State of Arizona: SIM Initiative Project Narrative

Introduction: The Arizona State Innovation Model (SIM) Plan is designed around three overarching strategies: 1) Facilitating Integration and Decreasing System Fragmentation; 2) Improving Care Coordination; 3) Driving Payment Reform. These efforts will accelerate the delivery system's evolution towards a value-based integrated model that focuses on whole person health throughout the continuum and in all settings. Each of the components of the Arizona Plan will 1) Improve population health; (2) Transform the health care delivery system; and/or (3) Decrease per capita health care spending. The design of the Arizona State Health System Innovation Plan (SHSIP) will position the state to sustain continued innovation in the health care delivery system through targeted efforts to reduce fragmentation, integrate the delivery system and align incentives to improve quality and lower costs.

A.i.(1) Plan for Improving Population Health. Arizona is developing a plan to improve the health and wellbeing of the state's population. The plan will assess the overall health of the state and identify measureable goals, objectives and evidence-based interventions that will (1) improve the health of the entire state population; (2) improve the quality of health care across the state; and (3) reduce health care costs. The Arizona Department of Health Services (ADHS) undertook a State Health Assessment, in partnership with each of the county health departments. This process engaged approximately 10,000 people statewide in identifying local community health priorities, the collection and analysis of data and information from a variety of sources, and assessing and prioritizing health issues and needs within communities (including system capacity) to determine the best allocation of resources to improve the health and wellness of Arizonans.

The assessment identified 15 leading health issues for Arizona including access to behavioral health services, substance abuse issues, chronic disease management and suicide prevention.[1] . Numerous other identified issues are significantly impacted by behavioral health needs, such as obesity, tobacco use, diabetes and unintentional injury. Progress on these identified issues will depend on

[1] http://azdhs.gov/diro/excellence/documents/az-state-health-assessment.pdf

appropriate access to integrated and well-coordinated care including addressing behavioral health needs. Three overarching priorities emerged from the assessment: 1) Improving access and coordination of care; 2) Advocating an environmental shift for individuals and families to live healthier lifestyles, where the healthy choice becomes the easy choice (including addressing underlying social determinants); and 3) Achieving healthier communities that are empowered to impact systems and policy-level change. Arizona is now using the results of the Assessment to develop the State Health Improvement Plan (SHIP), a state-wide plan to improve population health, which provides a 5-year strategy for partners to work together toward a healthier Arizona. ADHS has assembled a Steering Committee and workgroups, including representatives from the legislature, Arizona Health Care Cost Containment System (AHCCCS), business community, academia, healthcare, public health, human services, non-profit and faith-based organizations to formulate the draft plan by July 2015.[2] The State Health Assessment (see footnote 1) documents the numerous opportunities for CDC collaboration on these efforts. The Arizona SHSIP will integrate the Arizona SHIP findings so that population health priorities and strategies align with the delivery system innovations, priorities, and strategies. Priorities will be identified through stakeholder engagement and consideration of the status of each leading health issue, the ability to impact the issue based on community support, the availability of evidence-based and best practices, and the state's capacity. The partners and stakeholders will define specific, measurable, realistic and achievable annual and long-term (5 year) performance objectives that correlate with major initiatives in order to demonstrate progress toward achieving the targeted results.

A.i.(2) Health Care Delivery System Transformation Plan. The Arizona SHSIP will provide a planned, strategic approach to undertake transformation of the health care delivery system using three overarching

[2] http://azdhs.gov/diro/excellence/documents/state-health-assessment/launching-the-arizona-state-health-improvement-plan.pdf

strategies: 1) Facilitating Integration and Decreasing System Fragmentation; 2) Improving Care Coordination; 3) Driving payment reform.

Facilitating Integration and Decreasing System Fragmentation

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, regional behavioral health authorities (RBHAs) for behavioral health. 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 (CRS), and individuals with Serious Mental Illness (SMI). These transitions 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 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 D-SNPs and promotes enrollment of dual eligible members into the same health plan for both Medicare and Medicaid with over 45% of all duals aligned in the same health plan for their Medicare and Medicaid benefits.[3] However, each of these integration efforts exposed gaps in the system and identified additional opportunities for facilitating integration.

Additionally, AHCCCS has conducted significant stakeholder outreach to both its health plans (many of whom have commercial products and offer qualified health plans (QHPs) on the Federally Facilitated Marketplace (FFM)), as well as every Accountable Care Organization (ACO) or ACO-look-alike

[3] An analysis by Avalere Health of an AHCCCS contractor revealed that as compared to Medicare FFS members, duals enrolled in the D-SNP exhibited 43% fewer days in the hospital, 19% lower average length of stay, 21% lower readmission rate, 9% fewer ED visits and higher preventive benefits accessed.

in the state.[4] This outreach has shown the many significant reform efforts occurring across the state, including the development of ACOs, patient-centered medical homes, efforts to address super-utilizers, and payment modernization toward value-based payments. However, it is clear from stakeholder discussions that there are significant gaps in these efforts for individuals with behavioral health needs, and that the fragmentation of the delivery system is a clear barrier to fully integrated care delivery. Efforts that only focus on reducing emergency department use or readmissions without addressing behavioral health will have limited success. Integration is more than simply facilitating alignment across the continuum of physical health care services (hospitals, outpatient, physicians, and other providers). Behavioral health must be part of the conversation to truly make a difference in improving population health and decreasing per capita spending.

Improving Care Coordination

The Arizona SHSIP will identify critical populations to target for care coordination activities. These include individuals with SMI, individuals who are not identified as having SMI but who have substantial medical and behavioral health needs (super-utilizers), dual eligibles, individuals transitioning from the justice system, members moving between QHPs and AHCCCS health plans, and American Indians served by Medicaid.

Driving Payment Reform

Payment Modernization is a cornerstone of Arizona's efforts to bend the upward trajectory of health care costs.[5] The SHSIP will delineate how health care delivery and payment system transformation will be achieved through collaboration with stakeholders. There are numerous payment reform efforts underway in Arizona, such as commercial carriers, other health plans, and ACOs shifting towards value-based purchasing with varying degrees of maturity. These integrated delivery systems are moving to take on risk

[4] Additional detail on the scope of this outreach is available upon request.
[5] http://www.azahcccs.gov/reporting/Downloads/PaymentModernizationPlan_SFY2014.pdf

in exchange for sharing savings achieved through the delivery of high-quality coordinated care. However, gaps remain in many organizations' ability to address behavioral health, to access to data, and the ability to take on risk and new payment methodologies. A baseline survey of AHCCCS health plans indicated that only 8% of payments were in a non-fee for service (FFS) arrangement. To implement these three strategies, the Arizona SHSIP will be built through stakeholder-driven work with insurers, Medicare, providers (including integrated delivery systems such as ACOs), provider organizations, consumer groups, tribal representatives, and local governments (including justice system partners). By leveraging the existing reform efforts, the state will accelerate transformation for the preponderance of care in the state, and work together with stakeholders toward the eleven Transformation Goals identified by CMS on pp. 5 and 6 of the FOA. In each of the payment and/or service delivery model components identified below, we identify how we are working towards the Transformation Goals.

A.i.(3) Payment and/or Service Delivery Model. . The Arizona SHSIP will include the following service delivery/payment components.[6] All the components will impact the State's Medicaid program. As of February 1, 2015, 1,621,953 individuals were enrolled in Arizona's Medicaid program, representing an estimated 24.3% of the state's population.[7] In addition, many of the components' initiatives also impact Medicare beneficiaries and the commercially insured. Stakeholders from these payers will participate in the development of these initiatives in the SHSIP.

The ability to share, access, and analyze data at the provider level is critical and the existing programs in place to facilitate such sharing do not address infrastructure needs of behavioral health providers. Additionally, the lack of capacity to share data has contributed to most ACOs in the state having limited engagement with behavioral health providers. By providing planning and support for major providers to partner with behavioral health providers, Arizona expects improved health outcomes for individuals with

[6] The components may fit under more than one of the three overarching strategies.

[7] Based on official state 2014 population forecast: http://www.workforce.az.gov/population-projections.aspx

behavioral health needs, increased provider accountability for costs and outcomes, and enhanced ability of ACOs and similar providers to manage population health.

Plan Component 1: **Behavioral Health-Physical Health Integration (**delivery system goals a, c, d, e, f, i, j, k): Consistent with the overarching strategies of increased integration/reduced fragmentation and improved care coordination, the SHSIP will provide a roadmap and framework to accelerate the integration of care between and among behavioral health and physical health providers . Informed by stakeholders' input and guidance, and aligned with existing and ongoing HIT/HIE infrastructure efforts in the state, the SHSIP will be employed to catalyze data integration and interoperability among providers and with payers. It is anticipated that the SHSIP will specifically address items such as interoperability challenges, statewide infrastructure and access challenges, and telehealth opportunities. The planning process will assist with goal clarification; and with clarification of consent limitations, data security concerns, provider incentives, and population health metrics. The SHSIP will identify means to enable improved care coordination and information sharing capacity between behavioral health providers and the physical health providers caring for persons with SMI, including emergency department and inpatient providers. The resulting decreased system fragmentation would significantly improve the health outcomes and utilization of high resource utilizer segment of the population, encompassing those individuals who are in the top cohort for ED use, inpatient days and risk score. This component of the SHSIP will also address the care coordination needs of persons with general mental health and/or substance abuse. The improved HIE/HIT infrastructure and integrated care models planned in the SHSIP and accelerated through future SIM funding will enable primary care to be provided with a whole person perspective and enhance outcomes and reduce costs. Improved behavioral health-physical health integration is intended to address physical health conditions such as obesity, chronic diseases like diabetes, and unintentional injury negatively impacted by behavioral health needs. This focus aligns with findings of the recently completed State Health Assessment. Infrastructure established to reduce care fragmentation will benefit individuals served by Medicare and

commercial payers, particularly dual eligible individuals and persons served by qualified health plans (QHPs).

Plan Component 2: AHCCCS, Commercial and Medicare Value-Based Payment Models (delivery system goals a, b, c, f, k) **:** Consistent with the overarching strategies of improving care coordination and driving payment reform, the SHSIP will propose and detail payment and delivery models which align the incentives of behavioral health providers, physical health providers and payers. Through stakeholder engagement, Arizona has determined that there are particular challenges regarding value-based contracting with behavioral health providers. Because of the wide variation of behavioral health needs, provider network capacity, cultural values, and socio-economic conditions among Arizonans, it is anticipated that the SHSIP will propose more than one value based payment model for incentivizing care coordination and integration, reduced emergency department use, and increased use of primary care. Arizona typically does not dictate specific models but rather creates outcome expectations that payers and providers must meet. Through a stakeholder driven process, evidence based research, and leveraging existing Arizona models such as integrated RBHAs, a menu of value based models with system level care integration will be selected. For example, a SHSIP model could be the basis for a SIM Model Test grant to major providers such as ACOs and other large systems that partner with community-based behavioral health providers to improve the capability to integrate primary care. The value based integrated health models will be broad-based and sustainable. ACOs, hospitals, QHPs, Federally Qualified Health Centers (FQHC) small and large behavioral health organizations, rural and urban behavioral health providers, large and small physical health providers, adult and pediatric providers, long term care and post-acute providers will be consulted in the model design development. Alignment of financial incentives, ability to assume risk, HIT/HIE requirements, and social services coordination will be important considerations in model development, so that payment methodologies by major payers support integrated care delivery.

Plan Component 3: **Enhance and develop regionally-based care coordination models for the AIHP, including data sharing capacity, collaboration with Indian Health Services, 638 facilities and non-tribal providers, to support provider infrastructure development and reduced delivery system fragmentation** (delivery system goals , d, e, f, k) The delivery system for American Indians is among the most fragmented. Members are eligible for services through I.H.S. and 638 facilities. In addition, approximately half of Arizona's 350,000 American Indian (AI) population is enrolled in Medicaid, which provides payment for services delivered both inside and outside the I.H.S./638 system. The SHSIP will provide a roadmap for improving care integration, care coordination and the data needed to support it, as well as expanding current care high utilizer coordination models with non-tribal acute providers. The Plan will identify and evaluate systems gaps and barriers to care, and propose models which align with care coordination features in the recently approved American Indian Medical Home waiver.

Plan Component 4: Improve Justice System Transitions through development of HIT infrastructure and health plan interfaces to coordinate coverage and care with the Arizona Department of Corrections (ADOC), jails and probation systems(delivery system goals , d, e, f, k**):** Mental illness in jails and prisons is a national, well-documented challenge. ADOC reported that in FY13, of the estimated $140 to $150 million spent on health expenses each year, 60%-70% was for mental health and substance abuse treatment with similar proportions from the county jails. These individuals also require significant services when they are no longer incarcerated. Many individuals exit the justice system with acute medical needs and a need for behavioral health services, but without a direct connection to health care providers, they experience disruptions in care, which leads to poorer health outcomes and higher costs, as well as the potential for increased recidivism. AHCCCS already has data feeds in place with six of Arizona's largest counties and with ADOC that identify members who are incarcerated, and is working to expand these feeds to include other counties. In addition, AHCCCS has developed a special expedited

application enrollment processes with ADOC, Maricopa County, Pima County and Yavapai County to facilitate Medicaid enrollment upon release for super-utilizers and those with high risk physical and behavioral health conditions. The SHSIP will build upon these efforts to establish care coordination strategies for acute plans and RBHAs to connect with the justice system to share information and link members with acute needs upon their release. These efforts are critically dependent on the ability to share data among entities, so the SHSIP will focus on leveraging and accelerating IT infrastructure and interface development to allow for data exchange critical to care coordination. Improved justice system IT infrastructure and resulting timely primary care and behavioral health services engagement of recently incarcerated individuals, many of whom qualify for Medicaid, is expected to reduce costs such as ED utilization, inpatient admissions, ESRD complications, and pregnancy complications. With robust stakeholder engagement of this SHSIP plan component, additional initiatives will be evaluated such as health homes for individuals at high risk for chronic disease and substance use disease.

A.i.(4) Leveraging Regulatory Authority. Arizona is using multiple regulatory authorities to facilitate delivery system reform. Overall, Arizona has few regulatory restrictions impeding delivery system reform. It has a very competitive commercial insurance market as well as limited certificate of need requirements, It has relatively broad scope of practice laws for practitioners (e.g., nurse practitioners practice independently). As Arizona evaluated opportunities for integration and delivery system reform, a major barrier identified by stakeholders was the state's health care institution licensure regulations. Laws 2011, Ch. 96, § 1 required ADHS to adopt rules regarding health care institutions that reduce monetary or regulatory costs on persons or individuals and facilitate licensing of "integrated health programs that provide both behavioral and physical health services." The result was a complete overhaul of the State's regulations for hospitals, behavioral health inpatient facilities, nursing care institutions, recovery care centers, hospices, behavioral health residential facilities, assisted living facilities, outpatient surgical

centers, outpatient treatment centers, adult day health care facilities, home health agencies, behavioral health specialized transitional facilities, substance abuse transitional facilities, behavioral health respite homes, adult behavioral health therapeutic homes, child care facilities and the regulatory standards for licensed professional midwives. The SHSIP will build on this model which allows providers to offer integrated health services under one license, and which eliminates regulatory barriers for integrated whole person care. AHCCCS uses its regulatory authority over its health plans to influence the structure and performance of the delivery system. Through its contracts with health plans, AHCCCS has: required plans to become D-SNPs to better align care for dual eligibles, required plan participation in the Health Information Network of Arizona (the state HIE), required plans to develop and implement value based reimbursement strategies, and established incentive payments that reward high performance on quality measures. AHCCCS and ADHS have also used their contracts to drive integration through the structure of their procurements, and instituted care coordination requirements. Through the SHSIP Arizona is committed is continuing to use its regulatory authority to drive the goals of the SIM strategies.

A.i(5) Health Information Technology. The SHSIP will leverage Arizona's numerous successful HIT and HIE initiatives including an established and sustainable statewide HIE, a behavioral health HIE and a successful Medicaid Electronic Health Record (EHR) Incentive Program. The Arizona Health-e Connection (AZHeC), a statewide and non-profit organization, spearheads many of the State's HIT activities. The AZHeC Board includes major healthcare stakeholders such as BCBS, UnitedHealthcare, Healthnet, Medicaid MCOs, hospital systems, ASU, Arizona's Telemedicine program, Health Services Advisory Group (the Arizona QIO), Sonora Quest Laboratories, provider associations, behavioral health providers, and state agencies, AHCCCS, ADHS and the Arizona Strategic Enterprise Technology (ASET) office. High EHR adoption rates and participation in HIE and the EHR Incentive Program are a testament to Arizona's success. From 2007-2009 to 2013, Physician adoption increased from 45% to 85%, and Community Health Centers (which represent ~25% of Medicaid PCP assignments) increased from 40% to 92%. .

According to ONC, Arizona hospitals had a 72% adoption rate in 2013. Providers are also using HIT to exchange data. In 2013, 99.8 % of pharmacies enabled and participated in e-prescribing, and 60% of all eligible prescriptions were electronically routed, 65% of labs are sending structured results to providers and 48% of hospitals are sharing electronic care summaries with unaffiliated providers and hospitals. The Health Information Network of Arizona ("the Network," the state's HIE), is seeing increased participation as well. Thirty-seven organizations have signed the Network's participation agreement, including 12 hospital systems, the state's two main reference labs, community health centers and correctional facilities.[8] Currently 85 users have access to clinical patient information, including ADTs, lab results, radiology results, medication history and transcribed reports. The SHSIP will leverage these successes, through a plan to continue to build the functionality and features required by the proposed SIM activities.

HIT Initiatives: It is anticipated that the SHSIP will include a plan for adoption and implementation of interoperable EHRs by behavioral health providers to enable their participation in the electronic exchange of patient data. It will also include a plan for support of ACOs, large provider systems, FQHCs and behavioral health providers to partner and form Integrated Delivery Systems that focus on patient centered whole health care coordination strategies. These organizations will require the exchange of timely actionable data to be successful. The SHSIP will detail the IT and other infrastructure necessary to accelerate care coordination for super-utilizer individuals. These efforts will complement existing efforts regarding data sharing and care coordination by filling in gaps where robust data exchange is not occurring but is particularly critical to effectively managing high-need/high-cost individuals. The SHSIP will identify the resources necessary to build interfaces for data exchange between Qualified Health Plans, and Medicaid plans and RBHAs to ensure coordinated care for members transitioning between the two systems. For the American Indian Population, The SHSIP will leverage HIT in two ways:) a plan to develop a care

[8] Funds from the Medicaid EHR Incentive Program are currently being used to support statewide HIE participation, by subsidizing the one-time implementation costs of eligible hospitals, community health centers and rural health clinics.

coordination platform that will leverage the extensive claims data that resides within Medicaid to better coordinate care for American Indian members using a care management system with extensive data analytics to evaluate and provide better care to high cost members, and a plan for regional care coordination initiatives, which will need to leverage HIT to create actionable data as part of developing care coordination protocols and strategies. The SHSIP will propose resources needed to enable Criminal Justice entities to partner with Medicaid and greatly expand the capability to provide appropriate care coordination by leveraging actionable health care information for individuals transitioning between systems to prevent disruptions in care. This will expand current limited manual efforts through HIT improvement.

Governance: The SHSIP HIT initiatives will be developed with the experienced resources within AZHeC, ASET, AHCCCS and ADHS to achieve the multiple components of the proposal. These organizations have been heavily involved in HIT and HIE efforts to date and have an excellent understanding of strengths and challenges in Arizona. Arizona has taken advantage of multiple opportunities including Federal grants, the EHR incentive program, and community resources to build its existing HIT/HIE programs and infrastructure. Arizona uses ONC HIE Cooperative Agreement funds to support the Network, which now has a sustainable business model. Hospitals, insurers and community providers pay fees to support interface implementation, as well as ongoing operational and infrastructure costs. The SHSIP will also include leveraging the ONC HIE grant that ASET received for HIE technical and strategic planning support for mental health providers, Critical Access Hospitals, rural hospitals, long term care provider, correctional health providers, and Native Americans. These funds were also used for large organizations (behavioral health, ACOs, hospitals) that were initiating, improving, or maturing their HIE enterprise.

Policy: AzHeC will be significantly involved in developing the SHSIP Model to ensure existing HIT/HIE infrastructure is leveraged. Arizona's Health IT Roadmap 2.0, published jointly by AzHeC and ASET as part of the HIE Cooperative Agreement Program, outlined 19 initiatives identified by the Arizona health care

community that should be completed within the next 24 to 36 months.[9] Items in Roadmap 2.0 that the SHSIP will address include interoperability and content standards and adherence, addressing challenges with patient identification, identifying incentives to support continued expansion of HIT/HIE adoption and use, collaboration and support for broadband access and support, creating a common patient consent approach, developing and implementing a statewide strategy and supporting accelerated statewide behavioral health-physical health HIE adoption and use.

Infrastructure: Arizona will leverage the existing HIT/HIE infrastructure and coordinate the efforts of its public and private partners. ADHS is currently evaluating HINAz for transmission of public health MU measures as well as identifying coordinating registry data across several registries to improve public health coordination. In rural Arizona, robust telehealth networks exist and both the Integration and AI Care Coordination strategies will include plans to expand these efforts.

Technical Assistance: The SHSIP will describe services to be available to a range of providers including large hospital systems, IHS/ 638 providers, FQHCs, Behavioral Health providers, Criminal Justice Systems and insurers. Many of these have not been previously eligible for Medicaid incentive payments. AzHEC brings many of these organizations to the table as part of its membership and will be able to provide HIT/HIE technical support for the funded entities, as a continuation of its statewide Arizona Regional Extension Center program.

A.i(6) Stakeholder Engagement. Health care reform cannot be achieved without comprehensive engagement from various stakeholders. Arizona engages in robust stakeholder involvement on major initiatives, including the SIM strategies. As evidenced by letters of support from more than 50 organizations from across the state, the community has great confidence in Arizona's ability and willingness to partner and collaborate on the SIM strategies.

[9] http://www.azhec.org/?page=HealthIT_Roadmap

ADHS has been a leader in engaging the public through its State Health Assessment, the basis for development of the SHIP designed to target leading public health issues. ADHS worked with 15 county health departments and their local partners, who together reached approximately 10,000 people statewide to identify local community health priorities. That commitment is carried forward through development of the SHIP. In addition, AHCCCS has built a culture of learning regarding payment reform and health system transformation through robust stakeholder engagement including input from hospitals, ACOs, health plans, county governments, tribal stakeholders, and providers from all areas of the State. These stakeholders explained various initiatives being implemented across the State designed to achieve transformation within the health care delivery and payment systems. Stakeholders clearly articulated their passion and commitment to achieve the goal of health system transformation. Stakeholders were equally clear that collaborating with the State's largest insurer – AHCCCS – was fundamental in achieving success. This collaboration was particularly helpful in connecting all of these existing efforts and identifying the missing link – behavioral health. In addition to groups already mentioned, provider and community associations have expressed their support for the State's initiative and articulated their commitment to the proposal's aims.

The SHSIP will reach across various different types of stakeholders, each of whom will play slightly different roles in implementation. Step one will be to identify stakeholder roles; step two will be to develop workgroups specific to identified roles. Upon receiving the SIM award, Arizona will develop a stakeholder engagement plan to ensure each SHSIP Component proposed includes the relevant stakeholders and subject matter expertise to contribute to achieving key milestones during the development of the SHSIP design model. The Arizona Council of Human Services Providers which represents most of the behavioral health providers in the State will serve as a convener. The Council is already at the center of many of the initiatives that will be brought together through this proposal, including behavioral health HIE.

AHCCCS has an established tribal consultation process through its Office of Intergovernmental Affairs. The State has discussed care coordination for the American Indian/Alaska Native population in tribal consultation on numerous occasions and connected its effort to Indian Health Services national Improving Patient Care initiative. The State has a network of peers and family members that are committed stakeholders through the Office of Individual and Family Affairs (OIFA) at ADHS. OIFA works with the Arizona Peer and Family Coalition, the Arizona chapter of the National Alliance on Mental Illness (NAMI) and many others to ensure participation and outreach to AHCCCS members and families. In addition to already established partnerships and processes, the State will use multiple forms of communication to gather a robust level of stakeholder input to craft the SHSIP stakeholder engagement plan.

A.i(7) Quality Measure Alignment. AHCCCS aligns its measures with other payers through the adoption of CMS measure sets that are also being utilized for other programs such as Medicare and Qualified Health Plans. Many of these measures are also included in the NCQA HEDIS Measures. Meaningful Use measures required of providers to receive full Medicare or Medicaid payment also help with alignment since CMS has included for children and adults, and are also included in some of the proposed measures for SNP and long term care. AHCCCS incorporates HEDIS measures which are a major focus across all insurance types including Medicaid, Medicare, and all major commercial companies in Arizona. In addition, many HEDIS measure are nationally highlighted as part of Meaningful Use, Quality Reporting Document Architecture submissions, Physicians Quality Reporting System submissions, and PCMH or ACO monitoring. Consumer surveys are also included in most measure sets across multiple programs at the federal level including Medicare and QHPs, as well as commercial plans as part of NCQA.

Arizona's successful collaborative efforts have targeted specific initiatives and quality measures. For example, the Medicare QIO and a number of stakeholders convened to address Hospital Re-admissions. This effort of a combination of providers, payers, government and other experts resulted in the largest measurable decrease nationally in re-admissions. Other recent collaborative efforts include Dialysis

Infections, Hospital Acquired Infections, Improved Birth outcomes and the Arizona Prescription Drug Misuse and Abuse Initiative

The SHSIP will continue this alignment by engaging key organizations that cover multiple payer sources. For example companies like United Healthcare bring together multiple lines of Medicaid business, Medicare Advantage, Commercial populations, State employees and, Qualified Health Plans. Other payer organizations like Aetna, Blue Cross Blue Shield, HealthNet and others also bring multiple lines of business that span a full spectrum of insurance products. Through these efforts, it is envisioned 80 percent of the insured Arizona population would be represented in the Plan through aligned reporting on select measures. The SHSIP process will focus on establishing a comprehensive measure set that will provide for an appropriate baseline and track progress over time as the SIM initiative progresses. Given the existing number of measures sets used in the various insurance segments, there is enough overlap to create data sets that will be meaningful while not creating new administrative burdens for providers, members or insurers. These measures will also align well with tracking the impacts of expanded coverage and the SHIP. The plan would also keep the measure set manageable and meaningful by limiting the overall number of measures. Quality measurement efforts can easily become overly complex and burdensome. Arizona has had some of the best success by focusing on a limited number of measures. The SHSIP will be developed through a multi-payer/provider work group to leverage quality and outcomes measures that are consistent with measures required by CMS to reduce the administrative burden on providers. , Measure sets used by ACOs, value-based purchasing initiatives, Medicare, Medicaid, QHPs, Patient Centered Medical Homes, as well as Meaningful Use and measure sets that focus on the integration of physical and behavioral will be reviewed and considered. The measure selection process will consider opportunities for inclusion of e-measures and measures that will gauge the expanded use of EHRs, HIEs, care coordination and integration processes across systems of care as well as administrative measures that include data from these sources. In addition, the SIM HIT strategies will help expand opportunities for

the use of electronic measures as additional providers will have the capacity to participate and report data on these measures. The SHSIP will work to provide outcome measures on the domains of: 1) Access to health care, 2) Chronic conditions, 3) Health behaviors, 4) Mental/behavioral health, 5) Overall health status, 6) Use of emergency room and inpatient stays. Further, the metrics will connect the health care delivery system to public health initiatives such as smoking cessation, obesity, and diabetes care, suicide prevention and substance abuse. Examples of outcomes measures through the collaboration could include: Readmissions, Follow-up after discharge, Emergency department utilization (visits/1000), Inpatient utilization (days/1000), Access to primary care/ambulatory care, and Comprehensive diabetes care.

A.i(8) Monitoring and Evaluation Plan. The SHSIP will include an evaluation model which monitors the effects of various SIM initiative components on the costs and health outcomes of the target populations utilizing a set of Key Performance Indicators (KPIs) for the monitoring and evaluation of the care coordination populations. These KPIs will set the baseline measures from which we will measure progress toward our goals and will track that progress over time as the long-term effects of the initiatives take hold. The KPIs would be measureable within existing data analytics systems so that they utilize data with strong quality controls and a reliable data infrastructure.

The Plan will include both baseline metrics and annual performance goals which will help in determining whether the care coordination process is achieving the desired impact on costs and health outcomes. The focus under the three measure domains as designated in the grant announcement is to: **1) Strengthen population health** by reducing preventable problems and finding coordinated solutions to mental and physical health care needs, aligned with the SHIP; **2) Transform the health care delivery system** by breaking down the barriers between physical and behavioral health care and aligning provider and payer incentives; and **3) Decreasing per capita health care spending** by: a) using innovative methods to direct utilizers toward preventative and proactive health care rather than interacting with the health care system

through the ED and other more expensive means; b) aligning incentives of payers and providers toward measurably improved outcomes and decreased per capita costs.

1. **Strengthening population health**:

a. *Obesity* –Through these efforts Arizona will track and plan on seeing overall reductions in obesity which currently for adults is 25.2%. *Substance Abuse* –. Through improved integrated efforts it is expected that this measure will be favorably impacted.

b. *Diabetes* – The percentage of adults in Arizona diagnosed with diabetes increased from 7.5% in 2005 to 9.1% in 2010. In 2010, American Indians in Arizona were 4 times more likely to die from diabetes than the average Arizonan. Both these measures will be monitored and impacted by the SIM initiatives.

c. *Smoking Cessation* – From 2002 to 2010 adult smoking in Arizona decreased from 23.1% to 15% placing Arizona below the national rate. Through the SIM initiatives Arizona plans on continuing this favorable trend and the associated decrease in tobacco related spending.

d. *CAHPS Data* – Arizona will work to aggregate and analyze CAHPS to establish baseline information along with looking at specific populations in how they view the delivery system.

e. *Incarceration Recidivism* – While not a traditional public health measure one of the major SIM initiatives is around improved transition planning between the Justice system and the delivery system. . While there are a number of factors that impact recidivism, Arizona will track this measure to see what type of favorable impact integrated care coordination may have on this measure.

2. **Transforming the health care delivery system**:

a. *Percent of Spend in Value Based Payment arrangements and number of providers participating* – Currently less than 10% of the Medicaid spend by managed care organizations are in a quantifiable value based arrangements with aligned incentives. This measure will be tracked for both Medicaid and the almost $1 billion in aligned D-SNP spending to track progress annually. It is expected the SHSIP will also include these measures where possible to other payers.

b. *Increase use of e-prescribing by providers.* The SHSIP will include strategies that leverage existing efforts to expand the use of e-prescribing and connectivity in order to improve care coordination. *Increase providers connected to the Health Information Network of Arizona and Behavioral Health Information Network of Arizona.* The SHSIP will target infrastructure and capacity for improved care coordination through leveraging data sharing. Incredible effort has been expended to create Health Information Network of Arizona (HINAZ) and Behavioral Health Information Network of Arizona (BHINAZ) and the SHSIP will support expansion of these efforts.

c. *Increase Providers and Hospitals Achieving Meaningful Use* – The federal government has invested billions of dollars in electronic health record adoption. The SHSIP will leverage these tools for improved care coordination will allow more providers to qualify for meaningful use.

d. *Increase Indian Health Services and 638 facilities NDC reporting* – As part of claiming for the all-inclusive rate these facilities have historically not had to provide any NDC information as part of the claim record. A goal of the SHSIP will be working with these facilities to improve the data to make it more meaningful and robust.

e. *Reduce inpatient hospital readmissions per capita*. Integrating behavioral health providers into the hospital discharge process and coordinating follow-up care among providers will reduce preventable readmissions. Similar benefits are expected to accrue to the American Indian population. This measure will track Medicaid, aligned duals in D-SNPs, and Medicare FFS.

f. *Reduce the number of preventable adverse drug reactions per capita.* The use of e-prescribing, EHR tools that automatically alert the provider to potential adverse reactions and improved care co-ordination will help to prevent these occurrences and the dangerous health consequences for the patient.

3. **Decreasing per capita health care spending**:

a. *Reduce ED visits with a non-emergent diagnosis per capita.* The SHSIP will include this monitor on multiple levels: overall decrease in ED visits; ED utilization for members recently released from

incarceration, ED utilization for member with SMI, and ED utilization for the American Indian population. This measure may evolve to other populations where appropriate.

b. *Reduce overall costs per capita in super utilizer subpopulation.* The SHSIP will include measures of per capita costs for high cost/high utilization persons.

c. *Maintain the Medicaid program PMPM growth at the cost of inflation.* Sustainability is one of the ultimate challenges for Medicaid programs. In order to address other critical policy areas Medicaid must be manageable. This means overall PMPM growth cannot exceed inflation.

A.i(9) Alignment with State and Federal Innovation. This SHSIP will leverage, build and accelerate the innovation that is occurring within the Arizona health care delivery system which, as described below, aligns with many CMS initiatives. It will build on the ACO structures that have evolved as a result of the ACA and Medicare efforts, and expand the capacity of the ACO model to address significant behavioral health needs allowing for more integrated holistic treatment. While these efforts are well-aligned with the Medicare efforts and can build upon much of the same infrastructure, they are not duplicative due to the populations served and the enhanced focus on behavioral health. By targeting and incentivizing collaboration with providers not targeted as part of the Incentive program, the Arizona proposal will expand the distribution of actionable data necessary for integrated care, care coordination and payment reform. The effort is focused on behavioral health providers, the criminal justice system and providers serving American Indians that are willing to collaboratively and contractually partner with larger delivery systems and the Medicaid program. The SHSIP will also build on and support the Indian Health Services Improving Patient Care (IPC) model; Arizona has modeled its care coordination efforts on the IPC model. Another focus will be the development of care coordination opportunities between QHPs and Medicaid. No federal resources have been provided for that purpose. While considerable resources have been devoted to align dual eligible members, this proposal will leverage the D-SNP platform that Arizona has utilized to achieve significant alignment. Again these efforts are in concert with and supportive of CMS initiatives without

duplication. In addition, CMS has identified and promoted a number of innovations and opportunities for the Medicaid program that have been leveraged and are being put into place in Arizona: reducing non urgent use of the ED by focusing on super-utilizers and addressing needs of members with behavioral health problems, development of integrated care models, and emphasizing the creation of new forms of payments that focus on improving quality.