

# **Arizona Health Care Cost Containment System (AHCCCS), Methodology for Primary Care Provider Payment Increases Actuarial Memorandum**

## **I. Purpose**

Section 1902(a)(13)(C) of the Social Security Act, as amended by the Affordable Care Act, requires minimum levels of Medicaid payment for certain primary care services, provided by certain physicians. The purpose of this actuarial memorandum is to describe AHCCCS' intended methodology to identify payments attributable to the increased provider rates and the percentage of those payments eligible for 100% FMAP. This document will also demonstrate that the intended methodology is in compliance with 42 CFR 438.804 and with 42 CFR 438.6(c). It is not intended for any other purpose.

## **II. Overview of Methodology**

The AHCCCS managed care model, with strict requirements regarding actuarially-sound capitation rates, necessitates that Contractors be funded for expected cost increases due to primary care rate parity. AHCCCS proposes to provide Contractors the necessary funds to increase primary care payments by using Model 3: Non-risk Reconciled Payments for Enhanced Rates as referenced in the *Medicaid Managed Care Payment for PCP Services in 2013 and 2014, Technical Guidance and Rate Setting Practices* (Technical Guidance) document released by CMS.

As noted in the Technical Guidance, "Payment by state Medicaid agencies for primary care services administered by certain physicians must be at least as much as the greater of:

- The Medicare rates in effect in calendar years 2013 and 2014
- The rate that would be applicable using the calendar year 2009 Medicare physician fee schedule conversion factor (CF)"

For AHCCCS for rates effective January 1, 2013, the "greater of" calculation results in rates established by applying Medicare's 2009 conversion factor to the current RVU schedule. This test will be reapplied for rates effective January 1, 2014.

AHCCCS' intended methodology for determining the July 1, 2009 rates attributable to impacted services, and the amount of expenditures on eligible services for which the State can receive 100% match, will primarily be the same across all managed care programs and Fee for Service (FFS), for both calendar years 2013 and 2014. Any differences will be noted in this document. The methodology selected by AHCCCS for the managed care model is to utilize historical encounter data to derive the unit cost for the 2009 base rate; the FFS base rate for July 1, 2009 will come from the AHCCCS Physician Fee Schedule in place at that time. Actual/current claims and encounter data will be used to capture the 2013 unit cost rate. AHCCCS' claims and encounter data is readily available at the specific code level, accurate, and a clear reflection of payments to primary care physicians with the mandated specialties and sub-specialties.

Since AHCCCS' physician fee schedule has changed (primarily decreased) from the 2009 fee schedule, AHCCCS needs to determine three amounts: the amount to pay Contractors due to increased primary care rates, the amount eligible for 100% FMAP and the amount eligible for regular FMAP.

Each item is further described in the sections below.

### **III. Managed Care Risk Model**

In summary, under Model 3, prospective capitation rates would not be adjusted for the enhanced primary care payments. Rather, AHCCCS would query actual encounter data on a quarterly basis to calculate the total payments that eligible providers were paid for eligible services in order to reach the mandated enhanced payment rates. Once the data on this report is verified, AHCCCS would pay the Contractors the calculated additional payment amounts.

A more detailed explanation of the proposed process begins with the implementation of front-end editing that would "flag" an encounter upon submission that (1) includes a provider who has attested to his/her qualifications to participate (2) for a date of service covered by the provider's attestation (e.g. either retroactive to January 1, 2013 if attestation is received by April 30, 2013, or a prospective date if attestation occurs on or after May 1, 2013) and (3) for a qualifying procedure code. If AHCCCS flags an encounter and determines that the Contractor did not make the enhanced payment, the encounter will be pended/denied. Likewise, if the AHCCCS system-logic determines that a PCP enhanced payment was made but the flag was not triggered due to the absence of one of three criteria above, the encounter will be pended/denied.

AHCCCS would develop a quarterly report that would extract adjudicated/approved (paid) encounter data based on the adjudication date so that all new and replaced encounters since the last report are included. The quarterly report would include the Health Plan Paid Amount (this would be populated with the enhanced fee schedule payment) and the Health Plan Allowed Amount (this is what the Contractor would have paid the provider prior to the enhanced fee schedule) for each encounter. The difference between those two payment amounts would be the enhanced primary care payment. There are some exceptions including, but not limited to:

- If the Contractor is currently paying a provider a rate higher than the enhanced primary care fee payment, then there would be no additional reimbursement for impacted claims.
- For sub-capitated payment arrangements, Contractors must pay an enhanced amount based on the difference between how the Contractor valued the claim (which they provide today in the Health Plan Allowed Amount field) and the enhanced primary care fee schedule for each claim. This amount would be reported in the Health Plan Paid field, which is normally zero.
- Contractors will not make enhanced payments that exceed billed charges.
- AHCCCS would apply all TPL/COB and Medicare payment policies.
- AHCCCS would not share in any interest payments.

AHCCCS would send a report to Contractors with this information for review. Once the amount has been agreed upon between the two parties, AHCCCS would pay Contractors the additional payment amount. This would happen up until the two year claiming timeframe.

Because AHCCCS has decreased provider rates since July 1, 2009, a portion of the additional payment amount would be claimed at 100% FMAP and a portion would be claimed at the regular FMAP rate. The amount that is claimed at 100% FMAP would be calculated as described in Section IX below and will be calculated for each individual encounter that qualifies.

AHCCCS intends to pay the enhanced rates to qualifying providers, for qualifying codes, for both Medicaid and CHIP (KidsCare) members. However, KidsCare members are not eligible for 100% FMAP. Since AHCCCS is calculating what is claimed at 100% FMAP at an encounter level AHCCCS will exclude KidsCare members from any 100% FMAP calculation.

AHCCCS will also exclude premium tax from the 100% FMAP calculation since that is also not eligible for the enhanced funding. Since AHCCCS intends to use Model 3, AHCCCS does not need to adjust for Contractors' administration or risk contingency since those will not be added to the payment to Contractors.

#### **IV. Calculation of 2009 Unit Cost Rate**

AHCCCS intends to use encounter data to establish the 2009 unit costs. AHCCCS would extract encounter data for dates of service (DOS) of July 1, 2009 – September 30, 2009 to determine the amount Contractors paid to providers. If AHCCCS finds that the encounter data does not contain enough utilization data then AHCCCS would expand the extraction process to extract encounter data with additional DOS.

From this data AHCCCS would calculate the average unit cost across all Contractors (Health Plan Paid Amount / utilization); this would become the unit cost for the 2009 base rate (UC<sub>09</sub>). This would be calculated at the CPT/HCPCS procedure code level. If there are any qualified codes that do not have encounter utilization for the time period noted above, AHCCCS would use the July 2009 AHCCCS Physician Fee Schedule values.

AHCCCS is unable to utilize the methodology described in Section 4 – Calculating the 2009 Base Rate – in the Technical Guidance document. This methodology requires that “the 2009 base rate is developed based on the capitation rates that were in effect on 7/1/2009. The base rate for managed care is based on the payment between the state and the MCPs rather than the specific fee schedule between the MCPs and provider.” There are several reasons why this methodology does not work for Arizona:

- In addition to the AHCCCS FFS program, which accounts for approximately 10% of AHCCCS' annual expenditures, AHCCCS has six unique managed care programs. While AHCCCS attempts to use the same methodology to set managed care program capitation rates, there are unique circumstances that apply to each program which cause differences in the way rates are developed.

- The Acute Care program accounts for approximately 47% of AHCCCS' annual expenditures. AHCCCS goes out for competitive bid via an RFP every five years; CYE 2009 was the RFP year and encompassed the capitation rates effective at July 1, 2009. AHCCCS does not set the majority of the capitation rates in a bid year. Rather, the capitation rates are based on Offerors' bids submitted with their RFP offers. AHCCCS does not require that Offerors provide bids at the level of detail necessary for the calculation described by CMS thus there is no in-house data that AHCCCS could utilize to recreate Offerors' bids.
- The Arizona Long Term Care System (ALTCS) program, comprised of the Elderly and Physically Disabled (EPD) and Developmentally Disabled (DD) programs, accounts for approximately 27% of AHCCCS' annual expenditures. The acute care components for these rates are developed at a high level, thus the data extracted for the CYE 2009 cap rates does not provide the detail described by CMS. AHCCCS would need to extract new data to get to the required level of detail. Extracting data today, almost four years later, would result in a different data set due to encounter completion.
- The behavioral health carve-out for Acute Care members accounts for the remaining 16% of annual expenditures. There is an insignificant expenditure on impacted procedure codes by qualified providers. Despite this, the behavioral health Contractor will be mandated by contract amendment to comply with the enhanced payments when appropriate.

Due to these factors, AHCCCS would have to re-develop all historical capitation rates which imposes an administrative and financial burden. Given significant other federal mandates and current priorities this is not a resource allocation AHCCCS supports.

Additionally, the CFR at § 438.804 requires that:

“(i) The state develops a reasonable methodology, based on rational and documented data and assumptions, **for identifying the provider payments that would have been made by MCO, PIHP or PAHP for specified primary care services furnished as of July 1, 2009.** This methodology can take into consideration the availability of data, and the costs and burden of administering the method, but should produce a reliable and accurate result to the fullest extent possible.

(ii) The state develops a reasonable methodology, based on rational and documented data and assumptions, for identifying the differential in payment between **the provider payments that would have been made by the MCO, PIHP or PAHP on July 1, 2009** and the amount needed to comply with the contractual requirement under § 438.6(c)(5)(vi). This methodology can take into consideration the availability of data, and the costs and burden of administering the method, but should produce a reliable and accurate result to the fullest extent possible.”

(Emphasis added.)

As stated in the Technical Guidance document, “The state has the flexibility in determining the 2009 baseline rate and the rate differential to comply with this rule, but the approach taken must be based on reasonable and documented data sources available to the state to accurately define these amounts to the fullest extent possible.” AHCCCS believes that the proposed approach meets the requirements of § 438.804 provided above, and that reliance on AHCCCS’ rich encounter data is both reasonable and appropriate. Additionally, Contractors remain at-risk for all expenses covered by the capitation rates, including those related to the services eligible for enhanced payments. What Contractors are not at-risk for is the increase required to move from their current payments to the enhanced payment rates.

## **V. Methodology for Extraction of Data**

The 2009 data would be extracted by CPT/HCPCS procedure codes, provider type and place-of-service. AHCCCS would exclude any encounters where the Contractor was not the primary payer or where the Health Plan Paid Amount is not reasonable.

For vaccine administrative payments AHCCCS would have to impute the rate for new code 90460 by using encounter data for code 90471 (code 90460 was not a covered code in July 2009).

## **VI. Calculation of 2013 Unit Cost Rate**

Upon implementation, for every eligible encounter, AHCCCS is requiring Contractors to report what they would have paid prior to the implementation of the increased fee schedule (UC<sub>13p</sub>). AHCCCS is also requiring Contractors to report the 2013 enhanced rate (UC<sub>13a</sub>). These amounts would be validated by AHCCCS. If the enhanced rates increase for calendar year 2014, AHCCCS would use the new enhanced rates replacing the 2013 enhanced rates.

AHCCCS would use adjudicated/approved (paid) encounter data to calculate the amount of funding needed for each Contractor for enhanced payments. Since the analysis would be performed at the encounter level, it would be calculated at the CPT/HCPCS procedure code detail for all qualifying providers who attest.

## **VII. Calculation of Projected 2013 Utilization**

Since AHCCCS proposes to use Risk Model 3 there is no need to calculate projected 2013 utilization since AHCCCS will use actual utilization data to pay Contractors.

## **VIII. Calculating the Calendar Year 2013 Capitation Rate**

Funds paid to Contractors for enhanced payments would be based on Contractors’ actual adjudicated encounters and will be paid outside of capitation rates as described in Section III.

## IX. Calculating the Amount Eligible for 100% FFP

Because AHCCCS has decreased Physician Fee Schedule rates since July 2009, AHCCCS would need to calculate the percentage of payments to Contractors that would be eligible for the 100% FMAP. AHCCCS would calculate this at the encounter level for those encounters that qualify, as detailed below:

**The following information has been superseded by information in “Update per CMS” below.**

### Definitions:

Variable Name	Variable Definition
UC <sub>09</sub>	Unit costs for 2009 base rate
UC <sub>13p</sub>	Unit cost for the 2013 base rate prior to the enhanced fee schedule (this will be included on eligible encounters)
UC <sub>13a</sub>	Unit cost for the 2013 base rate after implementation of the enhanced fee schedule (this will be included on eligible encounters)
Amt <sub>Incr</sub>	Increased costs due to enhanced PCP fee schedule at the CPT/HCPCS procedure code level
F <sub>100Amt</sub>	Increased costs eligible for 100% FMAP due to increased fee schedule at the CPT/HCPCS procedure code level
F <sub>RegAmt</sub>	Increased costs eligible for regular FMAP due to increased fee schedule at the CPT/HCPCS procedure code level
Amt <sub>MCO</sub>	Amount paid to Contractors
PremTax	Amount paid to Contractors for premium tax

### Formulas:

#### *Calculations at Encounter level*

$Amt_{Incr} = UC_{13a} - UC_{13p}$ , if this amount is less than 0, then 0

$F_{100Amt} =$  If KidsCare Member Then 0

Else If  $Amt_{Incr} \leq 0$  Then 0

Else If  $UC_{13a} < UC_{09}$  Then 0

Else  $UC_{13a} - \max(UC_{09}, UC_{13p})$

$PremTax = Amt_{Incr} / 0.98 - Amt_{Incr}$

$Amt_{MCO} = Amt_{Incr} + PremTax$

$F_{RegAmt} = Amt_{MCO} - F_{100Amt}$

### Examples:

#### **Example 1**

Encounter Number: ABC

Member: Non-KidsCare

Code: XYZ123

UC<sub>13p</sub> = \$100.00

UC<sub>13a</sub> = \$113.00

UC<sub>09</sub> = \$110.00

$Amt_{Incr} = (\$113.00 - \$100.00) = \$13.00$

$F_{100Amt} = (\$113.00 - \max(\$110.00, \$100.00)) = \$3.00$

$PremTax = \$13.00 / 0.98 - \$13.00 = \$0.27$

$$\text{Amt}_{\text{MCO}} = \$13.00 + \$0.27 = \$13.27$$

$$\text{F}_{\text{RegAmt}} = \$13.27 - \$3.00 = \$10.27$$

**Example 2**

Encounter Number: DEF

Member: Non-KidsCare

Code: XYZ456

$\text{UC}_{13p} = \$100.00$

$\text{UC}_{13a} = \$113.00$

$\text{UC}_{09} = \$90.00$

$\text{Amt}_{\text{Incr}} = (\$113.00 - \$100.00) = \$13.00$

$\text{F}_{100\text{Amt}} = (\$113.00 - \max(\$90.00, \$100.00)) = \$13.00$

$\text{PremTax} = \$13.00 / 0.98 - \$13.00 = \$0.27$

$\text{Amt}_{\text{MCO}} = \$13.00 + \$0.27 = \$13.27$

$\text{F}_{\text{RegAmt}} = \$13.27 - \$13.00 = \$0.27$

**UPDATE PER CMS:**

**Changes to section IX:**

- **Add one variable to Definitions:  $\text{F}_{\text{RegAmtHist}}$**
- **Replace one formula  $\text{F}_{100\text{Amt}}$** 
  - **Remove the max from the formula**
- **Add one formula  $\text{F}_{\text{RegAmtHist}}$**
- **Change Examples:**
  - **Example 1 results will not change, but remove “max” from the  $\text{F}_{100\text{Amt}}$  calculation**
  - **Example 2 results change**

Definitions:

Variable Name	Variable Definition
$\text{UC}_{09}$	Unit costs for 2009 base rate
$\text{UC}_{13p}$	Unit cost for the 2013 base rate prior to the enhanced fee schedule (this will be included on eligible encounters)
$\text{UC}_{13a}$	Unit cost for the 2013 base rate after implementation of the enhanced fee schedule (this will be included on eligible encounters)
$\text{Amt}_{\text{Incr}}$	Increased costs due to enhanced PCP fee schedule at the CPT/HCPCS procedure code level
$\text{F}_{100\text{Amt}}$	Increased costs eligible for 100% FMAP due to increased fee schedule at the CPT/HCPCS procedure code level
$\text{F}_{\text{RegAmt}}$	Increased costs eligible for regular FMAP due to increased fee schedule at the CPT/HCPCS procedure code level
$\text{Amt}_{\text{MCO}}$	Amount paid to Contractors
PremTax	Amount paid to Contractors for premium tax
$\text{F}_{\text{RegAmtHist}}$	Historical costs paid at regular FMAP that will now be paid at 100% FMAP due to increase fee schedule at the CPT/HCPCS procedure code level thus will need to be “reimbursed” since already paid at regular FMAP

Formulas:

*Calculations at Encounter level*

$Amt_{Incr} = UC_{13a} - UC_{13p}$ , if this amount is less than 0, then 0

$F_{100Amt} = \text{If KidsCare Member Then } 0$

    Else If  $Amt_{Incr} \leq 0$  Then 0

    Else If  $UC_{13a} < UC_{09}$  Then 0

    Else  $UC_{13a} - UC_{09}$

$PremTax = Amt_{Incr} / 0.98 - Amt_{Incr}$

$Amt_{MCO} = Amt_{Incr} + PremTax$

$F_{RegAmt} = Amt_{MCO} - F_{100Amt}$

$F_{RegAmtHist} = \text{If } UC_{09} > UC_{13p} \text{ Then } 0$

    Else  $Amt_{Incr} - F_{100Amt}$

**Example 1**

Encounter Number: ABC

Member: Non-KidsCare

Code: XYZ123

$UC_{13p} = \$100.00$

$UC_{13a} = \$113.00$

$UC_{09} = \$110.00$

$Amt_{Incr} = (\$113.00 - \$100.00) = \$13.00$

$F_{100Amt} = (\$113.00 - \$110.00) = \$3.00$

$PremTax = \$13.00 / 0.98 - \$13.00 = \$0.27$

$Amt_{MCO} = \$13.00 + \$0.27 = \$13.27$

$F_{RegAmt} = \$13.27 - \$3.00 = \$10.27$

$F_{RegAmtHist} = \$0.00$

**Example 2**

Encounter Number: DEF

Member: Non-KidsCare

Code: XYZ456

$UC_{13p} = \$100.00$

$UC_{13a} = \$113.00$

$UC_{09} = \$90.00$

$Amt_{Incr} = (\$113.00 - \$100.00) = \$13.00$

$F_{100Amt} = (\$113.00 - \$90.00) = \$23.00$

$PremTax = \$13.00 / 0.98 - \$13.00 = \$0.27$

$Amt_{MCO} = \$13.00 + \$0.27 = \$13.27$

$F_{RegAmt} = \$13.27 - \$13.00 = \$0.27$

$F_{RegAmtHist} = \$13.00 - \$23.00 = -\$10.00$

**X. FFS Method**

The methodology for determining the 2009 base rate for the FFS model is to use the July 2009 AHCCCS Physician Fee Schedule values for the impacted procedure



codes. AHCCCS would pay the enhanced payments as impacted claims are adjudicated through the claims' system. Similar to the managed care model, a quarterly report would be developed to calculate what can be claimed at 100% FMAP versus regular FMAP.

## **XI. CMS Rate Setting Checklist**

### **1. Required Methodologies**

Please refer to Sections I and II.

### **2. Risk Models**

Please refer to Section III and X.

### **3. Calculation Methodology**

Please refer to Sections V.

### **4. Calculating the 2009 Base Rate**

Please refer to Section IV.

### **5. Calculating the 2013 Capitation Rate**

Please refer to Sections VI, VII and VIII.

### **6. Calculating the Differential that Qualifies for 100% FFP**

Please refer to Sections IX.