

DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) STRATEGY FOR ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) — REVISED DRAFT

A. Opportunity Statement

Managed care organizations (MCOs), Regional Behavioral Health Authorities (RBHAs), and Arizona Long-Term Care Systems (ALTCs) plans are the foundation of Arizona's management of its Medicaid program. Through its creative and effective use of Medicaid managed care for 1.9 million beneficiaries, Arizona has made great strides in serving its Medicaid members in a cost-effective and value-based manner. As the state seeks to advance the use of alternative payment models with providers through its managed care contractors, it finds that many health systems are ill positioned to assume accountability for providing integrated care for their most vulnerable patients. Arizona seeks to ensure that, as more providers assume more downside risk for management of population health, these providers also possess the care integration infrastructure necessary to successfully meet the needs of Medicaid beneficiaries. AHCCCS' managed care contractors, including MCOs and RBHAs, will be expected to play an active role in provider entities' DSRIP work.

Arizona's DSRIP program will help providers build capacity to succeed under payment reform and drive better health and financial outcomes. The DSRIP program design focuses on targeted populations of vulnerable Medicaid beneficiaries where care integration will likely have an immediate impact for enrollees and providers.

B. DSRIP Strategic Focus

Like many states, Arizona finds many large health systems, specialty health care, and social service providers with ill-defined and suboptimal operational relationships. For this reason, Arizona seeks to fund time-limited projects aimed at building necessary relational infrastructure to improve multi-agency, multi-provider care delivery for the following populations:

- American Indians (both adults and children), including both those served through the Indian health delivery system (e.g., Indian Health Service (IHS)/Tribal 638 organizations) and those receiving some or all of their care elsewhere.
- Individuals transitioning from incarceration who are AHCCCS-eligible and enrolled.
- Children with behavioral health needs, including children with and at risk for Autism Spectrum Disorder, and children engaged in the child welfare system.
- Adults with behavioral health needs.

At the crux of the projects is improved care coordination for these vulnerable AHCCCS members. For the purposes of the projects, care coordination will generally follow the Agency for Healthcare Research and Quality (AHRQ) definition, with each project operationalizing service delivery in a manner that is appropriate for the specific population and goals of the program. The AHRQ

definition “is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.”¹

American Indians

Forty percent of Arizona’s American Indian population of 350,000 is covered by Medicaid. AHCCCS has identified a significant opportunity to improve care for this member population by improving the integration of services among the state’s hospitals and health care provider organizations, including those located on and off Tribal reservations.

Medicaid covers services delivered both inside and outside the IHS/638 system. American Indian Medicaid members have the choice of receiving care through the AHCCCS acute plans (MCOs) or through the American Indian Health Program, a fee-for-service payment program administered by AHCCCS. Tribal members’ health disparities are exacerbated by a fragmented delivery system that is difficult to navigate and provides little in the way of care coordination. Providers often have limited-to-no access to data from other settings in which the members they are seeing also seek care, making effective coordinated care extremely challenging.

Adults Transitioning from the Justice System

Adults transitioning from the justice system are a second proposed population of focus. On average, there are 9,000 Arizona Medicaid beneficiaries incarcerated in a given month. Approximately 100,000 individuals transition from incarceration to AHCCCS every year. National research has found that 80% of released individuals have chronic medical, psychiatric, or substance abuse problems, yet only 15% to 25% report visiting a physician outside of the emergency department in the first year post release.² It has also revealed that there is little care coordination between prison/jail and community health systems. For example, few individuals are released with a sufficient supply of chronic medications or primary care follow-up.³ In addition, individuals leaving prison/jail may not fully understand the scope of Medicaid benefits available to them or how to appropriately access services. Given their additional need for support as they transition into the community, this population is likely to need a higher, more intense level of care coordination by providers as they are settled in the community.

¹ www.ahrq.gov/research/findings/evidence-based-reports/caregapt.html

² Mallik-Kane K, Visher CA. Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration. Washington, DC: The Urban Institute; 2008 and Mallik-Kane K. Returning Home Illinois Policy Brief: Health and Prisoner Reentry. Washington, DC: Urban Institute Justice Policy Center; 2005.

³ Wakeman SE, McKinney ME, Rich JD. Filling the gap: the importance of Medicaid continuity for former inmates. *J Gen Intern Med.* 2009;24(7):860---862 and Flanagan NA. Transitional health care for offenders being released from United States prisons. *Can J Nurs Res.* 2004;36(2):38---58.

Children with Behavioral Health Needs, Children with and At-Risk for Autism Spectrum Disorder, and Children Engaged in the Child Welfare System

Children with behavioral health needs, children with and at-risk for Autism Spectrum Disorder, and children engaged with the child welfare system and their families have found that insufficient and inconsistent linkages between community-based health and behavioral care, social service resources, and hospital care can leave them frustrated.

In addition to responding to Arizona children and families, there are multiple compelling reasons to focus upon these pediatric populations, based on national research:

- Behavioral health care accounts for approximately 38 percent of Medicaid expenditures for children.
- Children in child welfare system and those on Supplemental Security Income/disability represent one-third of the Medicaid child population using behavioral health care, but represent 56 percent of total behavioral health expenses.
- Almost 50 percent of children in Medicaid prescribed psychotropic medications receive no accompanying identifiable behavioral health services, such as medication management.⁴

As in the rest of the U.S., Medicaid-enrolled children with behavioral health needs often receive fragmented care from multiple public systems leading to poor health outcomes and costly utilization. A December 2013 report recommended that efforts be made nationally to improve care coordination for these children, including collaboration between child-serving systems, especially the child welfare, behavioral health, and primary care systems.⁵

Adults with Behavioral Health Needs

Adults with behavioral health needs constitute the fourth target population. While integrated RBHAs address both medical and behavioral health needs for the members with Serious Mentally Illness (SMI), for other adults who receive care through both MCOs and RBHAs, they too often find that the medical care, behavioral health care, and social services sectors rarely collaborate in a way that addresses their complex needs. A 2015 Government Accountability Office report showed that nationally over half of the Medicaid-only enrollees in the top 5% of expenditures had a mental health condition and one-fifth had a substance use disorder.⁶ That report also observed that “Although individuals with mental health conditions have some of the greatest health care needs (including complex polypharmacy regimens), the health care system is often too fragmented to effectively and efficiently serve them.”

⁴ Rires SA et al. Examining Children’s Behavioral Health Service Utilization and Expenditures. Center for Health Care Strategies, Inc. Hamilton, NJ December 2013.

⁵ Ibid.

⁶ General Accounting Office (GAO). A Small Share of Enrollees Consistently Accounted for a Large Share of Expenditures. GAO 15-460 May 2015.

C. System Transformation and DSRIP Entities

Current State and Transformation

Arizona's publicly funded health care system has historically been siloed, primarily due to a fragmented system of care prior to the state's participation in Medicaid, which began in 1982. For most Medicaid populations, services have been administered by different entities: acute care plans for physical health, RBHAs for behavioral health, and long-term care plans for long-term care. The system for providing care to American Indians has evolved alongside these delivery systems with little systematic integration. Recently, Arizona has taken significant steps towards integrating care for its Medicaid populations, making one contractor responsible for all services for specialized populations, including children served by Children's Rehabilitative Services and individuals with SMI. These improvements offered a new approach to integrated care, enhancing care- and case-management services. For other populations, Arizona has also required data sharing among its acute care plans and RBHAs to eliminate blind spots in data that each plan faced and allow the plans to see data regarding utilization across the entire continuum of care. Finally, Arizona has been a national leader in aligning care for dual eligibles. AHCCCS requires its health plans to serve as Medicare dual eligible, special needs plans and promotes enrollment of dual eligible members into the same health plan for both Medicare and Medicaid with over 45% of all dual eligible members aligned in the same health plan for their Medicare and Medicaid benefits. However, each of these integration efforts has exposed gaps in the delivery system and identified additional opportunities for facilitating integration. While the State's Innovation Plan under SIM is focusing on efforts to address these gaps, in order for those changes to be sustainable in the Medicaid program, the State believes that investments must be made in the system to ensure that real delivery system change occurs and has a lasting impact.

DSRIP Transformation

AHCCCS seeks to develop a program that will incentivize both providers and MCOs to collaborate more effectively, leverage available data, and develop standard clinical and administrative protocols that more effectively provide care for the defined program populations. Funding available through the incentive payments will provide fiscal support for providers electing to participate as DSRIP entities. The structure of the projects and the payment attribution and distribution will provide the catalyst for providers to jointly develop strategies and approaches to care that are beneficial to all stakeholders and, in particular, AHCCCS enrollees.

The common theme of transformation for all projects, providers, and populations will be integration, coordination, and data exchange and analysis applied to care delivery within the DSRIP entities. However, specific tactics, providers, and services will be highly dependent on the targeted populations that the DSRIP entities seek to engage.

DSRIP Entities

AHCCCS will not pre-determine participation in the DSRIP program. Interested providers must collaborate with other providers within the DSRIP entities with the goal of facilitating the creation of collaborative clinical and financial relationships that can most effectively impact care delivery for population(s) they select. Successful DSRIP entities must engage a minimum array of

providers needed to address core health and social needs of the target population(s) that they seek to address. Providers forming a DSRIP entity must consider historical patterns of care for targeted patients and must include provider partners to address:

- Acute inpatient care needs.
- Behavioral health care needs, including substance abuse disorders.
- MCOs (except for AIHP).
- Primary and specialty care.
- Social and community supports, as needed.
- Access to care.

As DSRIP entities will be unique to their population and projects, AHCCCS is not dictating governance structures for the participating DSRIP entities beyond a requirement that the participating providers have executed an agreement that defines how they will work together to accomplish selected projects. These agreements must describe, at a minimum:

- Which providers will act as ‘leads’ for purposes of developing applications, reporting milestones, convening meetings, and disbursing incentive payments.
- How the entities will engage in data sharing and data analytics, including clinical and financial measures.
- How entities will collaborate to develop shared clinical and administrative protocols.
- How MCOs and Arizona Health-e Connection (AzHeC) will participate in the partnership and projects.
- Geographic reach of entity.

AHCCCS will support the development and operation of the Care Management Collaboratives (CMCs) that will support the American Indian DSRIP strategic focus, but the participating providers will inform the operational structure of the CMCs. In the case of the justice system strategic focus, RBHAs will organize the providers within the DSRIP and provide support throughout the project, as they are best positioned to initiate projects in this category. Successful DSRIP entities will submit applications to the state that address how the entities will develop and implement projects. The applications will be scored, selected, and approved prior to any DSRIP activities or funding being released.

D. Projects

As described above, Arizona has drafted four unique strategic focus areas for its DSRIP. Selected DSRIP entities must address *all* projects in each selected focus area, with the exception of the AIHP focus area in which project 4 will be voluntary. Draft descriptions of the projects, including their core components and associated milestones and measures, are attached. AHCCCS will further refine the projects and project milestones and measures based on feedback from the Centers for Medicare and Medicaid Services (CMS) and stakeholders. A summary of the projects for each strategic focus area is provided below.

- **Adults and Children Served by the American Indian Health Program.** There is a need to improve health outcomes for American Indians by creating more robust care coordination and care management in the American Indian Health Program (AIHP), through a collaboration that seeks to improve infrastructure, communication, use of data, consistent outcome measures, and application of operational and clinical protocols. There are four projects for this strategic area. Projects 1–3 are mandatory for any participating provider; project 4 is optional. Each project is described below:
 - A. *Provider Role in CMC Formation, Governance and Management.* While AHCCCS will support the development and operations of CMCs, providers need to participate in CMC activities to ensure commonly understood and shared care management strategies are developed and implemented. This project focuses on the activities in which providers need to engage and thereby collaborate constructively in the formation of the CMCs, participate in training developed by the CMCs, and implement protocols created collaboratively by the CMCs and providers.
 - B. *Care Management.* The goal of this project is to develop a care management system for American Indian populations enrolled in AHCCCS and receiving treatment through Indian and non-Indian health provider organizations participating in the CMC. This project focuses on the development and implementation of specific care management protocols, including standard care plan development, when to engage members in care management, when care management services should be available, and ensuring records of care management activities are communicated appropriately.
 - C. *Care Management and Data Infrastructure.* The goal of this project is to develop a data infrastructure that can support data analytics using both clinical data and claims data for CMC participating providers. This project focuses on accessing and utilizing data analytics, requirements for which data must be shared/reported, use of state-based resources, including the Controlled Substances Prescription Monitoring Program and AzHeC, the state's health information exchange.
 - D. *Transform primary care sites serving AIHP members into Patient-Centered Medical Homes (PCMH).* The goal of this project is to train primary care practices on core PCMH skills and track their increased skill level over time. This optional project focuses on the core requirements to develop PCMH functionality, including adopting a quality improvement strategy, conducting care management activities, using evidence-based care, enhancing access, and integrating portions of behavioral health into the primary care setting, among other attributes. The project is built around the eight Qualis change concepts for safety net medical homes.⁷
- **Individuals Transitioning from the Justice System.** There is a need to facilitate better provider, community, and justice system coordination to ensure individuals transitioning out of incarceration are (i) enrolled in a health plan if eligible for AHCCCS, and (ii) have timely appropriate access to physician and behavioral health services. There is one project for this strategic focus area for adults, described below.

⁷ www.safetynetmedicalhome.org/change-concepts

- A. Develop an integrated health care setting within county probation offices or Department of Corrections (DOC) parole offices to address beneficiary health care needs upon release and throughout the term of probation/parole for individuals transitioning out of incarceration. The objective of this project is to develop an integrated health care setting within selected probation and parole offices to (i) coordinate eligibility and enrollment activities to maximize access to services, (ii) assist with health care system navigation, (iii) perform health care screenings, (iv) provide physical and behavioral health care services, (v) provide care coordination services to assist the individual in scheduling initial and follow-up appointments with necessary providers within or outside of the integrated setting, and (vi) assist individuals with arranging and coordinating continuing care once the individual is no longer required to participate in probation/parole activities.
 - B. A project targeting youth transitioning from the juvenile justice system is under consideration for future development.
- **Children with Behavioral Health Needs, Children with or At-Risk for Autism Spectrum Disorder, and Children Engaged in the Child Welfare System.** There is a need for a comprehensive approach to integrated care (physical and behavioral health) in any care setting in which an AHCCCS member under the age of 21 may receive either physical or behavioral health services (for example, from a primary care provider or a community behavioral health provider) to better address mental and physical health and addiction disorders. There are four projects for this strategic focus area, all of which are mandatory at the DSRIP-entity level.
 - A. *Integration of primary care and behavioral health services for children with behavioral health needs and their families (primary care site).* This project is for primary care practices to integrate behavioral health services [some of which are paid for by the RBHAs] within the primary care site. This project will include children with behavioral health needs enrolled in an integrated RBHA and children receiving services from both a RBHA and an acute care health plan. This project focuses on the actions necessary to fully integrate care, including managing high-risk patients using an integrated treatment plan where both physical health and behavioral health providers give input, developing referral, consultation, and warm hand-off protocols and integrating patient records.
 - B. *Integration of primary care and behavioral health services for children with behavioral health needs and their families (community behavioral health site).* This project is for community behavioral health sites to better integrate primary care services for the purposes of better care management of the preventive and chronic illnesses for children. This project will include children with behavioral health needs enrolled in an integrated RBHA and children receiving services from both a RBHA and an acute care health plan. This project focuses on the actions necessary to fully integrate care in a manner similar to project 1.
 - C. *Improving treatment for the care of children with and at-risk for Autism Spectrum Disorders.* The objective of this project is to improve the identification and care of Medicaid-enrolled children at-risk for Autism Spectrum Disorders or diagnosed with Autism Spectrum Disorder, and create sufficient and consistent linkages between primary care,

behavioral health, and social service resources. This project would begin in DSRIP Year (DY) 2 and all participating providers would need to first successfully complete project 1 in this strategic focus area, as this project builds upon the foundation for care provided in an integrated setting addressed in project 1. This project focuses specifically on care coordination with autism treatment teams, early intervention programs, and schools to improve the care outcomes of children with Autism Spectrum Disorder.

- D. *Improving treatment for the care of children engaged in the child welfare system (primary care site).* The objective of this project is to improve the care of Medicaid-enrolled children who are involved in the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in the child welfare system. This project would begin in DY 2, and all participating providers would need to complete project 1 in this strategic focus area, as it builds upon the care provided in an integrated setting. This project specifically focuses on developing clinical protocols to help identify and address medical or behavioral health issues a child engaged in the child welfare system may have and to conduct care using Trauma-Informed Care principles.
- E. *Improving treatment for the care of children engaged in the child welfare system (community behavioral health site).* The objective of this project is to improve the care of Medicaid-enrolled children who are engaged in the child welfare system and ensure continuity of care across providers over the continuum of the child's involvement in the child welfare system. This project would begin in DY 2 and all participating providers would need to successfully complete project 2 in this strategic focus area prior to starting this project, as it builds upon the foundation for care provided in an integrated treatment setting addressed in project 2. This project focuses on the actions to coordinate care specifically for children engaged in the child welfare system in a similar manner to project 4.

- **Adults with Behavioral Health Needs.** There is a need for a comprehensive approach to integrated care (physical and behavioral health) in any care setting in which an AHCCCS member may receive either physical or behavioral health services to better address mental and physical health and addiction disorders. There are four projects in this strategic focus area, all of which are mandatory at the DSRIP entity-level.
 - A. *Integration of primary care and community behavioral health services (primary care site).* The objectives of this project are identical to project 1 in the "children with behavioral health needs" strategic focus area. The differences between the two projects are only related to care that might be specific to an adult or child.
 - B. *Integration of primary care and community behavioral health services (community behavioral health site).* Similar to project 1 above, the objectives of this project are identical to project 2 in the "children with behavioral health needs" strategic focus area.
 - C. *Integration of primary care and behavioral health services (co-located site).* The objectives of this project are to achieve maximum impact from integration of primary care and behavioral health services to realize the potential and maximize the impact of service co-location to better address mental and physical health and addiction disorders.
 - D. *Care coordination for adults with behavioral health conditions being discharged from an inpatient behavioral health stay (hospital).* The objectives of this project are to more

effectively coordinate the care for adults with behavioral health conditions who are being discharged from an inpatient behavioral health stay. Hospitals participating in this project will be required to focus on care coordination with outpatient providers upon a patient's admission, and upon discharge, medication management, and communication with the RBHA.

Each of the projects has specific milestones associated with DY 1, and in some cases DY 2 and DY 3. For DY 2 (and for DY 3 for projects that start in DY 2), DSRIP entities, and participating providers, will be measured on and required to report a set of performance indicators to be determined by AHCCCS. Beginning in DY 3 (or DY 4 for projects that start in DY 2), DSRIP entities and providers will be expected to show improvement in their performance in order to earn DSRIP incentive payments.

E. Role of MCOs, RBHAs, and ALTCS Plans

MCOs, RBHAs, and ALTCS plans are the foundation for Arizona's management of its Medicaid program. AHCCCS intends to leverage its managed care infrastructure to make DSRIP a success. As a result, AHCCCS intends that these three partners – and in particular given the focus of its DSRIP, AHCCCS' MCOs and RBHAs – play an active role in the DSRIP provider entities' work.

For that reason, Arizona intends to ask that its MCOs and RBHAs not only participate as members of the DSRIP provider entities, but also:

- Provide the DSRIP provider entities with analytic support to inform their strategy development and implementation.
- Participate in joint planning and implementation of care coordination protocols and activities, particularly in light of existing care management and care coordination functions that MCOs and RBHAs operate, and thereby define the respective roles of MCOs, RBHAs, and DSRIP providers.
- Participate in the DSRIP learning collaboratives.
- Play a substantive role in relevant DSRIP projects and, in the case of the RBHAs, organize and support the DSRIP entities participating in the justice system strategic focus area.

F. Funding and Attribution

The State intends to access approximately \$1.6 billion in total computable funding over five years to support DSRIP initiatives. The non-federal share of the funding will be provided through Designated State Health Program funding during the waiver period. Post-waiver transformation will be funded through alternative payment model strategies, as well as the establishment of the American Indian Medical Home initiative. In addition, AHCCCS seeking 100% federal medical assistance percentage to support the American Indian strategy.

The attribution strategy will be finalized as projects are finalized. However, lives qualifying in each strategic focus areas will likely be attributed through health plan and RBHA enrollment as well as DSRIP provider networks.

G. Desired Outcomes

Consistent with AHCCCS contractual requirements, Arizona health plans have begun to contract with providers using alternative payment models.⁸ Many of these arrangements, however, do not yet require significant downside risk on the part of participating providers. Arizona seeks to implement a DSRIP that will ensure that, as providers begin to assume significant downside risk for management of population health, the providers will have developed the needed care integration infrastructure to successfully meet the needs of these four target high cost, high need populations.

With this in mind, AHCCCS will identify the desired metrics to measure the results for its DSRIP, against which it will assess DSRIP and DSRIP provider entity performance. Initial process milestones will evolve into Arizona reporting on specific DSRIP outcomes on an annual basis overall and at the provider level. These metrics will be finalized once projects are finalized with CMS and the stakeholder community.

⁸ For the current contract period, the eight acute plans that have 1.5 million members enrolled are responsible for having 20% of their medical spend in value-based arrangements. Based on AHCCCS policies, this can range from P4P all the way up to sub- capitated risk. AHCCCS has informed its MCOs that the alternative payment methodology percentage will be 35% for the contract period starting 10-1-16, and 50% for the contract period starting 10-1-17. Similar requirements exist for RBHAs and for Arizona Long Term Care System MCOs.