Access to AHCCCS
October 29, 2012
Access to Care

- Legal Aspects/Implications
- Federal Efforts to Date
- Arizona Access Efforts
- Strategies for the future
Legal Requirements

- Federal Statute 1902 (a)(30)(A)–
  - “A State plan for medical assistance must...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 under the plan at least to the extent that such care and services are available to the general population in the geographic area.”
Legal Issues

- Without clarifying regulations further interpretation left to the Courts
- Ninth Circuit Court of Appeals – several California cases over proposed rate reductions
- “We have several times held that the balance of hardships favors beneficiaries of public assistance who may be forced to do without needed medical services over a state concerned with conserving scarce resources”
- Standing issue went to Supreme Court (Douglas v Independent Living Centers)
“Finally, we have stated that even if § 30(A) imposes a substantive requirement, a rate reduction might still conflict with the statute if at least some providers stop treating Medi-Cal beneficiaries. Indep. Living II, 572 F.3d at 656-57.”
Arizona Ruling on rate reduction case

Hospital lawsuit over rate reductions
March 23, 2012
Secretary relied on (Administrative Record)
- Tribal Consultation
- Historical hospital provider participation
- Additional Measures tracked
- Arizona’s “robust” monitoring tools
Court found in favor of the State
CMS Proposed Regulations

- May 6, 2011
- First attempt to provide regulatory guidance regarding access requirement
- Framework – enrollee needs, availability of care and utilization
- Purpose “Create standardized transparent process for states to follow as part of compliance with (access)”
- States would have to review access by subset of services every year – all services at least once every 5 years
- Information included:
  - Beneficiary Input (hotline – surveys – ombudsman)
  - Data looking at costs charges – Medicare – other payers
  - Identify any access issues highlighted by the review
- Review must be completed if imposing rate reductions
- If state identifies issues – submit Corrective Action Plan
Arizona Response

- CMS proposed rule based on MACPAC framework looked at limited services and did not offer comparison to general population in area
- Recommended
  - CMS partner with states to determine framework
  - Relying on member satisfaction surveys is not an indication of community standard
  - Comparison to billed charges and Medicare not necessarily relevant
  - States should be provided with flexibility to determine the elements most appropriate for review
  - The inclusion of Corrective Action Plans will increase litigation
CMS Access Efforts

- CMS working on analytical approach to monitor access. Evaluating data sources that can be used
  1. Survey data (household and physician)
  2. Medicaid Claims data
- Work in progress
- Held some discussions with States
State Concerns

- No Specific Medicaid data other then old claims - currently no encounters (MCO)
- Weakness in surveys – what services did they get
- May provide national picture but is it really comparable?
- Is it enough information to inform and take action?
Significant Measurement Efforts

- Numerous fragmented federal efforts around updating and improving quality measures
- What is goal? *Actionable data that allows improvement in health care system*
  - CHIPRA Core
  - Comprehensive Well Child Core
  - Adult Core
  - Dual Eligible
  - Multiple Chronic Disease
  - Meaningful Use
  - CMS Access Measures
Arizona Access Principles

- Create Strong Contractual Network Requirements
- Robust real-time Monitoring with information from plans – systems
- Establish Quality expectations and measure
- Focus on actionable information to improve system
- Do not drown in data – generate information
- Disciplined Review of Information
- Accountability for plans to perform

“Reaching across Arizona to provide comprehensive quality health care for those in need”
Arizona Network Requirements

- Largely Managed Care
- Establish strong network requirements
  - PCP/Pharmacy within 5 miles (urban areas – 80%+ of population)
  - Hospital, NF, Assisted Living facilities by region
  - Appointment standards – emergency/urgent/ routine
  - Require adequate network for specialists
  - MCOs must monitor and ensure appointment availability

"Reaching across Arizona to provide comprehensive quality health care for those in need"
Arizona Robust Monitoring

- Provider Analysis
  - Hospital Analysis – other providers
  - Participation – Financial status – Reimbursement levels
- Quarterly MCO report on providers terminating contracts (250 out of 55,000 in past 2+ years)
- Requirement to notify immediately if substantive change in network
- Provider Affiliation Tape – electronic info on MCO providers
- Conduct Operational and Financial reviews
- Track Member and Provider Grievance and Appeals

"Reaching across Arizona to provide comprehensive quality health care for those in need"
Quality Measures

- **Quality of Care (QOC) process**
  - Significant sentinel events
  - MCO tracks and trends to determine system issues
  - Resolve care needed today issues

- **Performance measures** –
  - HEDIS like
  - well child visits – dental care
**Actionable Data/Review/Accountability**

- Measures previously identified are more real time – no significant lag –
- Important because Goal is to take appropriate actions to improve system
- Staff from various division meet quarterly to review health plan data
- Also look at medical management data – IP/ED trends – pharmacy lockdown etc…
- Agency willing to impose monetary sanctions – even have suspended enrollment

“Reaching across Arizona to provide comprehensive quality health care for those in need”
## Potential Arizona Population Growth (FY 16)

<table>
<thead>
<tr>
<th>Population</th>
<th>FPL</th>
<th>Est. #</th>
<th>State Cost</th>
<th>Total</th>
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<tr>
<td>Children 6-18</td>
<td>100-133</td>
<td>44,000</td>
<td>$33 m</td>
<td>$124 m</td>
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<td>Eligible not enrolled</td>
<td>0-133</td>
<td>137,000</td>
<td>$225 m</td>
<td>$656 m</td>
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<tr>
<td>Childless Adult Restoration</td>
<td>0-100</td>
<td>154,000</td>
<td>$170 m</td>
<td>$1.4 B</td>
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<tr>
<td>Childless Adult not previously enrolled</td>
<td>0-100</td>
<td>33,600</td>
<td>$37 m</td>
<td>$306 m</td>
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<tr>
<td>Optional Parent Expansion</td>
<td>100-133</td>
<td>42,000</td>
<td>$0</td>
<td>$289 m</td>
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<tr>
<td>Optional Childless Adult Expansion</td>
<td>100-133</td>
<td>18,000</td>
<td>$0</td>
<td>$165 m</td>
</tr>
</tbody>
</table>
Capacity/Access Strategies

- Currently serves population 1.3 million
- AZ looking at growth anywhere from 180,000 (14%) to 425,000 (33%) new members
- How to expand network capacity?
- Program has been increasing GME funding
- Currently in procurement – may add plan capacity?
- Lessen hassle factor – single credentialing process
- Continue to have plans add value for providers – care coordination data -
- Integration efforts – behavioral health – duals
- Payment Reform - Gainsharing

"Reaching across Arizona to provide comprehensive quality health care for those in need"
Reaching across Arizona to provide comprehensive quality health care for those in need

30 Years of Medicaid Innovation
Our first care is your health care
Arizona Health Care Cost Containment System

“Reaching across Arizona to provide comprehensive quality health care for those in need”
Access to Care: Balancing Medicaid’s Goals and Capacity

The Community Health Center Perspective


Heather Foster, MPH
Deputy Director, Federal Affairs
The NACHC Mission

To promote the provision of high quality, comprehensive and affordable health care that is coordinated, culturally and linguistically competent, and community directed for all medically underserved populations.
What are Community Health Centers?

1,200 Community Health Center Organizations
- Over 8,500 delivery sites

20 million patients served
- Nearly 1 million migrant and seasonal farm workers
- Over 1 million homeless patients
- 48% rural patients
- 92.5% of patients are under 200% FPL
- 37% uninsured, 39% Medicaid
- 35% Hispanic; 25% African American; 4% API

Saving over $24 billion each year!
What makes a CHC a CHC

- Must provide service to all regardless of patient’s ability to pay

- Community-driven: Health centers must have a patient-majority community board

- Located in or serving patients in a medically-underserved area

- Comprehensive primary care services (all ages)
Services Offered by Health Centers

- Primary Medical Care
- Preventive Health Care
- Prenatal, Perinatal, & Newborn Care
- Gynecological Care
- HIV Care
- Hearing/Vision Screening

- Oral Health
- Mental Health
- Substance Abuse
- Pharmacy
- X-Rays and Lab
- Specialty Medical Care
- Enabling Services
Enabling Services at CHCs

- Case Management
- Environmental Health Risk Reduction
- Health Education
- Interpretation/Translation Services
- Outreach
- Child Care (during visits)
- Housing Assistance
- Transportation
- Home Visiting
- Parenting Education
- Employment referral & counseling
- Testing for Blood Lead Levels
- Food bank/meal delivery
Health Centers Have a Unique Role as Primary Care Providers...
Health Center Patients: Disproportionately Poor, Uninsured, and Publicly-Insured

Figure 1.5
Health Center Patient Mix Is Unique Among Ambulatory Care Providers

Notes: Other public includes non-Medicaid SCHIP and other state-funded insurance programs.
Health Centers Save $$$

What Does it Mean for Access: Balancing Costs & Returns in Medicaid
Questions?

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For further information about NACHC and America’s Health Centers

Visit us at www.nachc.org
Measuring Access to Care in Medicaid Managed Care

Joe Moser
Director of Government Affairs
October 29, 2012

Hurricane Sandy
Medicaid Health Plans of America (MHPA)

111 Members
34 States + DC
Access to Care in Medicaid MCOs

• Balanced Budget Act of 1997:
  Medicaid managed care organizations must offer “an appropriate range of services and access to preventative and primary care for the population expected to be enrolled in such service area.”

• Federal Regulation 42 CFR §438.206:
  Requirement that each plan “maintain and monitor a network of appropriate providers that is...sufficient to provide adequate access to all services covered under the contract.”
Measuring Access

FIGURE a-1. The Commission’s Access Framework

- **Enrollees**
  - Enrollee characteristics and health needs
  - Eligibility requirements

- **Availability**
- **Utilization**

- **Access**
  - Appropriateness of services and settings
  - Efficiency, economy, and quality of care
  - Health outcomes
How is Access to Care Measured in Medicaid Health Plans?

• Provider to population ratios
  – Massachusetts and Maryland: PCPs 1/200
  – Virginia: PCPs 1/1500
  – South Carolina: PCPs 1/2500

• GeoAccess report and mapping

• Appointment timeliness standards

• Disenrollment reports
How is Access to Care Measured in Medicaid Health Plans? (cont.)

• CAHPS access questions
• HEDIS access measures
• External Quality Review and other state auditing
• Complaints and grievance data
• Internal monitoring
A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey

Kathleen Gifford
Vernon K. Smith
Dyke Snipes
Health Management Associates

Julia Paradise
Kaiser Family Foundation
Access

• Many but not all states reported that Medicaid MCO enrollees sometimes face access problems
• Improved access to care—both primary and specialty care—was cited most frequently as a perceived benefit of MCOs relative to FFS
• Access problems that exist are due to general problems encountered by all persons in those areas and not due to MCOs
• No assessment of access problems in FFS
Medicaid directors were asked: “Can MCOs absorb Medicaid enrollment growth under ACA?”
Medicaid Health Plans Prepare for Medicaid Expansion

• Building network capacity to meet demand
• Partnering to build a stronger healthcare workforce
• Reassessing role of mid-level practitioners
Community Health Centers

- Important source of primary and preventive care for MCO enrollees
- FQHCs recognized as MCO PCPs in 25 of 35 states responding to Kaiser survey
- 30 of 34 states encourage plans to contract with FQHCs in contract language
Questions?

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