004,843	10,342,151,069	11,190,297,197	8,274,396,987	55,727,130,166

Federal Share

Waiver Name	01	02	03	04	05	06	Total
AC	640,284,571	400,195,127	86,623,815	22,536,606	19,649,841	(244,143)	1,169,045,816
AFDC/SOBRA	2,386,397,675	2,467,702,533	2,498,360,479	2,579,455,635	2,811,074,722	1,955,958,019	14,698,949,063
ALTCS-EPD	716,855,277	770,397,726	807,297,334	855,052,161	871,824,208	661,170,512	4,682,597,218
ALTCS-DD	632,712,981	661,923,939	719,012,033	802,166,792	863,744,227	703,946,956	4,383,506,928
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	-	-	971,572,266	1,696,776,104	1,943,129,152	1,515,088,489	6,126,566,012
Family Planning Extension	767,009	927,946	174,071	(1,212)	(689)	(253)	1,866,872
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	932,721,004	968,631,430	1,070,508,567	1,219,550,151	1,280,476,224	951,898,391	6,423,785,767
Uncomp Care IHS/638	22,848,035	97,067,679	53,845,830	13,406,989	7,630,280	2,554,518	197,353,331
Subtotal	5,636,365,085	5,839,686,223	6,476,861,562	7,391,302,422	7,984,651,612	5,932,404,585	39,261,271,489
New Adult Group	-	-	108,363,046	303,792,807	481,495,491	345,231,005	1,238,882,349
Total	5,636,365,085	5,839,686,223	6,585,224,608	7,695,095,229	8,466,147,103	6,277,635,590	40,500,153,838

Calculation of Effective FMAP:

	01	02	03	04	05	06
AFDC/SOBRA						
Federal	2,386,397,675	2,467,702,533	2,498,360,479	2,579,455,635	2,811,074,722	1,955,958,019
Total	3,416,766,842	3,584,084,665	3,541,145,933	3,611,313,290	3,929,358,982	2,725,598,279
Effective FMAP	0.698437378	0.688516808	0.705523163	0.714270801	0.715402877	0.717625203
SSI						
Federal	932,721,004	968,631,430	1,070,508,567	1,219,550,151	1,280,476,224	951,898,391
Total	1,349,878,051	1,427,349,824	1,545,410,843	1,736,183,700	1,814,635,591	1,345,128,268
Effective FMAP	0.690966864	0.678622307	0.692701602	0.702431517	0.705638217	0.707663658
ALTCS-EPD						
Federal	716,855,277	770,397,726	807,297,334	855,052,161	871,824,208	661,170,512
Total	1,061,940,357	1,167,011,339	1,195,528,242	1,244,890,085	1,261,769,353	953,528,486
Effective FMAP	0.67504288	0.660145879	0.675264126	0.686849523	0.690953704	0.693393561
ALTCS-DD						
Federal	632,712,981	661,923,939	719,012,033	802,166,792	863,744,227	703,946,956
Total	939,086,691	1,005,552,529	1,067,544,854	1,170,386,428	1,252,457,466	1,016,239,125
Effective FMAP	0.673753538	0.658268882	0.673519272	0.685386273	0.689639569	0.692698144
AC						
Federal	640,284,571	400,195,127	86,623,815	22,536,606	19,649,841	(244,143)
Total	918,166,933	582,251,392	124,024,035	32,933,162	28,695,555	(339,975)
Effective FMAP	0.697350937	0.687323607	0.698443773	0.684313459	0.684769494	0.718122158
Expansion State Adults						
Federal	-	-	971,572,266	1,696,776,104	1,943,129,152	1,515,088,489
Total	-	-	1,138,095,227	1,933,621,057	2,142,337,587	1,669,245,139
Effective FMAP			0.853682753	0.877512219	0.907013518	0.907648885
New Adult Group						
Federal	-	-	108,363,046	303,792,807	481,495,491	345,231,005
Total	-	-	108,363,046	303,800,112	481,887,787	357,307,714
Effective FMAP			1	0.999975955	0.999185918	0.966200816

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V. Budget Neutrality Member Months and Cost Sharing Premium Collections

Budget Neutrality Member Months:	AFDC/SOBRA	SSI	ALTCS-DD	ALTCS-EPD	AC	MED	Family Plan Ext	Expan St Adults	New Adult Group
Quarter Ended December 31, 2011	2,932,519	487,575	72,516	85,463	527,244	467	12,471		
Quarter Ended March 31, 2012	2,920,210	489,003	73,152	85,509	430,723	-	12,424		
Quarter Ended June 30, 2012	2,914,090	489,032	73,962	85,733	365,132	-	12,440		
Quarter Ended September 30, 2012	2,938,820	491,682	74,817	86,515	310,396	-	12,689		
Quarter Ended December 31, 2012	2,911,453	494,769	75,636	86,832	274,990	-	13,104		
Quarter Ended March 31, 2013	2,891,209	497,163	76,464	86,078	248,817	-	13,824		
Quarter Ended June 30, 2013	2,903,049	499,785	77,278	86,306	228,204	-	14,187		
Quarter Ended September 30, 2013	2,918,929	503,412	78,032	87,136	217,114	-	14,856		
Quarter Ended December 31, 2013	2,891,787	506,815	78,838	87,682	206,419	-	14,885		
Quarter Ended March 31, 2014	2,839,380	514,492	79,680	87,896	87	-	-	443,881	38,998
Quarter Ended June 30, 2014	2,955,633	523,373	80,669	88,737	2	-	-	624,197	86,533
Quarter Ended September 30, 2014	3,113,481	529,552	81,755	89,362	-	-	-	755,729	122,898
Quarter Ended December 31, 2014	3,146,071	536,979	82,722	90,012	-	-	-	817,491	149,801
Quarter Ended March 31, 2015	3,084,870	543,518	83,824	89,877	-	-	-	835,585	191,143
Quarter Ended June 30, 2015	3,105,241	544,167	84,827	89,929	-	-	-	845,518	245,263
Quarter Ended September 30, 2015	3,209,379	544,139	85,603	90,018	-	-	-	865,954	284,888
Quarter Ended December 31, 2015	3,261,940	548,924	86,368	89,878	-	-	-	915,853	312,497
Quarter Ended March 31, 2016	3,258,834	551,332	87,129	89,452	-	-	-	930,172	331,697
Quarter Ended June 30, 2016	3,246,962	548,071	88,236	89,595	-	-	-	931,613	333,928
Quarter Ended September 30, 2016	3,331,829	550,466	89,204	89,873	-	-	-	937,705	325,108
Quarter Ended December 31, 2016	3,383,220	550,973	90,179	90,223	-	-	-	955,089	331,115
Quarter Ended March 31, 2017	3,387,102	551,275	91,237	89,588	-	-	-	961,412	334,958
Quarter Ended June 30, 2017	3,363,042	548,394	92,101	88,721				960,592	336,332
Quarter Ended September 30, 2017									

	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	-	-

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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**	**109,707,817**	**110,036,940**	**111,027,272**	**649,133,902**
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**	**154,267**	**3,377,393**	**12,503,322**	**16,636,040**

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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)

	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	-	38,998	86,533	122,898	248,429	143,726,114
		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	149,801	191,143	245,263	284,888	871,095	527,636,889
		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	99.92%	633.68	312,497	331,697	333,928	325,108	1,303,230	825,836,604
		DY 06 PM/PM			Member Months QE 12/16	QE 3/17	QE 6/17	QE 9/17	Total	
New Adult Group	1.047	664.01	96.62% QE 12/16	641.57	331,115				331,115	212,431,880
			95.00% QE 9/17	630.81		334,958	336,332	-	671,290	423,454,955
										635,886,835

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	22,561,903	-	22,561,903	13,870,414	8,691,489
QE 6/14	50,062,802	-	50,062,802	34,313,342	15,749,460
QE 9/14	71,101,409	-	71,101,409	47,984,458	23,116,951
QE 12/14	90,736,985	-	90,736,985	46,004,135	44,732,850
QE 3/15	115,778,529	-	115,778,529	70,387,348	45,391,181
QE 6/15	148,559,923	-	148,559,923	85,319,153	63,240,770
QE 9/15	172,561,452	-	172,561,452	97,948,283	74,613,169
QE 12/15	198,024,494	-	198,024,494	113,800,738	84,223,756
QE 3/16	210,191,236	-	210,191,236	122,290,142	87,901,094
QE 6/16	211,604,986	-	211,604,986	123,158,494	88,446,492
QE 9/16	206,015,889	-	206,015,889	108,777,377	97,238,512
QE 12/16	212,431,880	-	212,431,880	126,789,923	85,641,957
QE 3/17	211,294,113	-	211,294,113	122,882,603	88,411,510
QE 6/17	212,160,843	-	212,160,843	125,355,939	86,804,904
QE 9/17		-	-		-
	$ 2,133,086,441	$ -	$ 2,133,086,441	$ 1,238,882,349	$ 894,204,092

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	$ 143,726,114	$ 96,168,214	$ 47,557,900	33.09%				
DY 04	527,636,889	299,658,919	227,977,970	43.21%				
DY 05	825,836,604	468,026,751	357,809,853	43.33%				
DY 06	635,886,835	375,028,465	260,858,370	41.02%	$ 2,133,086,441	$ 1,238,882,349	$ 894,204,092	41.92%
	$ 2,133,086,441	$ 1,238,882,349	$ 894,204,092					

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