AHCCCS
Arizona Health Care Cost Containment System

Katie Hobbs, Governor
Carmen Heredia, Director

June 19, 2023

The Honorable David Livingston
Chairman, Joint Legislative Budget Committee
1700 W Washington
Phoenix, Arizona 85007

Dear Representative Livingston:

Please find enclosed AHCCCS' report on the adequacy and appropriateness of Title XIX reimbursement rates to providers of behavioral health services, prepared pursuant to A.R.S. §36-3403(E):

"E. The administration shall contract with an independent consulting firm for an annual study of the adequacy and appropriateness of title XIX reimbursement rates to providers of behavioral health services. The administration may require and the regional behavioral health authorities and service providers shall provide to the administration financial data in the format prescribed by the administration to assist in the study. A complete study of reimbursement rates shall be completed at least once every five years. The administration shall provide the report to the joint legislative budget committee on or before October 1 of each year. If results of the study are not completely incorporated into the capitation rate, the administration shall provide a report to the joint legislative budget committee within thirty days of setting the final capitation rate, including reasons for differences between the rate and the study."

AHCCCS contracted with Public Consulting Group (PCG) to produce this report, which found that overall, Arizona offers competitive Fee-For-Service (FFS) rates that are broadly adequate and compare favorably to the neighboring states for the services being offered in the behavioral health environment. In addition, utilization on a whole has steadily increased prior to the public health emergency for behavioral health services. While reimbursement rates appear competitive, PCG does note that the quickly changing economic landscape may provide an opportunity to adjust rates for staffing, technology, and travel costs in the future.

Should you have any questions please feel free to contact Jeffery Tegen, Chief Financial Officer, at Jeffery.tegen@azahcccs.gov.

Sincerely,

Carmen Heredia
Director

www.azahcccs.gov
602-417-4000
801 East Jefferson Street, Phoenix, AZ 85034

CC: The Honorable John Kavanaugh, Vice Chairman, Joint Legislative Budget Committee
Sarah Brown, Director, Governor's Office of Strategic Planning and Budgeting
Richard Stavneak, Director, Joint Legislative Budget Committee
Zaida Dedolph Piecoro, Health Policy Advisor, Office of the Governor

Arizona Health Care Cost Containment System Behavioral Health Rate Study

Public Consulting Group LLC

May 25, 2023

PUBLIC CONSULTING GROUP

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EXECUTIVE SUMMARY

As outlined in A.R.S. § 36-3403, the Arizona Health Care Cost Containment System (AHCCCS) is required to contract with an independent consulting firm to study and report on the adequacy and appropriateness of Title XIX reimbursement rates to providers of behavioral health services. Public Consulting Group LLC (PCG) has been selected by the AHCCCS to complete a Behavioral Health (BH) Rate Study, for their Medicaid covered BH Inpatient and Outpatient rates.

This rate study is to determine the adequacy and appropriateness of Title XIX reimbursement rates to providers of BH services, and to clearly define within this report if the rates have been determined to be adequate and appropriate. The AHCCCS Fee-For-Service (FFS) rates are in place 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 at least to the extent that such care and services are available to the general population in the geographic area.

As part of this process, PCG conducted a utilization review (UR) analysis using five (5) years of data provided to us by AHCCCS, for Federal Fiscal Year (FFY) 2017 to Federal Fiscal Year (FFY) 2022. Please note the rate increase presented by AHCCCS for BH Outpatient (OP) services on October 1, 2022 is not factored into the data analysis as data gathering was completed prior to their being issued. The review focuses on utilization trends over the five-year period, as overarching BH services, and by individual service type. PCG has also analyzed provider access over the five-year period and looked at utilization and access across counties and regionally. This analysis, broken down into Geographical Service Area (GSA), a grouping of counties that share similar geographic characteristics, gives PCG and AHCCCS a clear sense of where gaps may exist in the healthcare delivery system, and help form future recommendations.

A second part of this project includes a detailed Medicaid Rate Comparison, comparing service reimbursement rates to the rates in Utah, Nevada, Oklahoma, Colorado, and New Mexico. This comparison looked at like to like services, to determine how the reimbursement rates in Arizona compared on a percentage basis. We also included rate comparisons for Medicare, and commercial/private insurers.

The final aspect was developing rate recommendations for existing IP and OP services. PCG has identified the top 10 OP services via claim utilization and developed unique rate models for each of them. This was accomplished using data provided by AHCCCS, data collected by providers via survey, as well as researching national benchmarks, standards, and adjustment factors to determine appropriate rates. These rate recommendations are outlined in this report, as well as the methodology used to determine any rates and adjustment factors.

Through this process PCG was able to identify that Arizona Medicaid FFS rates for BH OP and IP services are competitive within the Southwest Region. The broad service offerings, and relative recent rate updates show a commitment to helping BH providers offer services. We also recognized a few opportunities to address the unique circumstances of this recent era in the United States and the impact large global events have had on BH providers, and their ability to deliver services efficiently and effectively. By reviewing some specific economic factors, and implementing a sustainable review process to rate updates, Arizona can continue to offer elevated levels of care to its Medicaid population while supporting the BH providers.

SERVICE OVERVIEW

SERVICE TYPE DESCRIPTIONS

Below are two charts outlining the outpatient and inpatient services being analyzed and updated as part of this study.

Outpatient Services

Figure 1

Procedure Code	Service Description
H0001	Alcohol and/or drug assessment
H0002	Behavioral health screening to determine eligibility for admission to treatment
H0004	Behavioral health counseling and therapy, per 15 minutes
H0006	Alcohol and/or drug services; case management
H0014	Alcohol and/or drug services; ambulatory detoxification
H0015	Alcohol and/or drug services; intensive outpatient
H0018	Behavioral health; short-term residential
H0019	Behavioral health; long-term residential
H0020	Alcohol and/or drug services; methadone administration and/or service
H0025	Behavioral health prevention education service
H0030	Behavioral health hotline service
H0031	Mental health assessment, by non-physician
H0034	Medication training and support, per 15 minutes
H0035	Mental health partial hospitalization, treatment, less than 24 hours
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes
H0037	Community psychiatric supportive treatment program, per diem
H0038	Self-help/peer services, per 15 minutes
H2010	Comprehensive medication services, per 15 minutes

H2011	Crisis intervention service, per 15 minutes
H2012	Behavioral health day treatment, per hour
H2014	Skills training and development, per 15 minutes
H2015	Comprehensive community support services, per 15 minutes
H2016	Comprehensive community support services, per diem
H2017	Psychosocial rehabilitation services, per 15 minutes
H2019	Therapeutic behavioral services, per 15 minutes
H2020	Therapeutic behavioral services, per diem
H2025	Ongoing support to maintain employment, per 15 minutes
H2026	Ongoing support to maintain employment, per diem
H2027	Psychoeducational service, per 15 minutes
H2033	Multisystemic therapy for juveniles, per 15 minutes
S5109	Home care training to home care client, per session
S5110	Home care training, family; per 15 minutes
S5131	Homemaker service, nos; per diem
S5140	Foster care, adult; per diem
S5145	Foster care, therapeutic, child; per diem
S5150	Unskilled respite care, not hospice; per 15 minutes
S5151	Unskilled respite care, not hospice; per diem
S9480	Intensive outpatient psychiatric services, per diem
S9484	Crisis intervention mental health services, per hour
S9485	Crisis intervention mental health services, per diem

T1002	Rn services, up to 15 minutes
T1003	Lpn/Lvn services, up to 15 minutes
T1016	Case management, each 15 minutes
T1019	Personal care services, per 15 minutes, not for an inpatient or resident of a
T1020	Personal care services, per diem, not for an inpatient or resident of a
T1503	Administration of medication other than oral and/or injectable by HC agency
T2020	Day habilitation, waiver; per diem
T2026	Specialized childcare, waiver; per diem

Inpatient Services

Figure 2

BH Inpatient Services		
Revenue Codes	**Service Description**	**Provider Types**
0110	Room-Board/Pvt	02, 71
0111	Med-Sur-Gyn/Pvt	02, 71
0112	Ob/Pvt	02, 71
0113	Peds/Pvt	02, 71
0114, 0124, 0134, 0154	Psychiatric Stay	02, 71
0114, 0124, 0134, 0154	Residential Treatment Center - Secure	78, B1
0114, 0124, 0134, 0154	Residential Treatment Center - Non-Secure	B2, B3
0114, 0124, 0134, 0154	Subacute Facility (non-IMD)	B5
0114, 0124, 0134, 0154	Subacute Facility (IMD)	B6
0116, 0126, 0136, 0156	Detoxification Stay	02, 71
0116, 0126, 0136, 0156	RTC-Detoxification Facility - Secure	78, B1
0116, 0126, 0136, 0156	RTC-Detoxification Facility - Non-Secure	B2, B3
0116, 0126, 0136, 0156	Detoxification Facility - (Non-IMD)	B5
0116, 0126, 0136, 0156	Detoxification Facility - (IMD)	B6
0120	Room/Board/Semi	02, 71
0160	Room & Board, General	02, 71
0183	Secure - Home Pass	78, B1
0183	Non-Secure - Home Pass	B2, B3
0189	Secure - Bed Hold	78, B1
0189	Non-Secure - Bed Hold	B2, B3

Services Without Rates

In addition to the services noted above, there was one service that did not have a posted rate at the onset of this study that was identified to ensure a rate could be set moving forward.

Figure 3

BH OP Services Without Posted Reimbursement Rate	
Service	**Code**
Alcohol and/or Drug Services Intensive Outpatient Treatment Program	H0015

A rate for H0015 was issued on 5/1/2023 by AHCCCS.

BEHAVIORAL HEALTH PROVIDER SURVEY

SURVEY DESIGN

PCG worked with AHCCCS to design, distribute, collect, and analyze the Arizona BH Rate Study Provider Survey. The survey was utilized by PCG to assist in updating rates for the Arizona BH Rate Methodology Study.

The PCG team developed the survey to collect information directly from providers. The survey was used to gain a better understanding of the current landscape of BH services, the challenges faced by BH providers and the impact a potential shift in reimbursement may have on operations and service delivery.

The Survey was distributed in an Excel workbook format on June 1, 2022, to approximately 489 individual email addresses at 204 separate agencies, with a due date of Friday, June 24th, 2022. An extension was granted to providers to allow further time to gather and enter data. Responses from twenty-six unique provider agencies were received.

The survey was designed with 4 main sections that collected information from Fiscal Years 2019-2021:

- Provider Information
- Staffing
- Costs
- Revenue

The staffing, costs, and revenue sections were selected to help give a broad sense of the current fiscal and personnel health of each survey respondent. Ancillary information like the impact of COVID-19 and telehealth were also gathered as they are topical subjects in today's behavioral health practice environment. In addition, the survey was an opportunity to engage with providers and hear directly from them on issues directly affecting them. The results outlined below are cited multiple times to support conclusions based on quantitative data such as claims utilization and rate comparisons.

The Provider Information consisted of one tab that collected basic information such as primary contact information, organization contact information, organization NPI, AHCCCS Provider ID, and Fiscal Year dates.

The Staffing section consisted of three separate tabs, one for each calendar year from 2019 to 2021. Quantitative data on Full-Time Equivalent (FTE) counts for Direct BH providers (staff providing direct behavioral health care), Direct BH support staff (Supporting the provision of direct care), and BH overhead staff (Behavioral Health portion of general staffing supporting overall operations such as HR and Finance) was requested. Year-over-year turnover statistics for these personnel categories were collected. Finally, qualitative data on several topics was gathered, including the impact of COVID-19, staffing levels for different service categories (such as services provided in a community setting, staff dedicated to telehealth, etc.), and benefits.

The Costs section consisted of three separate tabs, one for each calendar year from 2019 to 2021. Quantitative data was collected on costs for Direct BH Service Personnel, Direct Support and Overhead Personnel, Direct Services Non-Personnel, and Overhead Non-Personnel. In addition, qualitative data on other topics was gathered, including telehealth, community-based services costs, and other cost shifts.

The Revenue section consisted of three separate tabs, one for each calendar year from 2019 to 2021. Quantitative data was collected on total organizational revenue, participation in value-based payment arrangements, and shifts in revenue utilization. Finally, quantity (units) and amount paid ($) data was gathered for each service the respondent provided in each calendar year.

For all survey responses received the responses were combined into one primary file with duplicates and incomplete entries removed from the dataset. To analyze staffing costs, each category of costs had all provider level data aggregated, mean and medians calculated, and yearly trends mapped. These costs were also divided by FTE counts to determine cost per FTE units. For the staffing section, each discrete level of personnel category was aggregated, mean and medians calculated, and yearly trends mapped. Year-over-year turnover rates were calculated based on unfilled position figures. Finally, revenue figures were analyzed in the same manner as costs, with additional calculations to compare year-over-year trends in costs vs revenues.

In addition, a survey addendum was distributed on August 22, 2022, to all previous survey respondents, as well as participants in an August 8, 2022, meeting between PCG, AHCCCS, and the Arizona Council of Human Services Providers. The original due date was Tuesday September 6, 2022, but was later extended to September 15, 2022. The addendum was designed to collect available information from 2022 on the staffing, costs, and revenue sections, as well as a new section with topics based on information the providers had available and stated would be valuable in calculating the revised recommended rates:

- Average training time and costs by Provider Type
- Percentage of Missed Appointments by Year
- Ratio of In-Person Vs Out of Office Vs Telehealth Visits
- Average Travel Time and Distance for Out of Office Appointments
- Non-billable admin costs
- Top 5-billable hour service categories and billable hours per day per service

A total of seven addendum responses were received and incorporated into the previously received survey responses.

Provider Survey Responses

Staffing

AZ behavioral health provider staffing levels varied significantly from agency to agency. On average, an agency employed 190 FTEs, with an average number of direct service FTEs of 145. The average FTEs for direct support personnel was 22, and an average FTE count of 23 for overhead personnel. Turnover rates were already high (31%) before the COVID-19 pandemic in early 2020 accelerated this trend in 2020 (99.1%) and 2021 (62.8%).

Figure 4*

Agency FTE Count by Cost Category FY19-21		
Cost Category	**Average FTE Count**	**Median FTE Count**
Total Personnel	190	57
Direct Service	145	47
Direct Support	22	4
Overhead	23	6
**Figures have been rounded*		

Overall, all participants experienced a high rate of turnover. Year over year turnover rate for direct service personnel was 34%, while direct support staff experienced a turnover rate of 31.1%. Direct service turnover rates increased from 23.3% in 2019 to 37.9% in 2020 and 40.4% in 2021. The 3 year-average (2019-21) of unfilled Direct Service positions was 57 (82%), while unfilled Direct Support positions was 6 (12%), and unfilled Overhead positions was 3 (6%). The COVID-19 pandemic had a significant impact on turnover rate, with a 15% overall turnover rate in 2019 preceding a 2020 rate of 22%, and a 2021 rate of 22%.

Costs

Costs as a whole rose on a per agency basis between 2019 and 2021, with a particular rise in overhead and direct support costs. However, on average, direct service costs consisted of 77% of all spending in this time, while the remainder was split between support (10%) and overhead personnel costs (13%). There are multiple explanations that can explain this trend. The COVID-19 pandemic, combined with increased pressures on public healthcare providers, added stressors to the provider community. The need to service patients in diverse ways, such as the increase in telemedicine impacting technology costs, and inflationary pressures directly impacting staffing costs, also shifted the cost curve for providers.

Below is a table showing the total for each metric across all the reported FYs, and the 3-year trend.

Figure 5

Provider Survey Cost Metric Responses				
Metric	**FY2019**	**FY2020**	**FY2021**	**3 Year Trend**
Direct Service Personnel Cost	$157,548,719	$141,279,394	$149,929,286	-5%
Direct Support Personnel Cost	$17,688,144	$20,097,264.52	$23,141,632	31%
Overhead Personnel Cost	$26,158,911	$ 26,840,931	$23,090,928	-12%
Total Personnel Cost	$201,395,775	$188,217,590	$196,212,551	-3%
Direct Support Non-Personnel Cost*	$5,790,530	$4,640,749	$4,416,320	-24%
Overhead Non-Personnel Cost	$30,129,147	$35,971,218	$32,672,029	8%
Total Non-Personnel Cost	$35,919,677	$40,611,967	$37,088,349	5%
Total Direct Service FTE	3,514	3,180	3,409	-3%
Total Direct Support FTE	357	396	448	25%
Total Overhead FTE	382	418	467	22%
Total FTE	4,253	3,994	4,324	2%

The difference is in the Direct Support Personnel Cost which increased by 31% from FY2019 to FY2021. This is likely due to the increased direct support needs placed upon existing employees as staff turnover continued to increase leading to more unfilled positions. See Figure 5 for 3-year trend in unfilled positions by personnel category.

Personnel costs constituted 84% of providers' expenses, with 16% going towards non-personnel costs. Among personnel costs, 77% went towards direct service, 10% to direct support, and 13% to overhead. For non-personnel costs, 87% went towards overhead costs and 13% towards direct support.

Revenue

PCG collected information on overall organizational year-over-year revenue (both Behavioral Health and non-Behavioral Health revenues), along with revenue per each discrete service category. Overall revenue figures increased on average by 7% over 2019-2022, with a median growth figure of 4%.

Total revenue per year per organization averaged $20,460,539, with a median of $12,902,076. All respondents provided an average of 53,683 units per service per year, or a median of 52,975 units. Mean revenue per service per year was $1,709,467, with a median of $1,678,831. Revenue per unit averaged $69.19, with a median of $71.75.

Looking at FY21 claims data, we see that the mean revenue per service year across all providers is $1,030,985, while the mean units per service is 48,036. This gives a sense that while the overall revenue of these respondents might be higher than average, the number of billed units is within the average range of all Medicaid providers. We would also caveat this by noting that a provider reporting of their service revenue could be a slightly different calculation than simply amount paid by AHCCCS BH OP claims. The provider reported figure could be reporting revenue from other payors, or for other service types. We would conclude the survey respondents are within a representative range of the average Medicaid providers.

While the data included here covers 2020 and 2021, which was impacted by COVID-19, there was no subsequent noticeable decline in revenue for this period. However, data available in future years will tell if this trend holds. The switch to telehealth accelerated by COVID-19 may have an impact on service utilization and revenue streams in the years following 2020.

Provider Addendum Responses

The addendum to the initial survey was designed to collect available information from 2022 on the staffing, costs, and revenue sections, as well as a new section with topics based on information the providers had available and stated would be valuable in calculating the revised recommended rates.

Seven responses were received for the survey addendum. All figures below are for the time 2019- 2022 and are an average of all respondents.

Average Training Time and Cost by All Provider Types (Yearly)

Time spent on onboarding employees and funds spent on training were mentioned as significant costs for providers. Combined with the higher staff turnover rate post COVID-19 pandemic, new hire training can represent a significant cost to providers. Average training time per new hires across all positions on average was 125 hours, with a median of 87 hours. The average cost for training a new employee was $5,028, with a median of $3,630.

Percentage of Missed Appointments by Year (All Services)

Missed client appointments was mentioned as having an impact on billing and revenue optimization. On average, across all service types and for all provider types, 22.2% of appointments were missed. The median percentage of missed appointments was 16.0%. The fact that the average rate of missed appointments is significantly higher than the median rate of missed appointments suggests there are certain services which experience exceedingly elevated levels of missed appointments. However, the level of data collected for this study does not support identifying what services those may be. Providers mentioned anecdotal observations of a switch to more telehealth visits post COVID-19 pandemic, which helped lower the rate of missed appointments.

Ratio of In-Person Vs Out of Office Vs Telehealth Visits

Relatedly, provider survey responses indicated the difference between appointment types was a factor on missed appointment rate. On average, 35% of visits were in-office, 39% were out of office (i.e., in the community), and 33% were telehealth (percentages total to more than 100% due to double reporting of some visits). Due to the COVID-19 pandemic, in person office visits decreased by 26% over 2019-2022, while telehealth visits increased by 44%.

Average Travel Time and Distance for Out of Office Appointments

The decline in out of office visits was not enough to offset the impact of travel costs, which varied widely between providers. Factors that created these discrepancies include the services being provided and the patient population being served. Ultimately, travel costs can have a significant impact on providers if the service population requires significant distances or case load requirements. On average, providers spent 40.4 minutes on a round-trip visit (assuming only one stop), with an average distance of 21.4 miles commuted.

Non-billable Administrative Costs Unique to Behavioral Health

The table below lists the significant administrative costs per provider that are not currently billable hours. An example would include claims staffing. Four providers submitted responses for this category, with no repeat answers, indicating these costs may vary based on each specific provider's unique needs. The average cost across all categories was $750,156, with a median cost of $347,436. The large amount reported by Agency #2 under the category “Operations Overhead Labor” is likely a wide spectrum of costs that cannot be attributed to a service. This could include IT personnel and maintenance, human resources costs, recruiting and training, security, building maintenance/janitorial services, and advertising. As part of the survey process many providers indicated how their administrative costs were increasing and taking up a substantial portion of their budget. We believe it important to get a sense of providers' administrative costs as part of this process, to reflect the ongoing concerns agencies are feeling.

Figure 6

Provider Survey Non-Billable Administrative Cost Responses		
Provider	**Cost Category**	**Average FY Cost $**
Agency #2	Operations Overhead Labor	$ 5,314,000
Agency #2	Call Center / Operations	$ 958,000
Agency #4	Front Office	$ 923,869
Agency #3	Non-billable case management	$ 739,510
Agency #4	Maintenance	$ 501,892
Agency #4	Quality	$ 478,532
Agency #4	Claims	$ 353,850
Agency #3	Non-billable travel	$ 341,022
Agency #1	Outreach & Engagement	$ 235,795
Agency #4	Housing	$ 194,368
Agency #2	Credentialing	$ 168,750
Agency #4	Call Center	$ 164,729
Agency #1	Behavioral Health Training	$ 92,872
Agency #2	Malpractice Insurance Reimbursement	$ 35,000

Top 5 Billable Service Categories

Providers were also asked for the Top 5-billable hour service categories and billable hours per day per service, which are listed in the table below. This data was requested to help better understand what services providers currently rely on to bill for their costs and services provided, and how much they bill for each service. The top 3 listed categories were:

- Assessment, Evaluation and Screening Services
- Case Management and Skills Training

- Development and Psychosocial Rehabilitation Living Skills Training Skills

The survey addendum collected helps paint a larger picture of the costs and revenues for providers in 2022. Crucially, it helps reveal changes in revenues and costs that might not have been captured by current rates due to changes in service utilization brought on by COVID-19. Of note is the change in rate of telehealth visits vs in-person visits and the impact that has on missed appointments and revenue streams. In addition, drastically increased staff turnover has caused an increase in training costs, which may be under-reflected in current rates.

ACCESS ANALYSIS – BH OP AND IP SERVICES

When analyzing utilization over a five-year period, PCG used claims data provided by AHCCCS. This claiming data was broken out by county, provider, and procedure information, for each year of data received. This five-year period, Fiscal Years 2017-2021, was chosen to provide a comprehensive data set that encompassed both pre-COVID-19 pandemic data and data that may have been impacted by COVID-19. The unique circumstances of the previous few years had a major impact on the healthcare delivery system in Arizona and the United States. This impact needs to be accounted for to better understand the impact on providers, members, and overall health outcomes, as well as what steps can be taken moving forward.

Analyzing the data by multiple variables gives PCG and AHCCCS a true sense of utilization, and the trends within the BH delivery system in Arizona. We will be able to show the variability between large urban areas, such as Maricopa County, and the more remote rural areas in the northern part of Arizona. By understanding these differences, and using data to explain what trends are occurring, we can ensure that any future recommendations are designed to address the true issues that impact the BH delivery system in Arizona, with focused outcomes.

PCG notes that the FY2021 data might not be complete, and a completion factor was not applied to the data as part of this analysis. As noted in State of Arizona Medicaid regulations there is an initial six-month period for a provider to submit a claim for processing. If a claim is originally received within that six-month period, the provider has up to 12 months from the date of service to correctly resubmit the claim to achieve clean claim status. This creates an inherent lag for claim submission and data analysis.

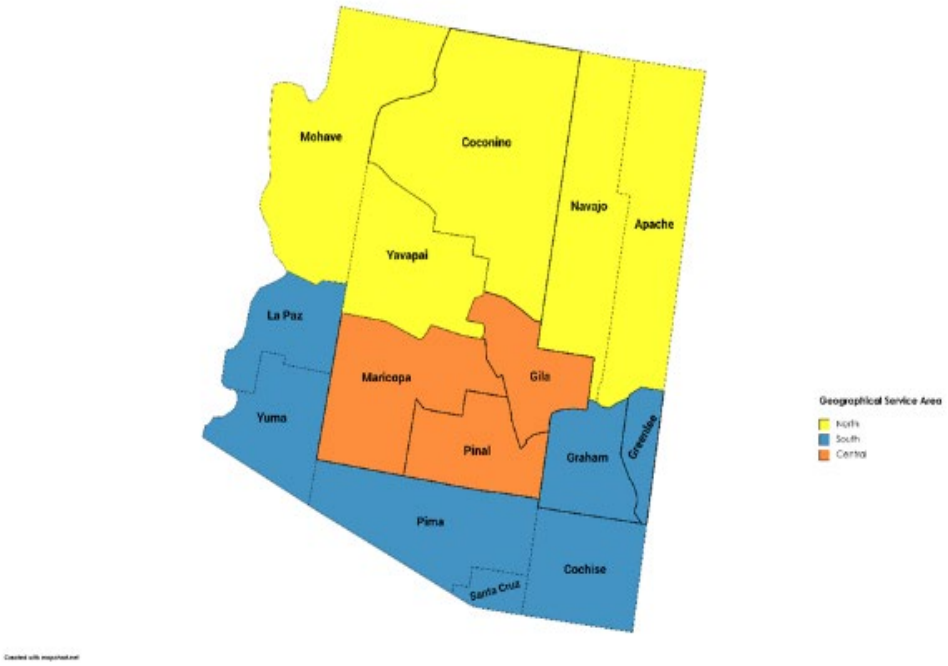
STATE OF ARIZONA DEMOGRAPHICS AND DETAILS

PCG was tasked with conducting an analysis of service utilization and provider access trends using claims data from Fiscal Year 2017 through Fiscal Year 2021. This included reviewing these trends by County and Geographical Service Area (GSA).

Arizona has three distinct GSAs: GSA North, GSA South and GSA Central. It is important to understand these distinct areas, and the different challenges that come with delivering health care services in them.

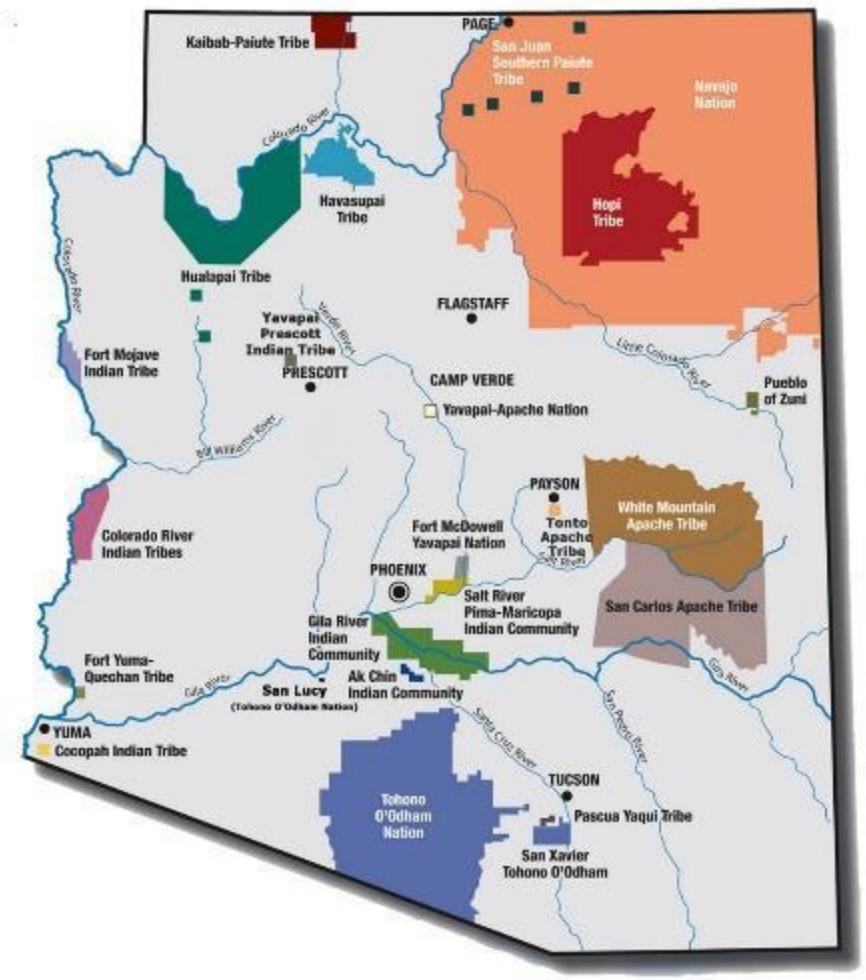
The map below shows the breakdown of counties in the respective GSAs.

Figure 7



It is also important to note that Arizona has twenty-two federally recognized Indigenous tribes, spread out across the state, as seen in the map below.

Figure 8



The largest tribe in the United States both in terms of population and land base, is the Navajo tribe. Approximately 300,000 tribal citizens live on the Navajo Nation, an area of land of more than 27,000 square miles, The Navajo Nation spans three counties in Arizona and extends into New Mexico and Utah. The capital, Window Rock, Arizona, located in Apache County, is approximately three hundred miles from Phoenix, Arizona, located in Maricopa County.

Navajo County is part of GSA North, indicated in yellow on Figure 7.

This GSA encompasses the northern border of the state and includes eleven different tribal lands. The amount of driving to reach patients located across the vast tribal landscape in the northern GSA can put a strain on provider agencies.

OUTPATIENT BEHAVIORAL HEALTH ACCESS REVIEW

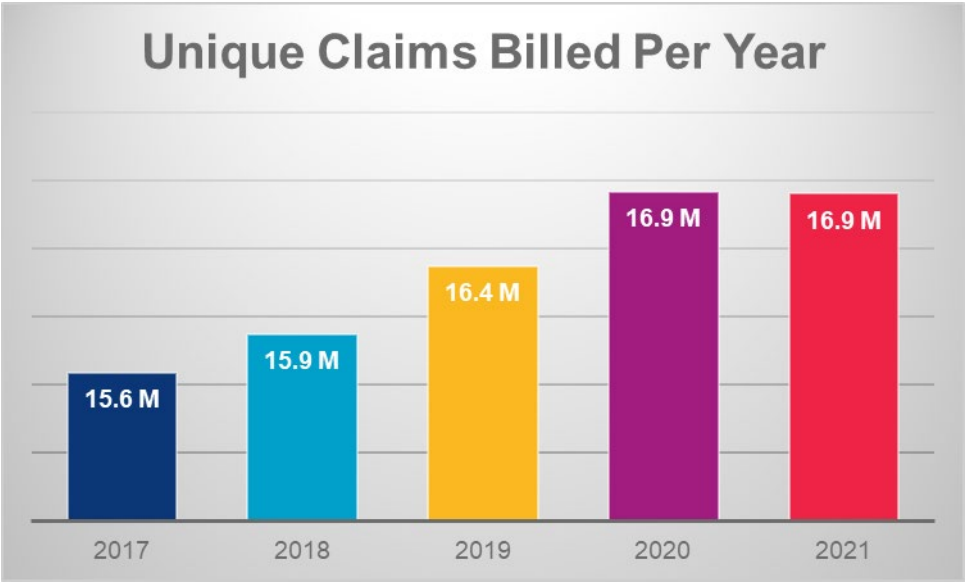
Overall Trends 2017-2021

As part of the project, PCG was asked to conduct an analysis on the utilization and access for outpatient behavioral health services in Arizona over a five-year period. To conduct this analysis PCG reviewed

Medicaid claims data provided to us by AHCCCS. This claims data encompassed the period from Fiscal Year 2017 through Fiscal Year 2021. PCG was able to use this data to get a true sense of utilization and access trends over the review period and help inform next steps in the rate setting process.

The first aspect is to understand overall utilization and access trends, across the entire state. Using a distinct count of claims, we see a steady increase in utilization across the reporting period until the most recent fiscal year of 2021. The graph below outlines the change in utilization.

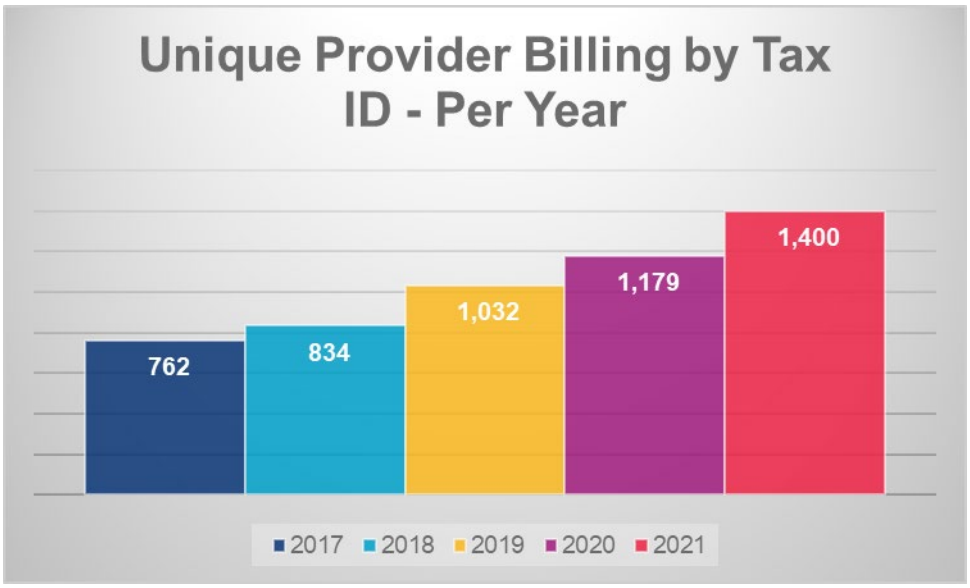
Figure 9



The one unique aspect is the slight drop in billed claims for Federal Fiscal Year 21. We would attribute this to FFY21 beginning on October 1, 2020, and ending on September 30, 2021. This period was during the COVID-19 pandemic that began in March 2020. The claim dataset might also be incomplete due to a claim reporting lag. Because of these factors, service utilization could have slightly dropped as providers either closed temporarily or permanently, while residents changed their behaviors due to the pandemic. Even after the State of Arizona relaxed public health measures, residents would have made personal decisions regarding their comfort in leaving their home, going to a medical practitioner office and other public spaces which would impact service utilization. PCG would not expect this trend to continue as Arizona and the nation have moved past the most critical portion of the pandemic, State and Local regulations have been removed entirely around social distancing and/or masking requirements and most residents have gained increased comfort with being in public spaces.

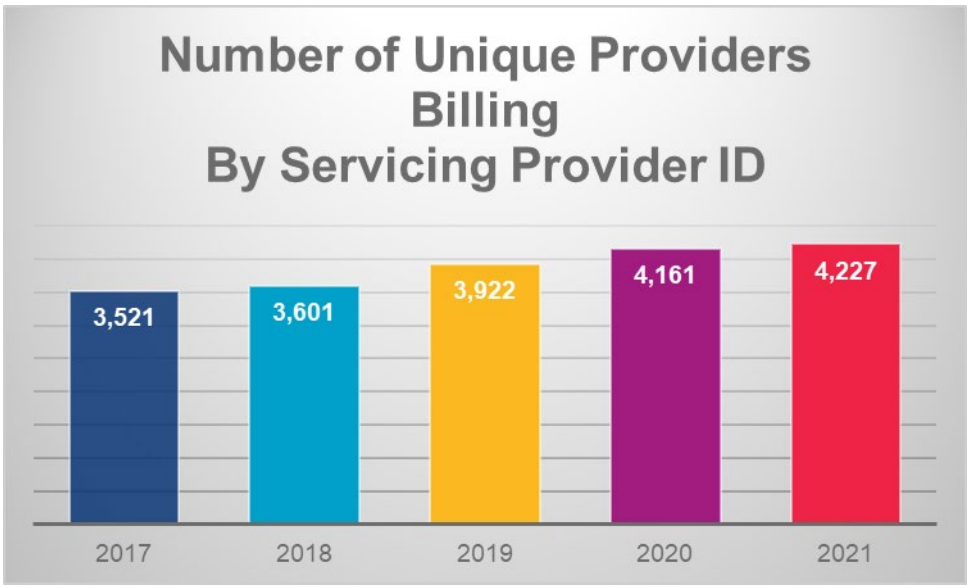
Related to utilization is the question of provider access. To accomplish this PCG analyzed the data by two distinct measurements. The first one we used as a distinct count of providers who billed claims in each year, as determined by Tax Identification Number (TIN). This shows a steady increase year over year, as outlined by the graph below.

Figure 10



There is a clear increase year over year, with the largest increase occurring from FY20 to FY21. This trend is similar but not as pronounced when using a distinct count of providers, as measured by Servicing Provider ID. The increase from FY20 to FY21 was smaller, indicating a potential leveling off in the overall number of servicing providers. This could indicate some locations are either closing or consolidating due to the impact of the pandemic on agency finances. There is also a potential for an increased reliance on telemedicine services, which we will outline.

Figure 11



To further quantify these trends, PCG calculated the average number of billed claims per unique provider, using both TIN and Servicing Provider ID.

Both measurements showed a decrease year over year in the average number of billed claims, as the increase in the number of providers offset the increased number of billed claims.

Figure 12

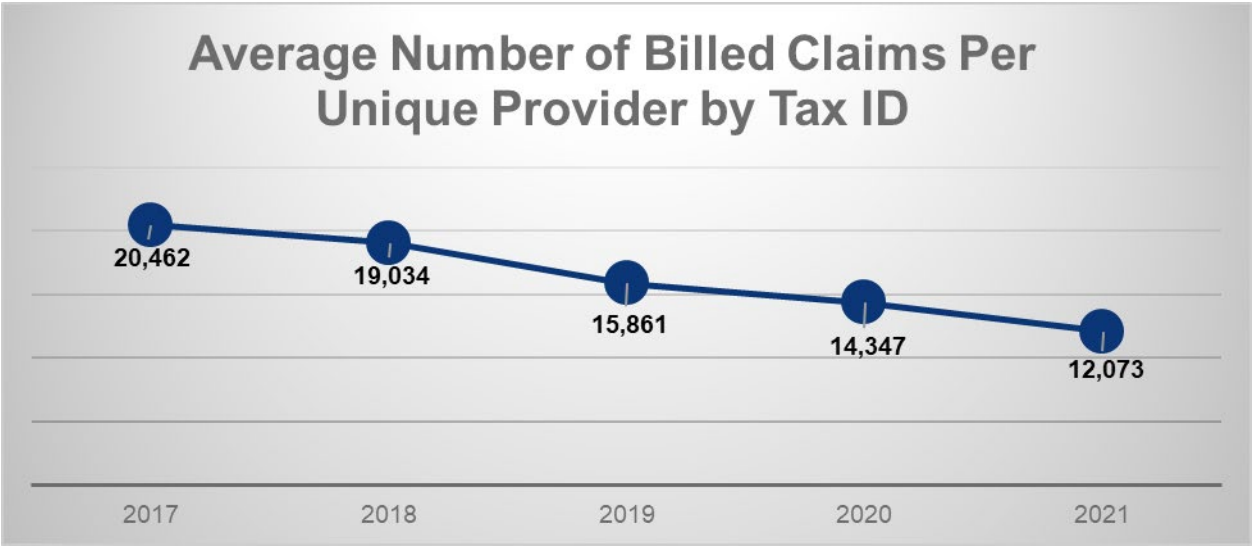
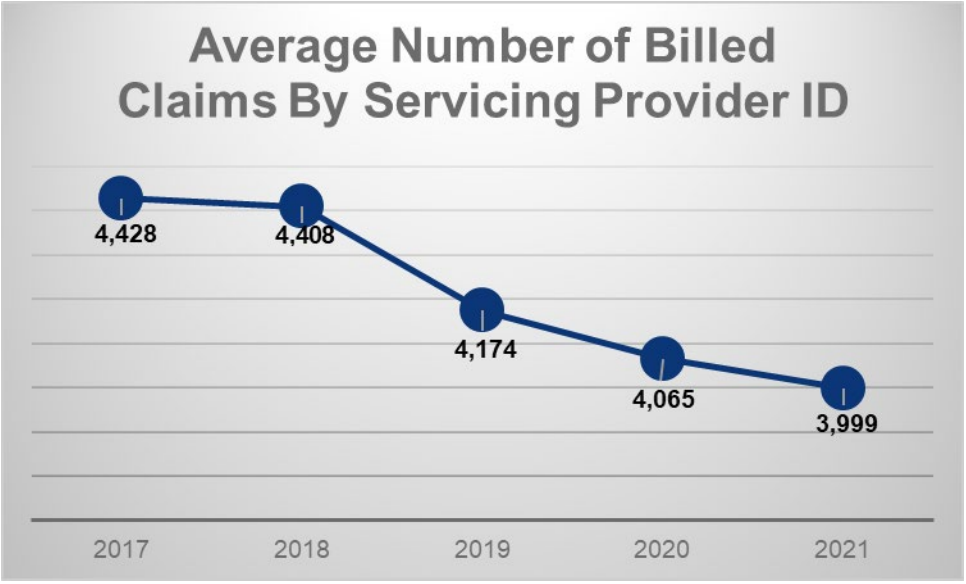


Figure 13



This indicates that providers on average are submitting fewer claims per year. The shifts in overall utilization can be related to agencies struggling to retain staff. This shift leads to an increased administrative burden on the Direct Service staff, as noted by the substantial increase in Overhead personnel turnover percentage, which reduces their billable hours and thus the productivity of the agency. The increase in staff turnover, and the higher number of unfilled positions means that there is fewer

overall staff to treat patients, manage the administrative work, and conduct all the aspects that the agency requires.

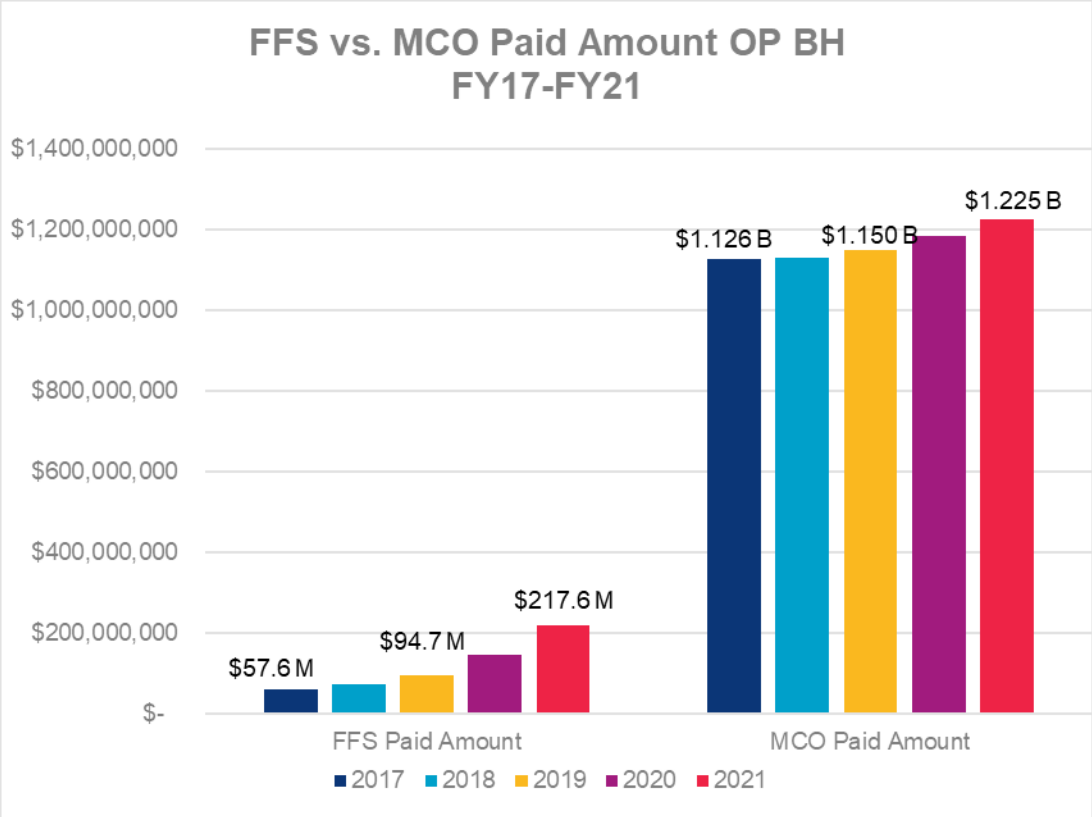
These factors would have a direct impact on the number of patients and services that an agency could administer.

The next aspect is to understand if this change is impacting overall spend by AHCCCS, or how the spend and utilization is trending based on region and service type.

Overall Spending FY17-FY21

To address the data around overall spending, we used the field "Alternative HP Valued Amount" from the MMIS claims data that we received from AHCCCS. The overall spend increased year over year, with the largest increase occurring from FY20 to FY21. The chart below outlines this clearly, broken out by Managed Care Organization (MCO) paid amount and Fee For Service (FFS) paid amount. While both categories saw increases in the overall paid amount from FY17-FY21, the percentage increase for FFS paid amount was 277% higher in FY21 from FY17. This is exponentially higher than the 9% increase in MCO paid amount.

Figure 14

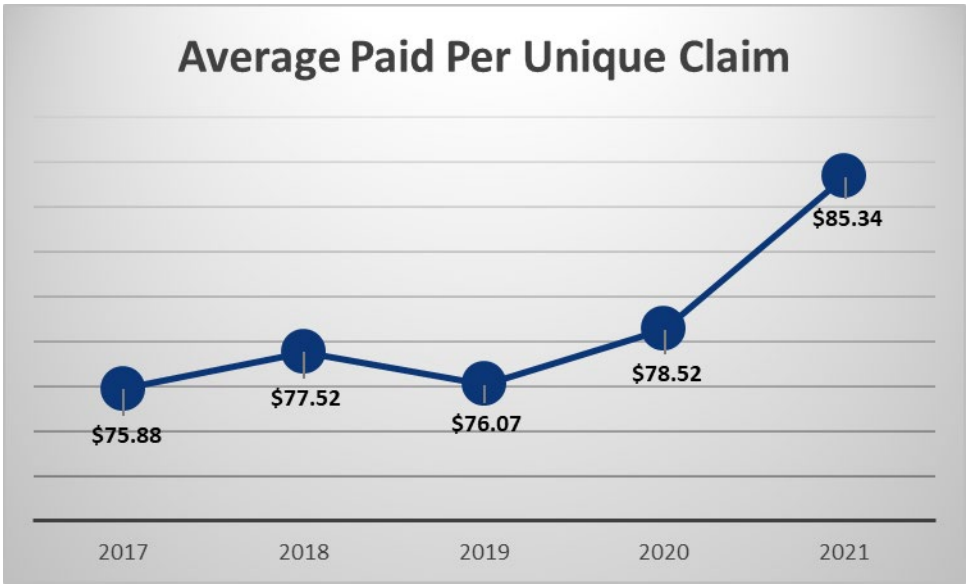


It is notable that the overall spend increased so clearly from FY20 to FY21 when the overall number of uniquely billed claims did not follow suit. This would suggest that providers are billing more for the services they provided in FY21, either due to a shift in service type or a choice to bill higher amounts for the few services that do not have a set rate by AHCCCS. We will outline this by looking into the number of billed claims by Procedure Code Class, which shows a substantial increase in Behavioral Health claims, and by breaking that down into a subsection of Mental Health vs. Substance Use Disorder claims. This shows that there is a clear increase in the number of claims with an SUD indicator. As these services

tend to be billed at higher rates, including billing for Intensive Outpatient (HCPCS code H0015), this would explain the increase in paid amount without a similar increase in claim utilization.

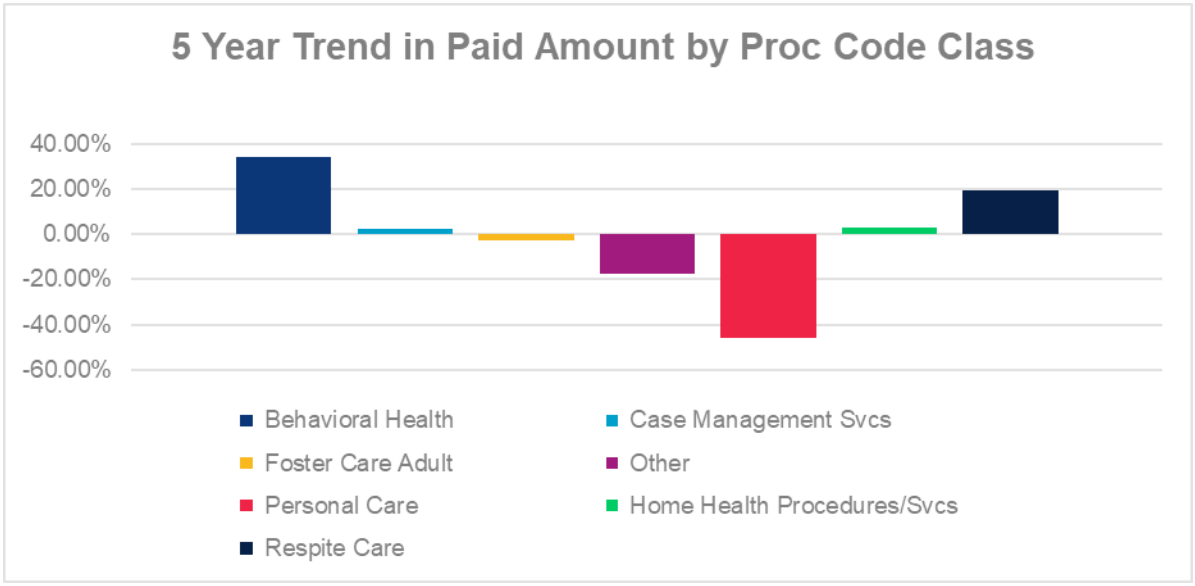
By calculating the average amount paid per unique claim, by dividing the overall spend by the number of unique claims per year, we see a substantial increase in average from FY20 to FY21.

Figure 15



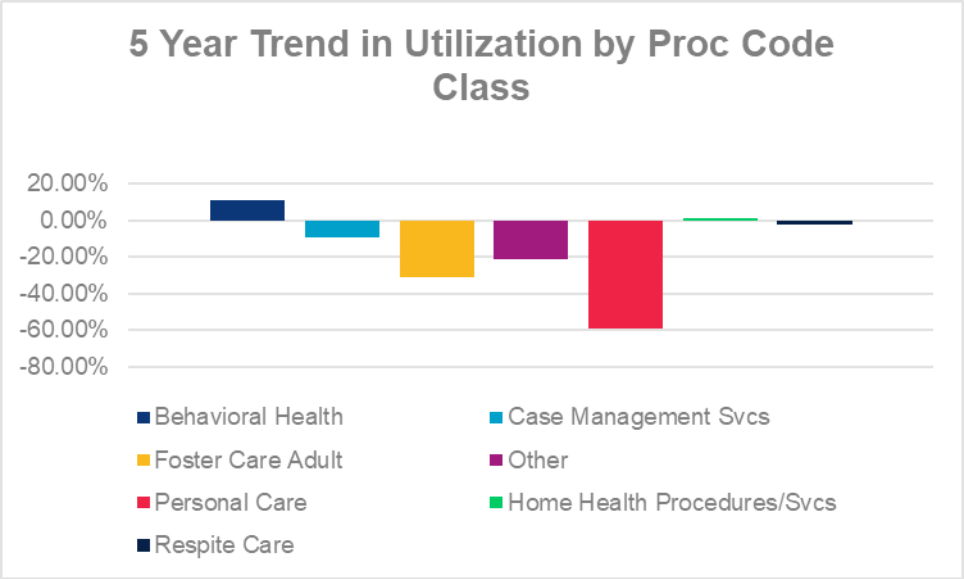
The prior years saw a consistent change in the average paid amount per claim, but from FY20 to FY21 the average increased by almost $7.00 per claim. This represents a 9% increase from FY20 to FY21. This increase in paid amount seems to be focused on two specific categories of service. The five-year trend for spending by category of service saw a clear increase in services classified under Behavioral Health and Respite Care. The other service categories held steady or showed a decrease.

Figure 16



This increase in paid amount was not directly matched by the change in billed units over the same five-year period. As outlined below, BH services saw a substantial increase in the number of billed units, while the other categories all held steady or decreased, including Respite Care.

Figure 17



The difference between amount paid and units billed, notably within services classified as Respite Care would indicate that those services saw consistent utilization, but the specific services were of a more intensive type, thus increasing the overall paid amount. This is in opposition to the services classified as BH, which saw both an increase in utilization as defined by number of billed units and overall paid amount suggesting a clear linear relationship. However, as BH services make up most of the utilization and spending for AHCCCS services it is important to analyze the specifics of those services, to determine if there is a secondary trend amongst the aggregated totals.

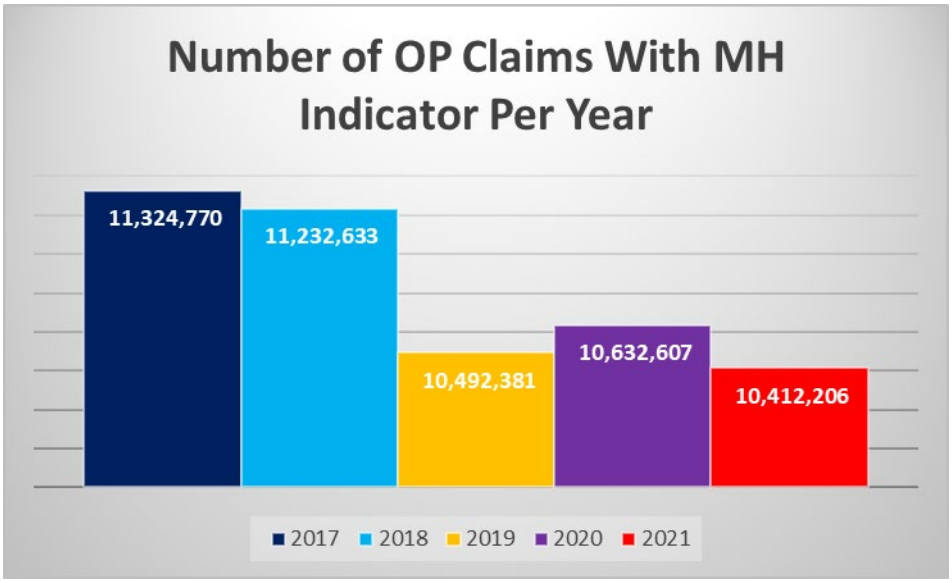
The final aspect PCG reviewed was how BH utilization and spend breaks down between Mental Health (MH) services and Substance Use Disorder (SUD) services. Was there a notable change in either service type across the reporting period that could explain the clear increase in billed amount per claim, and the overall trends? We analyzed the data to differentiate MH and SUD claiming to get an idea of the utilization patterns.

Utilization by MH and SUD Indicator

The claims data provided by AHCCCS notes if the claim has an MH Diagnosis Indicator or a SUD Diagnosis Indicator. These are unique fields where a claim with an MH indicator cannot be labeled with an SUD indicator or vice versa. This allowed PCG to review specifically the unique number of claims billed per year with an MH indicator and with an SUD indicator.

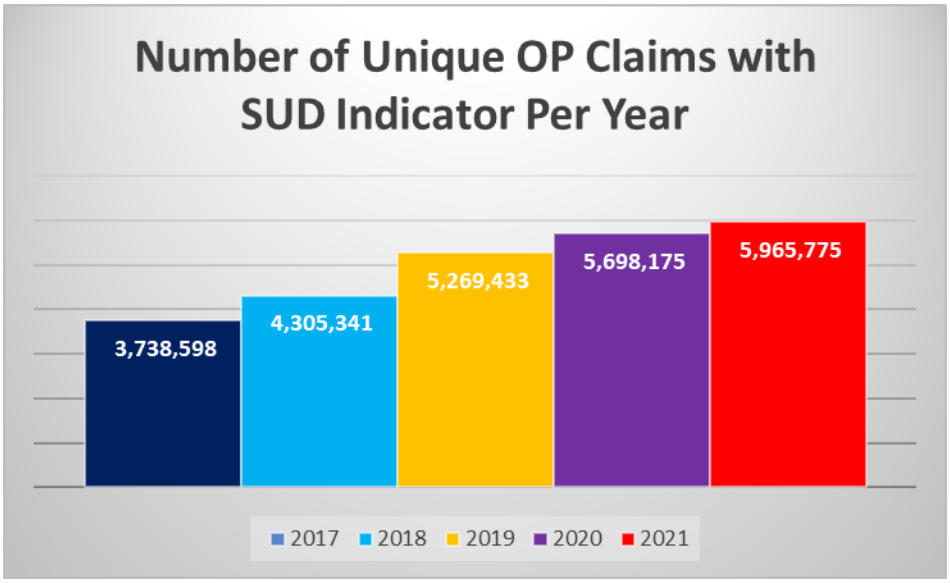
When reviewing the distinct count of claims billed each year of the reporting period with an MH indicator, we saw a leveling off, and eventual decline in that volume. This was in opposition to the overall trend of increased utilization, as noted previously in this report.

Figure 18



Relatedly, when analyzing the claims data and separating out those that had a SUD indicator, it showed the opposite trend. There was a clear increase in utilization year over year, indicating that an ever-increasing percentage of overall claims volume is for SUD claims.

Figure 19



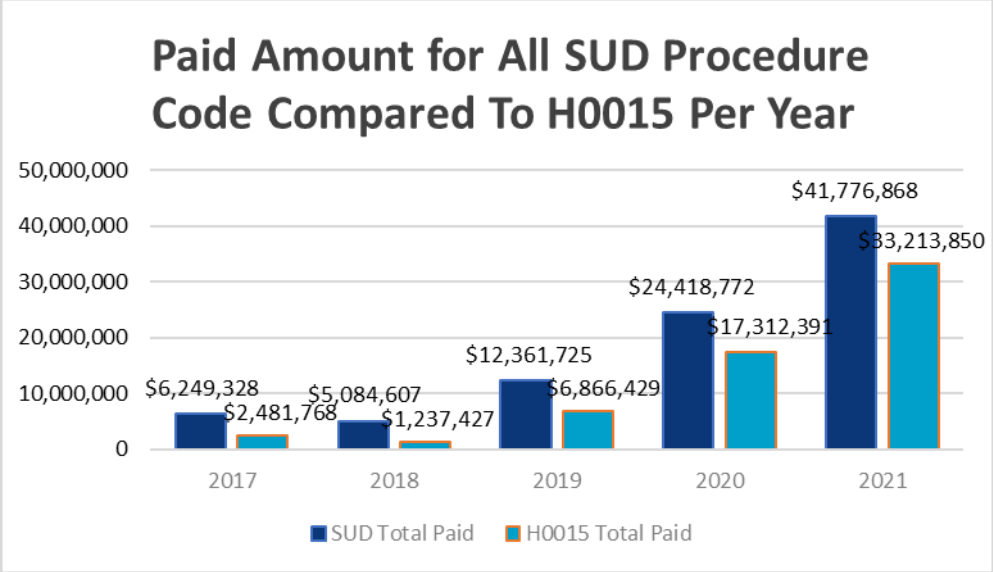
To further understand this trend, PCG then reviewed total spend related to SUD specific procedure codes. We identified these codes as the following, for sake of clarity:

- H0001 Alcohol And/or Drug Assessment
- H0006 Alcohol And/or Drug Services; Case Management

- H0014 Alcohol And/or Drug Services; Ambulatory Detoxification
- H0015 Alcohol And/or Drug Services; Intensive Outpatient
- H0020 Alcohol And/or Drug Services; Methadone Administration And/or Service

By totaling the paid amount for those procedure codes in each year we saw a dramatic increase in the overall spend for SUD related services. As outlined in the chart below, the total increased almost 7 times the amount from FY2017.

Figure 20



The biggest driver of the increase in paid amount was due to the increase in code H0015 – Intensive Outpatient Service. The table below shows the year over year spending and utilization for this code. Both numbers saw a clear increase.

Figure 21

H0015 Claims Trend FY17-FY21					
Year	2017	2018	2019	2020	2021
Spend	$ 2,481,768.00	$ 1,237,427.00	$ 6,866,429.00	$ 17,312,391.00	$ 33,213,850.00
Unique Claims	16,759	11,713	35,373	67,982	126,536
Average per Claim	$ 148.09	$ 105.65	$ 194.11	$ 254.66	$ 262.49

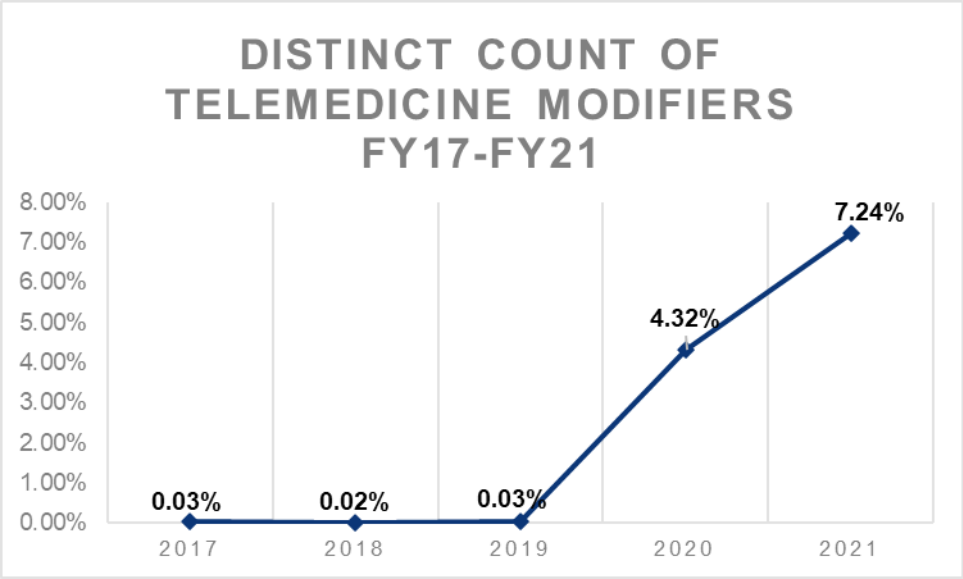
Trends in Telemedicine Service Delivery

The final specific trend that PCG analyzed was the use of telemedicine in the delivery of OP BH Services. To complete this analysis PCG used the five years of MMIS claims data received from AHCCCS. The use of Telemedicine is identified using specific modifiers. These modifiers indicate if a service was delivered using some sort of video or telephone conferencing. We calculated a distinct count of claims submitted with one of the following modifiers:

- Synchronous Telemedicine Service Rendered - 95
- Telehealth/Mcd Lvl Care 13 - UD
- Telemedicine - Via Interactive Audio/Vid - GT
- The Service Was Furnished Using Audio-Only - FQ
- Vua Asynchronous Telecommunications Sys - GQ

Using this method PCG determined that the number of claims submitted with a telemedicine modifier increased exponentially from FY17 to FY21. In FY17 only .03% of all claims included a telemedicine modifier. By FY21 over 7% of all claims included one of these modifiers. This increase clearly shows that telemedicine is a rapidly growing part of OP BH service delivery, across the entire state of Arizona, and PCG would expect it only to increase more moving forward.

Figure 22



PCG also recognizes this might underreport the overall total of telemedicine claims. Per provider survey responses the rate of telemedicine claims is much higher, and other industry studies suggest the same. PCG believes this is likely due to two factors. The first is billing discrepancies. As the rates do not vary between telemedicine service delivery versus face to face, it is likely that the modifier is not included on some claim submission when it should be. This would create a built-in underreporting.

The second aspect is that these modifiers likely do not tell the full story of telemedicine service delivery. We limited the analysis to these clearly defined modifiers to ensure data integrity. While this ensures the data we review is related to telemedicine, it leaves the potential for some services to not be included in the analysis. However, PCG feels the quality of the data, and the trend it shows are accurate and in-line with overall nationwide trends.

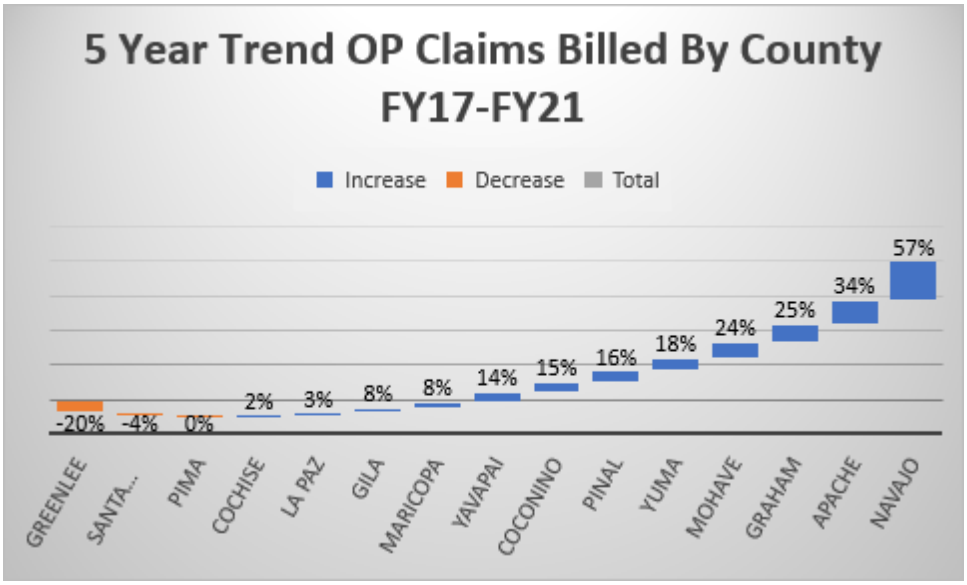
ACCESS ANALYSIS BY COUNTY AND REGION

Utilization by County and Region

To further understand the utilization and access patterns in the State of Arizona we took the same claims data set and analyzed it by County, and by Geographical Service Area (GSA). This allowed PCG to get a more in-depth understanding of how and where services are being delivered and identify more specific trends.

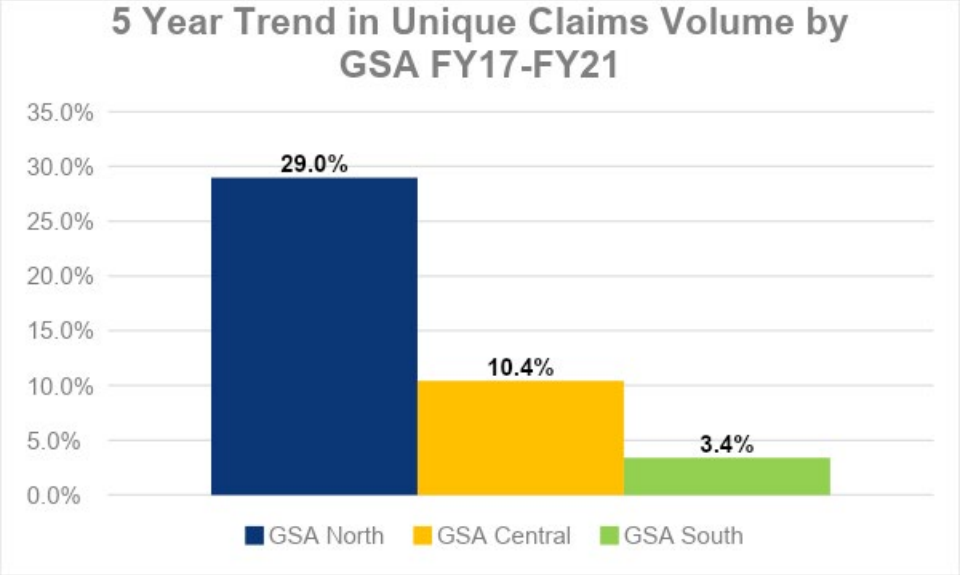
The first aspect we reviewed was the overall claims utilization broken out by county and GSA region. Using the same deduplicated count of claims as outlined in the overall utilization, we were able to determine a five-year trend by each county. The chart below shows how the utilization across the counties did not show a consistent trend, with some counties showing increases while a couple had a decrease in billed claims. Notably the increases in Apache and Navajo counties were 34.2% and 57.5% respectively, while Greenlee had an almost 20% decrease.

Figure 23



We then took the same claims data and grouped it by GSA region. This is where a clear trend began to emerge, as the largest increase in utilization was clearly in the GSA North region. While the South region showed a minimal increase from FY17-FY21.

Figure 24



The North region, which encompasses the largest portions of the Native American population in Arizona, showed an almost 30% increase from FY17-FY21. Looking at the claims data further showed that this region is a unique driver of service utilization in Arizona. As outlined earlier, the overall utilization across the state dipped slightly in FY21, likely due to the impact of the pandemic on providers and members. In the North region there was a 6% increase in claims utilization from FY20 to FY21, indicating clearly that the region is an outlier within the State of Arizona.

The differences between the regions do extend to the number of unique providers, though not as starkly. Looking at the number of unique providers who billed claims by TIN and by Servicing Provider ID show the largest increases in the North region, but all regions showed strong increases using either metric.

Figure 25

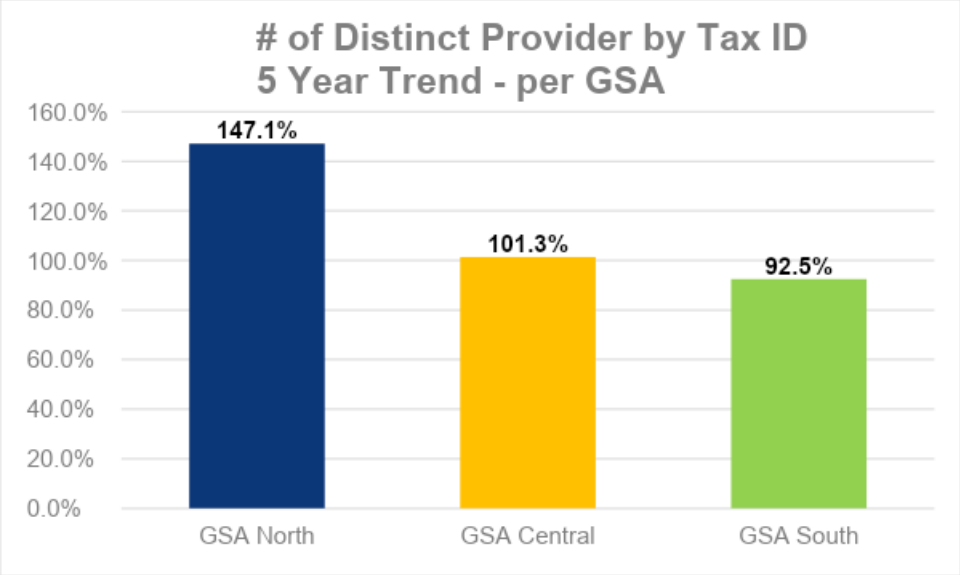
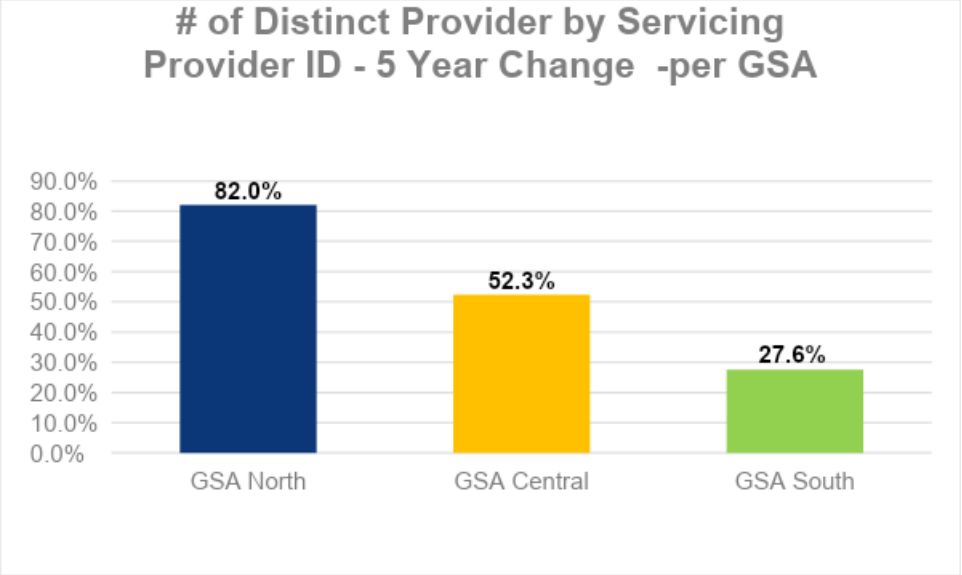


Figure 26



While the access to care trends went up across the state, the North region still saw the largest increases. This does not align with the utilization trends; however, it is important to analyze the data in a more detailed way to identify what could be causing the disparities in utilization across the state.

The trend starts to show itself as we parsed the data by MH Diagnosis Indicator and SUD Diagnosis Indicator. When looking at each region by MH indicator, we see that only the North Region had an increase over the reporting period, with an 11% change from FY17 to FY21. This shows that while the overall trend was a decrease in claims with an MH indicator, the North region went against that trend.

Using the claims data to review utilization by SUD Diagnosis Indicator, for each GSA, shows a clear overall trend. When claims billed for H0015 are separated out you see that H0015 claiming rose exponentially across all three GSAs from FY17-FY21. The non-H0015 SUD claims rose at a much more gradual pace with some indications of leveling off by FY21.

Figure 27

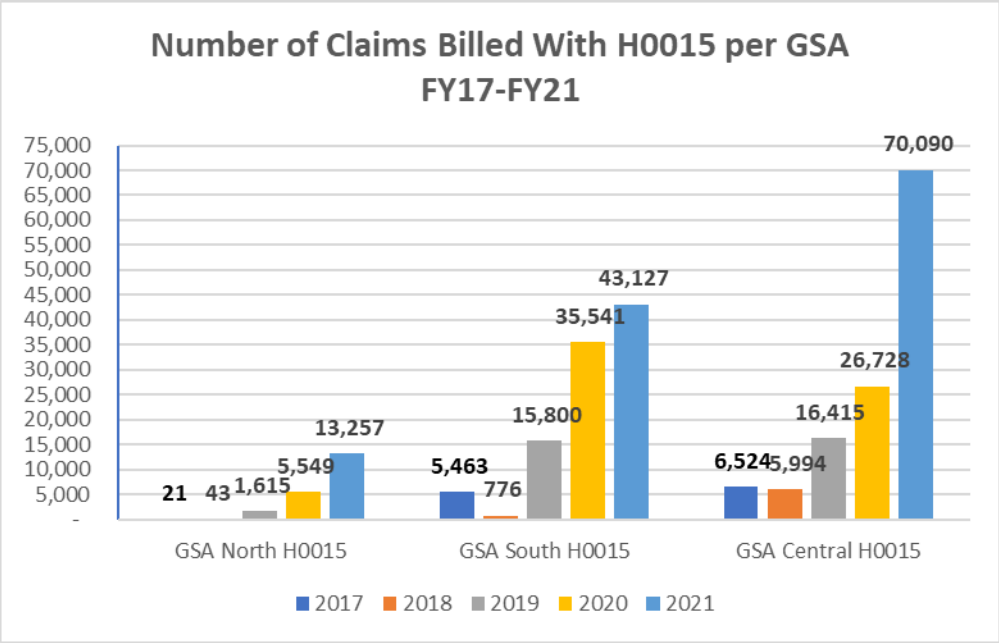
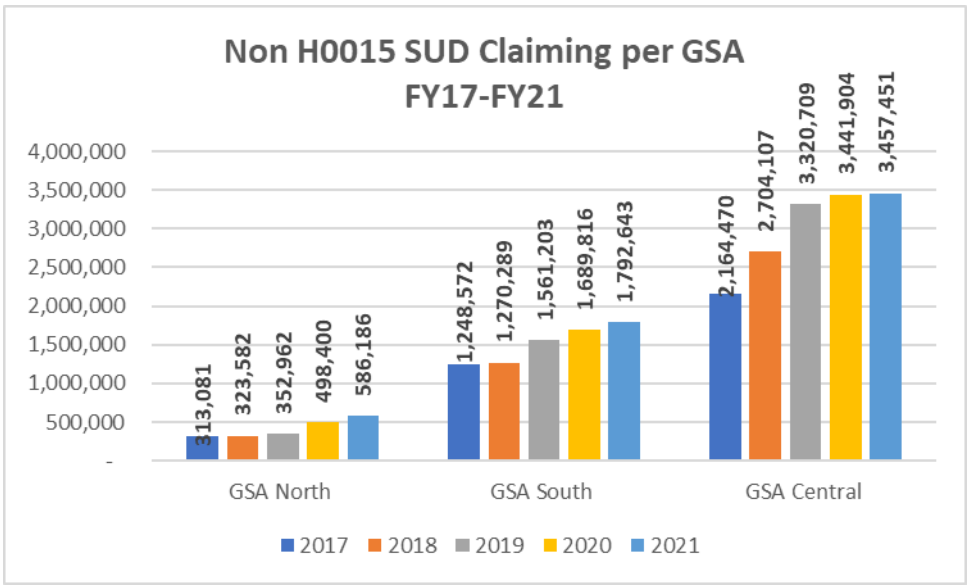


Figure 28



Spend by County and Region

The final aspect of the utilization analysis was to look at the trends related to spending, as defined by paid amount, by county and region, including the previously identified increase in SUD services. It is important to understand if there is a disparity in paid amount by county and GSA region and how that manifested itself.

When looking at the SUD spend, we again reviewed by the following procedure codes:

- H0001 Alcohol And/or Drug Assessment
- H0006 Alcohol And/or Drug Services; Case Management
- H0014 Alcohol And/or Drug Services; Ambulatory Detoxification
- H0015 Alcohol And/or Drug Services; Intensive Outpatient (Treatment Program That
- H0020 Alcohol And/or Drug Services; Methadone Administration And/or Service

We see some stark disparities. The overall spend by region shows that GSA NORTH started with a minimal number of services delivered and paid for under these codes in FY17. There was then an exponential increase by FY21, and while the overall spend lags the other regions, it is growing at a much higher rate.

Figure 29

GSA	2017	2018	2019	2020	2021
GSA North	$ 276,939	$ 301,234	$ 1,121,765	$ 2,786,053	$ 4,312,654
GSA South	$ 3,201,397	$ 1,671,986	$ 5,606,925	$ 10,081,786	$ 13,745,610
GSA Central	$ 2,770,679	$ 3,111,057	$ 5,631,777	$ 11,532,770	$ 23,522,141

5 Year Change in SUD Spend by GSA

- GSA Central – 749%
- GSA South – 329%
- GSA North – 1457%

Of note, in FY17 Apache County showed $0.00 spent on the codes noted above. By FY21 Apache had a total of $ 467,057 spent on these same services, thus indicating a renewed push to provide services in this county.

The variation in amount increased by region aligns with the overall OP BH services spend. While the percentages are much smaller, due to the much larger volume denominator for overall spend, the difference between the North region and the rest of the state is clear.

5 Year Trend in Overall Spend by GSA

- GSA Central – 94%
- GSA South – 10%
- GSA North – 12%

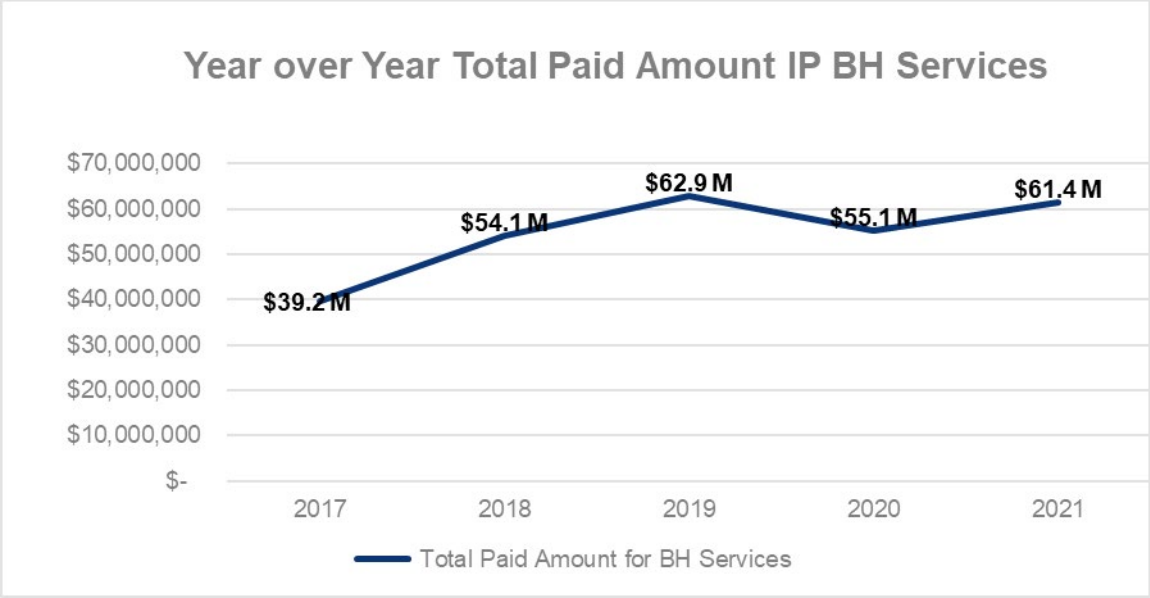
ACCESS TO CARE ANALYSIS INPATIENT

Overall Trends –IP

Reviewing overall utilization trends across the BH IP delivery system shows a clear trend over the five-year period. Overall BH service utilization trended upward year over year from 2017 through 2021, with the outlier of 2020 being explained by the COVID-19 pandemic. The outlier results in 2020 are not unexpected as the COVID-19 pandemic had a sizeable impact across many industries, including the BH delivery system. This is not unique to providers in Arizona. Many states saw a direct impact on their health providers, both physical and BH providers. The total paid amount for all IP services shows this trend.

This decline in 2020 is consistent with what PCG has observed across multiple clients.

Figure 30*



**Please note: These totals do not include AZ Tribal Providers Claims Data, as they get paid via a different methodology, outside of AHCCCS fee schedules.*

FY2021 shows another increase in service, and paid amount. The overall paid amount has reached 2019 levels, even with a potential claims lag on FY2021 data.

This shows a clear uptick in utilization of BH services, which supports the anecdotal statements from provider agencies throughout Arizona.

Access Trends by Agency

Another vital part of PCG's analysis is reviewing utilization trends over the five-year period by the agency. This is important to understand if there are shifts in what providers are being utilized, both from a service standpoint and a geographic standpoint.

PCG was able to use the claims data provided to us to review claims at the individual provider level, as identified by billing provider name, and determine a count of their individual billed claims per year. We used provider TIN and Servicing Provider ID as the differentiators to account for unique billing providers, and actualized total of servicing location. This analysis helps both PCG and AHCCCS see if provider utilization patterns are shifting how and where patients seek services.

The tables below show the year-over-year trend in number of unique claims submitted.

PROVIDER ACCESS ANALYSIS OVER 5 YEARS INPATIENT

Provider Access Trends

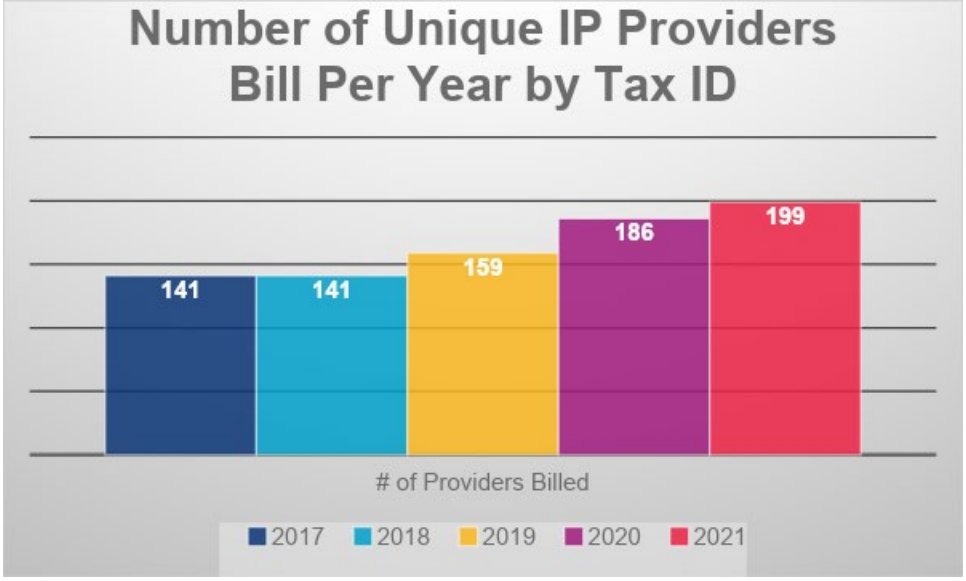
The next part of this analysis was to focus on the number of individual providers who submitted claims each year. This would help us understand if the change in the total paid amount was because of an increase in the number of billing providers, or another factor was present. This analysis of provider access is vital to understanding the current landscape of the BH delivery system in Arizona, as well as how it is shifting.

By using the claims data provided to us by AHCCCS we can see how many individual providers billed claims in a given Fiscal Year.

We reviewed this by unique provider TINs.

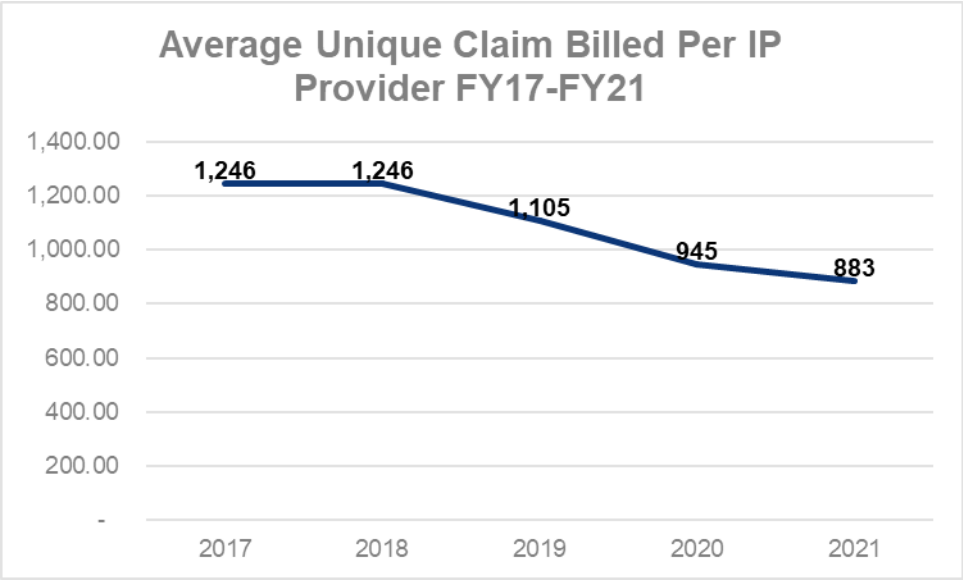
The overall number of individual billing providers by TIN rose year over year from 2018- 2021. In 2017 and 2018 the data showed 141 unique providers who billed for services, by 2021 this rose to 199. The biggest jump occurred from 2019 to 2020. In 2019 there were 159, and that rose to 186 in 2020.

Figure 31



In reviewing this data PCG notes the average number of services billed per unique provider dropped from 1,246 in 2017 and 2018 to 944 in 2020. This suggests that the increase in the number of unique providers meant a lower number of services provided per provider. This could occur for multiple reasons. The first is that more providers opened to new patients to help meet the demand. As noted in the previous section, demand did not dip, and is continuing to grow even as we get farther away from the initial shutdown during the pandemic. If more providers accepted patients, and were billing for Non-Medicaid covered BH services, the network would see a decrease in billable claims per provider.

Figure 32

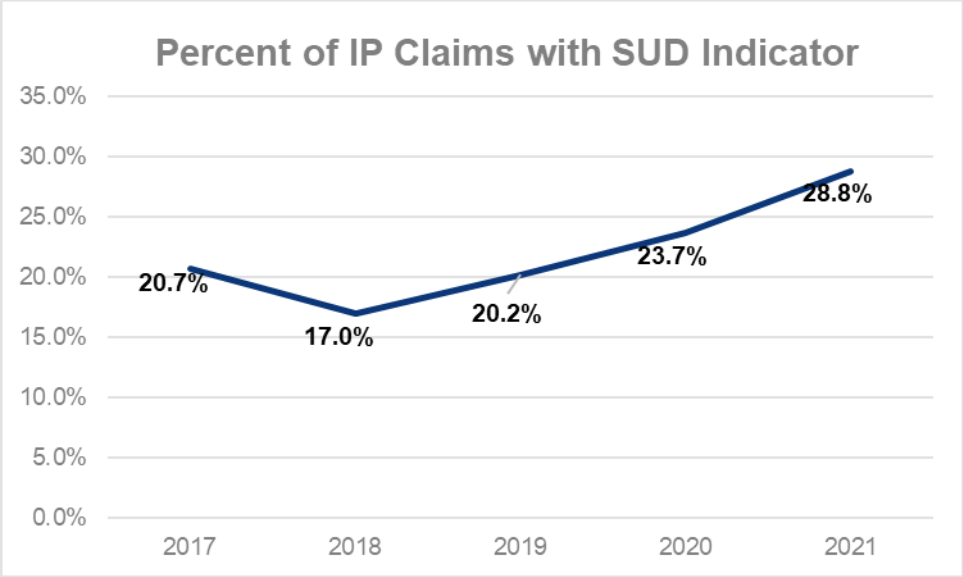


This does not necessarily mean that providers have less burden, as the number of billed services is not a sole indicator of demand. Issues regarding staff retention can create roadblocks in the providers ability to meet the demand of Behavioral Health services.

The next section will investigate how the trends in utilization and access may have shifted based on county level and GSA.

As with outpatient services PCG wanted to understand if there is an increase in SUD inpatient services over the reporting period. By using the same SUD indicator as on the outpatient claims data, we see that the percentage of SUD inpatient claims increased over the five-year period. The figure below clearly indicates that the trend of increased SUD services is not isolated to OP services.

Figure 33



Analysis by County and Region

Analyzing data on a county level can help us get a sense of the regional differences that could impact utilization and access of services.

The chart below shows which counties had an increase in unique submitted IP claims and which had a decrease.

Figure 34

Unique Submitted Medicaid Claims IP BH Year Over Year Change	
Increase	**Decrease**
Apache	Greenlee
Cochise	La Paz
Coconino	
Gila	
Graham	
Pima	
Pinal	
Santa Cruz	
Yuma	

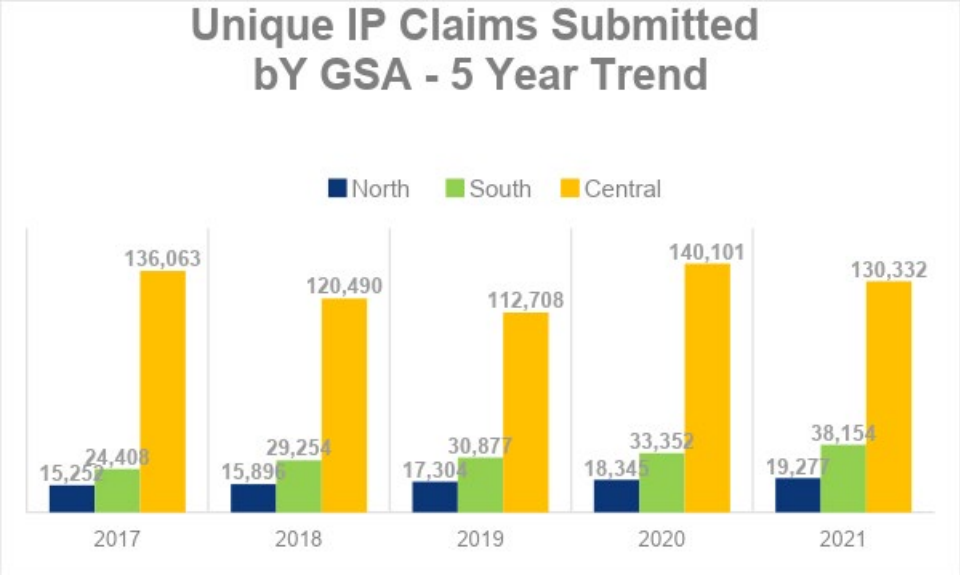
The remaining counties do not show a clear trend line, with 2021 being equal to past years, with the lone exception of 2020.

GSA Level Analysis - Inpatient

Overall Trends

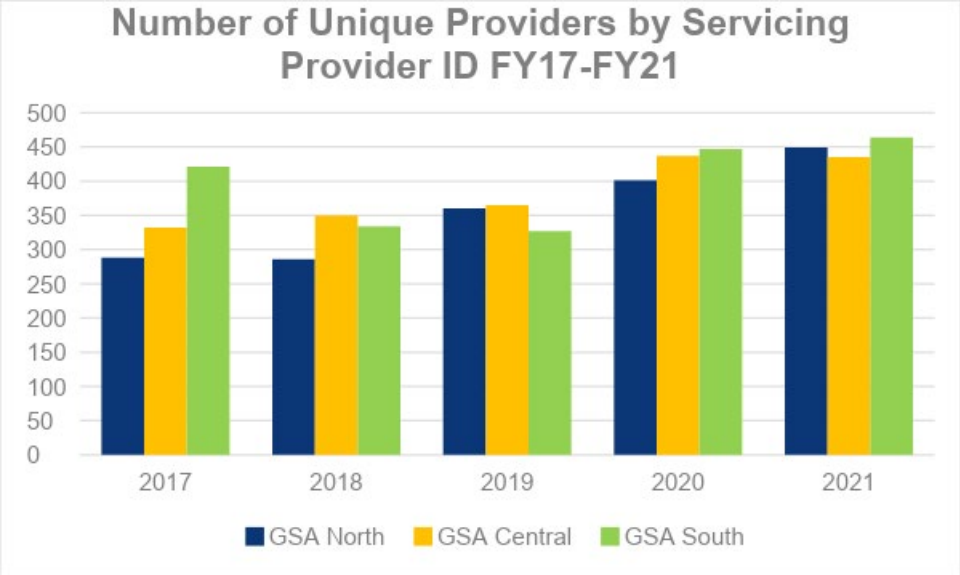
Looking at the number of unique claims per GSA shows a much clearer trend line. GSA North saw a small but consistent increase from 2017-2021. GSA South saw an even more pronounced increase in billed services with 2021 being the highest volume.

Figure 35



We also reviewed the number of unique providers by region, based on Servicing Provider ID. Figure 36 shows that the North and Central regions have a clear increase in providers from FY17-FY21, while the South varies over that span. There is a large decrease from FY17 to FY18, and then the numbers increase back to FY17 levels. This is interesting as it suggests while the need for services did not decrease in the South region, the number of available providers fluctuated. This could be due to the varying economic factors as noted in the provider survey responses.

Figure 36



SUD Trends By County and Region

The same trends that we see in OP SUD claiming are present with IP SUD Claiming. When analyzing the data by County and GSA, using the SUD Indicator, we see that each GSA had a steady increase year over year during the reporting period. As with the OP claims, the region with the largest increase is GSA North. By FY2021 almost 40% of all IP claims had an SUD indicator, an increase of over 50% from FY17. Figure 37 shows each GSA year over year percentage, while Figure 38 shows the five-year change for each GSA.

Figure 37

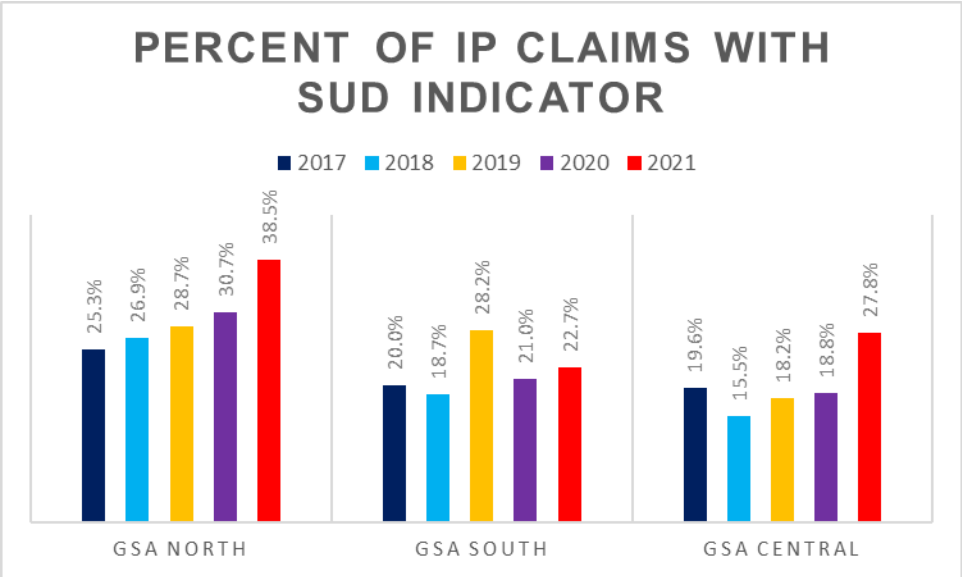
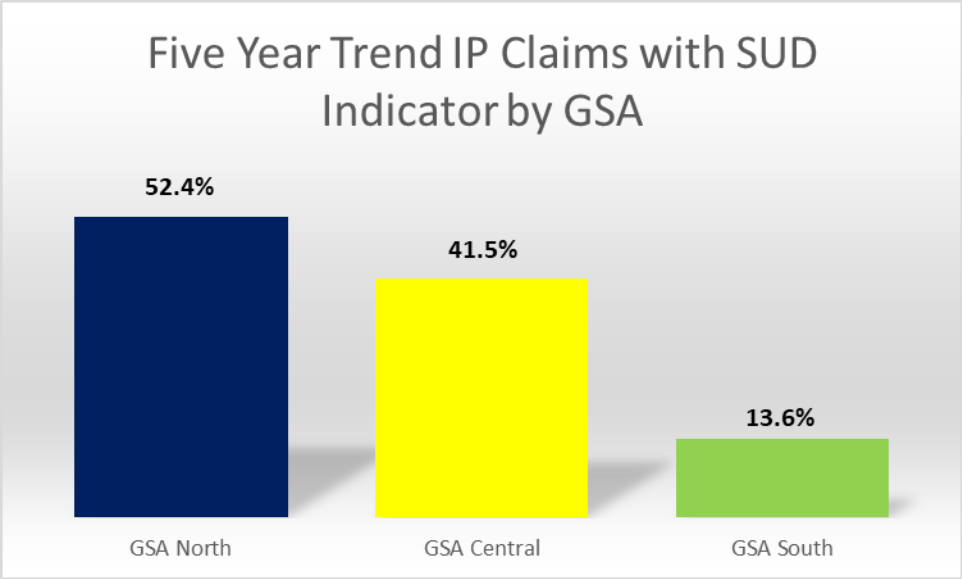


Figure 38



MEDICAID RATE COMPARISON

As part of the Arizona Health Care Cost Containment System (AHCCCS) Behavioral Health (BH) Rate Study, Public Consulting Group LLC (PCG) committed to completing a Rate Comparison project. This project entailed a review of current reimbursement practices in the State of Arizona for Medicaid covered BH services. PCG analyzed documents from the State of Arizona outlining current reimbursement rates and coverage for BH services to set a baseline for the rate comparison project.

PCG selected five (5) states to review as a comparison for the Medicaid Rate Comparison:

- Nevada
- Oklahoma
- Utah
- New Mexico
- Colorado

These states were selected based on their geographic and demographic similarities to Arizona, as well as similarities in service offerings, federal waivers and overall BH coverage. All five states are in the Southwest region of the United States, except for Oklahoma, which is in the Central Plains region but adjacent to New Mexico.

One significant consideration was finding demographically similar comparison states, in particular states with similar Native American populations. Arizona's Native American population is 5.5% of its total population, which is close to the comparison state average of 6.0%. A key difference between Arizona and the comparison states is that on average these five states have a population of 3.7 million, while AZ is slightly higher at 7.3 million. While higher than average, this difference in population is not statistically significant enough to affect the rate comparison analysis.

The reimbursement rates for BH services were reviewed on an individual service and programmatic basis to ascertain if Arizona reimbursement is adequate and in line with neighboring states.

PCG also analyzed up to five years of reimbursement rates, from FY2017 to FY2021, for the identified services across all five states to determine if rates have been adjusted for changing societal and economic factors. By reviewing the trend of reimbursement rates PCG can identify opportunities for rate updates, both now and in the future.

As a final part of the rate comparison, PCG analyzed available commercial and private payor rates and compared to the current service reimbursement rates for Medicaid in Arizona. This was done to ensure Arizona is meeting rate requirements as outlined by the Center for Medicare and Medicaid Services (CMS) as well as understanding the rate challenges that Medicaid providers are working through.

PCG undertook this in-depth multistep process in conjunction with, and approval from, their partners at AHCCCS.

CURRENT REIMBURSEMENT PRACTICES

Reimbursement

PCG was provided current reimbursement rates from AHCCCS for their BH services and programs. These rates were previously updated on October 1, 2021, for BH Outpatient and Inpatient services, with previous updates being effective on October 1st of each year, going back to 2017[1]. During the course of our analysis AHCCCS did provide a 2.5% increase to BH OP services codes effective October 1, 2022 however this report does not take that into account.

The rates noted represent the current BH Medicaid Fee-for-Service (FFS) reimbursement rates that are paid for covered Medicaid BH services, when administered by AHCCCS registered providers. These rates are dependent on accurate claim submission from the provider, including use of correct procedure codes, modifiers, place of service and claim forms. The rates are not a guarantee of payment and are used as a comparison tool to show how reimbursement would occur if all mandated billing practices were followed when billing Medicaid Fee-for-Service.

[1] https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/.

Behavioral Health Outpatient Rate Background

The BH outpatient reimbursement rates in Arizona are varied based on place of service, and in some cases modifiers. These modifiers, which can specify many factors such as practitioner level delivering the service, group setting, and use of telemedicine are also used for data collection purposes to track trends across the BH delivery system.

The fee schedule for Arizona lists covered procedures by Healthcare Common Procedure Coding System (HCPCS) designation. These codes are not time based, as opposed to Current Procedural Terminology (CPT) codes. This means that the rate for a standard counseling service is a 15-minute increment, and the provider would bill multiple units of the same HCPCS code to account for the time spent treating the patient. CPT codes are time-based, in that there is a distinct code for 30 minutes, versus a separate one for 45 minutes and other time intervals.

Behavioral Health Inpatient Rate Background

The BH inpatient rates are billed using revenue codes. The use of revenue codes, an industry standard for inpatient claims, helps identify where the patient was when they received treatment. In the State of Arizona, the rates are set based on broad service description types. The table below shows the rates unique to Inpatient Psychiatric services, as identified by the Revenue codes ending in "4."

The rates in Arizona do not vary based on region, or specific hospital location. This is different from some other states and as we will show makes a comparison of inpatient rates more complex.

COMPARISON OVER FIVE-YEAR PERIOD

Outpatient Rates

Reviewing the rates over the original five-year period within the State of Arizona, shows that the BH Outpatient FFS rates broadly have not been updated since 10/1/19, for Fiscal Year 2020. This will be almost three (3) years since BH OP rates were updated.

The rate of inflation since October 1, 2019, per the Consumer Price Index, is 15.40%[2].

To give a better sense of what reimbursement rates would be if we applied an inflation factor to existing rates, we took the rates from 2017 and calculated what they would be if they were adjusted for the rate of inflation since 10/1/17. Per CPI, the inflation rate since 10/1/17 is 20.13%. We then compared the hypothetical adjusted rates to what the ACTUAL current rates are. This added layer helps us understand how the rates were adjusted in 2019, and if they are within a reasonable range.

[2] https://www.usinflationcalculator.com/inflation/consumer-price-index-and-annual-percent-changes-from-1913-to-2008/

Figure 39

Current BH OP Rates Compared to Previous Rates if Adjusted for Rate of Inflation					
ProcedureCode	Procedure Code Description	FFY22 Rate	2017 Rate	2017 Adjusted Rate	% Difference 2017 Adjusted to FY22 Rate
H0001	ALCOHOL AND/OR DRUG ASSESSMENT	$36.73	$32.06	$38.51	-4.6%
H0002	BEHAVIORAL HEALTH SCREENING TO DETERMINE ELIGIBILITY FOR ADMISSION TO TREATMENT	$28.61	$22.14	$26.60	7.6%
H0004	BEHAVIORAL HEALTH COUNSELING AND THERAPY, PER 15 MINUTES	$44.41	$20.25	$24.33	82.6%
H0018	BEHAVIORAL HEALTH; SHORT-TERM RESIDENTIAL (NON-HOSPITAL RESIDENTIAL TREATMENT	$255.29	$196.02	$235.48	8.4%
H0020	ALCOHOL AND/OR DRUG SERVICES; METHADONE ADMINISTRATION AND/OR SERVICE	$4.31	$3.76	$4.52	-4.6%
H0025	BEHAVIORAL HEALTH PREVENTION EDUCATION SERVICE (DELIVERY OF SERVICES WITH	$19.87	$7.91	$9.50	109.1%
H0031	MENTAL HEALTH ASSESSMENT, BY NON-PHYSICIAN	$214.64	$155.00	$186.20	15.3%
H0034	MEDICATION TRAINING AND SUPPORT, PER 15 MINUTES	$11.03	$7.88	$9.47	16.5%
H0036	COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT, FACE-TO-FACE, PER 15 MINUTES	$6.98	$6.09	$7.32	-4.6%
H0037	COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT PROGRAM, PER DIEM	$167.12	$145.86	$175.22	-4.6%
H0038	SELF-HELP/PEER SERVICES, PER 15 MINUTES	$21.33	$12.16	$14.61	46.0%
H2010	COMPREHENSIVE MEDICATION SERVICES, PER 15 MINUTES	$15.64	$13.65	$16.40	-4.6%
H2011	CRISIS INTERVENTION SERVICE, PER 15 MINUTES	$48.64	$34.74	$41.73	16.5%
H2012	BEHAVIORAL HEALTH DAY TREATMENT, PER HOUR	$15.42	$13.46	$16.17	-4.6%
H2014	SKILLS TRAINING AND DEVELOPMENT, PER 15 MINUTES	$19.87	$14.19	$17.05	16.6%
H2015	COMPREHENSIVE COMMUNITY SUPPORT SERVICES, PER 15 MINUTES	$3.48	$3.04	$3.65	-4.7%
H2016	COMPREHENSIVE COMMUNITY SUPPORT SERVICES, PER DIEM	$322.08	$263.12	$316.09	1.9%
H2017	PSYCHOSOCIAL REHABILITATION SERVICES, PER 15 MINUTES	$16.29	$14.22	$17.08	-4.6%
H2019	THERAPEUTIC BEHAVIORAL SERVICES, PER 15 MINUTES	$5.42	$4.73	$5.68	-4.6%
H2020	THERAPEUTIC BEHAVIORAL SERVICES, PER DIEM	$123.63	$107.90	$129.62	-4.6%
H2025	ONGOING SUPPORT TO MAINTAIN EMPLOYMENT, PER 15 MINUTES	$14.17	$10.12	$12.16	16.6%
H2026	ONGOING SUPPORT TO MAINTAIN EMPLOYMENT, PER DIEM	$264.35	$230.72	$277.16	-4.6%
H2027	PSYCHOEDUCATIONAL SERVICE, PER 15 MINUTES	$20.27	$14.48	$17.39	16.5%
H2033	MULTISYSTEMIC THERAPY FOR JUVENILES, PER 15 MINUTES	$42.67	$16.95	$20.36	109.6%
S5109	HOME CARE TRAINING TO HOME CARE CLIENT, PER SESSION	$169.10	$143.28	$172.12	-1.8%
S5110	HOME CARE TRAINING, FAMILY; PER 15 MINUTES	$24.11	$17.22	$20.69	16.6%
S5150	HOME UNSKILLED RESPITE CARE, NOT HOSPICE; PER 15 MINUTES	$10.56	$7.80	$9.37	12.7%
S5151	UNSKILLED RESPITE CARE, NOT HOSPICE; PER DIEM	$303.48	$224.35	$269.51	12.6%
S9484	CRISIS INTERVENTION MENTAL HEALTH SERVICES, PER HOUR	$88.66	$63.33	$76.08	16.5%
S9485	CRISIS INTERVENTION MENTAL HEALTH SERVICES, PER DIEM	$490.71	$350.51	$421.07	16.5%
T1002	HOME RN SERVICES, UP TO 15 MINUTES	$27.16	$19.40	$23.31	16.5%
T1003	HOME LPN/LVN SERVICES, UP TO 15 MINUTES	$17.50	$15.27	$18.34	-4.6%
T1016	CASE MANAGEMENT, EACH 15 MINUTES	$28.52	$13.69	$16.45	73.4%
T1019	PERSONAL CARE SERVICES, PER 15 MINUTES, NOT FOR AN INPATIENT OR RESIDENT OF A	$9.04	$6.38	$7.66	17.9%
T1020	PERSONAL CARE SERVICES, PER DIEM, NOT FOR AN INPATIENT OR RESIDENT OF A	$316.92	$264.72	$318.01	-0.3%

This analysis shows that most of the current rates are higher than the rates from 2017 if they were adjusted to match the rate of inflation. The few instances where the adjusted 2017 rates are higher show no more than a 4.7% difference, suggesting that the rate adjustment in 2019 was appropriate and within line with the costs and challenges impacting providers at that point in time.

Inpatient Rates

To review inpatient rates across the five-year period in Arizona, we were able to review the publicly available rate fee schedules that go back until 2017. These fee schedules clearly notate the effective date, the service, the related codes, description, and the rate. When doing an in-depth review, we first want to look at the services that have been in place across the full five-year review period. The IP BH rates have not been updated since prior to 10/1/16, meaning that for this full five-year period of review the rates have not been adjusted. If the rate of inflation of 20.13% is factored in, before accounting for other cost shifts related to the COVID-19 pandemic and employment shifts, there is the opportunity to review and update rates.

Rates Comparison – Individual Services

Outpatient Rates

To complete a review against other states we first reviewed the current Medicaid covered BH services fee schedules for all states. We highlighted the individual outpatient rates that we could identify as being shared across a majority of the five states, by using the procedure code as the common point. This will help us standardize the review process and get a true sense of where Arizona's rates compare. The table

below shows this comparison. We did note any additional calculations that we needed to make to ensure an accurate like-to-like comparison as some states use a different time unit on their procedure codes from Arizona.

Figure 40

Multi State Individual Service Rate Comparison								
Code	Description	Rate Unit	Arizona	Oklahoma	Nevada	Utah	New Mexico	Colorado
H0001	Alcohol/Drug Assessment	Per 15 min	$36.73	$25.00	N/A	N/A	$65.42	$106.25
H0004	BH Counseling and Therapy	Per 15 min	$27.32	$19.03/$19.13	$30.28	$6.51	$33.42	$25.29
H0031	MH Assessment by Non-Physician	Per Event	$214.64	$103.33	$182.59	$190.98	$168.35	N/A
H2010	Comprehensive Medication Services	Per 15 min	$15.64	N/A	N/A	$9.04	$38.85	N/A
H2011	Crisis Intervention	Per 15 min	$48.64	$22.00	$21.71	N/A	$32.69	$12.42
H2014	Skills Training and Development	Per 15 min	$19.87	$4.22	$7.06	$17.92	$11.34	$12.45
H2017	Psychosocial Rehab	Per 15 min	$16.29	$11.79	$14.38	$4.29	$7.43	N/A
H2019	Therapeutic Behavioral Services	Per 15 min	$5.42	$7.77	N/A	$20.49	N/A	$3.63
T1016	Case Management	Per 15 min	$21.33	$15.23	$8.61	$18.11	N/A	$9.45

*New Mexico H0004 is 30 min rate, this rate is a calculation to a per 15 min unit

*Utah H0031 is per 15 min rate, This total is based on an average duration of 90 minutes.

There are ten services that are common across a majority of the five states. These services are offered across the entire spectrum of potential BH service offerings and help create an accurate comparison. The table below shows the percentage difference between Arizona and the four other states used in this review. We used Arizona as the baseline, with the other states showing a percentage higher (red) or lower (green). The codes listed represented 49% of all OP BH spending in Arizona in FY2021. As we researched “like to like” service descriptions and procedure codes across the comparison states, we feel confident that the differences in reimbursement are accurate as we also accounted for any unit measurements within those codes.

Figure 41

Multi State Individual Service Rate Difference						
Code	Arizona	Oklahoma	Nevada	Utah	New Mexico	Colorado
H0001	$36.73	32%			-78%	-189%
H0004	$27.32		-11%	76%	-22%	7%
H0031	$214.64	52%	15%	11%	22%	
H2010	$15.64			42%	-148%	
H2011	$48.64	55%	55%		33%	74%
H2014	$19.87	79%	64%	10%	43%	37%
H2017	$16.29	28%	12%	74%	54%	
H2019	$5.42	-43%		-278%		33%
T1016	$21.33	29%	60%	15%		56%

This table clearly shows that most shared services are reimbursed at a higher rate in Arizona than in the neighboring states. Of thirty-three total shared procedure codes across the five compared states, Arizona reimburses at a higher rate for twenty-six of them. This is an 82% rate favoring Arizona. One potential reason for this can be attributed to the effective date of the most recent update. Arizona has updated their BH FFS rates more recently than the compared states. This allows them to account for more updated utilization, as well as any additional factors that impact provider reimbursement.

As noted in Arizona, the OP rates reviewed in this report were last updated on October 1, 2019. While this was completed pre-pandemic, and prior to the inflationary changes in the United States and world economy, this is not an unprecedented amount of time. There are multiple states that last updated the BH OP rates longer than three years ago. This suggests a larger industry trend where BH rates have not been updated on a regular basis, before considering the changes throughout the country that have occurred since 2020.

Figure 42

Multi State Rate Effective Date By Procedure						
Code	Arizona	Oklahoma	Nevada	Utah	New Mexico	Colorado
H0001	10/1/2019	4/1/2015			10/1/2019	7/1/2022
H0004	10/1/2019	7/1/22 & 7/1/18	4/11/2012	4/1/2020		7/1/2022
H0031	10/1/2019	9/1/2016	1/1/2006	7/1/2021	10/1/2019	
H2010	10/1/2019			4/1/2020	10/1/2019	
H2011	10/1/2019	5/1/2016	1/1/2006		10/1/2019	7/1/2022
H2014	10/1/2019	3/1/2015	1/1/2019	7/1/2021	10/1/2019	7/1/2022
H2015	10/1/2019	7/1/2022			10/1/2019	7/1/2022
H2017	10/1/2019	9/1/2015	2/1/2010	7/1/2021	10/1/2019	
H2019	10/1/2019	9/1/2015		7/1/2021		7/1/2022
T1016	10/1/2019	5/1/2016	1/1/2006			7/1/2022

Inpatient Rates

We also reviewed the five noted states' BH Inpatient rates, to similar effect. We used service description and revenue code as the common reference point to account for the inherent differences in how inpatient rates are set. Inpatient rates fall into the "per diem" methodology so it is important to compare similar rate methodologies whenever possible. The per diem rate can include different details within different services and states and vary based on region, and specific hospital location.

The table below shows the common services amongst all five states.

Inpatient rates are impacted by many factors such as regional factors and hospital location. This comparison is the baseline for Inpatient psychiatric services.

Figure 43

Inpatient Psychiatric Rates - Baseline Average						
Description	Arizona	Oklahoma	Nevada	Utah	New Mexico	Colorado
Psychiatric Stay	$816.39	$596.91	$944.00	Could not definitively locate	Cost Reimbursement	$750.00

The information available to us indicates that Arizona IP rates are squarely in the middle of the range of the neighboring states reviewed. This indicates a clear opportunity for enhancement to assist IP providers with their increasing costs.

Rate Comparison by Outpatient Service Category

We also looked to review rates on a programmatic basis. Because individual service rates can be limited in the similarities, reviewing state by state program rates can help fill in the gaps. All five states have similar program offerings, from treatment services to rehabilitation services, including home and community-based service (HCBS) offerings.

To conduct this review, we looked at each state's service groupings and averaged the rates.

We also attempted to group the service groupings under the same terminology. This required some extrapolation as some states use different verbiage. We believe the best way was to review the individual service offerings and match them to the program terminology used in Arizona. This made for a much simpler review that added veracity to the results.

The table below shows the service groupings; as defined in Arizona; and how many services each state offers in those classifications.

By using this method, we were able to determine that Arizona offers a breadth of services equal to or greater than the states we compared to. We also were able to show that Arizona rate offerings are competitive and in-line with other states and the larger US Medicaid delivery system.

Figure 44

Number of Services Offered Within Program Type						
Program	Arizona	Oklahoma	Nevada	Utah	New Mexico	Colorado
Treatment services	7	5	3	3	8	2
Support Services	9	5	2	5	2	4
Rehabilitation Service	5	3	2	2	2	N/A
Crisis Intervention	3	3	1	N/A	4	1
BH Resident	2	1	N/A	2	2	1
BH Day Services	5	2	1	N/A	2	1

By averaging the rates for the services within the program, and standardizing the rate structure, we were able to see that Arizona offers rates that are more than competitive with their neighboring states. Figure 45 lists the average rate by service program type across the compared states. This combined with the information in Figure 44 outlining the full breadth of services that are offered in Arizona, gives a full overview of Arizona's position in the BH Medicaid FFS Healthcare landscape.

Figure 45

Rate Average by Program Type						
Program	Arizona	Oklahoma	Nevada	Utah	New Mexico	Colorado
Treatment Services	$39.78	$73.90	$53.23	$21.57	$28.09	$41.30
Support Services	$38.03	$18.97	$5.87	$28.50	$12.43	Prices Set Manually
Rehab	$48.21	$44.06	$15.50	$10.97	$23.33	N/A
Crisis Intervention	$174.97	$61.19	$23.66	N/A	$152.90	$12.42
BH Resident	$229.45	$161.91	N/A	$267.36	Cost Reporting	$127.50
BH Day	$43.93	$27.72	$32.43	N/A	$26.74	$3.63

COMMERCIAL PAYOR RATE COMPARISON

The final component of the requested scope of work was comparing AHCCCS BH OP service rates to the rates paid by commercial insurance payors for the same services. To complete this comparison PCG and AHCCCS worked with the Arizona Council of Human Services Providers to engage their member agencies. It was determined the most efficient path to completing this would be to issue a short direct survey for the agencies to complete.

SURVEY DESIGN

The survey was designed to be straightforward and efficient to ensure quick and accurate completion by providers. PCG pulled a full list of HCPCS codes billed from FFY2021 Outpatient Behavioral Health claims data. This full list was reviewed by AHCCCS staff who determined the procedure codes based on current Medicaid utilization volume. These procedure codes were included in the survey, and we asked for the following aggregated information for each procedure code across commercial payors.

- Total Number of Paid Units
- Total Paid Amount

These totals were requested for FFY2022 where the commercial insurer was the primary payor, to remove any billing anomalies associated with coordination of benefits.

PCG then put a locked formula in place so that once those metrics were entered it would automatically generate an average paid amount per unit. This would be done for each listed procedure code. The procedure codes we asked for payment data on are noted below:

- H0002 Behavioral Health Screening To Determine Eligibility For Admission To Treatment
- H0004 Behavioral Health Counseling And Therapy, Per 15 Minutes
- H0018 Behavioral Health; Short-Term Residential (Non-Hospital Residential Treatment)
- H0020 Alcohol And/or Drug Services; Methadone Administration And/or Service
- H0025 Behavioral Health Prevention Education Service
- H0031 Mental Health Assessment, By Non-Physician
- H0038 Self-Help/Peer Services, Per 15 Minutes
- H2010 Comprehensive Medication Services, Per 15 Minutes
- H2011 Crisis Intervention Service, Per 15 Minutes
- H2014 Skills Training And Development, Per 15 Minutes
- H2016 Comprehensive Community Support Services, Per Diem
- H2017 Psychosocial Rehabilitation Services, Per 15 Minutes
- H2019 Therapeutic Behavioral Services, Per 15 Minutes
- H2025 Ongoing Support To Maintain Employment, Per 15 Minutes
- H2027 Psychoeducational Service, Per 15 Minutes
- S5110 Home Care Training, Family; Per 15 Minutes
- S5150 Unskilled Respite Care, Not Hospice; Per 15 Minutes

- S9480 Intensive Outpatient Psychiatric Services, Per Diem
- S9484 Crisis Intervention Mental Health Services, Per Hour
- S9485 Crisis Intervention Mental Health Services, Per Diem
- T1016 Case Management, Each 15 Minutes
- T1019 Personal Care Services, Per 15 Minutes, Not For An Inpatient

AHCCCS asked the Council to distribute the survey to their member agencies, which helped ensure active participation.

We have received 13 separate responses, giving us an adequate amount of data to review and analyze. Within these 13 responses we received a reasonable amount of data on the following procedure codes:

- H0002 Behavioral Health Screening To Determine Eligibility For Admission To Treatment
- H0004 Behavioral Health Counseling And Therapy, Per 15 Minutes
- H0018 Behavioral Health; Short-Term Residential (Non-Hospital Residential Treatment)
- H0031 Mental Health Assessment, By Non-Physician
- H2014 Skills Training And Development, Per 15 Minutes
- H2027 Skills Training And Development, Per 15 Minutes
- S5110 Home Care Training, Family; Per 15 Minutes
- T1016 Case Management, Each 15 Minutes

The remaining procedure codes either had no data reported or a small volume that would not be able to provide appropriate analysis.

After calculating the average paid amount per unit, by dividing the aggregate total of amount paid by aggregate total of units paid we were able to calculate an approximate commercial rate.

Figure 46

Procedure Code	Average Paid Per Unit
H0002	$36.59
H0004	$34.99
H0018	$458.91
H0031	$166.19
H2014	$54.80
H2027	$12.87
S5110	$27.44
T1016	$41.26

By comparing these results to the posted FFY 21 AHCCCS Fee Schedules we can get a true sense of how AHCCCS reimbursement rates compare to Commercial payor rates. There are 8 unique procedure codes that we can compare, and of those 8 the AHCCCS reimbursement rate is higher for 3 of them, as highlighted in green. The services where AHCCCS rates are lower are highlighted in red.

For the 4 procedures that AHCCCS rates are lower they average a deficit of 78%. This is notably higher than the 24% average on the procedures that AHCCCS has higher reimbursement rates. This is mainly driven by the large difference in rates for H0018 and T1016. In these instances, the AHCCCS rate is 176% and 93% lower, respectively. We do note that there is no trend to the rates where AHCCCS is lower. They are a mix of Per Diem and Per 15-minute rates.

Figure 47

Procedure Code	Average Commercial Rate	FFY22 AHCCCS Rate	Unit Measurement	Higher (Commercial or AHCCCS)	% Difference
H0002	$ 36.59	$ 28.61	Per 15 Minute	Commercial	-28%
H0004	$ 34.99	$ 44.41	Per 15 Minute	AHCCCS	21%
H0018	$ 458.91	$ 255.29	Per Diem	Commercial	-80%
H0031	$ 185.80	$ 214.64	Per Diem	AHCCCS	13%
H2014	$ 54.80	$ 19.87	Per 15 Minute	Commercial	-176%
H2027	$ 12.77	$ 20.27	Per 15 Minute	AHCCCS	37%
S5110	$ 27.44	$ 24.11	Per 15 Minute	Commercial	-14%
T1016	$ 41.26	$ 21.33	Per 15 Minute	Commercial	-93%

To show the difference in projected revenue we used the FFY22 Reported Units from the Commercial Survey and calculated the revenue using the Commercial rates against the AHCCCS Rates. Using these inputs, we calculate that AHCCCS rates are creating a revenue gap of $1,990,903.61 versus the Commercial rates.

Figure 48

Procedure Code	Average Commercial Rate	FFY22 AHCCCS Rate	FY21 Commercial Unit Billed	Estimated Revenue Difference
H0002	$ 36.59	$ 28.61	204	$ (1,627.20)
H0004	$ 34.99	$ 44.41	57950	$ 546,127.46
H0018	$ 458.91	$ 255.29	12585	$ (2,562,513.00)
H0031	$ 185.80	$ 214.64	6562	$ 189,248.08
H2014	$ 54.80	$ 19.87	486	$ (16,974.56)
H2027	$ 12.77	$ 20.27	115	$ 862.90
S5110	$ 27.44	$ 24.11	196	$ (652.69)
T1016	$ 41.26	$ 21.33	7294	$ (145,374.60)
Total Difference				**$ (1,990,903.61)**

When we apply the adjustment factors to the 5 lower rates, we see that they become closer but still are lower by 43%.

Figure 49

Procedure Code	Average Commercial Rate	FFY22 AHCCCS Rate	Factors Included	% Difference	Adjustment Factors
H0002	$ 36.59	$ 29.33	$ 31.78	-25%	-15%
H0018	$ 458.91	$ 261.67	$ 271.46	-75%	-69%
H2014	$ 54.80	$ 20.37	$ 22.82	-169%	-140%
T1016	$ 41.26	$ 21.86	$ 24.31	-89%	-70%
S5110	$ 27.44	$ 24.11	$ 27.16	-14%	-1%

PCG recommends reviewing the 5 rates individually as needed. They are currently lower than the related rates in a commercial payor setting, which is appropriate. Like all other rates it would be useful for AHCCCS to continue to monitor if there is a need to recalculate later due to the changing staffing, retention, and economic conditions.

RATE CONSIDERATIONS

IDENTIFICATION OF RATE VARIANCES

PCG recommends that AHCCCS look to address specific cost factors that are impacting providers across the BH service delivery system. The factors identified, through national research, benchmarking and a comprehensive provider survey sent to AHCCCS providers are the impact of technology, staffing and recruitment and travel. These factors are not unique across the healthcare delivery system, but the impact they are having on providers costs are increasing as the system adapts to the changes brought upon by the COVID-19 pandemic and related economic influences.

Provider reimbursement analysis did not indicate any anomalies with the broad spectrum of BH OP and IP services. Upon further analysis of provider billing for code H0015, Intensive Outpatient Alcohol and/or Drug Services showed extreme variations in the billed amount as well as the applicable billed units.

AHCCCS determined a rate for H0015 that considered these variances and was issued on 5/1/23.

RATE AND SERVICE CONSIDERATIONS

In Office vs. Out of Office Rates for BH Services

The AHCCCS BH Outpatient Fee Schedule includes modifiers and Place of Service (POS) codes that impact the rates in several ways. The use of POS code 12 for services provided in the recipient's home is consistent with industry standards and marks a clear delineation of service with POS 11, representing an office setting. For the services where this POS is allowed there is not a clear and consistent rate difference. As an example, the base rate for H0004, with POS 11 is $28.00 per 15-minute unit. The base rate of H0004 with a POS code of 12, is $45.52 per 15-minute unit. However, if H0004, POS 11 is submitted with an HN or HO modifier (representing Bachelor's or Master's level practitioner) the rate is $28.48. This methodology shows that the impact on the rates is the HN and HO modifiers, but that impact is minimal.

PCG recommends that AHCCCS clearly delineate the factors that impact rates, including a clear factor for POS 11 vs. POS 12. PCG also recommends that AHCCCS outline the percentage adjustment for each modifier and/or POS rate factor so that all providers are clear as to how the rate is impacted based on the particulars of the service delivery.

Based on this PCG is recommending the travel adjustment factor, calculated based on the percentage of out of office visits as reported on the provider survey responses and the average cost of travel in the State of Arizona, would only apply to rates that have the POS code 12. This ensures a consistent approach that promotes transparency.

Considerations for serving members with a Designation of Serious Mental Illness (SMI)

AHCCCS providers are committed to assisting all eligible members with their BH needs. The prevalence of individuals who suffer from Serious Mental Illness (SMI) creates additional challenges that can be accounted for in a rate setting process.

SMI is defined by federal regulations as any diagnosable mental, behavioral, or emotional disorder experienced by persons aged 18 and older that is characterized by episodic, recurrent, or persistent features and substantially interferes with or limits the ability to participate in one or more major life activities.

Approximately five (5) percent of the U.S. population are determined to be living with SMI, and it is a leading cause of disability in the nation[3]. This is due to the additional stressors such as food insecurity, housing insecurity, illness management and isolation. These factors lead to an increased risk of morbidity and mortality.

It is important to identify individuals who are designated as living with SMI, which AHCCCS does per its SMI Determination Process.[4] This process is adept at identifying SMI designated members and lining them up with care through an Integrated Care plan. This is only the first step in the process, as it does not address the added strains on the provider community who treat SMI patients. The rate setting process can consider this strain and determine if additional considerations are needed.

PCG knows that a large part of treating patients determined to have an SMI is finding a way to reach them. Because of the housing insecurities, and isolation that SMI patients encounter, they often do not have adequate access to, or comfort using, transportation to reach an appointment. The use of different methods is needed to adequately treat the SMI population. This includes increased travel to the patient's residence, or the use of technology if possible. Some providers have worked to ensure that patients have pre-paid cellular devices so they can more easily reached via call or Short Messaging Service (SMS) text messaging. Taking these considerations into account is important in the rate setting process.

PCG is recommending the use of technological, and travel adjustments, for selected services partially to assist the treatment of the SMI population. By accounting for travel costs and technological assistance, rates could address some of the additional stressors that impact providers' ability to adequately offer services.

One of the major factors impacting accessibility to treatment for SMI patients, as well as all BH patients, is the workforce shortage. Even prior to COVID-19 pandemic and the impact on almost all employment opportunities, BH providers were experiencing difficulties in recruiting and retaining staff. As of September 30, 2020, Health Resources and Services Administration (HRSA) designated more than 5,700 mental health provider shortage areas, with more than one-third of Americans (119 million people) living in these shortage areas. In these areas, the number of mental health providers available were adequate to meet about 27 percent of the estimated need[5]. This shortage is even more pronounced for those patients with an SMI. Part of this shortage could be due to inadequate reimbursement rates.

To address these inefficiencies PCG recommends the turnover and recruitment adjustment, to increase reimbursement rates for all BH services in Arizona that are utilized by an SMI member. Workforce shortage and retention impacts all services, and providers, and addressing that through a rate adjustment can target that deficiency. By researching staffing costs within Arizona this adjustment is targeted at AHCCCS providers, and not based on data that applies solely in other parts of the country.

Telehealth Rate Considerations

Behavioral Health service delivery, and the methods by which it is offered, have seen a change in the last few years. The growth of tele-health services, spurred by the increase in available technology and consistent internet connections, has had a change on how patients are treated. For many providers, the idea of seeing more patients each day would allow for greater productivity. However, the reality is not as straightforward due to many factors. The increase in available technology does not equate to reduced costs. The use of technology, which is needed to offer tele-health services, has seen an increase in costs to providers.[6]To properly account for this PCG has undertaken research to determine the cost of

[3] http://www.nimh.nih.gov/statistics/1ANYDIS_ADULT.shtml
[4] https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320P.pdf
[5] https://www.gao.gov/assets/gao-22-104597.pdf
[6] https://www.medicaleconomics.com/view/telehealth-post-covid-going-digital-to-reduce-costs-

purchasing needed technologies. In addition, PCG has used the provider survey to get a better understanding of the percentage of tele-health services being conducted by AHCCCS providers.

The provider survey responses indicated that a steady percentage of tele-health services are being offered by AHCCCS providers, with the COVID-19 pandemic increasing this impact. The average percentage of telehealth appointments reported rose from 2% in FY2019 to 46% in FY22. The ratio of tele-health services is continuing to increase on a steady trend, and Arizona is seeing a similar trend that is being reported nationally.

Considerations for Services Offered in a School Setting

In the State of Arizona there are allowances for offering Medicaid services in a School-based setting through the AHCCCS Medicaid School Based Claiming (MSBC) Program, specifically, the Direct Service Claiming (DSC) Program that provides direct Medicaid reimbursement for certain Medicaid services provided by a participating Local Education Agency (LEA).

This program provides direct reimbursement for certain Medicaid services provided by the participating LEA. The reimbursable services must be provided by a qualified/credentialed practitioner, who has registered with AHCCCS, and the recipient needs to be enrolled in an AHCCCS program. The covered BH services include[7]:

i. Assessments,

ii. Individual, group, and family therapy and counseling,

iii. Psychological and developmental testing,

iv. Neurobehavioral status examinations and neuropsychological testing, and

v. Cognitive skills training.

b. Qualified provider shall be licensed or certified as follows:

i. Psychiatrists shall be licensed per requirements in A.R.S. § 36-501,

ii. Psychologists shall be licensed per requirements in A.R.S. § 32-2061,

iii. Licensed Clinical Social Workers (LCSW), Licensed Professional Counselors

(LPC), Licensed Marriage and Family Therapists (LMFT), and Licensed

Independent Substance Abuse Counselors (LISAC) shall have current

licensure by the Arizona Board of Behavioral Health Examiners as a LCSW,

LPC, LMFT or LISAC, and

iv. Board-Certified Behavior Analyst (BCBA) or Board-Certified Behavior

Analyst-Doctoral (BCBA-D) shall be licensed per requirements A.R.S. § 32-

2091 and services are provided in accordance with AMPM Policy 320-S.

When considering the school-based services currently offered in Arizona, and the continued work with CMS to ensure access to services for qualified students[8], PCG recognizes the strength of Arizona's commitment to students. The service offerings are robust, and because of the method of reimbursement the AHCCCS reimbursement rates that are currently in place do not factor into the delivery of these

[7] https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/700/710.pdf
[8] https://www.medicaid.gov/Medicaid/spa/downloads/AZ-21-0006

services. The use of Random Moment Time Studies to determine proportion of time committed to delivering Medicaid services, as well as the cost reporting process, is an industry standard process for school-based services.

PCG does recommend conducting a future in-depth analysis to understand the full cost of service delivery in the State of Arizona schools, to address any reimbursement concerns that cannot be identified through this rate study exercise. This process, which is being undertaken in other states, is a good exercise to understand the costs and effort associated with service delivery within schools, and a vital first step to a future alignment of school-based service rates within the larger Medicaid system.

Other Provider Considerations

A final aspect of reviewing provider access and utilization is addressing other factors that impact providers. The provider survey data has shown that almost all providers experienced cost increases, and many have declared that this has been driven by staffing costs. This trend, referred to in common parlance as The Great Resignation, is driven by many factors. Healthcare providers, especially those smaller non-for-profit organizations that often are vital to BH service delivery, are not able to offer the same level of base pay, organizational bonuses, benefits, or quality of work/life balance that other industries and providers can. For many people, the impact of the COVID-19 pandemic was determining what fits your lifestyle best from an employment standpoint and that can be strictly financial. It is this knowledge that informs the final recommendations offered by PCG.

RATE RECOMMENDATIONS AND METHODOLOGY

Rate setting methodologies are used to determine provider payment rates for delivery of health services. Reimbursement rates can be set in several diverse ways. Each methodology holds its own challenges and benefits that inform the process for rate setters and the network providers alike.

Some examples of different rate setting methodologies include:

- Determining a rate based on the average market price of all components necessary to provide a service. Components may include direct and indirect care, administration, facility overhead, and capital overhead.
- Using a cost-based rate methodology. This may involve collecting annual cost reports from facilities, hiring an auditor to review reported costs, adjusting reported costs to ensure alignment with state and federal regulations, and paying a final cost-based rate on a retrospective or prospective cost period.
- Tying a rate to a national benchmark rate, such as a rate found on the Medicare Fee Schedule, or a usual and customary rate paid by private parties.
- An additional methodology is taking existing rates, as published on a fee schedule, and adjusting for external factors such as inflationary percentages, new technological components, or changes in how and where the service is delivered.

Each methodology involves a unique level of effort. Developing a rate through cost-based analysis takes a high degree of effort as data needs to be collected and analyzed as the first step. Often a cost report or survey will need to be developed and deployed to provider stakeholders. The time commitment to this process can be an impediment as enough time will have to be budgeted to allow sufficient time for responses to be gathered and analyzed. This process does allow for direct provider engagement, with real feedback from the agencies that are delivering the services.

Using average market prices offers similar challenges, as the average prices will have to be researched or determined through other means. If the reviewer is using national benchmarks and research this can shorten the time but can create a scenario where the unique aspects of your region are missed using a broader data set. By keeping provider stakeholders out of the process there is a risk of creating an antagonistic relationship.

Tying your reimbursement rates to national benchmarks is a straightforward calculation but can leave providers feeling unheard. Using a Medicare rate as a starting point is a viable method that can be backed up by existing data and research. The downside to such a method is missing the unique aspects of your state/region and how those details may drive service delivery costs.

PCG believes it is important to understand the unique aspects of the client's region that we are working with. In this case AHCCCS has had fee schedules in place for many years. This aspect allowed PCG to conduct research to determine if those rates are adequate, in need of improvement or did not represent the reality of BH service delivery both regionally and nationally. By making this determination first on the existing rates we were then able to take the next steps in researching and recommending changes to the methodology or adjustment factors that would ensure rate adequacy, while using information gained from provider surveys and feedback, as well as additional research.

PCG determined a hybrid method to rate model calculation was a viable approach. This approach entailed calculating adjustment factors for the services with existing rates. These adjustment factors, for travel, staffing and recruitment, and technology, were based on the current and future state of the service delivery landscape. This was also done with the knowledge that the current healthcare landscape in the United States is putting additional economic stressors on providers. While using a forecasting model to

understand service volume is important, the unique aspects of the nation's economy, due to global events, is focusing provider concerns on cost of delivery in specific ways.

Recommendation of Sustainable Annual Rate Setting Methodology

To ensure rate adequacy and continued access to BH services, it is important to not only ensure current rate viability but to have a strategy for identifying any future pricing deficiencies. PCG recommends that AHCCCS have a regular, sustainable process where data is reviewed, and providers' concerns about financial stressors can be addressed.

PCG recommends that AHCCCS annually review the cost-of-living adjustment (COLA) factors that impact members and providers across Arizona. By reviewing the annual inflationary factors, specifically for Arizona with an eye on national standards, AHCCCS can put into place an annual review that can look to update the various adjustment factors that impact rate creation and service delivery. A recommended method is implementing a process upon annual budget approval, where the level of inflation as defined by the Consumer Price Index for the previous 12-month fiscal year period prior to the enacted budget is reviewed. The rates can be updated by a factor of this amount, such as 50% of the inflationary rate. By setting a minimum increase of the greater percentage of 1.0% or a calculation of the inflationary amount, AHCCCS can ensure a consistent approach that annually addresses the financial stressors that providers face, while also monitoring the service usage across providers. This will have the added benefit of giving providers a clear signal they recognize the strains they face by supporting them.

In conjunction PCG recommends a process where data is reviewed at set intervals (e.g., annually, bi-annually) to determine if shifts in service delivery have occurred. This review of utilization will allow AHCCCS to identify the underlying shifts in service delivery beyond the factor of cost. This would include reviewing the annual ratio of out of office services vs. in-office services, to account for any potential increase in services that require travel. Understanding the service volume and being able to trend how it is shifting is an important aspect of future rate setting. The changes in service method and volume will create a shift in delivery cost for providers, and it is important that the use of data analysis is used to impart consistency and transparency in the overall rate setting process.

This should be done in conjunction with reviewing the economic factors that impact providers, including the average cost of a gallon of gasoline, and the average reimbursement cost for mileage. A secondary factor of this would be reviewing the costs of staffing, including the question of staffing turnover. An annual study, in conjunction with AHCCCS providers, to determine if staffing turnover rates are changing, is important to understanding the actual cost of service delivery in Arizona.

These recommendations are meant to ensure continued communication with AHCCCS providers, to facilitate an open dialogue about the factors that impact service delivery. By addressing these COLA factors and implementing a sustainable process AHCCCS will be able to anticipate providers needs as opposed to reacting to them.

RATE ADJUSTMENT RECOMMENDATIONS

GOALS

When reviewing the FFY17 rates, we noted they were sufficient within the larger Medicaid service landscape when reviewed across five (5) neighboring states. By using those FFY17 rates as a starting point and adjusting for the posted CMS inflation rate, we also concluded the FFY22 rates are higher than those calculated adjustments, indicating the FFY22 rates are likely sufficient. As noted, this analysis did not consider the 2.5% increase for BH OP rates that was presented for 10/1/22. However, PCG and AHCCCS are acutely aware of the concerns providers have regarding staff retention, wage concerns and the larger economic landscape that is impacting everyone. As noted consistently throughout the provider survey responses, and through various national studies, the post COVID-19 pandemic inflationary factors are putting a strain on providers. We believe it is important to continue to review the reimbursement rates for OP BH services, and the broader economic conditions that are impacting providers. This should be a focus of AHCCCS to ensure rate fidelity annually and be able to quickly respond to any shifting market conditions.

Currently, Arizona offers a range of services and participation timelines to allow providers the flexibility to identify the best plan of care to meet the needs of each consumer. PCG sought to create additional recommendations that can be applied to some or all services. These adjustment factors were calculated to be in addition to the existing rates and seek to address the unique aspects of the current BH service landscape in Arizona. We used the industry wide information gathered from the Arizona BH Provider Survey and national benchmark research.

PCG is aware that the current fee schedules and rate calculations are inclusive of travel and technology costs. These additional adjustment factors are meant to augment the current rates, and account for the increasing cost of travel and technology in the quickly changing healthcare system. The impact of the COVID-19 pandemic, increased need for telemedicine services and the inflationary economic conditions are causing rising costs for all providers. By increasing the rates using these targeted factors, AHCCCS can assist providers with these specific rising costs while they review next steps for a more permanent update.

RATE ADJUSTMENT FACTORS

Telehealth

The telehealth landscape has undergone significant changes throughout the COVID-19 pandemic and was thus an important snapshot for PCG to capture. As learned via the 2021 Arizona BH Provider Survey, the pandemic motivated a large push across providers in the State to expand telehealth access. Providers previously unable to bill for telehealth – video and audio-based services – were particularly empowered by this substantial increase in flexibility.

March 2020 represented a turning point of the COVID-19 pandemic, which resulted in DBH providers abruptly and widely implementing telehealth. Over the course of FFY21, 8% of all claim submissions for OP Behavioral Health Services included a modifier that correlates to Telemedicine. This is in stark contrast to FFY17, when the same measurement showed only 0.03% of claims included a telemedicine modifier.

The provider survey and national industry research indicates both positives and negatives to the increased use of telehealth services. Participating providers were effusive in their praise for telehealth as having significantly expanded care access and cited the following specific benefits:

- **Benefits:**
    - Improved participation of clients' care team members (staff, parents, therapists) during telehealth visits and case conferences, particularly in developmental disability programs
    - Reduced transportation costs positively impacted provider overhead while increasing service access for disabled/mobility impaired clients
    - Medication/Somatic treatment, as well as school-based services, successfully expanded with the addition of virtual options
    - Providers serving deaf and/or hard of hearing clients cited minimal pain points transitioning to telehealth technology given that their clients were well acquainted with audio-based technology
    - Residential treatment providers also saw improved access to clinicians who completed remote visits with their clients

They also cited the following challenges experienced:

- **Challenges:**
    - Client access to the technology necessary to participate in telehealth varies widely with some parts of the State lacking reliable internet service
    - Clients who have limited data programs were more likely to skip appointments and/or ignore calls to avoid overages
    - New clients often experienced a learning curve when initially communicating with their counselor virtually, requiring additional provider time and training to overcome those obstacles

The provider survey supplied the percentages of AHCCCS providers that make all, some, or none of their services available via telehealth.

- 100% of respondents self-reported that one or more of their services are available via telehealth.
- 20% of respondents self-reported that all their services are available via telehealth.

PCG reviewed the feedback and data related to telehealth services and made the recommendation not to alter rates based on whether a service was rendered in person or via telehealth. The PCG team determined that assigning the same rate to telehealth and in person services ensured providers would focus their service delivery approach on patient preference and would not have a financial incentive to favor one setting over another. More information on all modifiers billed and their impact on proposed behavioral health rates can be found in the modifiers section below.

Turnover and Recruitment

PCG noted from the provider survey results that the increase in provider turnover, and cost of recruiting new employees was a large driver of the financial stresses impacting providers. Based on this information we believe it appropriate to calculate a turnover and recruitment adjustment factor that could be applied to current reimbursement rates as well as included in our unique rate model calculations. To calculate a turnover and recruitment adjustment we took Bureau of Labor Statistics (BLS) data for employer costs for employee compensation and average firing costs and the average cost of online job postings from online recruiting platforms. The BLS data is specific to the West Mountain Region which includes the states of

Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming[9]. This regional data provided the closest scope to the state level perspective. The employer costs for employee compensation are a per hour cost which includes wages/salaries and benefits as factors in total compensation. The firing cost is determined by the percentage of separation level in the West Mountain region where 3.7%. This percentage is applied to the mean salary to determine the cost. The cost of job posting per month is the mean monthly cost from recruiting sites Workable, Zip Recruiter, LinkedIn, and Career Builder[10].

The monthly costs for the factors were calculated into a total annual cost. With the annual cost we divided this cost by 365 to receive a daily cost. To generate the hourly cost, we worked with the assumption of 75% productivity of the provider where 6 hours of the 8-hour workday would be billable. After receiving the hourly cost, we divided this by four to generate a per 15-minute unit cost. For each procedure code the turnover and recruitment adjustment can be calculated to fit the billable unit of service.

Allocating this adjustment would decrease the impact on providers as there are portions of their rates allocated to these costs. For recruitment, the costs of posting jobs online and the time it takes from initial interviews to begin training new employees is significant. To ensure a large potential employee pool, posting a job online will aid that goal. Generating the average cost of having an online job posting will allow for mitigation of the recruitment costs. To account for the rising costs of hiring and retaining staff, as well as the increase in reported provider turnover, this adjustment serves to allocate funding for those efforts. These costs can create a burden on providers in their ability to offer services, staff clinics and conduct their administrative services. With limited staffing, the providers would not be able to offer their services and the individuals reliant on the service will be negatively affected. Costs associated with hiring staff like posting the job online and total cost of compensation are necessary costs that providers must incur. The turnover and recruitment adjustment allows for these costs to be considered and integrated into the rate analysis process.

Inflation

The use of FY19 – FFY21 data requires inflationary factors to accurately project costs and charges. Healthcare-specific inflation factors were applied to the historical survey data, and cost data used that was before FFY22. This is critical for understanding the impact on current and potential future costs. We used inflationary factors from the CMS Market Basket Index to standardize calculations where needed.

Travel

The State of Arizona offers a unique geography that, combined with the increasing need to meet people where they are at, leads to more travel. PCG believe a travel adjustment factor would impact the way providers have to account for travel costs across a state that has a wide variation in geographic makeup and population centers. The geographic makeup of Arizona means that travel times can vary between the cities, such as Phoenix in Maricopa County, and the more rural areas where the Native American reservations are located. Combining this with the increase in the price of gasoline that has also impacted agency's ability to adequately help the community and PCG felt an adjustment factor specific to travel would be appropriate.

To calculate the travel rate adjustment, we researched the location of every Tribal Reservation in Arizona, as well as the largest city by population in each county. Using a driving distance calculator, we determined the number of miles and the amount of time to get to the reservation from the largest city in the county[16].

[9] https://www.bls.gov/regions/southwest/newsrelease/employercostsforemployeecompensation_regions.htm
[10] https://www.glassdoor.com/employers/blog/how-much-it-costs-to-post-a-job-online/

To account for the related costs of travel, we reviewed the average price gasoline per gallon in Arizona, and the average miles per gallon for standard vehicles sold in the US. At the time of this research, August 2022, that was calculated at $4.042 per gallon and 25.7 miles per gallon.

We then calculated the average personnel cost for a round trip in the noted county, based on the travel time. Due to the differences in travel time in the Northern region of Arizona versus regions that had more urban centers, we weighted this calculation by the average across the entire state, thus ensuring equity across the differing regions. This weighted adjustment was determined by reviewing the claims data from FFY17 to FFY21 and calculating the percentage of claims submitted with POS 12 and POS 99 codes. This review showed that 33% of all claims were submitted with POS 12 and 99 across this period. By weighing this calculation, we can ensure equity across all the regions and apply the adjustment to all OP services.

This weighted annual cost was calculated into a per hour, and per 15-minute unit rate adjustment that can be applied to all OP services.

Technology

PCG determined a technology adjustment factor for OP BH services would have an impact in accounting for the increasing cost and need of technology in health care service delivery. The COVID-19 pandemic has increased the use of telehealth visits, which requires specific technology, and the trend towards more telehealth will only continue. Based on this PCG calculated a rate adjustment based on current costs for the technological infrastructure that is needed to deliver telehealth services in an OP setting

PCG believes it is important to address the current and prospective health care delivery landscape, and how structural changes will impact providers. We determined a technology adjustment would be an appropriate factor to apply to our rate recommendation. The increase in frequency and acceptance of telehealth services, combined with the ever growing need to be connected to the internet, can put a strain on providers who do not have the needed technological infrastructure.

To generate a technology adjustment, we researched the applicable costs for using computers in a health care service delivery standing. This includes the following aspects:

- Internet Access
- Electronic Health Record (EHR) system
- Server hosting
- Hardware (Computers both desktop and laptop)
- Software (Needed programs such as Microsoft Office)

We calculated the monthly costs for each of these elements and depreciated the cost of the computers over a 5-year period. This allowed us to calculate a standardized cost for each element, allowing for consistent calculations in annual and monthly totals. We assumed one computer per 3 Direct Service FTEs for the final calculation and used that factor to determine the overall annual cost. This averaged out to 5 computers total, based on survey data responses. This annual cost was used to calculate down to a per unit rate adjustment, with measurements of per month, per hour and per 15-minute unit being calculated to apply across the existing fee schedules.

Identification of Services For Adjustments

PCG then attempted to identify what services, and modifiers, these adjustments could apply towards. Through a process where we researched listed modifier and POS codes, as well as the traditional method of delivery for each service, we identified which services would have each factor applied to them. The travel adjustment was added to all services regardless of POS, with the calculation being weighted to

account for the percentage of claims historically billed outside an office setting. There are services where multiple or all adjustment factors are applied, and we will note those on their own tables to ensure a comprehensive understanding.

Rate Adjustment Recommendations

By calculating the adjustment factors to a per unit rate calculation, we were able to apply them to all services, regardless of the billable unit measurement. PCG wanted to ensure proportional increases and in conjunction with AHCCCS felt the best approach was to calculate the percentage increase for each adjustment factor based on a median rate.

To accomplish this, we calculated adjustment factors separately as a per unit rate adjustment. By using national benchmarking and survey responses we were able to calculate these rate increases as a stand-alone number. Please see Figure 50 for these calculations.

Figure 50

Rate Adjustment Amounts By Type			
Adjustment Type	Per Billing Day Adjustment	Per Billing Hour Adjustment	Per Billing 15 minute adjustment
Travel Adjustment	$ 38.91	$ 8.79	$ 2.20
Technology Adjustment	$ 30.95	$ 5.16	$ 1.29
Staffing and Recruitment	$ 27.78	$ 4.63	$ 1.16

Using the current FFY22 AHCCCS OP Fee Schedule we determined the Median rate to be approximately $45.00. The H0004 base rate is listed at $45.52 so we determined the percentage impact of each per 15-minute rate adjustment on this base rate. We then took that percentage impact and applied to all applicable BH OP and IP rates, thus ensuring proportional increases.

Please see calculated increase for each noted adjustment factor in Figure 51.

Figure 51

Adjustment Factor	Calculated % Impact
Travel Adjustment	5%
Technology Adjustment	3%
Staffing and Recruitment	3%

All tables identifying services for rate adjustment are in Appendix A.

All tables for recommended reimbursement rates with service adjustments included are in Appendix B

STRATEGIES/METHODOLOGIES FOR AND/OR ADDITIONAL REIMBURSEMENT STANDARDS

To control Medicaid spending, and improve care across the healthcare system, many states are looking to implement Alternative Payment Methodologies (APMs) across their Medicaid system. The flexibility of the Medicaid system, as outlined under Title XIX of the Social Security Act, gives states some discretion on how they fund their Medicaid systems, if they continue to meet minimum eligibility criteria and benefit offerings to receive their portion of federal funding. This structure is causing some states to look towards APMs to help control the rising Medicaid costs. Arizona has already taken steps to reform parts of their Medicaid system, per the recent approval of a request for an extension of the 1115(a)-demonstration waiver from the Center of Medicare and Medicaid Services (CMS). [11] This waiver, while an exciting step towards reforming the overall health care system, offers an extension of the Medicaid Managed Care System currently in place in Arizona but does not address the rising Medicaid FFS costs.

PCG recommends that AHCCCS continue to leverage their familiarity with Medicaid waivers, and the opportunities they can present, to address the rising cost in Medicaid FFS. If the State of Arizona is not looking to pivot care into a fully managed care environment, there are still many opportunities to innovate their Medicaid system, using APMs. [12]

The use of Differential Adjustment Payment (DAP), which Arizona has experience with[13], is a good step towards impacting the financial health by incentivizing providers. The continued development of these programs is important as the cost of healthcare, including Medicaid, continues to trend upward.

PCG also recommends continuing to develop services, and payment models, which incentivize providers to address Social Determinants of Health. These factors continue to play an influential role in patient care, and their eventual outcomes, which drives cost increases across the entire system. By recognizing the importance of Social Determinants of Health on the larger Medicaid system, and the cross-sector impact that SDOH has on costs, Arizona can continue to bend the cost curve and slow down the Medicaid cost increases. This will lead to a more consistent reimbursement structure, while allowing providers to focus more on care, and less on straight cost. Pursuing a flexible approach will be in line with the National Association of Medicaid Directors recommendations [14] while creating pathways to APMs that can impact all stakeholders.

[11] https://www.azahcccs.gov/Resources/Downloads/Federal/AHCCCS_ExtensionApprovalLetterFinal10142022.pdf
[12] https://innovation.cms.gov/key-concept/apms
[13] https://www.medicaid.gov/medicaid/spa/downloads/AZ-21-0024.pdf
[14] https://medicaiddirectors.org/wp-content/uploads/2022/02/NAMD-Highlights-Opportunities-to-Address-Social-Determinants-of-Health-in-Response-to-Congressional-Social-Determinants-of-Health-Caucus-Request_pdf.pdf

CONCLUSION

PCG appreciates the partnership with AHCCCS in this Behavioral Health (BH) Rate Study. The collaboration and assistance with data needs and understanding the unique landscape of the State of Arizona is greatly appreciated and allowed this study the breadth and scope needed to make impactful recommendations.

PCG undertook an extensive rate review of Behavioral Health Outpatient and Inpatient services, administered by AHCCCS. We analyzed the provider reimbursement rates against those of five neighboring states. When analyzing the reimbursement rates at a service level, as well as a broader program level, we note that Arizona offers competitive rates that are broadly adequate for the services being offered. They compared favorably to the neighboring states and offer a wide breadth of service types. However, PCG also notes that the rates have not been updated in some time, and while including staffing, travel, and technology costs in the calculation there is a chance the rates do not keep up with the quickly changing economic landscape. Because of the varying factors in service reimbursement, including use of telemedicine, and modifiers for services delivered outside the office, there are some aspects that need review. The access review helped to identify some areas of opportunity to review the rates or augment existing rates moving forward.

PCG undertook an extensive data review to get a sense of utilization trends and provider access in the Medicaid Behavioral Health delivery system in the State of Arizona. By working collaboratively with AHCCCS, and reviewing five years' worth of claims data, we were able to determine trends across utilization and provider access, and how they have shifted from 2017 until current. We were also able to identify trends across a county level and within Geographical Service Areas (GSAs).

Overall claim utilization is increasing year by year, as more people seek Behavioral Health services. The overall paid amount has continued to increase and is backed up by claims submission volume. The leveling off claims volume in FFY21 is likely due to the COVID-19 pandemic and did not correlate with a decrease in spending. This also shows in the volume of provider agencies submitting claims for Medicaid covered BH services in Arizona.

When analyzing the outpatient BH claims data from FFY17 to FFY21 in Arizona, there are some clear trends that can be accounted for in future policy decisions. As noted, utilization on a whole has steadily increased until FFY21. It is reasonable to extrapolate that the leveling off on claims submissions in FFY21 is due to the COVID-19 pandemic impacting providers and members alike, both in ability to offer services, and in the ability to leave your home to receive services. PCG would anticipate that FFY22 data would show a bounce back in claims utilization, with the increasing trend continuing.

The second aspect of that utilization is a clear trending increase in SUD services. We see this across the entire state, as the overall utilization on SUD services, and the overall spend on the same services continues to increase exponentially, even in FFY21 when overall utilization did not increase. This suggests an increased focus on SUD services by the State of Arizona, and an acknowledgement of the ever-urgent need for these services.

This also coincides with the levels of spending on SUD claims. By looking at the utilization and paid amount of dedicated SUD procedure codes we see clear trend lines, with a consistent increase from year over year.

The final and most revealing aspect of the data analysis is how the various regions, as defined by GSA, show a distinct difference in utilization patterns. The South region has remained flat overall in terms of utilization, with a slight increase over the reporting period. This is notable as the South region includes the City of Tucson. The Central region, which includes Maricopa County, and the city of Phoenix has shown a noticeable increase that is in line with overall trends. The North region is where the data shows a very stark difference, however, as utilization has increased at a much higher rate than the other parts of the State. As the North region includes the largest proportion of Native populations in Arizona, it is of note the

large increases that are occurring in service delivery in that region. This is notable because of the need for services in this region, as well as the additional strain of travel across this part of Arizona.

This trend is even more pronounced when looking at SUD services. The rate of growth in utilization for SUD services is exponentially higher than the rest of the state. It is important to note that the starting point in FFY17 for SUD services in the North region was small. This would indicate the continued need for providers and ways to offer services in this region, including the continued augmenting of travel costs, and ways to offer access to technology for more Telemedicine services.

PCG recommends that AHCCCS continue to identify means to get members access to services across the state, with a specific focus on the North region. We also recommend a focus on SUD services, as the increased utilization clearly suggests an urgent need.

Notably the geographic makeup of the provider access and utilization is shifting. Providers in GSA North, the Northern counties of Arizona, and GSA South, the Southern counties are showing a marked increase in service delivery from 2017 until the current. This contrasts with GSA Central which includes Maricopa County, where Phoenix is located. The overall trend in Maricopa county shows a slowing service utilization trend that is different from the other regions of the state. This is important to consider as the ability for providers to travel to see patients in GSA North is different from the potential transportation options in the greater Phoenix area. The extensive number of tribal lands, and need to traverse them, is something that must be considered when reviewing the reimbursement rates in the State of Arizona.

PCG believes that the State of Arizona, and the partners at AHCCCS, have an opportunity to address BH reimbursement rate challenges that are directly impacting almost the entire BH provider community.

PCG recommends a sustainable annual rate review methodology, to ensure reimbursement rates do not fall behind the increasing national costs associated with delivering healthcare in Arizona and the United States. By codifying a sustainable methodology and the related annual review, AHCCCS can guarantee a positive working partnership with their provider agencies, as well as reducing worry about solvency.

PCG also outlined a rate setting methodology for the highest utilized services, and the services that currently do not have a posted rate. This methodology considers the many factors that impact reimbursement rates, including Direct Service personnel costs, the administrative costs associated with running an agency, the cost of Overhead and Support personnel as well as adjusting for the national rate of inflation. Furthermore, we calculated these rates with consideration for travel costs, the increased cost of staffing and turnover and the increased need for technology to deliver telemedicine services.

After reviewing the provider submitted data for commercial reimbursement and comparing to the existing AHCCCS rates for OP BH, across 9 separate procedure codes, PCG feels that AHCCCS has competitive rates with commercial payors across the board. We do not feel that AHCCCS must undertake a systemic update to their rates to bring them in line with Commercial rates, and instead can review the reimbursement rates on an ongoing basis to determine if there is a need for recalculation. This allows AHCCCS to work closely with participating agencies to understand the challenges and costs of delivering these services and offer a more tailored response. There is no need for a one size fits all strategy, and in fact that would likely cause more confusion and struggles for the individual agencies. By dedicating time and focusing on these few outlier services AHCCCS can strengthen relationships with their participating providers and improve the overall quality of data collection and any future updates.

As a final part of this exercise PCG took the existing rates and calculated some adjustment factors that can apply to a selection of services. Travel costs for direct service staff, the challenge in hiring and retaining inexperienced staff during this period of economic uncertainty and global inflationary impact, as well as the rising need for technology to offer telehealth visits and meet patients where they are located, makes for a uniquely challenging time. While we recognize these factors were included in the previous rate calculations, we feel it is important to acknowledge the drastically changing landscape and believe these factors can be looked at much closer. When the rates were last calculated AHCCCS and other

State agencies could not have foreseen the rapid rise in telemedicine, the COVID-19 pandemic that has altered staffing and recruitment as well as the inflationary economy affecting all day-to-day costs. We wanted to ensure this option was researched to provide AHCCCS flexibility in their next steps.

PCG was able to take the results from the provider survey, and our discussions with the provider community, and tailor these adjustment factors to the actual data we were able to collect. As utilization continues to rise, and the costs associated with service delivery rise in concert, this allows for an opportunity to positively impact BH reimbursement in the State of Arizona.

By understanding the unique stressors on providers due to global events, as well as the current state of service access in Arizona, AHCCCS can create a sustainable process to review rates, create adjustment factors, or update their fee schedules to ensure a stable partnership with provider agencies, and foresee any future shifts in cost and utilization.

APPENDIX A

Identification of Services to receive calculated rate adjustment factors are in Appendix A.

- Appendix A.1 – Behavioral Health Outpatient Services
- Appendix A.2 – Behavioral Health Inpatient Services

Appendix A

APPENDIX B

Appendix B contains Proposed Rate Adjustments to existing Behavioral Health services with adjustment factors noted in Appendix A.

These apply to both Outpatient and Inpatient Services

- B.1 – Outpatient Rate Adjustments
- B.2 – Inpatient Rate Adjustments

Appendix B