

March 23, 2016

The Honorable Don Shooter
Chairman, Joint Legislative Budget Committee
Arizona State Senate
1700 West Washington
Phoenix, Arizona 85007

Dear Senator Shooter:

Pursuant to a footnote in the General Appropriation Act, the Arizona Health Care Cost Containment System (AHCCCS) is required to report to the Joint Legislative Budget Committee (JLBC) by March 1 annually “on the preliminary actuarial estimates of the capitation rate changes for the following fiscal year along with the reasons for the estimated changes.”

AHCCCS is Arizona’s single state Medicaid agency; however, the Arizona Medicaid system includes state agency subcontractors including the Department of Economic Security and the Department of Child Safety. The preliminary estimates contained in this letter address the capitation rates for Contract Year Ending (CYE) 2017 (October 1, 2016 through September 30, 2017, unless otherwise noted) for the following programs:

- Acute Care
- Behavioral Health¹
- Children’s Rehabilitative Services (CRS)
- Arizona Long Term Care System (ALTCS) Elderly and Physically Disabled (EPD)
- ALTCS DES/Division of Developmental Disabilities (DDD) (July 1, 2016 through June 30, 2017)
- DCS/Comprehensive Medical and Dental Program (CMDP) (July 1, 2016 through June 30, 2017)

This preliminary review of capitation rates for contract year ending (CYE) 2017 allows for the following:

- Funding utilization increases and unit cost trends
- Provider rate increases for select providers if access to care analysis merits such increases, and other provider rate considerations
- Continuation of mid-year provider rate changes
- Consideration of utilization increases for members with, or at risk of, Autism Spectrum Disorder (ASD)
- Consideration of behavioral health utilization increases for children in foster care
- Consideration of treatment for members with substance use disorder.

This letter is designed to provide policymakers with information to inform funding-related discussions during the legislative session, given that capitation rate calculations typically occur during the summer and fall months. Laws 2015, Chapter 14, limits AHCCCS capitation rate growth in fiscal years 17 and 18

¹Effective July 1, 2016, the current contract between AHCCCS and the Arizona Department of Health Services/Behavioral Health Services (ADHS/DBHS) for oversight of the behavioral health sub-contractors is terminated in accordance with Laws 2015, Chapter 19 and 195, which authorized the merger of AHCCCS’ and DBHS’ administrative structure and personnel, henceforth referred to as “Administrative Simplification.”

to 1.5%.² Over the past seven years, AHCCCS capitation rates have grown by 0.3% in total, at an average annual rate of 0.05%. Nationally, the average Medicaid per enrollee cost has increased by 7.8% in total, at an average annual rate of 1.3%, and is projected to grow at an average annual rate of 4.7% through 2024. Since FY 2008, General Fund support for Medicaid across all agencies has grown by only 7% while enrollment has increased by almost 800,000 members since that time.

It is clear AHCCCS has employed a variety of levers to keep growth in program spending low and far below national figures. AHCCCS continues to develop initiatives such as integration, value-based purchasing and care coordination projects designed to reduce the overall growth in the cost of care for its members. However, there are cost pressures that moving forward will need to be recognized in order to assure ongoing access to care for AHCCCS members. Broadly, AHCCCS has concerns about its ability to assure access to care without some recognition of increasing provider costs. The table below outlines changes in provider rates since 2009.

Provider	Rate Changes 2009 to 2016
Hospital Inpatient ³	(16)% nonoutliers (20)% outliers
Hospital Outpatient	(8.7)%
NF (EPD)	2.3%
Behavioral Health Outpatient	(4.6)%
Physician	(13.2)%
Ambulance – ADHS Regulated	29.5%
Non-Emergency Transportation	(11.3)%
Dental	(12.5)%

Given the myriad issues and pressures that will be discussed in this letter, AHCCCS has concerns about the actions that would need to be taken to meet the 1.5% target.

The issues that are outlined below will all be incorporated into the rates for October 1, 2016.

Utilization and Unit Cost Trends

AHCCCS' actuaries have not had an opportunity to update the comprehensive review of historical utilization or unit cost trend data based on the most recent dates of service. System programming to extract recent data is in process and such a review shall commence in the spring. The actuaries will ascertain how utilization and unit cost trends should impact capitation rates for CYE 2017 across all programs so that policy decisions can be finalized to develop the capitation rates in accordance with budgetary expectations. Please note that unit cost increases can occur for a variety of reasons, even when provider reimbursement levels are flat or decreasing. Unit cost trends increase when the mix of the

² The FY 2017 Executive Budget Recommendation includes language to permit AHCCCS to increase capitation rates above this 1.5% limit if required for the rates to be actuarially sound.

³ Long-Term Acute Care and Rehabilitation hospitals received a 1.1% increase in 2016, so their cumulative impacts are 1.1% less than the General Acute figures reported here.

services utilized by members shift to more costly services. Pharmacy costs also contribute to increasing trends as AHCCCS cannot influence pharmaceutical pricing. AHCCCS' actuaries have observed double-digit growth in the limited use of brand-name drug expenditures; the much more frequently utilized generic drug expenditures are growing at rates exceeding inflation.

Provider Rates

Provider Rate Adjustments Due to Access to Care

The AHCCCS Administration and its contracted Managed Care Organizations (MCOs) are responsible for ensuring an adequate network of providers to secure members' access to needed care. AHCCCS has extensive tools in place to monitor network adequacy among various provider types. As part of this process, AHCCCS conducts yearly reviews of how rate reductions, and conversely rate increases, impact access to care. Past studies have been published on the AHCCCS website, are made available for public comment, and can be found at:

<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/>

The provider reimbursement rate review considers, among other things, factors such as the economy and market trends (including employment trends and wage pressures for providers), access and network adequacy, and potential opportunities for efficiencies. AHCCCS will complete this access to care analysis to inform its provider rate decisions for CYE 2017. The Centers for Medicare and Medicaid Services (CMS) will review AHCCCS' recommendations to determine whether the proposal meets federal access to care requirements.

In addition to these standard reviews, CMS has recently implemented heightened scrutiny on rate changes, including establishing additional reporting requirements regarding fee-for-service (FFS) rate changes and the implications of those changes on access to care. These requirements include both a periodic monitoring report as well as a specific analysis each time rates are changed. The analysis is required for access to care for primary care services, specialist services, behavioral health services, obstetrics and home health. Arizona must consider the availability of Medicaid providers, utilization of Medicaid services and the extent to which Medicaid beneficiaries' healthcare needs are fully met and demonstrate that Medicaid beneficiaries have access to healthcare that is similar to that of the general population.

Below are specific areas of focus but ultimately the access to care analysis will further inform the need for rate changes.

Behavioral Health Outpatient Rates

As part of Administrative Simplification, AHCCCS staff will compute behavioral health provider rates along with all other reimbursement rates. For rates effective October 1, 2015, AHCCCS increased select FFS behavioral health inpatient rates to the average of the rates paid by MCOs, which did not require a capitation rate change since the rates were reflecting the MCO market rates. Outpatient behavioral health rates will be reviewed in response to persistent concerns that could impact member access to care, and adjusted as appropriate for CYE 2017.

Air Ambulance Transportation Rates

Effective January 1, 2016, AHCCCS increased air ambulance transportation rates to respond to concerns that could have impacted fee-for-service (FFS) members' access to care. The rate change did not have a material impact on MCO capitation rates and thus no adjustment was made mid-year to the CYE 2016 capitation rates. CYE 2017 capitation rates will be adjusted to

incorporate these FFS rate changes, or other adjustments to the air ambulance transportation rates that might occur for CYE 2017.

Pressures on Home and Community Based Services (HCBS) Rates

Recent Federal laws and regulations have created compounding pressure on in-home care providers who are critical partners in AHCCCS' cost-saving HCBS model of care and for whom AHCCCS is the predominant source of revenue. These requirements include:

- the Affordable Care Act's "large employer" health insurance coverage mandate for employers with at least 50 full-time employees (or equivalent full- and part-time workers) and their dependents
- the Department of Labor's (DOL) home care final rule which extends minimum wage and overtime protections to home care workers (for weekly hours exceeding 40)
- the DOL ruling that travel time between multiple clients during a workday is considered hours worked under the Fair Labor Standards Act and must be paid and counted toward the 40-hour work week

In addition to these federally-driven rate impacts, providers are reporting overall wage pressure and related challenges in recruiting HCBS providers. As we have previously reported, HCBS providers have continued challenges attracting individuals to work in direct care, which is more demanding both from a training and day-to-day work basis than jobs that pay comparable salaries. AHCCCS is working with its contractors to analyze these provider reports and determine strategies to address access to care issues, which could require additional funding to ensure continued availability of services.

Value Based Purchasing Differentiated Provider Rates

Value-Based Purchasing (VBP) is a cornerstone of AHCCCS' strategy to bend the upward trajectory of health care costs. AHCCCS is implementing initiatives to leverage the managed care model toward value based health care systems where members' experience and population health are improved, per-capita health care cost better managed through aligned incentives with managed care organization and provider partners, and there is a commitment to continuous quality improvement and learning. One such initiative for CYE 2017 is to establish a rate differential for for AHCCCS-registered Arizona hospitals and nursing facilities which meet established value based performance metrics requirements. The purpose of the VBP differentiated payment is to incentivize providers to take steps toward actions that improve patients' care experience, improve members' health, and ultimately reduce cost of care growth. More information is available here:

<https://www.azahcccs.gov/shared/Downloads/News/ValueBasedPaymentRateDifferentialPublicNotice1232015Final.pdf>.

Pediatric Hospital Funding

In 2012 CMS approved the Safety Net Care Pool (SNCP) program designed to help hospitals with managing the burden on uncompensated care costs. This was approved at a time when the State had frozen new enrollment for its childless adult category (0-100% FPL). Many hospitals across the State participated in the SNCP, and the program proved to be incredibly valuable as a bridge to 2014. The program ended on December 31, 2013, in anticipation of the State's restoration of childless adult coverage and addition of new coverage for adults 100-133% FPL. However, SNCP was extended on a short-term basis for Phoenix Children's Hospital (PCH), to address issues unique to this freestanding children's hospital that did not benefit from adult coverage restoration and expansion.

With the expiration of SNCP looming for PCH, AHCCCS has been exploring sustainable and appropriate options for increasing funds for the freestanding pediatric hospital as well as high acuity pediatric hospital providers to preserve access to care for this priority population. To that end, as was reported in our letter

on the October 1, 2015 capitation rates, effective January 1, 2016, AHCCCS introduced a high acuity pediatric adjustor for inpatient hospital claims described more fully below. AHCCCS will continue to identify new or expanded funding opportunities to support these critical pediatric services for CYE 2017.

Continuation of Mid-Year Funding

Annualize the Inpatient Hospital High Acuity Pediatric Adjustor

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

Beginning January 1, 2016, AHCCCS implemented a new payment adjustor associated with high-acuity pediatric cases. This payment modification provides for an adjustment factor of 1.60 in place of the original pediatric policy adjustor for claims which are determined to have higher acuity (identified by specific APR-DRG Severity of Illness codes). Funding for these high-acuity claims was included in the CYE 16 capitation rates for three-quarters of the year; the CYE 2017 rates will include the full-year impact.

Committee Recommendations for Specific Populations

Members With, or At Risk of, Autism Spectrum Disorder

In April 2015 the Governor's Office established the statewide ASD Advisory Committee representing a broad range of stakeholders to address and provide recommendations to strengthen services for members who have or at risk of having ASD. In February 2016 the ASD Advisory Committee finalized its recommendations to respond to the needs of AHCCCS members with or at risk for ASD. The recommendations include both systems-level changes that will take time to implement as well as short-term activities that could more quickly enhance access to services for members with or at risk of having ASD. Those short-term solutions cover myriad issues including, but not limited to, expansion of contracted providers; addition of behavioral health service codes; provision of education to members, families, providers and other stakeholders; and increased access to specified providers. AHCCCS' actuaries will have to monitor future utilization and cost trends to determine if adjustments are warranted due to this increased focus on members with or at risk of ASD.

Children in Foster Care

Children involved with the child welfare system have unique health care needs often characterized by significant risk of experiencing behavioral health conditions and concomitant chronic medical issues. Senate Bill 1375 (2013 Legislative Session) required AHCCCS, in collaboration with DCS and ADHS, to determine the most efficient and effective way to deliver services to children in foster care, and to examine specific issues related to the provision of behavioral health services to those children and their adoptive parents. A report published in October 2015 summarizes the recommendations of the state agency collaborative, including the need to institute continued improvement efforts through the existing delivery system structure through September 30, 2019, followed by the implementation of an integrated CMDP contracted network model beginning October 1, 2019. Those short-term solutions cover a myriad of issues including, but not limited to, extending Medicaid enrollment for children exiting foster care; ensuring 100% compliance utilizing the Child and Family Team model; increased monitoring regarding timeframes for behavioral health screening and evaluation; and training to foster caregivers. In addition, there is extensive legislative interest in access to behavioral health services for children involved in the child welfare system and through the legislative session, additional opportunities for improving service delivery to this population have been identified. AHCCCS' actuaries will have to monitor future

utilization and cost trends to determine if adjustments are warranted due to these initiatives to improve access to behavioral health services for children in foster care.

Substance Abuse Services

On February 23, 2016, Governor Doug Ducey established the Arizona Substance Abuse Task Force to focus on “addressing and reversing the growing epidemic of drug abuse and addiction in Arizona communities by finding the best treatments and reducing barriers to care.”⁴ The Governor identified a need to focus on prevention and treatment activities as a key component of addressing the needs of individuals with substance use disorder. The Task Force will provide recommendations on a variety of issues including access to treatment services. To the extent that the Task Force recommendations impact utilization or identify barriers to access to care, AHCCCS’ actuaries will have to determine if adjustments are warranted due to the implementation of any AHCCCS-related recommendations.

Other Changes

Health Insurer Fee

Under the Affordable Care Act, beginning on January 1, 2014, health insurers including Medicaid health plans are required to pay a health insurer assessment due by September 30 each year. Assessments are based on each insurer’s market share of the previous year’s revenue as calculated by the US Treasury Department, and increase each year. Certain exceptions apply. AHCCCS intends to update capitation rates annually on a retroactive basis after the Treasury Department notifies each entity of its Health Insurer Fee payable – such notification will occur after the capitation rates for the new contract year are already established. For this reason, AHCCCS will not include these assessment payments in the annual cap rates until later in the calendar year. The capitation rate amendments to include funding for the 2015 Health Insurer Fee were submitted to CMS for approval in January 2016 and resulted in a 1.02% increase to AHCCCS’ capitation rates inclusive of income taxes. Because the assessment amount for 2016 is unchanged from 2015, AHCCCS anticipates the 2016 Health Insurer Fee will impact AHCCCS’ capitation rates by a comparable amount.

The actuarial analysis for the rate adjustments will continue throughout the summer, and will be based on the most up-to-date encounter data and contractor financial statements available. Mandated or court-ordered program changes that occur prior to July 1, 2016 or October 1, 2016 may result in changes to these estimates.

Please direct any questions regarding this letter to Shelli Silver at shelli.silver@azahcccs.gov or (602) 417-4647.

Sincerely,



Thomas J. Betlach
Director

cc: The Honorable Justin Olson, House of Representatives
Richard Stavneak, Joint Legislative Budget Committee
Christina Corieri, Governor’s Office, Policy Advisor for Health and Human Services
Lorenzo Romero, Governor’s Office of Strategic Planning & Budgeting
Beth Kohler, AHCCCS Deputy Director

⁴ <http://azgovernor.gov/governor/news/2016/02/governor-doug-ducey-appoints-substance-abuse-task-force>.