

Bailit Health's
Recommendations to
AHCSS on ACOM
306 and ACOM 307

Final Report
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1 Executive Summary

Table 1 below summarizes Bailit Health’s high-level recommendations for Arizona Health Care Cost Containment System (AHCCCS) Contractor Operations Manual (ACOM) 307 and 306 policy modifications, starting in Contract Year End (CYE) 2023 or later. ACOM 307 refers to requirements for Contractor use of Alternative Payment Models (APMs) with network providers. ACOM 306 describes financial incentives for Contractors related to quality performance on state-defined measures.

Since ACOM 307 APM policies represent the bulk of the scope of work that AHCCCS asked Bailit Health to focus on, we describe ACOM 307 first throughout this report. Our recommendations on ACOM 306 focused on options for incorporating some health equity elements into Contractor performance incentives, the methodology for Contractors to earn financial incentives overall, and the linkages between ACOM 306 and ACOM 307. Outside of considering potential equity approaches, Bailit Health did not develop recommendations regarding performance measures that AHCCCS is utilizing for ACOM 306.

See Section 4, Recommendations, for more details and our rationale related to the following proposed ACOM 307 and ACOM 306 policy changes.

Table 1: Bailit Health's High-Level Recommendations

Policy Requirement	High-level Recommendations
ACOM 307 - APM - Strategies and Performance Based Payments Initiative	
APM Targets	<ol style="list-style-type: none"> 1. Reduce current AHCCCS APM target requirements to re-focus Contractor achievements on quality outcome improvements and the role of APMs in supporting and rewarding providers' efforts to meet quality benchmarks. 2. Set minimum Health Care Payment-Learning & Action Network (HCP-LAN)¹ APM Category 3 and 4 target sub-requirements only for AHCCCS Complete Care (ACC) and ACC-Regional Behavioral Health Agreements (ACC-RBHA) Contractors, excluding members with a Serious Mental Illness (SMI) designation and the non-integrated population. 3. Eliminate APM targets for ACC-RBHA's non-integrated population. 4. Do not significantly alter APM target requirements for AHCCCS Contractors between CYE 2023 and CYE 2025. 5. Do not require Contractors to meet specific APM targets in ACOM 307 in order to qualify for Quality Management Performance incentive payment as described in ACOM 306 Quality Withhold.
Performance Based Payment (PBP)	<ol style="list-style-type: none"> 6. Modify the "PBP Incentive" definition and related ACOM 307 policy to remove references to "reimbursement" of Contractor expenditures and instead describe this payment as a financial incentive for Contractors and for providers to engage in APMs. For CYE 23, limit AHCCCS' contribution to PBP at no more than 0.75 percent of Contractors' medical payments.
ACOM 307 Contractor APM Implementation and Reporting Approaches	<ol style="list-style-type: none"> 7. Facilitate conversations and more transparency among Contractors and provider stakeholders to better align APM approaches, increase effectiveness of APMs and reduce administrative burden for participating providers. 8. Require Contractors to include a minimum number or portion of priority quality measures as defined by AHCCCS in their APMs with providers in order to count these APMs towards meeting the ACOM 307 targets. 9. Modify how Contractors are required to report to AHCCCS on APM components and results related to quality and efficiency. 10. Require Contractors to develop and submit a multi-year APM Strategic Plan generally describing the Contractor's APM approach, proposed evolution, and key objectives.

¹ <https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>

Policy Requirement	High-level Recommendations
ACOM 306 - Withhold and Quality Measure Performance (QMP) Incentive	
Overall	<ol style="list-style-type: none"> 1. Utilize an ACOM 306 incentive methodology that rewards improvement consistent with Bailit Health’s recommended approach (see example in Appendix B). 2. More clearly incentivize all participating Contractors to achieve meaningful performance achievement (through Threshold and High-Performance Benchmarks) and improvement (through Improvement Benchmarks) for included measures. 3. Change the ACOM 306 methodology so that Contractors do not earn back a portion of their Withhold per measure if they do not meet the achievement and/or improvement benchmarks. 4. Use National Committee for Quality Assurance (NCQA) Medicaid MCO percentiles and consider historical AHCCCS Contractor performance when setting performance benchmarks. 5. Ensure Contractors know what their ACOM 306 measures and benchmarks are prior to the start of the measurement year. 6. Retain the concept of primary and secondary measures to account for potential challenges with primary measures.
Health Equity	<ol style="list-style-type: none"> 7. Consider working internally and with Contractors to improve the collection and accuracy of race, ethnicity, and language (REL) data for AHCCCS managed care enrollees. 8. Consider requiring Contractors to analyze and report stratified performance on select performance measures by demographic groups (e.g., race/ethnicity, disability status) as directed by AHCCCS to identify and understand disparities. 9. Consider reporting comparative disparity findings at the Contractor level on select measures to Contractors. 10. Consider gradually working towards allocating ten percent of each Contractor’s Withhold to reducing health disparities.

Feedback from AHCCCS, Contractors, and providers on current AHCCCS policies and initial recommendations to modify these policies helped inform Bailit Health’s final recommendations.

2 Introduction

2.1 Background

Among state Medicaid managed care programs, AHCCCS was an early adopter of value-based purchasing (VBP)² models to reward providers for providing high-quality care to members through financial incentives tied to improving health outcomes while reducing the cost of care. Since 2014, AHCCCS has made significant investments in a variety of VBP initiatives, including alternative payment models (APM)³ designed to align the incentives of managed care Contractors and providers to incentivize quality, health outcomes, and value over volume to achieve the goals of better care, smarter spending, and healthier people.

ACOM 307 applies to AHCCCS Complete Care (ACC), Arizona Long Term Care System (ALTCS)-Elderly and Physical Disabilities (EPD), Department of Child Safety (DCS) Children's Health Plan (CHP), ALTCS-Department of Economic Security/Division of Developmental Disabilities (DES/DDD), and ACC-Regional Behavioral Health Agreements (ACC-RBHA) Contractors. ACOM 307 establishes requirements for the APM Initiative - Strategies and Performance Based Payments (PBP) Incentive. ACOM 306 applies to ACC, ACC-RBHA, and ALTCS-EPD Contractors. AHCCCS stated that it intended to apply this policy to ACC-RBHA Contractors for members with a Serious Mental Illness (SMI) designation beginning on October 1, 2022.⁴ AHCCCS describes the purpose of these APM and quality initiatives as encouraging "Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, by aligning the incentives of the Contractor and provider through APM Strategies."

2.2 Purpose

In October 2021, AHCCCS engaged Bailit Health to review AHCCCS' current use of APMs in its managed care program and how other states and their contracted managed care organizations (MCOs) implement APM approaches and consider:

- the State's VBP/APM program goals and how that aligns with ACOM Policy [306](#) (Alternative Payment Model Initiative - Withhold and QMP Incentive) and ACOM

² In ACOM 307, AHCCCS defines Value-Based Purchasing (VBP) as a form of payment reform that seeks to reward providers for providing high-quality care to members through financial incentives tied to improving health outcomes while reducing the cost of care. VBP attempts to reduce inappropriate care and to identify and reward the best performing providers.

³ In ACOM 307, AHCCCS defines an Alternative Payment Model (APM) as a model which aligns payments between payers and providers to incentivize quality, health outcomes, and value over volume to achieve the goals of better care, smarter spending, and healthier people. Based on the strategies and categories defined in the APM Framework established by the Health Care Payment Learning & Action Network (HCP-LAN).

⁴ <https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/300/306.pdf>.

Policy [307](#) (Alternative Payment Model Initiative - Strategies and Performance Based Payments Incentive) policies;

- quality linkages across APM models used by AHCCCS Contractors;
- how the state and/or its Contractors can better support provider efforts to successfully implement APM models, and what specific challenges providers have in participating in such models;
- modifications to the state’s APM reporting requirements; and,
- how best to include health equity in the APM program.

With these considerations in mind, Bailit Health was charged with developing recommendations for improvements to AHCCCS’ APM policies. This report summarizes the results of Bailit Health’s contracted work; the sections that follow include Bailit Health’s project approach and specific recommendations for modifying ACOM 306 and 307 policies to ensure APM requirements and incentives are adequate to achieve AHCCCS’ program goals related to improved quality and health outcomes.

3 Approach

Bailit Health’s project approach included the following steps, which are further detailed in the below sections:

1. conduct background research;
2. interview AHCCCS leaders and staff;
3. research other states’ approaches to APMs;
4. facilitate stakeholder workgroup meetings; and,
5. develop recommendations.

3.1 Background Research

Bailit Health reviewed AHCCCS APM policies and related background documents, including:

- ACOM 306 and 307 policies and related attachments;
- Draft VBP Strategic Plan, as of January 2021;
- Strategic Plan, State Fiscal Years 2018-2023;
- 2021 Quality Strategy;
- 2018 - 2020 Quality Strategy Evaluation;
- May 2021 VBP Request For Information (RFI);
- VBP RFI Responses Summary and individual RFI responses;
- Contractor enrollment data;
- AHCCCS program dashboards; and,
- AHCCCS prior communications with Contractors related to VBP and Withhold initiatives.

These documents provided Bailit Health with a foundational understanding of AHCCCS VBP/APM strategies, policies, and considerations. Guiding principles described in AHCCCS' VBP Strategic Plan and RFI⁵ also helped frame Bailit Health's overall approach, which include: (1) engagement with stakeholders, (2) movement along the LAN-APM continuum, (3) balance of prescriptive requirements and health plan flexibility, and (4) data-driven decision making.

3.2 AHCCCS Interviews

In November 2021, Bailit Health conducted four one-hour interviews with AHCCCS leaders and staff representing managed care finance, quality, VBP, and data, to supplement and clarify the information learned through background research. In advance of the interviews, Bailit Health prepared and shared with interviewees an interview guide with key questions for discussion. These interviews offered Bailit Health a better understanding of AHCCCS' project and VBP/APM goals and insights related to current APM policies, including Contractor performance, challenges, and opportunities for improvement.

Findings from the AHCCCS interviews included:

- AHCCCS historically has had a solid and collaborative relationship with its Contractors.
- AHCCCS has detailed VBP/APM reporting requirements, but limited staff resources to validate and analyze the data from Contractors. There is interest among AHCCCS staff to modify Contractor reporting related to ACOM 307.
- It is challenging for AHCCCS to identify whether and to what extent Contractor APM and other VBP efforts are reducing costs and/or improving quality.
- Some AHCCCS staff expressed concern that current ACOM 307 policies are "check-the-box" requirements that may not drive delivery system change or cost containment.
- Some staff questioned the role of Accountable Care Organizations (ACO) versus the role of the Contractors.
- Comments were made regarding the unintended consequences of the significant APM percentage requirements in ACOM 307 on the leverage equation between Contractors and providers.
- Providers are not always aware of what is included in Contractor VBP/APM arrangements, such as which quality measures they are held accountable to, their current performance, and/or which members are assigned/attributed to them.
- AHCCCS staff and Contractors agree that providing flexibility for Contractors allows for innovation in payment reform. However, some AHCCCS staff seek greater consistency in APM approaches across Contractors, noting benefits and efficiencies to standardization or guidelines related to quality measures, member/patient attribution, and payment models. Similarly, some AHCCCS staff would like to create greater

⁵ More detail about AHCCCS' VBP guiding principles can be found in its 2021 VBP RFI: [YH21-0110ValueBasedPurchasingRFI.pdf \(azahcccs.gov\)](https://www.azahcccs.gov/ValueBasedPurchasingRFI.pdf)

transparency around how Contractors and ACOs are contracting with providers related to APMs, including quality measures, attribution, and financial incentives.

- There is some interest among AHCCCS staff to require or encourage its Contractors to create certain types of provider-specific APM arrangements (e.g., maternity care-focused arrangements).

Related to efforts to address health equity, interviewed AHCCCS staff agree that available demographic data for Medicaid enrollees is limited. AHCCCS has some information on languages spoken by enrollees. While more than 70 percent of enrollees provide race data on their current Medicaid application, only 50-55 percent of enrollees provide ethnicity data. AHCCCS' Health Equity Committee Data Subcommittee is conducting a project to determine if enrollees may have filled out race/ethnicity data on past eligibility applications. The Subcommittee is also exploring options to better understand and address race/ethnicity data gaps, including issuing a survey to AHCCCS Contractors about what demographic data they collect and use.

3.3 Other States' Approaches to APMs

To advance APM strategy discussions with AHCCCS, its Contractors, and providers, Bailit Health reviewed and shared findings from other states' approaches to APMs during the sixth Contractor Workgroup Meeting, including quality and health equity requirements. Bailit Health's initial review included the following six states: Louisiana, Michigan, Texas, New York, Oregon, and Washington. For each state, including Arizona, Bailit Health assessed:

- eligible LAN Categories that count towards the APM requirement;
- minimum thresholds (including LAN Category 3 or 4 requirements);
- how states require contracted MCOs to report on APM progress;
- preferred services/providers to include in APM models;
- quality metrics used in APM models;
- health equity requirements related to APMs; if any, and,
- Contractor/provider financial incentives related to VBP requirements.

In addition, Bailit Health reviewed the following states' approaches specific to quality withhold and health equity requirements: Louisiana, Massachusetts, Oregon, Rhode Island, Texas, and Washington. For each state, including Arizona, Bailit Health assessed:

- methodology for determining Contractor earned quality withhold;⁶
- methodology for earning funds not allocated under the initial quality withhold approach, if applicable;
- use of measures in provider APM contracts;

⁶ AHCCCS defines Earned Withhold in ACOM 306 as amounts returned to the Contractor, by Performance Measures, "based on the results of the Combined Performance Score, not to exceed 100% of each Contractor's Withhold."

- requirements for Contractors to receive quality withholds; and,
- health equity approaches in Contractor APM and quality requirements if any.

This review of state approaches provided AHCCCS and stakeholders with additional considerations and operational elements to consider adopting in AHCCCS’ APM strategy.

3.4 VBP Stakeholder Workgroup Meetings

Over the course of six months, Bailit Health facilitated six Contractor and one provider stakeholder workgroup meetings to solicit input on AHCCCS’ VBP/APM strategy. All AHCCCS Contractors, across all Medicaid lines of business, were represented in each of the Contractor workgroup meetings. Appendix A includes a list of participating organizations.

Meeting topics and materials were shared in advance with participants, and opportunities for written feedback were provided after the meetings. Table 2 highlights the topics for each meeting.

Table 2. VBP Workgroup Meeting Topics

Meeting	Meeting Topic(s)
11/29/21 Contractor Workgroup Meeting #1	VBP Workgroup Goals, Timeline, and Expectations; VBP Rationale and Background; Review of ACOM APM Policies (306/307); Review of Other States’ VBP/APM Policies
12/14/21 Contractor Workgroup Meeting #2	Contractor VBP/APM Presentations: <ul style="list-style-type: none"> ▪ What is working well within your current APM approach? ▪ What are the APM lessons learned and challenges? ▪ How can AHCCCS and Contractors work together to more effectively utilize APMs to improve quality and reduce cost growth? ▪ How can AHCCCS and Contractors work together to improve health equity and/or impact social determinants of health?
01/21/22 Contractor Workgroup Meeting #3	Medicaid Health Plan APM Reporting Templates – Michigan Examples
02/08/22 Provider Stakeholder Meeting	Project Overview and Timeline; Summary of AHCCCS VBP/APM Policies (ACOM 306/307); Stakeholder Feedback on ACOM 306/307

Meeting	Meeting Topic(s)
02/23/22 Contractor Workgroup Meeting #4	Contractor VBP/APM Presentations: <ul style="list-style-type: none"> ▪ Do providers participating in different APMs perform better on quality and/or cost measures compared to non-participating providers and/or providers in different types of APMs? ▪ Are there certain APMs that work better to improve provider performance on quality? In managing costs of care? ▪ Setting aside APM targets, where would Contractors focus APMs? With what types of services / providers? In which LAN APM Categories? Why? ▪ Other comments / perspective on materials from VBP Workgroup meeting #3 (January). ▪ What is working well within your current APM approach?
03/17/22 Contractor Workgroup Meeting #5	Review of Current AHCCCS ACOM 306 Policies; Review of State Approaches to Quality Withholds; Review of State Approaches to Health Equity
05/02/22 Contractor Workgroup Meeting #6	ACOM 307 Recommendations; ACOM 306 Recommendations
05/31/22 Contractor Workgroup Meeting #7	Proposed ACOM 306 Methodology

3.5 Recommendations Development

Bailit Health used an iterative process to develop and refine ACOM 306 and ACOM 307 recommendations, informed through stakeholder input and a better understanding of what could work in AHCCCS’ current environment. When developing recommendations, Bailit Health considered the skills and resources likely needed from AHCCCS, Contractors, and providers to meet current and proposed ACOM 306 and 307 policy and reporting requirements. For example, we tried to balance AHCCCS’ need for provider-level performance information with Contractors’ ability and potential to obtain this information and AHCCCS’ ability to analyze and act on required APM-related reports.

AHCCCS, Contractors, and providers had an opportunity to review proposed policy modifications and provide feedback, which has been considered in the development of the final recommendations in Section 4 below.



4 Recommendations

4.1 ACOM 307 Policy

4.1.1 Current AHCCCS Approach

Through ACOM 307, AHCCCS requires Contractors to meet or exceed specific percentages of overall medical spend based on provider payments within contracts that include APMs, as outlined in Table 3. For CYE 22, Overall Contractor APM requirements range from 25% to 65% of total medical spend; the highest percentage (65%) applies to ACC, ACC-RBHA, and ALTCS-EPD/DSNP Contractors. For CYE 22, Contractor sub-requirements for provider arrangements in Categories 3 and 4 of the LAN APM Framework range from 15% to 55% of medical spend; the highest percentage applies to ACC Contractors.

Table 3. ACOM 307 APM Targets for CYE 21 and CYE 22⁷

	ACC & ACC-RBHA	ALTCS - EPD and DSNP	ACC-RBHA SMI Int	RBHA Non-Int	DDD Sub	DDD LTSS	DCS CHP Sub
ACOM 307 APM Targets (Overall)							
CYE 21	65%	65%	55%	30%	55%	25%	N/A
CYE 22	65%	65%	55%	30%	55%	25%	25%
ACOM 307 APM targets (Category 3 & 4)							
CYE 21	55%	40%	25%	25%	55%	15%	N/A
CYE 22	55%	40%	25%	25%	55%	15%	20%

To qualify for an Earned Withhold and QMP incentive payment in ACOM 306, currently ACC and ALTCS-EPD Contractors must meet the ACOM 307 APM targets which are defined as qualifying APM requirements. Under current ACOM 307 policies, absent a Withhold requirement, other AHCCCS Contractors can be subject to limited financial sanctions for failure to reach ACOM 307 APM requirements.

AHCCCS does not currently require Contractors to utilize any specific quality measures or benchmarks in their APMs. Similarly, AHCCCS does not currently require Contractors to use any specific APMs.

⁷ DSNP: Medicare Advantage Dual Special Needs Plan; ACC-RBHA SMI Int: RBHA's with integrated physical and behavioral health services for members with a serious mental illness (SMI) designation; RBHA Non-Int: RBHA's without integrated services for members without an SMI designation; DDD Sub: DDD sub-contracted health plans; DDD LTSS: DDD long-term services and supports; DCS CHP Sub: CHP sub-contracted health plan.

4.1.2 ACOM 307 Recommendations for CYE 2023 and beyond

Bailit Health developed three different sets of policy recommendations related to ACOM 307 for CYE 2023 and beyond. First, we recommend significant changes to Contractor APM targets AHCCCS defines in ACOM 307. Our proposed approach would reduce, and in some cases eliminate, APM targets for certain AHCCCS Contractors beginning in CYE 2023. Second, Bailit Health suggests some changes to AHCCCS Performance Based Payment (PBP) Policies. Finally, we recommend ways for AHCCCS to consider modifying Contractor reporting approaches related to ACOM 307, both in terms of written deliverables and in terms of regular meetings with AHCCCS, ACOs, and other providers.

After each set of ACOM 307 recommendations, we describe our rationale. Bailit Health focused our proposed strategies on how best to incentivize Contractors and providers to engage in meaningful APM arrangements likely to support true delivery system transformation and performance improvements. We tried to balance the need for both standardization and flexibility within APM policies. There is not one way to develop successful APMs. While there are lessons learned about successful APMs, what works with one group of providers, services, or Contractors, may not work as well with another, particularly in a Medicaid managed care program as diverse as AHCCCS.

APM Targets

Bailit Health's first five ACOM 307 recommendations relate to revising APM targets and are described below.

1. Beginning in CYE23, reduce current APM target requirements to re-focus Contractor achievements on quality outcome improvements and the role of APMs in supporting and rewarding providers' efforts to meet quality benchmarks.

Rationale: AHCCCS' ultimate goal with its APM strategy is to sufficiently incentivize and reward providers for achieving meaningful improvements in quality and cost efficiency and to invest in delivery system reform rather than achievement of specific and ever higher APM thresholds.

The ACOM 307 CYE 2021 APM requirements and sub-requirements for Contractors were set significantly above national Medicaid MCO APM use reported by the LAN.⁸ Based on comments from Contractors and AHCCCS staff, the pressure on Contractors to meet these ever-higher APM targets has taken precedence over examining results that Contractors and AHCCCS may be obtaining from these APMs.

⁸ <https://hcp-lan.org/apm-measurement-effort/2020-2021-apm/2021-infographic/>

There is no specific percentage of provider payments in contracts that include at least one APM, and there are ways for Contractors to reach APM targets without having significant opportunities for providers to be paid differently based on performance.

2. Set minimum LAN APM Category 3 and 4 target sub-requirements only for ACC and ACC-RBHA Contractors.

Rationale: Category 3 and 4 APMs require each Contractor to have sufficient volume with contracted providers to develop and operate meaningful and fair shared savings and risk-based arrangements. Non-ACC Contractors have significantly smaller AHCCCS membership than ACC Contractors. Without sizable panel sizes or attributed members, population-based payment arrangements at the provider level run the risk of both putting providers at too much financial risk and holding them accountable (and in some cases rewarding providers) for changes in performance that may be related to random variation over time rather than statistically significant changes in quality or cost efficiency performance at the provider level.

3. Eliminate all APM targets for ACC-RBHA's non-integrated population.

Rationale: There are limited members and services remaining in the ACC-RBHA non-integrated population reducing the potential for meaningful APMs. We recommend that APMs targets no longer apply to ACC-RBHA's non-integrated population beginning in CYE 2023.

4. Do not require ACC, ACC-RBHA, or ALTCS Contractors to meet specific APM targets in ACOM 307 in order to be eligible to retain the one percent of medical revenues at risk under ACOM 306 based on the Contractor's performance to state-identified quality measures.

Rationale: Due to current incentives in ACOM 306 and 307 policies, the volume of provider payments in APMs may be a greater focus for Contractors than the performance results of the APMs. By removing ACOM 307 APM performance as a gate for ACOM 306, AHCCCS will better align Contractor financial incentives with quality improvement goals and reduce uncertainty as to whether a Contractor is eligible to participate in the ACOM 306 Quality Withhold prior to the start of the performance period. The proposed ACOM 307 changes, along with suggested revisions to the ACOM 306 approach, are designed to support and incentivize Contractor and provider investment in quality improvement and delivery system reform, AHCCCS' primary goals within ACOM 306 and 307. Maintaining contractual APM targets, modifying APM reporting, ensuring Contractor compliance with ACOM 307 and requiring Corrective Action Plans for non-compliant Contractors will enable AHCCCS to retain an emphasis on APMs to support delivery system reform and performance improvement.

5. Do not significantly alter APM target requirements between CYE 2023 and CYE 2025.

Rationale: We recommend that AHCCCS assess the impact of changes in ACOM 307 based on CYE 2023 and CYE 2024 APM policy results prior to considering any significant ACOM 307 changes. Given the complexity of many Contractor and provider APM negotiations, and the significant lag in availability of quality and cost efficiency performance data essential to assessing APM performance, we suggest providing predictability in APM policies from one year to the next.

Overall, our recommendations related to changing APM targets in ACOM 307 are designed to help AHCCCS and its Contractors focus on meaningful APMs at the provider level rather than focusing on the quantity of provider contractual payments that include APMs.

Specific APM Targets in ACOM 307

Bailit Health recommends that AHCCCS modify ACOM 307 overall and sub-requirement APM targets as outlined in Table 4 and Table 5 below. For example, we suggest that AHCCCS set the ACC minimum APM target at 45% overall for CYE 2023, close to the LAN Medicaid APM results and 20 percentage points lower than the CYE 2022 overall APM target. Bailit Health recommends a comparable 20 percentage point reduction for the CYE 2023 Category 3 and 4 sub-requirement targets to 35 percent.

Table 4. AHCCCS Historical and Bailit Health Proposed ACOM 307 APM Targets (Overall)

	ACC & ACC-RBHA	ALTCS-EPD and DSNP	ACC-RBHA SMI Int	DDD Sub	DDD LTSS	DCS CHP Sub
CYE 22	65%	65%	55%	55%	25%	25%
LAN Medicaid APM 2020	42%					
Proposed Overall CYE 23/24	Minimum 45%	Minimum 45%	Minimum 35%	Minimum 35%	Minimum 15%	Minimum 15%

Table 5. AHCCCS Historical and Bailit Health Proposed ACOM 307 APM Targets (Category 3 & 4)

	ACC & ACC-RBHA	ALTCS-EPD and DSNP	ACC-RBHA SMI Int	DDD Sub	DDD LTSS	DCS CHP Sub
CYE 22	55%	40%	25%	55%	15%	20%
LAN Medicaid APM 2020 category 3 & 4 APMs	35%					
Proposed Category 3 & 4 APMs CYE 23/24	35%	N/A	N/A	N/A	N/A	N/A

Recommendations related to Performance-based Payment (PBP) Policies

The PBP incentive is a financial incentive and contribution from AHCCCS to Contractors for a portion (up to a specified maximum) of the PBPs paid to providers who successfully met their APM targets during the Contract Year. The maximum contribution from AHCCCS under this PBP incentive structure is not intended to limit Contractor PBP payments to providers.

Bailit Health recommends that AHCCCS make only minor changes to the PBP policies included in ACOM 307 for CYE 23. Specifically, we suggest that AHCCCS:

- a. modify the “PBP Incentive” definition and related ACOM 307 policy to clarify that the PBP payment from AHCCCS to a Contractor is a financial incentive for Contractors and for providers to engage in APMs;
- b. continue to limit AHCCCS’ contribution to the PBP to no more than 0.75 percent of the Contractor’s medical payments as currently defined in ACOM 307;
- c. explicitly indicate that AHCCCS’ policies do not impose the 0.75 percent limit on Contractor payments to providers under APMs;
- d. consider how plan investments in APMs and quality improvement are considered in profit/loss reconciliation and in administrative expenses; and,
- e. retain the ability for Contractors that are state agencies and provide the state share of funding for the PBP incentive to utilize higher PBP incentive payments.

Bailit Health also recommends that AHCCCS continue discussions internally, with Contractors, and with actuaries related to potential changes in the PBP incentive payment policy for CYE 24 or later.

Rationale:

Outside of directed payments and performance-based withholds for managed care organizations, to our knowledge, no other state Medicaid programs have explicit payment arrangements to fund health plan APM payments to providers.

For Contractors that are state agencies that also supply the state share of funding for the PBP incentive, there is no financial impact on AHCCCS for allowing Contractors to support PBP incentive payments above the level that AHCCCS will recognize as its contribution under ACOM 307. This approach allows more support and financial incentive for state agency providers meeting APM metrics.

Given the number of other changes that we are recommending in ACOM 307, Bailit Health is not proposing significant changes to AHCCCS' PBP policies. However, Contractors have suggested changes to future PBP policies including potential changes ranging from the treatment of PBP in Contractors' profit/loss reconciliations to requests to increase the PBP incentive payment above 0.75 percent of medical expense as defined in ACOM 307. We recommend that AHCCCS review feedback from Contractors and continue internal conversations, discussions with AHCCCS actuaries, and dialogues with Contractors regarding potential changes to PBP policies on or after CYE 24.

ACOM 307 Recommendations Related to Assessing Impact on Quality and Cost Effectiveness

To better assess and align Contractor APMs with AHCCCS priorities and across Contractors and to better understand the impact of APMs, Bailit Health recommends the State consider amending ACOM 307 to require Contractors to:

1. include a minimum number of performance measures from a state-defined menu(s) or a specific performance measure(s) in their APMs in order to count these APMs towards meeting the ACOM 307 targets;
2. participate in at least annual meetings with AHCCCS, ACOs, and larger providers, to discuss APM policies, results, opportunities for improvement and challenges to date;
3. develop and submit an APM Strategic Plan prior to January 1, 2023, generally describing the Contractor's APM approach for the next three years, including proposed annual percentage targets for provider payments within APMs by LAN APM categories, expected percentage of medical expenses to be paid out in PBPs, and an approach to identify quality measures to be included in APMs for the next three years; and
4. report and present annually to AHCCCS on APM results, potential modifications to Contractor's multi-year APM Strategic Plan, and challenges to date.

For example, in CYE23, AHCCCS could require ACC and ALTCS-EPD Contractors to include at least one applicable ACOM 306 measure in each applicable APM in order for the Contractor to count that contract towards its APM target. Prior to requiring Contractors to include one or more state-defined measures in APMs, we recommend that AHCCCS consult with Contractors

to explain and discuss the minimum requirements for measure alignment as part of ACOM 307. In addition, as AHCCCS has done with its selection of ACOM 306 measures, any state-defined measures incorporated into APM reporting requirements should be reflective of populations and services included in different AHCCCS plans that must comply with ACOM 307.

We also suggest that AHCCCS work with Contractors, providers, and stakeholders to increase transparency and alignment around aspects of how Contractors and ACOs are attributing AHCCCS members to providers participating in APMs and which quality measures and benchmarks are used in APMs. For example, Bailit Health recommends that AHCCCS share the attribution and assignment approaches used by the Targeted Investment program and encourage Contractors and ACOs to:

- review and amend primary care provider (PCP) assignment in relation to each member's utilized PCP provider group (TIN and/or facility) to reconcile assignment at least quarterly,
- allow PCPs and other providers participating in APMs to request clarifications and/or changes in their assigned/attributed members for certain circumstances as defined by the Contractor,
- honor and act on member requests to change their PCP, including promptly communicating with members letting them know if and when their assigned PCP has been changed or the reasons for which their assigned PCP was not changed, and
- work to align APM performance measures with NCQA technical specifications as noted in ACOM 306.

We recommend that AHCCCS review and refine its reporting templates to collect only the level of information that it needs and can utilize and focus on deliverables and conversations that provide better insight into APM results, including which types of APM approaches are successful at incentivizing improved performance at the provider level.

4.2 ACOM 306 Policy

4.2.1 Current AHCCCS Approach

AHCCCS' current ACOM 306 policy provides an opportunity for Contractors to earn incentives from the Quality Withhold. For CYE 2022, the Quality Withhold was equivalent to one percent of a Contractor's prospective gross capitation. As a reminder, ACC and ALTCS-EPD Contractors must meet qualifying APM requirements in ACOM 307 to qualify for an Earned Withhold and QMP Incentive payment in ACOM 306. AHCCCS has indicated that ACOM 306 may also apply to ACC-RBHA Contractors for members with an SMI designation, beginning on October 1, 2022.

There are two ways Contractors can currently earn incentives via ACOM 306 policy - the Earned Withhold and the QMP Incentive payment. AHCCCS uses a Combined Performance

Score to determine each Contractor's Earned Withhold and QMP Incentive payment. The Combined Performance Score is based on two factors:

1. **Performance Measure Score:** assesses a Contractor's performance relative to the Minimum Performance Standards by measure, which was equivalent to the NCQA Medicaid Mean beginning in October 2020.
2. **Performance Rank Score:** assesses a Contractor's performance relative to other Contractors' performance by measure.

Some ACC Contractors noted that the current ACOM 306 Performance Rank Score methodology creates challenges. First, Contractors outside the central geographic service area (GSA) have indicated that it is hard to perform well relative to Contractors in the central GSA due to their more rural population and lower baseline performance. Second, some Contractors shared that a rank-based methodology prioritizes competition over collaboration because it is a zero-sum game – one Contractor's incentive is contingent upon another Contractor's performance. Third, some Contractors noted that they do not know their potential incentives until after the end of the measurement year, as they cannot predict how well they will perform relative to others.

Under ACOM 306 today, the Combined Performance Score first determines payments based on the Contractors' Performance Measure Score. Allocation of any remaining Quality Withhold funds are then determined by AHCCCS using the Contractors' Performance Rank Score.

Contractors who earn their entire Earned Withhold can earn additional incentives by measure through the QMP Incentive, so long as the total incentive earned across measures does not exceed five percent of the Contractor's annual capitation. The QMP Incentive for each Contractor for each measure is equal to the Contractor's Combined Performance Score payment, which equals a Contractor's Performance Measure Score plus Performance Rank Score, minus the Contractor's Earned Withhold payment, which is the amount returned to a Contractor that cannot exceed its measure-specific Withhold.

There are separate performance measures for ACC Contractors and ALTCS-EPD Contractors. For each Contractor type, there are primary measures, which are intended to be used for the measurement year. There are also secondary measures, which may replace primary measures if there is a major change or extenuating circumstances that make performance for a primary measure no longer comparable to prior performance. Table 6 summarizes the performance measures for CY 2022 by Contractor type.

Table 6. ACOM 306 Measures for CY 2022 by Contractor Type

	Measures for ACC Contractors	Measures for ALTCS-EPD Contractors
Primary Measures	<ol style="list-style-type: none"> 1. Prenatal and Postpartum Care: Timeliness of Prenatal Care 2. Breast Cancer Screening 3. Well-Child Visits in the First 30 Months of Life: 15 Months 4. Child and Adolescent Well Care Visits 5. Follow-Up After Hospitalization for Mental Illness: 7 Day 	<ol style="list-style-type: none"> 1. Use of Opioids at High Dosage 2. Breast Cancer Screening 3. HbA1c Control for Patients with Diabetes: HbA1c Poor Control
Secondary Measures	<ol style="list-style-type: none"> 1. Use of Opioids at High Dosage 2. HbA1c Control for Patients with Diabetes: HbA1c Poor Control 3. Cervical Cancer Screening 4. Antidepressant Medication Management: Effective Acute Phase Treatment 5. Follow-Up After ED Visit for Mental Illness: 7 Day 	<ol style="list-style-type: none"> 1. Controlling High Blood Pressure

4.2.2 ACOM 306 Recommendations for CY 2023 and Beyond

We make five high-level, overall recommendations for changing policies in ACOM 306:

1. Modify ACOM 306 to more clearly incentivize all participating Contractors to achieve meaningful performance achievement (through Threshold and High-Performance Benchmarks) and improvement (through Improvement Benchmarks) for included measures.⁹

Rationale: The High-Performance Benchmark rewards the highest performers for providing high-quality care. The Threshold and Improvement Benchmarks provide an opportunity for lower performers to earn a portion of their Withhold as they make progress towards meeting the High-Performance Benchmark. Using this approach, Contractors that operate in rural areas may currently have lower performance on ACOM 306 measures and consequently have a more challenging time meeting the High-Performance Benchmarks have the ability to earn a portion of their Withhold by meeting the lower Threshold Benchmark and/or by demonstrating significant improvement based on its own prior performance.

⁹ Of note, it may not be feasible to calculate statistically significant improvement for all utilization measures (e.g., measures that use an observed-to-expected ratio or measures that use a rate per 1,000 member months).

2. Change the ACOM 306 methodology so that Contractors do not earn back a portion of their Withhold per measure if they do not meet the achievement and/or improvement benchmarks.

Rationale: Contractors should only be rewarded financially for achieving the High-Performance Benchmark, the Threshold Benchmark, and/or for demonstrating statistically significant improvement in performance.¹⁰

3. Use NCQA Medicaid MCO percentiles and consider historical AHCCCS Contractor performance when setting performance benchmarks.

Rationale: Percentile data provides more flexibility for AHCCCS when setting benchmarks and still allows AHCCCS to compare Arizona's performance to national or regional performance.

4. Ensure Contractors know what their ACOM 306 measures and benchmarks are prior to the start of the measurement year.

Rationale: Contractors must know what they are striving to achieve in advance of a measurement year. This helps motivate Contractors to establish meaningful and appropriate quality improvement initiatives.

5. Retain the concept of primary and secondary measures to account for potential challenges with primary measures.¹¹

Rationale: If a primary measure has a major change that makes performance no longer comparable to prior performance, AHCCCS could replace the measure with a secondary measure.

6. Do not apply ACOM 306 to ACC-RBHA Contractors for their members with an SMI designation for October 1, 2022.

Rationale: ACC-RBHA Contractors, for members with an SMI designation, provide coverage for a small population with unique health needs. AHCCCS should prioritize revisions to the current methodology for ACC, ACC-RBHA, and ALTCS-EPD Contractors before introducing a new policy for ACC-RBHA Contractors for members with an SMI designation. In the future, AHCCCS could consider developing a small set

¹⁰ Of note, it may not be feasible to calculate statistically significant improvement for all utilization measures (e.g., measures that use an observed-to-expected ratio or measures that use a rate per 1,000 member months).

¹¹ Of note, Bailit Health did not develop recommendations regarding performance measures that AHCCCS is utilizing for ACOM 306. Bailit Health advises that such measures have opportunity for improvement among AHCCCS Contractors and align with the state's health priorities and quality strategy.

of measures tailored to populations with medical and behavioral health needs to use with ACC- RBHA Contractors for members with an SMI designation.

If AHCCCS were to adopt Bailit Health's recommendations, as outlined below and presented in the example in Appendix B, the Quality Withhold would still be equivalent to one percent of a Contractor's prospective gross capitation. ACC, ACC-RBHA, and ALTCS-EPD Contractors would no longer need to meet APM requirements in ACOM 307 in order to earn quality Withhold and QMP incentives.

Under the proposed Bailit Health approach, Contractors would still be able to earn incentives in two ways – the Earned Combined Performance Score payment (which replaces the Earned Withhold) and the QMP Incentive payment which is calculated differently than the current ACOM 306 approach. The Earned Combined Performance Score for each measure is equal to a Contractor's Combined Performance Score (which is a maximum of one point per measure) multiplied by its measure-specific Withhold. The Combined Performance Score is based on two factors:

1. **Performance Achievement Score:** assesses a Contractor's performance relative to two benchmarks for each measure. Having two benchmarks can reward higher performing plans while also motivating lower performing plans to improve their performance to meet a higher standard for quality. This type of two-pronged approach is especially relevant for measures where there is a wide variation in performance among Contractors.

Each measure has one Threshold Benchmark and one High-Performance Benchmark across Contractors. Performance below the Threshold Benchmark equals zero points. Performance at or above the Threshold Benchmark but below the High-Performance Benchmark equals a half a point. Performance at or above the High-Performance Benchmark equals one point.

The benchmarks for each measure would vary based on Contractors' current performance relative to national or regional Medicaid MCO percentiles.¹² This approach of varying benchmarks based on how Contractor performance compares to national benchmarks ensures that benchmarks are intentionally set to motivate and reward meaningful quality improvement. Benchmarks would be based on the most recent available data at the time of establishing the benchmarks so that all benchmarks are

¹² For example, if there is a wide range of Contractor performance, the Threshold Benchmark may be set at the national 50th percentile while the High-Performance Benchmark may be set at the national 90th percentile. If there is a narrow range of Contractor performance, the Threshold Benchmark may be set at the national 50th percentile while the High-Performance Benchmark may be set at the national 66th percentile.

known prior to the start of the measurement year.¹³ Consistent with its ongoing efforts at transparency, we encourage AHCCCS to develop and share guidelines to inform Contractors how it will set Threshold and High-Performance Benchmarks prior to establishing the specific benchmarks for ACOM 306 measures.

2. **Performance Improvement Score:** assesses whether a Contractor demonstrated statistically significant improvement over baseline performance, which is typically the previous years' performance unless otherwise specified by the state. Using statistical significance rather than another approach for defining improvement, e.g., a fixed percentage point improvement, ensures that Contractors are rewarded for actual improvement and not random variation in performance due to chance.

Contractors are only eligible to earn points through the Performance Improvement Score if their Performance Achievement Score is either zero or half a point. Contractors who demonstrate statistically significant improvement earn half a point. We recommend weighting improvement as a portion of the achievement score to allow Contractors to receive credit for making meaningful progress on quality while still rewarding Contractors that achieve a high level of performance on quality measures.

Statistically significant improvement is defined using a Pearson chi-squared test, for measures where applicable and appropriate.

Contractors who demonstrated achievement or improvement by meeting the Threshold Benchmark, High-Performance Benchmark and/or Improvement Benchmark can earn additional incentives by measure through the QMP Incentive, so long as the total incentive earned across measures does not exceed five percent of the Contractor's annual capitation. The QMP Incentive Pool is calculated on a measure-specific basis and is equal to the measure-specific Withhold across Contractors minus the total Earned Combined Performance Score payments across Contractors. Similar to the current ACOM 306 approach, based on our recommended model, QMP Incentive payments would continue to be distributed by measure based on a Contractor's performance relative to other Contractors, weighted to reflect the size of the Contractor's contribution to the measure-specific Withhold. The proposed ACOM 306 approach which uses the simplified formulas below, attempts to make the calculation more transparent.

¹³ For example, AHCCCS may use NCQA data for CY 2021, released in October 2022, to set Threshold and High-Performance Benchmarks for assessing Contractor performance in CY 2023 in late fall or early winter of 2022. While AHCCCS can provide insights into how it will set benchmarks, it is unlikely to be able to provide Contractors with specific benchmarks more than two months in advance of the measurement year given the timing of when NCQA releases annual reports on Medicaid managed care performance data.

$$QMP\ Incentive\ Weight = \frac{Contractor's\ Rate}{Sum\ of\ all\ Rates} \times \frac{Contractor's\ Measure - specific\ Withhold}{Total\ Measure - specific\ Withhold}$$

$$QMP\ Incentive = \frac{QMP\ Incentive\ Pool}{Total\ QMP\ Incentive\ Weights} \times Contractor's\ QMP\ Incentive\ Weight$$

Finally, we recommend that the ACOM 306 measures for ACC, ACC-RBHA, and ALTCS-EPD Contractors for CY 2023 largely remain the same as those included for CY 2022. For CY 2023, or over time, AHCCCS could consider adding utilization-focused measures to ACOM 306 such as *Plan All-Cause Readmissions* (stewarded by NCQA) and/or *Potentially Avoidable ED Visits* (stewarded by NYU)¹⁴. Of note, it may not be feasible to calculate statistically significant improvement for utilization measures (e.g., *Plan All-Cause Readmissions* calculates an observed-to-expected ratio rather than a percentage rate, while other utilization measures calculate rates per 1,000 member months). Furthermore, AHCCCS should continue to identify a set of secondary measures in case one or more of the primary measures are no longer appropriate to use in ACOM 306. AHCCCS should have processes to (a) annually assess measures to ensure there is sufficient opportunity for improvement and (b) retire measures as needed.¹⁵

4.3 Health Equity

4.3.1 Current AHCCCS Approach

AHCCCS currently does not have health equity requirements as part of ACOM 306, although AHCCCS does have several health equity initiatives, (e.g., Whole Person Care Initiative, Health Equity Committee, etc.). AHCCCS initially proposed revising ACOM 306 to include a component of the Contractors' one percent Withhold be based on health equity activities beginning for CYE 2021, but deferred adoption of this strategy due to the COVID-19 Public Health Emergency and Contractor concerns related to data availability.

4.3.2 Health Equity Recommendations for CY 2023 and Beyond

Bailit Health's recommendations related to health equity for ACOM 306 aim to gradually (a) improve the collection and accuracy of enrollees' health equity data, (b) identify and understand health disparities related to select performance measures, and (c) reduce health disparities among AHCCCS enrollees. We recommend introducing health equity activities in a stepwise fashion.

¹⁴ This utilization measure developed by NYU, however, is not in the CMS Medicaid Adult and Child Core Sets.

¹⁵ AHCCCS could use the Buying Value suite of resources to develop a set of criteria to inform measure selection and retention over time. The Buying Value Measure Selection Tool is also a useful resource to track measure status and rationale for measure inclusion or exclusion over time. For more information, see: <http://www.buyingvalue.org/resources/toolkit/>.

Beginning in CY 2023 or later

1. Work internally and with Contractors to improve the collection and accuracy of race, ethnicity, and language (REL) data.

Rationale: There are many entities in Arizona that are striving to improve the collection and accuracy of REL data, including AHCCCS, Contractors, and provider organizations. We are aware that AHCCCS is exploring several efforts to improve its REL data, including:

- a. updating the Medicaid enrollment process to improve member response rate,
- b. supplementing REL information with other databases, and
- c. establishing bidirectional data sharing with other sources.

Over time, AHCCCS can add to these efforts by encouraging all Contractors to supplement enrollment data in certain circumstances as defined by AHCCCS if the Contractor has more recent or more complete REL data for their enrollees. Establishing bidirectional sharing for REL data can significantly improve the collection and accuracy of these data.

2. Consider requiring Contractors to analyze and report stratified performance on select performance measures by demographic groups (e.g., race/ethnicity, disability status) as directed by AHCCCS based on demographic enrollee data for which AHCCCS has determined that there is more complete and accurate data.

Rationale: The first step in identifying and understanding disparities is to begin stratifying measure performance by health equity variables. We recommend that AHCCCS consider starting by using stratified performance data. For example, for *Child and Adolescent Well Care Visits* and *Prenatal and Postpartum Care*, Contractors are required to stratify results for NCQA for CY 2022. AHCCCS could consult these data to inform how it will approach stratification requirements for other measures in the future.

AHCCCS could also, or alternatively, direct Contractors to begin to stratify performance on select measures using the race/ethnicity data they have available. AHCCCS could consider adding additional stratifications, such as disability status, language, and geography, based on Contractor capacity and data availability and reliability.

AHCCCS can require Contractors to report stratified performance on select measures while it simultaneously works to improve the completeness and accuracy of demographic data, as it may take time for Contractors to build the capacity to report stratified performance.

3. Consider reporting comparative disparity findings on select measures to Contractors to provide more transparency on AHCCCS program-wide disparity findings and Contractor-level disparity findings based on demographic enrollee data for which AHCCCS has more complete and accurate data.

Rationale: Increased transparency of this type of disparity data will help AHCCCS and Contractors better understand the disparities and potential approaches to work collaboratively to improve demographic data and to reduce disparities. In addition, if Contractors know their stratified performance will be reported, they may be more likely to ensure their data are accurate. Further, Contractors may be more likely to supplement AHCCCS' health equity data with additional member data (e.g., obtained through member self-reporting to Contractors, and/or sharing of health equity data with provider organizations).

We recommend that AHCCCS take the following precautions when reporting performance:

- a. Indicate the level of confidence in the health equity data used to stratify performance, as Contractors with more complete health equity data may highlight more disparities than Contractors that have less complete health equity data that effectively hide disparities.
- b. Contextualize performance so as to not imply select populations are responsible for poor health outcomes, or discourage others from using performance to restrict access to care for select populations. For example, when reporting performance for select populations, it is important to highlight external factors that contribute to poor health outcomes (e.g., high diabetes rates could be a result of poor access to healthy foods or safe spaces to exercise).
- c. Adhere to commonly accepted measurement principles when stratifying performance. For example, do not report performance for stratifications with inadequate denominator size.
- d. Delay public reporting of stratified performance until there is a high level of confidence in the health equity data used to stratify performance. In the interim, report performance within AHCCCS and to Contractors.

Beginning for CY 2025 or later

4. Consider gradually working towards allocating ten percent of each Contractor's Withhold to reducing health disparities. In this example, over time, a Contractor would be able to earn 90 percent of the annual Withhold based on its performance on quality measures and ten percent of the annual Withhold based on measures designed to reduce health disparities.

Rationale: AHCCCS initially proposed allocating half of each Contractor's Withhold to reduce health disparities prior to the COVID-19 Public Health Emergency. We recommend gradually introducing the health equity component to the Withhold so that Contractors can gain experience with identifying, understanding, and then reducing disparities.

For example, AHCCCS could begin by allocating five or ten percent of each Contractor's Withhold (e.g., 0.05 to 0.1 percent of medical expenses) to a pay-for-reporting measure that requires Contractors that report performance for ACOM 306 measures stratified using

demographic data (e.g., race/ethnicity, language, disability status). Once a baseline is established, AHCCCS could allocate five or ten percent of each Contractor's Withhold to a pay-for-performance measure that requires Contractors to reduce the disparity in performance for two or more subpopulations (e.g., a ten percent reduction in the gap in measure performance for the English-speaking and non-English-speaking population). The remaining 90 to 95 percent of each Contractor's Withhold could continue to be allocated using Bailit Health's proposed approach with the Combined Performance Score and QMP Incentive methodology described previously.

5 Conclusion

AHCCCS has been a leader among states in requiring its Contractors to move to APMs and incentivize providers to improve care. The recommended policy changes to ACOM 307 are centered on a phased approach to refining the State's policies to place more focus on APMs and Contractor incentives that are aimed at meaningful improvement in quality and cost-effectiveness rather than attaining specific financial targets related to the percentage of provider contractual payments that include at least some APM approach. Throughout our work, Bailit Health specifically focused on recommended approaches and changes that consider and do not unduly strain State, Contractor, or provider resources. In addition, we recommend a number of changes to AHCCCS' ACOM 306 policy to more clearly incentivize Contractor improvement on state-defined quality performance measures, and over time to incentivize a better understanding of health disparities and ultimately some reductions in disparities in an effort to promote health equity for AHCCCS enrollees.

Appendix A: Contractor and Provider Organization Stakeholder Meeting Participants

Contractors

- Arizona Complete Health
- Banner Univ. Family Care
- Care1st
- Health Choice Arizona
- Mercy Care
- Molina Complete Care
- UnitedHealthcare Community Plan
- Comprehensive Health Plan
- Division of Developmental Disabilities (DDD)

Provider Organizations

- AZ Alliance for Community Health Centers
- AZ Care Network
- AZ Community Physicians
- AZ Council of Human Service Providers
- AZ Hospital and Healthcare Association
- Bandera Healthcare (Ensign AZ affiliates)
- Banner Health Network
- Callie Pediatrics
- Children's Clinics
- Cigna Medical Group
- Community Bridges, Inc.
- COPA
- COPE Community Services
- Crisis Preparation and Recovery
- Devoted Guardians
- El Rio Health
- Health System Alliance of AZ
- Horizon Health and Wellness
- Innovation Care Partners
- Intermountain Centers
- JFCS
- Mariposa Community Health Center
- Mountain Park Health Center
- Northern AZ Health Care
- North Country HealthCare
- OptumCare AZ
- Phoenix Children's Care Network
- PopHealthCare
- QPoint (Equality Health)
- Southwest Behavioral and Health Services
- Spectrum Healthcare Group
- Steward Health
- Tucson Medical Center
- Valleywise Health
- VBCare Network

Appendix B: Example of Bailit Health's Proposed ACOM 306 Model

An illustrative example of Bailit Health's proposed methodology for ACOM 306 follows on the next page.

Illustrative Example of Bailit Health's Proposed Methodology for ACOM 306 for CY 2023

The values contained in this spreadsheet are illustrative only and do not reflect real Contractor capitations or measure performance.

Withhold %	1%	
Plan	Total Capitation	\$ Withhold
Plan A	\$ 1,800,000,000.00	\$ 18,000,000.00
Plan B	\$ 900,000,000.00	\$ 9,000,000.00
Plan C	\$ 725,000,000.00	\$ 7,250,000.00
Plan D	\$ 550,000,000.00	\$ 5,500,000.00
Plan E	\$ 240,000,000.00	\$ 2,400,000.00
Plan F	\$ 450,000,000.00	\$ 4,500,000.00
Plan G	\$ 1,300,000,000.00	\$ 13,000,000.00
Line of Business Total	\$ 5,965,000,000.00	\$ 59,650,000.00

Points Associated with Achievement and Improvement Benchmarks (BM)	
Criteria	Points
Performance above or equal to High-Performance BM	1.0
Performance above or equal to Threshold BM but less than High-Performance BM	0.5
Performance below the Threshold BM	0.0
Statistically significant improvement	0.5
No improvement	0.0

Annual Dental Visits (ADV): 2-21 years *Higher is Better*

Percent of Withhold	15%												
Plan	2019 Rate	Performance Achievement Score	2018 Rate	Rate Δ	p-value*	Performance Improvement Score	Combined Performance Score	Measure-Specific Withhold	Measure-Specific Earned CPS	Rank	QMP Incentive Weights	Measure-Specific QMP Incentive	Measure-Specific Earned Incentive
Plan A	59.3%	0.5	58.9%	0.4%	0.08	0.0	0.5	\$ 2,700,000.00	\$ 1,350,000.00	3	0.044	\$ 730,919.41	\$ 2,080,919.41
Plan B	58.3%	0.5	54.5%	3.8%	0.00	0.5	1.0	\$ 1,350,000.00	\$ 1,350,000.00	5	0.022	\$ 359,296.81	\$ 1,709,296.81
Plan C	54.9%	0.0	54.0%	0.9%	0.00	0.5	0.5	\$ 1,087,500.00	\$ 543,750.00	7	0.016	\$ 272,554.06	\$ 816,304.06
Plan D	61.4%	1.0	61.7%	-0.3%	N/A	N/A	1.0	\$ 825,000.00	\$ 825,000.00	1	0.014	\$ 231,245.54	\$ 1,056,245.54
Plan E	55.0%	0.5	N/A	N/A	N/A	N/A	0.5	\$ 360,000.00	\$ 180,000.00	6	0.005	\$ 90,389.13	\$ 270,389.13
Plan F	58.5%	0.5	58.0%	0.5%	0.13	0.0	0.5	\$ 675,000.00	\$ 337,500.00	4	0.011	\$ 180,264.69	\$ 517,764.69
Plan G	61.4%	1.0	64.1%	-2.7%	N/A	N/A	1.0	\$ 1,950,000.00	\$ 1,950,000.00	1	0.033	\$ 546,580.36	\$ 2,496,580.36
Line of Business Total	58.4%		58.5%					\$ 8,947,500.00	\$ 6,536,250.00			\$ 2,411,250.00	\$ 8,947,500.00
Threshold Benchmark**	55.0%												
High-Performance Benchmark**	60.0%												
Minimum Denominator Size	30												

*The p-value is calculated using a Pearson Chi Squared statistical test.

**Moving forward, these absolute percent values would be based on national or regional NCQA Medicaid MCO percentiles.