AHCCCS
Arizona Health Care Cost Containment System

2016 ACCESS MONITORING ANALYSIS

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

OVERVIEW

42 CFR § 447.203 requires AHCCCS to develop an access monitoring review plan beginning in 2016 for the fee-for-service population and to update the plan by July of each subsequent year. The regulation also requires AHCCCS to complete an analysis of the data specified in the access monitoring review plan, beginning in 2016, with a separate analysis of each of the following provider types and types of service at least once every three years:

- Primary care services – including those provided by a physician, federally qualified health center (FQHC), clinic, or dental care
- Physician specialist services
- Behavioral health services – including mental health and substance use disorder
- Pre- and post-natal labor and delivery
- Home health services
- Additional types of services for which the state or the Centers for Medicare and Medicaid Services (CMS) has received a significantly higher than usual volume of beneficiary, provider, or other stakeholder fee-for-service (FFS) access complaints
- Any services for which the state proposes to reduce provider payment rates or restructure provider payments in circumstances when the changes could result in diminished access to care

The access monitoring review plan can be found on AHCCCS's public website and contains additonal information about the AHCCCS program, the benficiary population, and mechanisms for provider, beneficiary and other stakeholder input.

PROVIDER RATES

During the Great Recession, the AHCCCS Administration implemented a number of changes to the Arizona Medicaid program as part of an overarching strategy to deal with the state's revenue shortfall. These changes, included a series of provider rate reductions in federal fiscal years 2009, 2011, and 2012. Since then, AHCCCS rates have remained relatively flat, with selected increases for certain provider types.

As required by federal regulation, this report provides analysis of the percentage comparison of Medicaid payment rated to other public and private health insurer payment rates by geographic area when data is available for such a comparison. For purposes of this report, the State is defining "geographic area" as urban and rural areas of the state with urban areas being those counties with 500,000 or more persons (Maricopa and Pima counties) and rural areas being those counties with under 500,000 persons. Since some providers may have sites in multiple counties, it is possible for providers to practice in both an urban and rural area. With respect to the services covered by this analysis, neither the Medicare nor Medicaid programs for Arizona differentiate payment rates for urban and rural providers.

As discussed in the Access Monitoring Review Plan, AHCCCS FFS rates are compared to Medicare rates and Medicaid rates of four neighboring states (Colorado, New Mexico, Nevada, and Utah) when similar services are covered and information is available. At this point in

time, AHCCCS is unable to make rate comparisons to private health insurance payments because data is not available. When rate data for Medicare and Medicaid in neighboring states is unavailable, a comparison is also made to the AHCCCS MCO rates.

The next sections of the report provide an analysis by different types of services.

Analysis of Primary Care Services

42 CFR § 447.203 requires states to provide information on primary care services, including those provided by a physician, FQHC, rural health clinic (RHC), and dental care. Reimbursements for these services are delineated in several fee schedules including the physician fee schedules, FQHC/RHC PPS Rates, and Dental Services Fee Schedule as described in further detail below.

From FFY 2009 to FFY 2015, utilization for primary care, as measured by the number of claims per 1,000 FFS enrolled recipients, fluctuated from 2,779 to 3,496. While there is no agreed-upon level of appropriate use of primary care services for Medicaid recipients, a large decrease in utilization could signal that AHCCCS recipients are unable to find available providers. More details on utilization are provided in the table below.

Primary Care Service Claims Per 1,000 Enrolled Beneficiaries							
	FFY09	FFY10	FFY11	FFY12	FFY13	FFY14	FFY15
Primary Care Physicians	1,195	1,314	1,532	1,379	1,334	1,308	1,151
Non-Physician Specialists	228	254	298	271	294	325	295
Dentists/Dental Hygienists *	229	252	233	213	233	212	163
IHS/638 Facility **	1,126	1,279	1,433	1,298	1,297	1,382	1,226
FQHC/RHC ***	NA	NA	NA	NA	NA	NA	47
Total	*2,779*	*3,098*	*3,496*	*3,161*	*3,158*	*3,227*	*2,881*

* Dental services administered at IHS/638 facilities which focus on dental services are displayed in the Dentists/Dental Hygienists category.
** Includes claims from IHS/638 Clinics billed on the UB at an all-inclusive rate. While data does not specify if they were primary care, for purposes of this report, we have included them as primary care.
*** Prior to FFY 2015, claims for FQHCs and RHCs were not distinguishable in the claims system and are included in the physician, non-physician, and dentist claim totals shown above.

Physician Fee Schedules

The Physician Fee Schedules comprise a broad collection of services, including physician and non-physician practitioner procedures, drugs and biologicals, vaccines and toxoids, laboratory and pathology, and durable medical equipment and supplies. With the exception of the drug schedule, whose periodic updates account for changes in drug prices, these rates experienced reductions from FFY 2009 to FFY 2012.

This group of reimbursement rates includes physician and other practitioner rates based on the National Relative Value Scale, the physician drug schedule, and the anesthesia conversion factor. More than 90% of the annual provider reimbursements based on these rates cover services provided by physicians, physician assistants, and nurse practitioners.

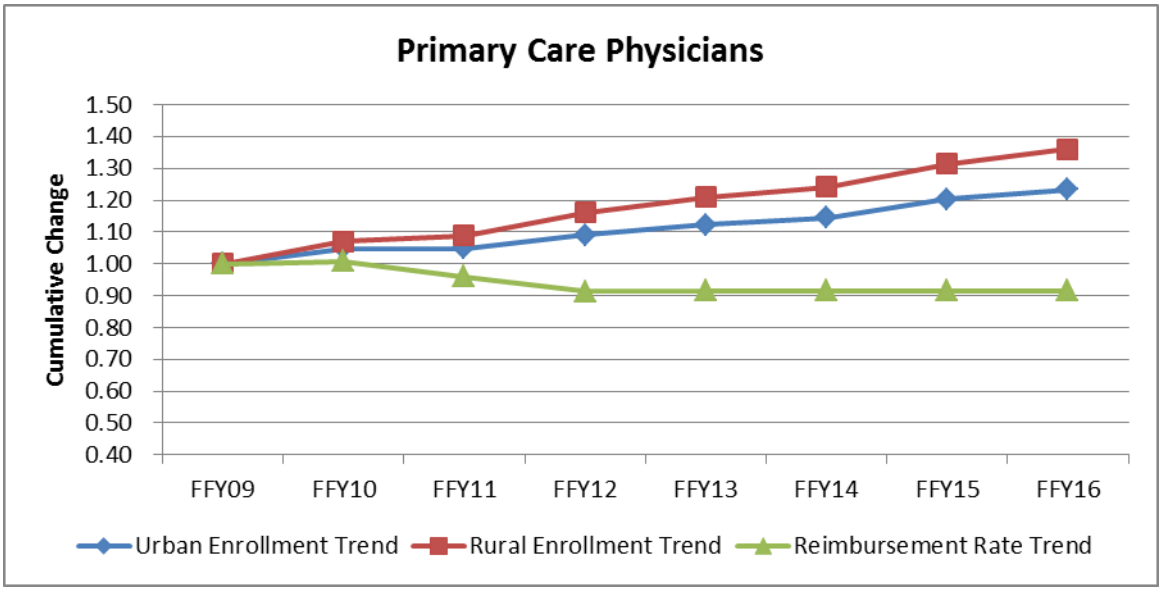
Throughout the period studied, the AHCCCS provider network has remained sufficient in number and availability, and the number of physicians delivering primary care services have steadily increased, as illustrated below. From FFY 2009 to FFY 2016, the number of primary

care physicians increased by 23% in urban areas and 36% in rural areas. According to information from the Kaiser Family Foundation, in April 2016 Arizona had 7,906 active state licensed primary care physicians in Arizona.[1] Therefore, it is estimated that the majority of primary care physicians in Arizona participate in Medicaid.

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 with 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. AHCCCS intends to review this methodology before submitting the next analysis and revise if appropriate.

More details on the number of primary care physicians and an illustration of the number of providers compared to the reimbursement rate trend are below.

AHCCCS-Enrolled Primary Care Physicians								
	FFY09	FFY10	FFY11	FFY12	FFY13	FFY14	FFY15	FFY16
Urban	5,409	5,665	5,664	5,899	6,077	6,196	6,509	6,675
Rural	2,026	2,168	2,206	2,351	2,448	2,516	2,661	2,755



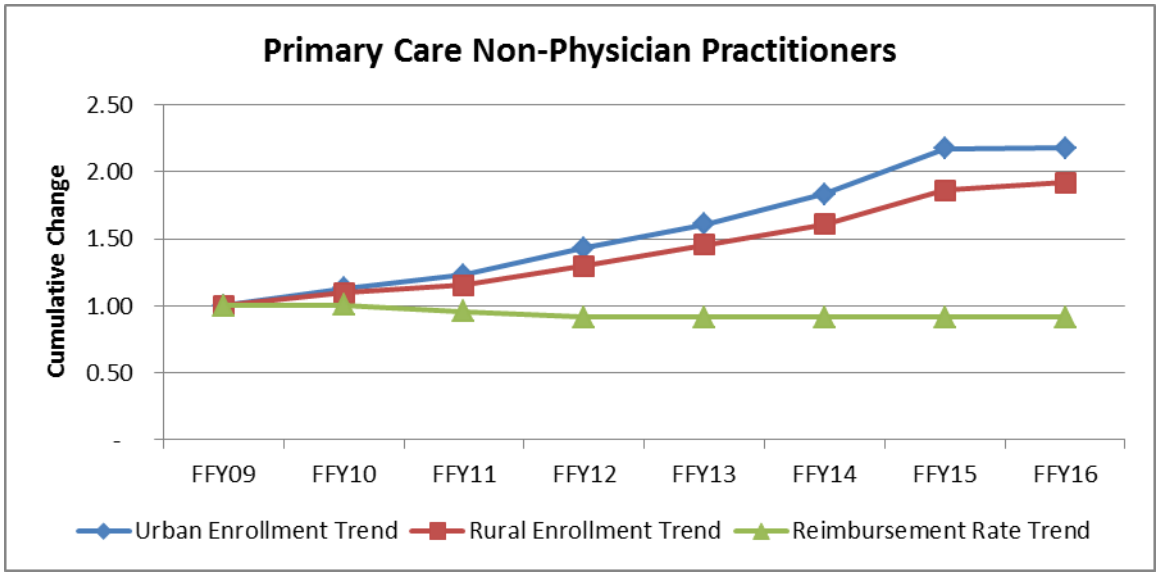
The primary care practitioner enhanced fee schedule mandated by ACA Sec. 1202 was discontinued effective January 1, 2015. As of April 1, 2016, AHCCCS has not experienced a decrease in the number of enrolled physicians, physician assistants, or nurse practitioners.

[1] Kaiser Family Foundation. Total Active Physicians. http://kff.org/other/state-indicator/total-active-physicians/

AHCCCS observed no issues with access to primary care before, during or after the ACA Sec. 1202 program.

Other major providers of services reimbursed from the physician fee schedules are primary care non-physician practitioners, which includes physician assistants, registered nurse practitioners, certified nurse-midwifes, and optometrists as primary care non-physician practitioners. AHCCCS enrollment of these provider types has increased year over year, more than doubling from FFY 2009 to FFY 2016, even through years of rate reductions. The table below provides more details, and the chart illustrates the rate trend over several years compared to the number of enrolled providers of these types.

AHCCCS-Enrolled Primary Care Non-Physician Practitioners								
	FFY09	FFY10	FFY11	FFY12	FFY13	FFY14	FFY15	FFY16
Urban	2,720	2,986	3,135	3,536	3,955	4,370	5,058	5,225
Rural	1,101	1,245	1,357	1,575	1,769	2,018	2,392	2,399



A 2014 survey of Medicaid rates ranks Arizona at 15 out of 50 for reimbursement based on the physician fee index. On average, Arizona physician reimbursement rates were 22% higher than the national average and ranked in the middle of comparable western states.[2] Compared to Medicare, Arizona Medicaid rates ranged from 73% to 92%, with an average of 81%.[3] Additional detail appears below.

[2] Kaiser Family Foundation. Medicaid Physician Fee Index. http://kff.org/medicaid/state-indicator/medicaid-fee-index/

[3] Kaiser Family Foundation. Medicaid-to_medicare Fee Index. http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/

Medicaid Physician Fee Index: 2014

Measure of each state's physician fees relative to national average Medicaid fees

Location	All Services	Primary Care	Obstetric Care	Other Services
New Mexico	1.32	1.34	1.29	1.33
Nevada	1.24	1.15	1.38	1.25
Arizona	1.22	1.25	1.19	1.17
Utah	1.11	1.24	0.91	1.04
Colorado	1.10	1.24	0.86	1.03

Medicaid-to-Medicare Fee Index: 2014

Measures each state's physician fees relative to Medicare fees in each state.

Location	All Services	Primary Care	Obstetric Care	Other Services
New Mexico	0.91	0.82	0.99	1.04
Nevada	0.81	0.66	1.02	0.92
Arizona	0.81	0.73	0.92	0.86
Utah	0.74	0.74	0.69	0.79
Colorado	0.72	0.73	0.66	0.77

For its Physician Fee Schedule, AHCCCS maintains a facility/non-facility rate structure, driven by place-of-service coding, similar to the Medicare Physician Fee Schedule. Based on paid claims for FFY2015, the AHCCCS non-facility rates were in aggregate 72.3% of the corresponding Medicare non-facility rates. For the same time period, the AHCCCS facility rates were in aggregate 84.5% of the corresponding Medicare facility rates. The AHCCCS Physician Fee Schedule also has, for most procedures, a distinct and higher reimbursement rate for IHS and Tribal 638 providers, likewise driven by place-of-service coding. The AHCCCS IHS/638 rates correspond to the non-facility rate for any given procedure. For FFY2015, the AHCCCS IHS/638 rates were in aggregate 92.7% of the corresponding Medicare non-facility rates.

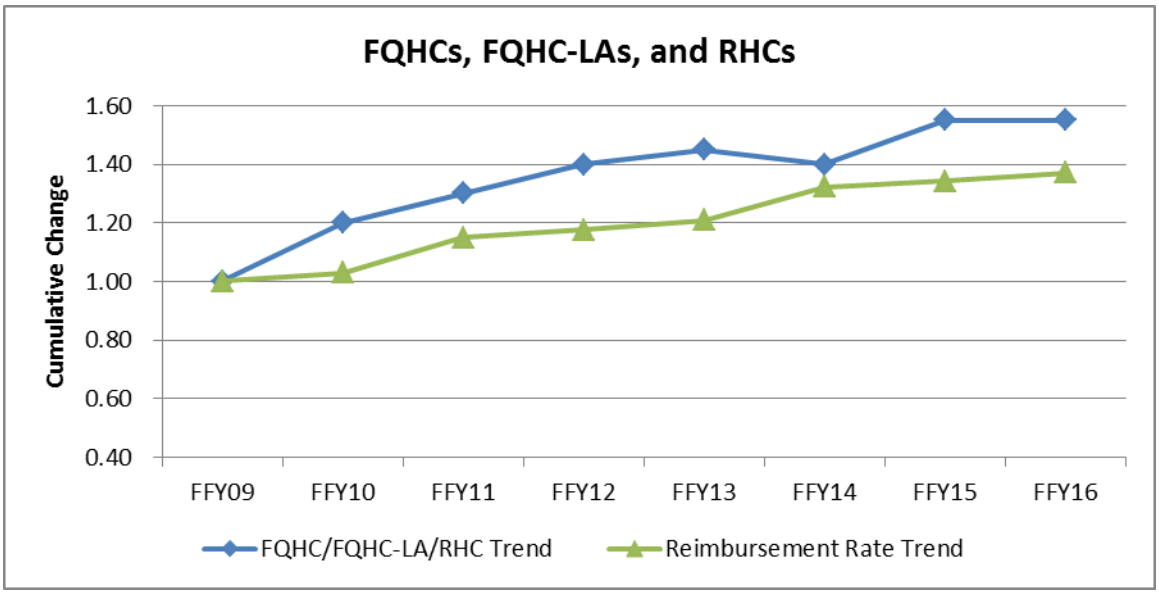
Federally Qualified Health Centers and Rural Health Centers

FQHCs, FQHC Look-Alikes (FQHC-LAs), and RHCs are a critically important part of the health care system and represent a valuable source of primary care for AHCCCS members. FQHCs and RHCs are required to serve an underserved population or geographic area, offer a sliding fee scale and provide comprehensive services. As shown below, the Arizona FQHC/RHC provider population continues to grow and these services are provided throughout the state of Arizona in both rural and urban areas.

From FFY 2009 to FFY 2016, the number of FQHCs/RHCs grew from 20 to 31, a 55% increase. The total shown for FFY 2016 represents 170 separate sites of service available to AHCCCS members throughout the state.

AHCCCS-Enrolled FQHCs, FQHC Look-Alikes, and RHCs								
	FFY09	FFY10	FFY11	FFY12	FFY13	FFY14	FFY15	FFY16
FQHCs	14	16	16	17	18	19	21	21
FQHC-LAs	1	2	2	2	1	1	2	2
RHCs	5	6	8	9	10	8	8	8
Total	20	24	26	28	29	28	31	31
Total Sites *	NA	NA	NA	NA	150	158	167	170

* Data on total number of sites unavailable before FFY 2013.



The Health Resources and Services Administration annually publishes statistics on FQHC operations, though the 2015 statistics were not yet available as of this writing. The following table contains information from 2014 and illustrates a steady growth trend in utilization of FQHC services in Arizona.

	2009	2010	2011	2012	2013	2014
Number of Patients	376,081	384,287	408,737	423,160	438,260	465,285
Number of Encounters	1,353,640	1,421,257	1,459,520	1,572,634	1,635,078	2,071,246
Total FTEs	2,705	2,955	3,155	3,345	3,481	4,352

The Benefits Improvement and Protection Act of 2000 (BIPA) established a prospective payment system (PPS) for Medicaid payments to FQHCs and RHCs. States may use an alternative methodology so long as the resulting PPS rate is no less than the PPS rate calculated under the BIPA methodology.

Arizona uses an alternative methodology, basing the PPS rate on each FQHC's and RHC's cost report, including some costs that are excluded by Medicare, and rebasing to the cost reports

every three years. This methodology produces reimbursement rates that are higher than the BIPA rates, making AHCCCS participation an attractive option for these safety-net providers.

In April 2015, AHCCCS implemented a payment process change for FQHC and RHC claims, under which AHCCCS and its contracted Managed Care Entities will reimburse FQHCs and RHCs at the prescribed PPS rate on a claim-by-claim basis. Historically, these providers have been paid under a capped fee-for-service fee schedule with wrap-around payments made by the Administration via quarterly supplemental payments, sometimes realizing their full PPS rate only after an annual reconciliation. The new payment process is expected to improve the providers' cash flows, as well as making the reimbursement process more transparent.[4]

PPS rates were rebased effective October 1, 2013, increasing FQHC/RHC rates by 6.6% in aggregate. Effective October 1, 2014, the rebased rates were adjusted by the Physician Services Index of the Consumer Price Index, increasing the rates 1.38% across-the-board. For October 1, 2015, rates were increased again by 2.08%.

Dental Fee Schedule

According to the American Dental Association, Arizona has approximately 4,000 dentists in the state with a population of 6.8 million (54.5 dentists for every 100,000 Arizonans). Approximately 38% of these dental providers are registered with AHCCCS, resulting in about 1,549[5] dentists for nearly approximately 1.8 million members (84.1 dentists per 100,000 AHCCCS members). With about 240,000 FFS members, AHCCCS is far exceeding the goal of "[A]t least to the extent that such care and services are available to the general population in the geographic area."

The AHCCCS Dental Fee Schedule is based on the biannual ADA Survey of Dental Fees, using the average fees among the western states. Dental services under the Arizona State Plan for Medicaid are limited primarily to children and persons under the age of 21 years under the requirements of Early Periodic Screening, Diagnosis, and Treatment. Routine dental is not a covered service for adults 21 years and older under the State Plan, as such, dental services for this population is limited to medical and surgical services furnished by a dentist to the extent such services may be performed under state law either by a doctor of medicine or by a doctor of dental surgery or dental medicine.

In federal fiscal years 2009, 2011, and 2012, dental rates experienced three reductions. The number of AHCCCS enrolled dentists increased each year during those reductions, indicating that Medicaid participation among these providers is not largely impacted by AHCCCS reimbursement rates. For FFY 2014, AHCCCS adjusted the dental rates for the first time since October 1, 2011, increasing by 3.2% the rates for selected pediatric preventive services.

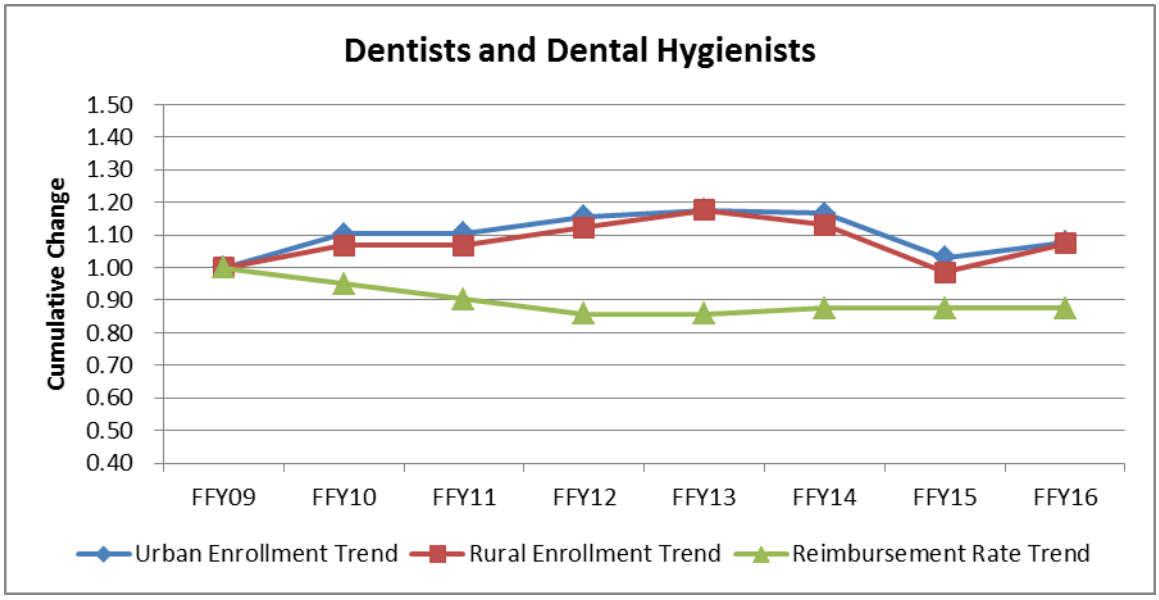
[4] AHCCCS still conducts a reconciliation and will make wrap-around payments as needed. However, given that the Managed Care Entities pay the PPS rates up front, these supplemental payments are expected to be small.

[5] This number is less than the total amount which appears in the table since some dentists have locations in both urban and rural areas.

The table below illustrates that while there have been some fluctuations, the number of dentists and dental hygienists has been relatively stable in recent years, with 1,277 dentists and dental hygienists participating with AHCCCS in urban areas and 505 in rural areas in FFY 2016, up from 1,185 and 470 in FFY 2009, respectively. According to information from the Kaiser Family Foundation, in April 2016, Arizona had 4,003 professionally active dentists in Arizona.[6] Therefore, it is estimated that approximately 38% of dentists participating in Medicaid.

The table and chart below provide additional information.

AHCCCS-Enrolled Dentists and Dental Hygienists								
	FFY09	FFY10	FFY11	FFY12	FFY13	FFY14	FFY15	FFY16
Urban	1,185	1,307	1,309	1,371	1,393	1,382	1,221	1,277
Rural	470	502	502	528	553	532	463	505



Using information on rates posted on state Medicaid websites, AHCCCS compared 27 dental procedure codes which account for 80% of dental services reimbursed by AHCCCS. The comparison shows that AHCCCS rates are higher than neighboring states, as illustrated by the table below which shows a ratio of AHCCCS rates to other states. [7]

[6] Kaiser Family Foundation. Professionally Active Dentists. http://kff.org/other/state-indicator/total-dentists/

[7] https://www.colorado.gov/pacific/hcpf/provider-rates-fee-
http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/schedule
http://www.hsd.state.nm.us/providers/fee-for-service.aspx
http://health.utah.gov/medicaid/stplan/lookup/FeeScheduleDownload.php

	Colorado	Nevada	New Mexico	Utah
Arizona Dental Rates Comparison	1.15	1.06	1.12	1.25

The FFY15 AHCCCS FFS Dental Rates were, in aggregate and for any site of service, 50% of the "fee most often charged for dental procedures" according the ADA 2013 Survey of Dental Fees. For purposes of this comparison, AHCCCS used the Mountain States survey results, which combines survey responses from dentists in Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming.

No access to care issues have been identified at this rate level.

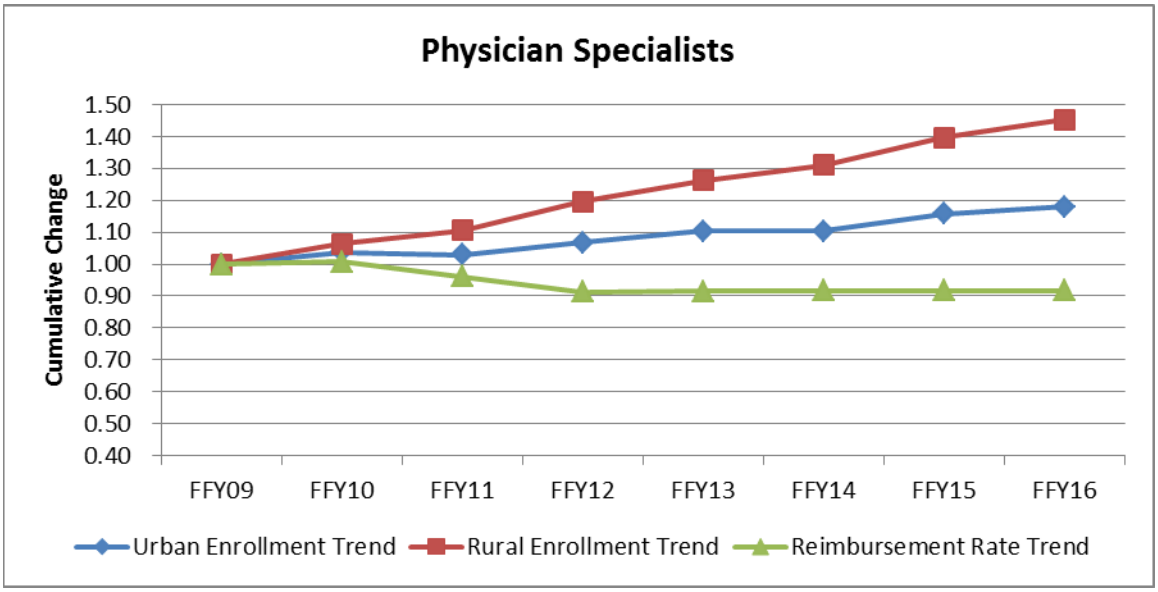
Analysis of Physician Specialist Services

Like primary care physicians, physician specialists use the physician fee schedule which is described in more detail in the prior section. AHCCCS utilization of services, as measured by the number of claims for physician specialists services per 1,000 enrolled beneficiaries fluctuated from 1,405 to 1,838 from FFY 2009 to FFY 2015. Meanwhile, the number of AHCCCS enrolled physician specialists increased by 18% in urban areas and 45% in rural areas despite the provider rate reductions. According to information from the Kaiser Family Foundation, in April 2016, Arizona had 8,636 active state licensed specialist physicians in Arizona.[8] Therefore, it is estimated that the majority of physician specialists in Arizona participate in Medicaid.

More information on physician specialists is below.

Physician Specialist Services Claims Per 1,000 Enrolled Beneficiaries							
	FFY09	FFY10	FFY11	FFY12	FFY13	FFY14	FFY15
Physician Specialists	1,405	1,606	1,838	1,629	1,413	1,518	1,485

AHCCCS-Enrolled Physician Specialists								
	FFY09	FFY10	FFY11	FFY12	FFY13	FFY14	FFY15	FFY16
Urban	5,988	6,211	6,159	6,397	6,602	6,605	6,934	7,068
Rural	1,965	2,089	2,173	2,349	2,479	2,576	2,744	2,856



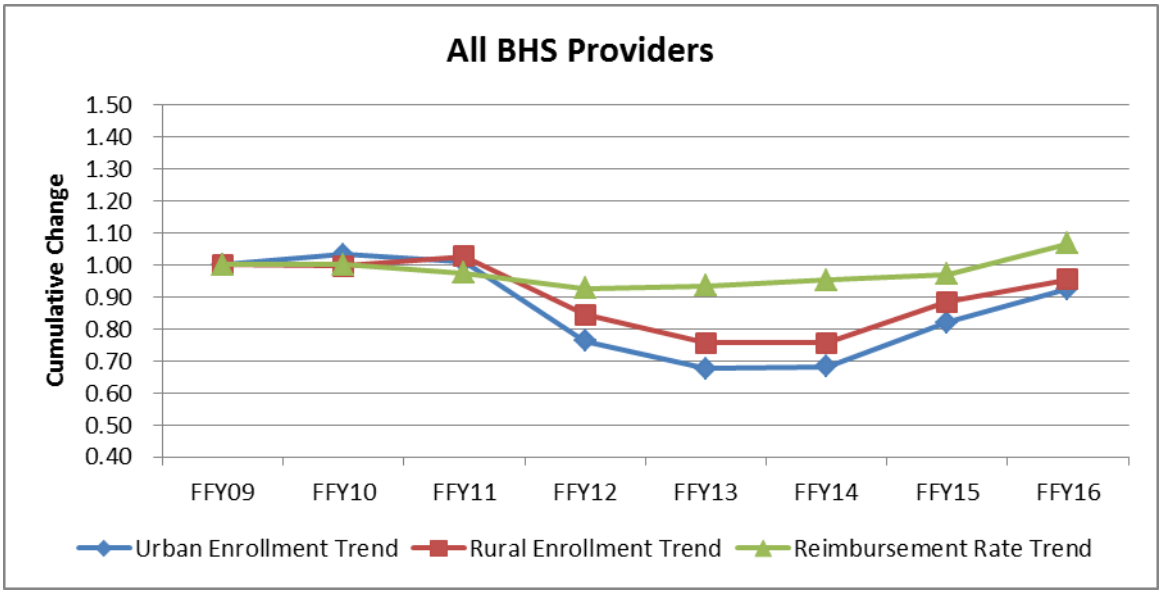
[8] Kaiser Family Foundation. Total Active Physicians. http://kff.org/other/state-indicator/total-active-physicians/

Analysis of Behavioral Health Services

Historically, the majority of behavioral health services were a carve-out service funded separately from medical services and managed through the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS). ADHS/DBHS contracted with Regional Behavioral Health Authorities (RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs) to provide behavioral health services. Beginning July 1, 2016, DBHS and AHCCCS consolidated the administration of physical and behavioral health services under one agency.

As shown below, from FFY 2009 to FFY 2016, the total number of behavioral health services providers decreased by 7% in urban areas and 5% in rural areas due to the consolidation of providers. Despite this change, overall utilization more than doubled during this time period, with the number of claims per 1,000 enrolled beneficiaries increasing from 957 in FFY 2009 to 2,018 in FFY 2015.

AHCCCS-Enrolled Providers								
	FFY09	FFY10	FFY11	FFY12	FFY13	FFY14	FFY15	FFY16
Urban	2,604	2,690	2,628	1,983	1,764	1,778	2,135	2,410
Rural	922	919	947	778	698	698	816	880



BHS FFS Claims Per 1,000 Enrolled Beneficiaries							
	FFY09	FFY10	FFY11	FFY12	FFY13	FFY14	FFY15
BHS Clinic/Outpatient	803	947	1,260	1,243	1,878	2,122	1,771
BHS Individual Practitioners	112	159	198	163	156	129	95
BHS Inpatient Facility	39	45	55	79	138	132	121
Substance Abuse	3	13	46	50	39	43	31
Total	*957*	*1,164*	*1,560*	*1,536*	*2,210*	*2,428*	*2,018*

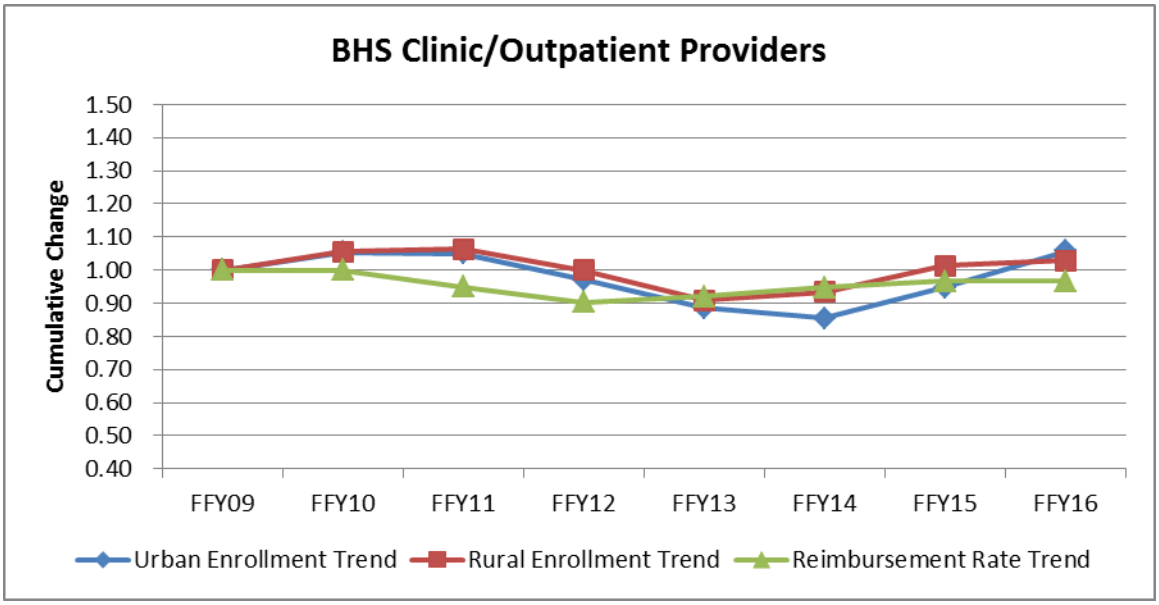
AHCCCS reimburses behavioral health providers based on two behavioral health fee schedules: inpatient and outpatient. For the purpose of this report, we also focus specifically on four categories of behavioral health services: Clinic/Outpatient Providers, Individual Practitioners, Inpatient Facilities, and Substance Abuse Services. The first two are reimbursed primarily through the outpatient fee-schedule. Inpatient facilities are reimbursed primarily through the inpatient fee schedule. Substance abuse services are reimbursed through a combination of the fee schedules depending on the type of service. More detail is contained below.

Behavioral Health Outpatient Fee Schedule

The behavioral health outpatient fee schedule, which provides the vast majority of reimbursement for Individual Practitioners and Clinic/Outpatient Providers, was subject to the rate reductions implemented in fiscal years 2009, 2011, and 2012. Though no access to care issues resulted, that fee schedule has since received several increases – 2% for April 1, 2013, 3% for October 1, 2013, and another 2% for October 1, 2014 to recover some of the lost rate level. For FFY 2017, AHCCCS is increasing outpatient behavioral health rates by 14% to align FFS rates with those rates being paid by Managed Care Organizations to ensure access to care issues do not occur.

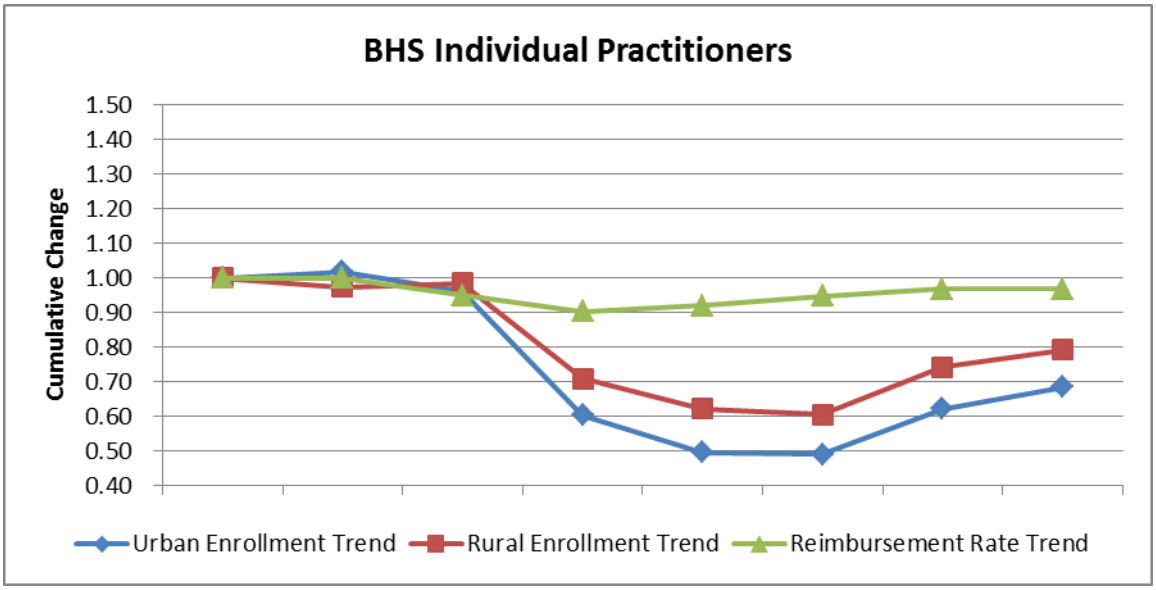
From FFY 2009 to FFY 2016, there were some fluctuations in the numbers of BHS Clinic/Outpatient Providers, some of which was driven by a licensing rule change which combined Level 2 and 3 into one residential category. The number of providers and a comparison to the changes in rates for BHS Clinic/Outpatient Providers is shown below.

AHCCCS-Enrolled BHS Clinic/Outpatient Providers								
	FFY09	FFY10	FFY11	FFY12	FFY13	FFY14	FFY15	FFY16
Urban	702	740	737	682	621	600	665	742
Rural	284	300	302	284	258	265	288	292



During the same period of time, the number of AHCCCS-enrolled BHS individual practitioners licensed with ADHS declined from FFY 2009 to FFY 2014. While there has been some increase since FFY 2014, the enrollment has not returned to FFY 2009 levels as shown below.

AHCCCS-Enrolled BHS Individual Practitioners								
	FFY09	FFY10	FFY11	FFY12	FFY13	FFY14	FFY15	FFY16
Urban	1,711	1,741	1,646	1,032	847	840	1,065	1,172
Rural	525	511	517	372	326	318	390	416



Despite the decline in AHCCCS-enrolled BHS individual practitioners, a review of the utilization indicates that there were no access to care issues during this time frame. Similar services can be obtained through Clinic/Outpatient providers. As a whole, the utilization of individual practitioners + Clinic/Outpatient providers increased by 157% over this seven year period.

A comparison between the AHCCCS rates and the current market rates, as indicated by prevailing rates paid for services by the RBHAs, has shown that the AHCCCS behavioral health outpatient rates are 81% of the median rate paid by RBHAs. AHCCCS specifies three places of service on the behavioral health outpatient fee schedule: in office, out-of-office, and home. On the AHCCCS outpatient behavioral health fee schedule, office reimbursement was reimbursed at 80% of the average MCO rates, out-of-office at 100% of the average MCO rates, home at 81% of the average reimbursement rates, and unspecified place of service at 74% of the average MCO rate.

Although Medicare does not have its own separate behavioral health outpatient fee schedule, it does cover a number of outpatient behavioral health services on the physician fee schedule. A comparison of these codes show that AHCCCS pays 86% of Medicare rates.

No access to care issues have been found at this rate level.

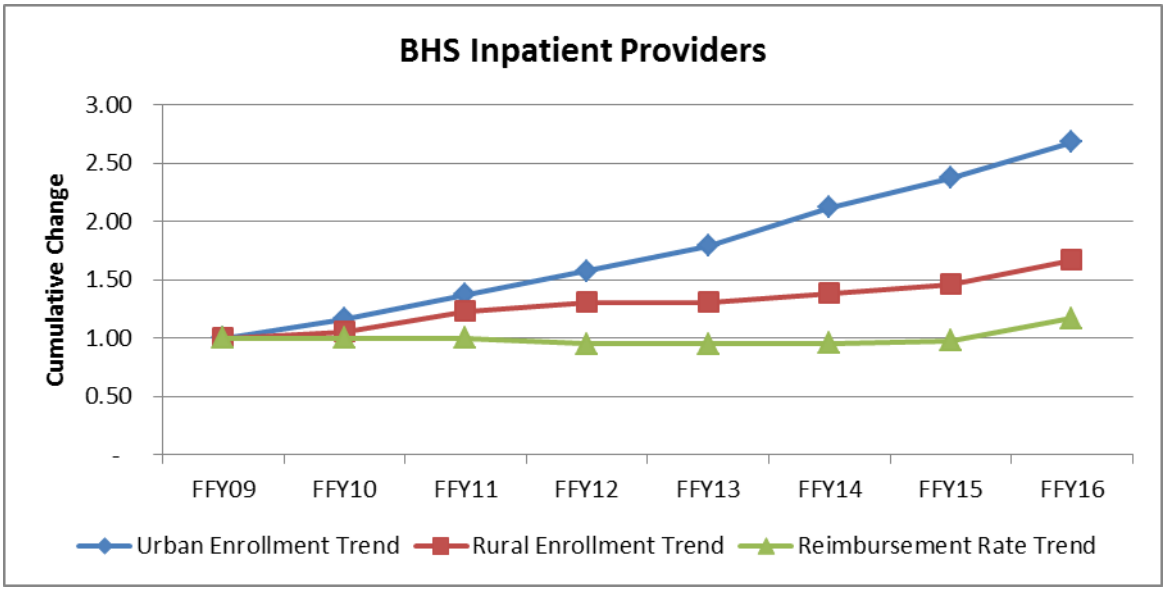
Behavioral Health Inpatient Fee Schedule

The behavioral health inpatient fee schedule was subject to the rate reductions implemented in fiscal years 2009 and 2012. Subsequently, that fee schedule remained largely unchanged until October 1, 2014 when the rates were increased by 2% at the direction of the state legislature. In FFY 2015, a comparison between the AHCCCS rates and the market rates, as indicated by prevailing rates paid for services by the RBHAs and TRBHAs, revealed that the AHCCCS behavioral health inpatient rates were on average less than 75% of the market. AHCCCS elected to move its FFS rates closer to the prevailing rates to assure continued access. For that purpose, the AHCCCS inpatient behavioral health fee schedule for FFY 2016 was an increase of 19.6% over the prior year.

More than 95% of the total annual reimbursements for inpatient behavioral health services are to psychiatric hospitals, acute care hospitals, and sub-acute facilities with 1 to 16 beds.

Since 2009, the number of BHS inpatient facilities has more than doubled, increasing from 142 to 380 in urban areas from FFY 2009 to 380 in FFY 2016. During that same time period, rural inpatient facilities increased from 39 to 65. A year-by-year comparison is below as well as a chart which illustrates the rate trend over several years compared to the number of enrolled providers of these types.

AHCCCS-Enrolled BHS Inpatient Facilities								
	FFY09	FFY10	FFY11	FFY12	FFY13	FFY14	FFY15	FFY16
Urban	142	165	195	224	254	301	337	380
Rural	39	41	48	51	51	54	57	65

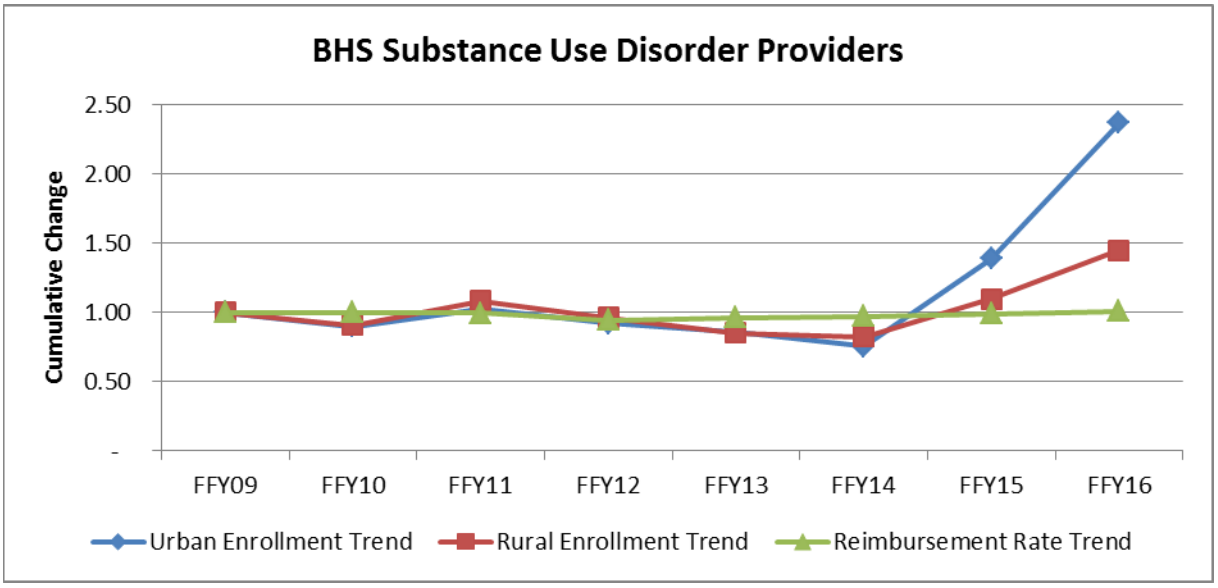


Substance Abuse Services

From FFY 2009 until FFY 2016, the number of substance use disorder providers more than doubled in urban areas and grew by 45% in rural areas despite rate decreases in some of these years. Substance use disorder providers are paid from both the inpatient and outpatient

behavioral health fee schedules. A table of the number of providers in recent years as well as a comparison to the rate schedules is below.

AHCCCS-Enrolled BHS Substance Use Disorder Providers								
	FFY09	FFY10	FFY11	FFY12	FFY13	FFY14	FFY15	FFY16
Urban	49	44	50	45	42	37	68	116
Rural	74	67	80	71	63	61	81	107



A comparison between the AHCCCS rates and the current market rates, as indicated by prevailing rates paid for services by the Managed Care Organizations, has shown that the AHCCCS rates for outpatient services are 82% of the median rate paid by MCOs. The AHCCCS rates for inpatient services are equal to the average rate paid by the MCOs in FFY 2015. No access to care issues have been identified at this rate level.

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 in the Access Monitoring Review Plan 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.

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

42 CFR § 447.203 defines home health services as including the following: 1) nursing services provided by a home health agency; 2) home health aide service provided by a home health agency; 3) physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency; and 4) medical supplies, equipment, and appliances suitable for use in the home.

Since DMEPOS may or may not be provided by a home health agency and these services are reimbursed on a separate rate schedule, we discuss these services separately below.

Services Provided by Home Health Agencies, exclusive of DMEPOS
There are two main groups of AHCCCS members who receive services provided by home health agencies: individuals who are elderly and/or have physical disabilities (EPD) and individuals with developmental disabilities served through the Arizona Department of Economic Security, Division of Developmental Disabilities (DDD). By definition, these services are provided in beneficiaries' homes. Thus, rates do not differ by place of service.

EPD services are mostly handled through several managed care organizations. Excluding DMEPOS, AHCCCS spends approximately $68.5 million annually on home health agencies, of which less than $500,000 (less than 1%) is on the fee-for-service population.

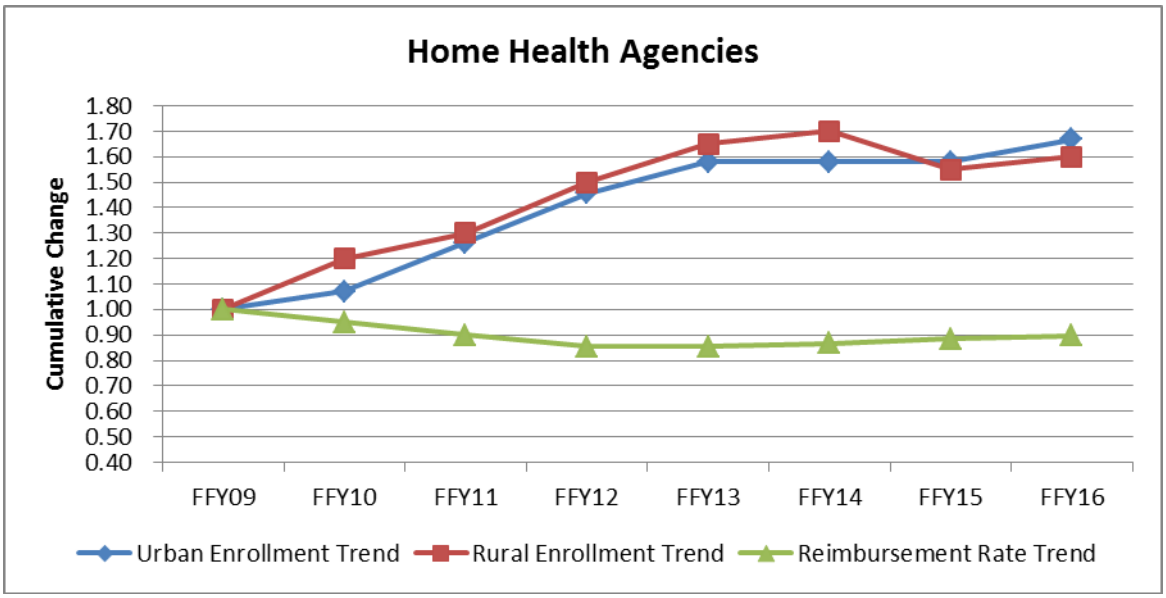
As the Arizona economy continues to improve, home health agencies are experiencing increased challenges to attracting individuals to work in direct care, which is more demanding on both a training and a day-to-day work basis than jobs that pay comparable salaries.

New federal mandates have also added financial pressure for providers. The U.S. Department of Labor passed new requirements related to payment for home care workers when traveling between patients, as well as overtime protections and compensation. In addition, the Affordable Care Act employer mandate became effective January 1, 2015 for businesses with 100 or more employees, and on January 1, 2016 for businesses with 50 or more.

Despite these challenges, the number of AHCCCS-enrolled home health agencies has increased by 67% in urban areas and 60% in rural areas from FFY 2009 until FFY 2016 as illustrated below. Claims also increased during this time period, growing by 27% from FFY 2009 to FFY 2015.

AHCCCS-Enrolled Home Health Agencies								
	FFY09	FFY10	FFY11	FFY12	FFY13	FFY14	FFY15	FFY16
Urban	57	61	72	83	90	90	90	95
Rural	20	24	26	30	33	34	31	32

Home Health Provider Claims Per 1,000 Enrolled Beneficiaries							
	FFY09	FFY10	FFY11	FFY12	FFY13	FFY14	FFY15
Home Health Providers	394	434	509	570	613	545	501



AHCCCS FFS reimbursement rates for home health agencies were increased by 1.5% on October 1, 2013, by 2% on October 1, 2014, and by another 1.5% on October 1, 2015.

As illustrated below, AHCCCS FFS rates compare well to the average AHCCCS MCO rates for the four most common home health service procedure codes below. Together, these four procedure codes account for 97% of AHCCCS home health agencies provided to FFS members. Amounts are broken out by Geographic Service Area (GSA). GSAs 02, 04, 06, 08, and 14 are located in rural areas of the state. GSA 12 is an urban area and GSA 10 covers both an urban a rural area of the state.

Comparison of MCO Rates to AHCCCS Rate for Home Health Agencies							
GSA	02	04	06	08	10	12	14
Procedure Code	G0154	G0154	G0154	G0154	G0154	G0154	G0154
MCO Rate	$46.25	$31.90	$22.72	$48.88	$29.96	$31.80	$26.38
AHCCCS Rate	**$23.11**	**$23.11**	**$23.11**	**$23.11**	**$23.11**	**$23.11**	**$23.11**

GSA		04		08	10	12	
Procedure Code		S5125		S5125	S5125	S5125	
MCO Rate		$3.82		$3.95	$3.38	$3.41	
AHCCCS Rate		**$4.08**		**$4.08**	**$4.08**	**$4.08**	

GSA	02	04	06	08	10	12	14
Procedure Code	S9123	S9123	S9123	S9123	S9123	S9123	S9123
MCO Rate	$66.85	$54.38	$54.05	$70.23	$63.45	$55.55	$68.39
AHCCCS Rate	**$60.47**	**$60.47**	**$60.47**	**$60.47**	**$60.47**	**$60.47**	**$60.47**

GSA	02	04	06	08	10	12	
Procedure Code	S9131	S9131	S9131	S9131	S9131	S9131	
MCO Rate	$135.00	$109.46	$98.88	$114.98	$111.89	$90.62	
AHCCCS Rate	**$109.04**	**$109.04**	**$109.04**	**$109.04**	**$109.04**	**$109.04**	

Durable Medical Equipment, Prosthetics, Orthotics and Supplies
Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) rates are based on the corresponding Medicare fee schedule. The key provider types reimbursed by this fee schedule are DME suppliers (74.5% of the annual total) and optometrists (14.5% of the annual total).

The chart below indicates a downward trend in the number of DME suppliers enrolled with AHCCCS, reflecting a continuing industry-wide trend toward consolidation.[9] Among the factors influencing the trend is the Medicare DMEPOS Competitive Bidding Program. Under this program, DMEPOS suppliers submit bids to provide medical equipment for Medicare users in certain areas and only the winning bidders can receive reimbursement from Medicare for DMEPOS.

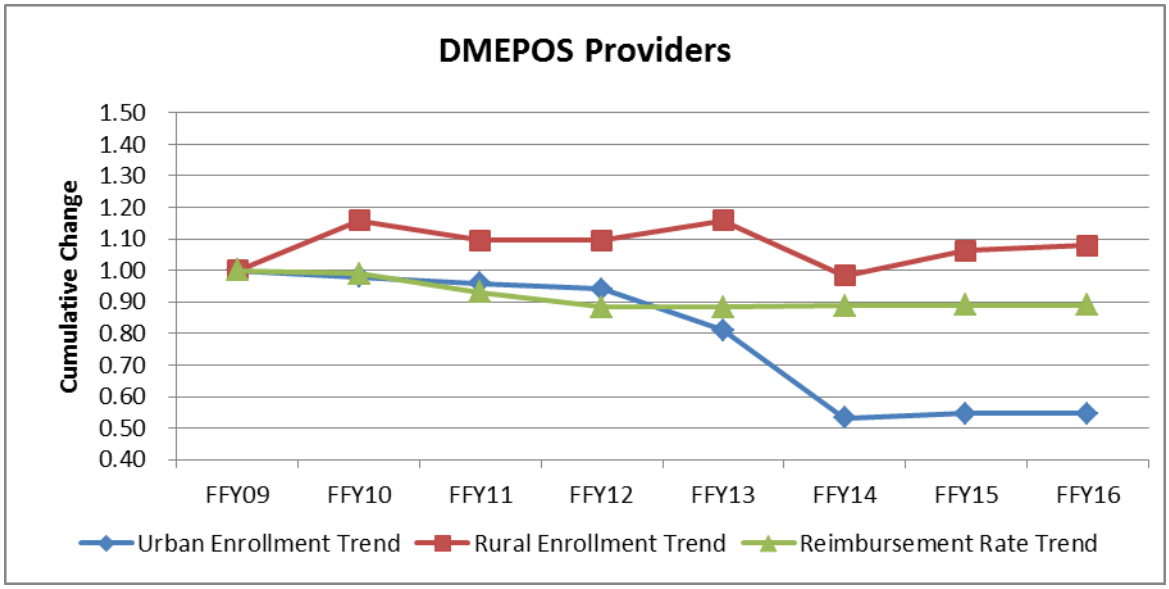
While the program's intent was to reduce the DMEPOS costs for Medicare, it has had the effect of hindering access to oxygen and related equipment for American Indian members in very rural areas. The competitive bidding process reduced the number of DMEPOS providers in Arizona and resulted in some providers greatly reducing their staffing levels. The Centers for Medicare and Medicaid did not include all of the Arizona zip codes in the bidding process, leaving certain rural areas without a Medicare contracted DMEPOS provider. With the omission of certain rural areas, particularly in American Indian reservation communities in Northern Arizona, and the layoffs from DMEPOS providers, DMEPOS providers have not found it cost effective to travel, in some cases, very large distances in order to supply Medicaid and dually eligible members with needed DMEPOS items. CMS has been made aware of the issue by Indian Health Service and Tribal stakeholders. Additionally, AHCCCS has been in communication with our regional office regarding the issue.

AHCCCS continues to work with Indian Health Services, Tribal 638 facilities, and other providers to ensure that members receive access to DMEPOS. AHCCCS has also had discussions with out-of-state providers in attempts to add DMEPOS providers to our network.

[9] Graham, Peg. "Smart durable medical equipment: An investment opportunity flying under the radar." *Becker's Hospital Review.* 22 October 2014. http://www.beckershospitalreview.com/hospital-management-administration/smart-durable-medical-equipment-an-investment-opportunity-flying-under-the-radar.html

Additional information about DMEPOS providers and claims is below.

AHCCCS-Enrolled DMEPOS Providers								
	FFY09	FFY10	FFY11	FFY12	FFY13	FFY14	FFY15	FFY16
Urban	201	197	193	189	163	107	110	110
Rural	63	73	69	69	73	62	67	68



Durable Medical Equipment Claims Per 1,000 Enrolled Beneficiaries							
	FFY09	FFY10	FFY11	FFY12	FFY13	FFY14	FFY15
Home Health Providers	185	207	230	206	206	162	137

In FFY 2015, AHCCCS FFS DME rates were 82.3% of Medicare DME rates for non-IHS/Tribal 638 sites of service and 91.2% of Medicare DME rates for IHS and Tribal 638 facilities.

The table below illustrates the comparison over several fiscal years.

AHCCCS FFS Rates as a Percentage of Medicare Rates				
	FFY13	FFY14	FFY15	FFY16
Overall	83.9%	83.8%	83.5%	82.3%
IHS and Tribal 638 Providers	92.9%	92.8%	92.5%	91.2%

CONCLUSION

AHCCCS reviewed primary care, physician specialist, behavioral health, pre- and post- natal obstetrics, and home health services for the FFS population. Although most providers experienced rate reductions during FFY 2009 to FFY 2012, and most rate increases have been flat or modest since then, the AHCCCS network continues to grow. Although claims during this time frame have fluctuated, overall, claims per beneficiary has increased from FFY 2009 to FFY 2015. After a thorough review of data, AHCCCS has not identified any access to care issues. AHCCCS intends to continue to monitor access to care and will continue to improve upon its monitoring as more data becomes available.