State Medicaid Advisory Committee (SMAC)

Wednesday, November 16, 2016
AHCCCS
Gold Room - 3rd Floor
701 E. Jefferson Street
1 p.m. – 3 p.m.

Agenda

I. Welcome	Director Thomas Betlach
II. Introductions of Members	ALL
III. Approval of August 17, 2016 meeting summary	ALL

Agency Updates

IV. AHCCCS Update	Director Thomas Betlach
V. Pediatric Prepared Emergency Care	Tomi St. Mars MSN, RN Peggy Stemmler, MD, MBA
VI. Opioid Update	Shana Malone

Discussion

VI. Call to the Public	Director Thomas Betlach
VII. Adjourn at 3:00 p.m.	ALL

***2016 SMAC Meetings**

Per SMAC Bylaws, meetings are to be held the 2nd Wednesday of January, April, July and October. All meetings will be held from 1 p.m.- 3 p.m. unless otherwise announced at the AHCCCS Administration 701 E. Jefferson, Phoenix, AZ 85034, 3rd Floor in the Gold Room:

~~**January 13, 2016**~~ **– Rescheduled to February 3, 2016**
April 13, 2016
~~**July 13, 2016**~~ **– Rescheduled to August 17, 2016**
~~**October 12, 2016**~~ **– Rescheduled to November 16, 2016**

For more information or assistance, please contact Yisel Sanchez at (602) 364-4577or yisel.sanchez@azahcccs.gov

AHCCCS Update

AHCCCS
Arizona Health Care Cost Containment System

AHCCCS Update

Overview

- Mission
  - Reaching across Arizona to provide comprehensive, quality health care to those in need
- Vision
  - Shaping tomorrow's managed care from today's experience, quality, and innovation
- Values
  - Passion, Community, Quality, Respect, Accountability, Innovation, Teamwork, Leadership

Select AHCCCS Initiatives

1. Active Thoughtful Purchaser
2. Integration efforts
3. Value Based Purchasing
4. Justice System transitions
5. Autism related services
6. Opioid Crisis
7. Program Integrity
8. Health Information Technology
9. American Indian care coordination and support

Potential Impact ACA Changes

	GF Costs	Total $ Removed from Economy	Members Losing Coverage
1. Eliminate non-categorical adults 0-138%	$328 m	$3,239 m	(425,338)
2. Waiver at regular FMAP 0-100%, Eliminate 100-138%	$1,021 m	$599 m	(115,823)
3. Waiver at regular FMAP 0-100%, Freeze enroll. 100-138%	$1,032 m	$175 m	-

Funding Sources impacting GF

1. Hospital Assessment tied to provisions of ACA with automatic repeal
2. Prescription drug rebate for MCO pharmacy spend
3. Enhanced CHIP match for children's expansion

Capitol Times – November 11th

All that, said Ducey, makes outright repeal without something else to take its place unacceptable.

"I'm not talking about repeal," he said.

"I'm talking about repeal and replace," Ducey continued. "I want to see all of our citizens have access to health care that's affordable."

With outright repeal unacceptable, the governor said it remains to be seen what Trump and Congress can come up with as an alternative.

"The devil is going to be in the details of a health care plan that allows accessibility to all of our citizens," he said.

"That's the discussion that we're going to have," the governor continued. "What we have currently isn't working."

Capitol Times – November 15th

Amid the discussion of the likely repeal-and-replace of Obamacare that will follow Trump's inauguration, Brewer said she hopes the expansion of AHCCCS, which she shepherded through the Legislature in 2013, stays intact.

"They can implement AHCCCS in all 50 states. They probably will tweak it or revise it some, but it's on the table, as far as I'm concerned, to be discussed. And I'm rooting for Arizona's AHCCCS program,"

ACA provisions outside coverage

- Essential benefits package
- MAGI income calculations and new eligibility systems
- Former foster youth who were in foster system for 6 months can stay on Medicaid until 25
- CHIP FMAP
- Hospital presumptive eligibility
- Family planning extension
- Drug rebates for managed care
- Authority for dual demonstrations (no direct impact on AZ)
- Program integrity requirements

Block Grant/PMPM discussion

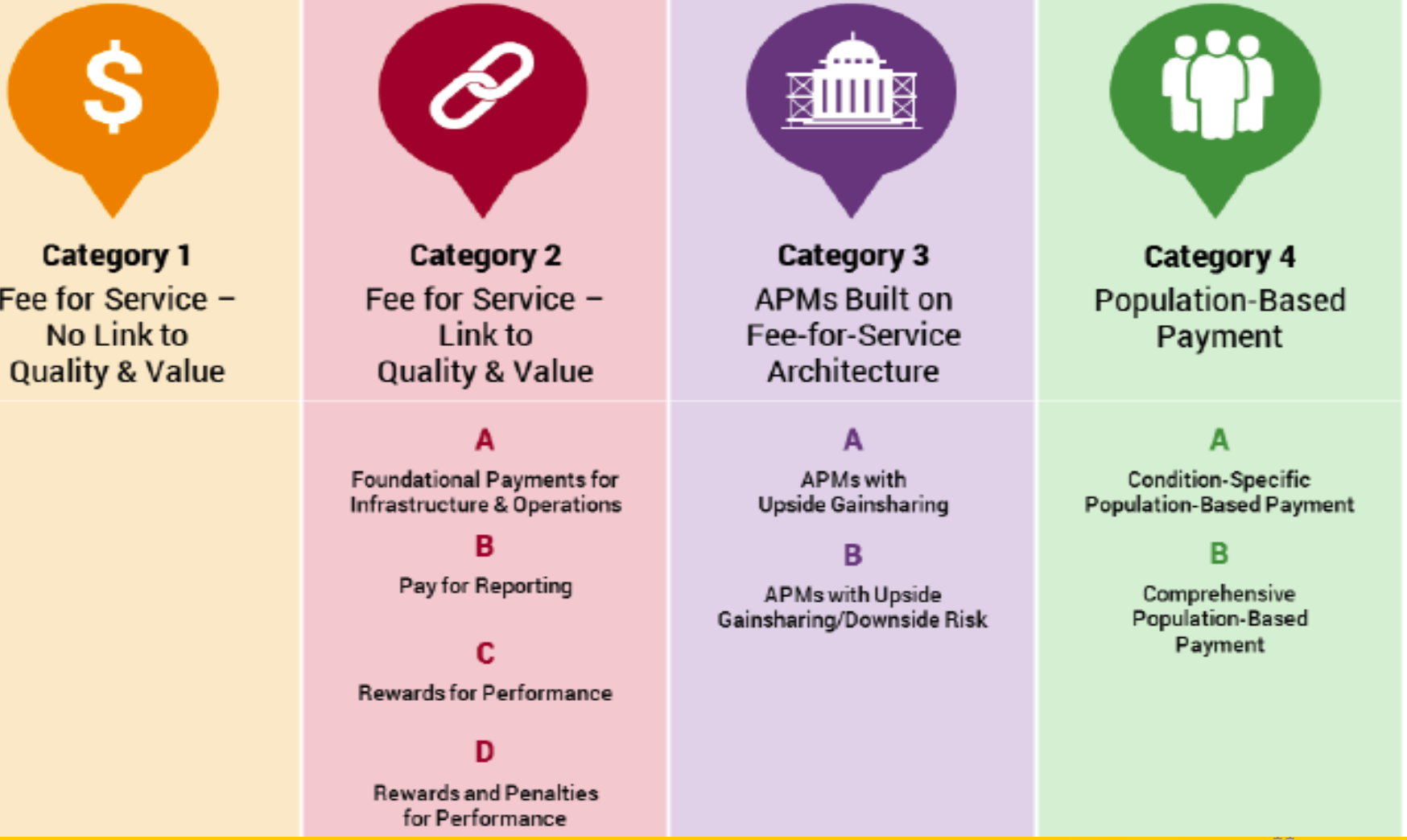
- What is in the base for federal grant? (e.g., A Better Way builds off 2016 and phases down enhanced ACA FMAP to regular FMAP.)
  - Note less efficient states may have room to make program changes to save funding and avoid cutting populations; Arizona has little room on benefits or provider rates or utilization rates (things like leveraging home and community services)
- What is the state match or maintenance of effort requirement?
- How is the expansion incorporated?

Block Grant/PMPM discussion

- What is in funding formula for growth and how is that calculated? What inflation factors are used?
- How is population growth accounted for? Is the formula a per member?
- What is the funding formula for recessions?
- What is in statutory framework for requirements?
  - Populations covered
  - Services covered? (mandatory vs optional?)
  - Payment levels? Access to care & network?
- What happens with existing regulatory structure including but not limited to State plans and 1115 waivers?

LAN Payment Reform Framework

Figure 1. APM Framework (At-A-Glance)



Potential Future VBP Levels

	Acute	ALTCS EPD	CRS	RBHA		DDD	
				SMI-Integrated	Non-Integrated	Sub-Contractors	LTSS
CYE 14	5%						
CYE 15	10%	5%/1.5%	5%				
CYE 16	20%	15%/15%	20%	5%			
CYE 17	35%	25%/25%	35%	15%			
CYE 18 Anticipated	50%	35%/35%	50%	25%	10%	20%	5%
CYE 19 Anticipated	60%	50%/50%	60%	35%	20%	35%	10%
CYE 20 Anticipated	70%	60%/60%	70%	50%	35%	50%	20%

APM Proposed Targets

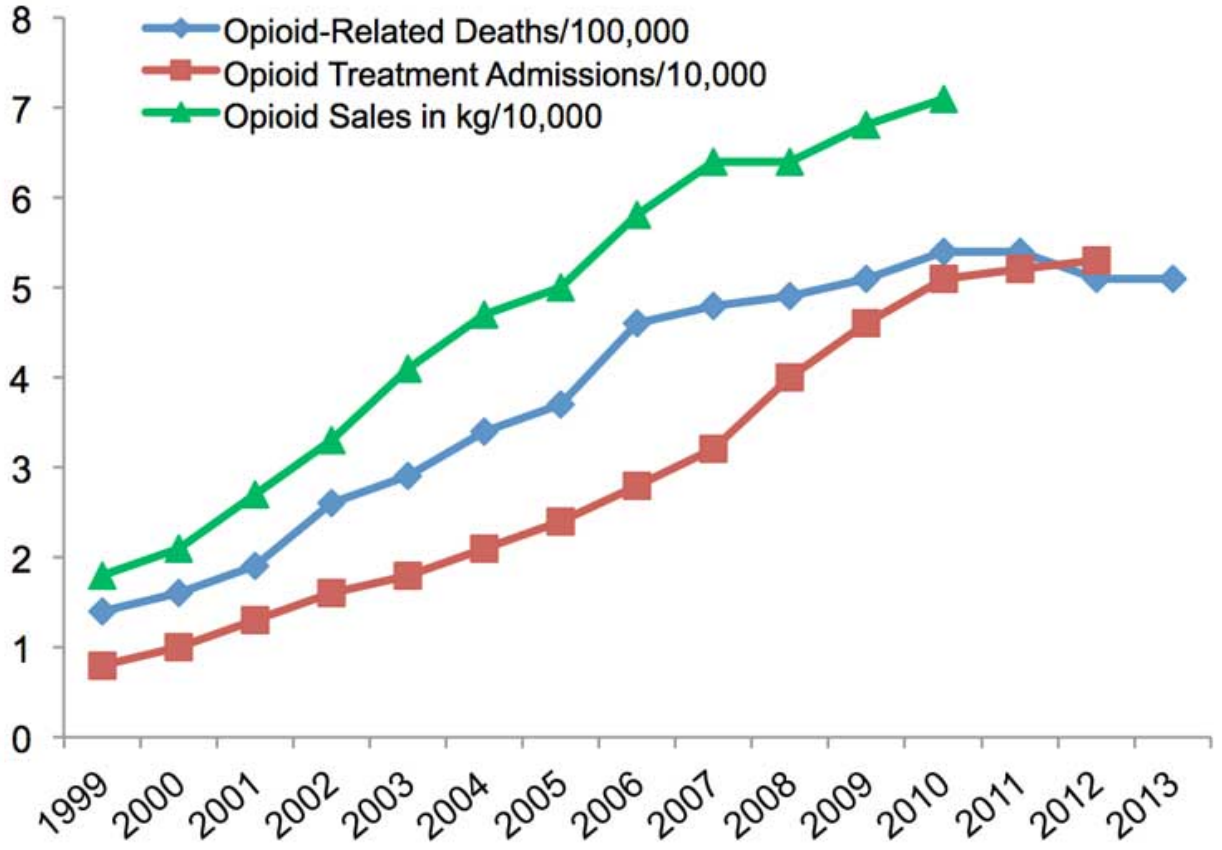
DSRIP Year	Percent Spend LAN 2-4	Percent Spend LAN 3 & 4
CYE 2017	30%	NA
CYE 2018	40%	5%
CYE 2019	50%	10%
CYE 2020	60%	20%

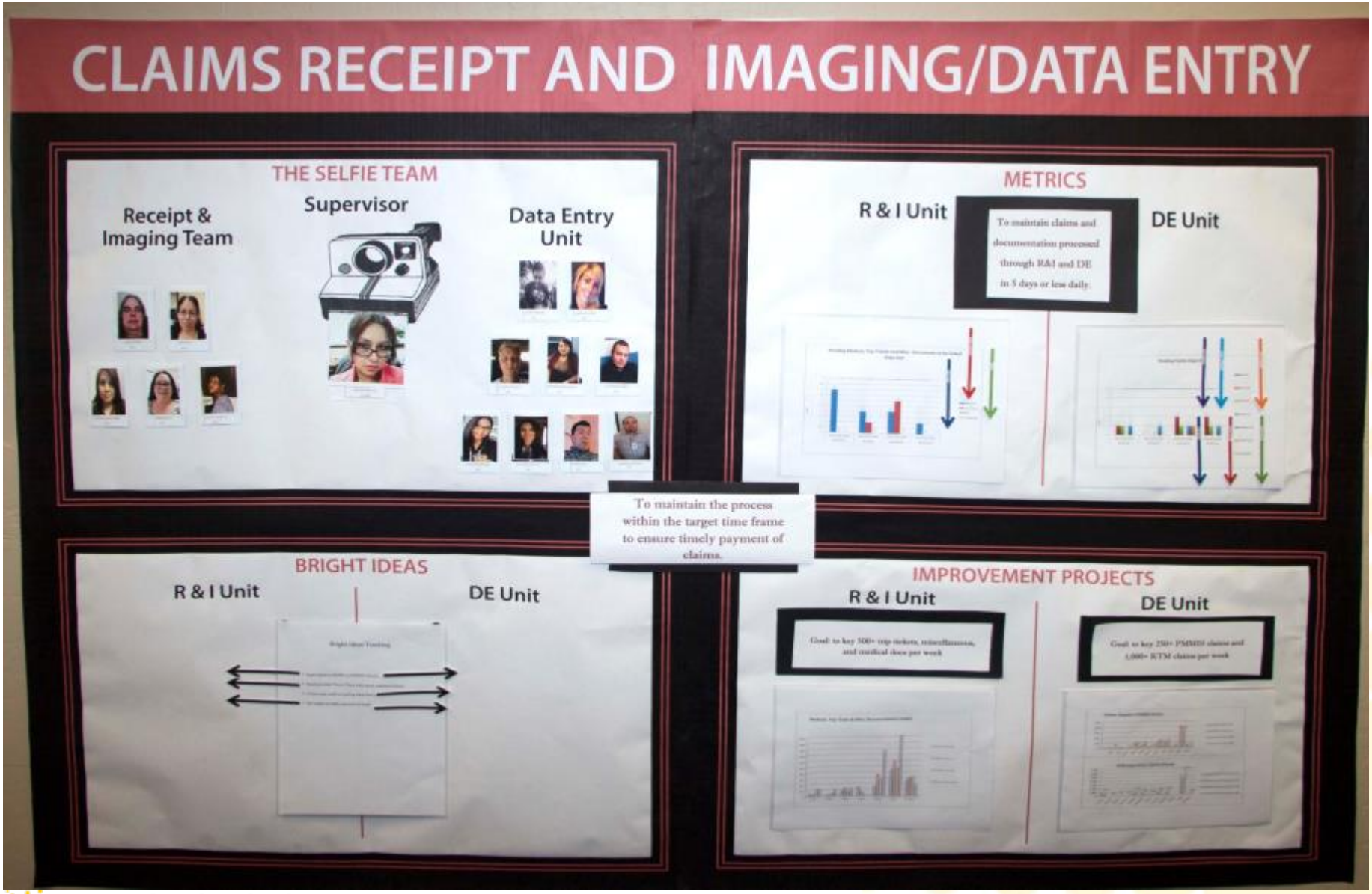
Arizona Management System

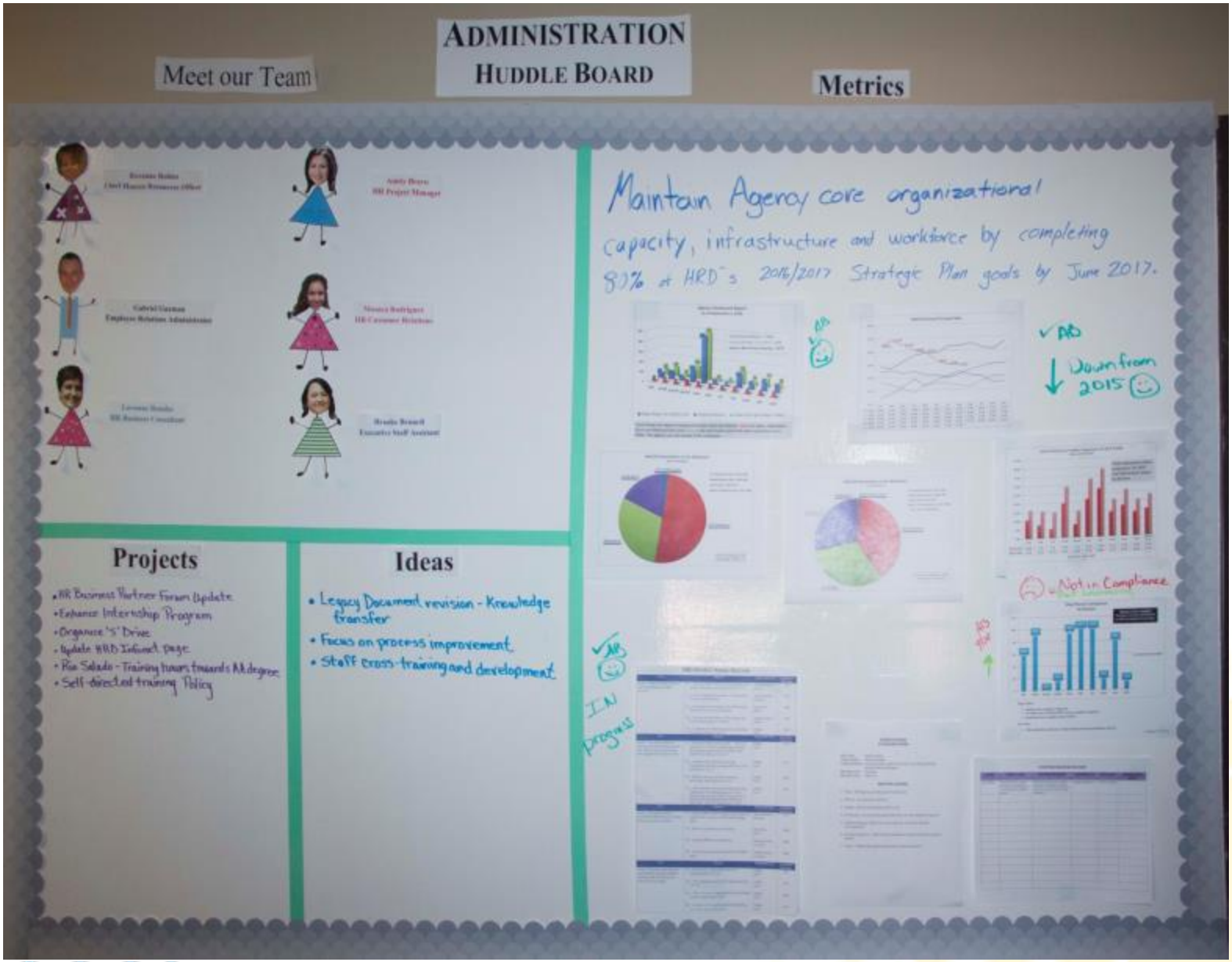
AMS Transformation in State Government

- Large Cabinet agencies actively pursuing
- MVD reduced wait times and increased throughput in very busy office
- DOC reduced CO hiring from 120 days to 30
- DES UI Call center 100 min to 10 sec
- ADOA building renew visual mgmt. board
- DOR Call center – 45 min drop – calls less than 1 min

National Rx Opioid Trends (NIDA)

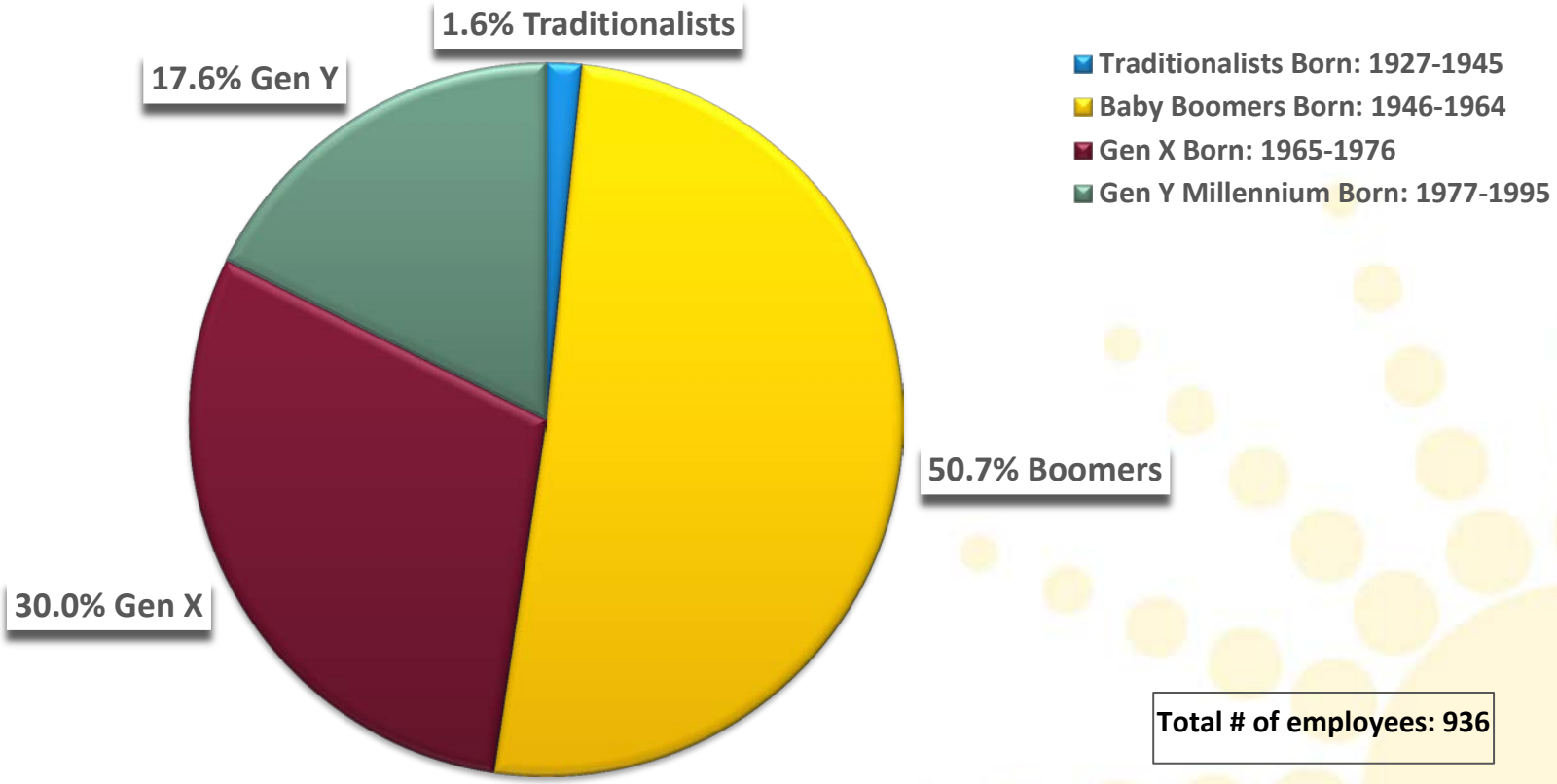



CLAIMS RECEIPT AND IMAGING/DATA ENTRY
THE SELFIE TEAM
Receipt & Imaging Team
Supervisor
Data Entry Unit
METRICS
R & I Unit
To maintain claims and documentation processed through R&I and DE in 5 days or less daily.
DE Unit
To maintain the process within the target time frame to ensure timely payment of claims.
BRIGHT IDEAS
R & I Unit
DE Unit
IMPROVEMENT PROJECTS
R & I Unit
DE Unit

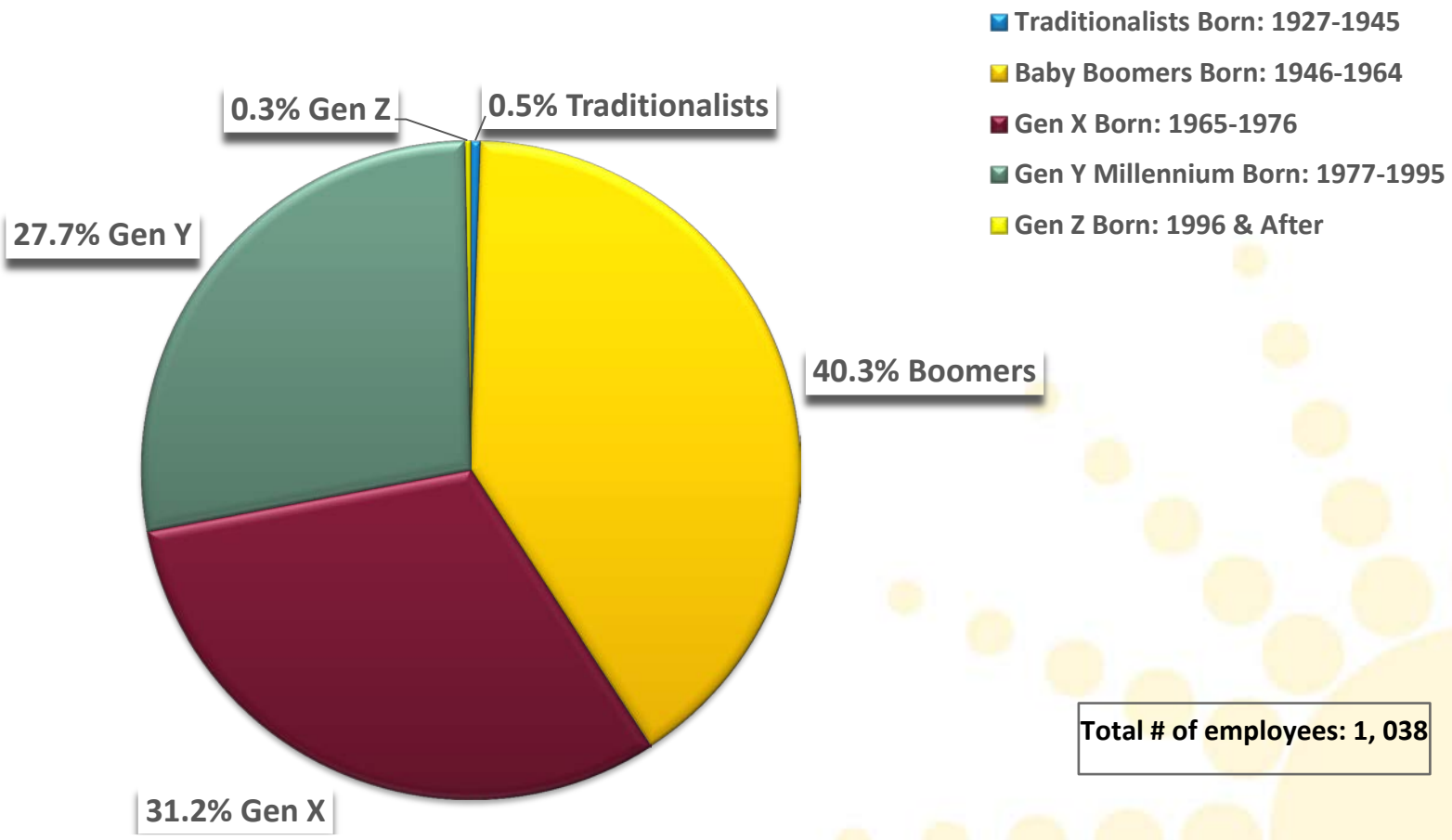

ADMINISTRATION
HUDDLE BOARD
Meet our Team
Metrics
Maintain Agency core organizational capacity, infrastructure and workforce by completing 80% of HRD's 2016/2017 Strategic Plan goals by June 2017.
Down from 2015
Not in Compliance
Projects
• HR Business Partner Forum Update
• Enhance Internship Program
• Organize 'S' Drive
• Update HRD Intranet page
• Ria Salado - Training hours towards AA degree
• Self-directed training Policy
Ideas
• Legacy Document revision - Knowledge transfer
• Focus on process improvement
• Staff cross-training and development
IN progress


55 Calendar Days
Open 1-27 days
Open 28-55 days
Open 55 days + over
INTERSTATE
55
STOP

AHCCCS Generations in workplace (2013)



AHCCCS Generations in workplace 2016



Total # of employees: 1, 038

Arizona's 1115 Waiver Status

- Arizona's application for a 5-year waiver included:
  - Part I: Governor Ducey's vision to modernize Medicaid: The AHCCCS CARE program
  - Part II: The Legislative Partnership
  - Part III: DSRIP: Arizona's Approach
  - Part IV: HCBS Final Rule
  - Part V: American Indian Medical Home
  - Part VI: Building Upon Past Successes
  - Part VII: Safety Net Care Pool

IMD Update
AHCCCS Care Update

Questions?

Pediatric Prepared Emergency Care

Tomi St. Mars MSN, RN

Peggy Stemmler MD, MBA

October 12, 2016

Partnership

- ADHS
- AzAAP - institutional home
- Steering Committee
- Members

Welcome to the National

Pediatric Readiness Assessment

Ensuring Emergency Care for All Children

National PRP Pediatric Readiness Project
Ensuring Emergency Care for All Children

2013-14 National Pediatric Readiness Project Assessment Results

Home | National Pediatric Readiness ED Participation by State/Territory

The following results represent a national initiative sponsored by the federal Emergency Medical Services for Children Program (EMSC) to ensure that **emergency departments (EDs)** are ready to care for children. EDs were asked to take an assessment regarding available resources for the care of children and received a score based on a **100 point scale**.

Rev. 3/21/2014

Average Pediatric Readiness Scores

Low Volume (<1800 patients)	Medium Volume (1800-4999 patients)	Medium to High Volume (5000-9999)	High Volume (>=10000)	All Participating Hospitals
62	70	74	84	69
n = 1629	n = 1248	n = 708	n = 561	n = 4146

ARIZONA DEPARTMENT OF HEALTH SERVICES

Health and Wellness for all Arizonans

PediatricPrepared Emergency Care

meeting the emergency needs for Arizona's children

Arizona

National Pediatric Readiness Project
Ensuring Emergency Care for All Children

State Name: Arizona

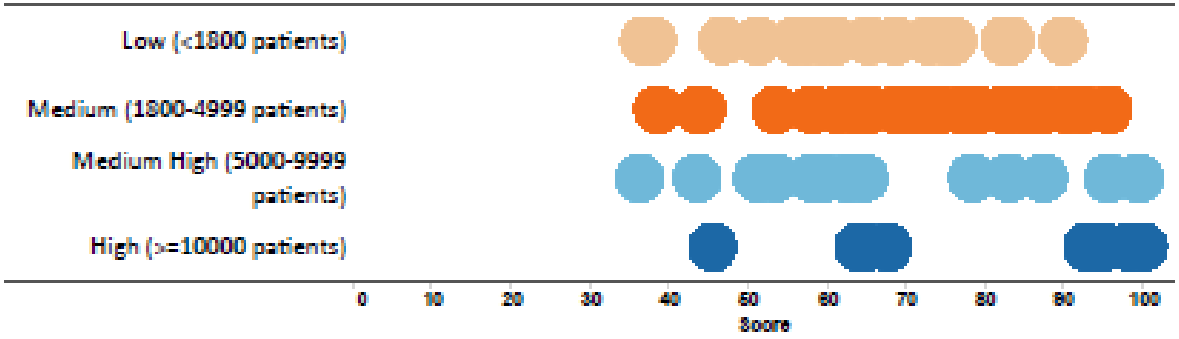
Report Date: 3/5/2014 11:35:46 AM

Number of Hospital Respondents:	77
Number of Hospitals Assessed:	77
Response Rate:	100.0%

STATE SCORE AND COMPARATIVE SCORES:

72	73	69
STATE AVERAGE HOSPITAL SCORE OUT OF 100	STATE MEDIAN HOSPITAL SCORE OUT OF 100	n = 4,146 NATIONAL MEDIAN OF PARTICIPATING HOSPITALS

DISTRIBUTION OF *STATE* SCORES FOR EACH VOLUME TYPE:



Voluntary Membership & Certification

- Based on national guidelines
  - American Academy of Pediatrics (AAP)
  - American College of Emergency Physicians (ACEP)
  - Emergency Nurses Association (ENA)
- Refined by Arizona stakeholders
  - Hospital CEOs, emergency department leadership
- Modeled on Arizona Perinatal Trust practices

3 Levels

- Advanced Care
  - Must have PICU and Pediatric Coordinator
  - Highest level of credentials, continuing education required
- Prepared Plus Care
  - Higher level of credentials, education requirements
- Prepared Care
  - Most community EDs inclusive of critical access/tribal hospitals

All Levels

- Pediatric-specific equipment
- Pediatric-specific quality review process
- Review of policies
- Review of facilities

Education

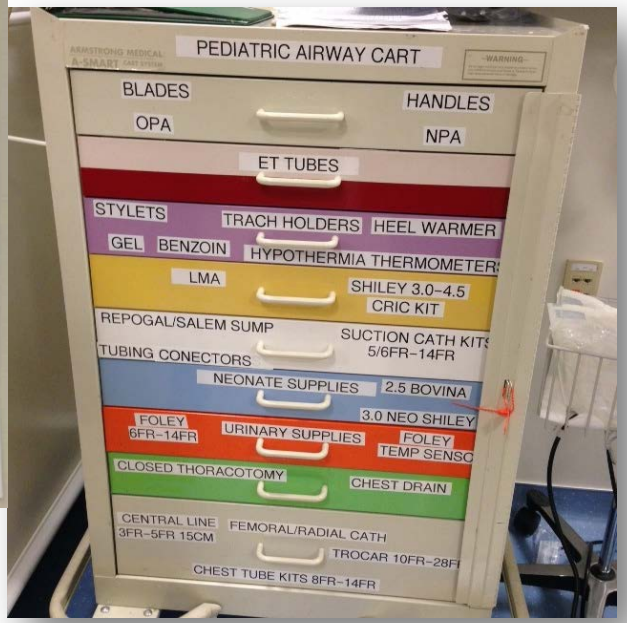
- Emergency Nurse Pediatric Course (ENPC)
- Emergency Nurse Certification prep (CEN)
- Pediatric Emergency Nurse Certification prep (CPEN)
- Focus on pediatric-specific CME
- Pediatric mock codes
- Arizona Pediatric Symposium
  - Annual pediatric conference
  - EMS and ED staff

Small Changes = Big Results

- Scales locked in kilograms
- Standardize code carts
- ENPC
- Membership resource site
- Raising the bar every 3 years


9107
MEDICATION DRAWER
3 KG - 9 KG
10 KG - 11 KG
12 KG - 14 KG
BROWN


ALL pediatric meds
MUST be double
checked with another
RN, pharmacist or
M.D.


PEDIATRIC AIRWAY CART
BLADES
HANDLES
OPA
NPA
ET TUBES
STYLETS
TRACH HOLDERS
HEEL WARMER
GEL
BENZOIN
HYPOTHERMIA THERMOMETER
LMA
SHILEY 3.0-4.5
CRIC KIT
REPOGAL/SALEM SUMP
SUCTION CATH KITS
5/6FR-14FR
TUBING CONECTORS
NEONATE SUPPLIES
2.5 BOVINA
3.0 NEO SHILEY
FOLEY
6FR-14FR
URINARY SUPPLIES
FOLEY
TEMP SENSO
CLOSED THORACOTOMY
CHEST DRAIN
CENTRAL LINE
3FR-5FR 15CM
FEMORAL/RADIAL CATH
TROCAR 10FR-28F
CHEST TUBE KITS 8FR-14FR

Common Challenges

- Pediatric disaster policies
- Behavioral health inpatient beds
- Child maltreatment protocols

Certification

- **Advanced Care**
  - Arizona Children's Center at Maricopa Medical Center
  - Banner Thunderbird Medical Center
  - Banner University Medical Center – Tucson
  - Cardon Children's Medical Center
  - Phoenix Children's Hospital
  - HonorHealth – Shea Medical Center
  - Tucson Medical Center for Children
- **Prepared Plus Care**
  - Dignity Mercy Gilbert Medical Center
  - HonorHealth Deer Valley Medical Center
  - HonorHealth Osborn Medical Center
  - HonorHealth Thompson Peak Medical Center
  - Summit Healthcare Regional Medical Center
  - Yuma Regional Medical Center

Certification

- **Prepared Care**
  - Abrazo Central Campus
  - Banner Baywood Medical Center
  - Banner Boswell Medical Center
  - Banner Del E Webb Medical Center
  - Banner Estrella Medical Center
  - Banner Gateway Medical Center
  - Banner Goldfield Medical Center
  - Banner Ironwood Medical Center
  - Banner Page Hospital
  - Chinle Comprehensive Health Care Facility
  - Cobre Valley Regional Medical Center
  - Copper Queen Community Hospital
  - Mount Graham Regional Medical Center
  - Northern Cochise Community Hospital
  - Oro Valley Hospital
  - Tuba City Regional Health Care Corporation
  - White Mountain Regional Medical Center

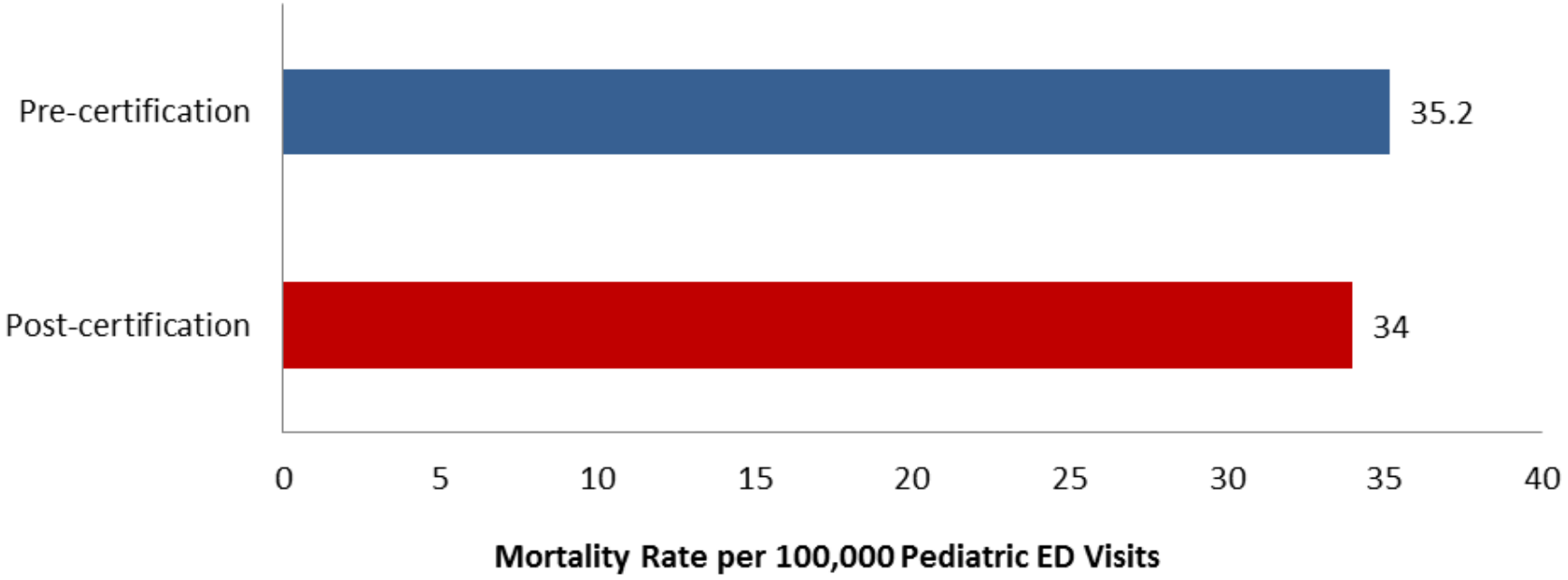
Members

- **In progress for certification**
  - Abrazo Maryvale
  - Banner Casa Grande Medical Center
  - Banner University Medical Center – South Campus
  - Benson Hospital
  - Cochise Regional Hospital
  - Gila River HuHuKam Memorial Hospital
  - La Paz Regional Hospital
  - Parker Indian Health Center
  - Phoenix Indian Medical Center

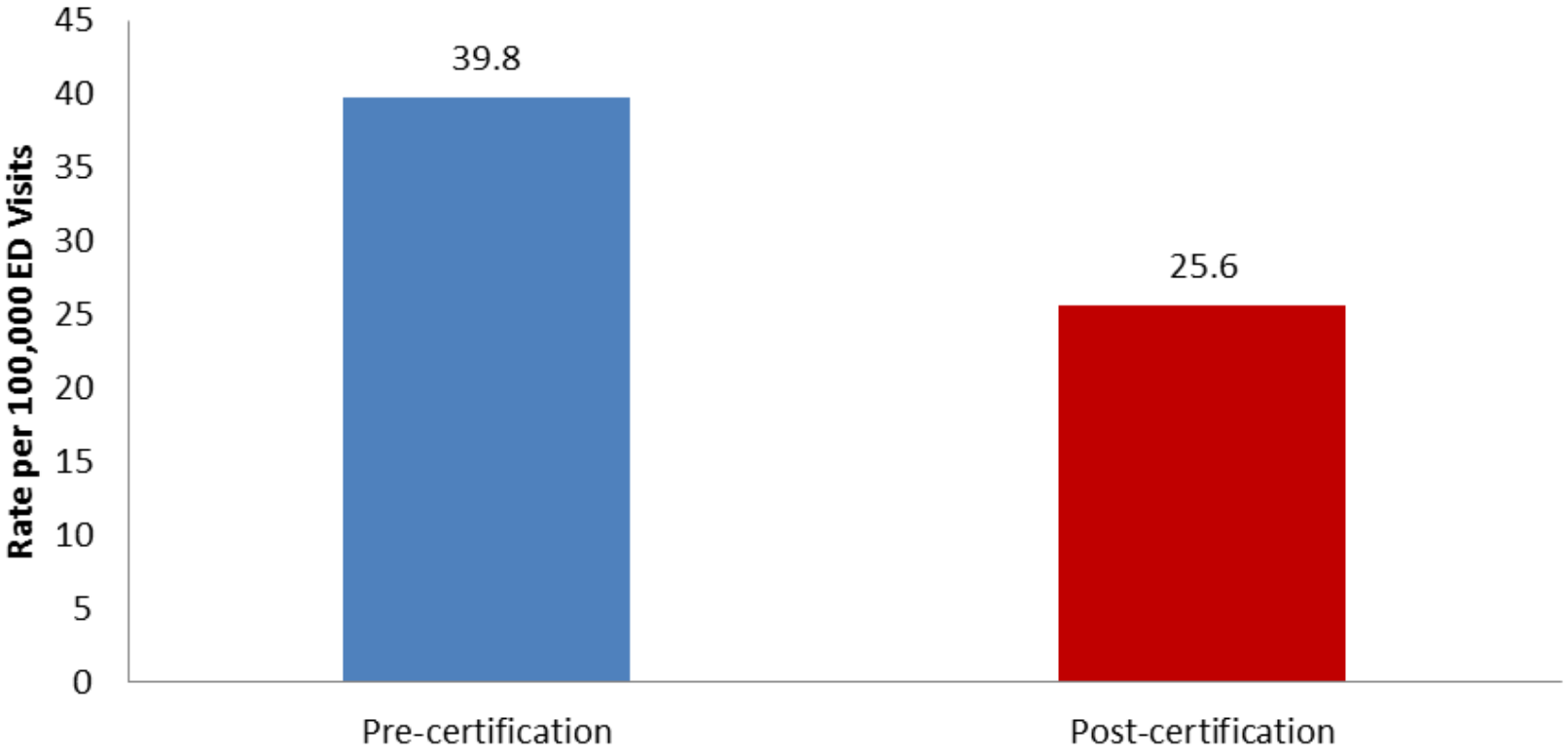
Analysis

- Emergency Department and Death data
- Facilities pre/post and non-verified centers
- Injury is a sensitive indicator
- Improvements

Pediatric Mortality Rates Pre/Post Emergency Department Certification (All Pedatric ED Visits), Arizona 2011-2014



Pediatric Injury Mortality Rate Pre/Post Emergency Department Certification, Arizona 2011-2014



Comparing the Certified Emergency Department's Pediatric Mortality Rate to the Overall Pedatric Injury Mortality Rate, Arizona 2011-2014

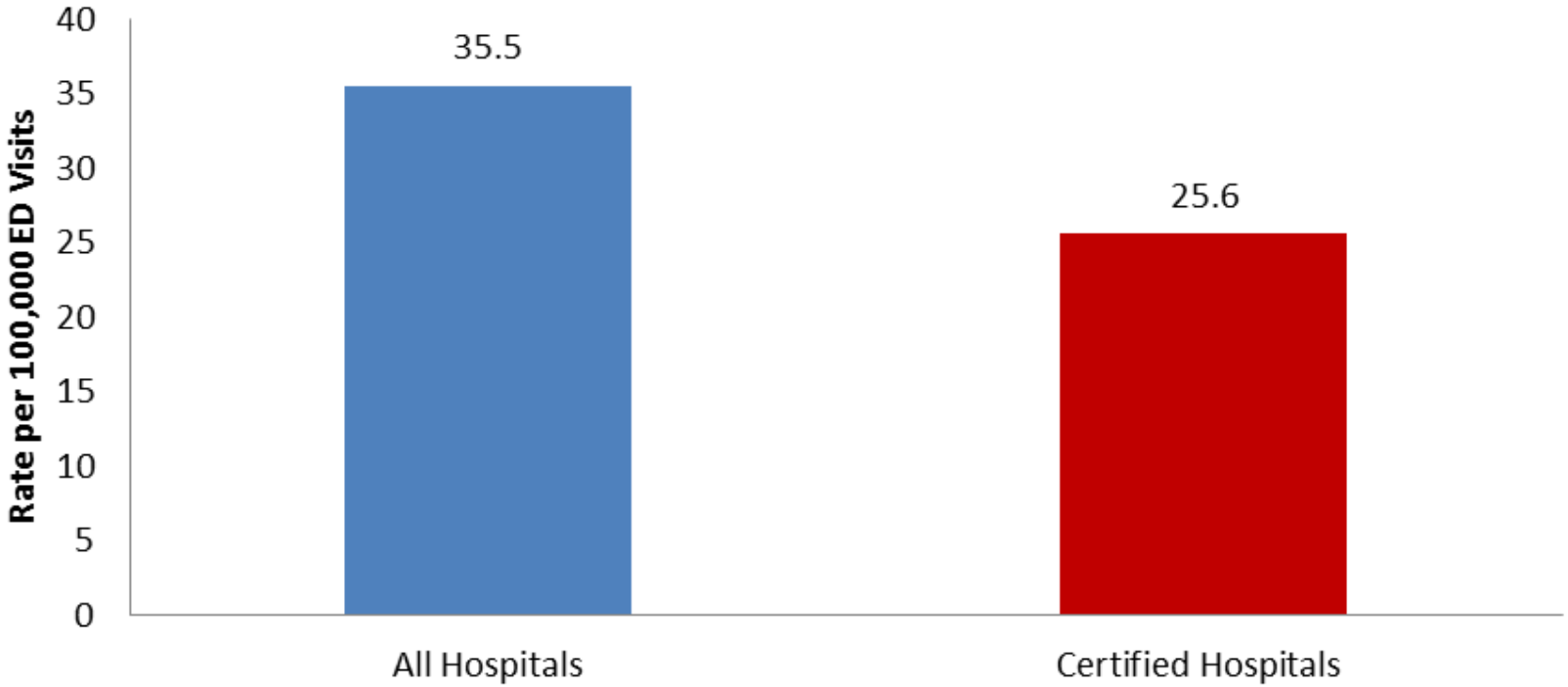


Figure 4. Pediatric Trauma Mortality Rates among Certified and Non-Certified Hospitals , 2011-2014

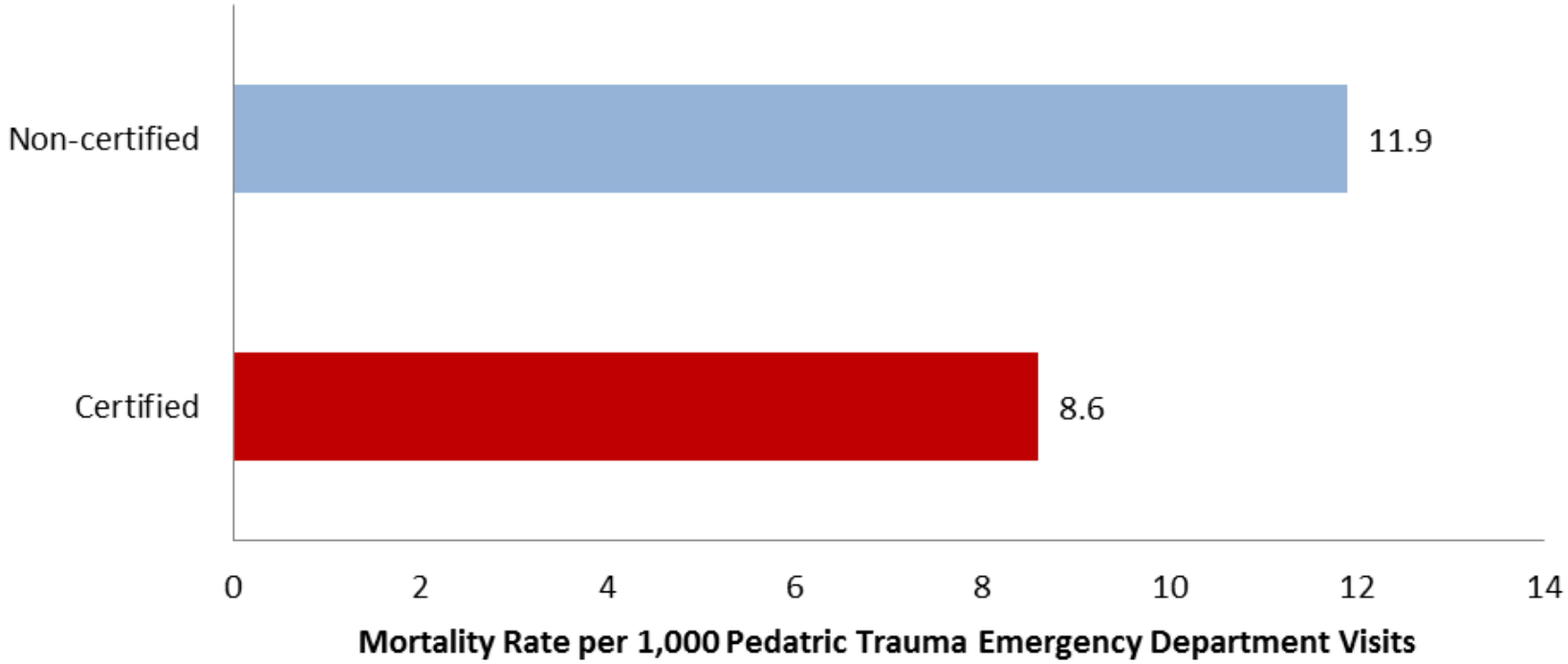
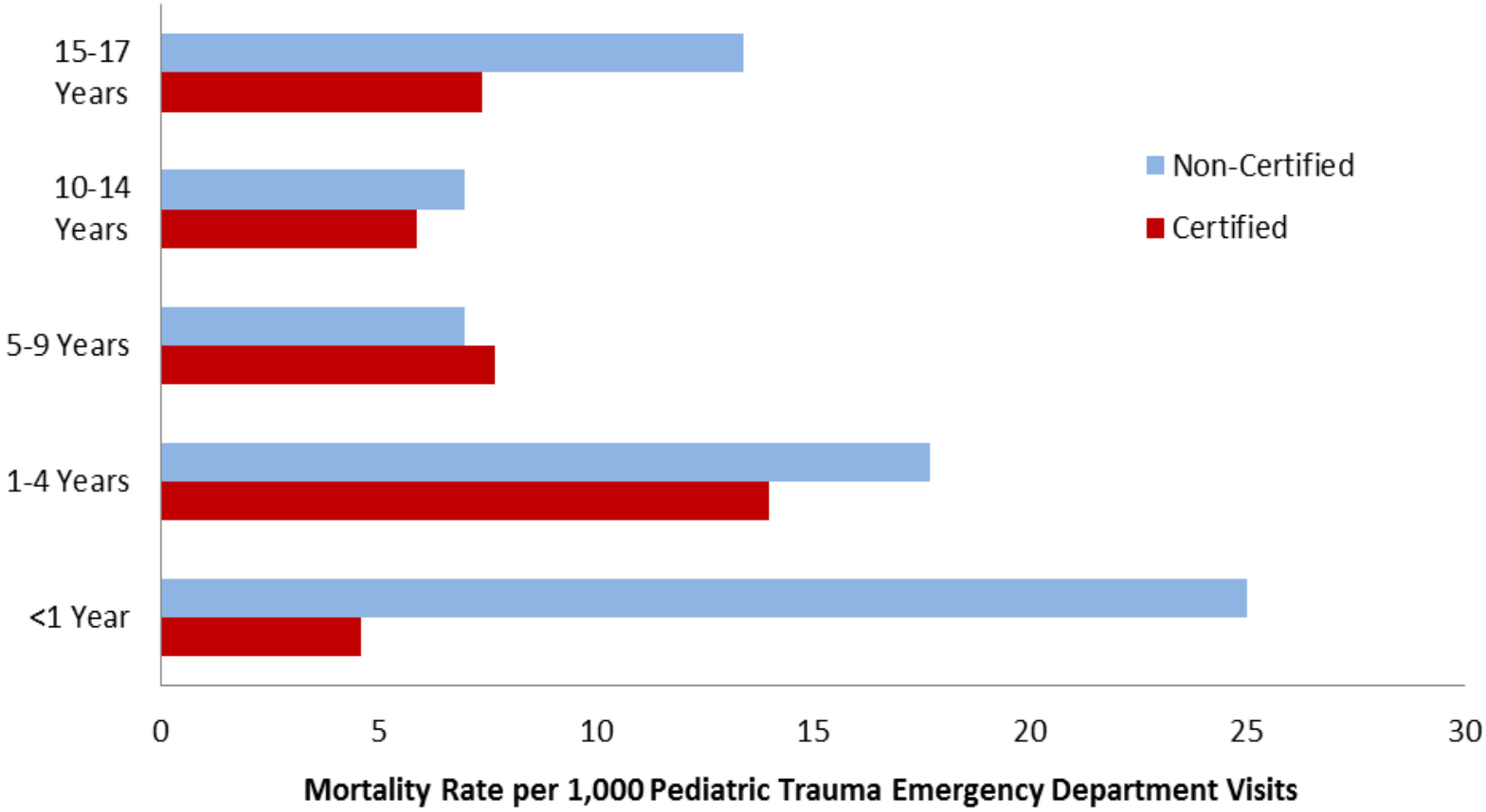


Figure 6. Pediatric Trauma Emergency Department Mortality Rates among Certified and Non-Certified Hospitals by Age Group, 2011-2014



Moving Evidence into Practice

- Demonstrating success
- Flexibility to respond to evidence
- Kids win regardless of geographic location

Questions?

www.azaap.org/Pediatric_Prepared_Emergency

Opioid Update

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Arizona's Opioid Epidemic

Understanding the Problem and Finding Solutions

The National Opioid Influx

- A 4 fold increase in the quantity of Rx Opioids sold in the U.S.
- The U.S. makes up 4.6% of the world's population, but consumes 80% of its Rx opioids
- ~52 deaths every day!

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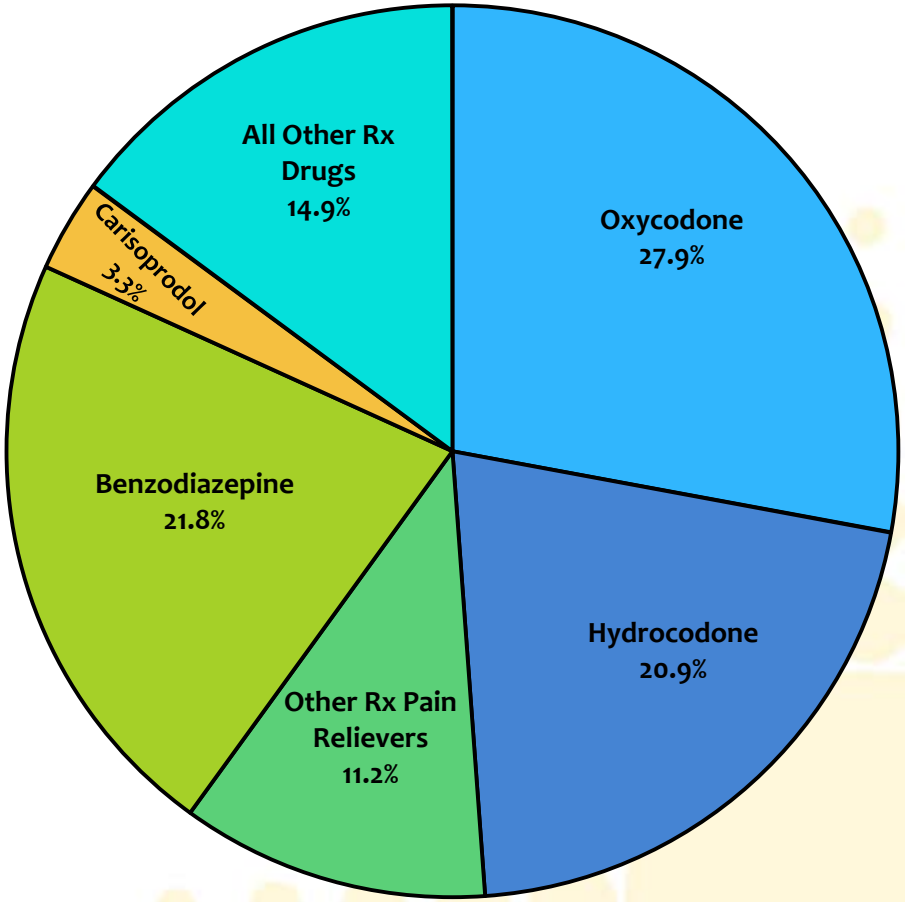
CDC National Estimates

Nearly **2 million** Americans abused or were dependent on prescription opioids in 2014.

Availability of Rx Opioids in Arizona

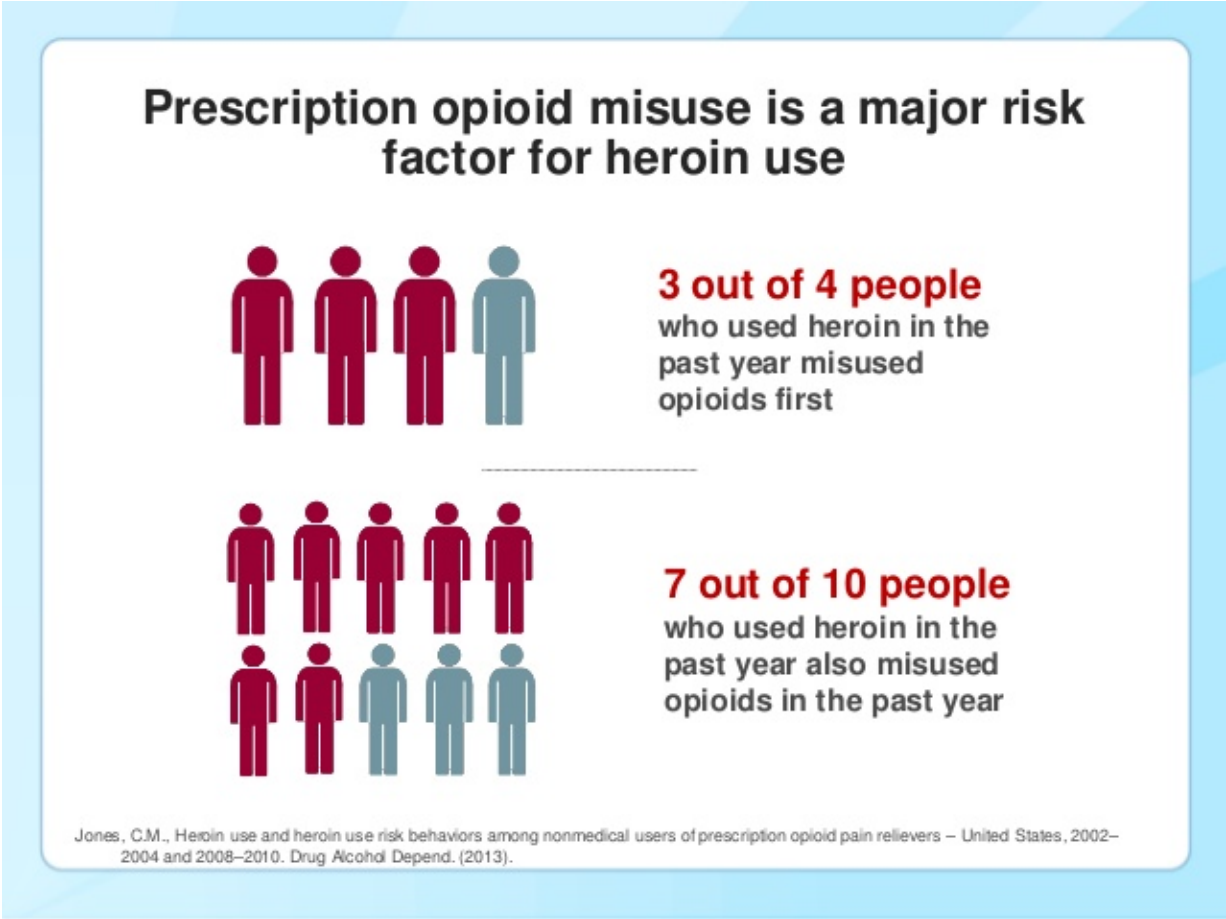
- ~575 million Class II-IV pills are dispensed each year in Arizona
- Opioids account for 60%
- Access & probability



Volume: Access Ratio

- Enough Rx opioids were dispensed last year to medicate every Arizona adult around the clock for more than 2 weeks

Emerging Heroin Trends

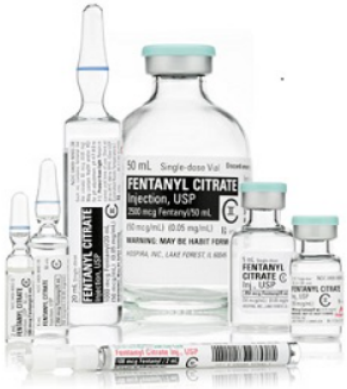


Fentanyl

DEA Issues Alert on Fentanyl-Laced Heroin as Overdose Deaths Surge Nationwide

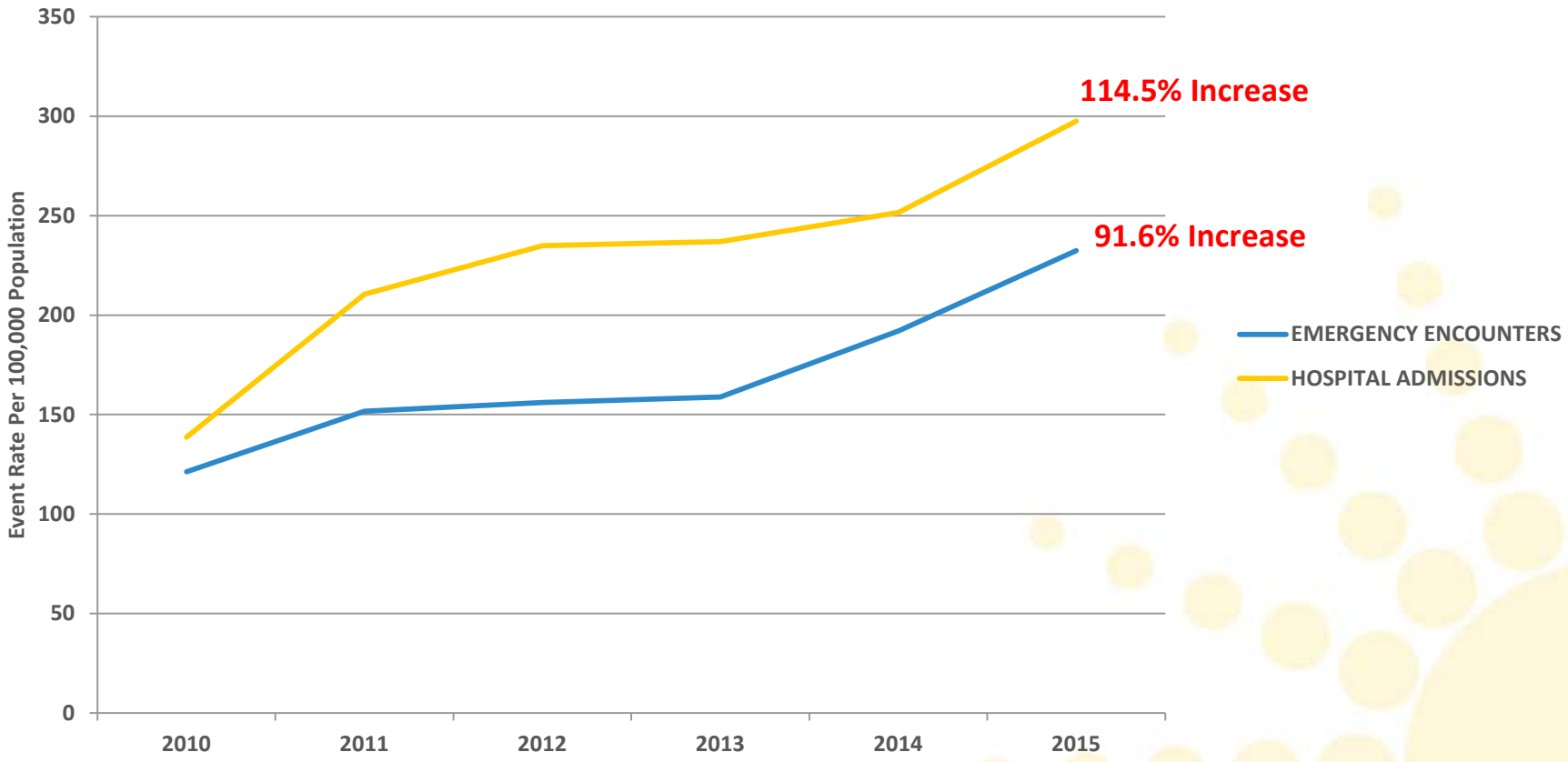
BY JOIN TOGETHER STAFF

March 19th, 2015



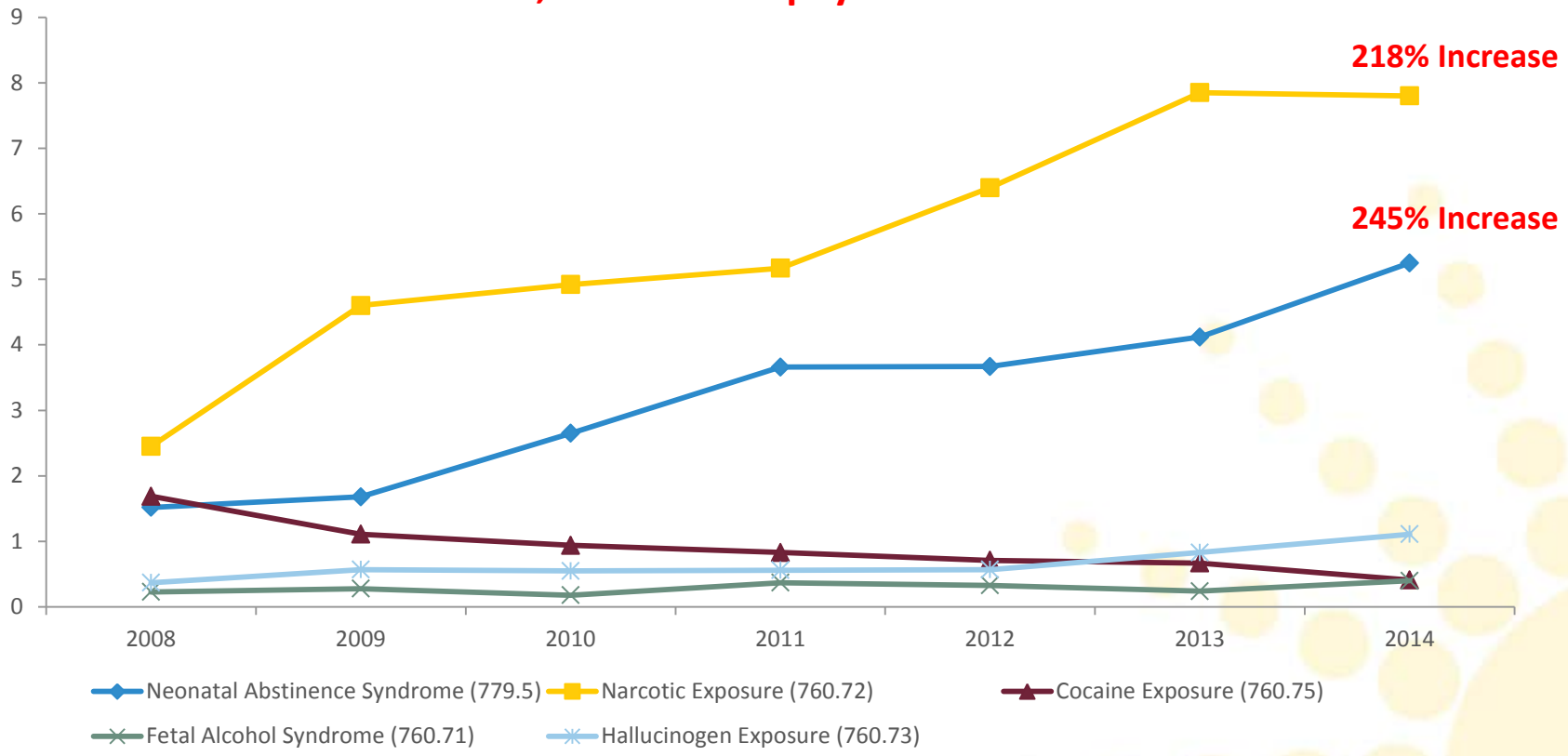
What the Opioid Epidemic is Costing Arizona

Arizona Opioid-Related ED Encounters and Hospital Admissions

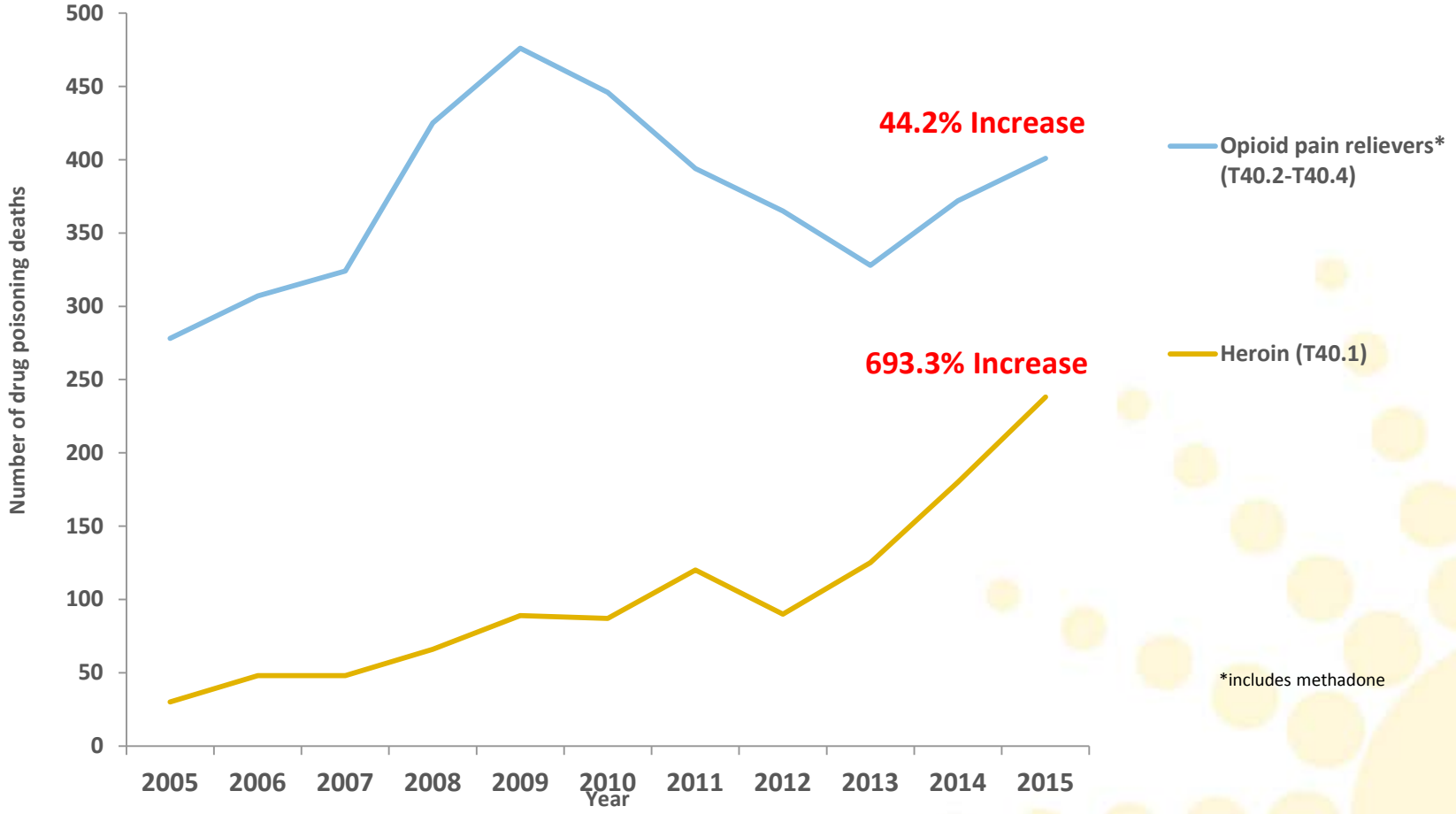


Neonatal Abstinence and Newborn Drug Exposure Rates per 1,000 Births

AHCCCS represented 51% of Arizona hospital births between 2008 and 2014, but was the payer for 79% of the NAS cases



Number of Drug Overdose Deaths Involving Opioids, Arizona 2005-2015 (ADHS)



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The Path to Opioid-Mortality

- Dosage too large for opioid-naïve individuals
- Given tolerance:threshold ratio, users begin taking more and more just to get to “baseline”
- Users in recovery who start again, often start with their last dose. If tolerance has lessened, body can’t accommodate
- Cocktailing with alcohol, Rx benzos, and Rx muscle relaxers

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Finding a Solution

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3 Groups to Target

1. Opioid-Naïve Individuals
2. The Chemically Dependent
3. Diverters

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Strategy #1

Promote Responsible Prescribing and Dispensing Policies and Practices

Opioid-Naïve Individuals

- Those who have never taken narcotics and have minimal experience with controlled substances
  - Don’t get them started if you don’t have to
  - Non-opioid Tx first
  - Minimal supply of opioids if necessary
  - No refills

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Talking to Uninformed Patients

- Educate patients about the importance of proper adherence and the risks of misuse
  - Taking more than prescribed
  - Mixing with other drugs and/or alcohol
  - Not sharing scripts with others and why
  - Proper storage and disposal – especially if kids are present in the home

The Chemically Dependent

- Individuals who have developed symptoms of tolerance or physiological and/or psychological withdrawal if use of the Rx drug (legitimately or illegally acquired) is reduced or discontinued

- At **GREATEST risk** for **overdose**!
  - Use data to identify “high risk” members – coordinate member care
  - Use data to identify problematic prescribing patterns – coordinate provider education

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High-Risk Groups

- 45-54 year olds
- Youth and young adults (quicker path to heroin)
- Women of child-bearing age
- Criminal Justice population
- American Indians
- Polypharm patients
  - Specifically those combining opioids with benzodiazepines and/or muscle relaxers
- Former users
- Medicaid patients

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Sign Up and USE the CSPMP

- Ensure Patient Safety
- Limit Liability
- Now Easier than Ever with Delegate Option

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Facilitate Use of Best Practices

ARIZONA MEDICAL ASSOCIATION

ADVANCING EMERGENCY CARE

Arizona College of Emergency Physicians

EMERGENCY NURSES ASSOCIATION Arizona State Council

Arizona Guidelines For Emergency Department Controlled Substance Prescribing

Arizona Department of Health Services

1. When possible one medical provider should provide all controlled substances to treat a patient's chronic pain.
2. The Prescription Monitoring Program should be checked prior to prescribing controlled substances.
3. The administration of intravenous and intramuscular controlled substances in the ED for the relief of acute exacerbations of chronic pain is discouraged.

SUMMARY OF ARIZONA OPIOID PRESCRIBING GUIDELINES FOR THE TREATMENT OF CHRONIC NON-TERMINAL PAIN (CNTP)

#1: A comprehensive medical and pain related evaluation that includes assessing for substance use, psychiatric comorbidities, and functional status should be performed before initiating opioid treatment for chronic pain.

#2: A goal directed trial of opioid therapy is considered appropriate when pain is severe enough to interfere with quality of life and function and the patient has failed to adequately respond to indicated non-opioid and non-drug therapeutic interventions. Potential benefits should be determined to outweigh risks. The patient should agree to participate in other aspects of a pain care plan such as physical therapy and cognitive behavioral therapy when these therapies are recommended and available.

#3: The provider should assess for risk of misuse, addiction, or adverse effects, and perform a risk stratification before initiating opioid treatment.

#4: Initiating opioids in patients with CNTP should ideally be limited to the evidence-based indication of short term therapy with the purpose of facilitating participation in a comprehensive care plan; however, if chronic opioid therapy (COT) is considered, a goal directed trial lasting 30-90 days should be the starting point. Continuing opioid treatment after the treatment trial should be a deliberate decision that weighs the risks and benefits of chronic opioid treatment for that

SUMMARY OF ARIZONA OPIOID PRESCRIBING GUIDELINES FOR THE TREATMENT OF ACUTE PAIN

The goal of these guidelines is to balance the appropriate treatment of pain with approaches to more safely prescribe opioids. Thoughtful opioid prescribing for acute and post-operative pain can improve safety, reduce harm, and prevent the unintended or inappropriate long-term use of opioid medications.

Note: These guidelines are not intended to apply to hospice or palliative care patients (as defined by the World Health Organization), patients at end of life, or cancer-related pain.

#1: Opioid medications should only be used for treatment of acute pain when the severity of the pain warrants that choice, and non-opioid pain medications or therapies will not provide adequate pain relief.

#2: When opioid medications are prescribed for treatment of acute pain, the number dispensed should be no more than the number of doses needed. This should be based on the expected duration of pain severe enough to justify prescribing opioids for that condition.

#3: When opioid medications are prescribed for acute pain, the patient should be counseled on the following:

- Sharing with others is illegal.

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Arizona Guidelines For Dispensing Controlled Substances

ARIZONA STATE BOARD OF PHARMACY ASBP 1912

AzPA Arizona Pharmacy Association

2013

Arizona Prescription Drug Misuse and Abuse Initiative

The abuse of prescription drugs is a serious social and health problem in the United States. Arizona is no exception to this problem. According to data from Arizona's Prescription Drug Monitoring Program, there are approximately 10 million Class II-IV prescriptions written

Register for FREE CME

www.VLH.com/AZPrescribing

Safe and Effective Opioid Prescribing WhileManaging Acute and Chronic Pain

An online program offering 2 Free CME Credits to help Arizona DEA prescribers incorporate into practice the **2014 Arizona Opioid Prescribing Guidelines.**

CLICK HERE to Get Started and Register Your VLH.com Account

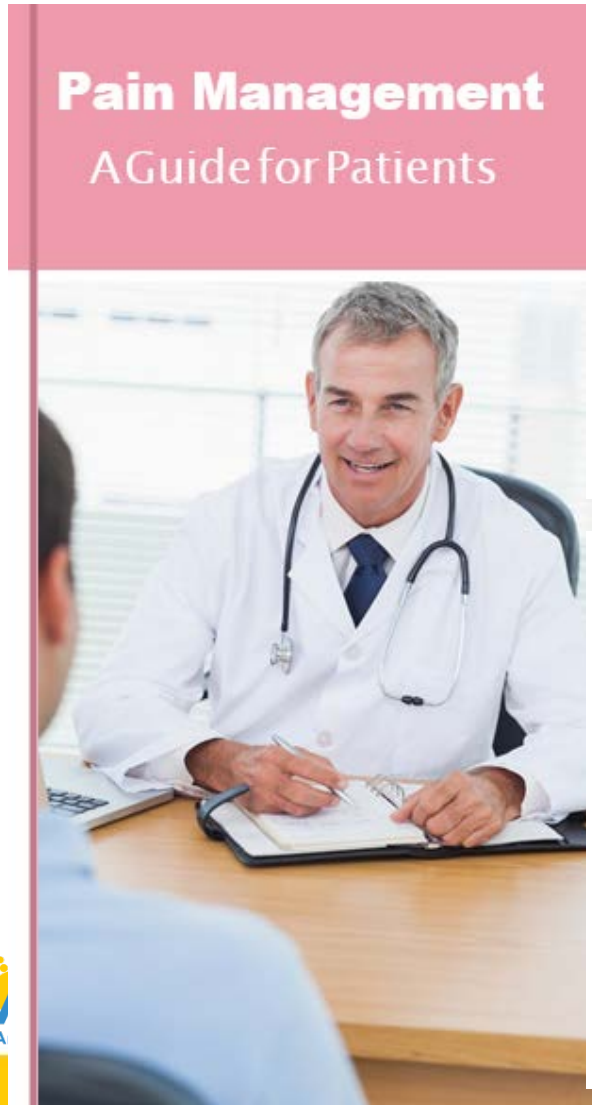
Learning Objectives

There is increasing evidence that opioid medications are over-prescribed and poorly managed because physicians are not aware of appropriate opioid risk management strategies and non-opioid approaches to treating chronic pain. This

AHC Arizona Health Care Co

Educate Patients

http://www.azcjc.gov/acjc.web/rx/default.aspx



Click here for Pain Management video

You would do anything for your friends...

but when it comes to medicine, sharing isn't caring!

Your meds are just for you.

Diverters

Doctor Shoppers, Pill Mills and the Candy Man

- Individuals seeking controlled substances for the purpose of selling them to others or healthcare professionals engaged in fraudulent prescribing practices
- What to do
  - Check the CSPMP
  - Safeguard DEA # and script pads
  - Communicate with other prescribers and pharmacists
  - Look for red flags
  - When to contact Regulatory Boards and Law Enforcement

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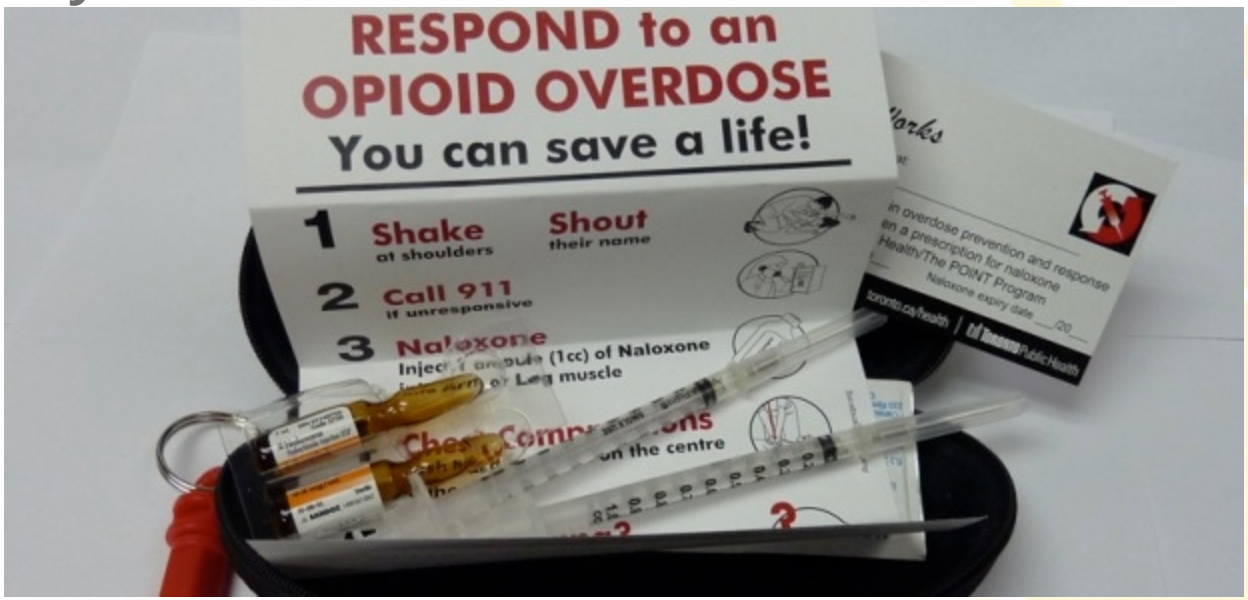
Strategy #2

Enhance Harm Reduction Strategies to Prevent Opioid Overdoses

Reverse Overdoses Through Naloxone

- HB2355
  - Pharmacists can dispense without a prescription to person at risk, family member or community member



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What's Needed for Naloxone?

1. Develop and disseminate CME training modules on Naloxone
2. Develop and disseminate community-based Naloxone trainings and educational material for members
3. Support community-based distribution project
4. Promote co-prescribing to high risk members

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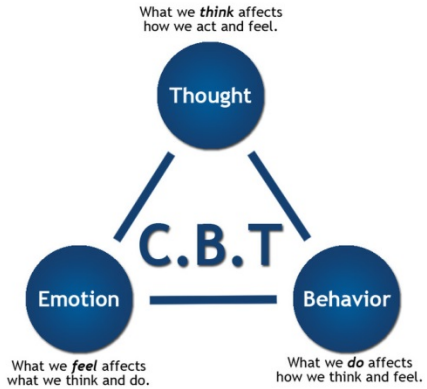
Strategy #3

Enhance Access to Integrated Medically Assisted Treatment

Evidence-Based Treatment



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Motivational Interviewing

What's Needed for Integrated MAT

- Capacity assessment and gap analysis
- Awareness of CARA ACT and Data2000 changes
- Expanding MAT providers into primary care practices
- Centers of Excellence for Integrated MAT?
- Education and training on MAT (members, community, providers and external partners)

Coming Soon!

NAS and pregnant member strategy

Thank You.