ACCESS TO CARE 2015 PROJECTION FOR FFY 2016

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INTRODUCTION

As AHCCCS looks to the upcoming contract year, the adequacy of the provider network is a major consideration in rate-setting. Statutory requirements in section 1902(a)(30)(A) of the Social Security Act direct the State to have "methods and procedures . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

This report will take a multi-faceted look at the main issues that affect access to care:

- AHCCCS Membership
- Arizona Economy
- Provider Population
- Provider Rates
- Managed Care Oversight
  - Provider Network Requirements
  - Quality Management

AHCCCS MEMBERSHIP

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 families. Since 1982, when it became the first statewide Medicaid managed care system in the nation, AHCCCS has operated under a federal Research and Demonstration 1115 Waiver which allows for the operation of a total managed care model.

AHCCCS selects contracted managed care organizations (MCOs) via a highly competitive request for proposal (RFP) process. Prospective capitation payments are made to the MCOs which are responsible for the delivery of medically necessary care to members. The result is a managed care system that mainstreams recipients, allows them to choose their providers, and encourages quality care and preventive services.

AHCCCS enrollment reached a historical peak of 1,369,637 members at July 1, 2011. Effective on that date, AHCCCS implemented an enrollment freeze on waiver members, which was followed by several years of decreasing membership. In January 2014, Governor Brewer's Medicaid Restoration Plan became effective. Under that plan, coverage was restored for childless adults under 100% of the Federal Poverty Level (FPL) formerly covered under the 1115 waiver for whom enrollment had been frozen. Coverage for new adults between 100-133% FPL also became effective on January 1, 2014. As a result, AHCCCS enrollment reached a

new peak of 1,552,186 members by July 1, 2014, and has continued to increase. As of May 2015, AHCCCS enrollment stood at 1,680,606 members.

AHCCCS Acute Care

The majority of Acute Care Program recipients are children and women who qualify for the federal Medicaid Program (Title XIX). While most AHCCCS members are required to enroll in contracted health plans, American Indians and Alaska Natives in the Acute Care Program may choose to receive services through the American Indian Health Program, AHCCCS' fee-for-service program. AHCCCS also administers an emergency services program for individuals who, but for immigration status, would qualify for full AHCCCS benefits.

ALTCS

The Arizona Long Term Care System (ALTCS) provides acute care, behavioral health, long-term care, and case management services for individuals who are elderly, who have a physical disability, or who have a developmental disability, and who meet the criteria for institutionalization. While ALTCS members account for less than 3.5% of the AHCCCS population, ALTCS services account for approximately 17% of AHCCCS expenditures. The ALTCS program encourages delivery of care in alternative residential settings. As in the Acute Care Program, ALTCS members of all ages receive care through contracted health plans.

KidsCare

The Children's Health Insurance Program (CHIP), known as KidsCare in Arizona, offers affordable insurance coverage for low income families. Children under age 19 may qualify for the program if their family's income exceeds the limit allowed for Medicaid eligibility, but is below 200% of the FPL. An enrollment freeze has been in place since January 2010. Federal authority under the 1115 demonstration allowed for temporary KidsCare coverage, but this authority expired in 2014 with the start date for the Federally Facilitated Marketplace. As of May 1, 2015, KidsCare enrollment was approximately 1,235. Families with incomes exceeding the limits for Medicaid eligibility can apply for subsidies on the Marketplace. The KidsCare numbers are lower due in part to shifting children to SOBRA.

Additional Program Detail

AHCCCS administers a Freedom to Work Program and a Breast and Cervical Cancer Treatment Program. These are considered Acute Care programs and included in Acute Care Program enrollment numbers.

Membership Fluctuations

Throughout the enrollment changes and membership fluctuations described above, there were no access to care issues. Since the AHCCCS provider network continues to grow, AHCCCS has not experienced any access to care issues despite the record member enrollment.

ARIZONA ECONOMY

In order to understand access to care for AHCCCS members, it is helpful to review the environment in which the Arizona health care delivery system operates and some of the challenges to be faced in 2016.

Employment

According to the U.S. Bureau of Labor Statistics the Arizona unemployment rate was 6.2% in March of 2015, down from 7% a year earlier. While the employment picture has improved, Arizona continues to add jobs at a slower rate than the nation overall, as the national unemployment rate for March 2015 was 5.5%. A report published by the Arizona Department of Administration (ADOA) in February 2015 suggests a positive trend, projecting that Arizona will add 120,000 jobs in both 2015 and 2016.

All major sectors of the Arizona economy are projected to gain jobs in 2015 and 2016. The ADOA expects the largest growth to come from the Education and Health Services sectors, estimating almost 30,000 jobs to be added by 2016. The state is still looking to recover all of the jobs lost in the great recession – approximately 74% of those jobs had been recovered as of December 2014.

Real Estate

Real Estate has historically been the driving force behind Arizona's economic growth. The housing market has slowed down in much of the nation and the same is true for Arizona. In a report published in January 2015, Wells Fargo states that home sales in Arizona were down more than 5% from January 2014. Though the report projects home prices to slightly increase above the current 3.5% yearly growth, it does not anticipate a significant uptick in new home construction.

State Budget

The Arizona Joint Legislative Budget Committee (JLBC) reports that, as of May 2015, State Fiscal Year (SFY) 2015 general fund ongoing revenues, excluding urban revenue sharing and one-time transfers, were 6.5% greater than SFY 2014. Collections for sales tax, individual income tax, and corporate income tax increased by 4.0%, 8.5% and 14.8% respectively. Through May 2015, JLBC reports that revenue collections are $257 million higher than the enacted budget forecast.

Despite Arizona's improved general fund revenues, the state faces uncertainty due to current litigation. Of particular budgetary significance is a lawsuit relating to K-12 education funding. If the state fails to prevail in that matter, Arizona will be required to provide an additional $262 million for education in SFY 2016, with the amount increasing slightly each year thereafter.

PROVIDER RATES

In March 2015 the legislature passed Senate Bill 1475, which authorized AHCCCS to reduce provider reimbursement rates up to 5% in aggregate for dates of service October 1, 2015 through September 30, 2016. In this process, the legislature also authorized the agency to account for changes in utilization that were less than the amounts appropriated, as long as the fiscal impact of final decisions on provider rates did not exceed the amount appropriated for capitation rates for fiscal year 2016.

On April 1, the agency opened up a public comment period seeking feedback on the impact a potential 5% rate reduction could have on providers. The agency reviewed comments submitted from 145 different providers and provider associations representing thousands of AHCCCS providers statewide. Based on the data and information provided through these public comments, along with lower than forecasted utilization and other available funding, AHCCCS has determined that no provider rate reductions are required at this time.

The AHCCCS reimbursement rate strategy for FFY 2016 will be a combination of budget-neutral updates on most fee schedules and selected rate increases on others, the increases being implemented in a stepped approach at October 1, 2015, January 1 and April 1 of 2016, as discussed in more detail below.

Hospital Reimbursement

Percentage of annual non-IHS reimbursements: Inpatient 16.1%, Outpatient: 12.0%

Fee-For-Service Reimbursements

Effective with dates of discharge on and after October 1, 2014, AHCCCS reimburses most inpatient hospital services under an All-Patient Refined Diagnosis Related Group (APR-DRG) methodology. The transition from tiered per diem reimbursement to the APR-DRG method was designed to be budget-neutral in aggregate for the population of impacted hospitals, and includes a two-year phase in of the fiscal impacts at the individual hospital level.

AHCCCS has retained the services of the Navigant Healthcare consulting group to complete a separate hospital-focused access to care study. Their report, *Arizona Medicaid Access to Hospital Care – 2014 Evaluation*, is available on the AHCCCS website. Following are selected key findings from the executive summary of that report:

- *From 2011 to 2013, the statewide number of hospitals with Arizona Uniform Accounting Reports (UARs) remained the same, the number of beds decreased slightly and the unused bed capacity increased slightly.*
- *Statewide aggregate hospital margin percentage and total net income increased from 2011 to 2013.*
- *There is no statistical relationship between hospital normalized costs and the key CMS quality measures.*

The last payment reduction by AHCCCS occurred in 2011. Since that time there have been no inpatient rate increases and a 1.2 percent outpatient fee schedule increase (on October 1, 2013). When pay-to-cost percentage estimates under current rates are considered along with our analysis of access to and quality of care, it does not appear that the overall payment levels have historically had a significant effect on access to quality hospital services in Arizona. It would be reasonable to assume that under current rates, access and quality will continue to be sufficient, and as such, it appears that the current payment system meets the Federal standards specified in 42 U.S.C. § 1396A(A)(30)(A).

For October 1, 2015, AHCCCS will update all APR-DRG reimbursement values for the second year of the phase-in transition. The update is projected to be budget-neutral in aggregate. In addition, for January 1, 2016, AHCCCS will update its existing pediatric policy adjustor to increase by 28% all reimbursements for high-acuity pediatric cases. This change is projected to add $20 million to inpatient hospital reimbursements on an annual basis.

Long-Term Acute Care Hospitals and Rehabilitation Hospitals

Medicaid utilization of Long-Term Acute Care Hospitals and Rehabilitation Hospitals was significantly impacted by benefit reductions implemented in FFY 2012. In particular, the 25-day limit on inpatient stays virtually eliminated these hospital types from active participation as Medicaid providers. Since the 25-day limit was lifted on October 1, 2014, AHCCCS has seen a surge in Medicaid utilization of LTAC and Rehab hospitals.

The APR-DRG method does not apply to LTAC and Rehab hospitals, which continue to be reimbursed on a per diem basis. For October 1, 2014, the per diem reimbursement rates for these hospitals were held constant. Though no access to care issues have resulted from that rate policy, information shared by members of this provider group during the public comment period has prompted AHCCCS to reassess the adequacy of the legacy per diem rates going forward.

For October 1, 2015, AHCCCS will update the rates for Rehab hospitals and begin a transition toward reimbursement rates that recognize the relative patient acuity in LTAC hospitals. The rate update is projected to be an increase of 1.1% in aggregate for the impacted hospitals, with no hospital ownership group experiencing a reimbursement decrease.

Organ Transplant Services

A small number of Arizona hospitals are certified to perform organ transplants, allowing AHCCCS members to remain in the state for needed services. Transplant hospitals contract directly with AHCCCS for reimbursement of transplant services; AHCCCS MCOs may also reimburse transplant services under these contracts. The organ transplant rates were increased by 3% at October 1, 2013, and by an additional 2.57% at October 1, 2014. For October 1, 2015, the transplant rates will remain at their current levels as no access to care issues have been identified.

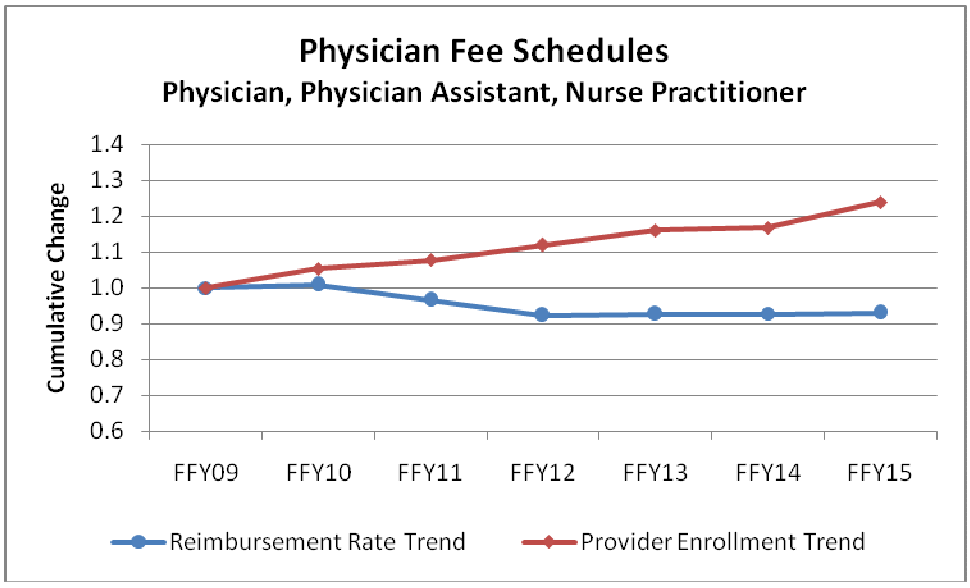
Physician Fee Schedules

Percentage of annual non-IHS reimbursements: 23.8%

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 have experienced budget-driven reductions since 2009. Throughout that period, the AHCCCS provider network has remained sufficient in number and availability, and the provider types delivering primary care services have steadily increased, as illustrated below.

Physicians and Other Practitioners

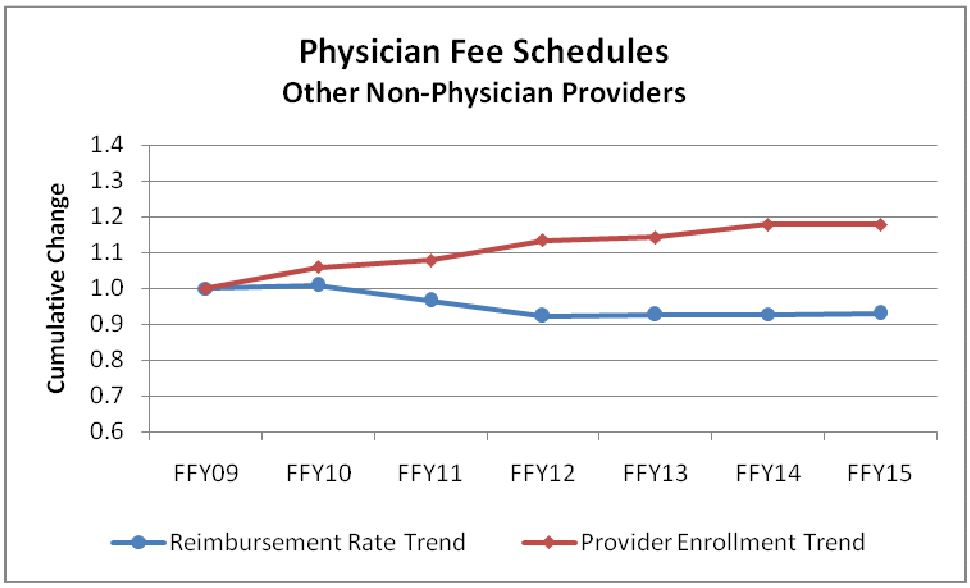
This group of reimbursement rates includes physician and other practitioner rates based on the National Relative Value Scale, the physician drug schedule, and the anesthesia conversion factor. More than 90% of the annual provider reimbursements based on these rates cover services provided by physicians, physician assistants, and nurse practitioners. The number of AHCCCS-enrolled providers of those types has increased each year since 2009, even through years of reimbursement rate reductions. The chart below illustrates the rate trend over several years compared to the number of enrolled providers of these types.



The primary care practitioner enhanced fee schedule mandated by ACA Sec. 1202 was discontinued effective January 1, 2015. As of April 1, 2015, AHCCCS has not experienced a decrease in the number of enrolled physicians, physician assistants, or nurse practitioners. 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 include physical therapists, clinics, nurse anesthetists, optometrists, speech/hearing therapists and nurse-midwives. AHCCCS enrollment of these provider types has increased year over year,

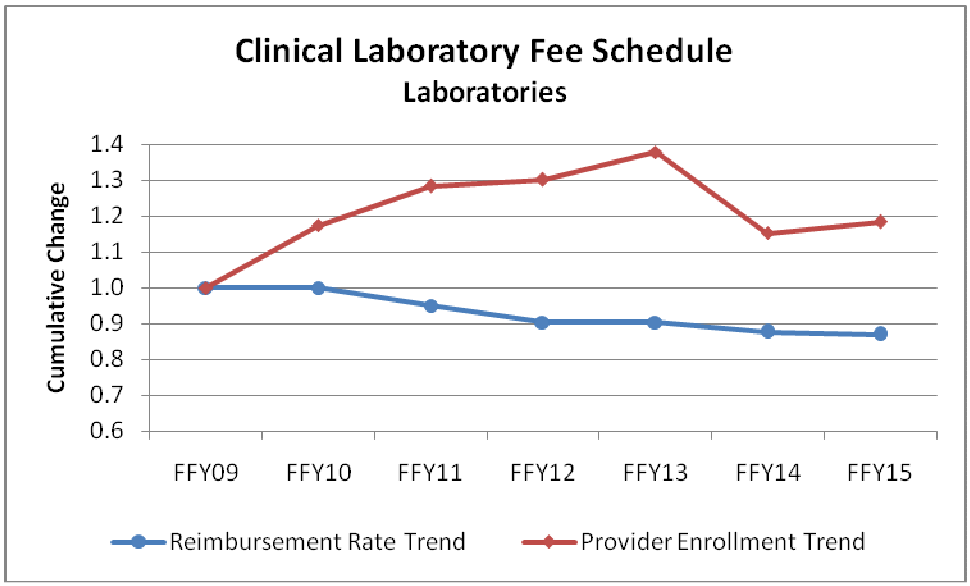
even through years of rate reductions. The chart below illustrates the rate trend over several years compared to the number of enrolled providers of these types.



For October 1, 2014, AHCCCS implemented an update to these rates that was budget-neutral in aggregate, except for the drug schedule which increased slightly. There have been no access to care issues during this fiscal year. For October 1, 2015, AHCCCS will again adopt a budget-neutral update to the RVU-based rates. The update to the Physician Drug Schedule is projected to be an increase of 2.3%.

Clinical Laboratory and Pathology

The AHCCCS clinical laboratory and pathology rates are based on the corresponding Medicare fee schedule. Nearly 93.5% of the provider reimbursements from this fee schedule are to independently enrolled laboratories. Recent years have seen a decrease in the number of in-state providers simultaneous with an increase in out-of-state providers, with no negative impact on access to laboratory services for AHCCCS members.



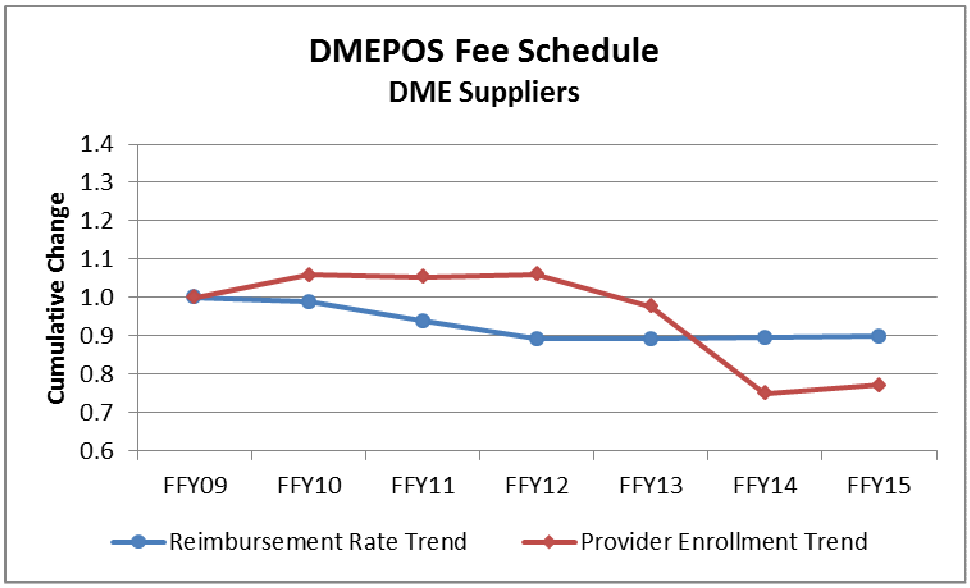
At October 1, 2014, AHCCCS set its rates for this fee schedule at 86.5% of the Medicare rates, and had no access to care issues. For October 1, 2015, the clinical laboratory and pathology fee schedule will again be indexed to the Medicare fee schedule and updated for a 0% aggregate fiscal impact.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

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. Among the factors influencing the trend is the Medicare DMEPOS Competitive Bidding Program.

AHCCCS has seen an upward trend in claims per year by this provider type -- an increase of 6% from FFY 2010 to FFY 2014, compared to an increase of 3.7% in AHCCCS membership during the same time period. The two trends together illustrate that there are no access to care issues for AHCCCS members.



At October 1, 2014, AHCCCS set its rates for this fee schedule at 83.5% of the Medicare rates, and had no access to care issues. For October 1, 2015, the DMEPOS fee schedule will again be indexed to the Medicare fee schedule and updated for a 0% aggregate fiscal impact.

Comparison to Medicare

A 2012 study by the Kaiser Commission on Medicaid and the Uninsured (KCMU) placed Arizona in the middle tier of their Medicaid-to-Medicare rate comparison, having reimbursement rates that compared to Medicare in the range of 76% to 85%. Nevada, Utah and Colorado all placed a tier below Arizona, and California placed in the lowest tier. The following summary information was taken from the KCMU report:

Medicaid-to-Medicare	Western States
> 100%	WY
86% - 100%	ID, MT, NM
76% - 85%	AZ, OR, WA
61% - 75%	CO, NV, UT
60% or less	CA

The AHCCCS Physician Fee Schedules established at October 1, 2014, excluding the ACA Sec. 1202 enhanced fee schedule rates and the anesthesia conversion factor, were in aggregate 82% of the Medicare rates for Arizona. This continues to rank as average among the western states generally, and favorable by comparison to neighboring states. In this reimbursement rate position, the AHCCCS provider population continues to grow.

Distinct from many of the western state Medicaid programs, AHCCCS sets its anesthesia rate independent of the corresponding Medicare rate, having in 2005 indexed the rate to the commercial market. Though the anesthesia rate has since been reduced three times with the budget-driven rate reductions, the AHCCCS anesthesia rate continues to compare favorably to

other states as well as to Medicare. The chart below illustrates the comparison with selected states, using information obtained from a report by the American Society of Anesthesiologists.

Anesthesia Conversion Factor	AZ	CO	ID	NM
Medicaid vs Commercial	42.4%	31.5%	23.6%	28.2%
Medicare vs Commercial	34.1%	34.8%	32.5%	34.5%
Difference	**8.3%**	**-3.3%**	**-8.9%**	**-6.3%**

Benchmark: The AHCCCS Physician Fee Schedule rates are, in aggregate, 82% of the Medicare rates, and the Anesthesia Conversion Factor is 8.3% better than the Medicare rate when compared to commercial insurance rates.

Home and Community-Based Services Fee Schedules

Percentage of annual non-IHS reimbursement: 14.1%

Medicaid is the primary – in most cases, the only – payer for in home care agencies. This means that AHCCCS rates can be the determining factor in whether these organizations exist and whether there will be enough providers to provide adequate access to care.

As the Arizona economy continues to improve, HCBS providers 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 ACA employer mandate became effective January 1, 2015 for businesses with 100 or more employees, and is scheduled to take effect on January 1, 2016 for businesses with 50 or more.

There are two groups of AHCCCS members who receive HCBS services: 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). While AHCCCS sets HCBS rates for the EPD population, DDD has its own fee schedule for HCBS services.

For the reasons stated above, AHCCCS increased EPD HCBS rates by 2.0% at October 1, 2014. That increase followed a 1.5% cost of living adjustment for rates effective October 1, 2013. The rate increases helped to continue the availability of HCBS services for AHCCCS members by supporting the HCBS provider network; these services are less expensive than the institutional services that would otherwise be required.

Senate Bill 1475, in authorizing AHCCCS to reduce provider rates up to 5%, exempted HCBS providers from the reduction. As stated above, AHCCCS will not be implementing rate reductions for fiscal 2016 and, as part of its reimbursement rate strategy for 2016, will increase HCBS rates another 1.5%.

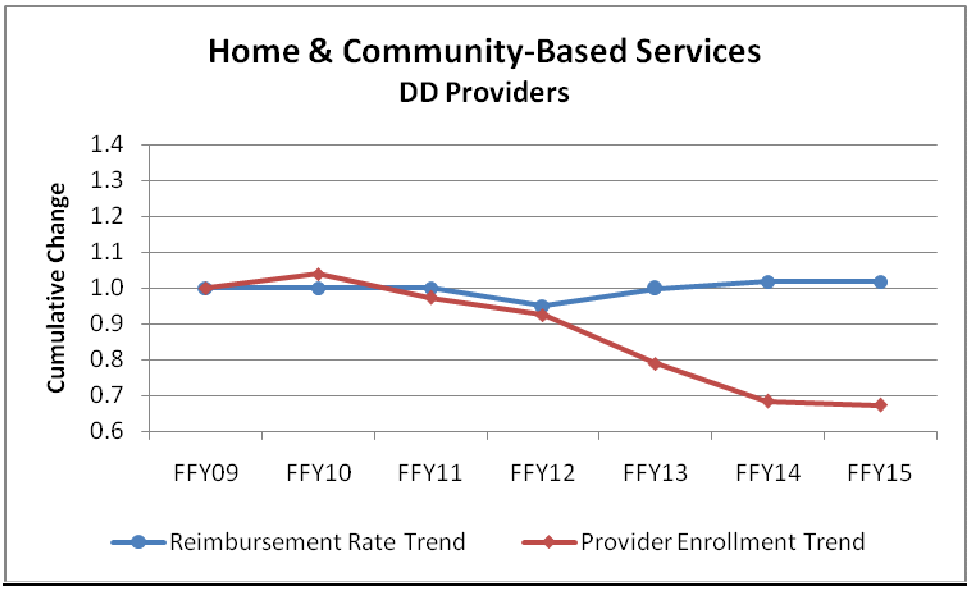
Division of Developmental Disabilities
Percentage of annual non-IHS reimbursement: 7.4%

DDD services help eligible individuals with developmental disabilities achieve self-sufficiency and independence through supports for family members and other caregivers. Because the division aims to support members in integrated community settings, the majority of the division's programs and services are tailored to meet individual needs in home and community environments. Currently, over 99% of DDD members reside in HCBS settings.

DDD maintains a list of Qualified Vendors who are independent providers that members seeking services can use. If a member elects, he can request DDD to issue a 'vendor call' to identify additional providers who can meet the individual member's needs. This strategy was designed to allow DDD to attain a large vendor network to ensure adequate and timely services to its members.

The reimbursement rates established by DDD are based on annual rate studies subject to legislative appropriations.

More than 98% of the total annual reimbursements for these services are for habilitation providers and home health agencies. The chart below indicates a downward trend in the number of habilitation providers, and this is largely due to provider consolidation. There has been an upward trend in claims per year for these provider types, increasing 38% from FFY 2010 to FFY 2014 compared to a 10.6% increase in ALTCS enrollment during the same time period.

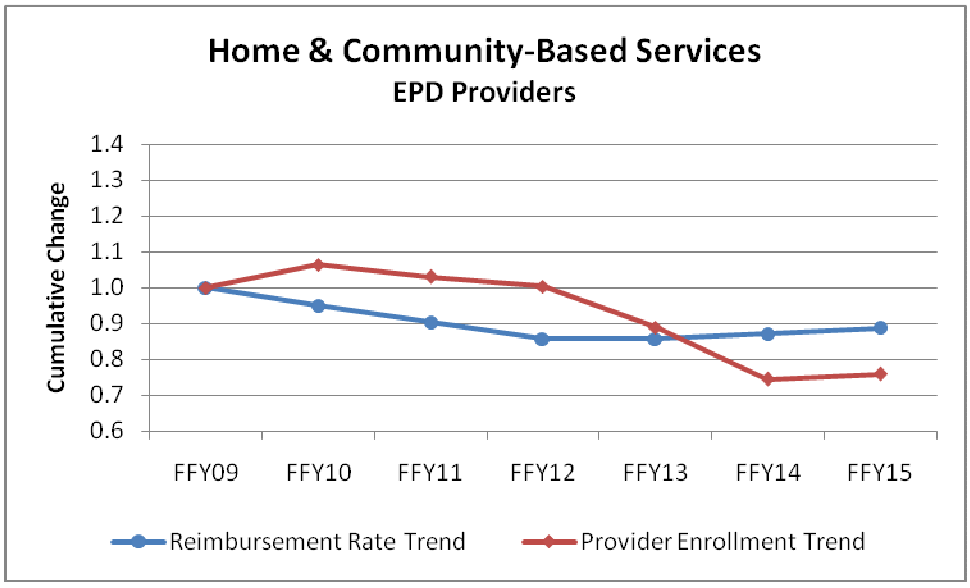


DDD reimbursement rates were increased by 2% on April 1, 2013, by another 3% on July 1, 2013, and again by 2% on July 1, 2014. For October 1, 2015, the rates will be increased by another 1.5%.

Elderly and Physically Disabled
Percentage of annual non-IHS reimbursement: 6.7%

The EPD program is for individuals who are 65 or older, blind, or disabled and need ongoing services at an institutional level of care. This program is designed to encourage participants to live in their own homes or in community assisted living facilities by providing needed in-home services. Seventy-three percent of EPD members live in home and community settings. A one percent shift in EPD members residing in nursing facilities rather than the less-costly home and community based alternatives would cost approximately $15 million.

Ninety two percent of the total annual reimbursements for these services are for attendant care providers, assisted living centers and homes, habilitation providers and home health agencies. There is an upward trend in claims per year by these provider types, increasing 33% from FFY 2010 to FFY 2014 compared to a 10.6% increase in ALTCS enrollment during the same time period.



EPD reimbursement rates were increased by 1.5% on October 1, 2013, and by another 2% on October 1, 2014. For October 1, 2015, the rates will be increased by another 1.5%.

Behavioral Health Fee Schedules
Percentage of annual non-IHS reimbursement: 12.5%.

Currently, the majority of behavioral health services for members in the Acute Care Program are managed through the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS). The services are provided through contracted Regional Behavioral Health Authorities (RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs). The T/RBHAs are contracted to administer managed care in six distinct geographic service areas throughout the state.

T/RBHAs are contractually required to provide prevention, treatment and rehabilitative services to the following populations:

- Children and Adolescents
- Adults with Serious Mental Illness (non-duals only effective October 1, 2015)
- Adults with General Mental Health disorders
- Adults with Substance Use disorders

Historically behavioral health services were a carve-out service funded separately from medical services. Effective April 1, 2015, the first integrated care contract was implemented between ADHS/DBHS and a RBHA wherein an adult with a diagnosis qualifying him to be in the population of "Adults with Serious Mental Illness" would receive both behavioral health and medical services from the same RBHA. Effective October 1, 2015, integrated care will be fully implemented across the state for the non-tribal population diagnosed with serious mental illness.

Also effective October 1, 2015, adult members treated for general mental health and substance abuse issues who are dually-eligible for Medicaid and Medicare will be fully-integrated to receive all services (physical and behavioral) through their Acute Care plans, which also participate as Duals Special Needs Plans for Medicare. For members who are aligned for Medicaid and Medicare with the same health plan, all of those members' services provided through both payer systems will be integrated. Non-dual adults and all children will continue to receive their behavioral health services through the T/RBHAs.

The services available within the BH system include: outpatient and inpatient treatment, substance abuse treatment, respite, counseling, medication management, case management, peer and family support services, psychosocial assessment and crisis services. Services provided are specific to the members' Individualized Service Plans.

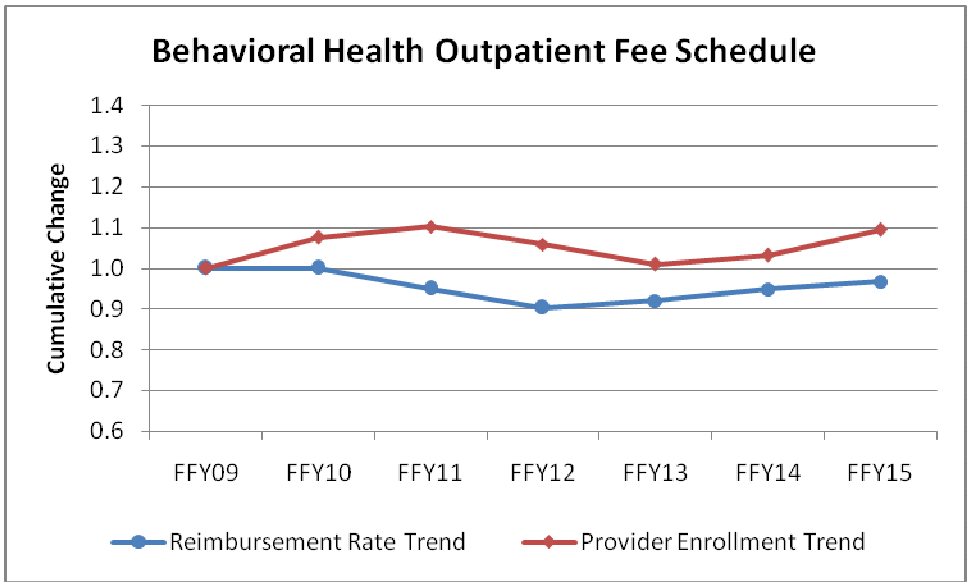
In previous years, reimbursement rates for behavioral health services were established by ADHS/DBHS subject to final approval by AHCCCS. State legislation passed during the 2015 legislative session merges DBHS into AHCCCS and thus transfers oversight and management of behavioral health services to AHCCCS effective July 1, 2016. In coordination with ADHS/DBHS, AHCCCS will assume immediate responsibility for the rate setting.

Outpatient
Percentage of total AHCCCS annual non-IHS reimbursement: 10.1%.

The behavioral health outpatient fee schedule, like most other provider fee schedules, 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.

More than 95% of the total annual reimbursement for outpatient services are to behavioral health outpatient clinics (67.5% of the total), behavioral health residential facilities,

community service agencies, behavioral health therapeutic homes and sub-acute facilities with 1 to 16 beds. There is currently an upward trend in the number of AHCCCS providers of these types. The chart below illustrates the rate trend over several years compared to the number of enrolled providers.



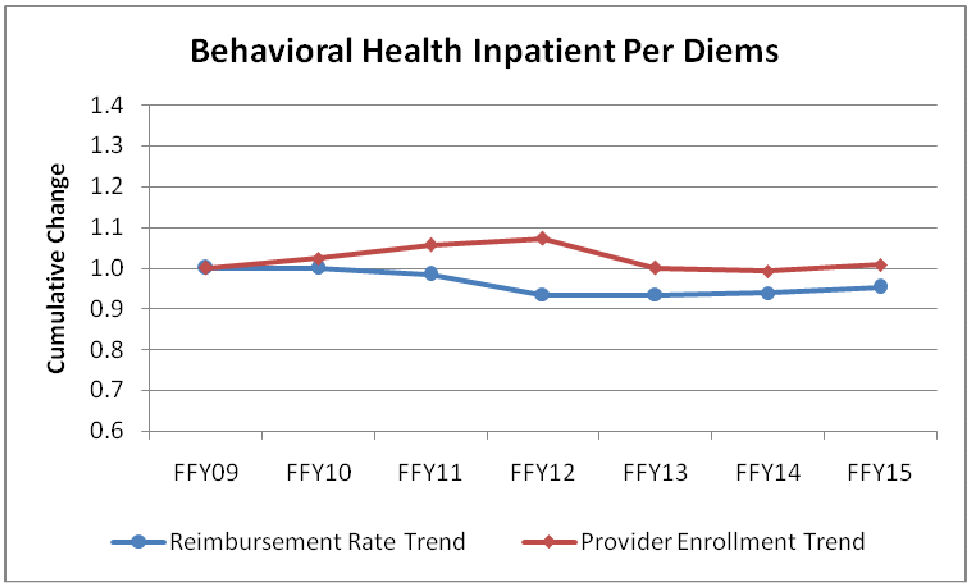
A comparison between the AHCCCS rates and the current market rates, as indicated by prevailing rates paid for services by the RBHAs, has shown that the AHCCCS behavioral health outpatient rates are on average 87% of the market. No access to care issues have been found at this rate level and, for October 1, 2015, these reimbursement rates will be held constant.

Benchmark: The AHCCCS behavioral health outpatient rates for FY 2016 will be, in aggregate, 87% of the weighted average rates paid by the RBHAs in FY 2015.

Inpatient
Percentage of total AHCCCS annual non-IHS reimbursement: 2.4%.

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.

More than 95% of the total annual reimbursements for inpatient services are to psychiatric hospitals, acute care hospitals, secure residential treatment centers with 17 or more beds and sub-acute facilities with 1 to 16 beds. The number of providers of these services has been relatively constant in recent years. The chart below illustrates the rate trend over several years compared to the number of enrolled providers of these types.



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 inpatient rates are on average less than 75% of the market. Though no immediate access to care issues are apparent, AHCCCS has adopted the preventive measure of moving its FFS rates closer to the prevailing rates. For that purpose, the October 1, 2015 AHCCCS inpatient behavioral health fee schedule will reflect an aggregate increase of 19.6%.

Benchmark: The AHCCCS behavioral health inpatient rates for FY 2016 will be equal to the weighted average rates paid by the RBHAs in FY 2015.

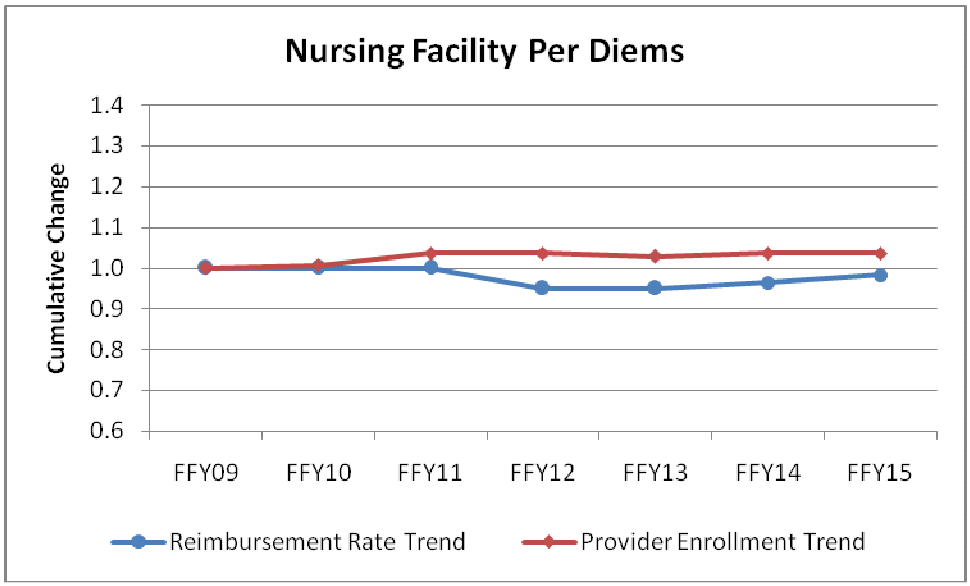
Nursing Facility Per Diem Rates

Percentage of annual non-IHS reimbursements: 8.5%.

Nursing facilities are the only providers reimbursed by the AHCCCS Nursing Facility Per Diem rates. AHCCCS sets reimbursement rates for three levels of care, with distinct rates for urban and rural providers.

These providers may also be separately reimbursed for covered services not included in the per diem rate. Separate reimbursement outside the per diem accounts for less than 0.2% of the total nursing facility expenditure, indicating that the per diem rates as established are adequate to cover most services performed.

Along with other provider rates, nursing facility rates were reduced by 5% for FY 2012. The rates have since received two increases – 1.5% for FY 2014 and 2% for FY 2015 – to recover a portion of the lost rate level. Although this provider type experiences frequent changes in ownership, the number of enrolled nursing facility providers has remained constant since 2011.



State legislation passed in 2012 established a provider assessment on nursing facilities. The monies collected through this assessment are matched with federal dollars and distributed to the nursing facilities in the form of supplemental funding. The supplemental payments totaled $49.5 million in contract year 2013, and $50.9 million in contract year 2014. Following an increase in the assessment, nursing facilities could expect to receive approximately $70 million in contract year 2015.

AHCCCS works closely with the Arizona Health Care Association which represents nursing facilities, keeping close touch with the industry through regularly scheduled meetings.

In June 2015, there were 144 licensed nursing facilities in Arizona; 133 (92%) of these are AHCCCS registered providers providing services to AHCCCS members. Arizona nursing facilities reported for 2013 an average occupancy rate of 72.5%, a slight increase over the 2012 average of 71.7%. Despite the increase, Arizona's occupancy rate for nursing facilities remains low compared to the national average. The general availability of nursing facility beds will keep AHCCCS rates adequate to maintain the network of providers.

Since October 1, 2011, the weighted average per diem rate paid to AHCCCS enrolled nursing facilities has increased more than 5%. The current weighted average rate for Arizona is $160.17, which compares well to the neighboring states of New Mexico and Nevada, with average rates of $155.34 and $161.58 respectively.

No access to care issues are apparent with respect to nursing facility services. For FY 2016, the AHCCCS nursing facility rates will remain unchanged.

Benchmark: The AHCCCS weighted average nursing facility per diem rate in FY 2015 was 3% above the neighboring state of New Mexico, and on par with the neighboring and similar state of Nevada.

Transportation Fee Schedules

Percentage of annual non-IHS reimbursements: 5.0%

AHCCCS establishes reimbursement rates for air ambulance services and for ground ambulance services provided by out-of-state companies, companies operated by American Indian tribes, and federal agencies such as the National Park Service that operates ambulances in Grand Canyon National Park and Lake Meade National Recreation Area.

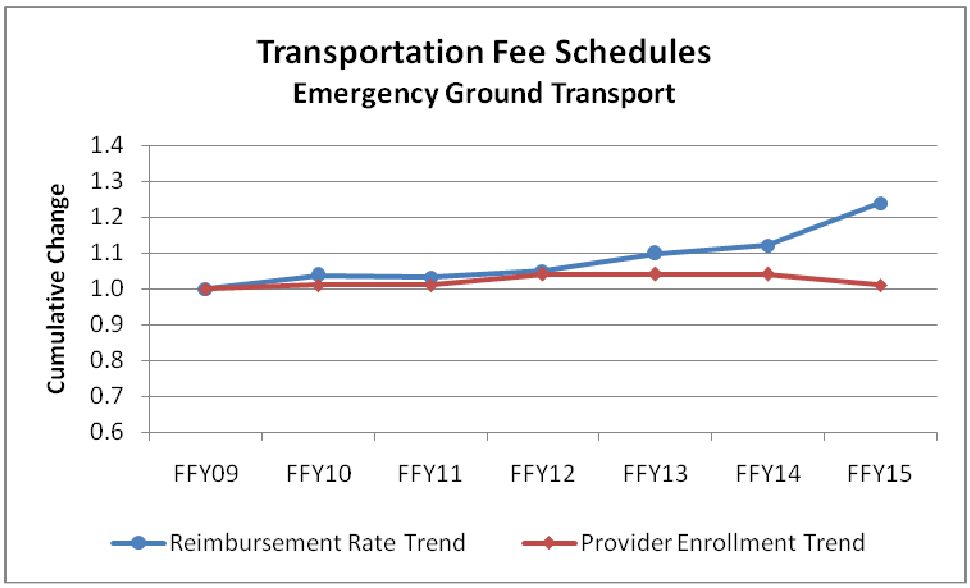
Emergency Ground Ambulance

Percentage of annual non-IHS reimbursements: 1.8%

More than 98.5% of the total annual reimbursement for these services are to emergency ground ambulance providers operating under a Certificate of Necessity issued by the Arizona Department of Health Services, Bureau of Emergency Medical Services (ADHS). Under state law, AHCCCS sets its rates for these providers as a percentage of the fee schedule established by ADHS.

The percentage applied effective October 1, 2015 will be 68.59% pursuant to legislation passed in March 2015. This is a decrease of 8.2% from the previous year's percentage of 74.74%. However, due to rate increases regularly granted by ADHS, AHCCCS estimates that the true impact of the legislation on related expenditures will be a decrease of 4.5%. Moving forward, rates paid by AHCCCS for emergency ground transportation will continue to compare favorably to rates paid by Medicare and by neighboring states.

The number of enrolled in-state emergency ground ambulance providers has remained relatively constant over the past six years. AHCCCS does not anticipate any access to care issues.



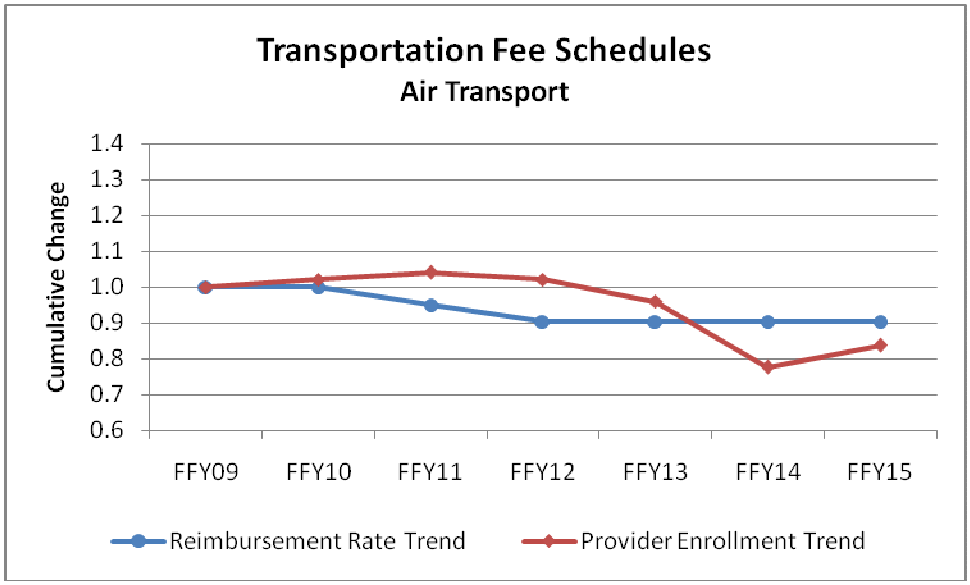
Benchmark: For basic life support and advanced life support transportation services, AHCCCS rates are on average 52% higher than Medicare. For transportation mileage, AHCCCS rates are on average 53% higher than Medicare.

Air Ambulance
Percentage of annual non-IHS reimbursements: 0.3%

Air Ambulance rates were initially established based on a study of air ambulance costs and have been adjusted as needed based on the Consumer Price Index for Other Medical Professionals, the CPI for Transportation, and the Federal Aviation Administration forecast of jet fuel prices.

AHCCCS air ambulance rates have historically been much lower than Medicare's rates, and are currently at about 50% of the Medicare rates. The air ambulance rates were subject to budget-driven reductions between fiscal years 2009 and 2012, and have remained constant since. AHCCCS studied reimbursement rates paid for air ambulance services in seven other western states and found that rates paid by AHCCCS are, on average, lower than the rates paid by six out the seven states surveyed.

Information shared by members of this provider group, in discussions with AHCCCS and during the public comment period mentioned above, indicates that air ambulance providers are beginning to feel the pressure of increasing costs for equipment, training and regulatory compliance. In light of this, AHCCCS plans to conduct an in-depth study of the air ambulance cost and reimbursement environment, with the goal of making a final determination after the first of the year on possible rate adjustments for this fee schedule. For October 1, 2015, the AHCCCS air ambulance fee schedule rates will remain unchanged.

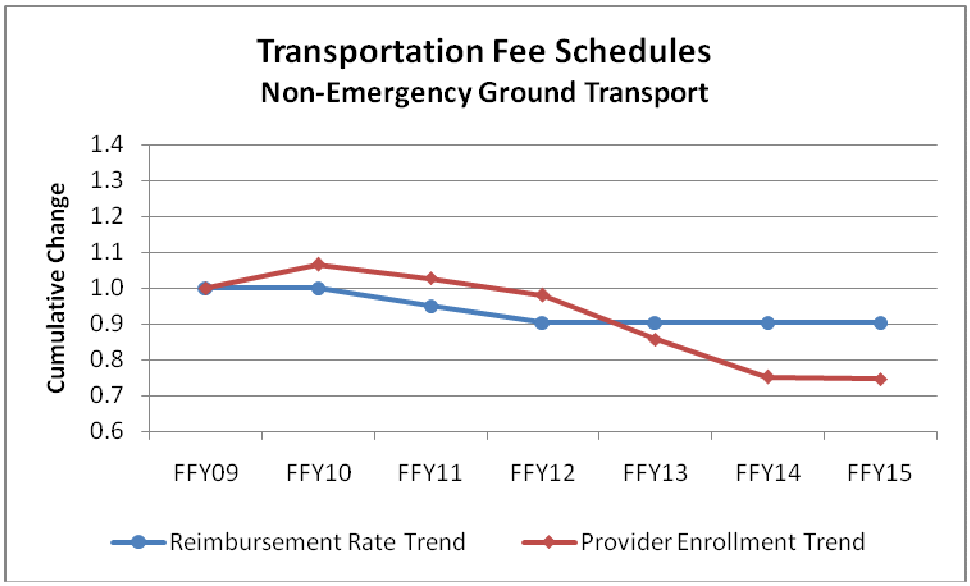


Benchmark: AHCCCS air ambulance rates are currently 50% of the Medicare rates, and are lower than six out of seven western states.

Non-Emergency Ground Transportation
Percentage of annual non-IHS reimbursements: 2.9%

AHCCCS reimburses NEMT services on a fee-for-service basis, and covers transportation by taxi, mini-bus, wheelchair van, and stretcher van in addition to non-emergency ambulance services. Among the western states, only Colorado reimburses this same range of services on a fee-for-service basis. AHCCCS rates were initially established based on the average reimbursement rates paid by commercial insurance companies and are adjusted as needed based on the Consumer Price Index for Medical Services, the Consumer Price Index for Other Medical Services and the price of gasoline in Arizona.

More than 98.5% of the total annual reimbursements for these services are to non-emergency transportation providers (67% of the total), behavioral health outpatient clinics, habilitation providers, school based bus transportation and attendant care providers. The chart below illustrates the rate trend over several years compared to the number of enrolled providers of these types.



AHCCCS NEMT rates were subject to budget-driven reductions between fiscal years 2009 and 2012, and have remained constant since. No access to care issues have arisen.

AHCCCS surveyed non-emergency transportation rates paid by other western states and, where direct rate comparisons were possible for non-ambulance NEMT services, observed that Arizona's rates are consistent with the average. For non-emergency ambulance services, AHCCCS reimburses more per unit than any other state surveyed and 52% more than the next highest state.

Non-Emergency Ambulance

	AZ	NV	OR	NM	CA	CO
Weighted Average Rate	$279.03	$183.23	$144.05	$139.33	$107.16	$100.29

Benchmark: In FY 2015, the weighted average AHCCCS rate for non-emergency transportation was 52% higher than the neighboring state of Nevada. For other NEMT services, the AHCCCS rates were average among western states that offer the same services.

Federally Qualified Health Centers

Percentage of annual non-IHS reimbursements: 3.7%

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (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 this invaluable service is provided throughout the state of Arizona in both rural and urban areas.

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
FQHCs	14	16	16	17	18	19	21
FQHC-LAs	1	2	2	2	1	1	2
RHCs	5	6	8	9	10	8	8
Total	**20**	**24**	**26**	**28**	**29**	**28**	**31**

The total shown for FY 2015 represents 158 separate sites of service available to AHCCCS members throughout the state.

The Health Resources and Services Administration annually publishes statistics on FQHC operations, though the 2014 statistics were not yet available as of this writing. The following table contains information from 2013 and illustrates a steady growth trend in utilization of FQHC services.

	2009	**2010**	**2011**	**2012**	**2013**
Number of Patients	376,081	384,287	408,737	423,160	438,260
Number of Encounters	1,353,640	1,421,257	1,459,520	1,572,634	1,635,078
Total FTEs	2,705	2,955	3,155	3,345	3,481
Physician FTEs	208	223	234	236	238
NP, PA, and CNM FTEs	106	124	135	145	164
Dental Services FTEs	157	178	192	217	226

The ability of FQHCs to absorb more patients is supported by their staffing ratios. Total FTEs per patient and practitioner FTEs per patient increased in each of the last four years shown, and increased by 10.4% and 14.4% respectively from 2009 to 2013. It is expected that the existing centers will increase access to care for Medicaid members.

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.

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, the rates will again be adjusted by the CPI-PSI, estimated at this time to be an increase of more than 2%.

Benchmark**:** The AHCCCS statewide average PPS rate is $209.67. The statewide average BIPA PPS rate is $158.82. The average AHCCCS PPS rate is 75.74% higher than the average BIPA PPS rate.

Dental Services Fee Schedule

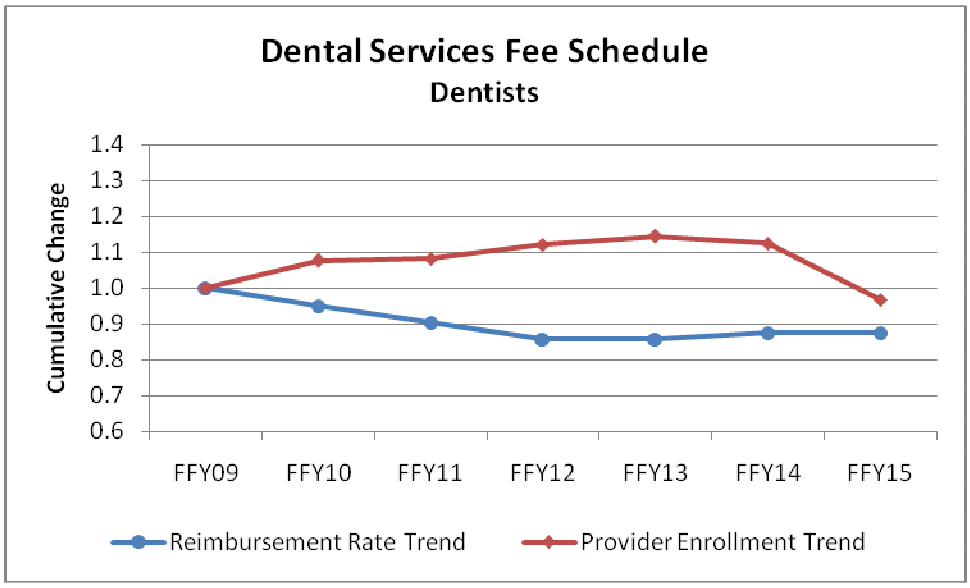
Percentage of annual non-IHS reimbursements: 2.6%

With a state population of more than 6.6 million, Arizona has 1 dentist for every 1,761 residents. By comparison, the AHCCCS program has 1 enrolled dentist for every 1,279 members, 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." While these numbers are state-wide averages, and the dentist-to-member ratio does vary among the regions of the state, the AHCCCS managed care contracts ensure the closest possible access to dental providers for AHCCCS members.

The AHCCCS Dental Fee Schedule is based on the bi-annual ADA Survey of Dental Fees, using the average fees among the western states. The last time the AHCCCS rates were indexed to that survey was 2007. Following that, dental rates experienced three budget-driven reductions, in fiscal years 2009, 2011 and 2012. 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 FY 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.

More than 99% of the total annual reimbursements for dental services are made to dentists. The remainder of the dental services are rendered by several provider types, including physicians and dental hygienists. The chart below illustrates the rate trend over several years compared to the number of enrolled dentists.



For FY 2016, dental rates paid by AHCCCS will be updated in a budget-neutral fashion, indexing rates to the *American Dental Association 2013 Survey of Dental Fees*. AHCCCS has not historically experienced access to dental care issues for its members, and does not anticipate an access to care issue in FY 2016.

Bi-annually, the ADA gathers information from dentists across the nation regarding their customary fees for services rendered. AHCCCS performed a study comparing Medicaid dental rates paid by eight western states to the latest dental fees survey published by the ADA. Arizona compares favorably to most other seven states. The following table illustrates the findings.

Average Medicaid Rates versus 2013 ADA Survey Rates

WY	AZ	MT	NM	CO	UT	WA	OR
56.5%	52.8%	50.1%	45.9%	45.6%	36.1%	35.9%	35.8%

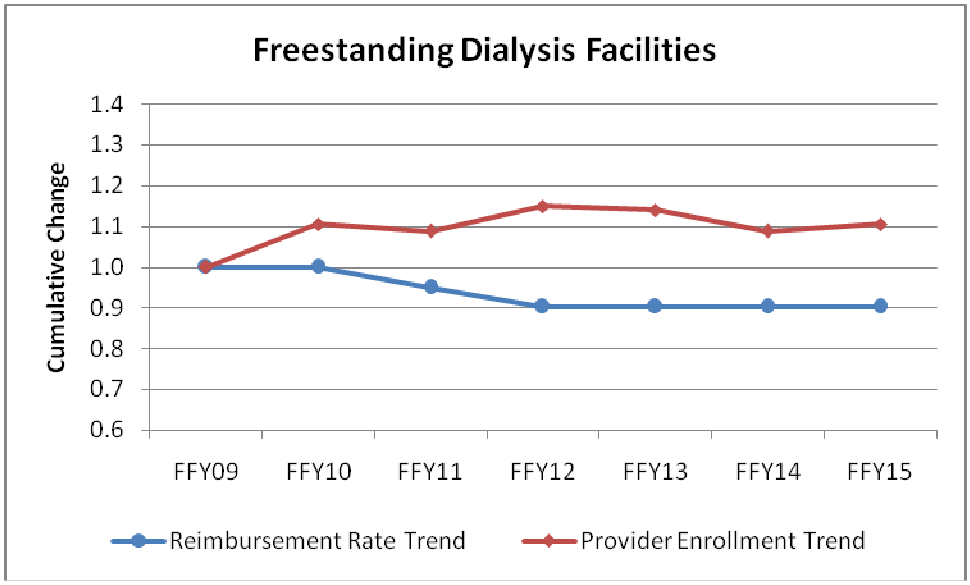
Benchmark: AHCCCS Dental Fee Schedule rates are, on average, 52.8% of the ADA surveyed fees for the western states and rank second out of eight states studied.

Freestanding Dialysis Facility Composite Rates

Percentage of annual non-IHS reimbursements: 0.8%

Freestanding dialysis facilities are reimbursed by composite rates which were last indexed to Medicare in 2004. These facilities may also be separately reimbursed for covered services not included in the composite rates.

The number of freestanding dialysis facilities enrolled with AHCCCS has remained relatively constant over several years and through budget-driven rate reductions.



Comparison of AHCCCS dialysis rates to Medicare, or to states that use the Medicare reimbursement method, is made difficult by the fact that AHCCCS does not use a case-mix adjusted methodology. The last comparison analysis was conducted in October of 2012. That study concluded that AHCCCS dialysis reimbursements were approximately 90% of Medicare. At that time, most other AHCCCS fee schedules were 85% - 86% of Medicare.

Ambulatory Surgery Center Fee Schedule
Percentage of annual non-IHS reimbursement: 0.6%

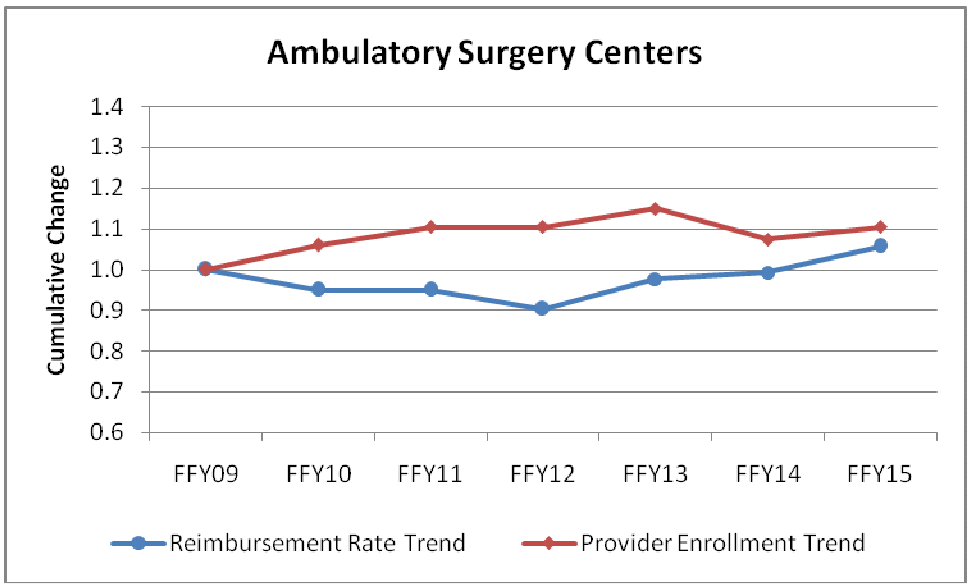
Ambulatory Surgery Centers (ASCs) provide services in facilities specifically designed to perform selected outpatient surgical services. ASCs consistently perform as well as, if not better than, hospital outpatient departments when quality and safety are examined. A study by Hair, Et al in 2012 (referenced by MedPac) reported that an ASC's average time for a visit is 39% that of outpatient hospitals specific to Medicare patients.

A March 2015 MedPac report submitted to congress indicated that the number of Medicare certified ASCs increased by 1.7% from 2008 to 2012 and by 1.1% in 2013. The volume of services between 2008 and 2012 was 2.1% and 0.5% in 2013. The slow growth for ASCs is attributed by the authors to higher rates for outpatient hospitals.

> *"This payment difference may help explain why several hospitals have recently expanded their outpatient surgery capacity. In addition, physicians have been increasingly selling their practices to hospitals, and these physicians are more likely to perform procedures at the hospitals that employ them than at free standing ambulatory surgery centers." MedPac Report, page 116.*

AHCCCS ASC fee schedule rates are based on the corresponding Medicare ASC fee schedule. ASCs are the only providers reimbursed by this fee schedule. For October 1, 2012, AHCCCS addressed provider concerns by revising the rate setting methodology for services having devices and pharmaceuticals built into the reimbursement rate. The resulting fee schedule was a rate increase of 8.3% in aggregate. The ASC fee schedule was updated October 1, 2013 for an increase of 1.6%, and October 1, 2014 for an increase of 6.4%.

Throughout those rate changes, the number of ASCs enrolled with AHCCCS has remained relatively constant, and AHCCCS has observed a decline in utilization of ASCs.

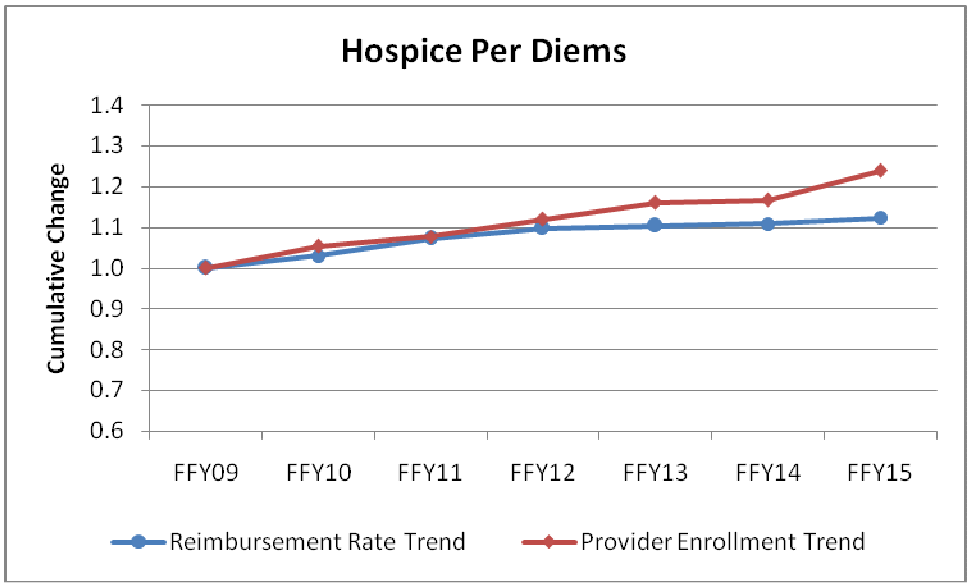


Benchmark: For ASC reimbursement, AHCCCS rates are currently 85.8% of Medicare in aggregate and 51.1% of the AHCCCS OPFS.

Hospice Per Diem Rates

Percentage of annual non-IHS reimbursements: 0.2%

AHCCCS matches the *Medicaid Hospice Payment Rates* established each year by Medicare. Despite those rates being relatively flat since 2012, AHCCCS has seen an increase in the number of enrolled hospice providers.



MANAGED CARE OVERSIGHT – PROVIDER NETWORK

The AHCCCS Managed Care contracts, at Section D, "Network Development," require that contractors providing acute care services have a network and the network shall be sufficient to provide covered services within designated time and distance limits. This includes a network such that 90% of its members residing in Maricopa and Pima counties do not have to travel more than 10 miles or 15 minutes to visit a PCP, dentist, or pharmacy unless accessing those services through a Multi-Specialty Interdisciplinary Clinic (MSIC).

AHCCCS also mandates minimum network standards for hospitals in these urban counties for contractors providing acute care services to members. The ALTCS/DDD Contractor must have contracts with a sufficient number of DD Group Homes. ALTCS/EPD and ALTCS/DDD Contractors must have contracts with a minimum number of Nursing Facilities, Assisted Living Centers and a combination of Assisted Living Homes or Adult Foster Care providers by district as identified in Policy.

AHCCCS monitors each Contractor's compliance with network standards through quarterly and annual deliverables and annual network plans submitted by each Contractor as well as during regular operational reviews. Contractors are required to monitor their networks to ensure provider appointment availability standards for primary care and dental, specialty, and maternity care services are met.

Monitoring Network Losses

AHCCCS tracks the number of providers who leave a Contractor's network due to dissatisfaction with rates. This tool was added to the Network Development and Management Policy regarding Access to Care and is reported by all Contractors. During 2014, Contractors

reported the following number of providers as having left AHCCCS Contractor provider networks citing rate reductions as the reason for their decision:

- Physician (MD): 15
- Physician (DO): 2
- Dentist: 29
- Certified Nurse Midwife: 1
- Mental Health Outpatient Clinic: 14

Contractors are obligated, by contract, to report provider network losses to AHCCCS when a provider had been providing services to a designated population and/or served 5 percent or more of its population. Included in this reporting requirement is notification of any short term gap that is caused by the network change and the process that will be implemented by the Contractor to ensure that member's medical needs are met until the gap is filled.

The Division of Health Care Management (DHCM) provides operational and financial oversight of the MCOs that contract with the State of Arizona to provide services to Medicaid enrolled members. Links to the primary documents which outline and detail Contractor requirements are found below, as well as AHCCCS' primary external review reports:
Contract requirements can be found on the AHCCCS website at:
http://www.azahcccs.gov/commercial/Purchasing/contracts.aspx

Reporting Guides for MCOs can be found on the AHCCCS website at:
http://www.azahcccs.gov/commercial/ContractorResources/manuals/manuals.aspx

The AHCCCS Contractor Operations Manual can be found on the AHCCCS website at:
http://www.azahcccs.gov/shared/ACOM/default.aspx

Annual External Quality Review Organization reports required by the Medicaid Managed Care Regulations can be found on the AHCCCS website at:
http://www.azahcccs.gov/reporting/reports/EQR.aspx

Responsibility for monitoring access to care is shared by two units within DHCM: the Operations Unit reviews contractor performance through the Network Development and Management Policy, and the Clinical Quality Management Unit reviews performance measures and quality of care concerns.

QUALITY MANAGEMENT

AHCCCS has a sentinel event monitoring system known as the quality-of-care (QOC) process. AHCCCS and its Contractors are required to track and trend all member complaints, and identify those complaints that rise to the level of a quality-of-care concern. When a QOC is identified, a Contractor must immediately remedy the specific member issue and resolve any care needed today issues. Further, the Contractor must trend complaints and QOCs to

determine if systemic issue exist and, if so, take action to remedy the systemic issue. See Chapter 900 of the AHCCCS Medical Policy Manual (AMPM) on line at: http://www.azahcccs.gov/shared/MedicalPolicyManual/MedicalPolicyManual.aspx?ID=contractormanuals

The following tables identify the number and rates per 1,000 of complaints that were determined to meet the definition of a potential quality-of-care issue, categorized as access-to-care that were received, researched and resolved by AHCCCS Contractors. The results indicate a slight increase between 2013 and 2014in the DDD number of reported complaints and rates per 1,000. The results also indicate a downward trend through 2014 in the Acute population. That trend was attributed to changes in mandatory processes that were designed to increase Contractor responsibility for the management and oversight of the complaint resolution process. In the Long Term Care population increases appearing in 2014 are attributable to changes in membership as well as extensive outreach and education efforts related to the QOC process and health plan reporting requirements.

Reflected in the Acute program numbers, the Arizona Department of Health Services, Behavioral Health Services (DBHS) initiated an improved system to identify, report and resolve complaints related to the care provided through the behavioral health system. During 2014, integration occurred for adults with diagnoses of Serious Mental Illness (SMI)combining Contractor responsibility for the delivery of behavioral and physical health care benefits which may also have had a positive impact on the access to care rates in the Acute Care population. Because children and other adults receiving behavioral health care in the behavioral health system receive their physical health care through the Acute Care system, a corresponding complaint may also be included in the Acute Care numbers.

AHCCCS continued its focused monitoring and oversight of Contractor reporting requirements of neglect, abuse, exploitation and unexpected death cases.

AHCCCS Member Complaints Regarding Contractors

Year	Acute	Population	Rate per 1,000	ALTCS	Population	Rate per 1,000	DDD	Population	Rate per 1,000
2007	2503	973,191	2.57	152	22,802	6.67	35	19,360	1.81
2008	1534	1,018,367	1.51	121	23,853	5.07	20	20,605	0.97
2009	1054	1,100,967	0.96	123	24,916	4.94	73	22,002	3.32
2010	944	1,273,326	0.74	110	27,547	3.99	34	22,854	1.49
2011	1472	1,173,764	1.25	162	27,656	5.86	24	23,800	1.01
2012	1170	1,204,375	0.97	166	28,181	5.89	6	24,858	0.24
2013	1846	1,173,994	1.57	305	28,259	10.79	273	25,828	10.57
2014	1791	1,525,807	1.17	285	18,984	15.01	408	27,126	15.04

The following table documents concerns received by AHCCCS that have been categorized as potential access-to-care (availability, accessibility and adequacy).

AHCCCS QOC Database Statistics

Availability, Accessibility, and Adequacy

Year	Acute	Population	Rate per 1,000	ALTCS	Population	Rate per 1,000	DDD	Population	Rate per 1,000
2007	93	973,191	0.10	25	22,802	1.10	13	19,360	0.67
2008	66	1,018,367	0.06	25	23,853	1.05	5	20,605	0.24
2009	49	1,100,967	0.04	16	24,916	0.64	9	22,002	0.41
2010	14	1,273,326	0.01	6	27,547	0.22	31	22,854	1.36
2011	17	1,173,764	0.01	6	27,656	0.22	4	23,800	0.17
2012	31	1,204,375	0.03	8	28,181	0.28	6	24,858	0.24
2013	31	1,173,994	0.03	47	28,259	1.66	8	25,828	0.31
2014	232	1,525,807	0.15	26	18,984	1.37	39	27,126	1.44

AHCCCS utilizes Clinical Performance Measures as another method to monitor members' access to care. The following are the most recent performance measure rates reported:

Performance Measure	AHCCCS CYE 10 Rates	AHCCCS CYE 11 Rates	AHCCCS CYE 12 Rates	NCQA Medicaid Mean	NCQA Commercial Mean
Acute-care Population					
Medicaid Children's Access to PCPs – 12-24 Months	87.00%	96.80%	97.00%	96.00%	97.90%
KidsCare Children's Access to PCPs – 12-24 Months	96.90%	N/A (5)	N/A (5)	96.00%	97.90%
Medicaid Children's Access to PCPs – 25 Months-6 Years	84.10%	86.90%	87.70%	88.30%	91.60%
KidsCare Children's Access to PCPs – 25 Months-6 Years	89.30%	93.40%	93.90%	88.30%	91.60%
Medicaid Children's Access to PCPs – 7-11 Years	83.50%	89.30%	89.90%	89.90%	92.20%
KidsCare Children's Access to PCPs – 7-11 Years	91.00%	95.30%	95.90%	89.90%	92.20%
Medicaid Children's Access to PCPs – 12-19 Years	83.90%	87.20%	87.70%	88.40%	89.70%
Medicaid Children's Access to PCPs – 12-19 Years	89.30%	93.80%	94.00%	88.40%	89.70%
Medicaid Well Child Visits in the First 15 Months of Life	64.10%	70.20%	67.80%	63.60%	78.20%
KidsCare Well Child Visits in the First 15 Months of Life	67.90%	N/A (5)	N/A (5)	63.60%	78.20%
Medicaid Well Child Visits, 3, 4, 5, 6 Years of Life	67.70%	67.70%	66.80%	72.00%	72.90%
KidsCare Well Child Visits 3, 4, 5, 6 Years of Life	75.90%	72.70%	76.60%	72.00%	72.90%
Medicaid Adolescent Well-Care Visits	42.10%	35.20%	38.00%	49.70%	43.30%
KidsCare Adolescent Well-Care Visits	52.90%	50.60%	55.10%	49.70%	43.30%

Medicaid Annual Dental Visits ages 2-21	64.70%	64.70%	61.80%	N/A (1)	N/A (1)
KidsCare Annual Dental Visits ages 2-19	76.40%	78.10%	77.90%	N/A (1)	N/A (1)
Adults' Access to Ambulatory Services – 20-44 Years	N/A(2)	N/A(2)	N/A(2)	-	-
Adults' Access to Ambulatory Services – 45-64 Years	N/A(2)	N/A (2)	N/A (2)	-	-
Breast Cancer Screening, ages 50-64	N/A(2)	N/A (2)	N/A (2)	-	-
Cervical Cancer Screening	N/A(2)	N/A (2)	N/A (2)	-	-
Chlamydia Screening, ages 16-24	N/A(2)	N/A (2)	N/A (2)	-	-
Appropriate Medications for Asthma	96.30%	N/A (2)	N/A (2)	83.90%	91.20%
Diabetic Care – HbA1c Testing	66.30%	N/A (2)	N/A (2)	83.00%	90.10%
Diabetic Care – Lipid Screening	63.20%	N/A (2)	N/A (2)	75.50%	85.40%
Diabetic Care – Retinal Exams	29.30%	N/A (2)	N/A (2)	53.20%	56.80%
Timeliness of Prenatal Care	78.10%	N/A (2)	N/A (2)	82.90%	89.60%
ALTCS E/PD Population					
Initiation of Home and Community Based Services	97.30%	96.30%	95.90%	-4	-4
Diabetes Care – HbA1c Testing	89.00%	84.30%	N/A (2)	83.00%	90.10%
Diabetes Care – Lipid Screening	83.50%	75.90%	N/A (2)	75.50%	85.40%
Diabetes Care – Retinal Exams	72.90%	71.20%	N/A (2)	53.20%	56.80%

(1) NQCA does not report a Medicaid or commercial rate for dental visits, since these services are typically provided under a separate plan from the medical plan.

(2) These measures have been suspended and were not reported in CYE 2010.

(3) CYE 2010 was a baseline year for these measures; there is no historical data to report.

(4) Not a HEDIS or other comparable measure, so no national comparison is available.

(5) KidsCare population in performance measure category fell below a valid sample size.

Four of the seven measures for DDD showed an improvement during the most recent measurement period. Please note that approximately 36 % of DDD members, particularly children, have other primary insurance. For that reason, a lower number of claims are submitted to DDD for payment and are not reflected in the AHCCCS data:

Performance Measure - DDD	CYE 10 Rates	CYE 11 Rates	CYE 12 Rates
Children's Access to PCPs – 12 to 24 months	91.40%	94.30%	93.70%
Children's Access to PCPs – 25 months to 6 years	87.00%	86.00%	86.30%
Children's Access to PCPs – 7 to 11 years	83.10%	84.40%	88.00%
Children's Access to PCPs – 12 to 19 years	82.30%	82.90%	85.20%
Well Child Visits 3, 4, 5, 6 Years of Life	52.20%	50.10%	51.10%
Adolescent Well-Care Visits	38.50%	37.50%	35.40%
Annual Dental Visits	50.60%	50.30%	47.70%

While not all of these measures directly measure access to care, they serve as a broader view of members' ability to obtain basic health care services.

AHCCCS has implemented new performance measure sets for all lines of business. The new measures and related Minimum Performance Standards/Goals became effective on October 1,

2013 which aligns with the start of the new five-year contract period for Acute-Care Contractors and the newly integrated programs for children with special health care needs, Children's Rehabilitative Services (CRS), and for members diagnosed with SMI. The AHCCCS decision to transition to a new measure set was partially driven by a desire to align with measures sets such as the CHIPRA Core Measure Set, the Adult Core Measure Set, Meaningful Use, and others measure sets being implemented by CMS. AHCCCS has also updated the measure sets with contracts to reflect changes on measures implemented by CMS for the next contract year. The system development and implementation of the new measure sets has resulted in a delay in reporting of 2013 Performance Measure results.

AHCCCS has implemented several efforts over the past several years in preparation for the performance measure transition described above. First and foremost, the Agency undertook extensive internal planning efforts, including evaluation of new requirements, future goals and desired capabilities, as well as barrier identification and associated risk. One risk that was identified was the possibility that the information system and data analytic staff resources were reduced which would not allow the level of review and validation of performance measure programming necessary to ensure the validity and accuracy of Performance Measures. To address this concern, the Agency is utilizing its External Quality Review Organization to perform the measurement calculations for the CYE 2013 and CYE 2014 measurement periods. Data validation and reports are currently being prepared for AHCCCS for both measurement periods.

SUMMARY

Recent reports by legislative budget staff indicate that revenue collections to-date have exceeded projections for FY 2015. There continues to be a risk associated with ongoing litigation over K-12 funding, which could result in budget shortfalls for FY 2015 and FY 2016.

AHCCCS member enrollment is at a historic peak, while AHCCCS provider enrollment also continues to increase at a steady pace overall.

Despite budget challenges, AHCCCS has avoided provider rate reductions, and will implement some modest rate increases in FY 2016. AHCCCS rates for fiscal years 2014 and 2015 caused no decrease in the AHCCCS provider network. Due to the modest rate increases and the enlargement of the AHCCCS population, there is no reason to believe that any significant number of providers will exit the network in FY 2016 due to rate issues.

The AHCCCS provider network has grown steadily over the past five years. The AHCCCS network is robust and already providing healthcare to the newly expanded and restored enrollees.

RESOURCES

U.S. Bureau of Labor Statistics
http://www.bls.gov/

Arizona Department of Administration – Employment and Population Statistics
https://laborstats.az.gov/

Wells Fargo Securities, LLC – Securities Economics Group
https://www.wellsfargo.com/com/insights/economics

JLBC – Monthly Fiscal Highlights; June 2015 Edition
http://www.azleg.gov/jlbc/mfh-jun-15.pdf

Kaiser Foundation
http://www.kff.org/statedata

DeciBio, LLC
Durable Medical Equipment: U.S. Market Size, Segments, Growth and Trends
www.decibio.com

KCMU Examines Medicaid and Medicare Reimbursement
http://itup.org/blog/2013/02/13/kcmu-examine-medicaid-and-medicare-reimbursement/

American Society of Anesthesiologists
Payment and Practice Management: ASA 2014 Survey Results for Commercial Fees Paid for Anesthesia Services
http://www.asahq.org/resources/publications/newsletter-articles/2014/october-2014/payment-and-practice-management

Centers for Medicare and Medicaid Services
http://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html

Colorado Department of Health Care, Policy and Financing
https://www.colorado.gov/pacific/hcpf/provider-rates-fee-schedule

Idaho Department of Health and Welfare
http://healthandwelfare.idaho.gov/Providers/MedicaidProviders/MedicaidFeeSchedule/tabid/268/default.aspx

New Mexico Human Services Department
http://www.hsd.state.nm.us/providers/fee-schedules.aspx

Arizona Department of Health Services, Department of Behavioral Health
http://www.azdhs.gov/bhs/index.htm

MEDPAC
March 2015 Report to Congress: Medicare Payment Policy, Chapter 5: Ambulatory Surgical Center Services
http://www.medpac.gov/documents/reports/chapter-5-ambulatory-surgical-center-services-(march-2015-report).pdf?sfvrsn=0