

Financial Models to Support State Efforts to Coordinate Care for Medicare-Medicaid Enrollees

Demonstration Proposal

Arizona

Summary: In July 2011, CMS released a State Medicaid Directors' letter regarding two new models CMS will test for States to better align the financing of the Medicare and Medicaid programs, and integrate primary, acute, behavioral health and long term supports and services for Medicare-Medicaid enrollees. These two models include:

- **Capitated Model:** A State, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care.
- **Managed Fee-for-Service Model:** A State and CMS enter into an agreement by which the State would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.

To participate, States must demonstrate their ability to meet or exceed certain CMS established standards and conditions in either/both of these models. These standards and conditions include factors such as beneficiary protections, stakeholder engagement, and network adequacy among others. In order for CMS to determine whether the standards and conditions have been met, States are asked to submit a demonstration proposal that outlines their proposed approach for the selected financial model(s). The Arizona Health Care Cost Containment System has submitted this proposal for CMS review.

As part of the review process, CMS will seek public comment through a 30-day notice period. During this time, interested individuals or groups may submit comments to help inform CMS' review of the proposal.

CMS will make all decisions related to the implementation of proposed demonstrations following a thorough review of the proposal and supporting documentation. Further discussion and/or development of certain aspects of the demonstration (e.g., quality measures, rate methodology, etc.) may be required before any formal agreement is finalized.

Publication of this proposal does not imply CMS approval of the demonstration.

Invitation for public comment: We welcome public input on this proposal. To be assured consideration, please submit comments by 5 p.m. EDT, July 1, 2012. You may submit comments on this proposal to AZ-MedicareMedicaidCoordination@cms.hhs.gov.

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
(AHCCCS)**

**MEDICARE-MEDICAID DUAL ELIGIBLE
DEMONSTRATION PROPOSAL**

Proposal Submitted May 31, 2012

TABLE OF CONTENTS

A. <u>Executive Summary</u>	1
B. <u>Background</u>	2
i. <i>Vision and Rationale for Proposed Demonstration</i>	2
ii. <i>Eligible Demonstration Population</i>	4
a. <u>Dual eligible members enrolled in the Arizona Long Term Care System (ALTCS) for the Elderly and Physically Disabled</u>	
b. <u>Acute care dual eligible members (i.e. do not qualify for ALTCS)</u>	
c. <u>Acute care dual eligible members with Serious Mental Illness in Maricopa County</u>	
C. <u>Care Model Overview</u>	7
i. <i>Delivery System and Programmatic Elements</i>	7
a. <u>Geographic Service Area</u>	
b. <u>Enrollment Methods</u>	
c. <u>Member Care Coordination</u>	
d. <u>Medical and Supportive Service Providers</u>	
e. <u>Addressing Arizona’s Carve Out of Behavioral Health Services</u>	
ii. <i>Proposed Benefit Design</i>	11
iii. <i>Supplemental Benefits/Ancillary and Supportive Services</i>	12
iv. <i>Evidence-based Practices</i>	13
v. <i>Compatibility with Current Program Model</i>	14
a. <u>Current Medicaid Waiver/State Plan Services</u>	
b. <u>Existing Managed Long Term Care Program</u>	
c. <u>Existing Specialty Behavioral Health Plans</u>	
d. <u>Integrated Programs via Medicare Advantage Special Needs Plans</u>	
e. <u>Additional State Payment/Delivery Efforts</u>	
D. <u>Stakeholder Engagement and Beneficiary Protections</u>	14
i. <i>Internal and External Stakeholder Engagement</i>	14
a. <u>Initial Planning</u>	
b. <u>Health Plans</u>	
c. <u>Member Focus Groups</u>	
d. <u>Healthcare Providers</u>	
e. <u>Advocacy Groups</u>	
f. <u>Online Survey</u>	
g. <u>Final Report</u>	
h. <u>Public Meetings</u>	
i. <u>Incorporation of Stakeholder Feedback</u>	
j. <u>Draft Proposal Comments</u>	

ii.	<i>Beneficiary Protections</i>	19
a.	<u>Opt-Out Provisions and Choice of MCO</u>	
b.	<u>Ensuring Continuity of Care during Member Transition to New MCOs</u>	
c.	<u>Maintaining Current Level of Benefits</u>	
d.	<u>Streamlining Grievances and Appeals</u>	
iii.	<i>Ongoing Stakeholder Engagement</i>	20
E.	<u>Financing and Payment</u>	21
i.	<i>Financial Alignment Model</i>	21
a.	<u>Upfront Savings Will Be Nominal</u>	
b.	<u>Adopting Actuarial Soundness</u>	
1.	Rate Setting for the ALTCS Elderly and Physically Disabled (E/PD) Duals	
2.	Rate Setting for Acute Duals	
3.	Rate Setting for Acute Duals with SMI in Maricopa County	
c.	<u>Setting the Medicare Rates</u>	
d.	<u>Application of State Upfront Savings</u>	
ii.	<i>Payments to Providers</i>	24
F.	<u>Expected Outcomes</u>	24
i.	<i>Data Collection and Monitoring</i>	24
ii.	<i>Potential Improvement Targets</i>	24
iii.	<i>Impact of Demonstration on Medicare and Medicaid Costs</i>	25
G.	<u>Infrastructure and Implementation</u>	26
i.	<i>State Infrastructure/Capacity</i>	26
a.	<u>Division of Health Care Management</u>	
b.	<u>Division of Member Services</u>	
c.	<u>Office of the Director</u>	
d.	<u>Office of Administrative Legal Services</u>	
e.	<u>Information Services Division</u>	
ii.	<i>Implementation Strategy and Timeline</i>	27
H.	<u>Feasibility and Sustainability</u>	29
i.	<i>Potential Barriers</i>	29
ii.	<i>State Statutory/Regulatory Changes</i>	29
iii.	<i>Future State Funding Commitments and Contracting Processes</i>	29
iv.	<i>Scalability to Other States</i>	30
v.	<i>Letters of Support</i>	30
I.	<u>Additional Documentation</u>	30
J.	<u>Interaction with Other HHS/CMS Initiatives</u>	30

Appendix A – Dual Eligibles within the AHCCCS Program	31
Appendix B – Map of Arizona Geographic Service Areas	32
Appendix C – Medicare Advantage Supplemental Benefits offered in Arizona	33
Appendix D – <i>Dual’s Digest</i>: A Newsletter on Arizona’s Dual Eligibles	34
Appendix E – Letters of Support	35

A. Executive Summary

The Arizona Health Care Cost Containment System (AHCCCS) is the State's Medicaid program as well as its largest single source of health insurance, providing coverage to nearly 1.3 million Arizonans. Approximately 120,000 (9%) of Arizonans covered by AHCCCS are eligible for full benefits from both Medicare and Medicaid. These beneficiaries, referred to as "dual eligibles," account for 13% of the State's Medicare population. Dual eligibles are 9% of the State's Medicaid population, but they account for 18% of AHCCCS costs.

While this seems disproportionately high, Arizona compares favorably to national statistics in which dual eligibles account for 15% of the Medicaid population but 39% of the program's spending. Arizona's reduced spending for all AHCCCS members, including dual eligible members, can be attributed to its mature managed care model and efficient provision of high quality health care. All AHCCCS members¹ are required to enroll in a Managed Care Organization (MCO) through which they receive their Medicaid benefits. Moreover, all of the AHCCCS contracted health plans also serve as Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs). This D-SNP model has led to a high degree of dual eligible alignment – 40,000 or one-third of all AHCCCS duals are enrolled in AHCCCS health plans that manage both their Medicare and Medicaid benefits. There also are a significant number of dual eligibles enrolled in Medicare Advantage plans not affiliated with the dual eligible members' AHCCCS health plans.

Despite Arizona's high rate of managed care penetration and dual eligible integration, there remains a significant untapped potential for increasing care coordination and alignment to improve health outcomes for duals. The Centers for Medicare and Medicaid Services (CMS) Capitated Financial Alignment Demonstration (the "Demonstration") presents a unique opportunity for AHCCCS to build upon its existing system of care for dual eligibles by expanding the number of "aligned" AHCCCS health plans to efficiently manage both Medicaid and Medicare benefits for dual eligible members.

Arizona is firmly convinced that expanded dual alignment will improve health outcomes, enhance care coordination, and increase member satisfaction. Additionally, greater efficiencies can be achieved and member confusion can be minimized by holding one MCO accountable for the services and care dual eligibles receive through the Medicare and Medicaid programs. Accordingly, the State is seeking the authority under the Demonstration to passively (or automatically) enroll dual eligible individuals into their current AHCCCS MCO that will be accountable for providing the full array of Medicare and Medicaid benefits for which the member is eligible. There are no Medicare or AHCCCS benefit changes proposed as part of this Demonstration, and the State is requesting that MCOs offer supplemental benefits to dual eligibles, which have proven to be an important tool for health plans to better manage care for duals.

Arizona is committed to continued stakeholder engagement not only as part of this planning phase, but also as the State moves forward in implementation of the Demonstration. The State also will continue ongoing monitoring of health plan performance and beneficiary experience.

¹ The only exceptions are Native Americans and persons who are limited to coverage of emergency services.

Table 1. Arizona Dual Eligible Target Population

Target Population (All full benefit Medicare-Medicaid enrollees/subset/etc.)	Full benefit Medicare dual eligible enrollees with Medicare A and/or B who are Medicaid eligible through: (1) the ALTCS E/PD program; (2) the Acute care program or (3) as an Acute care enrollee with Serious Mental Illness residing in Maricopa County, a subset of the Acute care program.
Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide	119,697
Total Number of Beneficiaries Eligible for Demonstration	115,065 (total eligible for Demonstration; see page 4) 105,104 (total eligible for passive enrollment)
Geographic Service Area (Statewide or listing of pilot service areas)	Statewide
Summary of Covered Benefits	<ul style="list-style-type: none"> ▪ Medicare Parts A, B, and D ▪ Medicaid State Plan and 1115 Waiver (as applicable) ▪ Medicare Supplemental benefits
Financing Model	Capitated
Summary of Stakeholder Engagement/Input (Provide high level listing of events/dates—Section D asks for more detailed information)	<ul style="list-style-type: none"> ▪ 8 Consumer Focus Groups (March/April 2012) ▪ 3 Provider Focus Groups (March/April 2012) ▪ 1 Advocacy Focus Group (March 2012) ▪ 2 Health Plan Meetings (February/May 2012) ▪ 2 Public Forums (April/June 2012)
Proposed Implementation Date(s)	January 1, 2014

B. Background

i. Vision and Rationale for Proposed Demonstration

The vision underlying the State’s proposal is to place accountability for management, oversight, and care delivery of both Medicare and Medicaid benefits for dual eligible members with one entity, the MCO. The objective of the Demonstration is to confirm that a single, at-risk entity that is responsible for the full spectrum of care of dual eligibles will build system efficiencies, improve care coordination, reduce member confusion, increase member satisfaction, produce better health outcomes, and enhance the long-term sustainability of the program by reducing costs.

The AHCCCS Program has proven that the managed care model, holding one entity responsible for the provision of all covered services, is successful. Applying this model to the Demonstration for dual eligibles will extend the benefits of this system design to dual eligible members. In the Arizona Long Term Care System (ALTCS), MCOs are financially at-risk to coordinate both Acute care and long term care services in a way that integrates care to the elderly and physically disabled (E/PD) who are at risk of institutionalization. The ALTCS E/PD MCOs coordinate Acute care services, home and community based services, other long term care supports, case management, behavioral health services, and prescriptions drugs for each member managed through a single entity. The ALTCS MCO’s responsibility to assess a member’s overall needs enables it to maximize the provision of long term care services in a home or community setting and consistently meet high quality of care

standards. Approximately 72% of ALTCS E/PD members receive their care at home or in the community, leading to increased member satisfaction, high quality of care, and reduced costs.

AHCCCS has also replicated the success of the Medicaid managed care model in Medicare benefits for certain dual eligible members. The creation of Medicare Advantage plans allowed the AHCCCS program to engage its MCOs in a new way – as Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs). By 2006, a majority of the AHCCCS health plans were also Medicare Advantage plans. The implementation of Medicare Part D in January 2006 created the vehicle through which the State passively enrolled its dual eligible members into their Medicare Advantage D-SNP health plan for their Medicare benefits. According to CMS, roughly 39,000 dual eligible members were passively enrolled into their AHCCCS plan for Medicare and Part D prescription drugs with a choice to opt-out before January 1, 2006. Only a small number chose to opt-out of this Medicare plan. By April of 2006, 34,000 dual eligibles were receiving all Medicare and Medicaid services through one AHCCCS MCO as a direct result of this one-time passive enrollment at the time of Part D implementation. Since 2006, one third of all dual eligible AHCCCS members have been aligned in the same D-SNP and Medicaid plan. Currently, all AHCCCS health plans are approved as D-SNPs in at least one, if not all, service areas where they also have Medicaid contracts.

For members in aligned MCOs for both Medicare and Medicaid, the advantages are significant. Members and their families have one point of contact for all issues related to services. One case manager is responsible for coordinating the member's Medicare and Medicaid benefits. The member's MCO is responsible for all claims and authorization functions as well as for network development and medical management. As a result, this single entity is far better positioned to comprehensively assess the health care needs of the member, timely coordinate delivery of needed services, manage the member's health care conditions and monitor health care outcomes.

An integrated Medicare/Medicaid system also benefits healthcare providers who, like dual eligible members, face the challenges and confusion of navigating an otherwise fragmented system. Promoting efficiencies and alleviating administrative burdens for providers is critical to maintaining adequate networks and access to care. In an integrated system under this Demonstration, providers have the advantage of submitting one claim and receiving payment for all covered Medicare and Medicaid services, including cost sharing, from one payer. Providers merely coordinate prior authorizations, hospitalizations, prescriptions and other services through one entity.

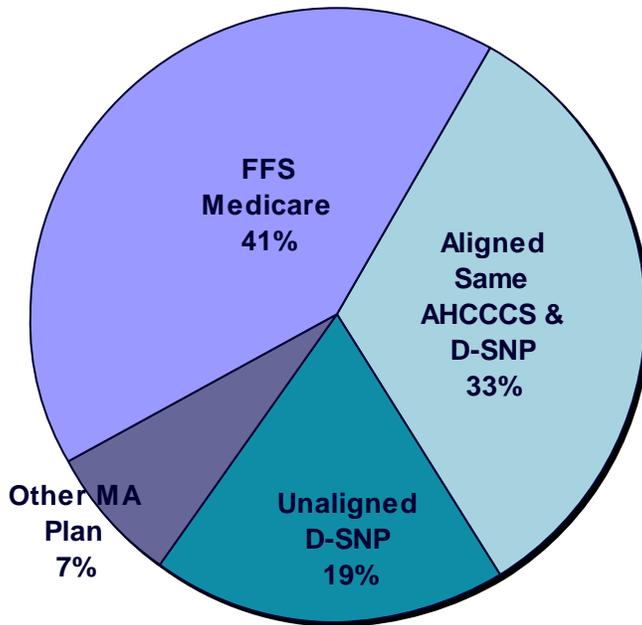
The benefits of alignment are clear. Despite Arizona's successes in achieving this alignment for one-third of its duals, increases in enrollment and alignment in D-SNPs have been slow. Far too many dual eligibles remain in Original Medicare or unaligned Medicare Advantage plans or D-SNPs. Arizona's experience suggests that passive enrollment is the best vehicle through which to align this untapped segment of the dual eligible population. Alignment will then promote improved care coordination, increased administrative efficiencies, reduced costs, long-term sustainability and most importantly, a seamless care delivery system for the member.

Moreover, ongoing passive enrollment addresses the key issue identified through extensive stakeholder engagement – confusion about these two mega systems, Medicare and Medicaid. Consumers and their families feel overwhelmed by the difficulty in navigating between the two systems and the lack of a clear point of contact to assist them in addressing questions or concerns. Juggling more than one health plan identification card and wading through communications from multiple health plans and governmental entities add to the burden on members and families. Providers and health plans expressed similar frustrations regarding the administrative burden of working within two distinct systems serving the same member, as well as their inability to efficiently and effectively

coordinate and manage care for un-aligned duals due to lack of information about their healthcare history.

To date, the D-SNP model has been the best opportunity available to coordinate care for duals in Arizona. The Demonstration provides an opportunity to build upon the D-SNP model and rectify the lingering inefficiencies and fragmentation in the current model through ongoing automatic Demonstration enrollment for duals.

Table 2. AHCCCS Dual Eligible Medicare Enrollment



*Includes duals with a Developmental Disability who will be excluded from the initial Demonstration

ii. Eligible Demonstration Population

There are 120,000 individuals in Arizona who are enrolled in Medicare and Medicaid. The flow chart at Appendix A shows the breakdown of the dual eligible population in Arizona. The total statewide dual population eligible for the Demonstration is 115,065². Approximately 10,000 of these dual eligible members are Native American. While these members will be offered the choice to participate in the Demonstration, they will not be passively enrolled unless they are currently enrolled in a MCO for their Medicaid benefit. More than 95% of Arizona’s dual population is eligible for participation in the Medicare-Medicaid integrated Demonstration, and more than 87% will be passively enrolled.

There are three populations eligible for the Demonstration: (a) ALTCS E/PD members; (b) Acute duals; and (c) Acute duals with Serious Mental Illness (SMI) in Maricopa County. These populations are described in more detail below. Additionally, the State seeks to include dual eligible members

² This total number of AHCCCS members eligible for the Demonstration reflects the exclusion of the ALTCS members with developmental disabilities receiving services through a contracted state agency, the Department of Economic Security/Division of Developmental Disabilities (DDD).

with either Medicare Part A or Part B to maximize the coordination and integration of care and to promote efficiency in the delivery of health care to these members. Approximately 8,400 duals in the ALTCS E/PD and Acute programs have Medicare Part A or B.

(a) Dual eligible members enrolled in the Arizona Long Term Care System (ALTCS) for the Elderly and Physically Disabled

The ALTCS program serves two populations – the elderly and physically disabled (E/PD) and individuals with developmental disabilities. In order to qualify for ALTCS, members must be determined at risk of an institutional level of care. By meeting medical eligibility and financial eligibility criteria, these individuals qualify for home and community based services (HCBS). Only members enrolled in the ALTCS E/PD program are eligible for the Demonstration. Members who are eligible for ALTCS through the Department of Economic Security/Division of Developmental Disabilities will not be eligible for enrollment in the Demonstration at this time. The ALTCS E/PD program is unique in that all Medicaid Acute, behavioral health, prescription drug, and long term care/HCBS services are provided by one capitated, at-risk health plan. Currently, 83% (or 21,000) of the ALTCS E/PD population is eligible for both Medicare and Medicaid. The Demonstration will further enhance care coordination for this population by aligning Medicare, the one component of their benefit package that is not yet integrated.

The ALTCS E/PD program recently completed its competitive procurement process and contracts have already been awarded to ALTCS MCOs.³ AHCCCS proposes to use the existing ALTCS contracted MCOs to serve as Demonstration plans that will manage the complete Medicaid and Medicare benefits to the ALTCS E/PD population.

(b) Acute care dual eligible members (i.e. do not qualify for ALTCS)

The majority of Arizona's dual eligible population receives its Medicaid benefit through a MCO contracted in the AHCCCS Acute care program (77,000⁴ of the 1.3 million acute care members are duals). Acute duals receive the majority of their benefits through Medicare. AHCCCS covers non-emergency transportation, cost sharing assistance and other services not covered by Medicare. Coordination of these benefits through one organization is anticipated to improve efficiencies, reduce confusion and decrease costs. There are also roughly 9,400 Native Americans enrolled in the AHCCCS fee-for-service American Indian Health Program. While these Native American members will not be passively enrolled,⁵ the option to participate in the Demonstration is available to them.

The Acute care MCO contracts expire September 30, 2013. The State is currently working on the Request for Proposal (RFP) for the selection of new five-year Medicaid contracts with MCOs that will be effective October 1, 2013.⁶ As part of this RFP, the State will not allow MCOs to exclusively serve the dual eligible population. Thus to participate in the Duals Demonstration, bidders must bid

³ See <http://www.azahcccs.gov/commercial/Purchasing/bidderslibrary/YH12-0001.aspx> for more information on the ALTCS E/PD RFP and see <http://www.azahcccs.gov/shared/Downloads/News/FINALWebsiteNotice061311.pdf> for ALTCS E/PD contract awards.

⁴ This number excludes the Acute duals with Serious Mental Illness residing in Maricopa County described in subsection (c) of this section who will receive their aligned Medicare benefit the integrated RBHA.

⁵ Only Native Americans enrolled in a MCO for their AHCCCS benefits will be passively enrolled into that AHCCCS health plan for their Medicaid benefit. Most (approximately 75%) of the AHCCCS Native American population is enrolled in the American Indian Health Program, a fee-for-service program where members access their Medicaid benefits through Indian Health Services or tribally operation 638 facilities.

⁶ See the AHCCCS website at: <http://www.azahcccs.gov/commercial/Purchasing/bidderslibrary/YH14-0001.aspx> for additional information on this RFP.

on the entire Acute Medicaid population for that Geographic Service Area. The AHCCCS Administration is considering whether the RFP will require all Acute plans to serve dual eligible members under the Demonstration or whether MCOs will have a choice to bid on contracts that will only serve Medicaid non-dual Acute members.

(c) Acute care dual eligible members with Serious Mental Illness in Maricopa County

In Arizona, behavioral health for acute care AHCCCS members is a carved-out benefit.⁷ Thus, AHCCCS acute care members do not receive behavioral health services through the AHCCCS Acute MCOs. Rather, AHCCCS contracts with the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) for the management of the AHCCCS behavioral health benefit. In turn, ADHS/DBHS contracts with Regional Behavioral Health Authorities (RBHAs) to provide the behavioral health benefit to AHCCCS members based on geographic service areas.

ADHS/DBHS and AHCCCS are working to integrate that system of care for persons with Serious Mental Illness (SMI) residing in Maricopa County. That integration will be achieved by requiring the RBHA serving Maricopa County to be responsible for providing integrated physical and behavioral health care services for members with SMI. In addition, AHCCCS is seeking to require that the Maricopa County RBHA also serve as a health plan under the Demonstration. Approximately 43% (or 7,000) of the AHCCCS members with SMI in Maricopa County are also Medicare enrolled. The current contract for the Maricopa County RBHA is set to expire September 30, 2013. Accordingly, these requirements are being incorporated into the RFP process for a new Maricopa County RBHA contract, which will be effective October 1, 2013.⁸ The newly selected RBHA will then also serve as the Demonstration plan for dual eligibles with SMI in Maricopa County.

The full integration of benefits and alignment of Medicare and Medicaid is integral in addressing the SMI population’s disproportionately high mortality rate. Currently, members with SMI in Arizona die 30 years younger than their peers without SMI. Often, this is due to preventable physical health care conditions. Arizona is pursuing integration for this population to improve the overall health outcomes for these members. In addition, the costs of providing care to this population are extraordinary; less than 500 people account for \$44 million in annual spending. While integration of Acute and behavioral health is critical for this population, improved health outcomes and a reduction in cost cannot be achieved without also allowing passive enrollment into the RBHA for the dual eligible’s Medicare benefit.

Table 3. Arizona Demonstration Population

	Overall	Individuals receiving LTSS in institutional settings	Individuals receiving LTSS in HCBS settings
Overall total	115,065	6,104	14,918
Individuals age 65+	65,983	5,225	11,160
Individuals under age 65	49,079	879	3,758
Individuals with serious mental illness	12,566	0	0

*Numbers as of April 1, 2012

**Members in the ALTCS program are not designated with serious mental illness

⁷ For more on how Arizona is addressing care coordination for this carved-out benefit, see page 8 of this proposal.

⁸ See <http://azdhs.gov/diro/integrated/index.htm> for additional information regarding the RFP for the Maricopa County RBHA.

C. Care Model Overview

AHCCCS currently operates in accordance with a managed care model of service delivery. This means that, through a competitive bid process, AHCCCS contracts with multiple Acute and long term care MCOs, paying them prospectively to provide primary, Acute, and long term care services to recipients. The health plans, in turn, are responsible for maintaining and reimbursing an adequate network of direct providers to deliver care to their respective members. The result is a managed care system that mainstreams recipients and allows them to select their providers. It is a system that reduces costly emergency services by emphasizing prevention, early intervention, and management of chronic illness. Ultimately, it supports State and local economies, strengthens the health care industry, and reduces uncompensated care.

Consistent with this model, AHCCCS hopes that dual eligible members take advantage of the full integration of services available through AHCCCS Dual-eligible Special Needs Plans (D-SNPs). As a result of the Demonstration, AHCCCS plans to build on this already successful model by streamlining systems and processes and, ultimately, increasing the number of dual eligibles receiving fully integrated services.

*i. **Delivery System and Programmatic Elements***

(a) Geographic Service Area

The Demonstration will be implemented State-wide across all seven AHCCCS Geographic Service Areas (GSAs), which represent all 15 Arizona counties.

Table 4. Arizona Geographic Service Areas by County

<u># of Acute Health Plans</u>	<u># of ALTCS Health Plans</u>	<u>County</u>
2	1	Yuma, La Paz
2	1	Apache, Coconino, Mohave, Navajo
2	1	Yavapai
2	1	Gila, Pinal
5	2 (Pima only)	Pima, Santa Cruz
6	3	Maricopa
2	1	Cochise, Graham, Greenlee

* Acute contracts end 9/30/13

(b) Enrollment Methods

Dual eligibles will be passively (automatically) enrolled in their AHCCCS health plan for the administration of both AHCCCS and Medicare benefits, including Part D prescription drugs. They will receive no less than a 90-day advance notice of their enrollment as well as information related to their right to opt out of the Demonstration and enroll, instead, in Original (or traditional fee-for-service) Medicare. The Demonstration preserves members’ rights to change Medicare enrollment throughout the year.

Limiting the opt-out provision to Original Medicare serves to prevent non-Demonstration Medicare Advantage plans from marketing to duals enrolled in the Demonstration. This measure also has nominal impact on beneficiary choice since only 7% of the dual population is enrolled in a MA plan that is not contracted as a D-SNP. Furthermore, Medicare Advantage D-SNPs are required to have a contract with

the State Medicaid Agency to operate as this specialized type of Medicare Advantage plan. The Demonstration provides the best opportunity to maximize alignment of duals. Consequently, the D-SNP model will be replaced by the Demonstration and AHCCCS will no longer enter into contracts with organizations to operate as D-SNPs. Table 2 shows 52% of duals are currently enrolled in D-SNPs, which will not be operating in 2014. Thus, most duals in Medicare Advantage plans will not have a Medicare plan into which they could re-enroll.

Members will have at least three months advance notice before enrollment in the Demonstration begins. If members prefer not to remain in the AHCCCS health plan for Medicare benefits, they will have the opportunity to opt out to Original Medicare; however, they will remain enrolled in the AHCCCS health plan for their Medicaid benefits. Monthly re-enrollment in the Demonstration will be allowed.

Dual eligibles new to the program following the Demonstration's implementation January 1, 2014, will be subject to existing AHCCCS enrollment procedures. Those not previously enrolled with a Medicaid plan will be given an opportunity to select from the Demonstration plans available in their respective GSAs. Lack of selection at the time of eligibility determination will trigger passive enrollment into a Demonstration plan. The purpose of such enrollment procedures is to limit administrative burdens, support network consistency, and ensure medical record consolidation so that primary attention is focused on direct patient services. AHCCCS is evaluating methods to give newly eligible duals advance notice before passive enrollment.

All dual eligibles within each target population will maintain choice of Medicaid MCO and will have the same annual opportunity to change their Medicaid health plan. Those who choose to change plans may select the new plan as a Demonstration plan that provides them with both Medicare and Medicaid benefits, or they may opt out of the Demonstration and seek traditional Medicare benefits. Dual eligibles may not choose a Demonstration plan for Medicare services and a different plan for Medicaid services. This is a change from the current D-SNP model that allows dual eligibles to enroll in one Medicaid plan for Medicare and another for Medicaid services. In addition, AHCCCS is evaluating an aligned annual enrollment period for dual eligible members so duals could choose a new Demonstration plan for Medicaid and Medicare at the same time.

AHCCCS will use state resources to manage eligibility and respond to questions regarding the full range of Medicare and AHCCCS eligibility issues. Enrollment changes will be reported to CMS and the Demonstration MCOs. AHCCCS is working with CMS to develop a real-time system for relaying eligibility and enrollment data to CMS and MCOs.

(c) Member Care Coordination

Care coordination is central to Arizona's current managed care model of service delivery. All AHCCCS MCOs, including those that currently function as D-SNPs, are at risk for the costs of providing care to their members. As a result, they have substantial incentive to coordinate and manage care. In fact, emphasis on prevention and early intervention, coordination of care, case management, and disease management are processes that are well integrated into the current AHCCCS model.

MCO responsibilities for case management and coordination of care are well-documented in AHCCCS contracts for both acute and long term care services. As an example, MCOs are required to have mechanisms in place to assess members' health risks and identify members with multiple and/or special health care needs. They are also required to share findings with other entities providing services to the same members in order to prevent duplication of or gaps in services. AHCCCS MCOs are well-staffed with experienced case managers and disease managers who are familiar with the array of resources that support successful coordination of care.

Arizona's existing managed care infrastructure supports a system that includes care coordination functions like:

- Conducting a comprehensive health risk assessment;
- Developing a care plan that is member-centered – i.e. involves input from the member, the member's family, and all providers involved in the member's care;
- Using evidence-based guidelines for care management and delivery;
- Communicating with member/family, physicians, and community providers;
- Educating the member about self-care, medications and how to communicate with providers;
- Monitoring the member's symptoms, well being and adherence to plan of care; and
- Arranging for all needed health-related and other support services.

How these functions actually are deployed by the AHCCCS MCOs is helpful in understanding the system into which the dual eligible member will be passively enrolled for their Medicare benefits. The following illustration provides a glimpse into what a typical ALTCS member can anticipate from his health plan:

John was recently deemed eligible for services through the Arizona Long Term Care System (ALTCS). John is quadriplegic and lives in his own home in the Phoenix metropolitan area. John has a choice of one of three ALTCS health plans available in Maricopa county. John has elected Plan A as his health plan because he is already enrolled with Plan A for his Medicare services. Plan A has been notified that John has enrolled with the health plan.

Upon notification, Plan A contacts John to initiate the care coordination process (initial contact must occur within 7 days). At the point of initial contact, Plan A also determines whether John has immediate service needs and sets up the initial face-to-face visit, which must occur within 12 days of enrollment. The assigned case manager from Plan A meets with John and other parties chosen by John to participate in the assessment and service planning process. During the initial meeting, the case manager conducts an assessment of John's needs, discusses service and placement options, and develops his individualized service plan based on John's overall service needs as well as his preferences. Specifically, the Plan A case manager works with John and his team to address the provision of critical services, including attendant care, durable medical equipment and supplies, transportation, and behavioral health services. For any medical services, the case manager coordinates with the member's primary care physician to obtain the appropriate medical order/prescription. For critical in-home care services, the case manager also works with John to develop a contingency/back-up plan, outlining who will provide care in the event that a provider does not show up as scheduled.

John's services are then initiated, as required, within a 30-day time frame. The case manager maintains ongoing contact with John to ensure that his service needs are being addressed and meets with John face-to-face at least every 90 days.

AHCCCS staff then oversees the MCO through a variety of reporting mechanisms and site visits to ensure the MCO is fulfilling its contractual obligations. Appropriate oversight is key to the success of this model.

The care coordination and case management operations explained above serve as an advantage to the Demonstration. The primary change under the Demonstration is that the MCO will receive the member's Medicare and Part D data. This only serves to better equip the MCO, which will now have a comprehensive picture of the member's needs.

Under the Demonstration, one MCO will retain all member information and, thereby, the ability to view a comprehensive picture of each member and his or her case management and care coordination needs. Health plan staff will have a clear picture of all individual member benefits for the purpose of authorizing services, customizing care, planning for discharge from inpatient facilities, and coordinating associated resources. Extremely important is the fact that health plan medical and case management staff will have ready access to all utilization data. A centralized, comprehensive picture of all prescribed and filled prescription drugs, hospital admissions, outpatient procedures, laboratory data, behavioral health care, and long term care supports cannot be over-valued. Neither can the ability to efficiently and effectively identify such concerns as duplication of services, drug interactions, and inappropriate utilization of emergency departments.

Thus, passive enrollment helps align all services in one location, a critical factor in eliminating the current challenges that arise when responsibilities for coordination, monitoring, and payment of care are dispersed among multiple organizations. Further, a coordinated benefit package managed by an aligned MCO reduces the probability of duplication, delays, and gaps in services.

(d) Medical and Supportive Service Providers

As a well-established managed care system, AHCCCS understands that maintaining a comprehensive system of care for enrollees is fundamentally dependent on its network of providers. Registration with AHCCCS is required of all providers, i.e. those who contract with AHCCCS and ALTCS MCOs as well as those who serve AHCCCS fee-for-service enrollees. Currently over 52,000 providers throughout the State are registered with AHCCCS, including a majority of Arizona physicians.

AHCCCS enrollees, including dual eligibles, enjoy access to a robust network of medical and supportive service providers that extends far beyond the safety net to include extensive private physician offices. The public/private partnership between AHCCCS and its MCOs provides maximizes leveraging of market forces and mainstreaming enrollees into the private sector, significantly expanding network opportunities.

All AHCCCS MCOs are contractually obligated to comply with stringent network adequacy standards that focus on type and sufficiency, geographical location, accessibility, and timeliness of service delivery. Plans serving dual eligibles in ALTCS are required to have a network of providers that includes, but is not limited to, nursing facilities, attendant care workers, assisted living facilities, adult day care and home health services. The Maricopa RBHA serving enrollees with SMI must demonstrate their networks adequately address behavioral health as well as physical health needs.

AHCCCS invests significant resources in monitoring network adequacy and access to care. The Demonstration would leverage existing capabilities and extend them where needed to ensure appropriate oversight. However, AHCCCS is concerned that current Medicare Advantage network requirements do not translate well to MCOs serving dual eligible members. Currently Medicare network standards have been an unnecessary road block for AHCCCS plans applying to become D-SNPs in counties where they have Medicaid contracts. Medicare Advantage network requirements, including those for D-SNPs, consider the *overall* Medicare population and not just the dual eligible population. This causes difficulties when plans are trying to expand, especially in rural counties. MCOs are forced to go through the onerous “exceptions” process and still not meet the requirements, even though the MCOS clearly has an adequate provider network in place to meet their members’ needs.

AHCCCS is committed to applying network requirements under the Demonstration that are appropriate and allow for access to care without causing undue burden on MCOs. In addition, Demonstration MCOs

need to have clear and attainable expectations in order to expand networks to accommodate new members and include current providers of new members at time of change in enrollment.

(e) Addressing Arizona's Carve Out of Behavioral Health Services

Arizona's managed care model is largely integrated with MCOs responsible for managing the care of AHCCCS members; however, behavioral health benefits for Acute care enrollees are carved out. Arizona's public system of care for the treatment of behavioral health conditions pre-dates the State's participation in the Medicaid program. When the State joined the Medicaid program in 1982, it incorporated behavioral health services over time as part of the Medicaid benefits package but maintained a separate system of care for the treatment of behavioral health needs, which is managed by the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS), an AHCCCS MCO. ADHS/DBHS then contracts with Regional Behavioral Health Authorities (RBHAs) in identified geographic services areas. The RBHAs are entities responsible for managing the behavioral health benefit of Acute care AHCCCS enrollees.

This separation of behavioral health was maintained at the request of community stakeholders who believed that a system focused solely on behavioral health was better suited to meet the behavioral health needs of AHCCCS Acute care enrollees. It was also believed that a carved out approach would better preserve behavioral health funding because by integrating behavioral health under the management of AHCCCS MCOs, behavioral health funding could be subsumed by Acute care needs.

Despite the success of integrating behavioral health in the ALTCS model, the State is sensitive to remaining stakeholder concerns about integrating behavioral health services into the AHCCCS Acute care model. Therefore, the State is taking an incremental approach to the integration of behavioral health by focusing first on the SMI population in Maricopa County. For this population only, the State will shift Acute (physical health) care delivery and oversight to the integrated RBHA, which will also serve as a Demonstration plan. The State will continue to evaluate expanding this model statewide.

Nevertheless, the State firmly believes that a level of integration of Acute and behavioral health can be achieved through the existing care delivery model by including care coordination policies in the Acute MCO contracts as part of the upcoming RFP. Likewise, the State can incorporate coordination requirements in its contracts with the existing RBHAs. Some of the policies being contemplated include data sharing between Acute MCOs and RBHAs of prescription drugs and physical and behavioral health services for members that the MCO and RBHA share in common. Under the Demonstration, MCOs serving as Demonstration plans would be required to contract with the RBHAs in the geographic service areas where they operate to formalize coordination of care and data sharing processes and detail responsibilities of each entity. This contracting requirement could also extend to allow financial or shared savings arrangements based on improved health outcomes and reduced costs. AHCCCS, in coordination with ADHS/DBHS, will oversee and monitor these contractual arrangements to ensure seamless overall health care delivery to Acute dual members.

ii. Proposed Benefit Design

The State Medicaid benefit package offers a comprehensive array of standard services including, but not limited to, inpatient services, inpatient and outpatient surgery, emergency care, primary and specialty provider visits, laboratory and imaging services, supplies and durable medical equipment, prescription

drugs, rehabilitation therapy, respiratory therapy, and medically necessary transportation.⁹ All enrollees are eligible for medically necessary behavioral health services including behavior management, case management, a variety of therapies, psychosocial rehabilitation, day treatment, and psychotropic medication.

In addition to the medical and behavioral health benefits, ALTCS enrollees are also eligible for a comprehensive array of long term care benefits including, but not limited to, nursing facility services, home and community-based services (HCBS), services delivered in HCBS alternative residential settings (e.g. assisted living facilities, adult foster homes), hospice, respite care, adult day care, and community transition services.¹⁰

Existing State Medicaid benefits will be integrated into a single benefit package for dual-eligibles enrolled in the Demonstration. The single benefit package will be managed by the respective contracted Demonstration health plan. For individuals with SMI in Maricopa County, the RBHA will serve as that single Demonstration plan. Demonstration benefits will incorporate:

- All Medicare benefits
- Part D drugs
- All Medicaid State Plan benefits¹¹
- All Medicaid 1115 Waiver benefits, including home and community based services for the ALTCS population¹²
- Behavioral health services¹³
- Medicare Supplemental benefits (proposed)

Demonstration health plans will administer Medicare and Medicaid benefits jointly for the targeted populations. The vision is to reduce the fragmentation between these two systems of care by creating a coordinated benefit package that the member receives from one single entity. This seamless care model will support the person-centered approach that has been highly successful within the ALTCS program. Engaging the members and their families as active participants in the planning of their health care is paramount to achieving the highest levels of self-sufficiency, particularly for fragile populations like the ALTCS E/PD and SMI populations. Also, the MCO is best positioned to more fully manage the member's care when it is the sole responsible entity for administering the combined benefit package.

iii. Supplemental Benefits/Ancillary and Supportive Services

AHCCCS believes that supplemental benefits currently offered by Medicare Advantage plans, including D-SNPs, (e.g. dental, vision exams, fitness programs) will play an important role in the Demonstration. Approximately 60% of all dual eligibles in Arizona are enrolled in Medicare Advantage or D-SNPs that offer supplemental benefits. Consumer research indicates that supplemental benefits are closely tied to

⁹ For more detail on the AHCCCS benefit package, see the AHCCCS Medical Policy Manual, which can be found on the AHCCCS website at:

<http://www.azahcccs.gov/shared/MedicalPolicyManual/MedicalPolicyManual.aspx?ID=policymanuals>.

¹⁰ For more detail on the ALTCS benefit package, see the ALTCS MCO contracts located on the AHCCCS website at: http://www.azahcccs.gov/commercial/Downloads/ContractAmendments/ALTCS/ALTCS2012/YH12-0001-01_Amend1_final.pdf.

¹¹ For more information, see Arizona's State Plan on the AHCCCS website at:

<http://www.azahcccs.gov/reporting/Downloads/MedicaidStatePlan/EntireStatePlan.pdf>

¹² See the Arizona 1115 Waiver located on the AHCCCS website at:

<http://www.azahcccs.gov/reporting/federal/waiver.aspx> for additional information.

¹³ See the Behavioral Health Benefits Guide located on the AHCCCS website at:

<http://www.azahcccs.gov/commercial/Downloads/BehavioralHealthServicesGuide.pdf>.

member satisfaction and that Medicare Advantage plans with the richest supplemental benefit packages have the highest penetration rate. Appendix C identifies the supplemental benefits offered by high-volume Arizona D-SNPs by plan.

In addition, maintaining the MCO's ability to offer supplemental benefits is critical to maximizing ongoing participation in the Demonstration. AHCCCS is exploring the most effective way to include supplemental benefits into the Demonstration plans. One option would be to pay Demonstration plans a fixed dollar amount per member per month to cover supplemental benefits. Each plan, however, would have the flexibility to establish the types of benefits most appropriate for its unique membership. In keeping with the AHCCCS concept of managed competition, plans will continue to compete for enrollment based on service and network.

iv. Evidence-based Practices

The health care system is changing in relation to how it measures quality, requiring evidence for both coverage and performance expectations. In accordance with 42 CFR 438.236, AHCCCS requires all MCOs to adopt and disseminate practice guidelines that are:

- Based on valid and reliable clinical evidence;
- Considerate of the needs of the MCO's members;
- Adopted in consultation with health care professionals and National Practice Standards; or
- Developed in consultation with health care professionals and, when National Practice Guidelines are not available, include a thorough examination of peer-reviewed articles in medical journals published in the United States. Published peer-reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources, include measureable results, and come with positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
- Disseminated by the MCO to all affected providers and, upon request, to members and potential members; and include
- A basis for consistent decision-making related to utilization management, member education coverage of services, and any other areas to which the guidelines apply (42 C.F.R. 438.236).

MCOs are required to evaluate the Practice Guidelines annually through a Medical Management/Utilization Management Multi-disciplinary Committee to determine if the guidelines remain applicable, represent the best practice standards, and reflect current medical standards. MCOs must document adoption, evaluation, and review of practice guidelines. The Demonstration will adopt these same evidence-based practices.

v. Compatibility with the Current Program Model

Historically, the AHCCCS managed care program has served as a national model for the efficient use of resources in the delivery of cost-effective, quality health care to those in need. The Demonstration fits well into the current structure, complementing and enhancing the foundation already in existence:

(a) Current Medicaid Waiver/State Plan Services: The AHCCCS 1115 Research and Demonstration Waiver supports the Demonstration. Dual eligibles are already mandated to enroll in MCOs, and AHCCCS does not expect to require additional Medicaid authority to enroll dual eligibles into the Demonstration. In addition, the State's 1115 Waiver allows it the flexibility to provide a full array of home and community based services (HCBS) for its ALTCS members with no enrollment caps or waiting periods. The current State Plan also supports the Demonstration. AHCCCS benefits already include a robust array of benefits that encompass Acute, long term care, and behavioral health services.

(b) Existing Managed Long Term Care Program: ALTCS is already an integrated program, which lends itself well to the Demonstration. Further integration of Medicare benefits can only serve to improve coordination of services for plans, providers, and enrollees.

(c) Existing Specialty Behavioral Health Plans: AHCCCS has engaged in extensive research and planning related to the establishment of a Maricopa County RBHA that will function as a fully integrated MCO for persons with SMI. The inclusion of Medicare into this program will complete the consolidation of service delivery, information, case management, and accountability, promoting its ultimate success. Outside of this special SMI program, RBHAs, per contractual requirement, will continue to partner with Demonstration plans to ensure well coordinated care.

(d) Integrated Programs via Medicare Advantage Special Needs Plans: Currently, all AHCCCS health plans offer a D-SNP in at least one, if not all, of the counties in which they have Medicaid contracts, and approximately one-third of dual eligibles are aligned to receive both Medicare and Medicaid services from their AHCCCS plan. When implementation of Part D moved prescription drug coverage for dual eligibles from Medicaid to Medicare, CMS allowed a one-time passive enrollment of dual eligibles into the Medicaid plan that previously provided their medications. This allowed dual eligibles to receive their Medicare services from that plan as well. In 2006 when this one-time enrollment transpired, approximately one-third of the affected population remained in their Medicaid plan for aligned services. This percentage has not increased since that time and the State believes that passive enrollment will serve to improve the current integrated programs and build upon the success of the D-SNP model.

(e) Additional State Payment/Delivery Efforts: Over 72% of ALTCS members reside in home and community based settings. ALTCS health plans receive capitation payments that are adjusted annually based, in part, on use of settings. This has resulted in more appropriate settings for enrollees and lower overall costs for the program. Enhancements in the alignment of services will add positively to the current model of care. On another front, AHCCCS is working to establish methods to recognize quality over quantity as well as cost savings to the system, by creating a mechanism for health plans and providers to share in the savings. Because of the potential for improvements in quality and cost savings, the Demonstration may play a role in this endeavor.

D. Stakeholder Engagement and Beneficiary Protections

i. Internal and External Stakeholder Engagement

Stakeholder engagement is a critical component to the State's ongoing planning and implementation of a system that improves the care for dual eligible members. Accordingly, the State initiated an engagement process that included outreach to consumers, family members or representatives, providers, advocacy organizations and others interested in the care of dual eligible members. AHCCCS communicated with stakeholders in a variety of formats, including planning meetings, public focus group sessions, e-mail announcements and outreach to advocates and providers, mailings, surveys, and a dedicated website with information about the proposed Demonstration. The AHCCCS website¹⁴ details the stakeholder meeting schedule; a final report from these sessions will be posted soon. A detailed description of the engagement process, timeline and outcomes are discussed below.

¹⁴ Information regarding the State's stakeholder engagement process can be found on its website at <http://www.azahcccs.gov/reporting/legislation/integration/Duals.aspx>.

(a) Initial Planning

To begin and help shape the engagement process, AHCCCS held a meeting with the Arizona chapter of the American Association of Retired Persons (AARP), the local Area Agencies on Aging (AAAs), and the Arizona State Health Insurance Program (SHIP) on Tuesday, February 21, 2012. AHCCCS gave an overview of the Demonstration concept, including the current system for dual eligibles in Arizona, the Demonstration target population, timelines, the Demonstration process and the importance of stakeholder input. All organizations expressed their support of the Demonstration alignment concept and their interest in assisting AHCCCS to obtain stakeholder input. AARP also co-signed letters that were mailed to members, inviting them to attend focus group sessions and complete an online survey.¹⁵ All three organizations understand the challenges dual members face and are looking forward to consumers participating in the development of an improved system.

(b) Health Plans

AHCCCS held a meeting with interested Medicare and AHCCCS health plans on February 28, 2012 to outline the dual Demonstration initiative.¹⁶ An overview was provided describing the current fragmented system and the importance of integrating services through the Medicare-Medicaid Demonstration. AHCCCS presented timelines, the Demonstration process, how these organizations may be impacted and expressed the importance of working with the health plans in the development process. Feedback from this meeting of 52 participants from a variety of health plans was overwhelmingly positive, with a major focus on the opportunities for improved care management for dual eligible members.

The discussion with health plans also highlighted many operational concerns. Health plan representatives expressed concerns with the lack of information about the rate setting process under the Demonstration, Star rating process, frailty adjustment and lack of an actuarial soundness requirement. Participants in this meeting also expressed their desire to be included in the rate development process. Another area of concern focused on enrollment and the ability of members to opt out of the Demonstration. Participants expressed concerns that non-Demonstration Medicare Advantage plans would market to Demonstration enrolled beneficiaries and those members would opt out of the integrated Demonstration plan. A recommendation was made that beneficiaries only have the choice to opt-out into Original Medicare, which AHCCCS included in this proposal. Another point of emphasis was concern in coordinating care when members can enroll in and out of the Demonstration monthly.

As a follow up, a health plan work group was held May 7, 2012 to discuss alignment of Medicare and AHCCCS requirements. The health plans discussed enrollment, network adequacy, marketing and member materials, and member appeals. This was a productive session where many areas of alignment possibilities were identified. AHCCCS will continue to engage health plans for feedback, particularly those who are experienced in managing care for dual eligible members for Medicare and Medicaid.¹⁷

(c) Member Focus Groups

AHCCCS engaged two external facilitators to conduct focus groups for members and their families or representatives throughout the State. A schedule of eight focus group sessions held in Phoenix, Mesa,

¹⁵ See letter at <http://www.azahcccs.gov/reporting/Downloads/Integration/DualsInvitationEnglishSpanish.pdf>.

¹⁶ Notes and information provided at the health plan meeting are available on the AHCCCS website at: <http://www.azahcccs.gov/reporting/Downloads/Integration/AHCCCSDualsDemonstrationPresentationPlans.pdf>.

¹⁷ For more information on the April 7 workgroup meeting, see http://www.azahcccs.gov/publicNotices/Downloads/DualIntegrationPlan_WorkGroupAgenda_5-7-12.pdf.

Surprise, Tucson, Flagstaff and Payson is available on the AHCCCS website.¹⁸ The facilitators gathered information on beneficiary experiences in the current system and their responses to the proposed changes, including the concept of automatic enrollment and opting out of the Demonstration. Members demonstrated many different levels of understanding about health care in general and personal benefits throughout the focus group sessions. Some participants were very knowledgeable about having Medicare and AHCCCS, while others were very confused about the differences. The different levels of understanding led to a variety of responses about satisfaction with the current system and responses to the proposed changes.

Major themes that emerged from these meetings are as follows:

- Positives of Current System: Many of the focus group participants felt satisfied with how they were receiving their health benefits and were questioning changes the State was proposing. They stated that their doctors and others assisted them in getting services so they had no major concerns.
- Challenges with Current System: Alternately, other participants were very confused about having both Medicare and AHCCCS and did not understand the two systems. Another challenge expressed was that there were limited resources to assist with questions about navigating the systems and being a dual eligible member.
- Supplemental Benefits: Dual eligible individuals overwhelmingly expressed support for maintaining Medicare supplemental benefits, specifically dental. Dual eligible individuals who had access to Medicare Advantage plans indicated that they made a yearly choice of plan based on the level of supplemental benefits the plan offered. Many of the beneficiaries gave specific examples of how these dental, vision, and hearing benefits are important to them and their health. Members who were accessing these benefits stated they would consider enrollment in the Demonstration plan as long as they did not lose any benefits and would be even more enticed by having additional benefits offered or reduced co-pays for prescription drugs.
- Enrollment: Most participants felt that automatic enrollment into an integrated plan would be a positive change and would alleviate confusion, but they also felt very strongly in support of their ability to opt out.
- Beneficiary Participation: Many individuals expressed a strong appreciation for being involved in the planning process and an interest in their continued ability to provide feedback in the future.

(d) Healthcare Providers

AHCCCS' external facilitators also conducted meetings with providers to gain their feedback on working with dual eligible members, including the challenges with the current system, their thoughts on the proposed system, and ideas for changes. These meetings were held in Tucson on March 22, 2012 and in Phoenix on March 27, 2012. Questions focused around both administrative and patient care issues.

Major themes that emerged from these meetings are as follows:

- Payment Difficulties: Providers expressed confusion and trouble with reimbursement of services for dual eligible members. Statements were made that having one health plan to call with questions and bill for services should make reimbursement easier. Eliminating co-pays and billing multiple payers was also voiced as a positive aspect of an integrated model.

¹⁸ See <http://www.azahcccs.gov/reporting/Downloads/Integration/DualsInvitationEnglishSpanish.pdf>; see also <http://www.azahcccs.gov/reporting/Downloads/Integration/DualsWithSeriousMentalIllness.pdf> for focus group sessions for individuals with Serious Mental Illness.

- Continuity of Care: There was strong support to ensure that under the Demonstration, members are able to continue relationships with their current doctors, especially in cases where a procedure is scheduled or there is a long-standing relationship.
- Coordination between Providers: Providers expressed that even under one health plan, it will be important for coordination between providers, suggesting the use of electronic medical records.
- Education: Providers expressed that education would be important for duals enrolled in the Demonstration, because many duals are currently confused and could benefit from education and understanding their options. A suggestion was made to have neutral parties provide education on Medicare choices.
- Reimbursement: Providers expressed concern about how provider rates would be set under the Demonstration.

(e) Advocacy Groups

AHCCCS' external facilitators also led a forum for advocacy organizations to learn about the Demonstration and express thoughts around the system for dual eligible members. This meeting was held on March 27, 2012 in Phoenix with the opportunity for advocacy organizations to participate from Tucson.

Major themes that emerged from these meetings are as follows:

- Simplification: Members of advocacy organizations expressed a strong desire for simplification of the enrollment and appeals process.
- Supplemental Benefits: Advocates express that dental benefits and wellness benefits, in addition to reduced drug co-pays, were important in the integrated Demonstration plan.
- Education: Advocates stated that beneficiary education around the Demonstration and options to opt out were important to the success of the program.

(f) Online Survey

In March, AHCCCS posted an online survey for stakeholders who were unable to attend meetings or wanted to express their comments anonymously.¹⁹ In addition, a notice of upcoming public meetings and a paper copy of the survey were mailed to over 5,000 dual members. Comments are also received through duals@azahcccs.gov, an e-mail address that was publicized to stakeholders in mailings and is on the AHCCCS website. As of May 31, 2012, AHCCCS has received 152 responses to the survey.

(g) Final Report

The online survey results, as well as a comprehensive overview of the focus groups and other facilitator sessions, were included in a final report prepared by the external facilitators and is available on the AHCCCS website.²⁰

(h) Public Meetings

A public meeting was held on April 18, 2012 to discuss the stakeholder feedback and how these efforts impacted the proposal.²¹ Attendees included consumers and family members, providers, and health plan

¹⁹ See survey at: <http://www.azahcccs.gov/reporting/legislation/integration/Duals.aspx>.

²⁰ See stakeholder engagement report at http://www.azahcccs.gov/reporting/Downloads/Integration/AHCCCS_DraftReport_041812kc.pdf.

²¹ For more information, see http://www.azahcccs.gov/reporting/Downloads/Integration/Duals_PublicNotice.pdf.

representatives. The external facilitators who conducted the stakeholder engagement presented their findings and answered questions. In addition, an AHCCCS representative gave an overview of the State's draft proposal and how stakeholder input shaped the draft. A question and answer period followed the presentation.

AHCCCS will hold an additional public meeting on June 8, 2012 after submission of the final proposal.

(i) Incorporation of Stakeholder Feedback

Stakeholder feedback has been considered in the development process for the Demonstration and will continue to be used in the planning, implementation, and operational phases. Specifically, input led to additional focus on education and training for current beneficiaries regarding the Demonstration. Focus group findings showed that when members understand their benefits and choices, they were more satisfied with their health care. When beneficiaries were confused and had trouble getting answers, there was an overwhelming sense of frustration and fear. AHCCCS will be initiating education and training to assist dual eligible members in finding resources and understanding their benefits under Medicare and AHCCCS. The more AHCCCS can do now, the smoother the transition will be during the Demonstration.

Additional input incorporated into AHCCCS' proposal includes:

- Member ability to opt-out of the Demonstration;
- No reduction in current Medicaid or Medicare benefits;
- Maintaining MCO flexibility to offer supplemental benefits;
- Protecting members' access to care and choice of doctor;
- Establishing one point of contact for members;
- Streamlining the system of care to minimize member confusion;
- Conservatively estimating short term savings when setting rates;
- Reinvesting some portion of State savings into care of members enrolled in the Demonstration;
- Adopting principles of actuarial soundness in rate setting; and
- Allowing providers to bill one health plan for both Medicare and Medicaid services provided to dual eligibles.

(j) Draft Proposal Comments

AHCCCS posted its draft proposal to the website on April 17, 2012 and sent an email to all stakeholders informing of the post and welcoming feedback. As of May 18, 2012, 33 comments were received from various provider organizations, advocacy groups, and health plans. Overall most respondents support the concept of integration that AHCCCS is proposing for dual eligible members. Many had questions about specific areas, such as more clarification around enrollment and member transition. Commentors also submitted recommendations for successful beneficiary experience.

AHCCCS is committed to addressing many of the issues raised through the public comments, including:

- Beneficiary education
- Beneficiary transition
- Network adequacy
- Inclusion of supplemental benefits
- Ongoing stakeholder involvement
- Administrative efficiencies
- Appropriate rates to health plans and providers

Over half of the 33 public comments came from local nursing facility (NF) administrators. The financial viability of NFs in Arizona is an ongoing concern. In part, those concerns arise from changes in Medicare

and Medicaid reimbursement. However, the other significant factor impacting NFs is excess capacity, the result of a continued shift away from NF placement for persons with long term care needs as this population seeks to receive services in the home or community. Arizona NFs expressed their concern that since Original Medicare's reimbursement rates are higher than those paid by MA plans, the fiscal impact from shifting AHCCCS dual eligibles out of Original Medicare to managed care may be more than they can absorb. Thus, while the NF comments expressed support for the concept of achieving administrative efficiencies, the industry has asked for a financial analysis of the impact to their facilities. Currently, 6,000 ALTCS duals, out of 120,000 total AHCCCS duals, reside in nursing facilities. AHCCCS acknowledges the unique position in which the NF industry finds itself. For instance, AHCCCS recognizes the increased acuity of the NF population and has factored that into recent rate decisions. AHCCCS remains committed to continue working with this group of providers.

ii. Beneficiary Protections

(a) Opt-Out Provisions and Choice of MCO

The passive enrollment of all dual eligible members is a key component of the Demonstration proposal. Accordingly, allowing members the choice to opt out of the Demonstration at any time is a critical beneficiary protection. The opt-out provision ensures that members are able to maintain their ability to choose Original Medicare if they determine the Demonstration does not meet their needs relating to their Medicare benefit.

In addition, AHCCCS has numerous mechanisms already in place through MCO contractual obligations to protect and enhance the beneficiary experience. Some of these protections include the right to change AHCCCS health plan during the Medicaid open enrollment period, as well as the right to choose one's physician.

(b) Ensuring Continuity of Care during Member Transition to New MCOs

Because a large portion of the beneficiaries will be passively enrolled into a health plan from their current Medicare health plan or Original Medicare, emphasis will also be placed on continuity of care during the transition of members into a Demonstration plan. AHCCCS already has a well-defined member transition process in place. For example, in the fall of 2011 after new contracts were awarded in the competitive bid process for the ALTCS E/PD program, AHCCCS successfully transitioned almost 8,500 ALTCS members from the outgoing health plan to the new plan. In 2008, over 150,000 Acute care members were transitioned to new plans as part of the Acute care bidding process. AHCCCS managed these processes collaboratively with extensive data sharing among the health plans to ensure appropriate care coordination.

These well-established practices will be applied to the transition of members under the Demonstration. Accordingly, health plans will be required to evaluate their provider network and expand the network as needed to accommodate the needs of beneficiaries for both primary care providers and specialists. AHCCCS will work with stakeholders to identify methods to address care issues and network impacts; however, AHCCCS anticipates there will be minimal disruption, as one-third of the population is currently in an aligned network and many providers already contract with Medicare and a variety of AHCCCS plans.

AHCCCS anticipates that the current Part D transition process will be applied for prescription drugs. This will allow members, providers and health plans adequate time to maintain medications or transition medications to alternatives on the health plan formulary (list of preferred drugs). Under Part D, members will receive a one-month fill of their current prescription drugs while working through the Demonstration

plan prior authorization process. This will allow transition time of medical records and address any possible provider changes.

(c) Maintaining Current Level of Benefits

In addition to the importance of continuity of care with current providers, beneficiaries, their advocates, and providers expressed the importance of continued benefits. There will be no changes to coverage of benefits under Medicare Parts A, B, D and AHCCCS. Stakeholders also clearly expressed the importance of Medicare supplemental benefits, including dental, vision, and wellness. AHCCCS is not seeking to restrict current benefits and will explore ways of incorporating benefits currently offered through Medicare Advantage plans as part of the Demonstration. Maintaining MCO flexibility to offer these supplemental benefits provides an additional protection to beneficiaries in addressing their overall health.

(d) Streamlining Grievances and Appeals

Finally, the State will work with CMS to identify any opportunities for streamlining grievances and appeals processes. Denial of service letters, Notice of Actions (NOAs), will be integrated to describe the appeal process for both Medicare and Medicaid benefits. AHCCCS proposes to integrate Medicare requirements into current AHCCCS practices for denials as these are the result of court orders. Demonstration plans will be required to follow the AHCCCS Guide to Language in Notices of Action,²² which ensures that members are notified of an adverse decision and provided with the factual basis or reason for that decision, and how to appeal that decision. Letters must be written in an easily understood manner giving members the ability to understand and appeal the decision. Plans undergo a critical review process prior to issuing an appeal decision that is monitored by AHCCCS. These requirements are more detailed than Medicare and are in the best interest of beneficiaries in understanding their health care rights. One process will provide uniformity and feasibility to all parties involved and most importantly, provides beneficiaries with a more streamlined approach to understanding and preserving their rights.

Providers have expressed interest in streamlining the provider appeal process for denied claims. Currently providers contracted with Medicare Advantage plans do not have appeal rights for denied claims, but AHCCCS providers do. AHCCCS will work with CMS to address any possible changes to this current restriction for contracted providers.

iii. Ongoing Stakeholder Engagement

Ongoing stakeholder input will be vital in the development, implementation and ongoing monitoring of this new integration of benefits and administrative processes. AHCCCS will take strides to keep all parties updated regarding developments via a dedicated page on the AHCCCS website, fliers at local community and senior centers and in-person meetings. Through stakeholder focus groups, beneficiaries expressed their appreciation for being invited to be part of the development and planning and would like to continue to be involved and updated by mail or via postings at local facilities. It became apparent that beneficiaries have a wide range of information sources, so AHCCCS needs to use various outlets to share information and gain feedback in order to accommodate as many members as possible. All information will be transmitted in easy-to-understand language, and made available in Spanish and alternative languages and communication formats as necessary. There will always be an opportunity for beneficiaries and their representatives to contact AHCCCS with questions by phone, mail, or email. To that end, AHCCCS created both a special phone number and email address for questions specific to this Demonstration. AHCCCS will also ensure that the local SHIP offices are informed and can provide assistance to beneficiaries.

²² See <http://www.azahcccs.gov/shared/Downloads/NOA/LanguageGuide.pdf>.

In response to stakeholder feedback, AHCCCS published the first issue of *Duals Digest* on May 14, 2012. The newsletter was sent by email to interested stakeholders and posted to the AHCCCS website.²³ (See Appendix D.) In addition, the newsletter was sent to local senior centers and community groups for posting. AHCCCS will use the newsletter as a vehicle through which to communicate major updates in the Demonstration process.

E. Financing and Payment

i. Financial Alignment Model

Arizona is pursuing the Capitated Financial Alignment model outlined in the July 8, 2011 State Medicaid Director Letter. Under this model, CMS, the State and Demonstration health plans will enter into a three-way contract. The three-way contract will permit CMS and the State to pay Demonstration health plans an amount sufficient to cover the full range of Medicare and AHCCCS benefits for the targeted populations and allow the health plans to offer and be accountable for the full spectrum of services available to dual eligible members.

The CMS stated goals of this model are to improve care and lower costs for dual eligible individuals. CMS anticipates an upfront savings that would be shared between CMS and the State. In addition, rates paid to the health plans under this model will be determined jointly by CMS and the State to estimate potential savings under the integrated model.

While the State agrees with assuming some degree of upfront savings and supports a model whereby rates are set jointly, AHCCCS proposes consideration of two key issues: (a) any estimate of upfront savings must be nominal in the early years; and (b) rate setting for Demonstration plans should adopt the Medicaid managed care principles of actuarial soundness.

(a) Upfront Savings Will Be Nominal

The State agrees that the integration of Medicare and Medicaid under one health plan will provide savings in the form of decreased hospitalizations, emergency room admissions, and reduction of duplication of services through administrative efficiencies, improved care coordination, alignment of incentives, and reduction of policy barriers. However, the degree to which savings can be achieved in Arizona in the short term is impacted by the State's early successes with alignment and its high penetration of dual eligible enrollment in managed care for both Medicaid and Medicare.

As has been previously mentioned, all AHCCCS duals are enrolled in Medicaid managed care plans, including members receiving long term care services. One third of Arizona's dual eligible population receives its Medicare and Medicaid benefits in an aligned Special Needs Plan (D-SNP). Over 60% of duals members receive Medicare through Medicare Advantage plans, including 50% enrolled in D-SNPs.

This high penetration of managed care throughout the State means that the level of additional savings under the new model is unknown. Because of the potentially devastating impact of overestimating savings on health plans' ability to perform under the contract and the impact that may have on member protections and benefits, savings in this environment should be conservatively estimated. The State continues to work with CMS to determine the level of estimated savings that may be achieved through further integration and coordination of Medicare and Medicaid benefits.

²³ See *Duals Digest* Newsletters at <http://www.azahcccs.gov/reporting/legislation/integration/Duals.aspx>.

(b) Adopting Actuarial Soundness

AHCCCS proposes, with feedback from Medicare and AHCCCS health plans, that the rates adopted for the Demonstration plans be actuarially sound for both Medicare and Medicaid. AHCCCS also proposes use of claims and experience data in setting the health plan rates. Requiring that rates be actuarially sound limits risk to health plans and ensures beneficiary protections that the rate is appropriate to meet the needs of the population being served.

AHCCCS has a long-standing and effective method for setting actuarially sound rates that ensures the plans' ability to provide quality care while maximizing cost containment. Due to these methods and an already integrated long term care program, it is expected that most of the savings under the Demonstration will be experienced on the Medicare benefit. Accordingly, AHCCCS proposes to use its current rate-setting methods for the Medicaid component of the Demonstration.

In order to assess AHCCCS' proposal, it is important to provide a brief overview of how rates are set for the programs serving the three populations targeted under the Demonstration.

1. Rate Setting for the ALTCS Elderly and Physically Disabled (E/PD) Duals

For members receiving Medicaid through the ALTCS E/PD program, capitation payments to plans are based on a mix of member placement in the home, in a community setting or in an institution. Various sources of information are used, including encounter data, audited and quarterly financial statements, programmatic changes, fee-for-service rate adjustments, fee schedule rebase, and changes in placement in home and community based services (HCBS). There is an HCBS reconciliation process, which is used to incentivize plans' promotion of member transition from nursing facility to a home or community based setting, when appropriate. A placement mix is established for members in an HCBS setting versus those in a nursing facility based on geographic service area and health plan. When health plans exceed the percentage of members in an HCBS setting than what is expected, there is a bonus. This, in addition to other contractual and quality requirements, has led to an overall state HCBS mix of over 70% in Contract Years Ending 2010 and 2011. In February 2010, for the first time in ALTCS program history, the percentage of members residing outside of a nursing facility exceeded 70%. That figure remained above 70% for the remainder of CYE 2010 and 2011. The figure is attributable, in part, to the addition of two service options in CYE 2008: Spouses as Paid Attendant Caregivers and Self Directed Attendant Care. These service options provide members with more HCBS choices and continue to have a positive impact on the overall growth of HCBS membership.

The effectiveness of the ALTCS program in promoting member placement in home and community based settings is attributable to both the AHCCCS model and the ALTCS MCOs. The missing piece to the ALTCS program has been Medicare as 83% of the enrollees are dual eligible. AHCCCS proposes to continue existing practices with this population, while integrating Medicare covered services, and Medicare payments to health plans. Consistent monitoring of the HCBS placement mix and the incenting of HCBS mix will continue to be vital in the success of the ALTCS program under the Demonstration. Increased methods of care coordination and prevention can now be explored with the inclusion Medicare information through coordination of prescription drugs, primary care, and hospitalizations.

2. Rate Setting for Acute Duals

The Acute care Medicaid rates are developed using historical Acute care data, including Arizona Medicaid managed care encounter data as well as health plan financial statements. Other data

sources include programmatic changes, anticipated AHCCCS Fee-For-Service rate changes, anticipated ADHS transportation increases, CMS National Health Expenditure (NHE) Report estimates and Global Insight Prospective Hospital Market Basket Inflation Index (GI) information. Rates for this population are set on average and then risk adjusted based on member acuity. AHCCCS proposes to apply these current practices to the Medicaid portion of rates for Acute Duals under the Demonstration. AHCCCS is also proposing that the Medicaid component of the Acute rates in the Demonstration be set as part of the Acute care Request For Proposals (RFP) using an actuarially sound range upon which offerors can bid. The Acute care RFP is expected to be issued sometime in the fall of 2012. CMS and the State would reserve the right to adjust as needed before implementation and throughout the three-year Demonstration.

3. Rate Setting for Acute Duals with SMI in Maricopa County

The integration of physical and behavioral health for people with Serious Mental Illness (SMI) in Maricopa County is important in providing coordinated care and savings. Bringing together these two siloed areas of Medicaid, which have been delivered through different state agencies, has been a collaborative effort. The State is contemplating developing rates through identifiable physical health and behavioral health components combined into one integrated care capitation rate for payment. Rate reconciliation using encounter data will be performed for all rates within some profit/loss corridor. As this is a new initiative and part of a RFP process for the Maricopa County Regional Behavioral Health Authority (RBHA), rate setting is still being evaluated, but will be blended based on current AHCCCS and ADHS/DBHS payment structures. AHCCCS will work with CMS to determine how payments for duals can be incorporated to achieve the greatest financial accountability and savings.

AHCCCS proposes that the Medicaid component of the rate for this population be set through the Maricopa RBHA RFP process. Through this process, the State will set an actuarially sound range and allow bidders to submit their rate. As the RFP and proposal submission will be over twelve months in advance of the Medicaid contract effective date and implementation of the Medicare benefits under the Demonstration, the State and CMS will reserve the right to adjust the awardee's bid as needed to establish an actuarially sound rate.

(c) Setting the Medicare Rates

AHCCCS has in-house actuaries who are involved in the overall development of the Demonstration. These actuaries will be valuable in working with CMS to set and monitor the Medicare rates. AHCCCS proposes Medicare rates be set based on a methodology using an established baseline spending figure and expected savings under the integrated model. In addition, rates need to be risk adjusted based on population and needs of beneficiaries. AHCCCS also proposes that the Medicare rate take into account the high penetration of duals that are enrolled in Medicare Advantage plans and those already aligned in the same Medicare and Medicaid plan. CMS has proposed establishing quality withholds and AHCCCS will continue to work with CMS to determine whether these methods are an effective strategy for the Arizona specific population. AHCCCS also proposes to establish mechanisms by which to evaluate and modify rates as needed during the three-year period.

(d) Application of State Upfront Savings

AHCCCS is exploring ways in which some portion of the State's savings can be reinvested into the Demonstration to further improve the quality of care provided to beneficiaries. As a result of stakeholder input, AHCCCS would like to consider using the upfront savings to:

- Extend the benefit package to include dental, vision or hearing benefits currently covered under Medicare Advantage plans as part of their supplemental benefits package;
- Reduce prescription drug co-pays; and
- Provide care managers who can assist members with questions and education.

AHCCCS welcomes CMS and stakeholder feedback on this part of the proposal and additional suggestions on how the savings from the Demonstration can be reinvested to support the Demonstration. AHCCCS acknowledges this proposal is in the exploration phase and additional discussions with CMS and the State policymakers will need to take place.

ii. Payments to Providers

Providers will be paid by contracted health plans. Health plans will maintain their current discretion to set provider payment rates. Competitive rate setting is effective in containing costs and promoting choice in the market.

F. Expected Outcomes

i. Data Collection and Monitoring

AHCCCS maintains a rigorous process for monitoring, collecting, and tracking outcomes. The process will continue throughout the Demonstration. A variety of measures, such as those related to cost and utilization, can be tracked and monitored through the AHCCCS encounter reporting system. (Claims reported to the AHCCCS Administration by contracted health plans are referred to as “encounters.”) Eventually performance measures are expected to evolve into outcome-based measures that will require expansion of data collection resources.

To support an easy transition, AHCCCS will require Demonstration plans to continue submitting encounters for both Medicare and Medicaid covered services. Avoiding the need for a new set of encounter submission requirements will ensure that health plans are ready to submit accurate data and the State is ready to accept it. Because the Demonstration period lasts only three years, it is imperative that collection of data for evaluative purposes begin immediately.

In addition to collection of encounter data, the State will develop measures that evaluate outcomes related to this target population. AHCCCS staff, including the Clinical Quality Management team, is acutely aware of the importance of monitoring and measurement in the oversight of contracted health plans, especially during the implementation of new programs. As in the past, staff will seek measures that come from reliable data sources, are reasonable to collect, provide an accurate representation of the target population, and would be actionable if quality improvement items are identified. Finally, AHCCCS will explore the most beneficial means of gathering enrollees’ feedback and incorporating it into evaluation activities.

AHCCCS will continue the use of selected Medicaid measures as well as selected core measures from the Medicare measure set. These measures will be used to compare the State’s Demonstration performance with the National aggregate. AHCCCS proposes to develop and incorporate CMS-proposed measures, particularly those that require new data sets (e.g. from EHRs and HIEs), on an incremental basis.

ii. Potential Improvement Targets

A potential improvement target is the rate of in-patient re-admissions within 15 and 30 days. AHCCCS has developed an initiative focused on decreasing the rate of inpatient re-admissions within 15 days and

30 days of a previous admission. The topic of readmissions has already been established as a Performance Improvement Project for AHCCCS health plans and will be developed into a contractually-mandated performance measure for all lines of business, including Demonstration health plans. AHCCCS will establish Performance Measure minimum standards in contract. Should Contractors not achieve the minimum performance standard, they will be required to submit a corrective action plan focused on implementing interventions to improve outcomes. Contractors may also be subject to financial sanctions if targets are not met.

AHCCCS and its Contractors will also increase their focus on discharge planning. This includes coordinating closely with the CMS Quality Improvement Organization, the Arizona Department of Health Services, hospitals and providers on this initiative. When developing the performance measurement targets, AHCCCS may consider a reimbursement strategy to assist with reducing re-admissions. It is anticipated that improved readmission rates will improve the quality of life for beneficiaries, promote patient-centered care, and reduce unnecessary health care utilization and costs. AHCCCS is also discussing opportunities to obtain information and member feedback related to member satisfaction with care and services. In combination, increased monitoring, implementation of improvement activities and interventions, and greater access to enrollees' information, is expected to reduce inappropriate readmissions and provide cost savings.

Stakeholder engagement throughout all phases of the Demonstration will offer additional opportunities for evaluation. AHCCCS will continue to evaluate additional initiatives that may be focused on reducing avoidable hospitalizations, emergency room admissions, and nursing facility placements.

iii. Impact of the Demonstration on Medicare and Medicaid Costs

Detailed financial projections related to the Demonstration are not available at this time; however, it is expected that savings may be realized through:

- Improved outcomes, including improved health status of dual eligibles enrolled in the Demonstration
- More efficient and effective utilization of services
- A reduction in cost-shifting between Medicare and Medicaid plans
- Improved access to information and data
- Consolidation of accountability for care
- A reduction in duplication of services
- An increase in enrollee satisfaction, leading to an increase in compliance
- Administrative efficiencies

AHCCCS continues to work with CMS to determine the level of expected savings through the integration of Medicare and Medicaid benefits under one point of accountability. These outcomes will continue to be monitored throughout the Demonstration period. Through data gathering and beneficiary feedback, AHCCCS and CMS will be able to evaluate further areas of improvement in health outcomes and savings for dual eligible members.

Preliminary findings indicate that Medicare savings will be achieved from:

- Inpatient reductions of avoidable preventable admissions and avoidable readmissions
- Skilled Nursing Facility reductions
- Emergency room reductions
- Other Medicare medical services

Medicaid savings are estimated to be low due to the current AHCCCS structure of:

- Managed care settings that control costs;
- Use of appropriate utilization management methods;
- Mature managed care environment;
- Operational and technical experience of State and Health plans; and
- High penetration of long term care members receiving services in the home or community rather than in an institutional setting.

AHCCCS believes that the Demonstration will achieve some savings; however, because the State's Medicare and Medicaid systems have operated in a mature managed care environment for many years, the savings remaining to be found may be minimal. For example, when Part D was established in 2006, FFIS pulled state expenditure data to determine the clawback requirements for states. Based on this data, Arizona had the lowest per member per month prescription drug cost of \$166 for dual members. The national weighted average was \$265.95.

Despite the possibility that the Demonstration may yield nominal short-term savings, AHCCCS believes implementation of a fully integrated model of care for dual-eligibles is worthwhile. It is the right thing to do for the member and presents an opportunity for long-term sustainability of the program.

G. Infrastructure and Implementation

i. State Infrastructure/Capacity

As a Medicaid program that has deployed managed care since its inception, AHCCCS is well prepared to implement and oversee the Demonstration both from a health plan monitoring perspective in addressing member and stakeholder issues.

(a) Division of Health Care Management

The AHCCCS Division of Health Care Management (DHCM) has over 30 years experience monitoring MCOs and developing contractual requirements and policies to ensure successful health plan performance. This Division currently has over 70 employees responsible for oversight and compliance, health plan procurement, data analysis, encounter collection, research and reimbursement, finance and reinsurance management, actuarial analysis and rate setting, clinical quality management, behavioral health and medical management.

DHCM effectively monitors overall health plan success through financial results, quality and performance measures, medical management, operations and claims. Staff conducts Operational and Financial Reviews (OFR) to ensure MCOs meet performance measures, complete performance improvement projects and submit all other deliverables required by contract, Medicaid managed care regulations and State law. As part of the OFRs, AHCCCS staff reviews MCO progress in implementing recommendations made during prior OFRs and determine MCO compliance with its own policies and procedures.

In addition, the DHCM includes a Data Analysis and Research team that oversees the transmission of health plan encounters to AHCCCS. As encounter data is used for rate setting for the Medicaid health plans, timely and accurate encounter submission is an important operational function. Encounters also include claims processed by health plans for Medicare cost sharing. Thus, AHCCCS is already receiving the majority of encounters that will be submitted under the Demonstration. AHCCCS is reviewing possible changes to identify and separate Demonstration plans, but otherwise the State does not foresee the need for major changes.

Under the Demonstration, DHCM will continue to deploy these monitoring activities to the Demonstration plans. In addition, DHCM and AHCCCS leadership will maintain appropriate communications with health plans, including regular CEO and Medical Director Meetings, one-on-one health plan meetings and other communication that maximizes health plan satisfaction.

(b) Division of Member Services

The Division of Member Services is responsible for member eligibility determinations and enrollment. This Division also oversees direct communications with members, including member notices and education. The Division of Member Services also includes an Office of the Client Advocate where members can call a customer service support line and speak to highly trained staff that can assist in health plan selection, eligibility inquiries and other matters. Member services staff are also trained to provide member information in a clear, easy-to-read and culturally appropriate manner. This division will have dedicated staff who are familiar with Demonstration eligibility and enrollment. These staff will be available for questions as well as processing enrollment changes.

(c) Office of the Director

The Office of the Director is responsible for waiver and State Plan oversight, as well as interfacing with CMS. In addition, this unit oversees external stakeholder engagement, tribal relations, media relations and website content that will help with maintaining ongoing outreach throughout the Demonstration.

(d) Office of Administrative Legal Services

The Office of Administrative Legal Services assists with program compliance to federal and state requirements, as well as grievances and appeals.

(e) Information Services Division

The Information Services Division is critical to making the necessary system changes and providing continued technical specifications needed for information sharing with CMS and Demonstration plans.

ii. *Implementation Strategy and Timeline*

The State is seeking to begin the Demonstration January 1, 2014. The timeline²⁴ below provides a broad overview of the work that must be accomplished to prepare for a January 1, 2014 implementation. Additional preparatory steps can be taken once AHCCCS and CMS resolve outstanding issues.

Timeframe	Key Activities/Milestones	Responsible Parties
March 2012	Ongoing Stakeholder Engagement	State
April 2012	Draft Proposal Posted to AHCCCS Website for 30 day Comment	State

²⁴ This work plan reflects steps identified as of submission of this draft proposal; items and date are subject to change.

April 2012	AHCCCS Interagency Work Group Begins	State
May 2012	Final Proposal Submitted to CMS for Review	State/CMS
Summer 2012	Proposal Review	CMS
July 2012	Maricopa RBHA RFP Issued	State
Summer/Fall 2012	Memorandum of Understanding (MOU) Negotiations	CMS/State
October 2012	Maricopa RBHA Proposals Due	Health Plans
October 2012	Expected finalization of MOU	CMS/State
November 2012	Acute RFP Issued	State
November 2012	Notice of Intent to Apply (NOIA) as Demonstration Plan Due	Health Plans
January 2013	Maricopa RBHA Contract Awarded	State
January 2013	Acute Proposals Due	Health Plans
February 2013	Demonstration Applications Due	Health Plans
February 2013	Readiness Review/Transition Begins for Maricopa RBHA	State/ Maricopa RBHA
March 2013	Acute Contracts Awarded	State
Spring 2013	3-Way Contracts Signed	CMS/State/ Health Plans
April 2013	Part D Formulary Submission	Health Plans
April 2013	Readiness Review/Transition Begins for ALTCS and Acute Plans	State/ Health Plans
June 2013	Demonstration Benefit Packages Due	Health Plans
September 2013	Letters mailed to Dual Eligible Members notifying of future enrollment	State
October 2013	Acute and Maricopa County RBHA Medicaid contracts begin	
November 2013	2 nd Letter mailed to Dual Eligible Members notifying of future enrollment	State
January 1, 2014	Implementation of Demonstration	CMS/State/ Health Plans

H. Feasibility and Sustainability

i. Potential Barriers

Overall Arizona is comfortable that this Demonstration fits well within its existing managed care model and that, for members, the Demonstration does not present a dramatic departure from the way they currently access services. Nevertheless, Arizona does not underestimate the challenges raised by this Demonstration, particularly the anxiety that dual eligible members may experience as the State undergoes this transition toward passive enrollment. The State is committed, first and foremost, to ensuring dual eligible members maintain access to care for the full array of Medicare and Medicaid benefits for which they are currently eligible and to minimizing disruption of care for dual eligible during the transition to the greatest extent. Current processes around member health plan transition will help achieve these goals. Continued consumer engagement and education, a priority of the AHCCCS program, will help address member concerns.

In addition, the State believes it has the capacity to appropriately and effectively implement and monitor the Demonstration plans. However, achieving health plan satisfaction and addressing plan concerns are keys to successfully implementing the Demonstration. Health plans raised a variety of questions and concerns at the engagement meeting held by AHCCCS on February 28, 2012. Many of these questions remain unanswered, particularly concerns around rate setting. AHCCCS will continue to work diligently to address MCO concerns with CMS. In addition, several aspects of this proposal are aimed at addressing MCO anxiety around participation in the Demonstration. Some of these include: conservatively estimating initial savings; applying actuarially sound rate setting principles; streamlining administrative burdens, such as allowing plans to process one claim for both Medicare and Medicaid; and identifying methods to streamline monitoring and reporting for Medicare and Medicaid requirements. Due consideration of MCO concerns is paramount in ensuring a successful Demonstration.

AHCCCS is prepared to work through these challenges because this Demonstration will facilitate better care for dual eligibles, improve the overall health care system and address long-term sustainability.

ii. State Statutory/Regulatory Changes

There are no Arizona statutory or regulatory barriers to full implementation of the Demonstration that have been identified at this time. If the State is able to align some grievance and appeals processes, statutory or regulatory changes may be needed. The State recognizes the need for Demonstration approval and that such approval may require conforming changes to its Section 1115 Research and Demonstration Waiver. Because this Demonstration is a State priority, Arizona commits to working with the Medicare-Medicaid Coordination Office to ensure it obtains all appropriate authorities necessary for full implementation.

iii. Future State Funding Commitments and Contracting Processes

AHCCCS must complete its competitive bid process and award new contracts for the Acute care population and the Maricopa County Regional Behavioral Health Authority. Current contracts for these MCOs end September 30, 2013 and by State law must be re-procured. This Medicaid contract selection process will incorporate selection of Demonstration plans for the Acute care and Maricopa County SMI population. These contracts will begin October 1, 2013 and will be in place before implementation of the Demonstration.

iv. Scalability to Other States

Arizona's Demonstration is statewide and includes almost the entire dual eligible population. The only dual population that is specifically excluded is the ALTCS Division of Developmental Disabilities (DDD). AHCCCS contracts with a state agency (Department of Economic Security) that serves as the MCO for that population. The Demonstration certainly could be applied to the ALTCS DDD program but only after appropriate evaluation to determine how the Demonstration may need to address the unique needs of this population.

The Arizona Demonstration can also be replicated in other states. Arizona's policies and processes around health plan oversight, staffing, member transition, data sharing and others can easily be adopted by other states. In addition, health plan integration practices, such as those adopted in the ALTCS E/PD program, can be modeled for use by other states for their long term care populations.

v. Letters of Support

See Appendix E.

I. Additional Documentation

None requested from CMS at this time.

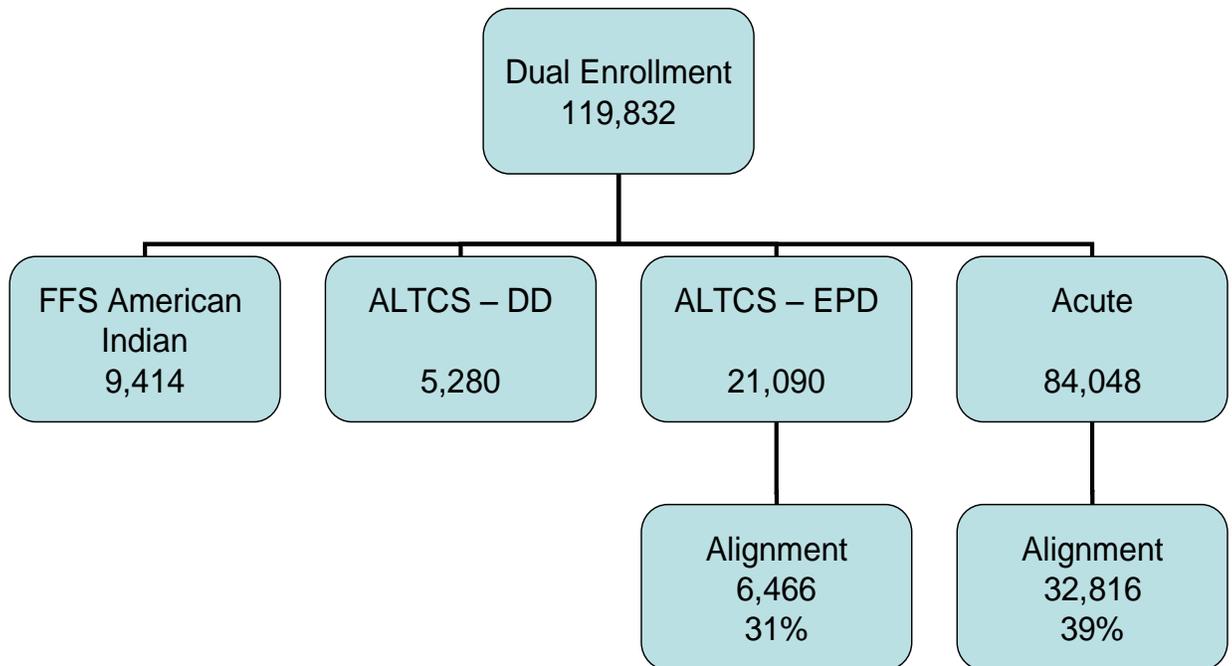
J. Interaction with Other HHS/CMS Initiatives

AHCCCS is exploring initiatives that have been launched by the Department of Health and Human Services and whether these may be incorporated into the Demonstration, and across the entire AHCCCS population.

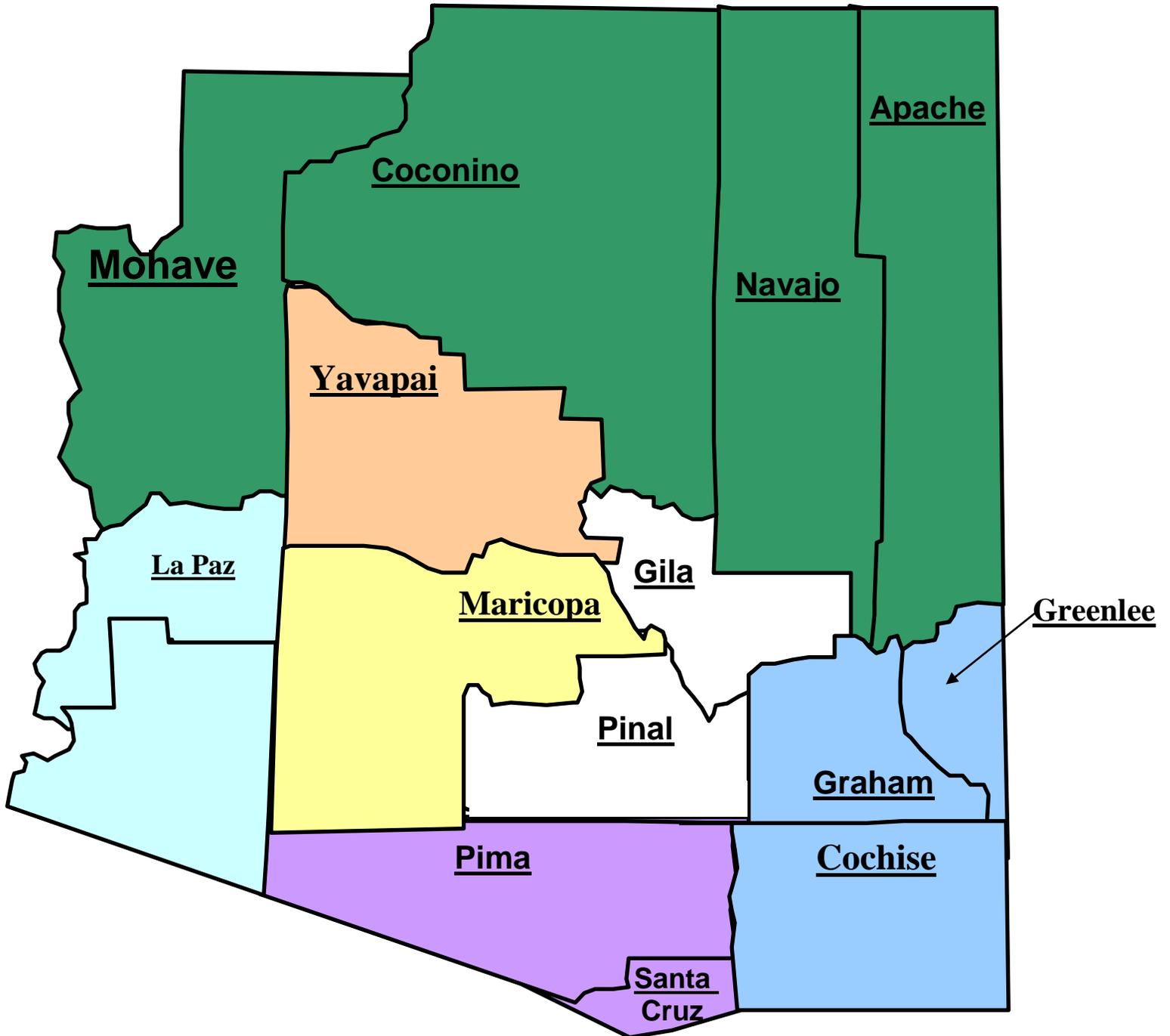
- Partnership for Patients: AHCCCS is working with the Health Services Advisory Group related to reducing patient readmissions. As was discussed in Section F, current AHCCCS plans are under a Performance Improvement Project to reduce readmissions through activities such as effective discharge planning. AHCCCS plans to make this a contract requirement that will apply to health plans administering Medicare and Medicaid benefits under the Demonstration.
- HHS Action Plan to reduce Racial and Ethnic Health Disparities: Although not officially participating in the HHS Action Plan to reduce racial and ethnic health disparities, AHCCCS includes racial and ethnic stratifications in Performance Measures and Performance Improvement Projects to encourage activities and interventions to reduce disparities should any be identified. These measures will apply to the Demonstration.
- Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents: This newly released initiative (March 15, 2011) provides an opportunity for organizations to work with nursing facilities to reduce avoidable inpatient hospital admissions. AHCCCS will be reviewing this initiative further to determine whether this would fit into the Demonstration model.

Appendix A – Dual Eligibles within the AHCCCS Program

AHCCCS Dual
Enrollment as of
January 2012



Appendix B – Map of Arizona Geographic Service Areas
AHCCCS Geographic Services Areas



Appendix C – Medicare Advantage Supplemental Benefits offered in Arizona

March Dual Enrollment	Dental	Hearing	Vision	Over-The-Counter	Fitness
Plan A (24,278)	1 Cleaning and oral exam every 6 months 1 x-ray \$1,500 for comprehensive dental benefits	1 routine hearing test every year \$1,500 plan coverage limit for hearing aids every two years.	1 eye exam per year \$150 limit for eyewear every 2 years	\$100/Quarterly benefit card for OTC medications, vitamins, incontinence, toothbrushes, etc...	
Plan B (16,025)	1 cleaning, oral exam, fluoride every 6 months 1 x-ray per year \$1,500 for comprehensive dental benefits	Hearing aids (up to \$1,200 every 3 years)	1 eye exam per year \$175 limit for eye wear every year		Group health and wellness activities and learning events. Up to (2) visits per month, (16) visits maximum per calendar year.
Plan C (4,025)	2 exams and cleanings per year 1 x-ray per year	\$1,500 limit for hearing aids every year	1 eye exam per year \$100 limit for eye wear every year	\$50/quarter for commonly used OTC items	
Plan D (2,814)	2 oral exams, cleanings, and x-rays per year \$1,000 for comprehensive dental benefits		\$10 co pay for 1 exam per year \$100 allowance for eye wear every 24 months		Silver Sneakers program
Plan E (2,151)	2 cleanings, exams, fluoride treatments/ year 1 x-ray per year \$500 dental benefits	1 routine hearing test every year Hearing aids (up to \$700 every year)	1 eye exam per year \$175 limit for glasses or contacts per year	\$52.50/quarterly for over-the-counter items	
Plan F (1,787)	Dental benefits for \$33/month	1 routine hearing test every year Hearing aids (up to \$100 every year)	1 eye exam per year \$30 copayment for standard lenses and frames up to \$70		Silver Sneakers program for \$13/month

Appendix D – *Dual's Digest*: A Newsletter on Activities Related to Arizona's Dual Eligibles

(See attached)

Appendix E – Letters of Support

(See attached)