

# Arizona 1115 Waiver Amendment Request

## Integration of Behavioral and Physical Health Services

### I. Summary

Arizona is requesting an amendment to the language found in Waiver #1 (and corresponding Special Terms and Conditions) as it relates to the provision of behavioral health services for acute care enrollees as found in its current 1115 Research and Demonstration Waiver List. Waiver #1 waives the State from requirements found in Section 1902(a)(4) of the Act and corresponding regulations as found in 42 CFR 438.52 and 438.56. This authority permits the State to limit acute care enrollees in the Arizona Health Care Cost Containment System (AHCCCS), Arizona's single state Medicaid agency, to a single Prepaid Inpatient Health Plan (PIHP) – the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) – for the treatment of behavioral health conditions.

The State's current Waiver authority reflects a health care delivery system that has carved out behavioral health services. On January 31, 2013, the Centers for Medicare and Medicaid Services (CMS) approved the State's request to amend Waiver #1 to allow for integration of physical and behavioral health services for a select population by requiring the ADHS/DBHS to serve as the only managed care plan for both acute and behavioral health conditions for AHCCCS acute care enrollees with Serious Mental Illness (SMI) in Maricopa County.<sup>1</sup> This request seeks to extend that same health plan<sup>2</sup> integration for individuals with SMI who are living outside of Maricopa County (or "Greater Arizona").

The request is intended to allow the State to:

- Transform care for individuals with SMI by operating a fully integrated health care system that would enroll individuals with SMI into one entity via ADHS/DBHS that would manage their physical and behavioral health and that may also serve as a Special Needs Plan for those individuals with SMI that are dual eligibles.
- Improve care coordination and health outcomes for individuals with SMI in Greater Arizona.
- Increase the ability of the ADHS/DBHS to collect and analyze data to better assess the health needs of their members with SMI from a holistic approach.
- Streamline the current fragmented health care delivery system, which has caused individuals with SMI to receive physical health care in a manner that has not maximized efficiencies and provided for the best coordination of care, contributing to poorer health outcomes.
- Reduce costs by, among other things, decreasing hospital admissions and readmissions, shortening lengths of stay when hospitalization is needed and increasing participation in wellness, prevention and disease management and recovery programs.
- Promote the sharing of information between physical and behavioral health providers to work as a team and manage treatment designed to address an individual's whole health needs.

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<sup>1</sup> Due to an unsuccessful bid protest, the start date for the integrated plan in Maricopa County was delayed to April 1, 2014.

<sup>2</sup> The term "health plan" is used generically to reference an entity responsible for managing the care of its members. It is not meant to refer only to AHCCCS acute care health plans, but is broad enough to include entities that currently manage the behavioral health needs of their members, such as Regional Behavioral Health Authorities (RBHAs) that contract with ADHS/DBHS.

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This request builds upon the steps the State is taking to follow recommendations made by Secretary Sebelius in a letter to Arizona Governor Jan Brewer dated February 15, 2011 to integrate behavioral and physical health services. The State agrees with the Secretary's recommendation and is pursuing this course in an incremental fashion focusing first on the adult population with SMI by weaving physical health care requirements into the existing behavioral health structure.

### II. Overview

#### *Discussing Integration in Arizona*

Arizona's public system of care for the treatment of behavioral health conditions pre-dated 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. This separation 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 enrollees. It was also believed that a carved-out approach would better preserve behavioral health funding. Today, the AHCCCS program serves over 23,000 members with SMI in Greater Arizona, with approximately 40% of these members being dually eligible in Medicare and Medicaid.

Meanwhile, Arizona's managed care model has evolved and matured, providing quality care at a modest cost. This success moved the State to adopt an integrated approach in the AHCCCS Arizona Long Term Care System (ALTCS), which serves members at risk of institutionalization. Health plans in the ALTCS system manage the physical and behavioral health care needs of AHCCCS long term care members, while also serving as Dual Special Needs Plans (D-SNPs), allowing ALTCS contractors to coordinate care for those dually eligible in Medicaid and Medicare. The ALTCS system, which has over 74% of its elderly and physically disabled members living at home or in the community, has served as a national model for quality, cost efficiency and integrated care.

Arizona's ALTCS model has proven that integration of behavioral and physical health is not only achievable but also successful. The State recognizes, however, that the ALTCS model may not be the best approach in terms of creating an integrated system of care for the AHCCCS acute care population.

As the national focus looks toward integrating care and at the urging of the Secretary, Arizona began to consider its options related to integration of behavioral health services. The State views its partnership with the community as critical in moving forward and, therefore, the State remains sensitive to lingering stakeholder concerns about integrating behavioral health services into the AHCCCS acute care model. Accordingly, the discussion of integration shifted to moving physical health care delivery and oversight to the entity responsible for the provision of behavioral health – that is, move physical health under the purview of ADHS/DBHS. Because this is a shift from the carved-out approach, the State believes an incremental approach is appropriate. This incremental approach would first focus on ADHS/DBHS being responsible for the provision of physical and behavioral health care services for individuals with SMI in Maricopa County. The second step sought here is to afford the same benefits of an integrated approach to all Arizonans with SMI.

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### *Why Individuals with Serious Mental Illness?*

In Arizona, persons determined to have SMI die 25 to 30 years earlier than persons in the general population. More often physical health problems, such as diabetes, heart disease, respiratory disease and other preventable or manageable physical illnesses contribute to this disparity. Many individuals with SMI experience poorer physical health outcomes because they simply are unable to navigate the fragmented and complex health care systems to receive the care they need for their physical illnesses. By creating greater alignment at the health plan level, the State can take important steps to address the health disparities that exist for this population.

The negative impact of system fragmentation on members with SMI was quantified in the State's recent Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The table below shows the difference in the experience for acute care children as compared to adults with SMI. AHCCCS health plans performed at the 4-star level for serving children (the 75-90<sup>th</sup> percentile based on over 10,000 responses). AHCCCS health plans received a 5-star rating for overall health care for children (90<sup>th</sup> percentile and above). The same plans and health care system scored 1 star or the bottom quartile nationally for serving the needs of adults with SMI.

2013 CAHPS Star Ratings

	Child	SMI
Health Plan	4	1
Health Care	5	1
Doctor	4	1
Specialist	4	2
Needed Care	3	2
Care Quickly	2	1
Dr. Communication	2	1
Customer Service	4	2
	10,302	555 Adults

System fragmentation is the leading cause of this pronounced variance with how two different populations view the same system. Some of the State's most vulnerable members are set up for failure when a system forces members with high needs in both physical and behavioral health to navigate up to four different systems for their care (Medicaid acute health plan, Medicaid regional behavioral health authority, Medicare FFS and Part D plan or Medicare Advantage plan). The CAHPS survey directs the State to change the structure of this system. Unfortunately, given the complexity of the system, it is highly likely members were unsure which entity they were being asked to evaluate.

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### *Arizona's Proposed Demonstration and Integrated Delivery System Aligns with Federal Initiatives*

CMS has provided substantive, helpful guidance to states on a number of important relevant topics. On July 24, 2013, CMS provided guidance to states on how to develop strategies around “super-utilizers.” CMS stated that in Medicaid 5% of the population account for 54% of the overall expenses. The memo focused on “beneficiaries with complex, unaddressed health issues and a history of frequent encounters with health care providers.” The average Medicaid cost for members with Serious Mental Illness in Arizona is in excess of \$30,000 per member per year; compare this to the average non-SMI cost for a childless adult, which is \$7,200 per member per year. Individuals with SMI also access services funded through Medicare and other programs supported by both federal and state governments to assist with housing, employment supports and other critical services. The State’s strategy to serve this population through an integrated health plan creates the foundation for a unified delivery system to allow for better focus on a population of super-utilizers and also bundles in other important social services that are critical to quality outcomes for these members.

This initiative also aligns with the recent CMS guidance (January 16, 2014) on Emergency Department diversion. In this memo, CMS highlighted the importance of focusing on the behavioral health needs of the Medicaid population. Current acute plans express frustration in their inability to properly manage more frequent users of the emergency department because a significant percentage of these members have behavioral health needs that acute plans are not authorized to address under our carve out model. One acute plan had data that showed over 80% of the higher emergency department utilizers had behavioral health care needs.

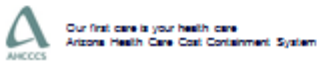
### *Arizona's Proposal Recognizes the Unique Geography of Greater Arizona*

The AHCCCS model is predicated on competition and choice. As detailed in the table below there is considerable health plan choice available for the vast majority of the AHCCCS membership and the State has leveraged the principles of choice and competition to build a very successful managed care model.

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## AHCCCS Health Plans

	Acute	ALTCS	Behavioral Health
Maricopa – 60% pop	7 Plans	3 Plans	1 Plan
Pima – 20% pop	5 Plans	2 Plans	1 Plan
Greater AZ	2 Plans	1 Plan	1 Plan



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

However, the State must pursue this choice waiver in order to overcome a major obstacle – geography – in developing this integrated model that, based on data and community input, the State believes to be in the best interest of Arizonans. A large part of Greater Arizona is designated as rural or frontier and is sparsely populated. For privacy reasons, the number of AHCCCS members with SMI by county cannot be disclosed. However, without disclosing the name of the counties, AHCCCS determined three rural counties had a total of 3,077 AHCCCS members with SMI; the total size of these 3 counties is 22,800 square miles. For comparison purposes, these three counties cover an area larger than Maryland, New Jersey and Delaware combined. Requiring multiple health plans to build networks to serve 3,077 members covering such a large expanse of territory is simply not feasible.

Fortunately, Arizona can point to the ALTCS program as a model of success in limiting choice of health plan. Over the past two decades Arizona has been able to partner with CMS to continue to operate with the flexibility necessary given the uniqueness of the State. Recognition of the complications associated with geographical challenges and low population in rural areas has been an important factor in the continuation of the waiver of choice in the ALTCS program. Over time, the ALTCS program offered choice in the two largest urban areas, but that only developed through partnership with the federal government while the model evolved. Ultimately, the most important factors regarding choice of provider and appropriate member protections were always in place.

It is envisioned that over time a similar evolution would transpire with the integrated program for members with Serious Mental Illness. However, given the vast service areas and limited membership, the only viable mechanism to establish integrated services for these members today is through a waiver from choice of plan to allow a single plan serving Greater Arizona. As the State

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develops its Request for Proposal for the Greater Arizona RBHA procurement, the State anticipates consolidating the number of Geographic Regions competitively bid.

### *Importance of Demonstration for Arizona's Crisis System*

Greater Arizona's geographic diversity is also a factor contributing to the importance of this proposal with respect to the strength and stability of the State's Crisis System. The Crisis System is a critical entry point into the healthcare system. How that system is able to assist an individual in crisis shapes that individual's flow into services. An effective crisis system ensures the individual enters the system through an appropriate setting, which is critical to placing that individual on the path to recovery. An ineffective system can impact that individual's entry point, which creates additional challenges to that individual's outcome.

Currently, the State's Crisis System maintains a contract with one Regional Behavioral Health Authority (RBHA) that oversees that system to ensure it is meeting the needs of their members. Without a waiver from choice of acute plan, the Crisis System is forced to navigate two different managed care organizations serving as RBHAs. Serving two managed care entities adds complexity to how the Crisis System interacts with the RBHAs. To illustrate, in some areas of Northern Arizona, there are eleven people per square mile. The State has struggled with how to shape an effective crisis system if that system must work with multiple MCOs within a large geographical region that is sparsely populated. While the State has requested significant input from a variety of stakeholders on this topic, identifying a resolution that could be implemented immediately has been elusive. The delicacy of managing the State's Crisis System requires a waiver of choice. Therefore, the State contends that, like with ALTCS, offering choice of health plan must be a change that evolves over time as the system demonstrates the capacity to be successful with multiple RBHAs.

### *Amending Arizona's 1115 Waiver to Achieve Integration*

Without aligning the financial incentives, there simply will not be an adequate connection between the acute care delivery system and the behavioral health care system. This means that integration must first be achieved at the administrative level, by making one entity responsible for the physical and behavioral health needs of individuals with SMI in Arizona. This type of structure would leverage the State's managed care infrastructure and maximize care coordination allowing one responsible entity to have access to all of the necessary data to target best practices for improving health outcomes within the identified population. In Arizona, that entity is the ADHS/DBHS, which serves as AHCCCS' contractor for behavioral health services to AHCCCS acute care enrollees.

The amendment to the current Waiver is needed in order to add the management of physical health care for members with SMI in Greater Arizona to the responsibilities of ADHS/DBHS. This means that those members with SMI would only be able to receive their physical health care through ADHS/DBHS, which is an expansion of the State's existing waiver authority.

For these reasons, Arizona seeks to be waived from the provisions found at Section 1902(a)(4) of the Act and corresponding regulations as found in 42 CFR 438.52 and 438.56 so that it can achieve integration and better health outcomes by requiring individuals with SMI to enroll with ADHS/DBHS for the treatment of their physical and behavioral health care conditions.

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### III. Public Process

The goal of designing an integrated system is to improve the overall health care and outcomes for AHCCCS members with SMI. In order to achieve this goal, obtaining input from peers and family members is critical to the State. Also important is a process to obtain input from providers in both the behavioral health and acute care systems.

As part of the amendment request for Maricopa County, the State engaged St. Luke's Health Initiatives (SLHI), a Phoenix-based public foundation focused on Arizona health policy and strength-based community development. For the consumer engagement process, SLHI worked in conjunction with members from the ADHS/DBHS Office of Individual and Family Affairs (OIFA) and a Peer and Family Engagement Workgroup designated by the Arizona Peer and Family Coalition to ensure member feedback during the State's review process. SLHI and a team of Peer leaders conducted a series of key interviews and focus groups with peers and family members. The results of this engagement were summarized by SLHI and their reports and subsequent OIFA activities can be found on the ADHS/DBHS website at: <http://azdhs.gov/diro/integrated/news/index.htm>.

For Greater Arizona, the State built upon this foundation forming a Community Engagement Greater Arizona Committee. The Committee is comprised of peers and community leaders working in coordination with OIFA. The Committee conducted 9 focus groups across the State covering Tucson, Yuma, Flagstaff, Parker, Sierra Vista, Bisbee and Payson. In all, over 123 individuals with SMI and their family members participated as part of the consumer engagement process. The aim of these sessions was to learn what was important to peers and family members in different regions of the State and use this information to make informed decisions while preparing the procurement for Greater Arizona.

In addition, the ADHS/DBHS, in collaboration with AHCCCS, also conducted a Request for Information to allow for public input on key questions that will shape the procurement for Greater Arizona. (See the ADHS website: <http://www.azdhs.gov/procurement/rfi.htm> also referenced on the AHCCCS website <http://www.azahcccs.gov/reporting/legislation/integration/integration.aspx#serious>.)

The public engagement process demonstrates support for a more holistic approach to healthcare, improving communication amongst the team of providers that work with individuals with SMI, and achieving greater accountability for the healthcare outcomes of this population. Additionally, the public engagement process confirms that consumers' primary concern is maintaining choice of provider not choice of acute care health plan. These were the three key elements that focus group participants highlighted for the Greater Arizona procurement:

1. Coordination of care: Emphasis on establishing robust communication systems that provide timely exchange of information between members, physicians and other providers involved in members' care.

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2. Service Delivery: Highlighting the importance of customer services, such as timely service delivery, access to a broad range of services, integration of services and education in regards to the benefit package.
3. Access to Care: Focusing on members' right to choose provider and treatment options.

Overall, the public engagement process supports the approach the State is seeking in this waiver request, provided that the State maintain ongoing dialogue with stakeholders and maintain sufficient flexibility to incorporate feedback, particularly from peers and family members where possible and appropriate.

The State has also held ongoing dialogue on the issue of integration for individuals with SMI at numerous tribal consultations. Most recently, the integrated RBHA approach was discussed on January 22, 2014 as part of the Medicaid Director's presentation. (See AHCCCS Update, slide 12 at <http://www.azahcccs.gov/tribal/consultations/meetings.aspx>.) The State views tribal consultation on this matter to be ongoing as issues related to American Indian members with SMI are unique since these members maintain choice of RBHA or Tribal RBHA and cannot be compelled into managed care. The State will continue to work with the Indian Health Services and tribally operated 638 facilities to design care coordination processes that will support tribal members with SMI that receive services through the AHCCCS fee-for-service program, known as the American Indian Health Program.

Additionally, the State discussed the Greater Arizona integrated RBHA at two open meetings of the State Medicaid Advisory Committee (SMAC): July 2013 (see <http://www.azahcccs.gov/community/Downloads/SMAC/July2013StateMedicaidAdvisoryCommittee.pdf> at page 47-48 and page 56); and January 2014 (see page 7 at [http://www.azahcccs.gov/community/Downloads/SMAC/agendas/January2014SMAC\\_Agenda.pdf](http://www.azahcccs.gov/community/Downloads/SMAC/agendas/January2014SMAC_Agenda.pdf)). The proposal can be found on the AHCCCS website where it has been posted for public comment. <http://www.azahcccs.gov/reporting/federal/waiver.aspx>

The State views the public engagement and tribal consultation process as ongoing. This has been demonstrated through activities conducted by the Community Engagement Greater Arizona Committee in cooperation with OIFA as well as the ongoing engagement as the State transitions to the integrated RBHA for Maricopa County.

#### **IV. Data Analysis- "With Waiver" vs. "Without Waiver"**

The State does not anticipate any change to budget neutrality since the same services will be provided and the same populations are being served.

#### **V. Allotment Neutrality**

N/A. The amendment does not impact the XXI population.



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### VI. Details

#### *A Modest Change in the Structure of Behavioral Health at ADHS/DBHS*

Currently, AHCCCS acute care members requiring treatment of behavioral health conditions do so through the ADHS/DBHS. Specifically, AHCCCS members are assigned to a Regional Behavioral Health Authority (RBHA) that serves their geographic service area. ADHS/DBHS subcontracts with a RBHA through a formal competitive bidding process and awards five-year contracts to private entities. There is only one RBHA for each geographical service area. The state is currently divided into six (6) geographic service areas. These geographic services areas are defined by zip code and roughly correspond to the following counties:

- GSA 1- Mohave, Coconino, Apache, Navajo and Yavapai Counties;
- GSA 2- Yuma and La Paz Counties;
- GSA 3- Graham, Greenlee, Cochise and Santa Cruz Counties;
- GSA 4- Pinal and Gila Counties;
- GSA 5- Pima County; and
- GSA 6- Maricopa County.

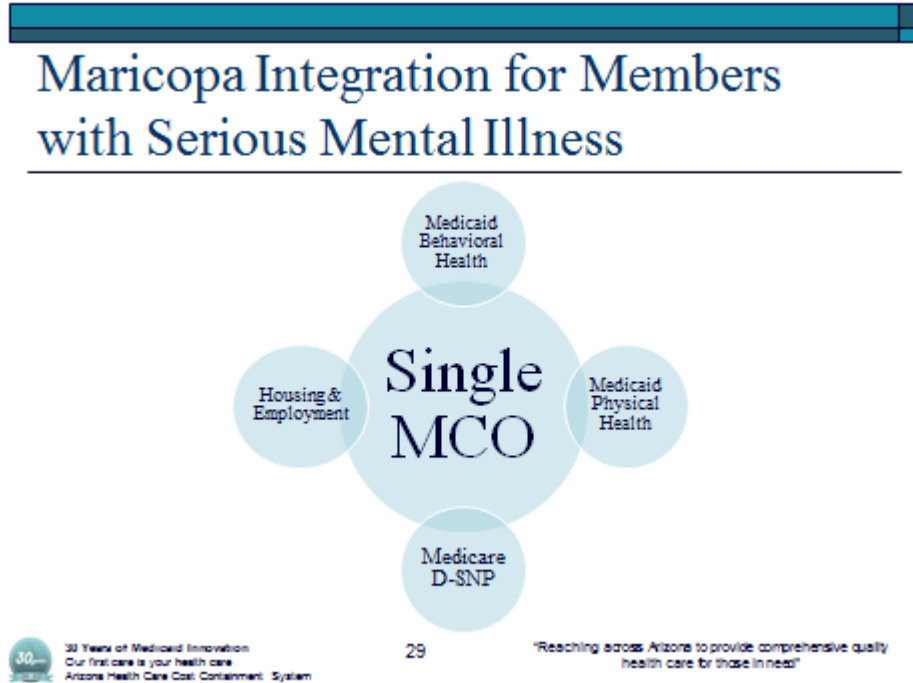
Greater Arizona is comprised of all of the GSAs except GSA 6 – Maricopa County. GSA 1 is served by a single RBHA (currently NARBHA). GSAs 2, 3 and 4 are served by a single RBHA (currently Cenpatico). GSA 5 is served by a single RBHA (currently CPSA). These contracts expire September 30, 2015 and the process of developing the new Request for Proposals has begun.

As part of the RFP process, the State has been soliciting input from members, families, managed care entities and other interested stakeholders about how the geographic regions should be established. Given the community feedback, the State will likely consolidate the five existing GSAs (excluding GSA 6 – Maricopa) into two GSAs moving forward for Greater Arizona.

The RBHAs are responsible for providing services to AHCCCS members in the areas of general mental health, substance abuse, crisis, and children's services. The RBHAs also serve a small portion of non-Title XIX eligible individuals with SMI. Under this waiver, if approved, the RBHAs for Greater Arizona will continue to provide all of the same services they do today, and will also be responsible for the provision of physical healthcare to members with SMI. The RBHAs will be held to the same standards as any acute care managed care organization serving the State's Medicaid program currently. The Greater Arizona RBHAs may also be required to become a SNP to enable coordination of care for its dual eligible members with SMI.

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To illustrate this model, see the diagram below:



Note: Housing services are funded with non-Medicaid dollars

## Timeline

At this time, the State has a broad estimated timeline, which is subject to change depending on approval of this waiver request and other factors.

Public Meetings	September – December 2013 and ongoing
Request for Information Issued	December 2013
Request for Proposal Issued	Summer of 2014
New Contracts Effective	October 1, 2015

## VII. Evaluation Design

The State would apply the same evaluation criteria to this proposal that it will apply to the demonstration for an integrated RBHA for Maricopa County. The evaluation would show that requiring one single entity (the RBHA) to be responsible for the physical and behavioral health care needs of individuals with SMI will improve health outcomes, increase life expectancy, reduce costs, and improve service delivery and care coordination.

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