AHCCCS Update

1115 Waiver Proposal

Arizona State Innovation Model Vision

*Accelerate the delivery system's evolution towards a **value-based, integrated** model that focuses on whole person health in all settings regardless of coverage source.*

Goals Stakeholder Process

- Value and need input on draft documents
- Want to engage on details around milestones and measures – these ultimately drive payments –
- Need measure feedback beyond year 1
- Want to ensure delivery system investments are meaningful
- Need stakeholder engagement from appropriate staff
- Creating more opportunities for dialogue beyond written comments – focus groups

SIM Sustainability - DSRIP Projects

1. American Indian Care Management Collaborative – *Organized by AHCCCS with CMC governance*
2. Physical Health - Behavioral Health Integration – *State contract with yet to be determined number of entities by region*
    a. Adults
    b. Children
3. Justice System Transitions – *Proposed that RBHAs administer*

Proposal Structure

- With the exception of one AIHP project, all projects for each strategic focus area are required
- Some projects are sequenced
- Providers can participate in projects in more than one strategic focus area although we are evaluating complexities of this for AIHP and integration

Integration Efforts to Date

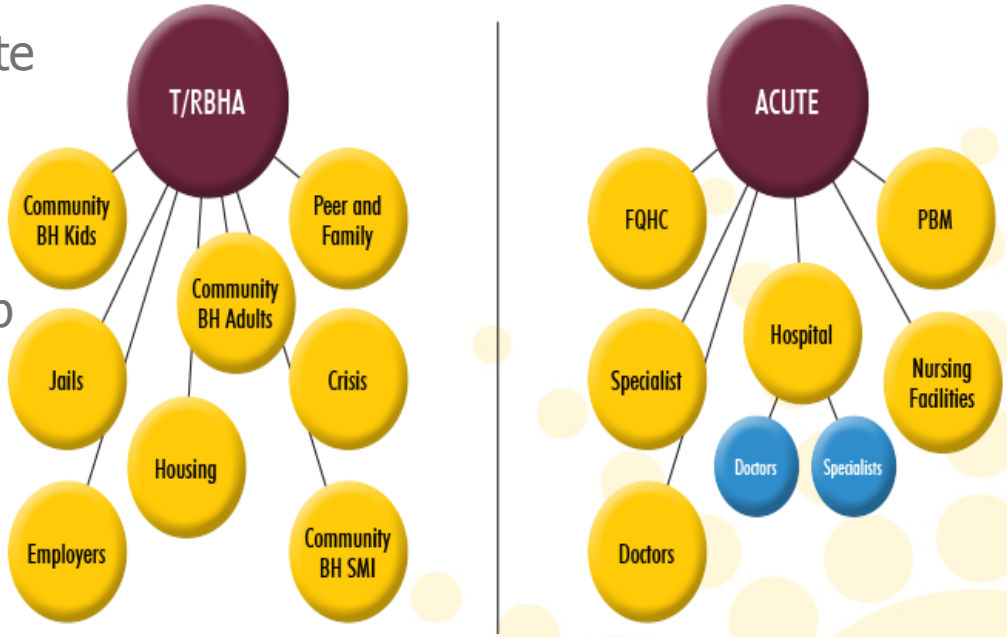
1. Ongoing – Duals – >40% alignment DSNP
2. 2013 – 17,000 Kids with special needs
3. 2014 – 20,000 Individuals with SMI – Maricopa
4. 2015 – 19,000 Individuals with SMI – Greater AZ
5. 2015 – 80,000 dual eligible members – Integrate BH
6. 2016 – Administrative Merger
7. Future Possibilities
    1. 2017 – 29,000 members with DD – BH & PH
    2. 2018 – 34,000 Children with Autism or at risk
    3. 2018 or future date – Non-SMI adults – BH

Overall Delivery System Limitations and Challenges

Medical care providers, behavioral health care providers, and social service organizations rarely collaborate in a way that addresses complex needs of members.

Due to fragmented funding streams providers have little or no relationship or recognition of critical potential partners.

Previous system design really limited ability to drive toward alternative payment models. Because of fragmentation providers do not have the network, capacity or infrastructure to manage risk.



Justice System Efforts to Date

- Have 9,000 unique Medicaid members incarcerated at some point monthly
- Daily match with county jails >90% population and DOC to suspend/reinstate – saved >$30m cap
- Make incarceration data available to plans daily
- RBHAs staff established in jails – Creating reach in requirements for other MCOs
- Partnering with DOC/Jails resulted in 1,500 pre-release apps processed
- 1,100 transitions included select care coordination efforts through manual process

Current System Limitations and Challenges

- 50% of population entering Pima county jail are AHCCCS enrolled – another 30% enrolled in past 2 years
- Need ability to make more scalable
- Need data to flow between justice system partners and Delivery system
- Need to be more strategic in delivering services – right service – right place – right time
- Need to ensure greater continuity to address Behavioral Health needs of population
- Continue to improve partnership with Justice System

American Indian Efforts to Date

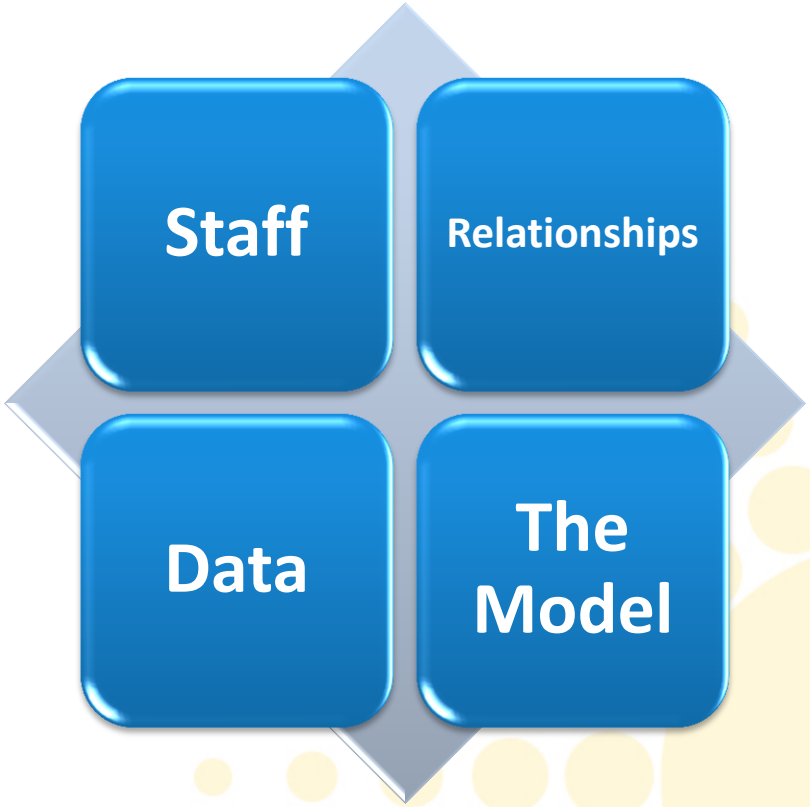
Staff – added new resources including BH manager and physician

Relationships–Have traveled statewide to visit Tribal providers and stakeholders

Data – Sharing data with 14 different organizations on member utilization

Model – Have 130 members in active care management with providers

Care Management Model



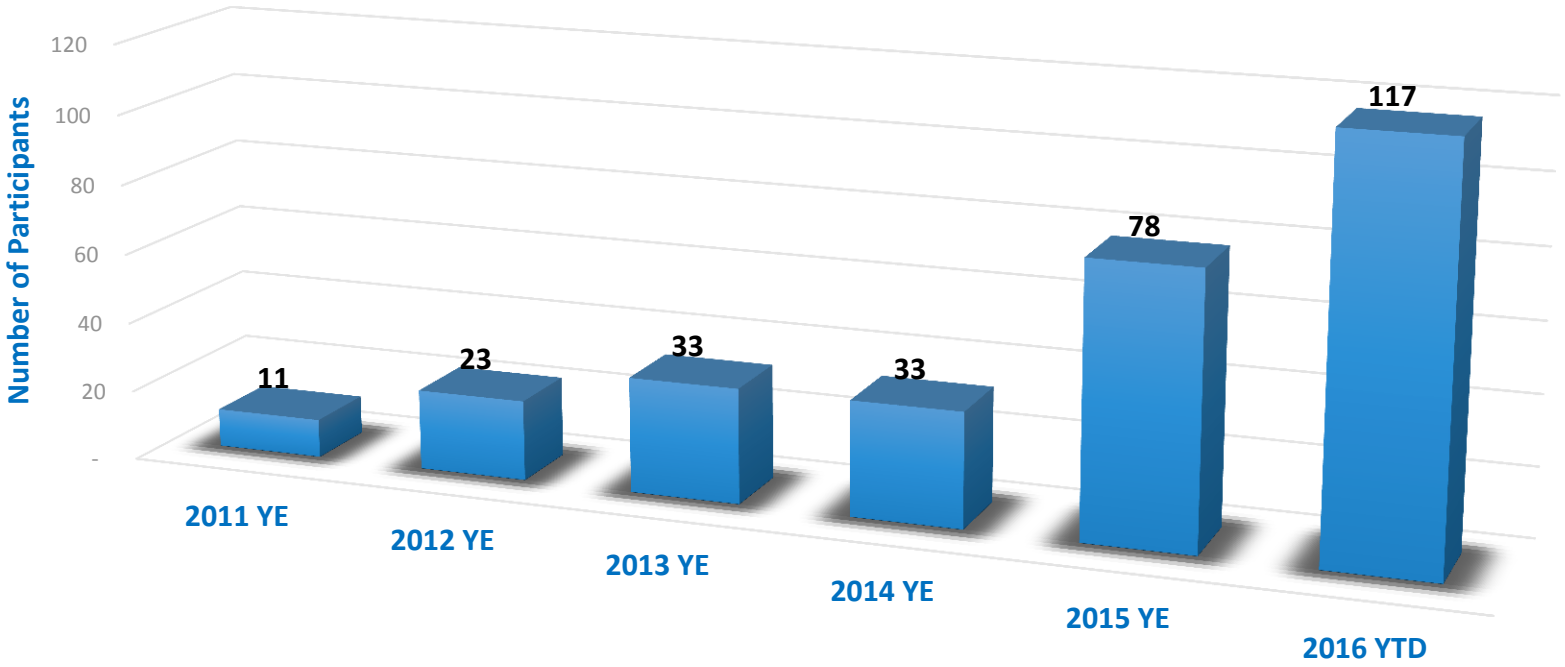
Current System Limitations and Challenges

- Scale of fragmentation is significant given broad network American Indians may access for services and geography of Arizona – 3 counties = 2 MA and 1 Maryland
- Resource limitations of Indian Health Provider Organizations to share or receive actionable data
- Limited resources within AHCCCS to create more scale around care management platform
- Historical limitations of Medicaid and other payers to cover costs of care management infrastructure.
- Significant healthcare disparities of American Indian population

Value Based Purchasing and Alternative Payment Models - Efforts to Date

1. AHCCCS role – establish broad goals for system
2. Select specific VBP methodologies – Hospitals (HIE and MU2) – SNFs – Integrated Providers - fee schedule
3. Goals and progress is incremental
4. System Design Matter - True VBP requires Integration to align incentives
5. Pursuing VBP requires resources and leadership
6. Creating a culture of learning
7. Requires improved access to actionable data
8. Defining measures is challenging

The Network – Growth
All Participants



Arizona Health Care Cost Containment System

Role of Managed Care Organizations

- Arizona has extensive history in leveraging managed care for all populations
- DSRIP compliments Arizona's efforts to integrate at payer and provider level.
- DSRIP looks to build on Value Based Payment efforts by requiring MCOs and providers to continue increased APM
- DSRIP envisions critical role for MCOs in data sharing and care coordination efforts
- DSRIP leverages important roles for MCOs in justice system initiative by having RBHAs partner with other MCOs and justice system to establish DSRIP entities
- DSRIP leverages MCO structure by requiring DSRIP entities pursuing integrated projects to have formal MCO commitment and role – considering allowing MCO to be lead entity for integration

Potential DSRIP Regions for Integration

AHCCCS
Arizona Health Care Cost Containment System

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

DSHP Funding

Program	Amount	Source	Services	Population
Smoking Cessation	$18 m	Tobacco Tax	Help line and other services	Smokers seeking assistance
Prevention Services	$19 m	Tobacco Tax	Screening and prevention	Children ages 0-5
Trauma Services	$25 m	Indian Gaming	Provides funds to 6 level 1 trauma facilities	Individuals served by facilities
DD HCBS Funding	$16 m	General Fund	Home and Community Based Services	State only members with income > Medicaid
Individuals with SMI	$50 m	General & County Funds	Prescription drugs – behavioral health	Individuals with SMI & income >Medicaid

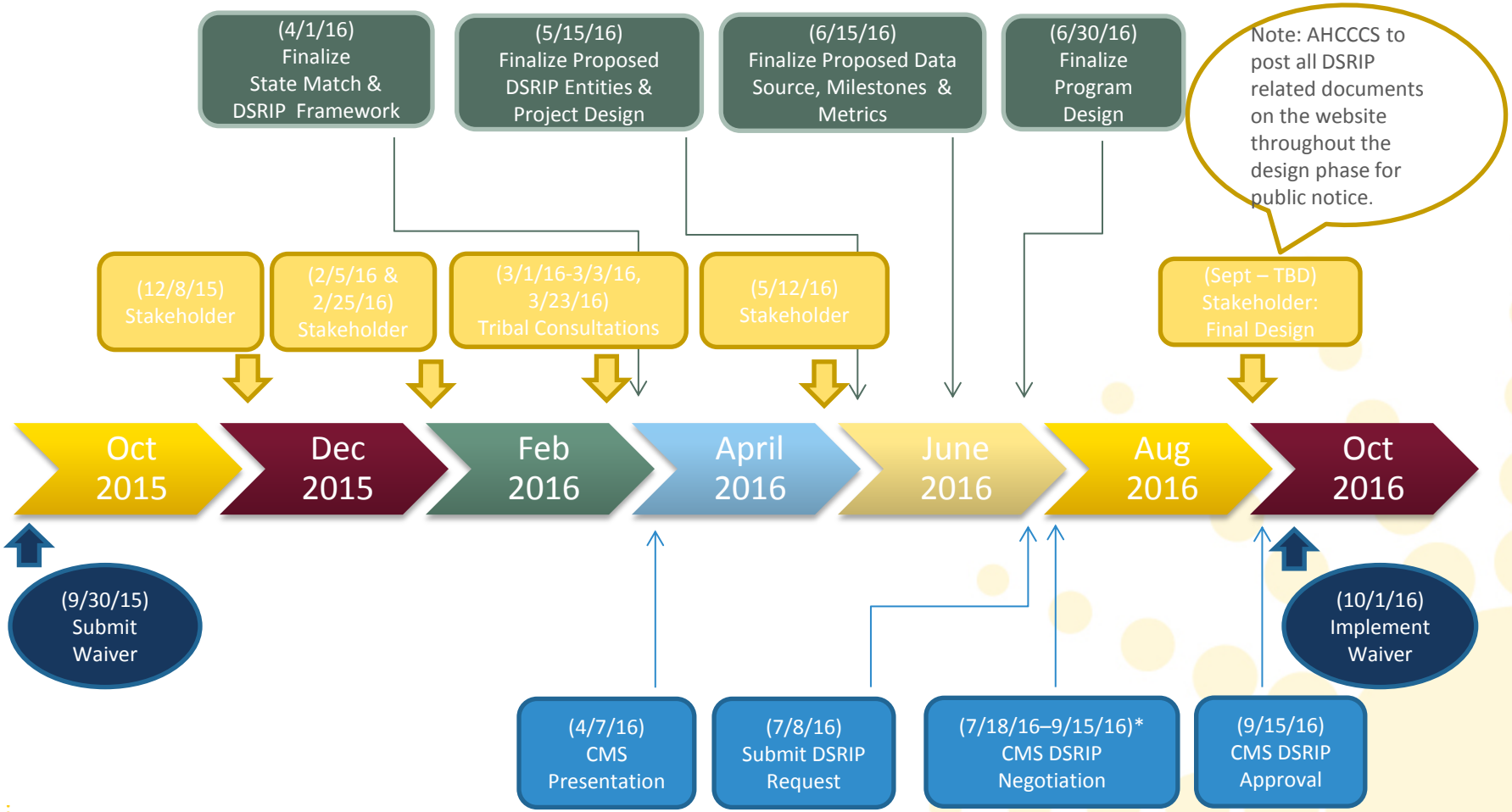
Proposed Funding (In Millions)

Program	DY 1	DY 2	DY 3	DY 4	DY 5	Totals
American Indian CMC	35	35	35	35	35	175
Justice	20	20	20	20	20	100
BH/PH Int. Adults	137.5	137.5	137.5	137.5	137.5	687.5
BH/PH Int. Kids	137.5	137.5	137.5	137.5	137.5	687.5
Totals	335	335	335	335	335	1,675

MERCER
MAKE TOMORROW, TODAY

bailit health

DSRIP Design Timeline



*Need to coordinate with the 1115 waiver negotiation.

AHCCCS
Arizona Health Care Cost Containment System

Rev. Date: 4/18/2016

Thank You.

Behavioral and Physical Health Integration

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Adults with Behavioral Health Needs

- Focus on integration of systems of care between primary care providers, behavioral health providers, acute care plans, and regional behavioral health authorities (RBHAs).
- Projects incentivize providers to:
  - Develop a shared care management plan of patients that takes into account the physical health, mental health, and substance use needs.
  - Collaborate more effectively with each other and with plans.
  - Leverage available data from plans and providers.
  - Develop standardized clinical and administrative protocols for the defined program populations.

DSRIP Entity Requirements for Both Adult and Pediatric Projects

- DSRIP entities must execute contracts that describe, at a minimum:
  - How providers will collaborate on data sharing, incentive payment distribution, and reporting of achievement of milestones and metrics.
  - How providers will develop shared clinical and administrative protocols.
  - Which providers are participating and how providers will work together on projects.
  - Support/participation of acute care plans and RBHAs.
- Geographic reach of DSRIP entities.
- How lead DSRIP providers will support entity providers with a portfolio of technical assistance, training, and peer to peer support.

Adult Behavioral Health Projects

- DSRIP entities must commit to implementing all four projects:
  - Integration of behavioral health care – primary care site.
  - Integration of primary care – behavioral health site.
  - Integration of primary care and behavioral health services (co-located site).
  - Care coordination for adults with behavioral health conditions being discharged from an inpatient behavioral health stay (hospital).

Metric/Benchmark Clusters - Years 1 and 2

- Movement Toward Integration (Projects 1-3):
  - Document self-assessment and identify integration toolkit.

- Management of High Risk Patients (Projects 1-3):
  - Document utilization of Care Coordinators, identify high risk patients, and analyze data from patient registries.
  - Develop and implement integrated care management plans.

Metric/Benchmark Clusters - Years 1 and 2

- Develop Relationships with Community Providers (Projects 1-3):
  - Develop and document referral agreements with community providers including SUD providers.
  - Develop shared administrative protocols (communication modalities, referral protocols, warm hand-offs, and protocols for team based care).
  - Develop protocols to work with hospitals to provide integrated clinical information.

- Clinical Care Strategies (Projects 1 and 2):
  - Implement standardized screening protocols for depression, anxiety, substance abuse, BMI, tobacco use, diabetes, and cardiovascular conditions among several identified.

Metric/Benchmark Clusters - Years 1 and 2

- Integrated Clinical Records/Functions (Projects 1-3):
  - Establish and implement integrated access between PH and BH providers.
  - Enhance electronic health record capabilities between PH and BH.
  - Integrate chart notes/integrate physical space (Project 3).

- E-prescribing (Projects 1-3):
  - Consult Arizona's Controlled Substance Monitoring Program before prescribing.
  - Utilize e-prescribing for schedule 2, 3, 4, and 5 controlled substances.

Metric/Benchmark Clusters - Years 1 and 2

- Integrated Clinical Records/Functions (Projects 1-3):
  - Establish and implement integrated access between PH and BH providers.
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Metric/Benchmark Clusters - Years 1 and 2

Project 4 – Care Coordination with IP facilities Post-Discharge for a BH stay.

- Care Coordination with OP, BH, and Primary Care Providers upon admission.
- Medication management.
- Care Coordination with OP, BH, and Primary Care Providers upon discharge.
- Care coordination protocols with RBHAs.
- Interaction with DSRIP (Projects 1-4).
- Participate in DSRIP training.

Metrics for Years 2-5

- Most metrics are outcome based.
- We recognize that BH integration is hard to measure, and the results of a fully-integrated system are hard to measure, but based on the research available for integrated systems, we think it is reasonable to expect improvement in:
  - Improved identification, management and care coordination of known co-existing conditions:
    - Diabetes.
    - Cardiovascular health.
    - Obesity.
    - Asthma.

Metrics for Years 2-5

- Improved screening and management of physical health and behavioral health conditions for people with SMI:
  - Cancer screening.
  - Tobacco and/or alcohol use.
  - Depression response.
- Reduced utilization of potentially avoidable services:
  - ED.
  - IP.
- There will likely be some "menu" of quality measures, some of which may be mandatory, others that providers may choose from.
- Reporting will begin in DY 2.
- Measureable improvement will be required in DYs 3-5.

Children with Behavioral Health Needs

- Pediatric Projects 1 and 2 – BH and PH Integration.
- Follow benchmark metrics for Adult Projects 1 and 2 for BH and PH integration.
- Modified for pediatric patients:
  - Especially cognizant of Trauma-Informed Care, coordination with family and schools.

Children with or At-Risk for Autism Spectrum Disorder (ASD)

Project 3 – Children with or At-Risk for Autism Spectrum Disorder (ASD).

- Prerequisite for implementing Project 3:
  - Completion of Pediatric Project one DY 1 requirements.
  - Can only begin in DY 2.

- Clinical Care in Primary Care:
  - Utilize commonly recognized toolkit for treating children with ASD.
  - Develop protocols for referring children with positive screening to treatment teams or programs including audiologist, AzEIP, school districts, and Development Disabilities Division for eligibility.
  - Ensure providers complete training programs in ASD.

Children with or At-Risk for Autism Spectrum Disorder (ASD)

- Relationships with ASD Treatment/Team Providers:
  - Develop referral agreements and treatment protocols with qualified providers.
  - Protocols for administrative (communication modalities, warm hand offs).
- Community Based Supports.
- Participate in DSRIP training.

Children Engaged in the Child Welfare System

Project 4 – Children Engaged in the Child Welfare System (Primary Care site).

- Prerequisite for Project 4 – Must complete all pediatric project 1 core components - starts in DY 2.

Children Engaged in the Child Welfare System

Clinical care:

- Coordinating with current and past providers, with assistance from RBHA.
- Using Trauma-Informed Care and Child and Family Team Practice principles.
- Shared decision making, especially for teens.
- Enhanced EPSDT care.
- Communication and coordination with foster family/guardians, including education to the family.

Children Engaged in the Child Welfare System

Project 5 - Children Engaged in the Child Welfare System (Behavioral Care site).

- Prerequisite for Project 5 – Must complete all pediatric project 2 core components - starts in DY 2.
- Clinical care:
  - The differences for behavioral health providers include:
    - Conducting a comprehensive behavioral health assessment.
    - Utilizing the Transition to Adulthood, and Transition to Independence Process (TIP), in addition to Trauma-Informed Care.
    - Adopting AACAP's policy statement on prescribing psychoactive medications to children.

Children Engaged in the Child Welfare System

- Similar to the adult focus area, the pediatric focus area will have outcome-based measures in some sort of menu style.
- Some will overlap with adult, but others will be focused specifically on pediatrics. For example:
  - Developmental screening in the first three years of life.
  - Immunization status for children and adolescents.
  - Lead screening.
  - Annual dental visits.
  - Well-care visits.

Questions?