



Janice K. Brewer, Governor
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Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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DATE: June 1, 2009
TO: Interested Parties
FROM: AHCCCS Administration
SUBJECT: Benefits Re-design for Adults in Acute Care

Background

In response to significant fiscal challenges facing the State and substantial recent growth in the Medicaid population, the Arizona Health Care Cost Containment System (AHCCCS) partnered with its acute care contracted Health Plans to review and provide preliminary recommendations to modify the acute care adult benefit package. As required by law, AHCCCS consulted with and received input from Arizona's tribes, Indian Health Service Area Offices, and tribal health programs and will continue working with them in determining the impact.

The workgroup, which included physicians, medical economists, data experts, coders, policy staff, and an independent consultant from the Lewin Group, spent a significant amount of hours compiling, reviewing and validating utilization data and trends. Consideration was given to multiple options, and potential savings were calculated including offsets due to costs of avoidable alternative treatments and adverse outcomes. Attached to this document is a summary of the benefits review process from the Lewin Group, which provided external validation and analytical resources for the project.

Population Impacted

As part of the FY 2009 budget fix, AHCCCS was mandated to establish a benchmark benefit package under authority of the Deficit Reduction Act for limited populations. However, due to the restrictions and significant complications in implementing a benchmark package, AHCCCS is proposing the approach be modified to implement benefit reductions and limitations across the entire Medicaid acute care adult population. The attached preliminary analysis was developed and provides detail based on two populations:

- Waiver Group – Childless adults up to 100% of the Federal Poverty Level (FPL) and adults with income up to 40% FPL after deducting medical expenses who do not otherwise qualify for any other Medicaid program;
- All Adults – All adults 21 and older, including the waiver group.

Effective Date

The assumed implementation date of any adopted changes would be January 1, 2010 with the exception of the non-emergency transportation reductions for the waiver group, which would be July 1, 2010. These dates are subject to change based on the CMS approval processes.

Next Steps

A public hearing is scheduled June 15th to present the recommendations to stakeholders. In addition to the public hearing, these preliminary recommendations will also be presented to the Arizona Legislature for consideration.

If ultimately approved through the legislative process, AHCCCS will submit the final proposal to the Centers for Medicare and Medicaid Services (CMS) for approval by way of amendments to the State Plan and Section 1115 Waiver. The final steps for implementation are to amend rule, contract, and medical policy. Additionally, AHCCCS will develop a revised capitation rate to reflect the revised benefit package. Affected members will be notified in advance of any changes to their benefits.

Preliminary Recommendation

Below is a preliminary list of benefits recommended for elimination or limitation followed by a worksheet with information on potential savings and applicable offsets.

Elimination:

- Emergency Dental Services
- Medically Necessary Dentures
- Genetic Testing
- Orthotics
- Insulin Pumps
- Services by a Podiatrist
- Percussive Vests
- Gastric Bypass Surgery
- Allergic Immunotherapy
- Well exams for adults
- Bone-Anchored Hearing Aids
- Cochlear Implants

Limitation:

- Non Emergency Medical Transportation (not available for waiver groups in Maricopa and Pima counties)
- Negative Pressure Wound Therapy
- Somnography (limit to 1 study/year)
- Physical Therapy (limit to 6 visits/year)
- Durable Medical Equipment (limit to Medicare covered items only)
- Prosthetics (limit non-implantable items to \$12,500/year)
- Transplants (selected limitations)



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memorandum

Date: May 28, 2009
To: Anthony Rodgers, Director, AHCCCS
From: Roshni Arora, Joel Menges
Re: AHCCCS Benefits Reductions and Limitations
cc: Kate Aurelius, Kathy Busby

Over the past six weeks, we have been engaged by the Arizona Association of Health Plans to assist Arizona Health Care Cost Containment System (AHCCCS) staff in analyzing potential benefit reduction and limitation options. This memo summarizes the overall process of considering potential options that Lewin participated in, our role, and guiding principles for selecting the final benefit reduction and limitation recommendations.

We appreciate the opportunity to assist AHCCCS in creating these recommendations. We believe that the benefit elimination and limitation recommendations presented in the accompanying matrix were selected through a considerate, rational, and consensus-oriented process. The AHCCCS Benefits Committee worked sincerely to identify areas for cost savings that would minimize adverse impacts on the health status of AHCCCS beneficiaries. It must also be acknowledged that a reduction to any covered benefits has the potential to negatively impact beneficiaries.

In addition, the benefit elimination and limitation recommendations agreed upon by the AHCCCS Benefits Committee are generally consistent with the experience of other state Medicaid programs.

Process of Selecting Benefit Reductions and Limitations

The AHCCCS Benefits Committee was convened in the Spring of 2009 to provide input on the potential elimination or limitation of AHCCCS benefits. The AHCCCS Benefits Committee was comprised of several AHCCCS managed care organizations, including:

- Arizona Physician's IPA,
- Bridgeway Health Solutions,
- Care 1st,
- Health Choice Arizona,
- Mercy Care Plan,

- Phoenix Health Plan, and
- Senior Care Action Network.

The AHCCCS Benefits Committee met in-person several times to engage in a thoughtful process that considered all options and the impact on beneficiaries. Specifically, for each benefit that was considered, the AHCCCS Benefits Committee reviewed and discussed the:

- Number of members receiving each benefit,
- Total cost of services,
- Cost per utilizing member,
- Advantages and disadvantages of eliminating or reducing the benefit,
- Potential adverse effects on the AHCCCS population,
- Exacerbation of related chronic conditions,
- Cost shifting to other covered services, and
- Delayed access to care.

After the AHCCCS Benefits Committee reached a consensus on whether to eliminate or limit a specific benefit, AHCCCS staff further analyzed claims data to estimate the expected cost savings for both the state and federal share combined. The AHCCCS Benefits Committee further decreased each estimate by the extent to which beneficiaries would shift costs to other covered services and the degree to which beneficiaries' health status would be adversely affected by the eliminated or reduced benefit.

Lewin's Role in the Process

Lewin staff participated in a two-day meeting of the AHCCCS Benefits Committee in-person on April 30, 2009 to May 1, 2009. As part of this meeting, Lewin presented a survey of other state Medicaid agencies on benefit cuts or reductions that had been implemented or were planned. Subsequently, AHCCCS staff and the Benefits Committee directed Lewin to focus on analyzing potential benefits eliminations and limitations of the following services:

- Health risk assessment, screening, and diagnostic tests, including preventive medical visits, pap screening, mammography, colonoscopy, cholesterol screening, and PSA screening,
- Orthotics,
- Prosthetics,
- Occupational therapy,
- Physical therapy, and
- Non-emergency transportation.

Lewin focused on the "Waiver" population, which includes selected AHCCCS adults. Lewin's modeling included a benefit limit analysis of beneficiary cost and utilization data, where possible. For each option, Lewin estimated the:

- Gross savings (amount that AHCCCS would save by a given benefits limit),

- Net savings (amount that AHCCCS would save after accounting for cost shifting [e.g., use of other types of services]),
- Impacts on health status,
- Number of beneficiaries affected by a benefit limit,
- Percent of users of the service affected by a benefit limit, and
- Percent of all covered beneficiaries affected by a benefit limit.

Lewin also suggested benefit limit recommendations for the AHCCCS Benefits Committee to consider and provided information regarding experience in other states. Throughout the last six weeks, Lewin frequently participated in meetings with the AHCCCS Benefits Committee and AHCCCS staff through telephone.

Guiding Principles for Final Recommendations

The AHCCCS Benefits Committee adhered to the following guiding principles when selecting benefit reduction or limitation recommendations:

- Only consider acute adult benefits for reductions or limitations.
- Every effort should be made to consider what other services would be utilized in lieu of the elimination or limitation of benefits.
- Benefit changes must be able to be easily operationalized by AHCCCS and contractors. Changes that could not be implemented by existing information systems or service delivery system design should be rejected (e.g., limiting transportation by diagnosis is not possible as transportation providers are not qualified to make diagnoses).

Benefit Re-design Worksheet

Financial Considerations

FY 08 - Adults 21+ (Exclude cost related to members with Medicare coverage)

| Benefit | Recommendation | FY08 Spend Waiver Adults | FY08 Spend All Adults | Recommendation Y = implement recommendation | | Gross Savings | | Offset due to alternative treatment cost | Offset due to adverse outcomes | Net savings | | |
|---------|------------------------------|--|--------------------------|---|---------------|---------------|-------------|---|--------------------------------------|---------------|-------------|-------------|
| | | | | Waiver Adults | All Adults | Waiver Adults | All Adults | | | Waiver Adults | All Adults | |
| | | | | Service Elimination | | | | | | | | |
| 1 | Emergency Dental Service | Eliminate emergency dental services (Dental office) | \$2,966,171 | \$8,020,437 | Y | Y | \$2,966,171 | \$8,020,437 | 25% | 15% | \$1,779,703 | \$4,812,262 |
| 2 | Emergency Dental Service | Eliminate emergency dental services (Clinics) ¹ | \$1,570,381 | \$4,640,853 | N | N | \$0 | \$0 | 0% | 0% | \$0 | \$0 |
| 3 | Medically Necessary Dentures | Through legislation, eliminate medically necessary dentures, including repairs on previously purchased dentures ² | \$19,406 | \$28,534 | Y | Y | \$19,406 | \$28,534 | 0% | 0% | \$19,406 | \$28,534 |
| 4 | Genetic Testing | Eliminate coverage of genetic testing | \$37,897 | \$203,576 | Y | Y | \$37,897 | \$203,576 | 2% | 2% | \$36,381 | \$195,433 |
| 5 | Orthotics | Eliminate coverage of orthotics | \$1,580,629 | \$3,665,774 | Y | Y | \$1,623,928 | \$3,649,599 | 10% | 10% | \$1,299,142 | \$2,919,679 |
| 6 | Insulin Pumps | Eliminate coverage of insulin pumps | \$219,167 | \$551,579 | Y | Y | \$219,167 | \$551,579 | 0% | 30% | \$153,417 | \$386,105 |
| 7 | Services by Podiatrist | Eliminate services provided by a podiatrist. | \$1,911,923 | \$4,533,703 | Y | Y | \$1,911,923 | \$4,533,703 | 60% | 15% | \$477,981 | \$1,133,426 |
| 8 | Percussive Vests | Eliminate coverage of percussive vests | \$7,475 | \$7,475 | Y | Y | \$7,475 | \$7,475 | 0% | 0% | \$7,475 | \$7,475 |
| 9 | Gastric Bypass Surgery | Eliminate coverage of gastric bypass surgery | \$7,741 | \$19,757 | Y | Y | \$7,741 | \$19,757 | 0% | 0% | \$7,741 | \$19,757 |
| 10 | Allergic Immunotherapy | Eliminate coverage of allergic immunotherapy (testing, treatment, injections) | \$502,278 | \$1,470,725 | Y | Y | \$502,278 | \$1,470,725 | 5% | 15% | \$401,822 | \$1,176,580 |

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| | Benefit | Recommendation | FY08 Spend Waiver Adults | FY08 Spend All Adults | Recommendation Y = implement recommendation | | Gross Savings | | Offset due to alternative treatment cost | Offset due to adverse outcomes | Net savings | |
|---|--|--|-----------------------------|--------------------------|---|---------------|---------------|-------------|---|--------------------------------------|---------------|-------------|
| | | | | | Waiver Adults | All Adults | Waiver Adults | All Adults | | | Waiver Adults | All Adults |
| 11 | Health Screening | Eliminate wellness exams. This does not exclude screening tests such as mamograms, pap smears, colonoscopies | \$2,346,751 | \$7,736,499 | Y | Y | \$2,346,751 | \$7,736,499 | 20% | 5% | \$1,760,063 | \$5,802,374 |
| 12 | Bone-Anchored Hearing Aid (BAHA) | Eliminate coverage of bone anchored hearing aid | \$12,079 | \$27,247 | Y | Y | \$12,079 | \$27,247 | 0% | 0% | \$12,079 | \$27,247 |
| 13 | Cochlear Implant | Eliminate coverage of cochlear implants | \$23,808 | \$160,980 | Y | Y | \$23,808 | \$160,980 | 0% | 0% | \$23,808 | \$160,980 |
| Limit amount, duration, or scope | | | | | | | | | | | | |
| 14 | Non-Emergency Transportation (Urban) | Eliminate non-emergency transport in urban areas for waiver group members only ³ | \$5,134,278 | \$20,651,274 | Y | N | \$5,134,278 | \$5,134,278 | 20% | 20% | \$3,080,567 | \$3,080,567 |
| 15 | Negative Pressure Wound Therapy | Improve medical necessity criteria and publish in AMPM to realize 25% gross savings. | \$1,213,997 | \$2,263,416 | Y | Y | \$303,499 | \$565,854 | 25% | 25% | \$151,750 | \$282,927 |
| 16 | Somnography | Limit to one study per contract year if criteria are met. Publish revised criteria in the AMPM. | \$1,305,271 | \$2,998,127 | Y | Y | \$262,116 | \$607,478 | 0% | 0% | \$262,116 | \$607,478 |
| 17 | Physical Therapy | Limit number of visits to 6 per member per year. | \$4,514,081 | \$9,659,236 | Y | Y | \$3,330,758 | \$6,811,378 | 10% | 25% | \$2,164,993 | \$4,427,396 |
| 18 | DME | Limit DME to Medicare-Covered Items Only | \$37,179 | \$99,510 | Y | Y | \$37,179 | \$99,510 | 20% | 0% | \$29,743 | \$79,608 |
| 19 | Prosthetics Excluding prosthetic implants ⁴ | Limit prosthetic benefit to \$12,500 per contract year | \$1,444,213 | \$4,036,157 | Y | Y | \$186,511 | \$511,798 | 0% | 0% | \$186,511 | \$511,798 |
| 20 | Transplants | See end notes for general and specific recommendations ⁵ | | | | | | | | | | \$4,000,000 |

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| Benefit | Recommendation | FY08 Spend Waiver Adults | FY08 Spend All Adults | Recommendation Y = implement recommendation | | Gross Savings | | Offset due to alternative treatment cost | Offset due to adverse outcomes | Net savings | |
|--------------|----------------|-----------------------------|--------------------------|---|---------------|---------------|--------------|---|--------------------------------------|---------------|--------------|
| | | | | Waiver Adults | All Adults | Waiver Adults | All Adults | | | Waiver Adults | All Adults |
| Total | | \$24,854,725 | \$70,774,859 | | | \$18,932,965 | \$40,140,407 | | | \$11,854,698 | \$29,659,626 |

End Notes

- 1) The FY 08 spend for this category primarily relates to IHS dental clinics and represents 100% Federal pass through. AHCCCS will pursue an exemption from CMS in order to continue services in this setting. If CMS does not allow an exemption, IHS dental clinics may lose approximately \$4 million.
- 2) Medically Necessary Dentures - Savings reflect current expenditures. Based on the Sharpe decision, total cost of dentures, if not eliminated, is expected to be \$25 mil
- 3) Non-Emergency Transportation (waiver only) - Implementation no sooner than 07-01-2010. Savings for this category relate only to waiver members. For purposes of this analysis Urban = Maricopa and Pima Counties.
- 4) Prosthetics (Excluding prosthetic Implants) - This category does not address implants related to dental, cochlear implants, or bone anchored hearing aids.
- 5) Transplants - All recommendations are awaiting comment from external consultants CYRCA.

General Recommendations:

1. Adopt more restrictive medical necessity criteria for all transplants. Due to high cost, high risk and poor outcomes coverage should be limited to those with the greatest expectation of a curative rather than a palliative outcome.
2. With the exception of kidneys, limit members to one transplant per covered organ.
3. With the exception of simultaneous pancreas/kidney, limit multi-organ transplants to covered organs as a single transplant.

Specific Recommendations

Pancreas Transplant: Limit coverage to simultaneous Kidney/Pancreas (SKP) transplant. Eliminate coverage for Pancreas only and Pancreas after Kidney (PAK). Scientific literature suggests the risk of SPK is substantially lower than PAK, and the effects of the multi-organ transplant, performed simultaneously, renders optimal clinical results.

Lung Transplant: Eliminate coverage. Scientific literature suggests lung transplant does not increase life expectancy over other treatments; Simply palliative

Hemopoetic Cell Transplant (HCT) Allogenic Unrelated: Eliminate coverage of all types (i.e. stem cell, cord blood, bone marrow). Scientific literature suggests no increase in life expectancy over other available treatment.

Heart Transplant: Eliminate coverage for non-ischemic cardiomyopathy (45% of all AHCCCS covered transplants). Scientific literature suggests outcomes are no better than less invasive treatment.

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| Benefit | Recommendation | FY08 Spend Waiver Adults | FY08 Spend All Adults | Recommendation Y = implement recommendation | | Gross Savings | | Offset due to alternative treatment cost | Offset due to adverse outcomes | Net savings | |
|---------|----------------|-----------------------------|--------------------------|---|---------------|---------------|------------|---|--------------------------------------|---------------|------------|
| | | | | Waiver Adults | All Adults | Waiver Adults | All Adults | | | Waiver Adults | All Adults |

Liver Transplant: Eliminate coverage for diagnosis of Hepatitis C.

**Benefit Re-design Worksheet
Financial Considerations
FY 08 - Adults 21+ (Exclude cost relat**

| | Benefit | Recommendation |
|----------------------------|------------------------------|--|
| Service Elimination | | |
| 1 | Emergency Dental Service | Eliminate emergency dental services (Dental office) |
| 2 | Emergency Dental Service | Eliminate emergency dental services (Clinics) ¹ |
| 3 | Medically Necessary Dentures | Through legislation, eliminate medically necessary dentures, including repairs on previously purchased dentures ² |
| 4 | Genetic Testing | Eliminate coverage of genetic testing |
| 5 | Orthotics | Eliminate coverage of orthotics |
| 6 | Insulin Pumps | Eliminate coverage of insulin pumps |
| 7 | Services by Podiatrist | Eliminate services provided by a podiatrist. |
| 8 | Percussive Vests | Eliminate coverage of percussive vests |
| 9 | Gastric Bypass Surgery | Eliminate coverage of gastric bypass surgery |
| 10 | Allergic Immunotherapy | Eliminate coverage of allergic immunotherapy (testing, treatment, injections) |

| Rationale for offset due to alternative treatment cost | Rationale for offset due to adverse outcomes |
|---|--|
| More beneficiaries will visit the ER with severe pain, increasing ER workload. | Some beneficiaries will go without care. Within this group some will recover, whereas others will need some form of medical treatment as their condition exacerbates. Some expensive medical events could occur. |
| See endnote #1 | See endnote #1 |
| No alternative benefit available. | No impact assumed. |
| No alternative benefit available, minimal offset | Benefit is more informational rather than therapeutic, thus offsets should be minimal. |
| Minimal cost shifting is expected. More beneficiaries may schedule appointments with providers. | Beneficiaries may develop more serious complications/conditions requiring more expensive care. Major high cost events are not expected. |
| Expect no offset because the cost of supplies related to insulin pumps are greater than the supply cost related to alternative treatments. | Expect some reduction in the quality of diabetic management (i.e. control), ultimately impacting overall health. Likely to result in some emergency admissions. |
| Elimination of "Podiatrist" as a covered provider type will likely shift podiatry services to alternative specialists (e.g. Orthopedists, Dermatologists, Vascular Surgeons). | Alternative specialists may not offer more routine, preventive foot care that is important to diabetics and those with vascular problems. This situation could increase concerns about individuals already at risk for vascular complications. |
| No alternative benefit available. | No impact assumed. |
| No alternative benefit available. | No impact assumed. |
| Expect increase in pharmaceuticals. | Beneficiaries with chronic respiratory conditions (e.g., asthma, COPD) may be adversely affected by elimination of this benefit. |

| | Benefit | Recommendation |
|---|--|--|
| 11 | Health Screening | Eliminate wellness exams. This does not exclude screening tests such as mamograms, pap smears, colonoscopies |
| 12 | Bone-Anchored Hearing Aid (BAHA) | Eliminate coverage of bone anchored hearing aid |
| 13 | Cochlear Implant | Eliminate coverage of cochlear implants |
| Limit amount, duration, or scope | | |
| 14 | Non-Emergency Transportation (Urban) | Eliminate non-emergency transport in urban areas for waiver group members only ³ |
| 15 | Negative Pressure Wound Therapy | Improve medical necessity criteria and publish in AMPM to realize 25% gross savings. |
| 16 | Somnography | Limit to one study per contract year if criteria are met. Publish revised criteria in the AMPM. |
| 17 | Physical Therapy | Limit number of visits to 6 per member per year. |
| 18 | DME | Limit DME to Medicare-Covered Items Only |
| 19 | Prosthetics Excluding prosthetic implants ⁴ | Limit prosthetic benefit to \$12,500 per contract year |
| 20 | Transplants | See end notes for general and specific recommendations ⁵ |

| Rationale for offset due to alternative treatment cost | Rationale for offset due to adverse outcomes |
|---|---|
| Expect increase in other physician visits. | Some impact related to delayed diagnoses (i.e. diagnoses that may be made at time of well visit). |
| No alternative benefit available. | No impact assumed. |
| No alternative benefit available. | No impact assumed. |
| Limit amount, duration, or scope | |
| Benefit coverage limited to rural members only. | Some impact on health status. Beneficiaries may forgo care due to lack of transportation. |
| Benefit coverage reduced to more cost-effective treatment plan via medical management. However, in some instances may result in surgery to repair wounds. | If wounds are not managed well may result in greater infections, office visits, and potential hospitalizations. |
| No alternative benefit available | Untreated sleep apnea may impact health status (e.g. lead to stroke, heart attack). |
| Benefit coverage reduced to limited number of visits; Additional visits not covered. | Minimal impact on health status. |
| Benefit coverage reduced to most economical items; but alternative DME may be purchased. | None anticipated |
| No impact assumed | No impact assumed; Members will receive more economical items. |
| | |
| | |