## Agenda

<table>
<thead>
<tr>
<th>I.</th>
<th>Welcome</th>
<th>Director Thomas Betlach</th>
</tr>
</thead>
<tbody>
<tr>
<td>II.</td>
<td>Introductions of Members</td>
<td>ALL</td>
</tr>
<tr>
<td>III.</td>
<td>Approval of February 3, 2016 meeting summary</td>
<td>ALL</td>
</tr>
</tbody>
</table>

### Agency Updates

<table>
<thead>
<tr>
<th>IV.</th>
<th>AHCCCS Update</th>
<th>Director Thomas Betlach</th>
</tr>
</thead>
</table>
| V.   | The Next Step Peer Mentoring and More Presentation | Nic Danger  
President, The Next Step Peer Mentoring and More |
| VI.  | Legislative Update | Christopher Vinyard  
Chief Legislative Liaison |
| VII. | Delivery System Reform Incentive Payments | Beth Kohler  
Deputy Director |
| VIII. | Arnold vs. Sam | Paul Galdys  
Assistant Director |

### Discussion

<table>
<thead>
<tr>
<th>IX.</th>
<th>Call to the Public</th>
<th>Director Thomas Betlach</th>
</tr>
</thead>
<tbody>
<tr>
<td>X.</td>
<td>Adjourn at 3:00 p.m.</td>
<td>ALL</td>
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*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**

For more information or assistance, please contact Yisel Sanchez at (602) 364-4577 or yisel.sanchez@azahcccs.gov
February 2016 Meeting Summary
State Medicaid Advisory Committee (SMAC) Meeting Summary  
Wednesday, February 3, 2015, AHCCCS, 701 E. Jefferson, Gold Room  
1:00 p.m. – 3:00 p.m.

Members in attendance:  
Tom Betlach  
Kathy Waite  
Tara McCollum Plese  
Kevin Earle  
Gina Judy  
Frank Scarpati  
Nic Danger  
Kathleen Collins Pagels  
Timothy Leffler  
Joyce Millard Hoie  
Daniel Haley  
Leonard Kirschner  
Steve Jennings  
Vernice Sampson  
Kim VanPelt  
Amanda Aguirre  
Barbara Fanning  
Phil Pangrazio via Phone

Members Absent: Cara Christ, Peggy Stemmler

Staff and public in attendance:  
Theresa Gonzales, Exe Const. III, AHCCCS  
Monica Coury, Assistant Director, AHCCCS  
Sara Salek, Chief Medical Officer, AHCCCS  
Beth Kohler, Deputy Director, AHCCCS  
Paul Galdys, Assistant Director, DBHS  
John Hogeboom, COO, CBI  
Mark Schwartz, Director, GSK  
Gregg Peterson, Director GSK  
Yisel Sanchez, HRC Coordinator, DBHS  
Jennifer Carusetta, Exec Dir, Health System Alliance of AZ  
Shirley Gunther, V.P. Ex Affairs, Dignity Health  
Matt Jewett, Assoc. Dir of Grants, MPHC  
Judith Walker, Ombudsman/Member Advocate, UHC  
John Logan, NAE, PCY  
James K., NAU, Gilead

AGENDA

I. Welcome & Introductions  
   Tom Betlach

II. Introductions of Members  
   All

III. Approval of October 7, 2015 Meeting Summary/Minutes  
    Unanimous

AGENCY UPDATES

IV. AHCCCS Updates  
   Tom Betlach
   - Medicaid 50th Anniversary
   - Eligibility and Payment Error Rate
   - Kaiser Medicaid Survey
   - Percent of Auto-Renewals
   - FY 2017 Budget
   - 10 Biggest HIPAA Breaches
   - CBO Federal Spending Estimates
   - Average Annual Capitation Growth
   - Overdose Death Rates in America
AHCCCS Updates (continued)

- Prevalence of Obesity in the U.S. on the Rise over the Past Two Decades
- Occupational Activity is also Declining
- Medicaid Director Tenure
- Average Medicaid Director Tenure
- Delivery System Initiatives
- Delivery System Reforms
- 2015 Accomplishments
- 2016 Opportunities
- Being Mortal – Atul Gawande

V. Introduction of New Division of Health Care Advocacy & Advancement  Paul Galdys

- DHCAA
- AHCCCS/DBHS Transition Org Chart
- The Office of Individual and Family Affairs (OIFA)
- The Office of Human Rights (OHR)
- Human Rights Committees Liaison (HRC)
- The State Medicaid Advisory Committee (SMAC)
- Arizona Long Term Care System Advisory Committee (ALTCS)
- Behavioral Health Planning Council

VI. Introduction of New Member Organization  Dr. Frank Scarpati

- Community Bridges, Inc.
  - Mission
  - Purpose
- Board of Directors
- Advisory of Board of Directors
- About CBI
  - The Beginning
  - CBI Today
- CBI System of Care
- Crisis/Psych/Detox Facilities
- Community Psychiatric Emergency Center (CPEC)
- Peer Navigators
- Homeless Services
- Veteran Support Services
- Community-Based Outreach Teams
- Center for Hope
- Northern Arizona
- Southern Arizona
- Opioid Treatment
- Unscript
VII. Autism Spectrum Disorder Report and Pharmacy and Therapeutics Committee Update

- AHCCCS CMO Update
- AHCCCS P&T Committee
- P&T Committee
- AHCCCS Drug List
- Current AZ Supplemental Rebate Classes
- Future Supplemental Rebate Classes
- ASD Advisory Committee
- ASD Advisory Committee: Charge
- Two-pronged approach
  - Short-term: Policy Level Changes
  - Long-term: System Level Changes
- Short-Term Solutions
- Long-Term Solutions
- System Design

VIII. System Integration 2.0

IX. Delivery System Reform Incentive Payment

- Arizona SIM Vision
- SIM/DSRIP Strategies
- Dec. 8 Provider & Health Plan Stakeholder Meeting
- Key Questions
- Role of MCO in Other States
- Arizona Role of MCO
- DSRIP Timeline
- Next Steps

X. Call to the Public

XI. Adjourn at 3:00 p.m.
AHCCCS Update
The Next Step Peer Mentoring and More Presentation
(no handouts)
Legislative Update
| AHCCCS Legislative Tracking |
|----------------------------------|-------------------|
| **HB 2309** | **HB 2442** |
| **Disposition** | Enacted; Chapter 71 |
| **Summary** | **Disposition** | **Summary** |
| Failed to pass out of Senate | ** Failed to pass out of Senate** |
| - Restores the CHIP (KidsCare) program. | - The out-of-home-placement shall receive immediately on placement of the child from the Department of Child Safety (DCS) an updated complete placement packet that includes: |
| - Requires AHCCCS to submit to CMS a SPA within 5 days of enactment to resume enrollment in the program. |  | - The child’s RBHA designated point of contact; |
| - Conditionally enacted on CMS approving the plan amendment to resume enrollment by July 1, 2017. |  | - AHCCCS customer service line; |
| | | - A list of AHCCCS registered providers; and |
| | | - Information regarding the out-of-home placement’s rights |
| | | - If it is determined the foster or adoptive child is in need of behavioral health services, and the child is eligible for either Title XIX or Title XXI services, the out-of-home placement or adoptive parent may directly contact the RBHA for a screening and evaluation. The process includes the following: |
| | |  | The RBHA shall dispatch an assessment team within seventy-two hours after being notified that the child has entered care in an out-of-home placement, or within two hours after being notified that the child has an urgent need; |
| | |  | The RBHA shall provide an initial evaluation of the child within seven calendar days after referral or request for services; and |
| | |  | If after the screening and evaluation it is determined that the child is in need of behavioral health services, the RBHA shall provide an initial appointment for the child within twenty-one calendar days. |
| | | - On completion of the initial evaluation, the out-of-home placement or adoptive parents: |
| | | - Shall call the RBHA designated point of contact and the AHCCCS customer service line if services are not received within twenty-one days to document the failure to receive services. |
| | | - May access services directly from any AHCCCS registered provider regardless of whether the provider is contracted with the RBHA and the provider must submit claims to the RBHA and |
accept the lesser of one hundred thirty percent of the AHCCCS fee schedule.

- If a request is made by the out-of-home placement or the adoptive parent for the child to be admitted to a residential treatment facility because the child is displaying threatening behavior, the RBHA shall respond within seventy-two hours after the request was made.
- If the child was hospitalized due to threatening behavior before the RBHA responds, the RBHA shall reimburse the hospital for all medically necessary care, including any days of the hospital stay during which the child does not meet criteria for an inpatient stay but is not discharged because the RBHA has not authorized a safe and appropriate placement.
- If the foster child moves into a different county because of the location of the child’s out-of-home placement, the child’s out-of-home placement may choose to have the child continue any current treatment in the previous county, or seek any new or additional treatment for the child in the out-of-home placement’s county of residence.
- AHCCCS shall track and report the following:
  - The number of times the RBHA coordinated crisis services because a crisis services provider was unresponsive;
  - The number of times services were not provided within the twenty-one day timeframe;
  - The amount of services accessed directly by an out-of-home placement or adoptive parents that were provided by non-contracted providers;
  - The list of providers that were formerly contracted with the RBHA but that terminated the contract and provided services pursuant to this section for one hundred thirty percent of the AHCCCS fee schedule; and
  - The amount AHCCCS spent on services pursuant to the bill.
- On or before July 1, 2017, AHCCCS shall complete a network adequacy study for behavioral health service providers that provide behavioral health services to children enrolled in the CMDP program.

<table>
<thead>
<tr>
<th>SB 1283</th>
<th>controlled substances prescription monitoring program (Sen. Kavanagh)</th>
</tr>
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<tbody>
<tr>
<td>Disposition Summary</td>
<td>Ready for Senate action on House amendments</td>
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<tr>
<td>- Beginning October 1, 2017, or 60 days after the statewide health information exchange has integrated the Controlled Substances Prescription Monitoring Program data in the exchange, a medical practitioner before prescribing an opioid analgesic or benzodiazepine controlled substance listed in schedule II, III or IV for a patient is required to do the following:</td>
<td></td>
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<tr>
<td>- Obtain a patient utilization report regarding the patient for the preceding 12 months from the program's central database tracking system at the beginning of each new course of treatment; and</td>
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<tr>
<td>- Reference the database at least quarterly while that prescription</td>
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</table>
remains a part of the treatment.

- Exceptions to the requirements include:
  - A patient receiving hospice care or palliative care for a serious or chronic illness;
  - A patient receiving care for cancer, a cancer-related illness or condition or dialysis treatment;
  - A medical practitioner will administer the controlled substance;
  - A patient is receiving the controlled substance during the course of inpatient or residential treatment in a hospital, nursing care facility, assisted living facility, correctional facility or mental health facility;
  - A medical practitioner is prescribing the controlled substance to the patient for no more than a ten-day period for an invasive medical or dental procedure or a medical or dental procedure that results in acute pain to the patient;
  - A medical practitioner is prescribing no more than a five-day prescription and has reviewed the program’s central database tracking system for that patient within the last thirty days, and the system shows that no other prescriber has prescribed a controlled substance in the preceding thirty-day period; and
  - A medical practitioner that uses electronic medical records that integrate data from the controlled substances prescription monitoring program.

<table>
<thead>
<tr>
<th>SB 1305 Disposition Summary</th>
<th>AHCCCS; covered services (Sen. Barto)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failed to pass out of House</td>
<td></td>
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<tr>
<td>• The list of medically necessary health and medical services covered by AHCCCS is expanded to include occupational therapy in an outpatient setting.</td>
<td></td>
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<tr>
<td>• General Fund cost: $113,300 - $271,900.</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>SB 1442 Disposition Summary</th>
<th>mental health services; information disclosure (Sen. Barto)</th>
</tr>
</thead>
<tbody>
<tr>
<td>House COW Approved – 3/29/16</td>
<td></td>
</tr>
<tr>
<td>• Requirements for a health care provider or entity to disclose confidential health care records are modified to allow the disclosure to relatives, close personal friends or any other person identified by the patient as otherwise authorized or required by state or federal law.</td>
<td></td>
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<table>
<thead>
<tr>
<th>SB 1507 Disposition Summary</th>
<th>ALTCS; dental services (Sen. Begay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failed to pass out of House</td>
<td></td>
</tr>
<tr>
<td>• The list of services that are required to be provided by Arizona Long-Term Care System (ALTCS) program contractors to ALTCS (DD/EPD) members is expanded to include dental services in an annual amount of not more than $1,000 per member.</td>
<td></td>
</tr>
<tr>
<td>• General Fund cost: $1,359,000 (EPD) &amp; $1,233,400 (DD)</td>
<td></td>
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</table>
AHCCCS Legislative Tracking

- Consistent with Executive’s FY 2017 Budget Recommendation

<table>
<thead>
<tr>
<th>SCR 1005 Disposition Summary</th>
<th>Rights of caregivers; recognition (Sen. Barto)</th>
<th>Transmitted to Secretary of State – 3/10/16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>The members of the Legislature recognize a list of specified rights that family members, caregivers and guardians of individuals with serious mental illness have.</td>
</tr>
</tbody>
</table>
Delivery System Reform
Incentive Payments
DSRI P Update
Arizona State Innovation Model Vision

Accelerate the delivery system’s evolution towards a value-based, integrated model that focuses on whole person health in all settings regardless of coverage source.
SIM Sustainability - DSRI P Projects

1. American Indian Care Management Collaborative

2. Physical Health - Behavioral Health Integration
   a. Adults
   b. Children

3. Justice System Transitions
AHCCCS Delivery System

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

AHCCCS

Behavioral Health
(BH services for acute care members carved out service)
- ADHS/DBHS
  - Mercy Maricopa Integrated *
  - Health Choice Integrated Care (HCIC)**
  - Cenpatico Integrated Care (CIC)**
  - TRBHA IGA

Arizona Long Term Care System
(ALTCS – E/PO and DD (acute, behavioral health, long term care services))
- Mercy Care
- Bridgeway
- United Healthcare Community Plan
- ADES/DDD – subcontract for acute (private) and BH (DBHS) services
- Tribal IGA’S for Case Management

Acute Care
(acute services only)
- Mercy Care Plan
- United Healthcare Community Plan
- Care 1st
- Health Choice
- UFC
- Maricopa
- Phoenix Health Plan
- Health Net
- Dept. of Child Safety (DCS)/CMDP (foster care, carved out population)
- Children’s Rehabilitative Services
  United Healthcare Community Plan
  (fully integrated acute, BH and CRS services)

Fee for Service System
(AHCCCS Administered)
- AIHP
- FES

* Mercy Maricopa is fully integrated for Acute and BH services for SMI effective 4/1/2014
**HCIC and CIC are fully integrated for acute and BH services for SMI effective 10/1/2015
**AHCCCS Delivery System**

<table>
<thead>
<tr>
<th>Regional Behavioral Health Authorities</th>
<th>Acute Care Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals with Serious Mental Illness – Integrated</td>
<td>Dual eligible members not in ALTCS – Integrated</td>
</tr>
<tr>
<td>Non-SMI, non-dual adults – behavioral health services</td>
<td>Most adults – physical health services</td>
</tr>
<tr>
<td>Children – behavioral health services</td>
<td>Children – physical health services</td>
</tr>
<tr>
<td>Provides crisis services, housing and employment and distributes SAMHSA funds</td>
<td>Single integrated plan for 17,000 children with special needs</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Asthma</th>
<th>Diabetes</th>
<th>HIV/AIDS</th>
<th>MH</th>
<th>SUD</th>
<th>Delivery</th>
<th>LTC</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>24.5</td>
<td>3.9</td>
<td>65.1</td>
<td>29.1</td>
<td>6.5</td>
<td>7.3</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>18.5</td>
<td>2.6</td>
<td>52.4</td>
<td>23.9</td>
<td>3.1</td>
<td>12.7</td>
<td>29.7</td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>17.9</td>
<td>15.6</td>
<td>48.1</td>
<td>39.4</td>
<td>2.1</td>
<td>7.2</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>MH</td>
<td>17.6</td>
<td>18.7</td>
<td>2.8</td>
<td>26.7</td>
<td>4.0</td>
<td>11.9</td>
<td>42.9</td>
<td></td>
</tr>
<tr>
<td>SUD</td>
<td>20.8</td>
<td>22.6</td>
<td>6.0</td>
<td>70.8</td>
<td>4.5</td>
<td>10.2</td>
<td>15.6</td>
<td></td>
</tr>
<tr>
<td>Delivery</td>
<td>9.3</td>
<td>5.9</td>
<td>0.7</td>
<td>21.3</td>
<td>9.0</td>
<td>0.5</td>
<td>66</td>
<td></td>
</tr>
<tr>
<td>LTC</td>
<td>12.5</td>
<td>28.6</td>
<td>2.8</td>
<td>74.7</td>
<td>24.4</td>
<td>0.6</td>
<td>14.1</td>
<td></td>
</tr>
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Reaching across Arizona to provide comprehensive quality health care for those in need
Vision - Integration at all 3 Levels

CURRENT CONFIGURATION

- PROVIDERS
- Health Plan (physical health)
- RBHA
- ADHS/DBHS (behavioral health)

STREAMLINED CONFIGURATION

- PROVIDERS
- Health Plan/RBHA (physical & behavioral health)

Reaching across Arizona to provide comprehensive quality health care for those in need
Multiple Plans have partnered to create and support community social service centers

MCO pilot to invest in low-income housing subsidy

AHCCCS has dedicated staff resources focused on housing – employment – peer services

State only investments made through RBHAs

State Housing Funding for Individuals with SMI

Reaching across Arizona to provide comprehensive quality health care for those in need
Value Based Purchasing and Alternative Payment Models - Efforts to Date

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

Reaching across Arizona to provide comprehensive quality health care for those in need
## Value Based Purchasing Goals

<table>
<thead>
<tr>
<th>Program</th>
<th>CYE 15</th>
<th>CYE 16</th>
<th>CYE 17</th>
<th>CYE 18</th>
<th>CYE 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>10%</td>
<td>20%</td>
<td>35%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>ALTCS EPD</td>
<td>5%</td>
<td>15%</td>
<td>25%</td>
<td>35%</td>
<td>50%</td>
</tr>
<tr>
<td>RBHA</td>
<td>5%</td>
<td>15%</td>
<td>25%</td>
<td>35%</td>
<td></td>
</tr>
</tbody>
</table>

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

• Plans have established total cost of care models
• Plans have created centers of excellence around joint replacement and pain management
• Plans have created Assertive Community Teams incentives for healthcare, housing and employment

Circle the City

Before
N=32
IP
During
N=34
ER
After
N=29
OV

Reaching across Arizona to provide comprehensive quality health care for those in need
88% of the 2015/2016 growth occurred after the implementation of the new HIE Infrastructure.
Overall Delivery System Limitations and Challenges

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

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

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

- Providers forming a DSRIIP 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, health plans, primary and specialty care, social and community supports, as needed, and access to care.

- AHCCCS is not dictating governance structures for the participating DSRIIP 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: (i) which providers will act as ‘leads’ for purposes of developing applications, reporting milestones, convening meetings, and disbursing incentive payments (ii) How the entities will engage in data sharing and data analytics, including clinical and financial measures (iii) How entities will collaborate to develop shared clinical and administrative protocols (iv) How health plans and AzHeC will participate in the partnership and projects.
Adult Integration DSRI P

Focus – Establish comprehensive approach to integrate care for adult Medicaid members that require physical and behavioral health services.

Proposal – Establish 4 projects that focus on:

1. Integration of primary care and behavioral health (primary care site)
2. Integration of primary care and behavioral health (behavioral health site)
3. Integration at co-located site
4. Care coordination for adults being discharged from inpatient behavioral health stay
Children Integration DSRIP

Focus – Establish a comprehensive approach to integrate care in any setting for Medicaid members under the age of 21 with special focus on children with and at risk of autism and children engaged in child welfare system.

Proposal – Establish 4 projects that focus on:

1. Integration of primary care and behavioral health services for children and families (primary care site)
2. Improving treatment for care of children with (or at risk of) Autism Spectrum Disorders (primary care site)
3. Improving treatment of care for children engaged in child welfare system (primary care site)
4. Same as #3 but at behavioral health site

Reaching across Arizona to provide comprehensive quality health care for those in need
Justice System Efforts to Date

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

• 50% of population entering Pima County jail are AHCCCS enrolled; another 30% enrolled in past 2 years

• Opportunities:
  o Ability to scale efforts
  o Data flow between justice system partners and delivery system
  o To be more strategic in delivering services: right service, right place, right time
  o To ensure greater continuity to address behavioral health needs of population
  o To continue to improve partnership with Justice System
Justice DSRI P Proposed Solution

Objective: RBHAs organize DSRI P entity to develop an integrated health care setting within the probation and parole offices and improve overall coordination:

(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 with co-located facility
(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,
(vi) assist individuals with coordinating/arranging continuing care within the health plan
(vii) leverage peer support services
(viii) establish capacity to share data between systems
American Indian Efforts to Date

Staff – added new resources including BH manager and physician

Relationships – traveled statewide to visit Tribal providers and stakeholders

Data – Sharing data with 14 different organizations on member utilization

Model – Have 130 members in active care management with providers

Care Management Model

Staff

Relationships

Data

The Model

Reaching across Arizona to provide comprehensive quality health care for those in need
Current System Limitations and Challenges

• Scale of fragmentation is significant given broad network American Indians may access for services and geography of Arizona – 3 counties = 2 MA and 1 Maryland

• Resource limitations of Indian Health Provider Organizations to share or receive actionable data

• Limited resources within AHCCCS to create more scale around care management platform

• Historical limitations of Medicaid and other payers to cover costs of care management infrastructure.

• Significant healthcare disparities of American Indian population

Reaching across Arizona to provide comprehensive quality health care for those in need
American Indian DSRIP Proposed Solution – Care Management Collaborative

Project 1. CMC Formation, Governance, and Management

Project 2. Care Management and Care Coordination. Develop a care management and coordination system that will support the care delivered to American Indian populations enrolled in AHCCCS.

Project 3. Care Management Data Infrastructure. Develop a data infrastructure that can support data analytics for both clinical data and claims data for participating providers through the CMC.

Compliments Medical Home Waiver

Care Management Collaborative Framework

Reaching across Arizona to provide comprehensive quality health care for those in need.
American Indian Reservations and ITU Health Facilities

Reaching across Arizona to provide comprehensive quality health care for those in need
Role of Managed Care Organizations

- Arizona has extensive history in leveraging managed care for all populations.
- DSRIP complements Arizona’s efforts to integrate at payer and provider level.
- DSRIP looks to build on Value Based Payment efforts by requiring MCOs and providers to continue increased APM.
- DSRIP leverages important roles for MCOs in justice system initiative by having RBHAs partner with other MCOs and justice system to establish DSRIP entities.
- DSRIP leverages MCO structure by requiring DSRIP entities pursuing integrated projects to have formal MCO commitment and role.

Reaching across Arizona to provide comprehensive quality health care for those in need.
### DSRI P Timeline

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
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<tr>
<td>(4/1/16)</td>
<td>Finalize State Match &amp; DSRI P Framework</td>
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<tr>
<td>(5/15/16)</td>
<td>Finalize Proposed DSRI P Entities &amp; Project Design</td>
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<tr>
<td>(6/15/16)</td>
<td>Finalize Proposed Data Source, Milestones &amp; Metrics</td>
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<td>(6/30/16)</td>
<td>Finalize Program Design</td>
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<td>(12/8/15)</td>
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<td>(2/5/16 &amp; 2/25/16)</td>
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<td>(3/1/16-3/3/16, 3/23/16)</td>
<td>Tribal Consultations</td>
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<td>(Early May-TBD)</td>
<td>Stakeholder</td>
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<tr>
<td>(Sept – TBD)</td>
<td>Stakeholder, Final Design</td>
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#### Milestones:
- **(9/30/15)** Submit Waiver
- **(4/7/16)** CMS Presentation
- **(7/8/16)** Submit DSRI P Request
- **(7/18/16-9/15/16)** CMS DSRI P Negotiation
- **(9/15/16)** CMS DSRI P Approval
- **(10/1/16)** Implement Waiver

*Note: AHCCCS to post all DSRI P related documents on the website throughout the design phase for public notice.

*Need to coordinate with the 1115 waiver negotiation.*

Reaching across Arizona to provide comprehensive quality health care for those in need
Arnold vs. Sarn
Arnold v Sarn (ADHS)

Paul Galdys, Assistant Director DHCAA
Brief History

• 1981- Class action lawsuit filed against ADHS and Maricopa County
  ○ Alleged lack of comprehensive community mental health system as required by statute
• 1986- Trial court entered judgment
• 1989- Affirmed by Supreme Court
• 2014- Stipulation to End Litigation
Arnold requirement is to develop 8 additional ACT teams, some of which may be specialized teams, for a total of 23 teams during Fiscal Years 2015 and 2016.
Arnold requirement is to develop additional service capacity for Family and Peer support services capable of serving 1500 Class Members during Fiscal Years 2015 and 2016.
Arnold requirement is to develop additional service capacity for Supported Employment services capable of serving 750 Class Members during Fiscal Years 2015 and 2016.
Permanent Supportive Housing

Arnold requirement is to develop additional service capacity for Supported Housing services capable of serving 1200 Class Members during Fiscal Years 2015 and 2016.

Contract Capacity (+966)

Contracted Capacity | Targeted Expanded Capacity

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Thank you!

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