PART V

The American Indian Medical Home

Supporting Arizona's Commitment to Addressing Health Care Disparities for American Indians/Alaska Natives

Overview

AHCCCS administers Medicaid to over 1.7 million members through a mandatory managed care delivery system. This system operates managed care insurance programs that establish each member with a Primary Care Physician (PCP) upon enrollment. Case management is provided as an administrative service to those members identified by their health plan to require care coordination or assistance in managing a chronic illness. Health plans also offer call lines staffed by medical professionals as an administrative service.

The AHCCCS model requires every Medicaid beneficiary to enroll with a managed care organization (MCO). The only exception to this requirement is for the American Indian/Alaska Native (AI/AN) population, which has the option of enrolling with an MCO or receiving services in the AHCCCS fee-for-service (FFS) program, known as the American Indian Health Program (AIHP). American Indians and Alaska Natives who enroll in the American Indian Health Program receive their care largely through Indian Health Services (IHS) facilities and Tribal facilities operated under Public Law (PL) 93-638. IHS and Tribal facilities do not have the administrative dollars to support case management functions or call lines to assist members in coordinating their care. The clinical leadership of IHS recognizes that fundamental changes in their system are required in this time of fewer resources and health reform.

The IHS Improving Patient Care (IPC) program goal is to engage IHS, Tribal, and Urban Indian health programs to improve the quality of, and access to, care for AI/AN members through the development of a system of care called the "Indian health medical home". The IPC program is focusing on patient-and-family-centered care while ensuring access to primary care for all AI/AN people. High-quality care will be delivered by health care teams who will be making sustainable and measurable improvements in care. Medicaid is IHS' biggest payor/partner. Therefore, AHCCCS would like to align its efforts in Arizona with the efforts being made by IHS and the federal government to modernize and improve the health care delivery system for the AI/AN population.

The most recent U.S. Census figures state the AI/AN population is approximately 350,000 in Arizona.[1] Almost half of the AI/AN population in Arizona is enrolled in AHCCCS, and approximately 75 percent of AI/AN AHCCCS members are enrolled in the American Indian Health Program. Significant health disparities exist between the AI/AN population

[1] Current tribal enrollment numbers collected by survey taken by AHCCCS estimate the AI/AN population in Arizona to be approximately 443,000.

and the general population of Arizona, including the average age of death (17.5 years lower for American Indians), and higher death rates from many preventable diseases. AHCCCS proposes an Indian Health Medical Home Program (IHMHP) that aligns with the IPC program in order to address some of these disparities and to support the ability of IHS, Tribal, and Urban Indian health programs, as well as non-IHS facilities with high AI/AN patient volumes, to better manage the care for American Indians and Alaska Natives enrolled in the American Indian Health Program.

Accordingly, to accomplish these goals AHCCCS seeks the following authority:

- **Comparability** - Waiver from §1902(a)(10)(B) and corresponding regulations at 42 CFR §§440.240, to allow the State to provide services that support a medical home for AI/AN members enrolled in FFS who receive services provided through the IHS and Tribal facilities. These services are Primary Care Case Management, diabetes education, after-hospital care coordination and 24-hour call lines staffed by medical professionals.
- **Reimbursement CNOM-** Expenditure authority to allow the State to pay for services that support a medical home for AI/AN members enrolled in FFS who receive services provided through the IHS and Tribal facilities. Expenditure authority to allow the State to pay non-IHS/Tribal facilities a shared savings payment to support the Indian Health Medical Home Program.

Developing the American Indian Medical Home through Consultation

Originally, this concept was proposed and brought to AHCCCS by the Tucson Area IHS. Verbal notification on the development of this proposal as well as notification that a future consultation meeting would be held to further discuss this topic was provided at an AHCCCS Consultation Meeting with Tribes and IHS, Tribal, and Urban Indian health programs (I/T/U) on March 31, 2011.

AHCCCS also obtained information related to medical home activities from the Navajo Area IHS, Phoenix Area IHS, Tucson Area IHS, and certain Tribal Facilities. This information was used in the development of the first waiver proposal. AHCCCS formally consulted with tribes and I/T/Us in Arizona on the components of the original waiver proposal in accordance with the AHCCCS Tribal Consultation Policy and Medicaid State Plan on August 4, 2011. The amendment was also placed on the AHCCCS website for public comment around that time.

Since then, AHCCCS has embarked upon a Tribal Care Coordination effort of its own. AHCCCS revised this proposal to align this amendment with the IPC and AHCCCS Tribal Care Coordination efforts. The AHCCCS Tribal Care Coordination initiative strives to improve the quality of care for its members by increasing the efficiency of the multiple systems of care in which members can access services. While there are various care coordination models being implemented across the nation, as well as here in Arizona, AHCCCS adopted the Indian Health Service's IPC Care Model to avoid creating

duplication in the system and confusion amongst the various efforts being implemented to improve the care for AI/AN members. Furthermore, the Agency recognizes the importance of promoting a shared message in working toward a common goal — improve the quality, connectivity, and accessibility of care in the American Indian healthcare delivery system. AHCCCS works toward that goal in its role as a facilitator of data exchange to inform providers of utilization trends among members empaneled to them. As a major payor, AHCCCS provides this data so that the medical home can develop interventions that will assist patients empaneled to them to better manage their health. I/T/Us, however, need additional tools to build their capacity to act as medical homes that can be held accountable for reducing emergency department utilization, admissions or readmissions, and improve outcomes.

Anticipated updates to the draft proposal were presented verbally at tribal consultation on August 15, 2013. AHCCCS has also posted the revision to its website for public comment. The revised amendment was also presented to the State Medicaid Advisory Committee on April 9, 2014. Subsequently, representatives from the three IHS Area offices made revisions to the proposal for consideration requiring additional review. These revisions have been incorporated here and will be presented for comment at the tribal consultation in August 21, 2015.

Arizona expects that the oversight and payment for IHMHP service delivery will necessitate close working relationships between the State and the IHS, Tribal, Urban Indian health program, and non-IHS facilities with AI/AN patient volumes greater than 30%, and that this process will enhance collaboration toward similar goals of reducing health disparities and delivering cost-effective care.

Provider Payments

The American Indian Health Program has worked in conjunction with tribes and IHS facilities to determine the cost of delivering an IHMHP, which would reimburse for Primary Care Case Management, a 24-hour call line and care coordination. In order to simplify claiming and payment, AHCCCS has elected not to offer a tiered payment structure, but to combine requirements and payment into one flat rate. The American Indian Health Program cost data from IHS and tribal facilities in Arizona were evaluated to determine a PMPM payment of $7.11 with an annual increase of 4.6%, which is based upon the average annual increase of the outpatient all-inclusive rate over the past ten years. For approved medical homes providing diabetes education pursuant to guidelines established within that model and herein, an additional $2.00 PMPM will be available.

The medical home services for which AHCCCS proposes to reimburse are currently not reimbursed through the all-inclusive rate and will therefore be billable by IHS and Tribal facilities only on a monthly basis to AHCCCS. PMPM payments will be made with 100% FFP dollars and will only be available for IHS and tribally operated 638 facilities for FFS members in order to avoid duplicative payment. Facilities will be required to submit an IHMHP claim for each member that is empanelled in their medical home on a monthly

basis. Empanelment will be determined by AHCCCS based on the criteria discussed below.

Overview Development of Medical Home Criteria

IHS and Tribal facilities may choose whether or not to provide an Indian Health Medical Home Program (IHMHP) for their members. In order to receive reimbursement for services provided by their IHMHP, facilities must present their proposal to AHCCCS for review every three years or sooner if their program structure changes. This proposal should detail the mechanisms in place to meet the criteria outlined in the definition of an IHMHP below. For example, when the IHMHP requires that each member be empanelled to a personal Primary Care Provider (PCP), the facility should describe how they empanel patients, what their empanelment rate is, and what type of providers they employ as PCPs. When approved as medical home providers, IHS and Tribal facilities should have a goal of 100% empanelment of their FFS AHCCCS members. However, FFS AHCCCS members will have the option to not be empaneled so as not to restrict choice; reimbursement will be based upon only those members that are formally part of the medical home. To ensure there is choice given, the AHCCCS FFS member must sign a form at the facility stating they are agreeing to be empaneled to that particular facility.

AHCCCS recognizes the importance of prior research and development in the area of medical homes. The AHCCCS criteria for medical home designation are based upon the following Joint Principles of the Patient Centered Medical Home as presented in February 2007 by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association, combined with AHCCCS Tribal Care Coordination and IPC principles.

- ***Personal physician*** – Each patient has an ongoing relationship with a personal, licensed primary care provider trained to provide first contact, continuous and comprehensive care.
- ***Physician directed medical practice*** – The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- ***Whole person orientation*** – The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; behavioral health; chronic care; preventive services; and end of life care.
- ***Care is coordinated and/or integrated*** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

- ***Quality and safety*** are hallmarks of the medical home.
- ***Enhanced access*** to care is available through systems, such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
- ***Payment*** appropriately recognizes the added value provided to patients who have a patient-centered medical home.

With these guidelines in mind and in conjunction with the IHS, tribally operated 638 programs and the American Indian Health Program, AHCCCS has developed the following mandatory criteria for IHMHP designation when provided by IHS and tribally owned or operated 638 facilities in Arizona.

Medical Home Program Mandatory Criteria:

1. Assigns the member to a primary care team led by a primary care physician, nurse practitioner or physician's assistant. When staffing limitations prevent direct patient empanelment to a primary care physician, a primary care physician must be available for consultation and advisement as needed. The primary care team may consist of, but is not limited to, a combination of the following professionals: physician's assistants, nurse practitioners, registered nurses, licensed practical nurses, pharmacists, social workers, case managers, community health representatives (CHRs), diabetes health educators, behavioral health professionals, and medical assistants.
2. Provides or coordinates medically necessary primary and preventive services.
3. Organizes clinical data in an electronic format as a patient-specific charting system for individual patients.
4. Reviews all medications a patient is taking including prescriptions and maintains the patient's medication list in the chart.
5. Maintains a system to track tests and provide follow-up on test results.
6. Maintains a system to track referrals including referral plan and patient report on self-referrals.
7. Provides Care Coordination and Continuity of Care to the member, especially following hospital discharge, and supports family participation in coordinating care. Agrees to provide follow-up with the member within five days of hospital discharge. Provides various administrative functions including but not limited to securing referrals for specialty care and prior authorizations, including referrals for behavioral health treatment.
8. Provides patient education and support as needed.
9. Provides 24/7 voice to voice telephone call-line coverage with immediate availability of an on-call medical professional.
10. Uses mental health and substance abuse screening and referral procedures.
11. Agrees to follow and report to AHCCCS on an annual basis the following measures:
    a. Hospital readmissions within 30 days of discharge;
    b. Number of hospital readmissions within 30 days of discharge with a behavioral health diagnosis;
    c. Average number of ED visits per empanelled patient per year;
    d. GPRA measure: Childhood immunizations; and

e. Additional GPRA measures will be added following two years of successful implementation of these criteria.

Patient Empanelment

While an AHCCCS member retains the right to seek care from any AHCCCS registered provider, AHCCCS may only pay for one medical home per member. In order to avoid reimbursement to two different IHMHPs for the same member, AHCCCS will recognize patient empanelment to a specific IHMHP by the receipt of claims for at least three distinct dates of services within a six month time period within the member's service area. An IHMHP will not be able to be reimbursed for PMPM claims until the empanelment process has been completed

After a facility is approved as a medical home by AHCCCS, the facility must submit to AHCCCS Division of Fee-for-Service Management (DFSM) a file of empaneled members. Members submitted that already have been empaneled in a medical home will be rejected back to the facility; in this case, the facility or member can request a transfer through the transfer process.

All empanelment files and transfers must be submitted to AHCCCS by the 22nd of the month for the facility to be able to submit a claim for the following month. Information received after the 22nd of the month will not be able to be claimed until the following month.

The AHCCCS transfer process can be utilized when a member is empaneled with another facility. In this case, the facility that would like the member to be transferred must complete the AHCCCS approved transfer form. This form must be signed by the requesting facility, the currently empaneled facility and the member.

Diabetes Education Mandatory Criteria

IHMHPs providing diabetes education must provide an evidence-based curriculum designed to enhance regular treatment and disease-specific education, such as diabetes instruction. The Diabetes Education Program provides individuals with the skill sets necessary to coordinate all the things needed to manage their health, which is particularly helpful for individuals with more than one chronic condition. Subjects covered by an IHMPP Diabetes Education Program must include:

1. Education on techniques to deal with problems such as frustration, fatigue, pain and isolation
2. Education on appropriate exercise for maintaining and improving strength, flexibility, and endurance
3. Education on the appropriate use of medications and medication compliance
4. Education on how to communicate effectively with family, friends, and health professionals
5. Nutrition Education
6. Education on decision making
7. Education on how to evaluate new treatments

IHMHPs using a diabetes education curriculum and receiving an additional PMPM for these services must separately report the following:

- Hospital readmissions within 30 days of discharge with a diabetes diagnosis
- Number of ED visits with a diabetes diagnosis

Non-IHS/Tribal facilities: Supporting the IHS Indian Health Medical Home Model

American Indian members are not limited to using only IHS/Tribal facilities. They access care from non-IHS/Tribal facilities particularly in areas where a non-IHS/638 facility is more readily available than an IHS/Tribal facility. Additionally, AI/AN members often access non-IHS/638 facilities and providers for specialty care that may not be accessible at an IHS/Tribal facility. As a result, there are a number of non-IHS/Tribal facilities with high AI/AN patient volumes that can help support the IHMHP. These facilities are grappling with issues of care coordination, hospital readmissions and non-emergent use of the emergency department related to the AI/AN population.

Facilities with high AI/AN inpatient enrollment in AIHP, specialty care (e.g., OB/GYN) or emergency department patient volumes can help support the IHMHP model by allowing an IHS/Tribal facility to embed an IHS/Tribal care coordinator within their facility. Non-IHS/Tribal facilities that exceed 30% AI/AN patient volumes are eligible to receive shared savings payments through structured arrangements with AHCCCS that, among other measures: reduce emergency department use; reduce readmissions, coordinate with behavioral health; and share data with AHCCCS. These initiatives will be arranged on a case-by-case basis depending on the specialty of the provider type.

By supporting the model in this way, the non-IHS/Tribal facilities will be partnering with the IHMHP to connect AIHP enrolled members with the services necessary to address the health disparities that exist within the population, thereby, reducing the rate of hospital readmissions and non-emergent use of the emergency department. These facilities should be rewarded for the improvements in care delivery and in savings achieved for their efforts in supporting this model. Addressing healthcare disparities for the AI/AN population is not possible without the participation of non-IHS/Tribal facilities.

Arizona is proposing to offer services that support an Indian Health Medical Home Program – Primary Care Case Management, 24-hour call line, diabetes education and care coordination – to its acute care FFS Population. IHMHPs will be charged with addressing health disparities between American Indians and other populations in Arizona, specifically by enhancing case management and care coordination. In tracking the successes of IHMHPs across the state, Arizona expects to see trends indicating cost savings through the prevention of hospital readmissions and improved control of non-emergent use of the emergency department. Non-IHS/Tribal facilities will also share in those savings as critical players in addressing healthcare disparities for the AI/AN population.