



# 2020 ACCESS MONITORING REVIEW PLAN



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## 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 individuals and families.
- In Federal Fiscal Year 2019, the AHCCCS program provided coverage to nearly 1,900,000 enrolled beneficiaries, or 26% of Arizona's 7.2 million population. Approximately 87% of beneficiaries are enrolled in managed care. The remaining 13%, or approximately 236,000 members, received services through the state's Fee-for-Service program. Altogether, \$13.7<sup>1</sup> billion were expended on Arizona Medicaid recipients in FFY 2019.
- Arizona comprises 15 counties totaling almost 114,000 square miles, the size of New York, Connecticut, Vermont, New Hampshire, and Maine combined.<sup>2</sup> About 74% of its 7.2 million residents live in two counties: Maricopa County (60%) and Pima County (14%).<sup>3</sup> The overall population density of the State is 63 residents per square mile. As of September 30, 2019, Arizona had 37 Medically Underserved Areas and 194 primary medical care, 187 dental, and 189 mental health Health Professional Shortage Areas.<sup>4</sup>
- With 89 general acute care hospitals (including 11 Indian Health Services/638 tribal hospitals), 20 psychiatric hospitals, 6 long-term acute care hospitals, and 12 rehabilitation hospitals, AHCCCS currently contracts with all but 2 hospitals within the state. These registered hospitals, along with a network of 154 federally designated health centers throughout the state,<sup>5</sup> provide for numerous options for Medicaid beneficiaries to receive healthcare.
- All providers of AHCCCS-covered services must be registered with AHCCCS. Since many of AHCCCS' providers who serve Fee-for-Service (FFS) members also have contracts in place with managed care organizations, most of the managed care monitoring activities apply to monitoring FFS beneficiaries.
- Arizona measures and monitors indicators of healthcare access to ensure that its Medicaid beneficiaries have access to care that is comparable to the general population.
- In accordance with 42 CFR § 447.203, Arizona developed an access review monitoring plan, and has completed an analysis in accordance with service

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<sup>1</sup> <https://www.azahcccs.gov/Resources/Downloads/AnnualReports/FY2019AnnualReport.pdf>

<sup>2</sup> <https://www.census.gov/geographies/reference-files/2010/geo/state-area.html>

<sup>3</sup> <https://www.indexmundi.com/facts/united-states/quick-facts/arizona/population#table>

<sup>4</sup> <https://data.hrsa.gov/tools/shortage-area>

<sup>5</sup> Id.

categories provided under a FFS arrangement. A list of service categories being analyzed is below:

- o Primary care services
  - o Physician specialist services
  - o Behavioral health services
  - o Pre- and post-natal obstetric services, including labor and delivery
  - o Home health services including durable medical equipment.
- The plan describes data that is used to measure access to care for FFS beneficiaries. The plan considers the availability of Medicaid providers, utilization of Medicaid services, and the extent to which Medicaid beneficiaries' healthcare needs are fully met.

## **MANAGED CARE AND FEE-FOR-SERVICE PROGRAMS**

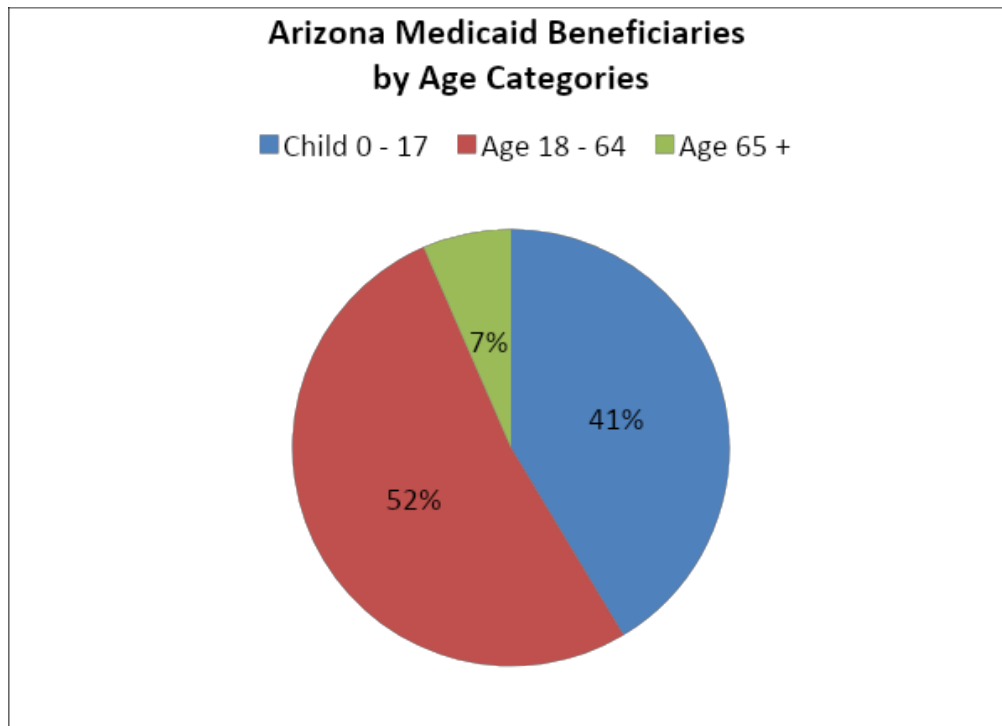
Since 1982, when it became the first statewide Medicaid managed care system in the nation, AHCCCS has operated under a Section 1115 Demonstration Project Waiver which authorizes the operation of a managed care model. AHCCCS selects contracted managed care organizations (MCOs) via a highly competitive request for proposal (RFP) process. MCOs are responsible for the delivery of medically necessary care to members, and are paid via prospective monthly capitation payments. The result is a managed care system that mainstreams recipients, allows them to choose their providers, and encourages quality care and preventive services.

In Arizona's Medicaid Program, providers are reimbursed on a FFS basis for: (1) American Indians and Alaska Natives (AI/AN) enrolled in the AHCCCS Complete Care Program who choose to receive their physical health coverage through the AHCCCS American Indian Health Program (AIHP) rather than one of the AHCCCS-contracted managed health plans; (2) AHCCCS Complete Care AI/AN members who choose to receive their behavioral health services through a Tribal Regional Behavioral Health Authority (TRBHA); (3) Tribal ALTCS members who choose not to enroll in an Arizona Long Term Care System (ALTCS) MCO; (4) Children and adults who, but for their citizenship/immigration status, would otherwise qualify for comprehensive Medicaid eligibility coverage, but due to their status, are eligible for Federal Emergency Services (FES); (5) Beneficiaries who are found eligible for AHCCCS via Hospital Presumptive Eligibility; (6) Populations subject to retroactive eligibility (also referred to as Retroactive Coverage); and (7) Beneficiaries who receive services in situations in which there is less than 30 days from the processing date to the end of their eligibility.

Since many of the FFS providers also have contracts in place with managed care organizations, many of the managed care monitoring activities apply to monitoring FFS.

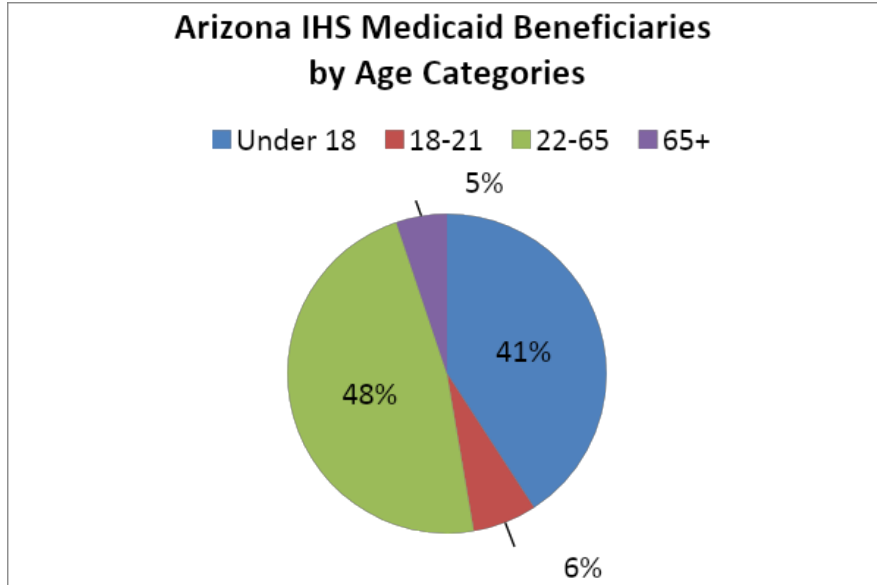
## **BENEFICIARY POPULATION**

In FFY 2019, the AHCCCS program provided coverage to nearly 1,900,000 enrolled beneficiaries. Approximately 87% of these beneficiaries were enrolled in managed care with the rest receiving services through the FFS program. Of those, approximately 41% were children ages 0-17, 52% were ages 18-64, and 7% were age 65 or greater as shown below.

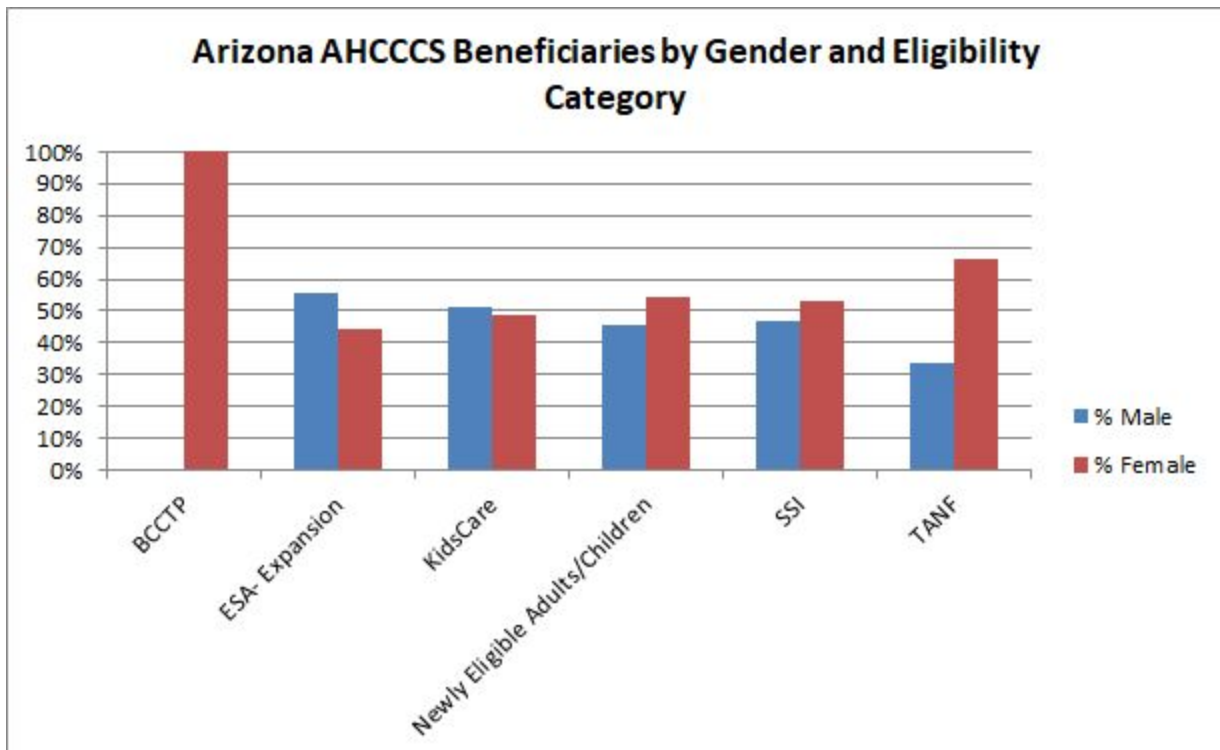


As of October 2019, approximately 9% of the 1,900,000 persons enrolled in Medicaid in Arizona identified as Native American<sup>6</sup>. Each of these individuals has the option to receive covered services – including the services described in this analysis - on a fee-for-service basis. Of those, 120,968 elected to receive services through the FFS program. As shown below, the age profile of the Native American population within our FFS program is comparable to the overall Medicaid population.

<sup>6</sup>[https://archive.azahcccs.gov/archive/Resources/Reports/Population%20Statistics/2020/Jan/AHCCCS\\_Demographics.pdf](https://archive.azahcccs.gov/archive/Resources/Reports/Population%20Statistics/2020/Jan/AHCCCS_Demographics.pdf)



Overall, slightly more than half (54%) of Medicaid beneficiaries are female. Females represent 100% of the Breast and Cervical Cancer Treatment Program, which provides treatment for women up to 250% of the federal poverty level under specific circumstances. Females also constitute approximately two-thirds of the TANF population among the AHCCCS beneficiaries. The remainder of the populations are split fairly evenly between males and females. A breakout by eligibility category and sex is provided below.



As of September 2019, 112,975 individuals were enrolled with AHCCCS on a fee-for-service basis with coverage limited to emergency services (including labor and delivery) due to their status as non qualified aliens such as undocumented immigrants.<sup>7</sup> Physician specialist services and behavioral health services are limited to care necessary to treat an emergency medical condition as defined in federal law.

## **BENEFICIARY INPUT**

To meet the requirements of 42 CFR § 447.203, a page on the AHCCCS public website developed exclusively for reporting access to care issues serves as the single point of entry for tracking access to care concerns and trends. The page continuously offers beneficiaries, providers, and stakeholders the opportunity to submit access to care concerns electronically. Beneficiaries and providers are also provided a phone number and mailing address so that they may submit concerns and information through those means if preferred. The single point of entry, as well as the phone number and mailing address, are overseen by the AHCCCS Division of Health Care Management (DHCM) Clinical Quality Management Unit (CQM). CQM is responsible for managing, among other things, all access to care and Quality of Care concerns. If a concern is submitted specific to a FFS member, the CQM team refers the information to the Division of Fee for Service Management (DFSM) Quality Management (QM) team for review and appropriate next steps.

When comments are submitted through the website, the sender receives an automatic response acknowledging receipt of submission. DHCM CQM/DFSM QM promptly reviews the responses. Depending on the nature of the comment, CQM does one of the following:

- The DFSM QM or Care Coordination team directly intervenes to help FFS beneficiaries obtain services in the event they are having difficulty obtaining access to care (e.g. a FFS member needs help scheduling a surgery or finding a provider). The team maintains a record of the specific access issue and the resolution.
- When beneficiaries enrolled in MCOs present access to care issues, CQM directs beneficiaries to the MCO responsible to ensure adequate access to care. In accordance with longstanding AHCCCS requirements, MCOs maintain detailed records of access to care concerns and report these issues to AHCCCS on a quarterly basis. If a member is not comfortable engaging with their MCO on the matter, CQM handles the issue directly on behalf of the member. More significant concerns which may arise are reported on an ad hoc basis by the MCO.
- When comments involve multiple beneficiaries, CQM conducts an appropriate investigation, analyzes the concerns, responds to the commenter, and maintains a

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<https://archive.azahcccs.gov/archive/Resources/Reports/Population%20Statistics/2019/Sep/AHCCSPopulationbyCategory.pdf>

record of the specific access issues and resolutions. As necessary, CQM involves other AHCCCS divisions and MCOs in this process.

- When appropriate (e.g. a provider rate issue), CQM directs the commenter to the appropriate resource, maintains a record of the issue, and works with the resource to ensure a resolution. For example, a provider rate issue will be referred to the AHCCCS Reimbursement Unit to assist on the matter while a claim issue will be addressed by the DFSM claims unit. CQM maintains a record of the specific access issues and resolutions.
- When comments are not related to access to care issues, CQM directs the commenter to the appropriate resource.

AHCCCS also manages the Access to Care Committee, a cross-divisional committee that reviews individual and systemic Access to Care issues for AHCCCS members enrolled in MCO's, the Department of Economic Security Developmental Disabilities Program, the Comprehensive Medical and Dental Program, and the Fee for Service program, to inform Medicaid health care delivery decisions as well as the development of reimbursement rates to ensure the availability of AHCCCS-covered services. The Committee generally convenes on a quarterly basis and includes representation from DHCM Operations, Clinical, Network, Rates and Reimbursement functions, as well as from the Division of Fee for Service Management, Office of Administrative Legal Services (OALS) and Division of Community Advocacy and Intergovernmental Relations (DCAIR). The Committee operates in compliance with federal access to care requirements for FFS Programs as specified in 42 USC 1396a(a)(30)(A) and 42 CFR Part 447 as well as Contractor service availability and accessibility requirements delineated in 42 CFR Part 438.200 et seq.

Agency hearing records do not identify FFS requests for hearing pertaining to access to care issues filed by beneficiaries in FFY 2018 and FFY 2019. Moreover, discussions with AHCCCS employees responding to these matters and addressing beneficiary concerns have not identified such concerns

As discussed earlier in the report, approximately 87% of AHCCCS beneficiaries are enrolled in managed care, and the managed care organization is responsible for oversight and resolution of access to care concerns. Of those members who are in the fee-for-service program, about half are enrolled in the federal emergency services program where services are limited to emergency services. AHCCCS contracts with almost all hospitals in the state, and AHCCCS staff did not identify access to care concerns from the FES population. Thus, the limited concerns expressed by FFS members regarding access issues are most likely to come from American Indian/Alaska Native members who chose not to participate in Medicaid managed care.

## **PROVIDER INPUT**

In addition to offering providers the same mechanisms for providing input as beneficiaries, AHCCCS additionally provides a variety of opportunities for providers to furnish feedback and express concerns relative to rates and access to care issues:

- Prior to updating rates, AHCCCS posts a Notice of Public Information on its website and allows for no less than a 30-day comment period. Public Notices for institutional rates are posted on two separate occasions: once to post notice of proposed rates where a minimum 30-day public comment period is offered, and a second time for notice of final rates after Agency consideration of public comments. Although AHCCCS has historically posted an overall aggregate rate change for each fee schedule, beginning in July 2016, AHCCCS began publishing each individual fee schedule that is a subject of the Notice of Public Information.
- AHCCCS works closely with the tribes, Indian Health Services, tribal health programs operated under P.L. 93-638, and urban Indian health programs, conducting approximately six AHCCCS Tribal Consultation Meetings each year in order to convey information on policy and programmatic changes that may impact Native American members and to solicit valuable input from these entities. Additionally, the AHCCCS Tribal Liaison communicates extensively with Tribal organizations and representatives and is available to address any relevant concerns.
- On a quarterly basis, AHCCCS hosts a State Medicaid Advisory Committee meeting which presents topical information regarding the AHCCCS Program and solicits feedback. Meetings are open to the public and every meeting has an open discussion period.
- The Division of Fee-for-Service Management [Policy & Education Unit](#) provides professional and technical assistance to providers, developing resources and publications that are relevant for policy questions and billing issues. This unit also coordinates and facilitates education and training for providers conducting large and smaller group sessions targeting specific provider types or specific billing/policy issues. Training materials are created and updated continually, ensuring the providers are given current and relevant information for their claim submissions. This library of training resources is shared with providers upon request, to reinforce the information disseminated in the training sessions and to provide a resource for provider's staff who may need a refresher on the material.
- The DHCM Reimbursement Unit operates a Fee-for-Service Rates email box through which providers may ask questions about reimbursement rates and express rate concerns. Providers and provider associations also provide feedback to the Reimbursement Unit throughout the year, and this feedback is taken into consideration when updating rates at least annually.
- The DHCM Reimbursement Unit also actively engages providers and provider associations when significant changes are made to rates and/or reimbursement methodologies. For example, the Agency's FFY 2017 creation of a new provider type and fee schedule for the Treat and Refer service was accomplished in coordination and collaboration with representatives of other state agencies and potential providers.



- Provider concerns about access to care issues inform the Agency's policies. For example, AHCCCS has used public comments to help develop Differential Adjusted Payment opportunities to address some of these concerns, such as provisions of services to members in a difficult-to-access location.
- The public is invited to submit comments to all proposed regulations which implicate rate issues. The Arizona Administrative Procedure Act (APA) mandates a thirty day comment period where the public has the opportunity to submit comments and is notified of scheduled public hearings in different regions of the State. AHCCCS publishes proposed regulations subject to the APA in the Arizona Administrative Register which is published throughout the State, inviting the public to submit input. As mentioned, AHCCCS also schedules public hearings in different areas of the State to invite participation, so that individuals may appear and submit comments in person for rules promulgated pursuant to the APA. As an additional forum, AHCCCS also publishes the proposed regulations on its public website where it also invites public commentary. All comments received from the public, as well as the Agency's response to each comment, are published on the Agency website.

AHCCCS will continue to maintain these avenues for providers to express input on rates and will formally track these concerns.

## **DATA AND ANALYSIS**

AHCCCS [will analyze](#) the following service categories: primary care services, physician specialist services, behavioral health services, pre- and post- natal obstetric services, home health services, and durable medical equipment, prosthetics, orthotics and supplies. If AHCCCS implements a rate reduction or payment restructuring of a state plan service when the changes could result in diminished access, AHCCCS will monitor access to care of such service in accordance with public review requirements, at least annually for a period three years after the effective date of the State Plan Amendment authorizing the reduction or restructuring.

A comparison to Medicare rates will be made when Medicare provides coverage for similar services. Since Medicare only provides limited dental, home health, and inpatient behavioral health services, a comparison is not included in the Access Monitoring Review Plan. Rate comparisons will also be included to four neighboring states (Colorado, New Mexico, Nevada, and Utah) when those states make their rates available on their website and reimburse using a similar rate structure.

### *Data Limitations*

There are a number of data limitations encountered when analyzing access to care:

- Indian Health Services (IHS) and Tribal 638 facilities often bill on the UB Form and are paid at an all-inclusive rate. This type of billing does not always allow AHCCCS to determine the type of services (e.g., primary care physician visit, dental services)

that were provided to the beneficiaries. For purposes of this report, we have included claims from IHS and Tribal 638 *clinics* in the primary care data, based on the assumption that services provided at the clinics are likely and mostly primary care services. Claims would be included with the Dentists/Dental Hygienists claims if dental service claims administered at IHS and Tribal 638 facilities used a form that allowed for the identification of dental services.

- Prior to April 1, 2015, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) were not distinguishable from other provider types in the AHCCCS claims system.
- AHCCCS does not differentiate between primary care physicians and specialty physicians for purposes of reimbursement. For the purpose of this report, AHCCCS looked at the specialties which Doctors of Medicine (M.D.) and Doctors of Osteopathic Medicine (D.O.) reported when registering with AHCCCS. Physicians reporting the following specialties were classified as primary care physicians: family practice, general medicine, internal medicine, obstetrician and gynecologist, gynecologist, obstetrician, pediatrician, and gerontologist. All other physicians were classified as physician specialists.
- Medicaid rate comparisons for neighboring states are unavailable for behavioral health services and home health services.
- Medicare rate comparisons are unavailable for behavioral health services, dental and home health services.
- Private health insurance payments are proprietary and unavailable to the AHCCCS Administration.

More details about the data sources and information to be reviewed appears below.

### ***Review Analysis of Primary Care Services***

Data Sources:

- Medicaid claims payment data- Program Management and Medical Information System (PMMIS)
- Medicaid websites from neighboring states
- Kaiser Family Foundation
- American Dental Association

Availability of primary care providers:

- Explanation of AHCCCS Physician, Dental, and FQHC and RHC prospective payment system (PPS) Rates fee schedules
- Number of the following AHCCCS-enrolled primary care providers, trended over time, by Arizona urban and rural areas:
  - Primary Care Physicians
  - Primary Care Non-Physician Practitioners
  - Dentists and Dental Hygienists
- Comparison of cumulative change of provider rates, trended over time, for the aforementioned providers
- Number of AHCCCS claims per 1,000 beneficiaries trended over time by:

- o Primary Care Physicians
- o Primary Care Non-Physician Practitioners
- o Dentists/Dental Hygienists
- o IHS/638 Clinics
- o FQHC/FQHC Look-Alikes (FQHC-LAs), and RHCs
- Comparison of AHCCCS physician rates to Medicare rates and Medicaid rates for western states. If available, breakout of rates by all services, primary care, obstetric care, and other services
- Comparison of physician fee schedules to Medicare rates by place of service: facility, non-facility, and IHS/638
- Estimated percentage of Arizona physicians participating with AHCCCS
- Number of AHCCCS-enrolled FQHCs, FQHC-LAs, and RHCs trended over time
- Number of AHCCCS FQHC patients, FFS claims, and FTEs
- Estimated number of Arizona dentists participating with AHCCCS
- Comparison of average Medicaid dental rates in western states

### ***Review Analysis of Physician Specialists***

#### Data Sources:

- Medicaid claims payment data (PMMIS)
- Medicaid websites from neighboring states
- Kaiser Family Foundation

#### Availability of physician specialists:

- Explanation of AHCCCS physician fee schedules
- Number of AHCCCS-enrolled physician specialist providers trended over time and broken out by Arizona urban and rural areas
- Number of AHCCCS claims per 1,000 beneficiaries trended over time
- Comparison of cumulative change of AHCCCS physician fee schedules and physician specialist providers
- Comparison of AHCCCS physician rates to Medicare rates and Medicaid rates for western states

### ***Review Analysis of Behavioral Health Services***

#### Data Sources:

- Medicaid claims payment data (PMMIS)

#### Availability of behavioral health services:

- Explanation of AHCCCS behavioral health inpatient and behavioral health outpatient fee schedules
- Number of AHCCCS-enrolled behavioral health providers trended over time, broken out by Arizona urban and rural areas, and broken out by the following:
  - o Clinic/Outpatient Providers
  - o Individual Practitioners
  - o Inpatient Facilities
  - o Substance Abuse Services

- Number of AHCCCS claims per 1,000 beneficiaries trended over time broken out by providers mentioned above
- Comparison of covered Medicare outpatient behavioral health procedure codes to AHCCCS rates
- Comparison of outpatient behavioral health fee schedule to AHCCCS MCO fee schedule broken out by place of service
- Comparison of cumulative change of provider rates and the providers mentioned above trended over time

***Review Analysis of Pre- and Post-Natal Obstetric Services***

In Arizona, Medicaid-covered prenatal and postnatal obstetric services are paid primarily through capitated arrangements between the AHCCCS MCOs and providers, including the costs associated with labor and delivery. Due to the data limitations described above with respect to IHS and Tribal 638 billing and reimbursements, the number of FFS claims that are identifiable as prenatal and/or postnatal obstetric services is negligible. For that reason, AHCCCS is not including an analysis of prenatal and postnatal obstetric services as part of this access review monitoring plan submission.

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

Data Sources:

- Medicaid claims payment data (PMMIS)

Availability of home health services:

- Explanation of AHCCCS home health and DMEPOS fee schedule
- Number of AHCCCS-enrolled home health services and DMEPOS providers trended over time and broken out by Arizona urban and rural areas
- Number of AHCCCS claims per 1,000 beneficiaries trended over time
- Comparison of AHCCCS FFS rates to MCO rates for most common services broken out by Geographic Service Area
- Comparison of cumulative change of fee schedule and providers
- Comparison of DME rates to Medicare rates broken out by IHS/Tribal 638 facilities and non-IHS/Tribal 638 facilities.