

STATE OF ARIZONA APPLICATION FOR STATE DEMONSTRATION CONTRACT TO INTEGRATE CARE FOR DUAL ELIGIBLE INDIVIDUALS

L-2 PROPOSAL INSTRUCTIONS

To be considered for a contract, states are asked to provide the following information (not to exceed eight to 10 (8-10) pages):

- 1. High level description of the state's proposed approach to integrating care: In addition to information on the target population, covered benefits, and proposed service delivery system, the description should also contain an explicit problem statement that describes the current coverage and payment policy, and how or why changes to current policy would lead to improvements in access and quality as well reductions in Medicare and Medicaid expenditures over time. It should also describe the policy rationale for the proposal, who will benefit and why, and any previous experience with the intervention/model proposed in the demonstration.**

Background

The Arizona Health Care Cost Containment System (AHCCCS) is the Arizona Medicaid Program. Since the inception of the program in 1982, AHCCCS has operated as a mandatory managed care program under an 1115 Research and Demonstration Waiver. All AHCCCS populations, including individuals in the Long Term Care program, are included in managed care. This model has proven effective in delivering high quality care while controlling costs and, at the same time, preserving member and provider satisfaction. Currently, over 70% of the elderly and physically disabled long term care members reside in the community, while 99% of the developmentally disabled long term members reside in the community. AHCCCS Acute Care Program clinical performance measures meet or exceed the National HEDIS Medicaid Mean. The annual per member per month (PMPM) rates are among the lowest in the country.

Current Approach to Integration of Care for Dual Eligible Individuals

For some time AHCCCS has recognized the problems experienced by dual eligible individuals. These well-documented problems are most certainly the result of a fragmented health care funding and delivery system as well as excessive Medicaid and Medicare costs.

AHCCCS initially approached CMS in 1996 regarding integration of dual eligible individuals into the State's managed care program. When MIPPA became law in 2004, AHCCCS and its contracted health plans explored new options for integrating care for dual eligible members. AHCCCS contracted with Mercer Consulting to compare Medicare Advantage requirements to AHCCCS requirements. Additionally, AHCCCS sought and received technical assistance from CMS Region IX Medicare Managed Care staff. At the end of these activities, six of 18 AHCCCS Managed Care contractors became Medicare Advantage plans. Four of them became Special Needs Plans, effective January 1, 2006.

Challenges

After four years experience contracting with both Medicaid and Medicare, and integrating care under current regulatory authority, AHCCCS contractors have identified significant challenges. From a business perspective, the continuance of this model is unsustainable. Because AHCCCS

desires to maintain, as well as increase, the number of dual eligibles receiving both Medicaid and Medicare benefits from a single plan, it proposes to collaborate with CMS to overcome the challenges contractors face dealing with two regulators.

The challenges faced by the contractors fall into 4 basic categories:

1. Misalignment of administrative requirements between Medicare and Medicaid:

- Grievance and Appeals
- Prior Authorization
- Lack of authority from CMS to apply managed care techniques for duals (i.e. no authority to “lock” members to one pharmacy when drug seeking patterns are identified)
- Risk Adjustment (i.e. administrative processes; annual recoding; recipient accessibility)
- HEDIS
- CAHPS
- Encounter reporting
- Member education and communications (handbooks, provider directories, etc.)

2. Operating costs of Special Needs Plans v. Non Special Needs Plans and the belief these differences are not adequately funded by CMS

- Individualized care plans
- Initial and ongoing health risk assessments
- Model of Care requirements
- NCQA approval and annual submission of SNP proposals
- Compliance with submission of Structure and Process Measures
- SNP specific HEDIS reporting
- Care Coordination expectations
- Medicaid eligibility verification

3. CMS rate setting process

- HCCs (risk adjustment factors) must be coded and reported annually. If the HCC is not reported annually, there is no financial adjustment, even if the member still has the same condition/diagnosis. For dual SNPs, this requirement presents additional financial and resource challenges/requirements as dual SNPs must:
 - Expend additional resources attempting to locate the members and get them into their providers.
 - Employ multiple touch points and follow up initiatives
 - Recode and report annually. The percentage of members in a dual SNP plan with multiple conditions is greater than that in a traditional Medicare Advantage plan, creating a disproportionate share of members that must be recoded annually. The Plans technically do not report the codes. Rather, providers must report the correct diagnosis codes for each member. If providers do not report these conditions each year, Plans must expend additional resources to get members into their providers and/or conduct chart reviews to ensure providers coded claims correctly.
- The basic Medicaid demographic risk adjustment factor is intended to account for the social costs and utilization patterns associated with the Medicaid population (ex.-more frequent use of OP Clinics & ER vs. PCP, large SMI population, etc.), however, it does not currently take into account the difference in administrative requirements imposed specifically on dual SNPs that are not required of non-SNP plans.

4. Future CMS activities regarding rates:

- The benchmarks (base rates), excluding the impact of STARS, will be reduced by as much as 10.2% (Maricopa County) over the 2-6 year phase in period. The percent

reduction and phase in period is dependent upon county. This means, even if the plans can manage medical trend to the CMS growth rate, there will be material reductions to current margin levels.

- STAR Bonus Payment Calculations - beginning in 2012, base rates will decrease and it is expected that bonus payments from STAR ratings will help offset these losses and reward plans with higher quality. However, since dual SNP STAR ratings are calculated using the same methodology as traditional Medicare Advantage (MA) plans, there is concern that dual SNPs will be significantly disadvantaged because the methodology does not take into account the uniqueness of dual SNP members, thereby impacting the sustainability of dual products in the future.

Description of Proposed Approach

AHCCCS proposes to work with CMS and all stakeholders to implement a managed care program for dual eligible members in Arizona that comports with the requirements of the Arizona State Plan and 1115 waiver requirements, including:

1. Mandatory enrollment of dual eligibles in AHCCCS contracted managed care organizations, with the exception of those who have previously enrolled in a non-AHCCCS contracted MA plan and American Indians. Opt out and annual choice of Plan would also be dictated by the AHCCCS program rules.
2. All benefits, Medicare and Medicaid would be provided by the single contractor.
3. AHCCCS would be the single regulatory authority over the contractors.
4. Medicare would capitate the contractors directly (the state is not seeking direct payment).

When a single health plan assumes the management of both benefits, the recipient is relieved of coordination issues and benefits from integration of care. The managing health plan, on the other hand, must assume the challenges relinquished by the recipient. A managed care program for dual-eligible members that comports with the requirements of the Arizona State Plan and 1115 Waiver requirements could respond to these challenges.

2. **Overview of state capacity and infrastructure to design, develop and implement the proposed model: The overview should include key state staff by area and the expected use of any external consultants/contractors.**

Because AHCCCS has operated a managed care program since its inception, the agency has built significant infrastructure and expertise around managing contractors. The Division of Health Care Management within AHCCCS is responsible for contract procurement and ongoing oversight. The Division includes:

- Actuarial Services – sets capitation rates.
- Finance Unit – monitors financial solvency
- Operations – monitors member services, network development and management,
- Data Analysis and Research
- Clinical Quality Management
- Medical Management

3. **Description of current analytic capacity: The description should include whether the state has access to Medicare data and, if so, whether the Medicare and Medicaid data are linked and have been analyzed. If the state does not currently have access to Medicare data, the description should include plans to access, link and analyze the linked data set. In addition, states with managed care programs should address**

how encounter claims data are or are not being included in the linked data set and resulting analysis.

AHCCCS has significant data analytic capacity. We implemented and have been using an EDS data warehouse since 2005. We are able to readily match, retrieve and use data for analysis.

Currently AHCCCS has complete Medicare utilization data for dual eligible members who are both Medicare and Medicaid fee-for-service (COBA process). However, we have incomplete Medicare data for dual eligible members enrolled in:

- Medicaid FFS/Medicare Advantage
- Medicaid Managed Care/Medicare FFS
- Medicaid Managed Care/Medicare Advantage

We are currently dependent upon the provider for information. Part of this contract would allow the State to develop a plan and process to obtain Medicare encounter data and link it to AHCCCS data analyses tools to more effectively analyze the population and set rates.

4. Summary of stakeholder environment. The summary should include any current or planned stakeholder engagement efforts and/or discussions with potential providers, health plans, PACE, or other delivery system partners.

Because integration of care has occurred through existing mechanisms, AHCCCS has not engaged the dual eligible members regarding integration of care via a single health plan. Rather we have simply created an opportunity for which they may or may not avail themselves. This is an area requiring significant effort. Should AHCCCS be awarded a contract as a result of this opportunity, it would fund significant outreach in order to educate and seek feed-back from dual eligibles, their representatives, and professional advocates. Based on past experience, we would expect some support and some resistance from the members and their advocates.

AHCCCS has enjoyed a long and robust relationship with Health Services Advisory Group (HSAG), the Medicare Quality Improvement organization for Arizona. We have completed joint projects in the past that have improved access to care for dual eligible members. HSAG is committed to working with AHCCCS to implement an integrated program that meets the needs of members.

While AHCCCS contractors have been intimately involved in and provided feedback on integration efforts, we will need to engage and seek input from non-AHCCCS-contracted Medicare Advantage (MA) plans as well.

While specific feedback has not been sought from the provider community, unsolicited comments indicate that providers are pleased with the single health plan, which creates administrative efficiencies for them in regards to prior authorization and claims payment. The only provider group to express dissatisfaction with the current model is the nursing home industry. The industry, as a whole, has experienced a reduction in Part A revenue for members enrolled in MA plans, and they prefer members receive care through traditional Medicare.

AHCCCS must engage dual eligible individuals as well as their representatives and advocates, the provider community, and AHCCCS-contracted and non-contracted health plans. A large portion of the contract funds would be directed toward this effort.

5. Timeframe: States should provide expected target implementation date, including whether any legislative authority is required.

AHCCCS would implement the planning process immediately upon award of contract. AHCCCS would divide the planning process into three areas: 1) Stakeholder participation and engagement; 2) Review of data analytics and information and technology needs; 3) Consideration of policy structures and potential need for legislative authority. These functions would be undertaken in parallel tracks over the period of 12 months.

6. Budget and use of funds: Please provide a budget outlining the requested amount (up to \$1 million) and use of funding to support the design costs (e.g., staffing, travel, analytic or actuarial support, etc.) associated with designing the demonstration model.

In Section Five (5) AHCCCS identified three planning areas: Stakeholder participation; Data analytics; and Policy structures. Because of the significant time and resource commitment required for each of the three planning areas, one-third of the funding (\$333,000) would be dedicated to each.

Budget Presentation

Expenditure	Amount
Stakeholder/Consumer Engagement	\$333,000
Data Analytics	\$333,000
Policy Structures	\$333,000
Total Request	\$1,000,000