



AHCCCS Update



FY 2016 Accomplishments

- BHS/AHCCCS Merger
- Transitions:
 - Greater AZ RBHAs
 - Duals BH Integration
- Initiative Expansions
 - CRN – SMI Determination statewide
 - DES Medicaid in HEAPlus
 - Over 80 AIHP members in care coordination
- Avoided 5% provider rate reductions
- System Improvement Activities – Reports on:
 - Children with or at risk of ASD
 - CMDP
- Federal Submissions:
 - 1115 Waiver Proposal
 - AHCCCS Care
 - DSRIP
 - HCBS Plan

FY 2017 Opportunities

- Merger:
 - 7-1-16 – Complete Formal Transition
 - Ongoing activities
- 10-1-16 – New 1115 Waiver
- Procurements:
 - ALTCS EPD
 - DD Subcontractors
 - Begin work on Acute
- Integration 2.0 Planning – Stakeholder Engagement
- Value Based Purchasing
- Health Information Exchange
- Justice System Initiatives
- Clinical initiatives:
 - ASD
 - Substance Use Disorder
- New Federal MCO Regulations – Access Requirements
- Continue AIHP Care Coordination - DSRIP

Ongoing Opportunities

- Sustainability – including VBP
- Employee Support
- DCS System
- Behavioral Health–Physical Health Integration
- Care Coordination
- Social and Economic Determinants
- Opioid Crisis

10/1/16 FFS Rates



VBP Differential Adjusted Rates

- Effective for dates of service 10/1/16 - 9/30/17
 - Inpatient/outpatient hospital services increased by 0.5%
 - Nursing facility services increased by 1%
 - Select physical health services for Integrated Clinics increased by 10%
- IC: List of proposed procedure codes on web is still under discussion – more information to be provided ASAP

VBP Differential Adjusted Rates, cont.

- Qualifying hospitals and NFs will be determined prior to 10/1/16
- ICs can qualify throughout CYE 2017 for dates of service that coincide with IC registration
- MCOs will be mandated to pass-through differential adjustments on MCOs' rates

Free-Standing Emergency Departments (FrEDs)

- New Provider Type 10/1/16 – effective 1/1/17
- Rate methodology (dates of service on and after) effective 1/1/17
- Reimbursement based on a percentage of OFPS
 - 60% for a level 1 emergency department visit
 - 80% for a level 2 emergency department visit
 - 90% for a level 3 emergency department visit
 - 100% for a level 4 or 5 emergency department visit

FrEDs, cont.

- No PGM except unique circumstance:
 - City or town in county less than 500,000 residents
 - Only hospital in the city or town operating an emergency department closed on or after January 1, 2015
- THEN
- PGM associated with nearest hospital with which the FrED shares an ownership interest

Treat and Refer

- New Provider Type effective 10/1/16
- A0988 – Ambulance Response, No Transport
- Modifiers:
 - UA – Treat at home, refer to PCP/specialist
 - UB – Treat at home, refer to Crisis Response
 - UC – Treat at home, refer to BH Provider
 - UD – Treat at home, refer to Urgent Care
- Will require CMS approval prior to implementation

Long-Acting Reversible Contraception

- Effective 10/1/16 AHCCCS will pay hospitals for LARC device in addition to DRG
 - Will be eliminated in future, if and when ICD-10 PCS code is established and DRG Grouper updated
- Billing requirements will direct hospitals to bill the device on Form 1500
- Codes/rates utilized from Physician Fee Schedule for device

Behavioral Health Outpatient Rates

- Identified a sustainable methodology for computing and updating rates
- Setting 10/1/16 rates at median of RBHAs FFS rates utilizing this methodology – 13.8% increase to FFS rate
- Will review for potential impacts to cap rates

AzEIP Speech Therapy Rates

- Procedure code 92507
Treatment of Speech, Language, Voice, Communication, and/or Auditory Processing
 - Place of Service differentiation
 - Clinic setting
 - Natural setting
 - Group Size Modifier – 1 to 3 clients
 - Unique rate by County
- AzEIP flagged children only

340B

- Drugs dispensed by 340B covered entities or administered by 340B providers (including physicians) shall be billed and reimbursed the lesser of: 1) the actual acquisition cost of the drug or 2) the 340B ceiling price
- Does not apply to licensed hospitals and outpatient facilities that are owned or operated by a licensed hospital at this time

340B, cont.

- MCOs will be mandated to comply with all changes to reimbursement methodology for 340B entities
- 10/1/16 effective date for roll-out
- IHS/638 facilities receive AIR for service so 340B provisions do not apply

Other 10/1/16 Rate Issues

- HCBS rates – 2% increase proposed (EPD)
- NF rates – 1% increase proposed
- Hospice – updated to Medicare
- DRG – 3rd year of phase-in
 - Outlier CCRs will be updated to 9/1 CMS
- FQHC PPS rates rebased
- Stakeholder-driven realignment
 - Air Ambulance realignment
 - Dental realignment
 - LTAC and Rehab

Other 10/1/16 Rate Issues, cont.

- Physician Drug Schedule update for pricing
 - 3.3% aggregate increase
- Ground Ambulance –
 - ADHS - aggregate 0%
 - Non-ADHS FFS – 15% including rural differential
- Other 0% aggregate updates:
 - ASC, Outpatient Hosp., Physician, Lab, DMEPOS

Other 10/1/16 Rate Issues, cont.

- ALTCS Adult Dental of \$1000 per member begins – dates of service 10/1/16 forward
- Services provided by a licensed podiatrist covered – dates of service 10/1/16 forward
- BCBA Provider Type – BC – begins effective 10/1/16

Nursing Facility Supplemental Payments

- Increase in FFS NF Supplemental payments by \$3,235,000
- Assessment increases from:
- \$10.50/non-Medicare day to **\$15.63.**
- For certain high-Medicaid facilities, \$1.40/non-Medicare day to **\$1.80.**
- IHS/638 facilities continue to be exempt from assessment

Public Notice

- See the Public Notice regarding all 10/1/16 FFS rates at:

https://www.azahcccs.gov/AHCCCS/Downloads/PublicNotices/rates/NOPI_FFS_RateChange07182016.pdf

- See all proposed 10/1/16 rates at:

<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/AHCCCSProviderRateAnalysis2016.html>

Managed Care IMD Provisions



Institution for Mental Diseases

- Federal statutory exclusion of Medicaid funding for IMDs
- New managed care regulations allows only for IMD stays less than 15 days (adults)
 - Eliminates existing in lieu option
- If stay is longer, state must recoup ENTIRE capitation payment for the month (not just amount associated with IMD stay)
 - Member still enrolled with plan - plan still responsible for care

What is an IMD?

- 42 C.F.R. 435.1010
- “a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases.”

Next steps

- Working to identify complete list of IMDs – some obvious, others less clear
- Options discussed include for managed care members (but are not limited to):
 - Prohibit IMD stays at all
 - Prohibit IMD stays more than 15 days
- Need to assure network capacity
- Have solution for TRBHAs

Access Monitoring Review Plan

Monitoring Access to Care for
Fee-for-Service Populations



Overview - Access Monitoring Review Plan for FFS populations

CMS amended 42 CFR Part 447

- Requires Medicaid agencies to establish an Access Monitoring Review Plan to ensure adequate access to care for FFS population
- Plan must be updated at least annually and is subject to 30-day public comment period
- Must complete analysis of services included in review plan at least once every three years
- Provide mechanisms for ongoing beneficiary and provider input

Services Categories to Evaluate

- Primary care services
- Physician specialist services
- Behavioral health services
- Pre- and post- natal obstetric services (including labor and delivery)
- Home health services

Services Categories to Evaluate (con't)

- Additional types of services with a higher than usual volume of access complaints
- Additional types of services selected by the state-AHCCCS has chosen to include Durable Medical Equipment

Provider Rate Reductions/Restructuring

When a state proposes to reduce or restructure provider payments in circumstances where the changes could result in diminished access:

- Must submit access monitoring analysis for each service potentially effected and show that currently has sufficient access
- Must review access for those services at least annually for at least three years

Measures to Analyze Access to Care

For each of the service categories AHCCCS will:

- Discuss fee schedules and recent changes
- Evaluate number of AHCCCS-enrolled providers trended over time, broken out by urban & rural areas
- Compare AHCCCS enrolled providers to cumulative changes in AHCCCS fee schedules
- Analyze number of AHCCCS claims trended over time
- When available, compare to Medicare rates, Medicaid rates of western states, and AHCCCS MCOs

FFS Access to Care Input

States must have ongoing mechanisms for beneficiary and provider input on access to care for FFS population

- Have begun developing a page on the AHCCCS website for reporting access to care issues
 - Will allow beneficiaries, providers, and stakeholders the opportunity to submit access to care concerns
 - Page will be available by October 1
- Will provide mailing address and phone number to submit access to care concerns

Final comments

- Limitations: available data
- Evolving document which will develop greater sophistication over time
- The Access Monitoring Plan is scheduled to be published on our website soon and will be open to 30-day public comment period

<https://www.azahcccs.gov/AHCCCS/PublicNotices/>

- Final report due to CMS on October 1

CMS Guidance on 100% FMAP



CMS Guidance on 100% FMAP

- Currently, if the service is provided by an IHS/638 facility (whether it be an agent, employee, and contracted provider) **and** the service is billed by the IHS/638 facility, State claims 100% match.
 - The service must be furnished to a Medicaid-eligible AI/AN;
 - The service must be a “facility service” – i.e., within the scope of services that a facility (e.g., inpatient hospital, outpatient hospital, clinic, Federally Qualified Health Center/Rural Health Clinic, nursing facility) can offer under Medicaid law and regulation;
 - The service must be furnished by an IHS/Tribal facility or by its contractual agent as part of the facility’s services; and
 - The IHS/Tribal facility must maintain responsibility for the provision of the service and must bill the state Medicaid program directly for the service.

CMS Guidance on 100% FMAP

- New CMS guidance reinterprets what it means for a service to be “received through” an IHS/638 facility to include when:
 - An IHS/638 facility practitioner requests the service for his or her patient from a non-IHS/638 provider (outside of the IHS/Tribal facility)
 - The non-IHS/638 provider is a Medicaid provider
 - The IHS/638 provider and non-IHS/638 provider have a care coordination agreement in place
- Under the circumstances, Non-IHS/Tribal providers may bill directly for these services and the State may receive a 100% federal match.

Care coordination agreement

- Care coordination agreement between an IHS/638 facility practitioner and a non-IHS/638 facility practitioner must be written
- The IHS/638 facility practitioner remains responsible for overseeing patient's care and retain control over medical records

Care coordination agreement requirements

- Care coordination must include:
 - IHS/638 facility practitioner requests the specific service and providers relevant information to the non-IHS/Tribal provider;
 - the non-IHS/638 provider sends patient care information and results to the IHS/638 facility practitioner;
 - IHS/638 facility practitioner takes appropriate action with that information
 - IHS/638 facility incorporates the patient's information in the medical record.

Billing Options

- Non-IHS/638 facility practitioner bills directly
- IHS/638 facility practitioner bills
- In either case must be documented/separately identified

Next Steps

- AHCCCS working through internal operational issues
- Stakeholder discussions
- Legislative report by December 1, 2016 on financial implications and strategies to encourage care coordination agreements.

Questions?

