AHCCCS
Arizona Health Care Cost Containment System

2016 ACCESS MONITORING REVIEW PLAN

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Thomas J. Betlach, Director
AHCCCS
www.azahcccs.gov

OVERVIEW

- The Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid agency, uses federal, state, county, and provider-assessed funds to provide health care coverage to the state's acute and long-term care Medicaid populations, and low-income individuals and families.

- In Federal Fiscal Year (FFY) 2015, the AHCCCS program provided coverage to approximately 1.7 million enrolled beneficiaries at any given point in time, or 25% of Arizona's 6.8 million population. Approximately 88% of beneficiaries are enrolled in managed care. The remaining 12%, or approximately 210,000 members, received services through the state's Fee-for-Service program. Altogether, $11.0 billion were expended on Arizona Medicaid recipients in FFY 2015.

- Arizona is comprised of 15 counties totaling almost 114,000 square miles, the size of New York, Connecticut, Vermont, New Hampshire, and Maine combined.[1] About 75% of its 6.8 million residents live in two counties: Maricopa County (60%) and Pima County (15%). The overall population density of the State is 57 residents per square mile.[2] As of July 7, 2016, Arizona has 37 Medically Underserved Areas and 160 primary medical care, 177 dental, and 102 mental health Health Professional Shortage Areas.[3]

- With 85 general acute care hospitals (including 11 Indian Health Services/638 tribal hospitals), 17 psychiatric hospitals, 7 long-term acute care hospitals, and 8 rehabilitation hospitals, AHCCCS currently contracts with all but 3 hospitals within the state. These registered hospitals, along with a network of 156 federally designated health centers throughout the state,[4] provide for numerous options for Medicaid beneficiaries to receive healthcare.

- All providers of AHCCCS-covered services must be registered with AHCCCS. Since many of AHCCCS' providers who serve Fee-for-Service (FFS) members also have contracts in place with managed care organizations, most of the managed care monitoring activities apply to monitoring FFS beneficiaries.

- Arizona measures and monitors indicators of healthcare access to ensure that its Medicaid beneficiaries have access to care that is comparable to the general population.

- In accordance with 42 CFR § 447.203, Arizona developed an access review monitoring plan, and has completed an analysis in accordance with service

1 https://www.census.gov/geo/reference/state-area.html
2 https://en.wikipedia.org/wiki/Arizona
3 https://datawarehouse.hrsa.gov/topics/HrsaInYour/FactSheetState.aspx?geocd=04
4 Id.

categories provided under a FFS arrangement. A list of service categories being analyzed is below:

  - Primary care services
  - Physician specialist services
  - Behavioral health services
  - Pre- and post-natal obstetric services, including labor and delivery
  - Home health services including durable medical equipment.

- The plan describes data that will be used to measure access to care for FFS beneficiaries. The plan considers the availability of Medicaid providers, utilization of Medicaid services, and the extent to which Medicaid beneficiaries' healthcare needs are fully met.

- The plan was developed during the months of January – July 2016 and was posted on the state Medicaid agency's website from July 29, 2016 – August 29, 2016 to allow for public review and feedback. No public comments were received.

- Analysis of the data and information contained in this report show that Arizona Medicaid beneficiaries have access to healthcare at least to the extent of that of the general population in Arizona.

MANAGED CARE AND FEE-FOR-SERVICE PROGRAMS

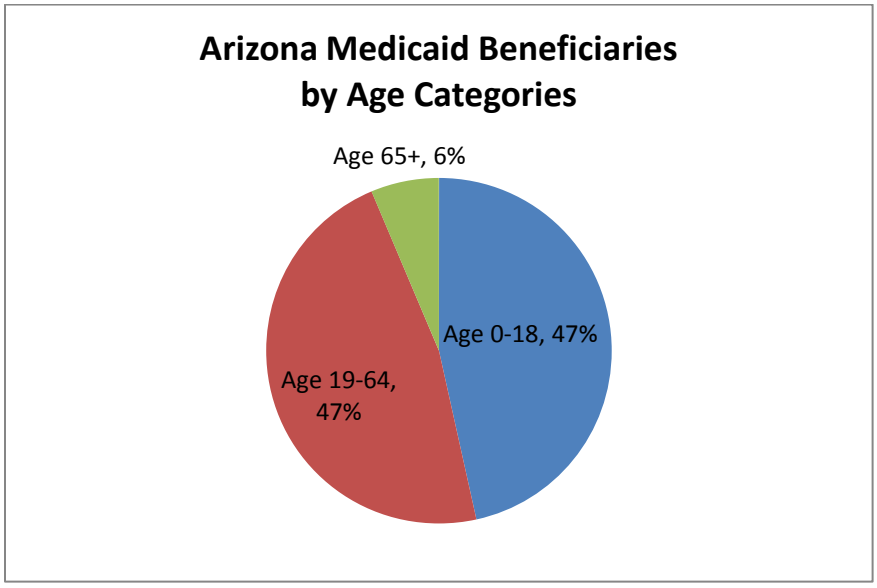
Since 1982, when it became the first statewide Medicaid managed care system in the nation, AHCCCS has operated under a Section 1115 Demonstration Project Waiver which authorizes the operation of a managed care model. AHCCCS selects contracted managed care organizations (MCOs) via a highly competitive request for proposal (RFP) process. MCOs are responsible for the delivery of medically necessary care to members, and are paid via prospective monthly capitation payments. The result is a managed care system that mainstreams recipients, allows them to choose their providers, and encourages quality care and preventive services.

In Arizona's Medicaid Program, providers are reimbursed on a FFS basis for: (1) American Indians and Alaska Natives (AI/AN) enrolled in the AHCCCS Acute Care Program who choose to receive their physical health coverage through the AHCCCS American Indian Health Program (AIHP) rather than one of the AHCCCS-contracted managed health plans; (2) AHCCCS Acute Care AI/AN members who choose to receive their behavioral health services through a Tribal Regional Behavioral Health Authority (TRBHA) – this choice is available both to FFS-enrolled and MCO-enrolled members; (3) Tribal ALTCS members who choose not to enroll in an Arizona Long Term Care System (ALTCS) MCO; (4) Children and adults who, but for their citizenship/immigration status, would qualify for Medicaid eligibility. These individuals are only eligible for Federal Emergency Services (FES); (5) Beneficiaries who are found eligible for AHCCCS via Hospital Presumptive Eligibility; (6) Prior Quarter Coverage; and (7) Situations in which there is less than 30 days from the processing date to the end of the eligibility.

Since many of the FFS providers also have contracts in place with managed care organizations, many of the managed care monitoring activities apply to monitoring FFS.

BENEFICIARY POPULATION

In FFY 2015, the AHCCCS program provided coverage to approximately 1.7 million enrolled beneficiaries at any given point in time. Approximately 88% of these beneficiaries were enrolled in managed care with the rest receiving services through the FFS program. Of those, approximately 6% were age 65 or greater. The remaining population was evenly split between ages 0-18 and ages 19-64 as shown below.



Overall, slightly more than half (53%) of Medicaid beneficiaries are female. Females represent 100% of the Breast and Cervical Cancer Treatment Program, which provides treatment for women up to 250% of the federal poverty level under specific circumstances. Females also constute approximately two-thirds of parents enrolled in Medicaid and 57% of dually eligible members. The remainer of the populations are split fairly evenly between males and females. A breakout by eligiblity category and sex is provided below.

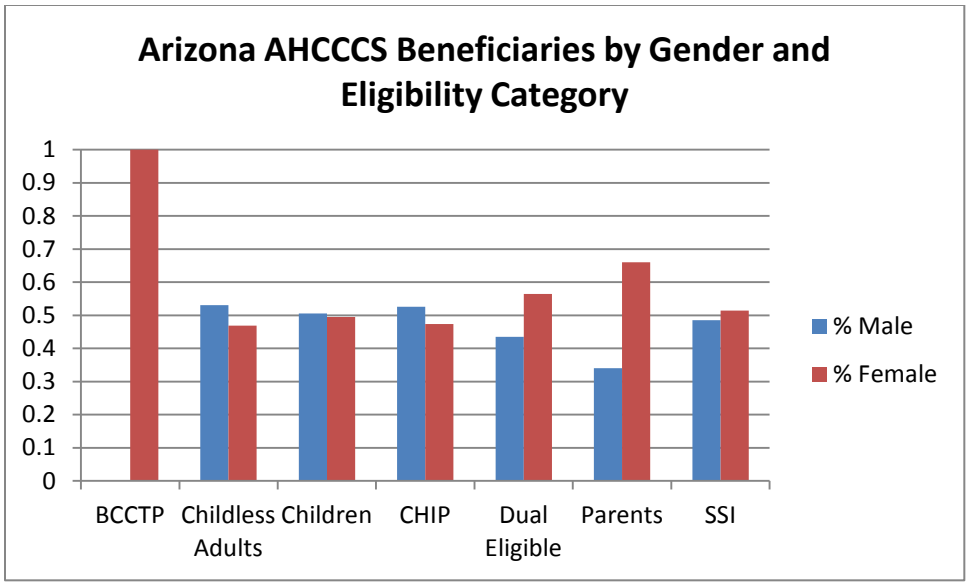
As of April 1, 2016, slightly more than 9% of the 1,841,997 persons enrolled in Medicaid in Arizona identified as Native American[5]. Each of these individuals has the option to receive covered services – including the services described in this analysis - on a fee-for-service basis. Of those, 119,726 elected to receive services through the FFS program. Unlike the rest of the AHCCCS population, AIHP members tend to live in rural areas, and approximately two-thirds of FFS payments are made to IHS and Tribal 638 facilities. Below is a breakout of AIHP members by county in April 2016. Of the counties listed below, only two (Maricopa and Pima) have populations greater than 500,000.

[5] https://azahcccs.gov/Resources/Downloads/PopulationStatistics/2016/Apr/AHCCCS_Demographics.pdf

County	AHCCCS Count
APACHE	38,412
COCHISE	258
COCONINO	20,231
GILA	7,568
GRAHAM	8,289
GREENLEE	75
MARICOPA	34,359
MOHAVE	1,716
NAVAJO	37,247
PIMA	13,719
PINAL	11,059
SANTA CRUZ	39
YAVAPAI	1,169
YUMA	540
LA PAZ	1,915
TOTAL	**119,726**

As of July 1, 2016, 116,256 individuals were enrolled with AHCCCS on a fee-for-service basis as non-qualified aliens[6]. These individuals are only entitled to coverage for the treatment of emergency medical conditions (including labor and delivery) which are almost always provided in an inpatient or outpatient hospital setting. Except in unusual circumstances, this population is not entitled to primary care, pre- or post-natal obstetric care, or home health services. Physician specialist services and behavioral health services are limited to care necessary to treat an emergency medical condition as defined in federal law.

[6] https://azahcccs.gov/Resources/Downloads/PopulationStatistics/2016/July/AHCCCS_Population_by_Category.pdf



BENEFICIARY INPUT

To meet the requirements of 42 CFR § 447.203, a page on the AHCCCS public website developed exclusively for reporting access to care issues will serve as the single point of entry for tracking access to care concerns and trends. The page will continuously offer beneficiaries, providers, and stakeholders the opportunity to submit access to care concerns electronically. Beneficiaries and providers will also be provided a phone number and mailing address so that they may submit concerns and information through those means. The single point of entry, as well as the phone number and mailing address, will be overseen by the AHCCCS Division of Health Care Management (DHCM) Clinical Quality Management Unit (CQM). CQM is responsible for managing, among other things, all access to care and Quality of Care concerns for all AHCCCS members – whether enrolled in managed care or FFS.

When comments are submitted through the website, the sender will receive an automatic response acknowledging receipt of submission. CQM will promptly review responses. Depending on the nature of the comment, CQM will do one of the following:

- CQM will directly intervene to help FFS beneficiaries obtain services who are having difficulty obtaining access to care (e.g. a FFS member needs help scheduling a surgery or finding a provider) and maintain a record of the specific access issue and the resolution.
- When beneficiaries enrolled in MCOs present access to care issues, CQM will direct beneficiaries to the MCO responsible to ensure adequate access to care. In accordance with longstanding AHCCCS requirements, MCOs maintain detailed records of access to care concerns and report these issues to AHCCCS on quarterly basis. More significant concerns which may arise are reported on an ad hoc basis.
- When comments involve multiple beneficiaries, CQM will conduct an appropriate investigation, analyze the concerns, respond to the commenter, maintain a record

of the specific access issue(s) and resolution(s). As necessary, CQM will involve other AHCCCS divisions in this process.

- When appropriate (e.g. a provider rate issue), CQM will direct the commenter to the appropriate resource, maintain a record of the issue, and work with the appropriate resource to ensure a resolution. CQM will maintain a record of the specific access issue(s) and resolution(s).
- When comments are not related to access to care issues, CQM will direct the commenter to the appropriate resource.

CQM will also evaluate feedback for trends and will chair the newly created Access Monitoring Team (AMT) which will meet, at a minimum, on a quarterly basis, or more frequently when potential access to care trends are identified. In addition to CQM, AMT members will include key personnel from AHCCCS customer service units across the Agency and other units throughout the Agency to identify access to care concerns that may not be communicated through the Agency's single point of entry (e.g., referrals from the State ombudsperson, the fair hearing process). The AMT will discuss best practices, improvements to access to care, and potential trends. Rate-setting staff will also serve on this committee in order to stay abreast of any concerns that might result in the need for a rate adjustment. As needed, the Team will develop a corrective action plan as specified in 42 CFR § 447.203 along with the specific steps and timeline to address access to care issues when appropriate and determine when updating to the Access Monitoring Review Plan is necessary to comply with 42 CFR § 447.203(b)(6)(ii).

While AHCCCS has not formally tracked access to care concerns among the FFS beneficiary population specifically for this purpose in the past, agency hearing records demonstrate that no FFS requests for hearings pertaining to access to care issues have been filed by beneficiaries in the past three years. Moreover, discussions with AHCCCS employees responding to these matters and addressing beneficiary concerns identified very limited concerns regarding access to care.

As discussed earlier in the report, approximately 88% of AHCCCS beneficiaries are enrolled in managed care, and the managed care organization is responsible for oversight and resolution of access to care concerns. Of those members who are in the fee-for-service program, about half are enrolled in the federal emergency services program where services are limited to emergency services. AHCCCS contracts with almost all hospitals in the state, and staff did not identify access to care concerns from the FES population. Thus, the limited concerns expressed by FFS members regarding access issues are most likely to come from American Indian/Alaska Native members who chose not to participate in Medicaid managed care.

PROVIDER INPUT

In addition to offering providers the same mechanisms for providing input as beneficiaries, AHCCCS additionally provides a variety of opportunities for providers to furnish feedback and express concerns relative to rates and access to care issues:

- Prior to updating rates, AHCCCS posts a Notice of Public Information on its website and allows for no less than a 30-day comment period. Public Notices for institutional rates are posted on two separate occasions: once to post notice of proposed rates where a minimum 30-day public comment period is offered, and a second time for notice of final rates after Agency consideration of public comments. Although AHCCCS has historically posted an overall aggregate rate change for each fee schedule, beginning in July 2016, AHCCCS will publish each individual fee schedule that is a subject of the Notice of Public Information in response to public input received in the past year.
- AHCCCS works closely with the tribes, Indian Health Services, tribal health programs operated under P.L. 93-638, and urban Indian health programs, conducting approximately six AHCCCS Tribal Consultation Meetings each year in order to convey information on policy and programmatic changes that may impact Native American members and to solicit valuable input from these entities. Additionally, the AHCCCS Tribal Liaison communicates extensively with Tribal organizations and representatives and is available to address any relevant concerns.
- On a quarterly basis, AHCCCS hosts a State Medicaid Advisory Committee meeting which presents topical information regarding the AHCCCS Program and solicits feedback. Meetings are open to the public and every meeting has an open discussion period.
- The Division for Fee-for-Service Management Training Unit provides professional and technical assistance to providers, developing resources and publications that are relevant for policy questions and billing issues. This unit also coordinates and facilitates education and training for providers conducting large and smaller group sessions targeting specific provider types or specific billing/policy issues. Training materials are created and updated continually, ensuring the providers are given current and relevant information for their claim submissions. This library of training resources is shared with providers upon request, to reinforce the information disseminated in the training sessions and to allow as a refresher for the provider's staff, as needed.
- The DHCM Reimbursement Unit operates a Fee-for-Service Rates email box through which providers may ask questions about reimbursement rates and express rate concerns. Providers and provider associations also provide feedback to the Reimbursement Unit throughout the year, and this feedback is taken into consideration when updating rates at least annually.
- The DHCM Reimbursement Unit also actively engages providers and provider associations when significant changes are made to rates and/or reimbursement methodologies. For example, the Agency's FFY 2015 transition to an All Patient Refined Diagnosis Related Groups (APR-DRG) methodology for inpatient hospital reimbursement was accomplished in coordination and collaboration with representatives of the impacted hospitals.
- Provider concerns about access to care issues inform the Agency's policies. For example, in 2015 the Arizona legislature authorized AHCCCS to reduce provider rates by 5%. Before implementing the reduction, the Agency opened up a public comment period seeking feedback on the impact a potential 5% rate reduction

could have on access to care. Based on the responses received, AHCCCS and the Governor's Office developed an alternative budget-reduction approach.

- The public is invited to submit comments to all proposed regulations which implicate rate issues. The Arizona Administrative Procedure Act (APA) mandates a thirty day comment period where the public has the opportunity to submit comments and is notified of scheduled public hearings in different regions of the State. AHCCCS publishes proposed regulations subject to the APA in the Arizona Administrative Register which is published throughout the State, inviting the public to submit input. As mentioned, AHCCCS also schedules a public hearing in different areas of the State to invite in person attendance so that individuals may appear and submit comments in person for rules promulgated pursuant to the APA. As an additional forum, AHCCCS also publishes the proposed regulations on its public website where it also invites public commentary. All comments received from the public are published on the Agency website as well as the Agency's response to each comment.

AHCCCS will continue to maintain these avenues for providers to express input on rates and will formally track these concerns. Providers may further express access to care concerns through the newly developed Agency website page described above.

DATA AND ANALYSIS

AHCCCS will analyze the following service categories: primary care services, physician specialist services, behavioral health services, pre- and post- natal obstetric services, home health services, and durable medical equipment, prosthetics, orthotics and supplies. If AHCCCS implements a rate reduction or payment restructuring of a state plan service when the changes could result in an diminished access, AHCCCS will monitor access to care of such service in accordance with public review requirements, at least annually for a period three years after the effective date of the State Plan Amendment authorizing the reduction or restructuring.

A comparison to Medicare rates will be made when Medicare provides coverage for similar services. Since Medicare only provides limited dental, home health, and inpatient behavioral health services, a comparison is not included in the Access Monitoring Review Plan. Rate comparisons will also be included to four neighboring states (Colorado, New Mexico, Nevada, and Utah) when those states make their rates available on their website and reimburse using a similar rate structure.

Data Limitations
There are a number of data limitations encountered when analyzing access to care:

- Indian Health Services (IHS) and Tribal 638 facilities often bill on the UB Form and are paid at an all-inclusive rate. This type of billing does not allow AHCCCS to determine the type of services (e.g., primary care physician visit, dental services) that were provided to the beneficiaries. For purposes of this report, we have included claims from IHS and Tribal 638 *clinics* in the primary care data, based on

the assumption that services provided at the clinics are likely and mostly primary care services. Dental service claims administered at IHS and Tribal 638 facilities which focus on dental services have been included with Dentists/Dental Hygienists claims.

- Prior to April 1, 2015, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) were not distinguishable from other provider types in the AHCCCS claims system.
- AHCCCS does not differentiate between primary care physicians and specialty physicians for purposes of reimbursement. For the purpose of this report, AHCCCS looked at the specialties which Doctors of Medicine (M.D.) and Doctors of Osteopathic Medicine (D.O.) reported when registering with AHCCCS. Physicians reporting the following specialties were classified as primary care physicians: family practice, general medicine, internal medicine, obstetrician and gynecologist, gynecologist, obstetrician, pediatrician, and gerontologist. All other physicians were classified as physician specialists.
- Medicaid rate comparisons for neighboring states are unavailable for behavioral health services and home health services.
- Medicare rate comparisons are unavailable for behavioral health services and home health services.
- Private health insurance payments are proprietary and unavailable to the AHCCCS Administration.

More details about the data sources and information to be reviewed appears below.

Review Analysis of Primary Care Services

Data Sources:

- Medicaid claims payment data (MMIS)
- Medicaid websites from neighboring states
- Kaiser Family Foundation
- American Dental Association

Availability of primary care providers:

- Explanation of AHCCCS Physician, Dental, and FQHC and RHC PPS Rates fee schedules
- Number of the following AHCCCS-enrolled primary care providers, trended over time, by Arizona urban and rural areas:
    - Primary Care Physicians
    - Primary Care Non-Physician Practitioners
    - Dentists and Dental Hygienists
- Comparison of cumulative change of provider rates, trended over time, for the aforementioned providers
- Number of AHCCCS claims per 1,000 beneficiaries trended over time by:
    - Primary Care Physicians
    - Primary Care Non-Physician Practitioners
    - Dentists/Dental Hygienists

    - IHS/638 Clinics
    - FQHCs/FQHC Look-Alikes (FQHC-LAs), and RHCs
- Comparison of AHCCCS physician rates to Medicare rates and Medicaid rates for western states. If available, breakout of rates by all services, primary care, obstetric care, and other services
- Comparison of physician fee schedules to Medicare rates by place of service: facility, non-facility, and IHS/638
- Estimated percentage of Arizona physicians participating with AHCCCS
- Number of AHCCCS-enrolled FQHCs, FQHC-LAs, and RHCs trended over time
- Number of AHCCCS FQHC patients, FFS claims, and FTEs
- Estimated number of Arizona dentists participating with AHCCCS
- Comparison of average Medicaid dental rates in western states

Review Analysis of Physician Specialists

Data Sources:

- Medicaid claims payment data (MMIS)
- Medicaid websites from other neighboring states
- Kaiser Family Foundation

Availability of physician specialists:

- Explanation of AHCCCS physician fee schedules
- Number of AHCCCS-enrolled physician specialist providers trended over time and broken out by Arizona urban and rural areas
- Number of AHCCCS claims per 1,000 beneficiaries trended over time
- Comparison of cumulative change of AHCCCS physician fee schedules and physician specialist providers
- Comparison of AHCCCS physician rates to Medicare rates and Medicaid rates for western states

Review Analysis of Behavioral Health Services

Data Sources:

- Medicaid claims payment data (MMIS)

Availability of behavioral health services:

- Explanation of AHCCCS behavioral health inpatient and behavioral health outpatient fee schedules
- Number of AHCCCS-enrolled behavioral health providers trended over time, broken out by Arizona urban and rural areas, and broken out by the following:
    - Clinic/Outpatient Providers
    - Individual Practitioners
    - Inpatient Facilities
    - Substance Abuse Services
- Number of AHCCCS claims per 1,000 beneficiaries trended over time broken out by providers mentioned above

- Comparison of covered Medicare outpatient behavioral health procedure codes to AHCCCS rates
- Comparison of outpatient behavioral health fee schedule to AHCCCS MCO fee schedule broken out by place of service
- Comparison of cumulative change of provider rates and the providers mentioned above trended over time

Review Analysis of Pre- and Post-Natal Obstetric Services

In Arizona, Medicaid-covered pre-natal and post-natal obstetric services are paid primarily through capitated arrangements between the AHCCCS MCOs and providers, including the costs associated with labor and delivery. Due to the data limitations described above with respect to IHS and Tribal 638 billing and reimbursements, the number of FFS claims that are identifiable as pre-natal and/or post-natal obstetric services is negligible. For that reason, AHCCCS is not including an analysis of pre-natal and post-natal obstetric services as part of this access review monitoring plan submission.

Review Analysis of Home Health Services, including Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

Data Sources:

- Medicaid claims payment data (MMIS)

Availability of home health services:

- Explanation of AHCCCS home health and DMEPOS fee schedule
- Number of AHCCCS-enrolled home health services and DMEPOS providers trended over time and broken out by Arizona urban and rural areas
- Number of AHCCCS claims per 1,000 beneficiaries trended over time
- Comparison of AHCCCS FFS rates to MCO rates for most common services broken out by Geographic Service Area
- Comparison of cumulative change of fee schedule and providers
- Comparison of DME rates to Medicare rates broken out by IHS/Tribal 638 facilities and non-IHS/Tribal 638 facilities.