PROGRAM CHANGES AND FEE SCHEDULE CHANGES

Introduction

This document contains historical and future program changes as well as historical changes to the AHCCCS Fee For Service rates.

Program Changes

Each program change listed below was either effective during or after the time period of encounters included in the Data Book. As such, each contract year contained in the Data Book reflects a different benefit design. The list below is a brief description of the program changes and their effective dates. Additional information can be found in the actuarial certifications which are posted on the Arizona Health Care Cost Containment System (AHCCCS) website. Note: Each actuarial certification and associated fiscal impact estimates will be specific to the program addressed by the certification and not necessarily specific to the population targeted in this RFP.

Table I – Program Change Items and Effective Date

Program Change Item	Effective Date(s)
Primary Care Provider (PCP) Parity Payment Increase	January 2013 and January 2014
Physical Therapy Benefits	January 2014
Human Papillomavirus (HPV)	January 2014
Mandatory Copay Elimination	January 2014
Dental Varnish and Dental Homes	April 2014
Newborn Screenings	April 2014
SMI Integration – Maricopa County	April 2014
Automated Visual Screenings	October 2014
Insulin Pumps	October 2014
Diagnosis Related Group (DRG) Impacts	October 2014
Hepatitis C Drugs	October 2014 and October 2016
Medically Preferred Treatment Options	October 2014 and August 2015
FQHC/RHC All-Inclusive PPS Rates	April 2015
ACOM Policy 432 BH/PH	April 2015
Integration of GMH-SA Duals	October 2015
SMI Integration – Greater Arizona	October 2015
Nominal Copay	October 2015
Newborn Eligibility Change	October 2015
High Acuity Pediatric Adjustor	January 2016 and January 2017

In-Lieu of Services	July 2016
Podiatry for Adults	October 2016
Long-Acting Reversible Contraception (LARC)	October 2016
Arizona Early Intervention Program (AzEIP)	October 2016
Minimum Wage Increases	January 2017, July 2017 and January 2018
Abilify to Aripiprazole	April 2017
Vivitrol Initiative	April 2017
Adult Emergency Dental	October 2017
Adult Occupational Therapy	October 2017
Service Expansion	Multiple
Health Insurer Provider Fee	Multiple
Other Program Changes to be Determined	Multiple

Detailed Descriptions: For Table I Program Change Items

Primary Care Provider (PCP) Parity Payment Increase – Effective January 2013 through December 2014
Section 1902(a)(13)(C) of the Social Security Act, as amended by the Affordable Care Act, required minimum levels of Medicaid payment for certain primary care services, provided by certain physicians. The AHCCCS managed care model, with strict requirements regarding actuarially-sound capitation rates, necessitates that Contractors be funded for expected cost increases due to primary care rate parity. AHCCCS proposed to provide Contractors the necessary funds to increase primary care payments by using Model 3: Non-risk Reconciled Payments for Enhanced Rates as referenced in the *Medicaid Managed Care Payment for PCP Services in 2013 and 2014, Technical Guidance and Rate Setting Practices* (Technical Guidance) document released by CMS.

In summary, under Model 3, prospective capitation rates were not adjusted for the enhanced primary care payments. Rather, AHCCCS queried actual encounter data on a quarterly basis to calculate the total payments that eligible providers were paid for eligible services in order to reach the mandated enhanced payment rates. Once the data on this report was verified, AHCCCS paid the Contractors the calculated additional payment amounts. A more detailed explanation of the process and methodology can be found in the Actuarial Certification submitted to CMS for approval of AHCCCS methodology.

Physical Therapy Benefits – Effective January 2014
Effective January 1, 2014, AHCCCS Contractors must provide physical therapy benefits to get and keep a level of function for members twenty one years of age and older, limited to fifteen visits per year.

Human Papillomavirus (HPV) – Effective January 2014
AHCCCS expanded the coverage for the HPV vaccine to include coverage for all adults (females and males) aged 21-26. AHCCCS has covered females aged 11-20 since December 2006 and has covered males aged 11-20 since July 1, 2010.

Mandatory Copay Elimination – Effective January 2014
Effective October 1, 2010, AHCCCS reinstated mandatory copays for adults in the AHCCCS Care population. There were a myriad of exclusions for adult copays related to both specific services and specific members as detailed in contract. Additionally, effective April 1, 2012, AHCCCS Care members in Maricopa and Pima counties became subject to a $2 mandatory copayment for taxi services per one-way trip. Mandatory copayments permit providers to deny services due to lack of member payment. These AHCCCS Care copays expired December 31, 2013.

Dental Varnish and Dental Homes – Effective April 2014
Effective April 1, 2014, AHCCCS Contractors must develop a process to assign all children ages 0 to 21 years of age (Early and Periodic Screening, Diagnostic and Treatment (EPSDT) members) to a dental home by one year of age or upon assignment to the Contractor, and to communicate the assignment to the member. The Contractor must regularly notify the oral health professional which members have been assigned to the provider's dental home for routine preventative care. This provides a "panel" of patients for outreach purposes so that the oral health professional can deliver services, send reminder notifications, etc. The goal of this program is to increase utilization of EPSDT oral health services to a level/rate mandated by CMS.

Effective April 1, 2014, AHCCCS is allowing PCPs (physicians, physician's assistants or nurse practitioners) to apply fluoride varnish during EPSDT visits beginning at first tooth eruption up to age two. The frequency is limited to no more than one every six months. There is an additional payment outside the EPSDT visit fee for this application. This increase includes the PCP education and discussion with the parents of the need for oral health care and referral to a dental home.

Newborn Screenings – Effective April 2014
Effective April 1, 2014, per Arizona Revised Statutes (A.R.S.) §41-1032, the newborn screening fee increased from $40.00 to $65.00. This increase in fee allows for more accurate testing with fewer false positives, more thorough follow-up on abnormal results, more extensive provider education to reduce time from specimen collection to submission and testing and more comprehensive quality assurance activities.

SMI Integration – Maricopa County– Effective April 2014
AHCCCS contracted with the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) for the provision of behavioral health services to AHCCCS Acute Care members. ADHS/DBHS sub-contracted with Regional Behavioral Health Authorities (RBHAs). In Maricopa County, the RBHA is responsible for the integration of physical health and behavioral health service delivery for members who are SMI.

Automated Visual Screenings – Effective October 2014
Effective October 1, 2014, AHCCCS provides coverage for automated visual screenings for children aged one to three years of age. Children ages four to five years of age may have a second screening if shown to be developmentally disabled or otherwise incapable of cooperating with traditional visual screening techniques.

Insulin Pumps – Effective October 2014
Effective October 1, 2014, the State of Arizona's 2014 Health and Welfare Budget Reconciliation Bill (BRB) reinstated insulin pumps, which were previously eliminated October 1, 2010, as a covered service for enrolled adults.

Diagnosis Related Group (DRG) Impacts – Effective October 2014
Acute hospital inpatient stays with dates of discharge on and after October 1, 2014 are paid using an All Patient Refined Diagnosis Related Group (APR-DRG) payment system (with certain exclusions). This payment system replaced the 20+ year tiered per diem inpatient reimbursement system in accordance with A.R.S. § 36-2903.01 and Arizona Administrative Code (A.A.C.) R9-22-712.60 through 712.81. The impact of this move to APR-DRG was budget neutral to the state, but did vary by Program. In addition to the methodological change, there were impacts to what qualifies for reinsurance.

Hepatitis C – Sovaldi and New Hepatitis C Drugs - Effective October 2014
The Food and Drug Administration (FDA) approved Sovaldi, a treatment option for hepatitis C, in December 2013. Sovaldi has the potential to positively impact the care and outcomes for certain Hepatitis C-positive individuals, but it also has significant financial implications. New Hepatitis C drugs were released in the fall of 2014.

Medically Preferred Treatment Options - Effective October 2014
Effective October 1, 2014, AHCCCS began providing medically necessary orthotics services that are recognized as a preferred treatment option and are less expensive than other treatment or surgical options. More specifically, AHCCCS reinstated orthotics instead of imminent surgery, or as necessary as a result of surgery, with prescribed criteria.

FQHC/RHC All-Inclusive PPS Rates - Effective April 2015
AHCCCS shifted payment responsibility for FQHC/RHC PPS rates to the Contractors in order to properly account for FQHC/RHC expenditures for managed care enrollees. To identify the amount of full-funding needed for Contractors to pay the PPS rates on a per visit basis, it was necessary to identify the historical FQHC/RHC visits in order to distribute the quarterly supplemental and annual reconciliation payments made by the Administration.

The historical encounter data for FQHC/RHC expenditures was paid on a per service basis while the new mandate required payment on a per visit basis, thus AHCCCS had to group the encounter service data to represent visits. A visit is defined as a face-to-face encounter with a licensed AHCCCS-registered practitioner during which an AHCCCS-covered ambulatory service is provided when that service is not incident to another service. Multiple encounters with more than one practitioner within the same discipline, i.e., dental, physical, behavioral health, or with the

same practitioner and which take place on the same day and at a single location, constitute a single visit unless the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. In this circumstance, the subsequent encounter is considered a separate visit. A service which is provided incident to another service, whether or not on the same day or at the same location, is considered to be part of the visit and is not reimbursed separately.

ACOM Policy 432 BH/PH – Effective April 2015
AHCCCS policy dictates that the principal diagnosis on an inpatient hospital claim determines the appropriate party payer: a claim with a physical health principal diagnosis code is paid by the Acute Care Contractor, and a claim with a behavioral health principal diagnosis code is paid by the Behavioral Health Contractor (the Regional Behavioral Health Authority – RBHA). Under certain circumstances however, when both physical and behavioral health services were provided during the same inpatient stay, Acute Care Contractors sometimes paid claims even when the principal diagnoses were for behavioral health.

AHCCCS policy and administrative rule were amended to emphasize that inpatient hospital claims' payments shall be based on the principal diagnosis, even when both physical and behavioral services are found on the claim.

Medically Preferred Treatment Options – Effective August 2015
Effective August 1, 2015, AHCCCS expanded the coverage of orthotics for members age 21 and over. More specifically, AHCCCS allowed orthotics when the use of orthotics was medically necessary as the preferred treatment option and consistent with Medicare guidelines; the orthotic was less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition; and the orthotic was ordered by a physician or a primary care practitioner.

Integration of GMH-SA Duals – Effective October 2015
In order to facilitate efficient coordination of care and improve member outcomes, AHCCCS integrated the physical and behavioral health services for dual eligible adults members with GMH/SA needs through the Acute Care program statewide effective October 1, 2015. These members now receive their physical and behavioral health services through the Acute Contractors, which are also Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs), and thus may have some alignment between their Medicaid and Medicare services. Immediate crisis services provided via telephone hotline and mobile teams, as well as stabilization and observation within the first 24 hours, remain the responsibility of the RBHAs due to the complex nature of establishing and maintaining a crisis system for all residents.

SMI Integration – Greater Arizona – Effective October 2015
In order to facilitate efficient coordination of care and improve member outcomes, AHCCCS integrated physical and behavioral health services for members with SMI in Greater Arizona (outside Maricopa County) through the RBHA system effective October 1, 2015. This integration was preceded by the integration of members with SMI in Maricopa County through the RBHA system effective April 1, 2014. These members in Greater Arizona shifted from the Acute Care program and now receive their physical and behavioral health services through the RBHAs.

Nominal Copays – Effective October 2015
Due to the requirements of federal regulation 42 CFR 447.56(d), AHCCCS has included consideration of nominal copayments for outpatient physical, occupational and speech therapies, and physician or other provider outpatient office visits for evaluation and management as specified in the State Plan in the calculation of capitation rates to Managed Care Organizations (MCO), regardless of whether or not the nominal copayment is actually imposed on MCO members or collected by the MCO (or its providers).

Newborn Eligibility Change – Effective October 2015
Effective October 1, 2015, AHCCCS is amending the enrollment date for certain newborns determined eligible for the Children's Rehabilitative Services (CRS) program. The original enrollment date for any AHCCCS member subsequently found medically eligible for CRS was the day the medical eligibility determination is made. The amended enrollment date will be the date of birth when the CRS application is received by the AHCCCS CRS Enrollment Unit within 28 days of birth (and a positive decision is made based on that documentation), beginning with applications received on and after October 1, 2015. The CRS Contractor will be responsible for payment of medically necessary covered services retroactive to the member's date of birth which will equal the member's enrollment date with the Contractor.

High Acuity Pediatric Adjustor – Effective January 2016
The AHCCCS All Patient Refined Diagnosis Related Group (APR-DRG) payment system included several policy adjustors. One such adjustor applies a factor of 1.25 to the reimbursement amount that would otherwise apply for "claims for members under age 19," as long as the claim is not subject to one of the other policy adjustors.

Beginning January 1, 2016, AHCCCS addressed the costs associated with high-acuity pediatric cases by using an adjustment factor of 1.60 in place of the above pediatric policy adjustor in the following instances only: for inpatient stays, where an APR-DRG assignment of level 3 or 4 Severity of Illness is indicated.

In-Lieu of Services – Effective July 2016
AHCCCS previously permitted funding for "in lieu of" services, substituting cost-effective alternative inpatient settings in place of more costly inpatient non-specialty hospital placements. In accordance with 438.6(e) in the Medicaid Managed Care Regulations, IMD utilization data for adults aged 21-64 were repriced at the higher State Plan service rate.

Hepatitis C – Effective October 2016
Effective October 1, 2016, AHCCCS amended clinical criteria for members utilizing Hepatitis C drugs including, but not limited to, lowering the liver fibrosis/cirrhosis of Metavir stage (i.e. fibrosis level) to F2 from F3 for members with Hepatitis B or HIV. This action will increase utilization of direct-acting antiviral medications including Daklinza, Epclusa, Harvoni, Sovaldi, Technivie, Viekira, and their successors.

Podiatry for Adults – Effective October 2016
As part of the 2016 Legislative session, the Arizona Legislature passed HB 2704, reinstating podiatry services for adults aged 21 and over, a covered service prior to October 1, 2010. AHCCCS restored this as a covered service effective October 1, 2016.

Long-Acting Reversible Contraception (LARC) – Effective October 2016
Many repeat births could be prevented through postpartum use of Long-Acting Reversible Contraception (LARC). Offering members access to LARC devices in the hospital after delivery is expected to increase utilization of such devices since many members do not attend their 6-week post-partum office visits. Currently no ICD-10 PCS code for the LARC device exists for inpatient hospital use thus, effective October 1, 2016, AHCCCS will pay hospitals for the device in addition to a DRG payment.

Arizona Early Intervention Program (AzEIP) – Effective October 2016
The Arizona Early Intervention Program (AzEIP) is a program that provides services to enhance the capacity of families and caregivers to support infants and toddlers with developmental delays or disabilities in their development. AzEIP members may be AHCCCS enrolled, in which case AHCCCS pays for the services, or non-AHCCCS enrolled, in which case AzEIP pays directly. Effective October 1, 2016, AHCCCS modified the speech therapy rate structure for services provided to a member who is a child identified in the AHCCCS system as an AzEIP recipient in order to more closely align the rates with the AzEIP rate structure. This change was intended to assure continued access to care, particularly for rural AzEIP members, where providers often travel to provide services in the natural setting, and to limit the rate differential whether the provider is paid the AHCCCS rates or the AzEIP rates. This will ensure there is not different access to services for AzEIP children based on whether the payer is AHCCCS or AzEIP.

High Acuity Pediatric Adjustor – Effective January 2017
The AHCCCS All Patient Refined Diagnosis Related Group (APR-DRG) payment system includes several policy adjustors. One such adjustor applies a factor of 1.25 to the reimbursement amount that would otherwise apply for "claims for members under age 19," as long as the claim is not subject to one of the other policy adjustors.

On January 1, 2016, AHCCCS addressed the costs associated with high-acuity pediatric cases by using an adjustment factor of 1.60 in place of the above pediatric policy adjustor in the following instances only: for inpatient stays, where an APR-DRG assignment of level 3 or 4 Severity of Illness is indicated. Effective January 1, 2017, AHCCCS changed the adjustment factor of 1.60 established January 1, 2016 to 1.945.

Minimum Wage Increase – Effective January 2017, July 2017 and January 2018
Effective January 1, 2017 and July 1, 2017, AHCCCS increased fee schedule rates for select Home and Community-Based Services (HCBS) procedure codes, all Nursing Facility (NF) revenue codes, and all Alternative Living Facility (ALF) procedure codes. The increase addressed the increased labor costs resulting from the Arizona minimum wage increase and employee benefit provisions as approved by voters as Proposition 206 and Proposition 414. Another increase in minimum wage will be effective January 1, 2018.

Abilify to Aripiprazole – Effective April 2017
Effective April 1, 2017, AHCCCS, on the recommendation of the Pharmacy and Therapeutics Committee, made policy changes to allow RBHAs to approve the generic drug aripiprazole in place of the brand drug Abilify. This change was based on the AHCCCS Pharmacy and Therapeutics

Committee's determination and recommendation that the generic drug, aripiprazole, is equally efficacious to Abilify, the most cost effective to the State and offers members the same value and clinical outcome.

Vivitrol Initiative – Effective April 2017
AHCCCS implemented the Governor's Office Vivitrol initiative effective April 1, 2017. The Vivitrol initiative is an increased focus within Maricopa County to provide individuals being discharged from the Arizona Department of Corrections (ADC) who meet specific criteria with a medication to prevent relapse to opioid dependence, which is administered via a monthly shot for up to 12 months. The monthly dose is expected to cost $1,000 and the manufacturer will pay for the first month of treatment. The Vivitrol initiative is expected to treat 100 members over a two-year time period beginning April 1, 2017.

Adult Emergency Dental – Effective October 2017
As part of the 2017 Legislative session, the Arizona Legislature passed SB 1527, reinstating emergency adult dental services and extractions up to a limit of $1,000 annually, a covered service prior to October 1, 2010. AHCCCS restored this as a covered service effective October 1, 2017.

Adult Occupational Therapy – Effective October 2017
As part of the 2017 Legislative session, the Arizona Legislature passed SB 1527 which added occupational therapy in an outpatient setting for adults aged 21 and over (OT for Adults). AHCCCS began coverage for this service effective October 1, 2017.

Service Expansion – Effective Multiple Dates
The projected benefit costs described in the RBHA actuarial certification for capitation rates effective October 1, 2017 for the Integrated Care Initiative, Arnold Vs Sarn Agreement, Autism Spectrum Disorder, Children in Foster Care, First Episode Psychosis, Opioid Epidemic, and Substance Use Disorder program, changes, were developed through a collaborative effort between the RBHAs and multiple teams at AHCCCS.

Health Insurer Provider Fees – Effective Multiple Dates
The Affordable Care Act (ACA) places an annual fee on the health insurance industry nationwide including most Medicaid health plans effective January 1, 2014. The fee is allocated to health insurers based on their respective market share of premium revenue in the previous year. The fee due from each insurer or Medicaid plan will be calculated by the Treasury Department and will consider the market share of applicable revenue that each plan receives. Exclusions apply to nonprofit county health plans, small plans with less than $25 million in revenue, and nonprofit entities that receive at least 80% of their revenue from Medicare, Medicaid, SCHIP, or dual-eligible members. The capitation rates do not include the fee; that adjustment will be addressed in a retroactive capitation rate adjustment once the fees are known. Historical actuarial certifications for health insurer fee adjustment can be found on the AHCCCS website:
https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ManagedCare/capitationrates.html

Other Program Changes to be Determined
As AHCCCS learns of additional program changes impacting Contractors' expenditures in CYE 19, cost/savings estimates will be evaluated to determine if capitation rates should be adjusted.

Fee Schedule Changes

This table outlines the fee schedule changes by year and service matrix categories. Differential Adjustment Payment (DAP) fee schedule changes are not shown below. Additional information can be found in the actuarial certifications which are posted on the AHCCCS website:

Contract Year	2014	2014	2014	2015	2016	2016	2017	2017	2017	2018
date of rate change	10/1/2013	1/1/2014	7/1/2014	10/1/2014	10/1/2015	1/1/2016	10/1/2016	1/1/2017	7/1/2017	10/1/2017
	(1)	(1)								
Hospital Inpatient	0.0%	0.0%		0.0%	0.0%	2.1%	0.0%	1.6%	0.0%	0.0%
Hospital Inpatient-LTAC/Rehab Hospitals	0.0%	0.0%		0.0%	1.1%	0.0%	0.0%	0.0%	0.0%	0.5%
Hospital Outpatient	1.2%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Nursing Facility (DDD)	0.0%	0.0%		0.0%	0.0%	0.0%	1.0%	3.5%	0.3%	0.0%
Nursing Facility (Non DDD)	1.5%	0.0%		2.0%	0.0%	0.0%	1.0%	3.5%	0.3%	0.0%
HCBS - (DDD)	0.0%	0.0%	2.0%	0.0%	1.5%	0.0%	2.0%	6.6%	1.9%	0.0%
HCBS - In home services & adult day health (Non DDD)	1.5%	0.0%	0.0%	2.0%	1.5%	0.0%	2.0%	6.6%	1.9%	0.0%
Behavioral Health										
Inpatient -- Psych	0.7%	0.0%		2.0%	2.1%	0.0%	0.0%	0.0%	0.0%	0.0%
Outpatient -- Psych	3.0%	0.0%		2.0%	0.0%	0.0%	1.8%	0.0%	0.1%	0.0%
Tiered per diem at acute hospital	0.0%	0.0%		DRG	DRG		DRG		DRG	DRG
Physician Fee Schedule -- Excluding categories below	0.1%	0.0%		0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.1%
Clinical Lab	-3.0%	0.0%		-0.7%	0.0%	0.0%	0.1%	0.0%	0.0%	0.1%
DMEPOS	0.4%	0.0%		0.4%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
Drugs and Injectables	0.5%	0.0%		4.2%	2.3%	0.0%	5.7%	0.0%	0.0%	3.8%
Anesthesia	0.0%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Free-Standing Dialysis	0.0%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Transportation	(2)	(2)		(2)	(2)		(2)		(2)	(2)
Emergency Ground (ADHS)	2.2%	0.0%		11.3%	-6.5%	0.0%	0.4%	0.0%	0.0%	3.0%
Emergency Ground (Tribal, OOS)	0.0%	0.0%		0.0%	0.0%	0.0%	14.9%	0.0%	0.0%	2.7%
Non Emergency Ground	0.0%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Emergency Air	0.0%	0.0%		0.0%	0.0%	8.1%	0.0%	0.0%	0.0%	0.0%
Dental	2.0%	0.0%		0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%
Hospice	0.5%	0.0%		1.3%	-0.3%	0.0%	2.0%	0.0%	0.0%	0.0%
ASCs	1.6%	0.0%		6.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%

(1) Freezing threshold changes for outlier and prior year CCR changes

(2) Continue to pay a 68.59% of ADHS rate as of 8/2/12 for CYE 13 and 14. Will increase to 74.74% of ADHS in CYE 15