PROGRAM CHANGES AND FEE SCHEDULE CHANGES

Introduction

This document contains historical and future program changes as well as historical changes to the AHCCCS Fee For Service rates to aid in capitation rate development and/or review.

Program Changes

When preparing the capitation rate bid submissions, the following program changes should be considered when reviewing the Data Book and financial statement information provided in the data supplement.

Each program change listed below took effect during the base period, October 1, 2012 to September 30, 2015, for which encounters have been presented or following the base period for which encounters have not been presented. As such, each contract year contained in the Data Book reflects a different benefit design, which can skew PMPM trend development. AHCCCS capitation rate development thus includes adjusting data for the impact of each program change as shown below. Except where noted in regards to PCP Parity payments, the data adjustments involve adding positive PMPM amounts to, or subtracting negative PMPM amounts from, the PMPM encounter totals in the Data Book for the timeframe prior to the effective date of each program change. In instances where the program change started or ended during a Data Book contract year rather than at the beginning or end, it would be appropriate to add or subtract a portion of the listed PMPM amounts to the Data Book cost totals for that contract year.

Below is a brief description of the AHCCCS EPD program changes and their effective dates:

Table I – Program Change Items Considered in Development of Capitation Rate Ranges Published with RFP

Program Change Item	Effective Date(s)
Primary Care Provider (PCP) Parity Payment Increase	January 2013 and January 2014
Children's Rehabilitative Services (CRS) Costs Moved to EPD	October 2013
Medical Management Changes	October 2013
Diagnosis Related Group (DRG) Impacts	October 2014
Hepatitis C – Sovaldi and New Hepatitis C Drugs	October 2014 and October 2016
Medically Preferred Treatment Options	October 2014 and August 2015
FQHC/RHC All-Inclusive PPS Rates	April 2015
Incontinence Briefs	April 2015
High Acuity Pediatric Adjustor	January 2016 and January 2017
In-Lieu of Services	July 5, 2016
VBP Differential	October 2016
Podiatry	October 2016
ALTCS Adult Dental	October 2016

Table II: Program Change Items NOT Considered in Development of Capitation Rate Ranges Published with RFP, But May Be Included as a Capitation Rate Adjustment

Program Change Item	Effective Date(s)
Pharmacy Analysis	CYE 17
Minimum Wage Increase	January 2017
Nursing Facility Assessment	Multiple
Health Insurer Fee	January 2018
Other Program Changes to be Determined	Multiple

Detailed Descriptions: For Table I Program Change Items

Primary Care Provider (PCP) Parity Payment Increase – Effective January 2013 through December 2014
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 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 proposed 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.

In summary, under Model 3, prospective capitation rates were not adjusted for the enhanced primary care payments. Rather, AHCCCS queried 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 was verified, AHCCCS paid the Contractors the calculated additional payment amounts. A more detailed explanation of the process and methodology can be found in the Actuarial Certification submitted to CMS for approval of AHCCCS methodology.

The dollar amounts below are not included in the capitation rates or capitation rate ranges for the effective time frame, but the increased payments are included in the Data Book cost amounts and should be removed from the Data Book cost amounts in order to reflect current conditions in provider reimbursement. The table below supplies the dollar amounts by GSA and risk group to be removed from the Data Book cost amounts before computing PMPMs:

CYE	Dual North	Dual South	Dual Central	Non-Dual North	Non-Dual South	Non-Dual Central
FFY13	$5,821.57	$19,574.50	$61,124.53	$36,739.38	$157,075.92	$843,628.68
FFY14	$19,170.24	$28,960.82	$121,490.93	$78,295.39	$214,066.38	$1,034,444.59
FFY15	$1,555.42	$10,971.16	$38,833.93	$14,492.27	$52,111.66	$244,697.12

Children's Rehabilitative Services (CRS) Costs Moved to EPD – Effective October 2013

Some EPD members with special health care needs received services related to specific conditions through the Children's Rehabilitative Services (CRS) program at the same time they were enrolled with an EPD Contractor for unrelated physical health services, and long-term care and behavioral health services. Effective October 1, 2013, the CRS-specific services for those members are now delivered through the members' EPD Contractors in order to integrate total member service delivery through a single Contractor. The estimated impact varied by GSA and risk group as listed below on a PMPM basis:

Dual	Dual	Dual	Non-Dual	Non-Dual	Non-Dual
North	South	Central	North	South	Central
$0.00	$0.25	$0.07	$62.92	$72.60	$121.76

Medical Management Changes – Effective October 2013

The State of Arizona's 2013 Health and Welfare Budget Reconciliation Bill (BRB) reinstated well visits, which were previously eliminated October 1, 2010, as a covered service for enrolled adults for federal fiscal year 2014. The estimated impact is shown below on a PMPM basis:

Dual	Dual	Dual	Non-Dual	Non-Dual	Non-Dual
North	South	Central	North	South	Central
$0.04	$0.14	$0.14	$0.72	$0.76	$1.11

Diagnosis Related Group (DRG) Impacts – Effective October 2014

Acute hospital inpatient stays with dates of discharge on and after October 1, 2014 are paid using an All Patient Refined Diagnosis Related Group (APR-DRG) payment system (with certain exclusions). This payment system replaced the 20+ year tiered per diem inpatient reimbursement system in accordance with A.R.S. § 36-2903.01 and Arizona Administrative Code (A.A.C.) R9-22-712.60 through 712.81. The impact of this move to APR-DRG was budget neutral to the state, but did vary by Program. In addition to the methodological change, there were impacts to what qualifies for reinsurance. The estimated, combined impact of both the methodological and reinsurance change to the EPD program is listed below on a PMPM basis:

Dual	Dual	Dual	Non-Dual	Non-Dual	Non-Dual
North	South	Central	North	South	Central
$0.05	$1.80	($1.19)	($39.32)	($46.27)	($5.80)

Hepatitis C – Sovaldi and New Hepatitis C Drugs - Effective October 2014

The Food and Drug Administration (FDA) approved Sovaldi, a treatment option for hepatitis C, in December 2013. Sovaldi has the potential to positively impact the care and outcomes for certain Hepatitis C-positive individuals, but it also has significant financial implications. New Hepatitis C drugs were released in the fall of 2014. The estimated impact varied by GSA and risk group as listed below on a PMPM basis:

Dual North	Dual South	Dual Central	Non-Dual North	Non-Dual South	Non-Dual Central
$0.00	$0.00	$0.00	$0.00	$13.29	$27.42

Medically Preferred Treatment Options - Effective October 2014

Effective October 1, 2014, AHCCCS began providing medically necessary orthotics services that are recognized as a preferred treatment option and are less expensive than other treatment or surgical options. More specifically, AHCCCS reinstated orthotics instead of imminent surgery, or as necessary as a result of surgery, with prescribed criteria. There was no impact to rates as these orthotics were offered in place of more costly interventions.

FQHC/RHC All-Inclusive PPS Rates - Effective April 2015

AHCCCS shifted payment responsibility for FQHC/RHC PPS rates to the Contractors in order to properly account for FQHC/RHC expenditures for managed care enrollees. To identify the amount of full-funding needed for Contractors to pay the PPS rates on a per visit basis, it was necessary to identify the historical FQHC/RHC visits in order to distribute the quarterly supplemental and annual reconciliation payments made by the Administration.

The historical encounter data for FQHC/RHC expenditures was paid on a per service basis while the new mandate required payment on a per visit basis, thus AHCCCS had to group the encounter service data to represent visits. A visit is defined as a face-to-face encounter with a licensed AHCCCS-registered practitioner during which an AHCCCS-covered ambulatory service is provided when that service is not incident to another service. Multiple encounters with more than one practitioner within the same discipline, i.e., dental, physical, behavioral health, or with the same practitioner and which take place on the same day and at a single location, constitute a single visit unless the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. In this circumstance, the subsequent encounter is considered a separate visit. A service which is provided incident to another service, whether or not on the same day or at the same location, is considered to be part of the visit and is not reimbursed separately.

The visits from the historical encounter data were then used to develop the distribution of FQHC/RHC utilization by AHCCCS line of business (or program), Geographical Service Area (GSA) and risk group. Capitation rates were increased by the amount of the quarterly supplemental and annual reconciliation payments made by the Administration for managed care program visits, trended forward to federal fiscal year 2015. The trended Administration payment amounts were then multiplied by the visit distribution percentages by FQHC/RHC to determine the impact by program, GSA and risk group.

Additional adjustments were made to the data due to:

- The introduction of three new FQHCs/RHCs - historical encounter data is available since these providers were in place during the data period, but they did not have historical supplemental or reconciliation payments since they were not designated as FQHCs/RHCs until after the data period
- The integration of services in the Children Rehabilitative Services (CRS) program

The adjustments made to account for each of these unique situations are described below:

- The adjustment for the new FQHCs/RHCs involved projecting the reconciliation and quarterly supplemental payments from historical visits multiplied by the PPS rates and subtracting historical encounter payments
- The integration model necessitated a reassignment of historical encounter and member month data for members moved to the integrated program

The estimated impact varied by GSA and risk group as listed below on a PMPM basis: As noted previously, these amounts should be added to the PMPM costs from the Data Book for CYE 13 and 14. However, since half of CYE 15 already reflects this change, it would be appropriate to add half of these PMPM amounts to the Data Book cost totals for CYE 15.

Dual	Dual	Dual	Non-Dual	Non-Dual	Non-Dual
North	South	Central	North	South	Central
$2.44	$7.02	$3.31	$11.42	$20.38	$6.50

Incontinence Briefs – Effective April 2015

AHCCCS adjusted capitation rates effective April 1, 2015 to fund required coverage for incontinence briefs for members age 21 and older. The estimated impact varied by GSA and risk group on a PMPM basis. As noted previously, these amounts should be added to the PMPM costs from the Data Book for CYE 13 and 14. However, since half of CYE 15 already reflects this change, it would be appropriate to add half of these PMPM amounts to the Data Book cost totals for CYE 15. The PMPM amounts below are reflective of actual experience since the program change, and do not tie to the PMPM estimates added to the capitation rates effective April 1, 2015.

Dual	Dual	Dual	Non-Dual	Non-Dual	Non-Dual
North	South	Central	North	South	Central
$14.41	$14.41	$14.41	$8.77	$8.77	$8.77

Medically Preferred Treatment Options – Effective August 2015

Effective August 1, 2015, AHCCCS expanded the coverage of orthotics for members age 21 and over. More specifically, AHCCCS allowed orthotics when the use of orthotics was medically necessary as the preferred treatment option and consistent with Medicare guidelines; the orthotic was less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition; and the orthotic was ordered by a physician or a primary care practitioner. There was no impact to capitation rates as orthotics were offered in place of more costly interventions.

High Acuity Pediatric Adjustor – Effective January 2016
The AHCCCS All Patient Refined Diagnosis Related Group (APR-DRG) payment system included several policy adjustors. One such adjustor applies a factor of 1.25 to the reimbursement amount that would otherwise apply for "claims for members under age 19," as long as the claim is not subject to one of the other policy adjustors.

Beginning January 1, 2016, AHCCCS addressed the costs associated with high-acuity pediatric cases by using an adjustment factor of 1.60 in place of the above pediatric policy adjustor in the following instances only: for inpatient stays, where an APR-DRG assignment of level 3 or 4 Severity of Illness is indicated. The estimated impact varied by GSA and risk group as listed below on a PMPM basis:

Dual North	Dual South	Dual Central	Non-Dual North	Non-Dual South	Non-Dual Central
$0.00	$0.00	$0.00	$0.60	$4.17	$10.28

In-Lieu of Services – Effective July 2016
AHCCCS previously permitted funding for "in lieu of" services, substituting cost-effective alternative inpatient settings in place of more costly inpatient non-specialty hospital placements. In accordance with 438.6(e) in the Medicaid Managed Care Regulations, IMD utilization data for adults aged 21-64 were repriced at the higher State Plan service rate. The estimated impact to the ALTCS/EPD program is immaterial.

VBP Differential – Effective October 2016
AHCCCS proposed Value-Based Purchasing (VBP) Differential Adjusted Fee Schedule rates to distinguish providers who have committed to supporting designated actions that improve the patient care experience, improve member health, and reduce cost of care growth. The proposed VBP differential rates are applicable for dates of service from October 1, 2016 through September 30, 2017. FFS rates for select providers meeting specific criteria are increased 1% for qualified AHCCCS-registered Arizona Nursing Facility providers and 0.5% for qualified AHCCCS-registered Arizona Hospital providers for inpatient and outpatient services. Contractors are required to adopt the VBP Differential payment adjustments for qualified providers meeting the specific criteria. The estimated impact varied by GSA and risk group as listed below on a PMPM basis:

Dual North	Dual South	Dual Central	Non-Dual North	Non-Dual South	Non-Dual Central
$0.05	$0.13	$0.20	$1.83	$1.82	$3.14

Hepatitis C – Effective October 2016

Effective October 1, 2016, AHCCCS amended clinical criteria for members utilizing Hepatitis C drugs including, but not limited to, lowering the liver fibrosis/cirrhosis of Metavir stage (i.e. fibrosis level) to F2 from F3 for members with Hepatitis B or HIV. This action will increase utilization of direct-acting antiviral medications including Daklinza, Epclusa, Harvoni, Sovaldi, Technivie, Viekira, and their successors. In addition, AHCCCS has seen a marked increase in utilization of these drugs based on current clinical criteria. The estimated impact varied by GSA and risk group as listed below on a PMPM basis:

Dual	Dual	Dual	Non-Dual	Non-Dual	Non-Dual
North	South	Central	North	South	Central
$0.00	$0.00	$0.00	$0.00	$6.38	$12.87

Podiatry – Effective October 2016

During the 2016 legislative session, services provided by a podiatrist were reinstated. Effective October 1, 2016 AHCCCS restored this covered service. The estimated impact varied by GSA and risk group as listed below on a PMPM basis:

Dual	Dual	Dual	Non-Dual	Non-Dual	Non-Dual
North	South	Central	North	South	Central
$0.47	$0.47	$0.47	$0.47	$0.47	$0.47

ALTCS Adult Dental – Effective October 2016

During the 2016 legislative session, non-emergency (basic and preventive) dental services were reinstated for ALTCS adults up to a limit of $1,000 annually per elderly and physically disabled (EPD) member. Effective October 1, 2016 AHCCCS restored this covered service. The estimated impact varied by GSA and risk group as listed below on a PMPM basis:

Dual	Dual	Dual	Non-Dual	Non-Dual	Non-Dual
North	South	Central	North	South	Central
$6.24	$6.24	$6.24	$6.24	$6.24	$6.24

High Acuity Pediatric Adjustor – Effective January 2017

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

On January 1, 2016, AHCCCS addressed the costs associated with high-acuity pediatric cases by using an adjustment factor of 1.60 in place of the above pediatric policy adjustor in the following instances only: for inpatient stays, where an APR-DRG assignment of level 3 or 4 Severity of Illness is indicated. Effective January 1, 2017, AHCCCS will change the adjustment factor of 1.60 established January 1, 2016 to 1.945. The estimated impact varies by GSA and risk group as listed below on a PMPM basis:

Dual	Dual	Dual	Non-Dual	Non-Dual	Non-Dual
North	South	Central	North	South	Central
$0.00	$0.00	$0.00	$0.49	$3.77	$9.64

Detailed Descriptions: For Table II Program Change Items

Pharmacy Analysis

AHCCCS will be performing a deep dive into the most current pharmacy data available in early 2017 to study utilization and unit cost trends observed more recently than the base period in the Data Book, and to evaluate the impact of decisions made during the last twelve months by the Pharmacy & Therapeutics Committee to require prescriptions for specific brand-name drugs even when a generic equivalent is available. The capitation ranges will not reflect the results of this research and Offerors should not build this potential increase into their bids. Awarded capitation rates will be adjusted appropriately for this change.

Minimum Wage Increase

Proposition 206 increased the minimum wage effective January 1, 2017. The capitation ranges will not reflect this increase and Offerors should not build this increase into their bid. Awarded capitation rates will be adjusted appropriately for this change.

Nursing Facility (NF) Assessment

Arizona NFs are eligible for enhanced payments based on utilization funded through an assessment paid by the nursing facilities and matched with Federal Medicaid dollars (https://www.azahcccs.gov/PlansProviders/CurrentProviders/nursingfacilityinfo.html). AHCCCS retroactively adjusts capitation rates on a quarterly basis to reflect the enhanced payments. Historical actuarial certifications for nursing facility adjustment can be found on the AHCCCS website:
https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ManagedCare/capitationrates.html
Since the enhanced payments are calculated and implemented on a retroactive basis, the capitation ranges will not reflect enhancements related to the NF assessment, and Offerors should not build considerations for it into their bids.

Health Insurer Fees

The Affordable Care Act (ACA) places an annual fee on the health insurance industry nationwide including most Medicaid health plans effective January 1, 2014. The fee will be allocated to health insurers based on their respective market share of premium revenue in the previous year. The fee due from each insurer or Medicaid plan will be calculated by the Treasury Department and will consider the market share of applicable revenue that each plan receives. Exclusions apply to nonprofit county health plans, small plans with less than $25 million in revenue, and nonprofit entities that receive at least 80% of their revenue from Medicare, Medicaid, SCHIP, or dual-eligible members. The capitation rates do not include the fee; that adjustment will be addressed in a retroactive capitation rate adjustment once the fees are known. Historical actuarial certifications for health insurer fee adjustment can be found on the AHCCCS website:
https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ManagedCare/capitationrates.html

Other Program Changes to be Determined

As AHCCCS learns of additional program changes impacting Contractors' expenditures in CYE 18, cost/savings estimates will be evaluated to determine if capitation rates should be adjusted. Awarded capitation rates will be adjusted appropriately for any additional program changes.

Fee Schedule Changes

To aid in capitation rate development and/or review, the following AHCCCS/BHS fee schedule changes should be considered in addition to the encounter and financial statement information provided in the data supplement. These changes may impact the historical unit cost trends. This table outlines the fee schedule changes by year and service matrix categories. Additional information can be found in the actuarial certifications which are posted on the AHCCCS website:

Contract Year	2013	2013	2013	2014	2014	2014	2015	2016	2016	2017
date of rate change	10/1/2012	4/1/2013	7/1/2013	10/1/2013	1/1/2014	7/1/2014	10/1/2014	10/1/2015	1/1/2016	10/1/2016
	(1)	(1)		(1)	(1)					
Hospital Inpatient	0.0%	0.0%	0.0%	0.0%	0.0%		0.0%	0.0%	2.1%	0.0%
Hospital Inpatient-LTAC/Rehab Hospitals	0.0%	0.0%	0.0%	0.0%	0.0%		0.0%	1.1%	0.0%	0.0%
Hospital Outpatient	0.0%	0.0%	0.0%	1.2%	0.0%		0.0%	0.0%	0.0%	0.0%
Nursing Facility (DDD)	0.0%	0.7%	0.0%	0.0%	0.0%		0.0%	0.0%	0.0%	1.0%
Nursing Facility (Non DDD)	0.0%	0.0%	0.0%	1.5%	0.0%		2.0%	0.0%	0.0%	1.0%
HCBS - (DDD)	0.0%	2.0%	3.1%	0.0%	0.0%	2.0%	0.0%	1.5%	0.0%	2.0%
HCBS - In home services & adult day health (Non DDD)	0.0%	0.0%	0.0%	1.5%	0.0%	0.0%	2.0%	1.5%	0.0%	2.0%
Behavioral Health										
Inpatient -- Psych	0.0%	0.0%	0.0%	0.7%	0.0%		2.0%	2.1%	0.0%	0.0%
Outpatient -- Psych	0.0%	2.0%	0.0%	3.0%	0.0%		2.0%	0.0%	0.0%	1.8%
Tiered per diem at acute hospital	0.0%	0.0%	0.0%	0.0%	0.0%		DRG	DRG		DRG
Physician Fee Schedule -- Excluding categories below	0.2%	0.0%	0.0%	0.1%	0.0%		0.0%	0.0%	0.0%	0.1%
Clinical Lab	0.0%	0.0%	0.0%	-3.0%	0.0%		-0.7%	0.0%	0.0%	0.1%
DMEPOS	0.0%	0.0%	0.0%	0.4%	0.0%		0.4%	0.0%	0.0%	0.3%
Drugs and Injectables	1.8%	0.0%	0.0%	0.5%	0.0%		4.2%	2.3%	0.0%	5.7%
Anesthesia	0.0%	0.0%	0.0%	0.0%	0.0%		0.0%	0.0%	0.0%	0.0%
Free-Standing Dialysis	0.0%	0.0%	0.0%	0.0%	0.0%		0.0%	0.0%	0.0%	0.0%
Transportation	(2)	(2)	(2)	(2)	(2)		(2)	(2)		(2)
Emergency Ground (ADHS)	5.0%	0.0%	0.0%	2.2%	0.0%		11.3%	-6.5%	0.0%	0.4%
Emergency Ground (Tribal, OOS)	0.0%	0.0%	0.0%	0.0%	0.0%		0.0%	0.0%	0.0%	14.9%
Non Emergency Ground	0.0%	0.0%	0.0%	0.0%	0.0%		0.0%	0.0%	0.0%	0.0%
Emergency Air	0.0%	0.0%	0.0%	0.0%	0.0%		0.0%	0.0%	8.1%	0.0%
Dental	0.0%	0.0%	0.0%	2.0%	0.0%		0.0%	0.0%	0.0%	0.1%
Hospice	0.6%	0.0%	0.0%	0.5%	0.0%		1.3%	-0.3%	0.0%	2.0%
ASCs	8.3%	0.0%	0.0%	1.6%	0.0%		6.4%	0.0%	0.0%	0.0%

(1) Freezing threshold changes for outlier and prior year CCR changes

(2) Continue to pay a 68.59% of ADHS rate as of 8/2/12 for CYE 13 and 14. Increased to 74.74% of ADHS in CYE 15. Reverted to 68.59% of ADHS for CYE 16 and 17.