AHCCCS
Arizona Health Care Cost Containment System

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

June 7, 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
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Dear Ms. Woodard:

In accordance with Special Terms and Conditions paragraph 41, enclosed please find the Quarterly Progress Report for January 1, 2017 through March 31, 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,

[redacted]

Elizabeth Lorenz
Assistant Director
AHCCCS Office of Intergovernmental Relations

Enclosure

cc: Brian Zolynas
Hee Young Ansell
Susan Ruiz

AHCCCS Quarterly Report
January 1, 2017 through March 31, 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: 2nd (January 1, 2017 – March 31, 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 January 1, 2017 – March 31, 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	1,229,318	1,821	276,381
Acute SSI	189,247	306	35,670
Prop 204 Restoration	513,961	442	77,145
Adult Expansion	127,308	158	31,939
LTC DD	30,677	49	2,131
LTC EPD	31,263	40	3,806
Non-Waiver	21,865	143	8,564
Total	**2,143,639**	**2,959**	**435,636**

Table 2 is a snapshot of the number of current enrollees (as of January 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]	**1,380,413**
Title XXI funded State Plan [2]	**17,271**

[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]	**399,266**
• **Prop 204 Restoration (0-100% FPL)**	317,249
• **Adult Expansion (100% - 133% FPL)**	82,017
Enrollment Current as of	4/1/17

OPERATIONAL/POLICY DEVELOPMENTS/ISSUES

Waiver Update

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:

- Adults with behavioral health needs;
- 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
- Individuals transitioning from incarceration who are AHCCCS-eligible.

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.

Below is a summary of the TI program implementation activities conducted by AHCCCS from January 18, 2017 through March 31, 2017:

- AHCCCS has worked closely with CMS to draft the Designated State Health Programs (DSHP) protocol. AHCCCS anticipates finalizing the protocol in June 2017.
- 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; (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.

State Plan Update

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

[3] Prop 204 Restoration & Adult Expansion

SPA #	Description	Filed	Approved	Eff. Date
Title XIX				
SPA 15-004 - Ambulance Rates	Updates Ambulance Rates in the State Plan.	6/01/15	1/30/17	10/1/15
SPA 16-012-C – Value Based Purchasing Nursing Facilities	Updates the State Plan to include Value Based Purchasing (VBP) differential adjusted payment for nursing facilities.	12/30/16	3/23/17	10/1/16
SPA 16-010-B – Outpatient Hospital Rates	Updates the State Plan to make changes to outpatient hospital rates.	12/30/16	3/23/17	10/1/16
SPA 16-008 – LTAC and Rehab Hospitals	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
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, 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 8, 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 January 1, 2017 – March 31, 2017.

Table 1 **Advocacy Issues**	Jan.	Feb.	Mar.	Total
9+Billing Issues	24	20	24	68
• Member reimbursements				
• Unpaid bills				
Cost Sharing	6	1	3	10
• Co-pays				
• Share of Cost (ALTCS)				
• Premiums (Kids Care, Medicare)				
Covered Services	23	15	28	66
Eligibility Issues by Program				
Can't get coverage due to :				
ALTCS				
• Resources	1	7	5	13
• Income				
• Medical				
DES				
• Income	71	78	87	236
• Incorrect determination				
• Improper referrals				
Kids Care				
• Income	0	1	4	5
• Incorrect determination				
SSI/Medical Assistance Only				
• Income	8	18	13	39
• Not categorically linked				
Information	112	145	120	377
• Status of application				
• Eligibility Criteria				
• Community Resources				
• Notification (Did not receive or didn't understand)				
Medicare	1	2	2	5
• Medicare Coverage				
• Medicare Savings Program				
• Medicare Part D				
Prescriptions	30	25	25	80

• Prescription coverage • Prescription denial				
Issues Referred to other Divisions:				
1.Fraud-Referred to Office of Inspector General (OIG)	0	0	0	0
2.Quality of Care-Referred to Division of Health Care Management (DHCM)	10	5	10	25
• Health Plans/Providers *(*Caregiver issues, Lack of providers) • Services *(*Equipment, Nursing Homes, Optical and Surgical)				
Total	**286**	**317**	**321**	**924**

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**	**Jan.**	**Feb.**	**Mar.**	**Total**
Applicant, Member or Representative	214	267	254	735
CMS	6	3	2	11
Governor's Office	13	7	18	38
Ombudsmen/Advocates/Other Agencies…	49	36	40	125
Senate & House	4	4	7	15
Total	**286**	**317**	**321**	**924**

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	Jan-17	Feb-17	Mar-17	**Total**
Access to Care	44	38	47	129
Health Plan	167	78	105	350
Provider Satisfaction	386	325	330	1041
Total	**597**	**441**	**482**	**1520**

CRS Member Grievances and Complaints	Jan-17	Feb-17	Mar-17	Total
Access to Care	0	0	0	0
Health Plan	3	2	2	7
Provider Satisfaction	9	7	10	26
Total	**12**	**9**	**12**	**33**

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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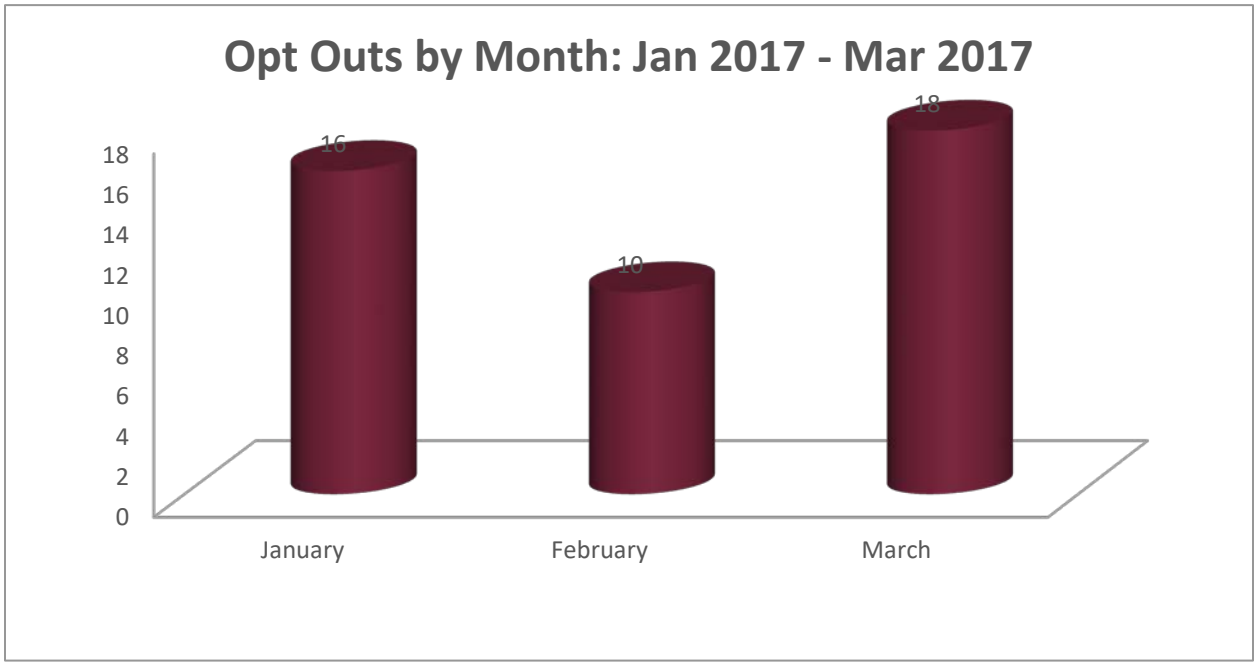
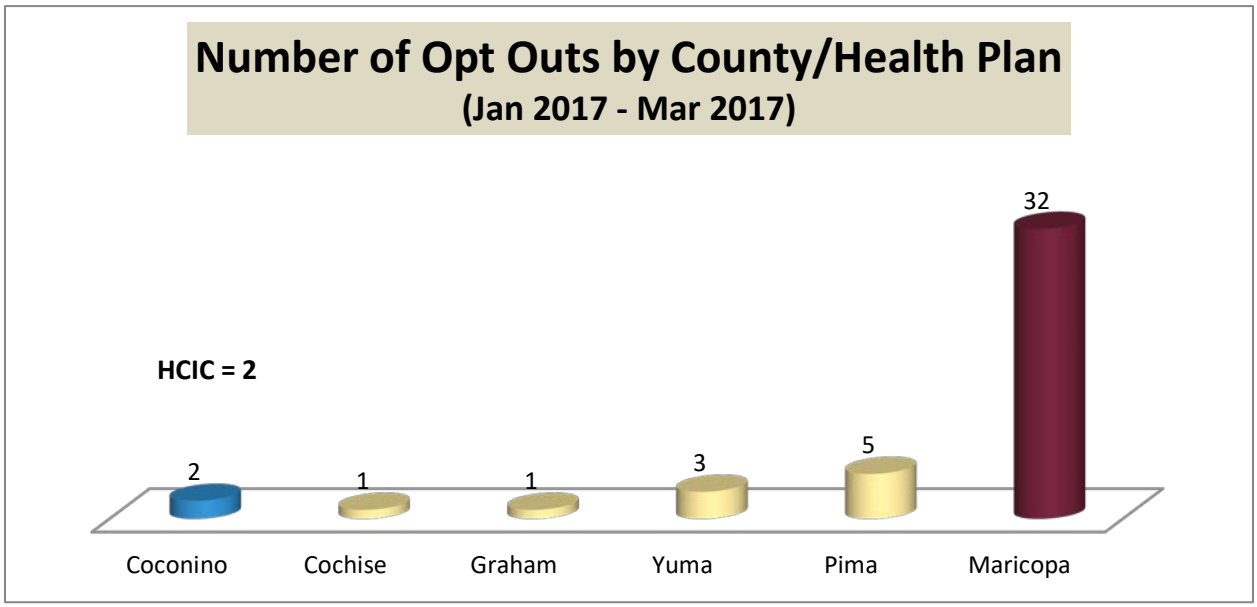
DATE SUBMITTED TO CMS

June 7, 2017

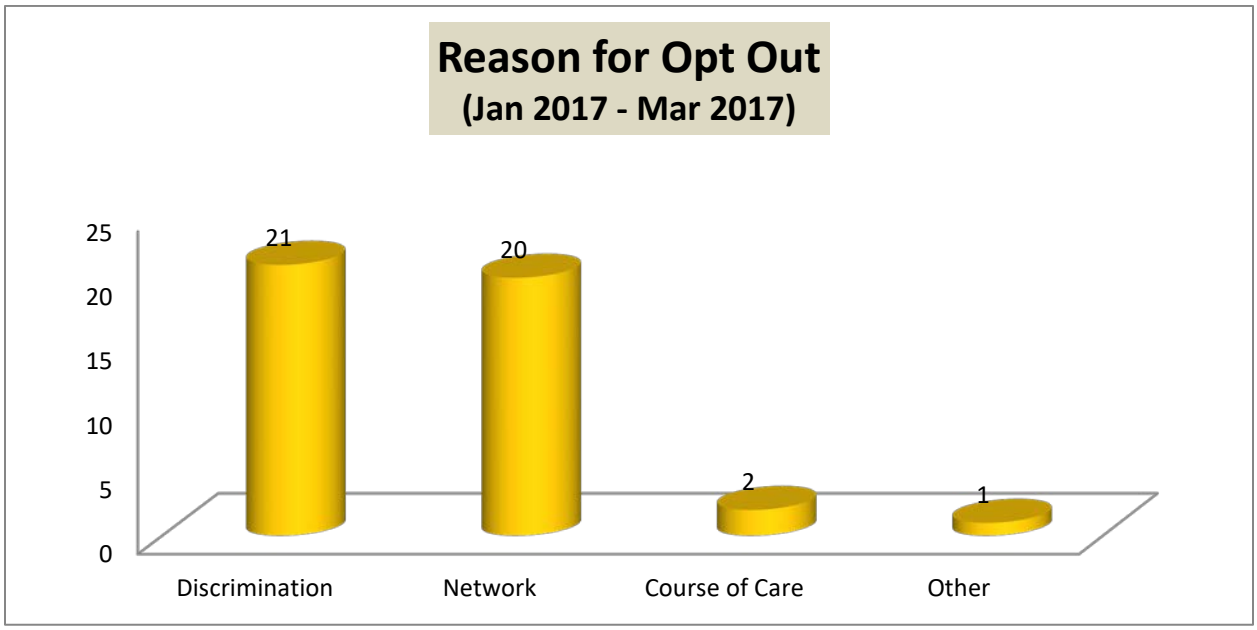
Attachment 1: SMI Opt-Out for Cause Report



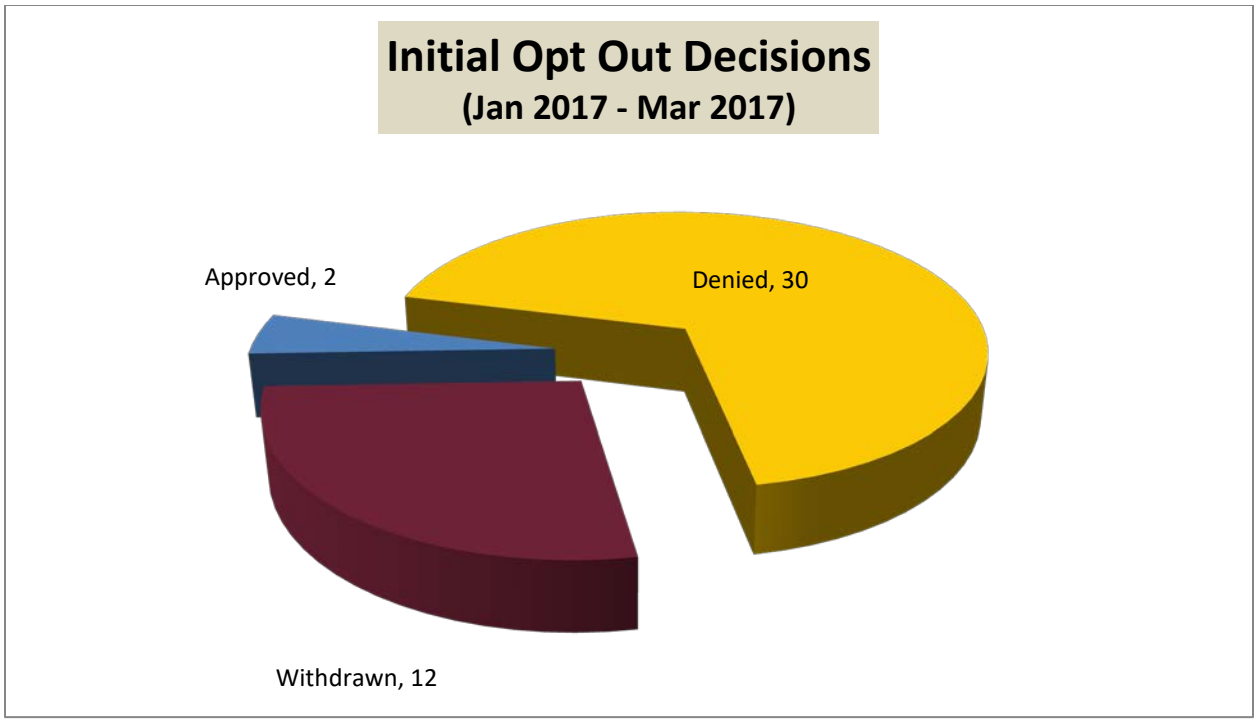
January – March 2017 Opt-Out Request		
January 2017	February 2017	March 2017
16	10	18



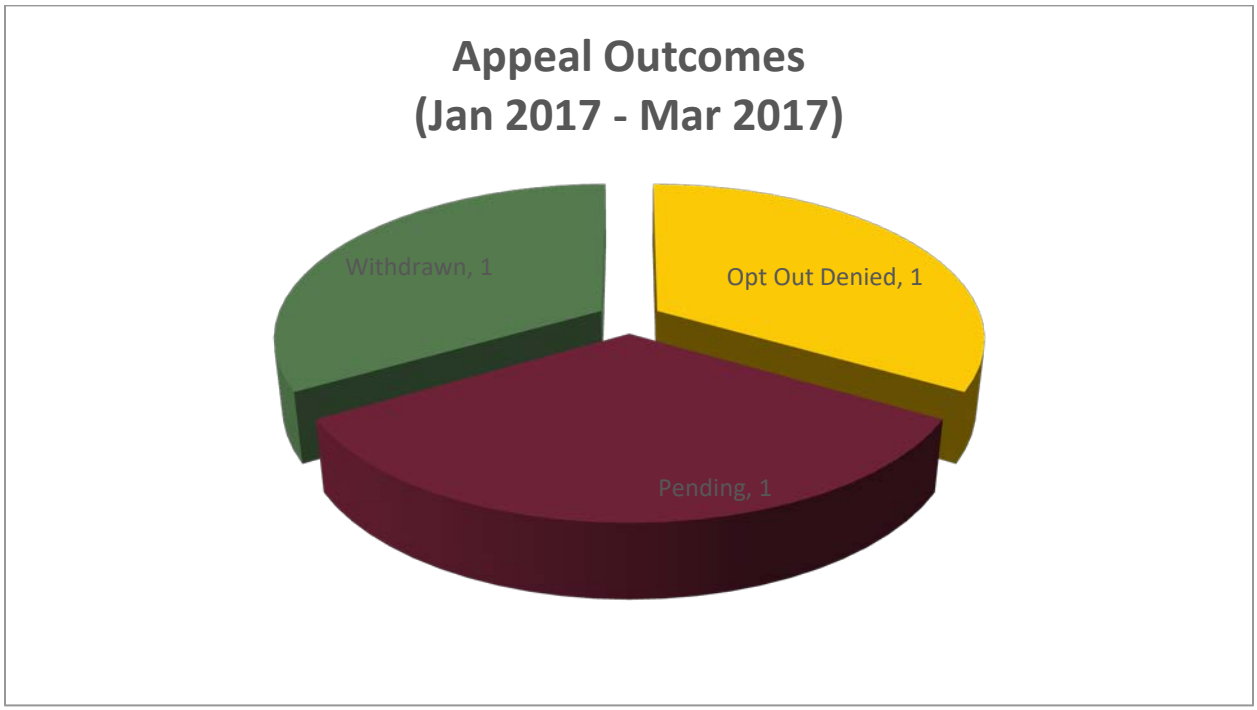
Number of Opt-Out by County /Health Plans: January 2017 – March 2017		
HCIC	Gila	0
HCIC	Navajo	0
HCIC	Coconino	2
HCIC	Yavapai	0
HCIC	**Total**	**2**
CIC	La Paz	0
CIC	Cochise	1
CIC	Graham	1
CIC	Yuma	3
CIC	Pinal	0
CIC	Pima	5
CIC	**Total**	**10**
MMIC	Maricopa	**32**
Grand Total	**All Counties**	**44**



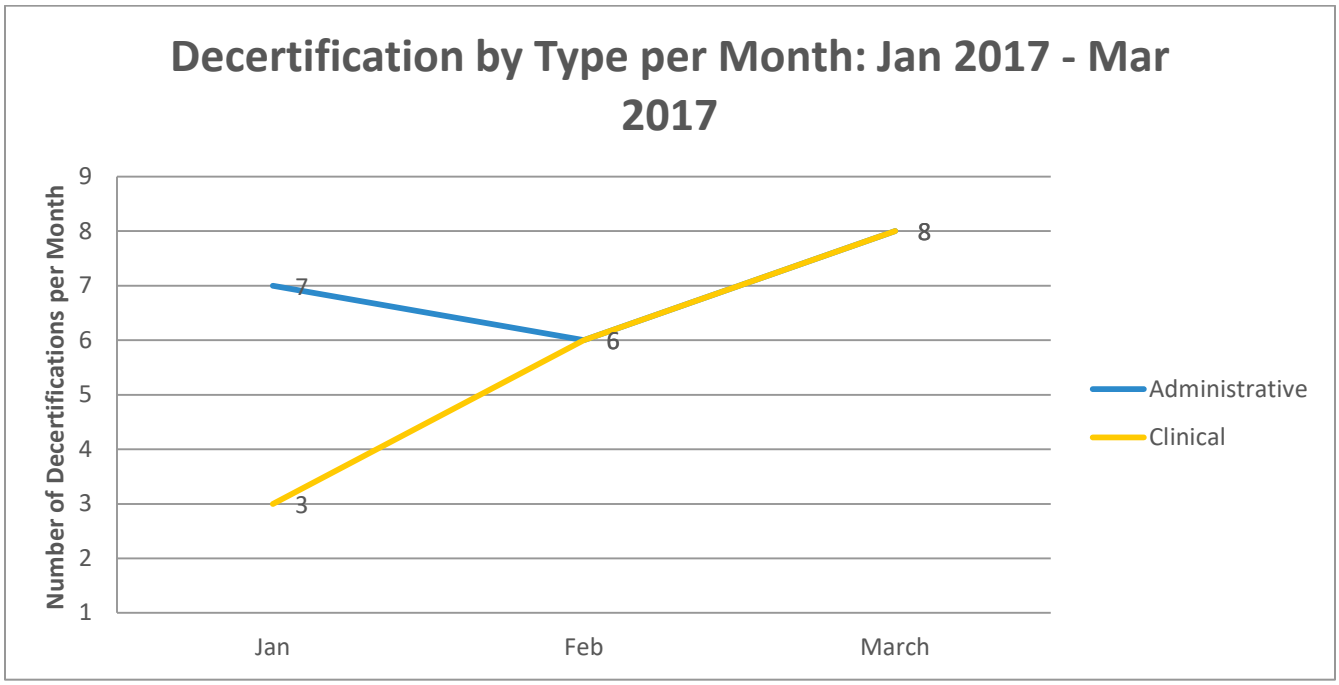
Network	Discrimination	Other	Course of Care
20	**21**	**1**	**2**



Oct 15- June 2016 Opt Out Decisions			
Denied	**Withdraw**	**Approved**	**Pending**
30	12	2	0



Oct 15- Jan 2016 Post Appeal Opt Out Outcomes	
Pending	1
Withdrawn	1
Denied	1
Approved	0



January – March 2017 Opt-Out Request			
	January 2017	February 2017	March 2017
Admin	7	6	8
Clinical	3	6	8

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.

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 2/2017 (1/1/17 – 3/31/17)

Prepared by the Division of Health Care Management
May, 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 2016, as required in STC 37 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 focus 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.

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;
- Implementation of regular community-based meetings open to AHCCCS membership; meeting focus is to enhance 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 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 with a designation of 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 illness.

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 designated as having 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

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, (3) whether current priority areas coincide with CMS and state leadership, and (4) if 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 first quarter, two initiatives focused on specific Contractor involvement and improvement for the EPSDT population and children within Arizona's Foster Care System.

- Coordination with the Arizona Early Intervention Program (AzEIP): One of the most challenging parts of the care delivery system has always been how the MCOs coordinate care with AzEIP for one of the youngest and most vulnerable populations served. AzEIP focuses on early intervention for members up to three years of age; their efforts to ensure

services are sometimes blurred with the requirements of the MCOs. As an ongoing effort to promote care coordination and system clarification the MCH/EPSDT Manager undertook extensive efforts to create detailed flow charts that outline the process from multiple points of entry and across many different MCO types, and member conditions. These flow charts have been promoted at several stakeholder groups, with their collaborative feedback implemented as applicable. Once the charts go through final review, the tools will be made available on the AHCCCS website.

- Behavioral health care for children in the foster care system: 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.

- Updating Guidance tools to ensure recognition of current Best or Evidence-based Practice: AHCCCS is currently revising the Birth to Five Psychiatric Prescribing Guidance document to ensure the most recent research on appropriate prescribing is provided to providers, children and families. Although the focus of the document is on the most current prescribing practices, significant effort is being put forth to also provide information on current best practice psychotherapeutic approaches, 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 aligns 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. improve individual patient outcomes,
3. guide population health management,
4. improve patient satisfaction with the care experience,
5. increase efficiencies and,
6. reduce health care costs.

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						AHCCCS		
Access to Behavioral Health Services (7 days) - TABLED										
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 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 Performance Improvement Project (PIP) is to increase the number of prescribers electronically prescribing at least one prescription and increase the percentage of prescriptions which are submitted electronically, in order to improve patient safety. 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; *federal fiscal year*) 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).

- *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 (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
January 2017 – March 2017

The January through March 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	January - March 2017
Administrative	3,158
Direct Service	3,278
Personal Care	5,094

The table below demonstrates the administrative, direct service, and personal care time study achieved the 85% return rate in the January to March 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	3,104	97.00%
Direct Service	3,400	3,292	96.82%
Personal Care	3,500	3,169	90.54%

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended March 31, 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	2,932,529	2,920,219	2,914,097	2,938,828	11,705,673	$ 4,785,058,963	
SSI	835.29	1.06	885.41	69.10%	611.79	487,578	489,003	489,026	491,675	1,957,282	1,197,439,808	
AC [1]			562.09	69.74%	391.97	527,244	430,723	365,132	310,396	1,633,495	640,285,348	
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	1,097,553,720	
Family Plan Ext [1]		1.058	17.04	90.00%	15.33	12,471	12,424	12,440	12,689	50,024	767,009	
											$ 8,697,668,573	MAP Subtotal
											103,890,985	Add DSH Allotment
											$ 8,801,559,558	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	68.87%	424.03	2,911,474	2,891,233	2,903,066	2,918,954	11,624,727	$ 4,929,275,700	
SSI	938.53	67.86%	636.90	494,757	497,144	499,769	503,390	1,995,060	1,270,650,840	
AC [1]	601.21	68.73%	413.21	274,990	248,817	228,204	217,114	969,125	400,453,856	
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%	3289.97	86,829	86,075	86,303	87,133	346,340	1,139,449,661	
Family Plan Ext [1]	18.42	90.00%	16.58	13,104	13,824	14,187	14,856	55,971	927,946	
									$ 8,796,648,378	MAP Subtotal
									106,384,369	Add DSH Allotment
									$ 8,903,032,747	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	2,891,823	2,839,414	2,955,703	3,113,597	11,800,537	$ 5,392,693,323	
SSI	994.84	69.27%	689.13	506,775	514,410	523,234	529,284	2,073,703	1,429,048,143	
AC [1]	600.65	69.84%	419.52	206,419	87	2	-	206,508	86,635,025	
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	89,359	353,665	1,252,086,214	
Family Plan Ext [1]	12.99	90.00%	11.69	14,885	-	-	-	14,885	174,071.00	
Expansion State Adults [1]	624.05	85.37%	532.74	-	443,946	624,301	755,916	1,824,163	971,810,057	
									$ 10,328,028,500	MAP Subtotal
									108,086,519	Add DSH Allotment
									$ 10,436,115,019	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%	486.70	3,146,217	3,085,048	3,105,483	3,209,720	12,546,468	$ 6,106,378,413	
SSI	1054.53	70.25%	740.78	536,642	543,104	543,729	543,689	2,167,164	1,605,393,114	
AC	0.00	68.42%	0.00	-	-	-	-	-	-	
ALTCS-DD	5862.63	68.54%	4018.16	82,725	83,827	84,833	85,609	336,994	1,354,097,457	
ALTCS-EPD	5515.49	68.68%	3788.29	90,010	89,877	89,926	90,014	359,827	1,363,127,930	
Family Plan Ext	0.00	90.00%	0.00	-	-	-	-	-	-	
Expansion State Adults	585.86	87.73%	513.98	817,741	835,906	845,899.00	866,412.00	3,365,958	1,730,026,969	
									$ 12,159,023,882	MAP Subtotal
									109,707,817	Add DSH Allotment
									$ 12,268,731,699	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	71.59%	513.22	3,262,272	3,259,131	3,246,875	3,332,104	13,100,382	$ 6,723,419,955	
SSI	1117.81	70.58%	789.00	548,392	550,691	547,012	548,889	2,194,984	1,731,839,187	
AC	0.00	88.99%	0.00	-	-	-	-	-	-	
ALTCS-DD	6214.39	68.96%	4285.66	86,374	87,136	88,244	89,210	350,964	1,504,110,941	
ALTCS-EPD	5802.30	69.09%	4008.99	89,875	89,451	89,589	89,855	358,770	1,438,305,924	
Family Plan Ext	0.00	90.00%	0.00	-	-	-	-	-	-	
Expansion State Adults	574.39	90.70%	520.98	916,391	930,760	932,268	938,591	3,718,010	1,936,998,119	
									$ 13,334,674,126	MAP Subtotal
									110,036,940	Add DSH Allotment
									$ 13,444,711,066	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	71.68%	540.56	3,383,557	3,381,387			6,764,944	3,656,891,760	
SSI	1184.87	70.76%	838.40	548,385	547,377			1,095,762	918,683,820	
AC	0.00	73.78%	0.00	-	-			-	-	
ALTCS-DD	6587.25	69.26%	4562.52	90,159	90,936			181,095	826,248,875	
ALTCS-EPD	6104.02	69.31%	4230.64	90,067	88,155			178,222	753,993,168	
Family Plan Ext	0.00	90.00%	0.00	-	-			-	-	
Expansion State Adults	562.61	90.86%	511.21	956,452	960,776			1,917,228	980,107,019	
									$ 7,135,924,641	MAP Subtotal
									111,027,272	Add DSH Allotment
									$ 7,246,951,913	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 3/31/2017

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
Budget Neutrality Tracking Report
For the Period Ended March 31, 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	$ 2,217,714,703	$ 103,890,985	$ 2,321,605,688	$ 502,890,921	$ 191,249,757	$ 175,610,617	$ 151,638,753	$ 164,685,415	$ 167,197	$ -	$ -	$ -	$ 458,635	$ -	$ 1,186,701,295	$ 1,134,904,393
QE 3/12	2,177,976,469	-	2,177,976,469	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	883,203,881
QE 6/12	2,153,181,024	-	2,153,181,024	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	717,909,224
QE 9/12	2,148,796,377	-	2,148,796,377	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	808,142,790
QE 12/12	2,208,978,892	106,384,369	2,315,363,261	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	877,073,878
QE 3/13	2,191,476,507	-	2,191,476,507	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	847,121,251
QE 6/13	2,193,200,368	-	2,193,200,368	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	777,891,823
QE 9/13	2,202,992,611	-	2,202,992,611	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	682,689,566
QE 12/13	2,361,631,831	108,086,519	2,469,718,350	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	964,094,659
QE 3/14	2,496,611,104	-	2,496,611,104	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	1,011,959,729
QE 6/14	2,658,543,270	-	2,658,543,270	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	1,050,518,195
QE 9/14	2,811,242,294	-	2,811,242,294	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	946,668,265
QE 12/14	3,022,487,876	109,707,817	3,132,195,693	768,767,395	322,908,117	24,114,620	197,157,685	209,877,907	254	9,813,379	78,963,846	3,397,109	-	411,351,488	2,026,351,800	1,105,843,893
QE 3/15	3,010,764,366	-	3,010,764,366	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	1,257,185,085
QE 6/15	3,030,537,166	-	3,030,537,166	676,953,007	301,501,985	1,376,095	136,222,624	210,766,873	(1,609)	111,644,096	32,871,414	4,867,076	-	434,840,685	1,911,042,246	1,119,494,920
QE 9/15	3,095,234,474	-	3,095,234,474	660,928,120	297,720,765	(1,214,417)	269,436,928	218,219,020	(26)	1,465,978	(14,698,940)	2,512,551	-	449,692,969	1,884,062,948	1,211,171,526
QE 12/15	3,314,850,266	110,036,940	3,424,887,206	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	1,401,922,423
QE 3/16	3,324,103,917	-	3,324,103,917	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	1,377,423,926
QE 6/16	3,320,998,509	-	3,320,998,509	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	1,350,460,506
QE 9/16	3,374,721,433	-	3,374,721,433	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	1,464,209,114
QE 12/16	3,570,138,103	-	3,570,138,103	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	1,523,322,333
QE 3/17	3,565,786,538	111,027,272	3,676,813,810	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	1,635,228,511
QE 6/17			-												-	-
QE 9/17			-												-	-
	$ 60,451,968,100	$ 649,133,902	$ 61,101,102,002	$ 13,932,751,809	$ 6,036,228,123	$ 1,142,105,089	$ 4,131,620,388	$ 4,434,996,167	$ 1,866,942	$ 544,778,027	$ 917,416,735	$ 197,084,311	$ 453,960	$ 5,613,360,558	$ 36,952,662,109	$ 24,148,439,893

Last Updated: 6/12/2017

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	$ 8,801,559,558	$ 5,636,374,046	$ 3,165,185,512	35.96%				
DY 02	8,903,032,747	5,841,035,418	3,061,997,329	34.39%				
DY 03	10,436,115,019	6,477,343,733	3,958,771,286	37.93%				
DY 04	12,268,731,699	7,405,735,732	4,862,995,967	39.64%				
DY 05	13,444,711,066	7,840,925,565	5,603,785,501	41.68%				
DY 06	7,246,951,913	3,751,247,615	3,495,704,298	48.24%	$ 61,101,102,002	$ 36,952,662,109	$ 24,148,439,893	39.52%
	$ 61,101,102,002	$ 36,952,662,109	$ 24,148,439,893					

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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	917,854,516	582,434,560	123,951,999	23,156,932	(633,793)	(190,492)	1,646,573,722
AFDC/SOBRA	3,415,754,950	3,584,603,774	3,540,601,175	3,610,122,345	3,823,151,084	1,763,770,707	19,738,004,035
ALTCS-EPD	1,061,941,034	1,167,110,637	1,195,547,952	1,247,265,857	1,254,599,663	601,430,301	6,527,895,444
ALTCS-DD	939,086,691	1,005,552,529	1,067,544,854	1,170,386,644	1,251,835,057	653,301,700	6,087,707,475
DSH/CAHP	155,762,651	161,526,080	162,262,955	168,351,054	153,634,100	5,245,950	806,782,790
Expansion State Adults	0	0	1,138,154,248	1,968,923,279	2,132,361,595	1,077,008,178	6,316,447,300
Family Planning Extension	830,631	1,008,110	190,026	(1,337)	(763)	(202)	2,026,465
MED	673,818	0	0	0	0	0	673,818
SNCP/DSHP	296,636,120	558,334,298	240,250,917	119,071,612	115,407,642	41,147,594	1,370,848,183
SSI	1,349,521,411	1,427,655,925	1,544,897,231	1,728,464,997	1,765,485,169	854,030,905	8,670,055,638
Uncomp Care IHS/638	22,866,717	97,192,513	53,888,765	13,437,080	7,647,155	2,290,500	197,322,730
Subtotal	8,160,928,539	8,585,418,426	9,067,290,122	10,049,178,463	10,503,486,909	4,998,035,141	51,364,337,600
New Adult Group	0	0	108,384,170	303,805,036	479,004,205	228,555,495	1,119,748,906
Total	8,160,928,539	8,585,418,426	9,175,674,292	10,352,983,499	10,982,491,114	5,226,590,636	52,484,086,506

Federal Share

Waiver Name	01	02	03	04	05	06	Total
AC	640,074,314	400,315,432	86,576,034	15,843,799	(563,946)	(140,544)	1,142,105,089
AFDC/SOBRA	2,385,716,672	2,468,700,662	2,497,996,093	2,578,687,630	2,737,298,621	1,264,352,131	13,932,751,809
ALTCS-EPD	716,855,733	770,462,943	807,310,588	856,678,090	866,842,773	416,846,040	4,434,996,167
ALTCS-DD	632,712,981	661,923,939	719,012,033	802,167,050	863,308,966	452,495,419	4,131,620,388
DSH/CAHP	104,828,265	106,090,329	109,089,385	115,253,130	105,884,622	3,632,296	544,778,027
Expansion State Adults	0	0	971,659,974	1,727,943,222	1,934,786,919	978,970,443	5,613,360,558
Family Planning Extension	767,009	927,946	174,071	(1,212)	(689)	(183)	1,866,942
MED	453,960	0	0	0	0	0	453,960
SNCP/DSHP	199,636,108	366,713,968	161,520,692	81,516,426	79,538,947	28,490,594	917,416,735
SSI	932,480,969	968,832,520	1,070,159,033	1,214,240,608	1,246,199,072	604,315,921	6,036,228,123
Uncomp Care IHS/638	22,848,035	97,067,679	53,845,830	13,406,989	7,630,280	2,285,498	197,084,311
Subtotal	5,636,374,046	5,841,035,418	6,477,343,733	7,405,735,732	7,840,925,565	3,751,247,615	36,952,662,109
New Adult Group	0	0	108,384,170	303,801,660	478,740,762	222,599,818	1,113,526,410
Total	5,636,374,046	5,841,035,418	6,585,727,903	7,709,537,392	8,319,666,327	3,973,847,433	38,066,188,519

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	73	612,465
AFDC/SOBRA	1,014,881	1,090,143	990,293	5,056,392	4,912,060	2,404,639	15,468,409
SSI	365,158	399,101	398,723	2,391,771	2,371,156	1,199,735	7,125,644
Expansion State Adults	-	-	223,239	3,043,744	3,208,358	1,641,502	8,116,843
ALTCS-DD (Cost Sharing)[1]	-	-	-	-	-	-	-
CAHP[2]	(1,693,611)	(1,700,000)	(1,700,000)	(10,491,900)	(10,491,900)	(5,245,950)	(31,323,361)
Total	-	-	-	-	-	-	-

Federal Share

Waiver Name	01	02	03	04	05	06	Total
AC	211,034	138,424	58,991	(5)	225	51	408,719
AFDC/SOBRA	683,014	716,006	665,774	3,461,607	3,385,392	1,664,972	10,576,765
SSI	245,752	262,130	268,062	1,637,406	1,634,201	830,697	4,878,248
Expansion State Adults	-	-	150,083	2,083,747	2,211,200	1,136,576	5,581,606
ALTCS-DD (Cost Sharing)[1]	-	-	-	-	-	-	-
CAHP[2]	(1,139,800)	(1,116,560)	(1,142,910)	(7,182,755)	(7,231,017)	(3,632,296)	(21,445,338)
Total	-	-	-	-	-	-	-

[1] The CMS 1115 Waiver, Special Term and Condition 42,d requires that premiums collected by the State shall be reported on Form CMS-64 Summary 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	918,168,088	582,645,316	124,039,744	23,156,925	(633,467)	(190,419)	1,647,186,187
AFDC/SOBRA	3,416,769,831	3,585,693,917	3,541,591,468	3,615,178,737	3,828,063,144	1,766,175,346	19,753,472,444
ALTCS-EPD	1,061,941,034	1,167,110,637	1,195,547,952	1,247,265,857	1,254,599,663	601,430,301	6,527,895,444
ALTCS-DD	939,086,691	1,005,552,529	1,067,544,854	1,170,386,644	1,251,835,057	653,301,700	6,087,707,475
DSH/CAHP	154,069,040	159,826,080	160,562,955	157,859,154	143,142,200	-	775,459,429
Expansion State Adults	-	-	1,138,377,487	1,971,967,023	2,135,569,953	1,078,649,680	6,324,564,143
Family Planning Extension	830,631	1,008,110	190,026	(1,337)	(763)	(202)	2,026,465
MED	673,818	-	-	-	-	-	673,818
SNCP/DSHP	296,636,120	558,334,298	240,250,917	119,071,612	115,407,642	41,147,594	1,370,848,183
SSI	1,349,886,569	1,428,055,026	1,545,295,954	1,730,856,768	1,767,856,325	855,230,640	8,677,181,282
Uncomp Care IHS/638	22,866,717	97,192,513	53,888,765	13,437,080	7,647,155	2,290,500	197,322,730
Subtotal	8,160,928,539	8,585,418,426	9,067,290,122	10,049,178,463	10,503,486,909	4,998,035,141	51,364,337,600
New Adult Group	-	-	108,384,170	303,805,036	479,004,205	228,555,495	1,119,748,906
Total	8,160,928,539	8,585,418,426	9,175,674,292	10,352,983,499	10,982,491,114	5,226,590,636	52,484,086,506

Federal Share

Waiver Name	01	02	03	04	05	06	Total
AC	640,285,348	400,453,856	86,635,025	15,843,794	(563,721)	(140,493)	1,142,513,808
AFDC/SOBRA	2,386,399,686	2,469,416,668	2,498,661,867	2,582,149,237	2,740,684,013	1,266,017,103	13,943,328,574
ALTCS-EPD	716,855,733	770,462,943	807,310,588	856,678,090	866,842,773	416,846,040	4,434,996,167
ALTCS-DD	632,712,981	661,923,939	719,012,033	802,167,050	863,308,966	452,495,419	4,131,620,388
DSH/CAHP	103,688,465	104,973,769	107,946,475	108,070,375	98,653,605	0	523,332,689
Expansion State Adults	-	-	971,810,057	1,730,026,969	1,936,998,119	980,107,019	5,618,942,164
Family Planning Extension	767,009	927,946	174,071	(1,212)	(689)	(183)	1,866,942
MED	453,960	-	-	-	-	-	453,960
SNCP/DSHP	199,636,108	366,713,968	161,520,692	81,516,426	79,538,947	28,490,594	917,416,735
SSI	932,726,721	969,094,650	1,070,427,095	1,215,878,014	1,247,833,273	605,146,618	6,041,106,371
Uncomp Care IHS/638	22,848,035	97,067,679	53,845,830	13,406,989	7,630,280	2,285,498	197,084,311
Subtotal	5,636,374,046	5,841,035,418	6,477,343,733	7,405,735,732	7,840,925,565	3,751,247,615	36,952,662,109
New Adult Group	-	-	108,384,170	303,801,660	478,740,762	222,599,818	1,113,526,410
Total	5,636,374,046	5,841,035,418	6,585,727,903	7,709,537,392	8,319,666,327	3,973,847,433	38,066,188,519

Calculation of Effective FMAP:

AFDC/SOBRA						
Federal	2,386,399,686	2,469,416,668	2,498,661,867	2,582,149,237	2,740,684,013	1,266,017,103
Total	3,416,769,831	3,585,693,917	3,541,591,468	3,615,178,737	3,828,063,144	1,766,175,346
Effective FMAP	0.698437356	0.688685851	0.705519507	0.714252164	0.715945351	0.716812805
SSI						
Federal	932,726,721	969,094,650	1,070,427,095	1,215,878,014	1,247,833,273	605,146,618
Total	1,349,886,569	1,428,055,026	1,545,295,954	1,730,856,768	1,767,856,325	855,230,640
Effective FMAP	0.690966739	0.678611561	0.69270038	0.702471768	0.70584541	0.707582948
ALTCS-EPD						
Federal	716,855,733	770,462,943	807,310,588	856,678,090	866,842,773	416,846,040
Total	1,061,941,034	1,167,110,637	1,195,547,952	1,247,265,857	1,254,599,663	601,430,301
Effective FMAP	0.675042879	0.660145593	0.67526408	0.686844818	0.690931776	0.693091185
ALTCS-DD						
Federal	632,712,981	661,923,939	719,012,033	802,167,050	863,308,966	452,495,419
Total	939,086,691	1,005,552,529	1,067,544,854	1,170,386,644	1,251,835,057	653,301,700
Effective FMAP	0.673753538	0.658268882	0.673519272	0.685386367	0.689634758	0.692628565
AC						
Federal	640,285,348	400,453,856	86,635,025	15,843,794	(563,721)	(140,493)
Total	918,168,088	582,645,316	124,039,744	23,156,925	(633,467)	(190,419)
Effective FMAP	0.697350906	0.68730297	0.698445693	0.684192482	0.889898405	0.737812205
Expansion State Adults						
Federal	-	-	971,810,057	1,730,026,969	1,936,998,119	980,107,019
Total	-	-	1,138,377,487	1,971,967,023	2,135,569,953	1,078,649,680
Effective FMAP			0.853679968	0.877310294	0.907016938	0.908642571
New Adult Group						
Federal	-	-	108,384,170	303,801,660	478,740,762	222,599,818
Total	-	-	108,384,170	303,805,036	479,004,205	228,555,495
Effective FMAP			1	0.999988888	0.999450019	0.973942097

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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	2,932,529	487,578	72,519	85,460	527,244	467	12,471		
Quarter Ended March 31, 2012	2,920,219	489,003	73,155	85,506	430,723	-	12,424		
Quarter Ended June 30, 2012	2,914,097	489,026	73,965	85,730	365,132	-	12,440		
Quarter Ended September 30, 2012	2,938,828	491,675	74,820	86,512	310,396	-	12,689		
Quarter Ended December 31, 2012	2,911,474	494,757	75,639	86,829	274,990	-	13,104		
Quarter Ended March 31, 2013	2,891,233	497,144	76,467	86,075	248,817	-	13,824		
Quarter Ended June 30, 2013	2,903,066	499,769	77,281	86,303	228,204	-	14,187		
Quarter Ended September 30, 2013	2,918,954	503,390	78,035	87,133	217,114	-	14,856		
Quarter Ended December 31, 2013	2,891,823	506,775	78,841	87,679	206,419	-	14,885		
Quarter Ended March 31, 2014	2,839,414	514,410	79,683	87,893	87	-	-	443,946	39,001
Quarter Ended June 30, 2014	2,955,703	523,234	80,672	88,734	2	-	-	624,301	86,540
Quarter Ended September 30, 2014	3,113,597	529,284	81,758	89,359	-	-	-	755,916	122,916
Quarter Ended December 31, 2014	3,146,217	536,642	82,725	90,010	-	-	-	817,741	149,817
Quarter Ended March 31, 2015	3,085,048	543,104	83,827	89,877	-	-	-	835,906	191,160
Quarter Ended June 30, 2015	3,105,483	543,729	84,833	89,926	-	-	-	845,899	245,284
Quarter Ended September 30, 2015	3,209,720	543,689	85,609	90,014	-	-	-	866,412	284,919
Quarter Ended December 31, 2015	3,262,272	548,392	86,374	89,875	-	-	-	916,391	312,504
Quarter Ended March 31, 2016	3,259,131	550,691	87,136	89,451	-	-	-	930,760	331,687
Quarter Ended June 30, 2016	3,246,875	547,012	88,244	89,589	-	-	-	932,268	333,797
Quarter Ended September 30, 2016	3,332,104	548,889	89,210	89,855	-	-	-	938,591	324,973
Quarter Ended December 31, 2016	3,383,557	548,385	90,159	90,067	-	-	-	956,452	330,850
Quarter Ended March 31, 2017	3,381,387	547,377	90,936	88,155	-	-	-	960,776	333,249
Quarter Ended June 30, 2017									
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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For the Period Ended March 31, 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**	**109,707,817**	**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							-
Sep-17							-
Dec-17							-
Total Reported to Date	103,688,465	104,973,769	107,946,475	108,070,376	98,653,604	-	523,332,689
Unused Allotment	**202,520**	**1,410,600**	**140,044**	**1,637,441**	**11,383,336**	**111,027,272**	**125,801,213**

Arizona Health Care Cost Containment System
Medicaid Section 1115 Demonstration Number 11-W00275/9
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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	-	39,001	86,540	122,916	248,457	143,742,313

		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	149,817	191,160	245,284	284,919	871,180	527,695,200

		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	99.95%	633.85	312,504	331,687	333,797	324,973	1,302,961	825,884,379

		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	97.39% QE 12/16	646.71	330,850				330,850	213,962,524
			95.00% QE 9/17	630.81		333,249	-	-	333,249	210,216,062
										424,178,586

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

	Budget Neutrality Limit - Federal Share			Expenditures	
	MAP	DSH	Total	New Adult Grp	VARIANCE
QE 12/13	$ -	$ -	$ -	$ -	$ -
QE 3/14	22,563,639	-	22,563,639	13,870,414	8,693,225
QE 6/14	50,066,852	-	50,066,852	34,313,342	15,753,510
QE 9/14	71,111,823	-	71,111,823	47,984,458	23,127,365
QE 12/14	90,747,850	-	90,747,850	46,004,135	44,743,715
QE 3/15	115,790,324	-	115,790,324	70,387,348	45,402,976
QE 6/15	148,574,565	-	148,574,565	85,319,153	63,255,412
QE 9/15	172,582,461	-	172,582,461	97,948,283	74,634,178
QE 12/15	198,081,272	-	198,081,272	113,800,738	84,280,534
QE 3/16	210,240,454	-	210,240,454	122,290,142	87,950,312
QE 6/16	211,577,882	-	211,577,882	123,158,494	88,419,388
QE 9/16	205,984,772	-	205,984,772	108,777,377	97,207,395
QE 12/16	213,962,524	-	213,962,524	126,789,923	87,172,601
QE 3/17	210,216,062	-	210,216,062	122,882,603	87,333,459
QE 6/17		-	-		-
QE 9/17		-	-		-
	$ 1,921,500,478	$ -	$ 1,921,500,478	$ 1,113,526,410	$ 807,974,068

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	$ 143,742,313	$ 96,168,214	$ 47,574,099	33.10%				
DY 04	527,695,200	299,658,919	228,036,281	43.21%				
DY 05	825,884,379	468,026,751	357,857,628	43.33%				
DY 06	424,178,586	249,672,526	174,506,060	41.14%	$ 1,921,500,478	$ 1,113,526,410	$ 807,974,068	42.05%
	$ 1,921,500,478	$ 1,113,526,410	$ 807,974,068					

Based on CMS-64 certification date of 6/12/2017