
**Arizona Response to the Centers for Medicare and Medicaid Services
Center for Medicare and Medicaid Innovation Request for Information:
Innovation Center New Direction**

Introduction

Arizona appreciates the opportunity to provide comments in response to the Centers for Medicare and Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (Innovation Center) Request for Information (RFI) on market-driven reform concepts that promote patient-centered care, increase choices and competition, reduce costs, and improve outcomes. The need to create new advanced Alternative Payment Models (APMs) is incredibly difficult and important work that must be a priority to advance our shared goal of a sustainable health care delivery system.

Arizona's Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS), has long been a leader in innovation, serving its 1.92 million members through the creative and effective use of managed care delivery systems. Since its inception in 1982, AHCCCS has been a mandatory managed care state, except for its American Indian population, and has employed innovative approaches to health care delivery and payment systems. With a model based on competition and member choice, Arizona has frequently been a pioneer in testing health care policies and financing strategies, continuously seeking to improve health care outcomes while containing costs.

It is well-recognized that the misaligned incentives of a fee-for-service (FFS) payment model, which rewards volume over value, result in reimbursements that often fail to deliver either high-quality or cost-effective care for beneficiaries. Recognizing this, many states have made significant investments in designing health care delivery systems to move providers away from traditional FFS payments to alternative payment models (APMs) that reward value. These state-led transformation efforts are happening in different ways, at different paces, and according to the specific needs and characteristics of each state's population. Additionally, it is also critical to recognize that Managed Care Organizations (MCOs) and provider organizations have invested enormous amounts of resources to develop and support APMs.

Medicaid is the nation's largest insurer, covering more than 70 million people. As co-financers of the Medicaid program, states are uniquely positioned as equity partners with CMS in setting a course for a value-driven health care system. AHCCCS supports the Innovation Center's mission to design and test new models of health care delivery and payment that have the potential to reduce costs while maintaining or improving the quality of care in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). In particular, AHCCCS urges CMS to leverage its unique and powerful role to continue building states' capacity to lead the movement towards a value-based health care system.

AHCCCS's Value-Based Purchasing Journey

For the past several years, AHCCCS has supported a market-based approach that incentivizes payers and providers to establish new value-based arrangements that align incentives to improve efficiency and member outcomes. When it first began these efforts, AHCCCS recognized that contracted MCOs and providers were well-positioned to create new payment models, rather than having these methods dictated by the State. To support this private-sector innovation, AHCCCS established broad value-based goals for the system and allowed its MCOs to advance APMs to best meet the needs of their own unique populations, provider mix, and geographic regions. As detailed in the table below, AHCCCS established these multi-year goals by various lines of business, recognizing the differing levels of provider maturity and transition time needed within each program.

AHCCCS Contractor Value-Based Purchasing Requirements

Program	CYE 15	CYE 16	CYE 17	CYE 18	CYE 19
Acute	10%	20%	35%	50%	50%
Integrated LTSS, Medical and Behavioral Health for Elderly & Phys. Disabled	5%	15%	25%	35%	50%
Behavioral Health	-	5%	15%	25%	35%

AHCCCS has also moved to align with the CMS Healthcare Payment Learning and Action Network (LAN) APM Framework by establishing expectations for contractors to move an increasing portion of their APMs to Categories 3 and 4 of the Framework.

Examples of VBPs implemented by AHCCCS contractors under this market-based model include:

- Total cost of care models that incentivize primary care providers to manage costs and improve overall outcomes.
- Leveraging bundled payments for lower-extremity joint replacements and expanding to cardiac bundles.
- Home- and Community-Based Services incentive payments predicated on total cost of care and quality measures.

Lessons Learned and Success Stories

Over the past several years that AHCCCS has been engaged in this work, it has learned many important lessons, a few of which we will highlight here because we believe they are critical for CMS to consider. First, this is really difficult work that requires committed leadership. We can unequivocally say that strong leadership makes a significant difference in both the pace and success of implementation. Second, moving to new models requires plans and providers to make substantial investments in infrastructure. From a business perspective, plans and

providers must see the value in moving to value. Third, this leadership and investment has created substantial momentum in the delivery system to take on new payment structures. Fourth, there are statutory and regulatory limitations to some models that CMS should recognize and examine. For example, required cost-based models like the Prospective Payment System for Federally Qualified Health Centers are a major impediment to new payment models.

A critical element of AHCCCS's success in this area has been our efforts to engage a wide variety of stakeholders on the development of value-based requirements. AHCCCS has consulted with all the major providers and provider groups, large delivery systems and Medicaid MCOs across the state in its design and implementation of value-based models. All AHCCCS policies include a public comment period, allowing these same stakeholders as well as the broader community to inform the establishment of our requirements. This stakeholder engagement has been invaluable in building support for the AHCCCS approach. It also ensured the mandatory levels of value-based reimbursement reflected realistic expectations for providers that were achievable but also moved the system forward towards value.

Moving to reimbursing for value is an incremental process. For every success, payers find other models did not produce expected results. But as payers become more mature, they can identify which models work and determine how to replicate and scale them. As the Innovation Center recognized in its 2016 *Report to Congress*, evaluating success takes years of data.¹ However, some early results are promising and should be both celebrated and monitored as they are brought to scale.

As the Innovation Center notes in its 2016 Report to Congress:

To date, two CMS Innovation Center models have met the statutory criteria to be eligible for expansion by reducing program spending while preserving or enhancing quality—the Pioneer Accountable Care Organization (ACO) Model and the Diabetes Prevention Program (DPP) Model. The Pioneer ACO Model generated more than \$384 million in savings to Medicare over its first two years—an average of approximately \$300 per participating beneficiary per year. Meanwhile, the DPP model has saved Medicare an estimated \$2,650 per beneficiary over a 15-month period, which covered program costs and helped participants lose an average of 5 percent of their body weight to significantly reduce their risk of developing diabetes.²

Arizona has participating providers in both the above efforts. Banner Health Network was a Pioneer ACO in Arizona that demonstrated annual savings ranging from \$15 million to \$35 million between 2012 and 2016 while maintaining high quality for its members.³ Arizona YMCAs participated in the DPP and the CMS Office of the Actuary noted the program's success

¹ Centers for Medicare and Medicaid Services, Center for Medicare and Medicaid Innovation, *Report to Congress*, December 2016.

² *ibid.*

³ <https://innovation.cms.gov/initiatives/Pioneer-aco-model/>

in helping participants lose weight and reduce the incidence of diabetes without increasing the overall costs of the program.⁴

AHCCCS also has early examples of success. The managed care organization responsible for services to individuals with serious mental illness established an APM with three Forensic Assertive Community Treatment (FACT) teams. These FACT teams are responsible for care for among the most complex members in the program who also require engagement on a variety of social determinants of health. Over an approximately two-year period, these teams produced the following results:

- ↓ 31% reduction in psychiatric hospital admissions.
- ↓ 18% reduction in the members using the Emergency Department.
- ↓ 19% reduction in the number of members experiencing homelessness.
- ↓ 76% reduction in the number of jail bookings.
- ↑ 84% increase in the percent of members who saw a medical provider at least once per year.

AHCCCS RFI Comments

AHCCCS broadly supports the principles and strategies laid out by the Innovation Center. Our comments focus on two main areas: 1) CMS must leverage its purchasing power to drive delivery system change; and 2) CMS should continue and enhance opportunities to improve integrated care for dual eligibles.

CMS Must Leverage Its Influence to Lead on Value

In its RFI, the Innovation Center outlined its Guiding Principles, which include competition and choice, as well as transparency and a patient-centered focus. As mentioned above, the AHCCCS program was built on a firm foundation of competition and choice. AHCCCS also supports the other principles that CMS has outlined. Its focus on reducing the administrative burden and unnecessary regulations is critical to assure ongoing participation by providers, both in value-based models and in the Medicaid program as a whole. However, AHCCCS strongly believes that the Innovation Center must establish an additional Guiding Principle: *As the largest health care coverage programs in the country, Medicaid and Medicare must mandate and drive the change.*

For the healthcare system be sustainable, it must move from a system predicated on quantity to one based on quality. This ultimately means that the way we pay for services must change. Providers and payers will not move into a new world of value-based payments through voluntary small pilots. The FFS system has too many misaligned economic incentives to expect change without making value-based models more attractive than traditional, volume-based reimbursement methods. To fulfill their fiduciary responsibility to taxpayers, public programs must establish required reimbursement mechanisms that ensure member access to care but reward quality over quantity.

⁴ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/Diabetes-Prevention-Certification-2016-03-14.pdf>

Payers and providers have spent considerable resources over the past several years developing infrastructure and new systems to support the drive toward APMs. Without clearly articulated and mandatory requirements and expectations from the largest payers in the country, it will be difficult for these systems to justify ongoing support of this new infrastructure. Medicare and Medicaid have led the way in many markets across the country. If they fail to provide that leadership moving forward, there will be significant retrenchment in the levels of infrastructure, commitment and maturity of APMs. This is a critical juncture on the journey to value-based reimbursement. If CMS pulls back and limits its efforts to small volunteer pilots, other payers will likely end up following.

Promise of Multi-Payer Initiatives

CMS should be mindful of the critical role that the current authority has played in the successful launch of demonstrations that align services for those eligible for both Medicare and Medicaid (“duals” or “dual eligibles”). With almost 11 million duals nationally, it is critical that CMS and states work together to develop new systems of care that will better meet the complex needs of dual eligibles.

The creation of the Office of Medicare and Medicaid in combination with the authority provided to the Innovation Center has not only resulted in new models of care, but also documented the incredible opportunity to improve outcomes and bend the cost curve. The third-party evaluations for Minnesota and Washington validate the great promise these new models hold for a very complex population stuck in an incredibly hard-to-navigate, fragmented system. These third-party evaluations not only documented improved outcomes but also significantly lower hospitalization and readmission rates for members in aligned models of care.

CMS must make efforts to bring these models to scale. Previous initiatives have been too restrictive and reached only a limited segment of the population. From January 2006 to May 2017, enrollment in Dual Special Needs Plans (D-SNP) increased from just over 400,000 to almost 2 million. Enrollment in Duals Demonstration plans began in 2013 and has provided another approximately 400,000 members the opportunity to receive aligned Medicare and Medicaid benefits.⁵ While this growth is encouraging, over 80% of the duals population nationally is still unaligned in a very fragmented system (with different entities responsible for their Medicare and Medicaid benefits). Similar to the efforts with the Innovation Accelerator Program, CMS should dedicate resources that serve as start-up capital for states to create the infrastructure necessary to develop better systems of care for duals.

As the use of managed long term services and supports continues to grow significantly in Medicaid, there is a unique opportunity for states to develop a strategy for incorporating Medicare benefits into an aligned structure. AHCCCS has developed strategies to encourage alignment by assigning dual members to Medicaid plans aligned with their Medicare plan. In

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http://www.integratedcareresourcecenter.com/PDFs/ICRC_Growing_Enrollment_in_Integrated_Managed_Care_Plans_FINAL_6-01-17.pdf

addition, AHCCCS requires its Medicaid plans to offer D-SNPs and has established value-based requirements for the LTSS D-SNP population, requiring an increasing percentage of that population's spend to be in a value-based arrangement each year.⁶ However, states must have the opportunity to partner with CMS to do more.

While there are efforts by other organizations like the Center for Health Care Strategies and the National Association of Medicaid Directors to support states with these efforts, CMS, through the Innovation Center and the Office of Medicare and Medicaid, needs to continue and strengthen the partnership with states and dedicate even more resources to creating new systems of care for duals.

In conclusion, we appreciate the opportunity to provide our perspective to CMS and are happy to answer any questions on these comments as well as provide additional information on any of the programs we mentioned. Our experience over the past few years demonstrates the need for both collaboration and leadership from both CMS and states and we look forward to continued partnership and dialogue.

⁶ 15% in Contract Year Ending (CYE) 16, 25% in CYE 17, increasing to an estimated 70% in CYE 21.