

What is AHCCCS Managed Care?

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Traditionally, Medicaid has been administered on a “fee-for-service” basis, meaning that states will employ or contract directly with providers for the care of Medicaid enrollees. This is how Medicaid was originally structured under the Social Security Act. States operating under this model draw down federal matching dollars for the care of the members and then, combined with state funds, use the dollars to pay providers directly for services.

States may also choose to manage their program through a Medicaid Managed Care model. Under this model, states are permitted to enter into contracts with private and non-profit Managed Care Organizations (MCOs) who in turn use their market leverage to negotiate rates and contract with a network of providers adequate to meet the needs of their members. This model of healthcare delivery has historically proven to be cost-effective in rewarding quality over quantity and better managing the care of members. States may draw down federal funding for this model, but must be able to continually demonstrate adequate access to care and compliance with all other federal rules and statutory requirements.

What is the history of Managed Care in Arizona?

Arizona has the distinction of being the last state to enter into Medicaid, but the first state to create a “mandatory” Managed Care model, meaning that with the exception of the American Indian population, who under federal law cannot be mandated into managed care, all Medicaid enrollees must be enrolled in an MCO, including dual eligible and long term care members.

Prior to the inception of this model in 1982, healthcare for low income Arizonans was provided through the counties. However, as the state grew, so too did the healthcare needs of this population. The counties were no longer able to manage this program. In 1982, as a resolution to this growing crisis, Arizona sought and received approval to create a Mandatory Managed Care Medicaid program, known as the Arizona Health Care Cost Containment System (AHCCCS).

Since its inception in 1982, AHCCCS has significantly evolved by integrating new programs and reshaping payment and service models in order to provide the best quality care possible to its members. In 2013, AHCCCS integrated all services for most children enrolled in the acute care program with rehabilitative qualifying conditions under one Children’s Rehabilitative Services (CRS) contractor. In the same year, AHCCCS led an effort to improve care coordination for AHCCCS dual eligible members; AHCCCS now requires the Contractor, or its corporate affiliate, to be a Medicare Advantage Dual Eligible Special Needs Plan in all service areas in which they hold a Medicaid contract. In 2015, AHCCCS integrated behavioral health services into three Regional Behavioral Health Authorities (RBHA) for qualifying members to create a more streamlined system of health care delivery for members with Serious Mental Illness. Furthermore, in 2015 AHCCCS integrated general mental health/substance abuse service delivery for dually enrolled members in Acute Health Plans.

AHCCCS has also integrated new payment modernization models in order to reduce costs for beneficiaries. Through value based purchasing, AHCCCS is committing resources to leverage the State’s successful managed care model to address inadequacies of the current health care delivery system, such as fragmentation, and to continue to lead efforts to bend the health care cost curve to sustainable levels. Four

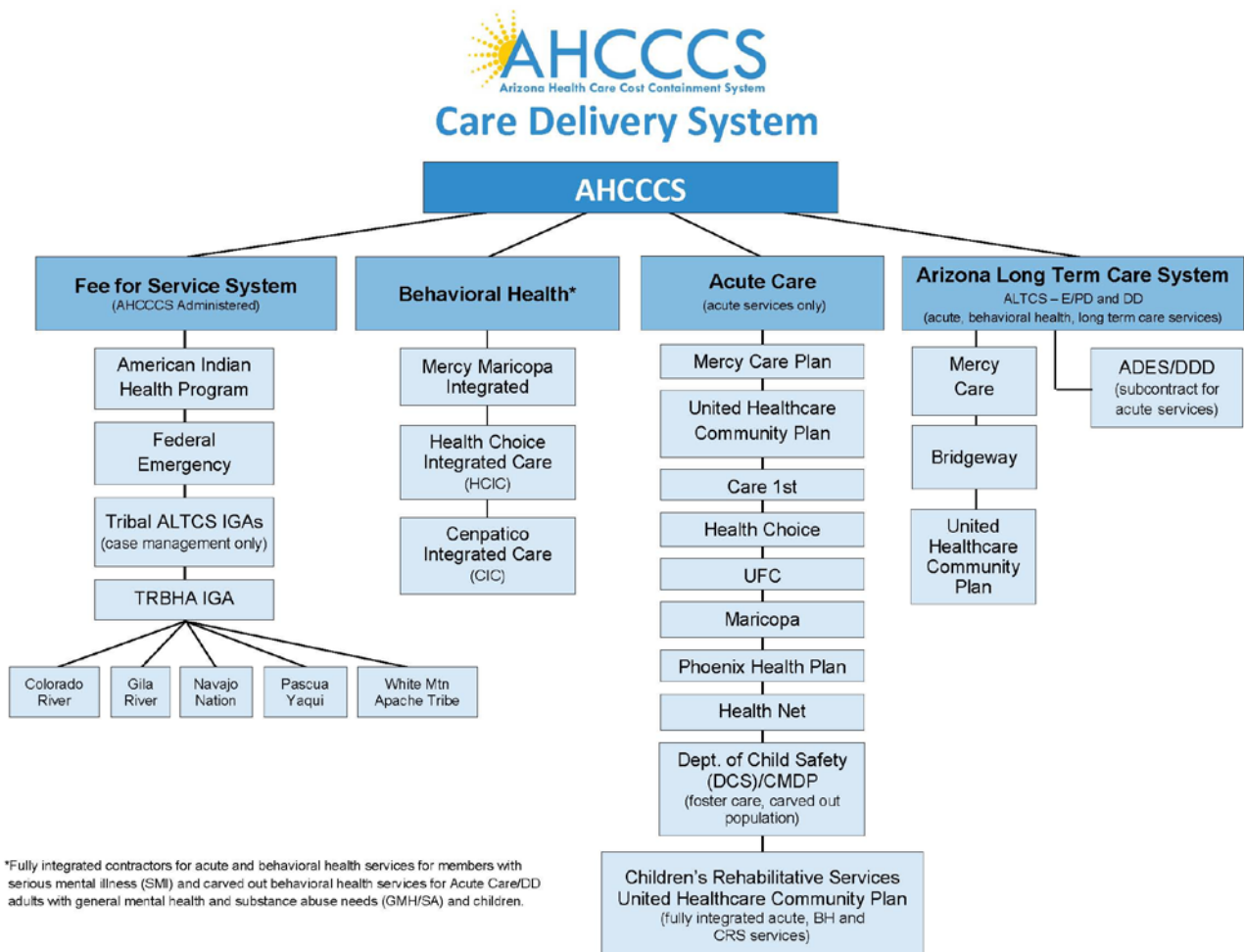
new models have been implemented by AHCCCS Managed Care Organizations within their provider networks all based around the concept of incentivizing providers to provide quality over quantity of care.

How many managed health care plans does AHCCCS contract with?

AHCCCS contracts with 17 MCOs statewide to provide Acute (general medical care), behavioral health, and Long-Term healthcare services to its members. Members may choose which MCO they would like to participate in upon enrollment in AHCCCS.

AHCCCS also contracts with sister state agencies, such as the Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD), to manage care for enrolled ALTCS members with an intellectual or cognitive disability.

As of July 1, 2016 AHCCCS and the Division of Behavioral Health Services (DBHS) joined forces to administratively streamline monitoring and oversight of the RBHAs throughout Arizona. To carry out this new approach, RBHAs manage the delivery of physical health and behavioral health services for members who have been diagnosed with a Serious Mental Illness (SMI). This integrated model aims to increase member engagement in obtaining both medically necessary physical and behavioral health services. Members qualified to receive integrated behavioral health services are assigned to Cenpatico Integrated Care in the southern region, Health Choice Integrated Care in the northern region, or Mercy Maricopa Integrated Care in Maricopa County. Also, AHCCCS is contracted with the Department of Child Safety, a sister state agency, to administer healthcare for children in out-of-home placement through the Comprehensive Medical Dental Program (CMDP).



Managing care for dual eligible members

All AHCCCS contracted MCOs across all lines of business (acute, behavioral health, and ALTCS) must also be Medicare Dual Eligible Special Needs Plans (D-SNPs). Nearly half of all AHCCCS dual eligible members are in an aligned MCO for both their Medicaid and Medicare benefits.

There are three dual eligible populations; the Qualified Medicare Beneficiary Program (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and QI-1. QMB covers payments of part A & B premiums, coinsurance, and deductibles for members below 100% FPL. SLMB covers payment of the part B premium for members below 120% FPL. QI-1 covers a payment of the part B premium for members under 135% FPL not otherwise receiving Medicaid benefits.

How does the managed care model support quality and affordable costs?

AHCCCS prepays its health plans for the services that are provided to its membership. This prepayment is known as “capitation”. The AHCCCS capitation rates are set and certified by AHCCCS actuaries who employ a formula, largely based on historical utilization, population trends and policy changes to forecast how much it will cost to care for AHCCCS members in the upcoming year.

AHCCCS MCOs are at-risk in their contracts with the State, meaning that if they exceed the amount that they are appropriated through the capitation payments, they, rather than the State, are responsible for absorbing the additional costs. Thus, they are incentivized to promote health and wellness, ensure members have access to preventative services, and be innovative in identifying ways to improve outcomes, while also lowering costs.

The MCOs are also required to assign all members to a primary care physician within their immediate geographic area, who act as a medical home to the member and keep them out of more acute, high cost care settings, such as an emergency room. All children are also assigned a Dental Home, where necessary oral healthcare screenings and services can be delivered. As a condition of its federal funding, AHCCCS closely monitors network adequacy for all Primary Care Physician (PCP), oral health, behavioral health, and specialty and long-term care providers to ensure that members are able to access effective, efficient, quality care when and where they need it. AHCCCS tracks health plan performance through quality metrics and other performance measures MCOs are contractually required to meet.