AHCCCS PROVIDER REIMBURSEMENT

February 4, 2020

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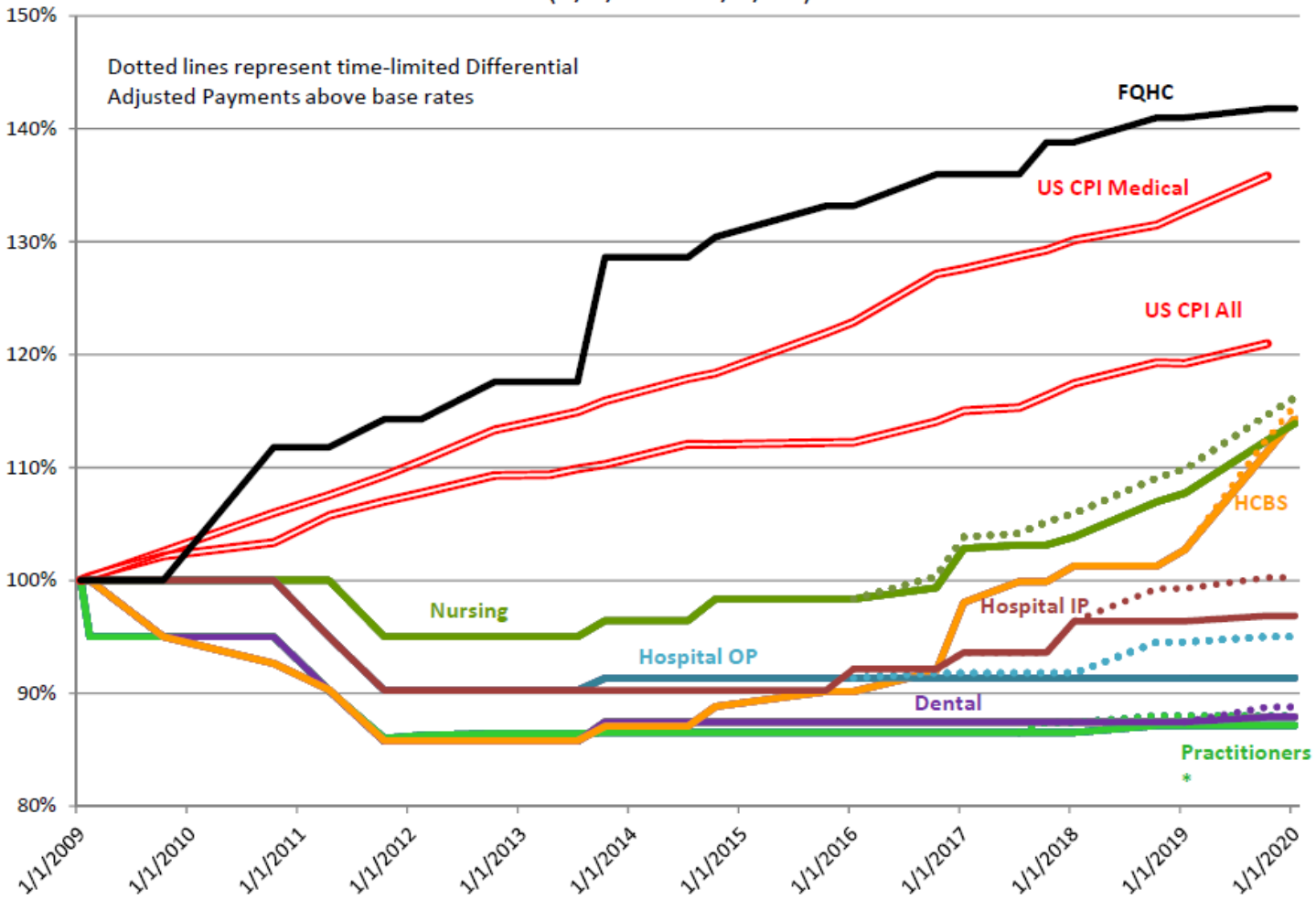
AHCCCS Reimbursement History by Provider

(1/1/09 to 1/1/20)



* Excludes time-limited rate increases to select practitioners provided through the Access to Professional Services Initiative.

AHCCCS PROVIDER REIMBURSEMENT

- Base Payments
- Supplemental Payments - Hospitals
  - *CAHs*
  - *Rural Hospital Inpatient*
  - *Prop 202 Trauma and Emergency Fund payments*
  - *GME*
  - *DSH*
  - *EHRs*
- Supplemental Payments – NFs
- APSI

AHCCCS HOSPITAL ASSESSMENT LEGISLATION (HB 2668)

- New assessment on IP and OP Revenues levied by AHCCCS director
- Used for provider rate increases
  - Hospitals
  - Physicians, PCPs and Dentists to 2009 levels (capped at 20% or $70.5M of assessment monies)
- Projected to generate $350 million, for a total of $1.4 billion when matched with federal funds
  - Hospitals receive $1.1 billion (net $760 million)
  - Other providers receive ~$350 million

10/1/19 BH OUTPATIENT RATE INCREASES

- 23% FFS rate increases
  - 19.6% BHRF
  - 30.9% counseling and therapy
  - 40% crisis intervention
- BHRF rates (MCO + FFS)
  - 2.6% per diem
  - 4.8% for licensed personal care on top of this (7.4% cumulative)

10/1/19 OTHER RATE INCREASES

- Legislative mandates (including 206)
  - 11.5% HCBS
  - 5.8% NF
  - 1.1% non-ADHS ground ambulance (0.2% ADHS statutory)
- 8.1% Air Ambulance
- 1.3% - Physician Drugs
- 0.8% FQHC

DIFFERENTIAL ADJUSTED PAYMENTS

- *"The purpose of the DAP is to distinguish providers which have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth."*
- Generally designed as a year-by-year initiative.

CY 2020 DAPS

Provider Type	DAP and criteria
DRG Hospitals	up to 4% • 2.5% for HIE • 1% Sepsis • 0.5% Pediatric Prepared Emergency Care)
Critical Access Hospitals	up to 28%; 8% HIE, 20% Trauma Center off I-10, 0.5% PPEC)
Other Hospitals and IP Facilities	up to 4% • 2% HIE • 2% IP Psych Quality • 2% each for LTC and IP Rehab Pressure Ulcers)
Nursing Facilities	up to 2% • 1% Pressure Ulcers • 1% UTI

CY 2020 DAPS

Provider Type	DAP and criteria
Integrated Clinics	up to 10% for PH services, if utilization > 40% BH services +HIE participation
BH Outpatient Clinics and Integrated Clinics	up to 7% • 1% for MOU/MOA with 3+ schools for BH services on campus • 3% for Autism Center of Excellence • 3% for MOU/MOA with tribal government to access tribal lands to provide BH services in Grand Canyon
Physicians, PA, NP	1% if write at least 80 prescriptions and >65% are electronic
Dental	1% if increased sealants between CY 17 and CY 18
HCBS	1% if complete EVV survey

2021 DAP TIMING

- Preliminary public notice 2/28/2020
  - Open for comment
- Final notice 4/30/2020
- Identification of Qualifying Providers 5/1/2020
- 10/1/2020 implementation

IMPORTANCE OF DATA

- Accurate, timely data needed to:
  - Assess quality
  - Attribute services
  - Generate analytics
- Providers need data access to appropriately and efficiently manage care
- Staffing for state Medicaid programs can be a challenge

OBSTACLES TO VALUE-BASED PAYMENTS

- Inertia among
  - State staff
  - Providers
  - Payers
- Constant delivery system changes
- Lack of resources
- Measurement
- Economic implications

CHALLENGES OF MEASUREMENT

- What should we measure?
- Timeliness of measurement
- What's in or out?
- Reliability of data

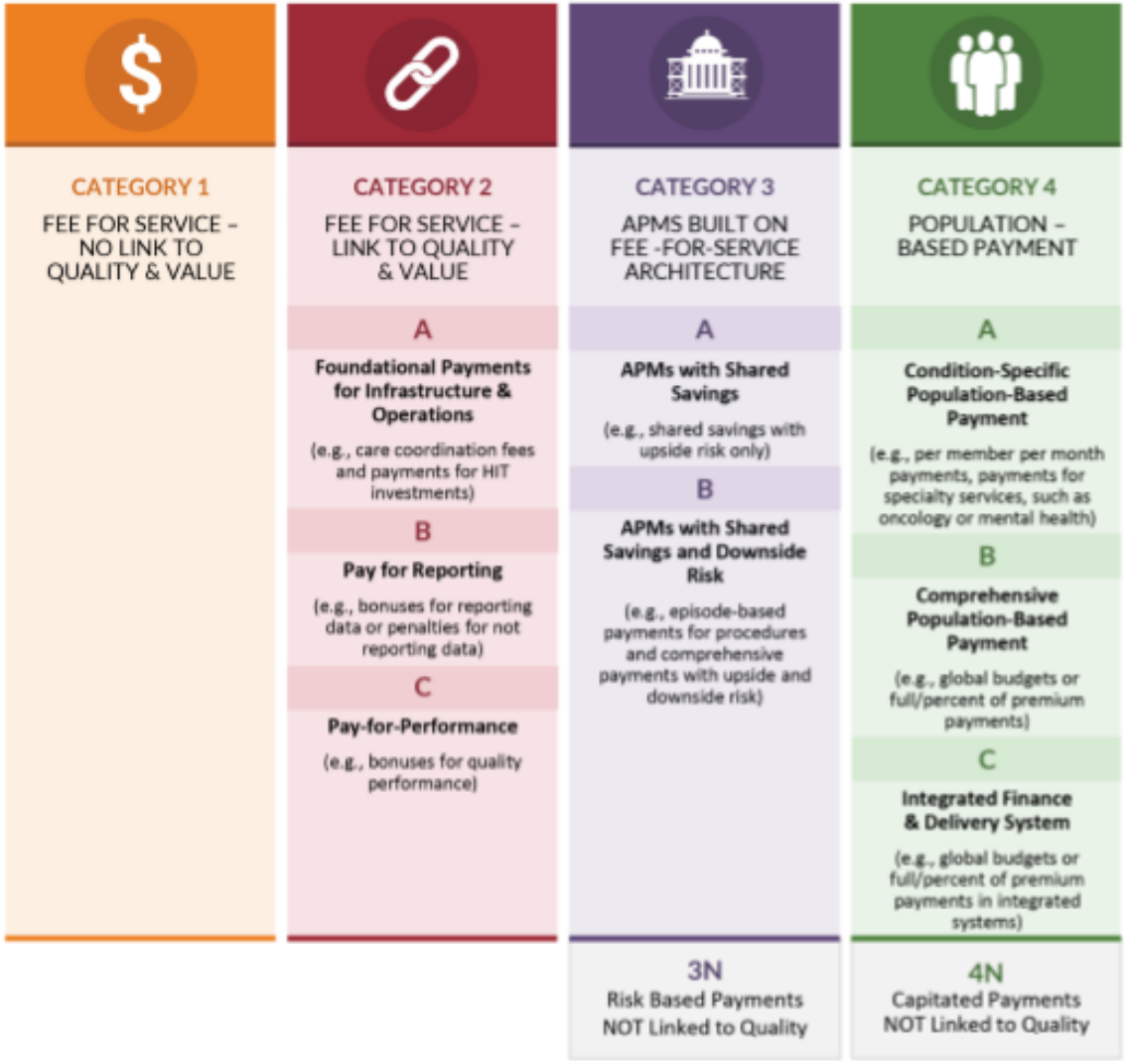
AHCCCS MCO APM Target Requirements

Contract Year	AHCCCS Complete Care	ALTCS EPD	RBHA		ALTCS DDD	
		EPD & MA-DSNP	SMI-Integrated	Non-Integrated	Sub-Contractors	LTSS
CY 19	50%	50%	35%	20%	35%	10%
CY 20	60%	60%	50%	25%	50%	20%
CY 21	70%	70%	60%	25%	60%	35%

AHCCCS MCO LAN 3 & 4 APM Target Requirements

Contract Year	AHCCCS Complete Care	ALTCS EPD	RBHA		ALTCS DDD	
		EPD & MA-DSNP	SMI-Integrated	Non-Integrated	Sub-Contractors	LTSS
CY 19	40%	25%	10%	10%	40%	5%
CY 20	50%	35%	20%	20%	50%	10%
CY 21	60%	45%	30%	30%	60%	15%

Figure 1 & 4: The Updated APM Framework



This Framework represents payments from public and private payers to provider organizations (including payments between the payment and delivery arms of highly integrated health systems). It is designed to accommodate payments in multiple categories that are made by a single payer, as well as single provider organizations that receive payments in different categories—potentially from the same payer. Although payments will be classified in discrete categories, the Framework captures a continuum of clinical and financial risk for provider organizations.