ARIZONA STATE HEALTH CARE INNOVATION PLAN

DATE SUBMITTED: JULY 5, 2016

LETTER FROM DIRECTOR OF THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

On December 16, 2014, the Centers for Medicare & Medicaid Services (CMS) awarded the round two grant funding for State Innovation Model (SIM) to support and fund states in planning, designing and testing new payment and service delivery models to advance broad based health system reform. The purpose of SIM is to spur state-led healthcare innovation that improves system performance, enhances quality of care, and reduces costs for beneficiaries of Medicare, Medicaid, and the Children's Health Insurance Program and for all residents of participating states.

Arizona applied for, and was awarded, a $2.5 million SIM Model Design grant to develop this State Health Care Innovation Plan (the "Innovation Plan"). This funding permitted the State to engage a diverse group of stakeholders to develop specific goals for delivery system reform and payment transformation that aims to achieve better health, better care, and lower costs. The resulting Innovation Plan will serve as Arizona's roadmap to achieve these goals.

The Innovation Plan centers on three main initiatives that ultimately focus on enhanced coordination for vulnerable populations; specifically, individuals served by the American Indian Health Program, individuals transitioning out of incarceration and into the community, and individuals with physical and behavioral health needs. The specific goals developed for each of these initiatives take into account diverse stakeholder input and recognize some of the unique aspects of Arizona, such as our geographic makeup, regional variation and diverse population.

The three main initiatives are also woven together by a few foundational issues that must also be addressed to ensure success of the main initiatives. Specifically, these foundational issues include payment reform, workforce needs, population health, health information technology, and the Arizona health information exchange.

We believe the initiatives put forward in the Innovation Plan will accelerate our State's ultimate goal, which is the delivery system's evolution towards a value based, integrated model that focuses on whole person health in all settings regardless of coverage source.

I would like to thank all of the participants in the stakeholder process and the numerous state staff who have given their time and energy to develop this Innovation Plan specifically those from the Arizona Health Care Cost Containment System and the Arizona Department of Health Services. I am grateful for their commitment to our State's goals and their demonstrated leadership in helping us develop a roadmap to get there.

Thomas J. Betlach
Director of the Arizona Health Care Cost Containment System

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List of Frequently Used Acronyms

ACOM — AHCCCS Contractor Operations Manual

ADHS — Arizona Department of Health Services

ADJC — Arizona Department of Juvenile Corrections

AHCCCS — Arizona Health Care Cost Containment System

AI/AN — American Indian/Alaskan Native

AIHP — American Indian Health Program

ALTCS — Arizona Long-Term Care System

ASD — Autism Spectrum Disorder

AzHeC — Arizona Health-e Connection

AzHIP — Arizona State Health Improvement Plan

CMC — Care Management Collaborative

CMMI — Center for Medicaid and Medicare Innovation

CMS — Centers for Medicare & Medicaid Services

DBHS — Division of Behavioral Health Services

DES — Department of Economic Security

DFSM — Division of Fee-for-Service Management

DOC — Department of Corrections

D-SNP — Dual Eligible Special Needs Plan

ED — Emergency Department

EPD — Elderly and Physically Disabled

FFS — Fee-for-Service

FFY — Federal Fiscal Year

FMAP — Federal Medical Assistance Percentage

FQHC — Federally Qualified Health Center

GMH/SA — General Mental Health/ Substance Abuse Disorders

HIE — Health Information Exchange

HIT — Health Information Technology

HPSA — Health Professional Shortage Area

IHMHP — Indian Health Medical Home Program

IHS — Indian Health Services

IPC — Improving Patient Care Program

ITU — Indian Health Service, Tribal 638, and Urban Indian Health

MCO — Managed Care Organization

ONC — Office of the National Coordinator

PCMH — Patient Centered Medical Home

PMPM — Per Member Per Month

RBHAs — Regional Behavioral Health Authorities

SAMHSA — Substance Abuse and Mental Health Services Administration

SHA — State Health Assessment

SIM — State Innovation Model

SMI — Serious Mental Illness

SUD — Substance Use Disorder

SUD/SA — Adults with Substance Use Disorders

TRBHAs — Tribal Regional Behavioral Health Authorities

T/RBHAs – Tribal Regional Behavioral Health Authorities and Regional Behavioral Health Authorities

TCPI — Transforming Clinical Practice Initiative

VBP — Value Based Payment

I. Executive Summary

Arizona's Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS) has been a leader in transforming the State's health care delivery system since it implemented Medicaid through a Social Security Act section 1115 demonstration in 1982. From the beginning, AHCCCS has employed innovative approaches to health care delivery and payment systems, frequently emerging as a pioneer in the testing of health care policies and financing strategies as the State has continuously sought to improve health care while containing health care costs.

Arizona has three overarching health care system goals. The State's goals align perfectly with the Triple Aim[1] and the goals of the State Innovation Model (SIM) Initiative.

Arizona Goals

1. Improve the health of the population,
2. Deliver better health care by reducing fragmentation and improving the quality of care, and
3. Decrease per capital health care spending.

Arizona focused its SIM Model Design on advancing these goals and achieving the Triple Aim. Specifically, Arizona's planning during the SIM Design grant year focused on:

- Identifying possible new payment approaches to drive health care system improvements, and
- Identifying delivery system initiatives that will improve the care, and ultimately the health, of vulnerable populations across Arizona.

The decision to focus planning efforts on specific vulnerable populations across the State emerged from knowledge obtained through the State's efforts to reform the delivery system utilizing financing strategies that link payment to value. Both previously and throughout the SIM Model Design planning, AHCCCS has spent significant time with payers, regional behavioral health authorities[2] (RBHAs), and providers to explain the various alternative payment model options and the State's vision for payment reform across the health care system. Staying true to the Arizona culture of permitting the free market to work without prescriptive dictation, AHCCCS included contractual requirements with all of its health plans that incentivize the health plans to work with their providers to develop value based payment (VBP) arrangements that work best for their populations. Health plans that meet a certain percentage of VBPs each contract year and that meet specified quality measures, achieve financial incentives. AHCCCS provided definitions

[1] The Triple Aim framework was developed by the Institute of Healthcare Improvement and is defined as 1) Improving the patient experience of care; 2) Improving the health of populations; and 3) Reducing the per capita cost of health care. www.ihi.org.

[2] RBHAs are managed care organizations that contract with AHCCCS to administer behavioral health services for state-funded health programs. As of July 1, 2016, the merger of AHCCCS the Arizona Department of Health Services (ADHS)/Division of Behavioral Health Services (DBHS) was officially completed.

of the VBP options and provided a framework for VBP in Medicaid policy manuals. In allowing the health plans to pursue a variety of arrangements, AHCCCS has created mini testing grounds for VBPs in the State, which also provides insight into best practices and valuable lessons learned about the State's delivery system.

Despite progress with VBP efforts, significant gaps in the delivery system remain and identified additional work must be done to ensure that the delivery system is working effectively for all Arizonans. Specifically, these gaps exist for certain populations in the State because, among other things, (i) more collaboration is needed between provider organizations, (ii) some organizations who are not necessarily natural partners (e.g., probation/parole and the AHCCCS health plans) need to effectively communicate to achieve continuity of care, and (iii) certain unique challenges that present with particular populations require additional attention, (e.g., individuals with serious mental illness (SMI)). The delivery system gaps were underscored by the results of Arizona's State Health Assessment (SHA), a comprehensive summary of leading public health issues in the State. The SHA, conducted by the Arizona Department of Health Services (ADHS) with input from thousands of stakeholders throughout the State, included both quantitative and qualitative data analysis to assess the public health status of Arizona. The SHA identified the health needs of Arizonans, and brought to the forefront the health disparities that exist among the State's vulnerable populations. Following completion of the SHA in April 2014, ADHS led the development of a statewide population health plan, the Arizona State Health Improvement Plan (AzHIP), *Healthy People, Healthy Communities.* AzHIP provides a structure to align community and statewide resources to maximize efforts to improve the health of Arizonans.

Given the significant health needs of vulnerable populations within the State, Arizona chose to focus its SIM Model Design planning efforts on designing care models and payment approaches that will close the gap in care for these specific populations, while simultaneously continuing its pursuit for broader delivery system transformation. Working closely with stakeholders, Arizona has developed specific strategic initiatives to test within the Medicaid program with the goal of expanding lessons learned and best practices to the rest of the State in the near future. In addition, the expectation is that the care delivery transformation that is being proposed through this Innovation Plan will impact all Arizonans. For example, if behavioral health services are better integrated in hospital emergency departments for AHCCCS enrolled patients, it should also improve care for all emergency department patients.

The specific gaps in the delivery system impacting vulnerable populations across Arizona are the following:

- Care coordination efforts for individuals served by the American Indian Health Program,
- Care coordination efforts for individuals transitioning out of the incarceration, and
- Behavioral and physical health integration for individuals with complex health conditions.

For each area, as described in this Innovation Plan, AHCCCS and stakeholders identified statewide goals, action steps to achieve the goals, and an approach to test whether the model designed has a positive impact in closing the identified gaps in the delivery system. A key theme that emerged throughout the planning was the need to expand Health Information Technology (HIT) and enrollment in the Arizona Health Information Exchange (HIE) in order to improve the delivery system statewide, and, in particular, support the implementation of care coordination models for vulnerable populations. Through the SIM Model Design, Arizona sharpened its focus on how the State's HIT policies and infrastructure must be developed to support new delivery system and payment models. Many of the action steps described in Arizona's SIM Model Design call for HIT policies, governance, and a statewide technology infrastructure to support coordinated

care across the myriad of health-related service providers caring for vulnerable populations and to support expansion of VBP models. One of the most important activities that occurred during the SIM Model Design planning period was working with stakeholders to understand the challenges that prevent data exchange and analysis needed to coordinate and improve clinical care. AHCCCS engaged the Arizona Health-e Connection (AzHeC), the non-profit, public-private partnership organization that operates Arizona's statewide HIE ("The Network") and Arizona's Regional Extension Center (REC), to assist the State in obtaining input from stakeholders on barriers and solutions needed to improve the coordination and delivery of care of the State's vulnerable population through the 1) expansion of exchange of clinical information on a real time basis, and 2) the provision of data and analytical capability to support providers, payers and other relevant organizations. Policy and technical issues related to barriers to EHR adoption, readiness for HIE utilization, and levels of integrated care were examined for each of the three targeted population groups. The identification of existing barriers informed the State's understanding of the HIT policies and infrastructure that must be developed and expanded, as well as the technical assistance that providers must receive to overcome current barriers. This stakeholder information provided the groundwork needed to develop the State's SIM HIT Plan included in this Innovation Plan.

Arizona's Innovation Plan explains the delivery system transformation work that has been done and continues in the State and further explains the goals of the strategic initiatives to be tested. In addition, the Innovation Plan describes how the State plans to test the initiatives designed to address the gaps in the current delivery system, while continuing to advance financing strategies that link payment to value. The Innovation Plan also addresses additional key themes impacting the care delivery and payment system across the State, including (i) population health impact, (ii) enhanced health information technology capabilities, (iii) connection to the health information exchange, (iv) workforce initiatives, (v) policy levers to ensure the initiatives are successful, and (vi) sustainability of the proposed initiatives. The latter was of particular concern to stakeholders throughout the SIM Model Design planning process as it appears unlikely that SIM Model Test grant funds will be available to support testing of the models. As such, AHCCCS and stakeholders focused a significant amount of their time exploring and investigating opportunities to test and sustain the models developed during the SIM Model Design grant period.

While this document is submitted to CMS as part of the SIM Model Design grant requirement,[3] the utility of Arizona's Innovation Plan far exceeds that of meeting a grant funding requirement. The State will use this document as a roadmap for continued care delivery and payment system reform and to assist the State as it moves forward in meeting its goals and testing its initiatives. The Innovation Plan will continue to evolve and be updated as the models are further developed with stakeholder input and opportunities to test the models are realized.

[3] For ease of CMMI review, the State has included a checklist that identifies the requirements of the SIM Model Design grant with the specific section of the Innovation Plan that addresses the requirement.

II. Introduction & Overview of Innovation Plan

Vision, Values, & Guiding Principles

Arizona has historically been an innovator and a leader in testing health care policies and financing strategies as the State has worked to achieve its vision of improving the health care system and the population's health while containing health care costs.

This vision is reflected in Arizona's goals that are aligned with the Triple Aim and are as follows:

- Improve the health of the population,
- Deliver better health care by reducing fragmentation and improving the quality of care, and
- Decrease per capital health care spending.

Arizona's Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS), led the State's SIM Model Design planning efforts, focusing on advancing attainment of the State's goals. Throughout the SIM Model Design work, AHCCCS employed the same guiding principles to health care transformation planning that have led to the State's previous success in creating health care system changes. The key tenet upon which Arizona's guiding principles are based is that solutions designed must be done in partnership with stakeholders. AHCCCS' success thus far in transforming the State's health care delivery and payment system has been built on broad stakeholder input and support across the State. Care delivery models and payment approaches have been historically developed through extensive planning efforts with the State's provider network and payers to be responsive to Arizona's culturally and geographically diverse population health needs. This long-standing approach to stakeholder engagement provided a foundation upon which Arizona's SIM Model Design planning was conducted.

Another guiding principle driving Arizona's planning phase is that all solutions designed must be responsive to the State's unique characteristics, values, and needs. AHCCCS' SIM Model Design planning was conducted with an understanding that Arizona is a State that prefers not to rely on regulation to prescribe and force change. In contrast to many of its sister states, Arizona presents its principles and expectations for change and then allows competitive innovation to drive solutions that meet the State's goals and objectives. AHCCCS' past efforts with value based payments (VBPs), and throughout the current SIM Model Design planning, have followed this path. AHCCCS has outlined its expectations for the Medicaid system while permitting its contractors to be creative and implement arrangements that are appropriate for their respective members and providers. Through these efforts in the Medicaid program, AHCCCS has been a leader in VBP transformation in the State with a focus on reducing system fragmentation and improved care coordination for individuals with complex needs. Working with stakeholders and with an understanding of Arizona's values, AHCCCS is moving the system toward an evolution to a value-based, integrated model that focuses on the whole person health in all settings, regardless of coverage source.

Arizona has a long-standing history of using financing strategies that link payment to value to drive improvements in the health care system while containing costs. In 1982, Arizona was the first state to launch its Medicaid program in a managed care environment. Since that time, the State has continued to be a pioneer in exploring and advancing VBPs. As a result, Arizona has made significant progress in moving towards VBPs and using those models to transform the delivery system. While recognizing that Arizona is ahead of many states in this area, Arizona has still looked to federal initiatives, other state experiences, and evidenced-based practices in developing and designing these delivery system reform initiatives. Arizona has been mindful to learn from other states experiences, while not being constrained by those examples. Specific examples of Arizona's consideration of other federal and state efforts are addressed within the

initiatives are described later the "Alignment with Other Initiatives" described throughout Section IV "Proposed Payment and Delivery System Initiatives" of this Innovation Plan.

While continuing to advance the use of VBPs to drive delivery system reform, Arizona has identified additional efforts and tools that must be employed to ensure that the delivery system is working effectively for all Arizonans. Specifically, AHCCCS has recognized that the care delivery and funding structures utilized to date have not been as effective for certain populations in the State because of the need for enhanced collaboration between different partners, challenges in exchanging clinical information between health care providers that is needed to provide comprehensive, coordinated care, and unique challenges in providing coordinated care for certain populations. Accordingly, while pursuing efforts for broader delivery system transformation, Arizona focused its SIM Model Design planning efforts on designing care models and payment approaches that will close the gap in care for these specific populations. Working closely with stakeholders, Arizona has developed specific strategic initiatives to test within the Medicaid program with the goal of expanding lessons learned and best practices to the rest of the State in the near future.

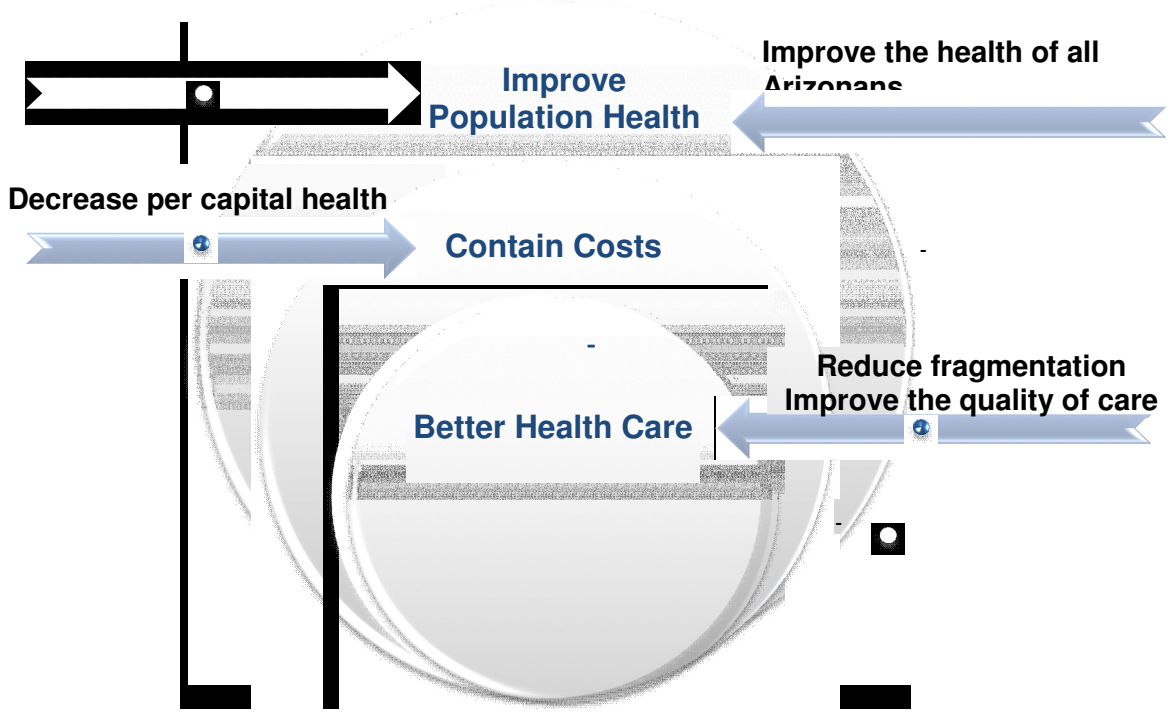
Arizona's Vision – To accelerate the delivery system's evolution towards a value-based, integrated model that focuses on whole person health in all settings regardless of coverage source.

Arizona's SIM Model Design provided the State an opportunity to refine its vision for the State's health care delivery and payment system. Together with stakeholders, AHCCCS focused the State's SIM planning around Arizona's vision to 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. To move toward achievement of the State's vision, the SIM Model Design focused on i) identifying possible new payment approaches to drive health care system improvements, and ii) identifying delivery system initiatives that will improve the care, and ultimately the health, of vulnerable populations across Arizona. The latter focused specifically on identifying delivery system initiatives that will:

- Improve care coordination for individuals served by the American Indian Health Program,
- Improve care coordination for incarcerated individuals as they transition to the community, and
- Expand behavioral and physical health integration to better address the needs of individuals with complex health conditions.

Ultimately through the pursuit of these strategic initiatives, Arizona will advance its three overarching health care system goals to achieve its vision of a health care system that result in improved health for all Arizonans.

Arizona's Health Care System



Overview of Initiatives

In furtherance of Arizona's pursuit of its health care system goals, Arizona has outlined three areas where additional assistance with delivery reform is necessary to ensure effective change within Arizona's health care system.

- *American Indian Health Program (AIHP).* Improve care integration, care coordination, and data sharing capability for individuals treated both within and outside of Indian Health Services (IHS) and Tribal 638 programs and facilities.
- *Criminal Justice System.* Improve transitions between the health care system and the Arizona Department of Corrections, county jails, and probation systems.
- *Behavioral Health and Physical Health Integration*. Improve health care integration, reduce system fragmentation, and appropriately address care coordination needs of (i) adults with serious mental illness (SMI) and individuals with general mental health and/or substance use disorder and (ii) children with or at-risk for autism spectrum disorder and/or engaged in the child welfare system.

These initiatives were identified through stakeholder input and have been the focus of stakeholder discussions organized by AHCCCS throughout the past year. Arizona's strategy has been to develop delivery system model solutions with key stakeholders and to start with a focus on initiating within the Medicaid program. Given that over twenty-five percent of the State's population is covered by Medicaid, and the fact that all Medicaid plans provide Dual Eligible Special Need Plans (D-SNPs) and many also provide commercial plans, the expectation is that the reforms in Medicaid will have a ripple effect on other payers.

These initiatives are tied together through a common foundation related to alternative payment models, HIT, and strategies to address population health. As such these key themes which are central and imperative to the success of the initiatives are described in Section V, "Foundation of Delivery System Initiatives."

Approach to Stakeholder Engagement

As noted previously, the importance of seeking and maintaining stakeholder feedback and support is a core guiding principal for Arizona. Indeed, stakeholders played a critical role in developing Arizona's Innovation Plan throughout the planning phase and will continue to be imperative to the success of these initiatives. For each initiative, stakeholders had the opportunity to provide input and feedback to assist in developing goals, understanding resource needs, and next steps. Given that the initiatives are addressing specific gaps in care in the delivery system, stakeholder representation and discussions varied according to the initiative. As such, specific detail on stakeholder engagement for each initiative is discussed in their respective sections of the SIM Innovation Plan. Included in this section is a description of the approach taken by AHCCCS to ensure that appropriately broad, diverse, and comprehensive stakeholder engagement occurred during the SIM planning activities.

AHCCCS approaches stakeholder engagement with an understanding that one of the keys to effective and lasting health care system change is developing and sustaining a group of engaged stakeholders who represent varied aspects of the service delivery system. Inclusive participation by members, providers, health plans, and others shapes the ultimate plan with depth and vision to truly drive system change. In addition, when stakeholder groups are thoughtfully chosen, and their participation is focused, they represent the diversity that allows for a system design that honors the different cultures, beliefs, and needs of Arizonans. Arizona has a rich and vibrant culture that the Innovation Plan strives to have reflected in the system of care design.

AHCCCS developed an effective stakeholder engagement plan for the SIM Model Design by first identifying and successfully recruiting a broad group of stakeholders to inform the design of a health care delivery model that will meet the unique and diverse health and related needs of Arizona residents. Stakeholders were recruited based on the role they would fulfill in the SIM Model Design planning, such as whether the stakeholder would be a participant in discussions regarding specific initiatives and/or serve on the SIM Steering Committee. Some stakeholders were recruited based on their experience of traditionally providing input on AHCCCS programs and policies as their historical and current knowledge of the Arizona's health care system was considered to be an invaluable stakeholder perspective. However, AHCCCS also recognized that new voices were needed to ensure the development of a model that is responsive to the unique needs of vulnerable populations and delivery system gaps that is the focus of SIM Model Design planning. To identify and recruit new stakeholders, AHCCCS worked with other state agencies and community partners. When selecting stakeholders, AHCCCS considered both the impact of the stakeholder on the delivery system model development and the impact of the proposed model on the stakeholder to help ensure selection of stakeholders who support and are committed to the objectives of Arizona's health care transformation. Availability of stakeholders to commit to the entire planning process was also a fundamental consideration, as well the appropriate geographic diversity of the stakeholder group. The list of stakeholders was captured in a "Master Stakeholder List" (See Exhibit A).

AHCCCS' approach also reflected an understanding that meaningful stakeholder input requires subject-matter education and preparation for stakeholder activities. AHCCCS worked with stakeholders to make sure that workgroup and forum participants understood the role of the work groups, the purpose of the forums, the objectives of new delivery system design and payment

reform, and how their work would contribute to a better health care system in Arizona. To further support stakeholder participation, AHCCCS scheduled meetings far enough in the future to maximize participation, provided agendas and meeting materials well in advance of meetings, and provided timely follow up communications and meeting notes. These materials were also included on AHCCCS' website on the SIM Initiative dedicated page.[4]

Most importantly, AHCCCS used the following guiding principles when working with SIM Model Design stakeholders to effectively develop a genuine partnership in the planning and deliberations regarding delivery system needs for Arizona's vulnerable populations:

- Ensure goals and messages are clearly conveyed to all members of the stakeholder group,
- Practice open and effective communication both in listening to and sharing information with participants,
- Provide clear and transparent feedback processes in a timely fashion to encourage open and productive participation,
- Create a climate of collaboration, and
- Conduct meetings and all communications in a matter that fosters inclusive involvement in the process.

Meetings with Tribal community members and formal Tribal consultations was an essential part of the planning process, particularly as it relates to improving care coordination for American Indians living in Arizona. AHCCCS' engagement of Tribal leaders and relevant health care providers is discussed in Section IV: "Proposed Payment and Delivery System Initiatives, Coordination for American Indian Health Program."

Throughout the SIM Model Design planning period, AHCCCS gathered, synthesized, and updated stakeholder input as it was received. Continuous feedback to stakeholders was provided to ensure that AHCCCS correctly understood and interpreted the input and developed into information used to create the Innovation Plan. Stakeholder input within the three discrete areas of the delivery system, e.g., behavioral health integration, and across the broader initiative to expand VBPs, were presented to the SIM Steering Committee and SIM Executive Committee to guide their recommendations and decisions regarding the SIM Model Design.

The SIM Steering Committee is comprised of state agency subject matter experts across health care delivery, payment and financing strategies, and population health needs. The Steering Committee is responsible for considering stakeholder input and using the information to formulate recommendations to the SIM Executive Committee regarding new delivery and payment models. Specifically, the Steering Committee was charged with:

- Providing subject matter expertise for development of SIM sub-plans and deliverables,
- Reviewing and making recommendations centered on stakeholder input, and
- Serving as an advisory body to the Executive Committee regarding the determination of selected initiatives and innovations and Innovation Plan development.

[4] Available at https://www.azahcccs.gov/Resources/Grants/SIM/; see also https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/justiceinitiatives.html

Arizona SIM Steering Committee Membership

Steering Committee Member	Area of Responsibility and Expertise
Tom Betlach	Medicaid Director
Beth Kohler	Medicaid Deputy Director, health care policy expert, SIM Project Director
Lorie Mayer	Arizona HIT Coordinator
Elizabeth Carpio	American Indian health programs
Michal Rudnick	Justice system programs
Shelli Silver	Finance, rate development and data; Health care management
Mohamed Arif	Medicaid program analyst; Project management
Cara Christ	Director, Arizona Department of Health Services
Janet Mullet	Deputy Director, Arizona Department of Health Services, Planning and Operations
Melissa Kotrys	CEO, AzHeC (Arizona statewide HIE)
David Spitzer	COO and Chief Privacy Officer, AzHeC
Mike Mote	Chief Information Officer, AzHeC
George Jacobson	Payment Modernization, SIM Project Manager
Sara Salek	Medicaid Chief Medical Officer
Mark Carroll	AHCCCS Physician Program Consultant, Provider network; clinical expertise

The Steering Committee meeting dates and agenda topics can be found in Exhibit B.

The Executive Committee was comprised of the AHCCCS Director, AHCCCS Deputy Director (also serving as the SIM Project Director), and the SIM Project Manager. The Executive Committee structure allowed for efficient-decision making required due to the short SIM Model Design planning period.

III. Description of Arizona's Health Care Environment

Arizona Health Care Market

Arizona's legacy as a frontier state remains today, shaped by a diverse population and distinct landscape. Arizona is the sixth geographically largest state and has a population of over 6.8 million.[5] Approximately 90% of the residents live in metropolitan areas, leaving large pockets of frontier land, often with limited access to care and Health Professional Shortage Area (HPSA) designations.[6] Of the total population, a large percentage is Hispanic/Latino (30.5% versus 17.4% nationally). The State also has a large percentage of American Indian/Alaskan Natives (AI/AN) (5.3% versus 1.2% nationally), which is also reflected in the geographic size of tribal land within the State.

Despite many thriving industries, the rate of poverty is high. Over 18% of the State's residents live in poverty, compared to 14.8% nationally.[7] In addition, Arizona's unemployment rate (seasonally adjusted) was 5.5% as of April 2016 compared to the national rate of 5.0%.[8] Fewer residents are covered by employer-sponsored insurance (43% versus 49% nationally), and more receive coverage through the Medicaid program, (27% versus 22% nationally).[9] As of 2014, approximately 827,100 residents (12% of the population) were uninsured.[10] For those who are enrolled in private coverage, Blue Cross Blue Shield (BCBS) of Arizona has the largest number of enrollees. Other major carriers include UnitedHealthcare, Humana, Aetna, and Health Net. Importantly, UnitedHealth and Health Net are also managed care contractors in AHCCCS.

Health Insurance Coverage of the Total Arizona Population, 2014[11]

Coverage Source	Percentage of Population	Number of Individuals
Employer	43%	2,835,200
Non-Group	5%	333,500
Medicaid	25%	1,639,400
Medicare	14%	911,000
Uninsured	12%	827,100

With the passage of the Affordable Care Act, individuals in Arizona now also have an opportunity to purchase private insurance through the health insurance exchange. During 2016 open enrollment, 203,066 individuals in Arizona enrolled in private health plans through the Arizona exchange representing about 3% of the State's population.[12] In 2016 there were eight carriers offering plans on the exchange (i) Aetna, (ii) Blue Cross Blue Shield of Arizona, (iii) Cigna, (iv) Health Choice, (v) Health Net Life Insurance (PPO) and Health Net of Arizona (HMO), (vi) Humana, (vii) Phoenix Health Plans and (viii) UnitedHealthcare (All Savers). Humana and UnitedHealthcare are exiting the exchange at the end of 2016.

[5] Census Quick Facts: http://quickfacts.census.gov/qfd/states/04000.html
[6] http://kff.org/other/state-indicator/metropolitan-distribution/
[7] Census Quick Facts
[8] Arizona Department of Administration Office of Employment and Population Statistics Monthly Employment Report, released May 19, 2016 available at https://laborstats.az.gov/sites/default/files/APR-Emp-Report.pdf
[9] See http://kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/; https://azahcccs.gov/Resources/Downloads/PopulationStatistics/2016/May/AHCCCS_Population_Highlights.pdf
[10] http://kff.org/other/state-indicator/total-population/
[11] http://kff.org/other/state-indicator/total-population/
[12] *See https://www.healthinsurance.org/arizona-state-health-insurance-exchange/*

Medicaid and Medicare Coverage

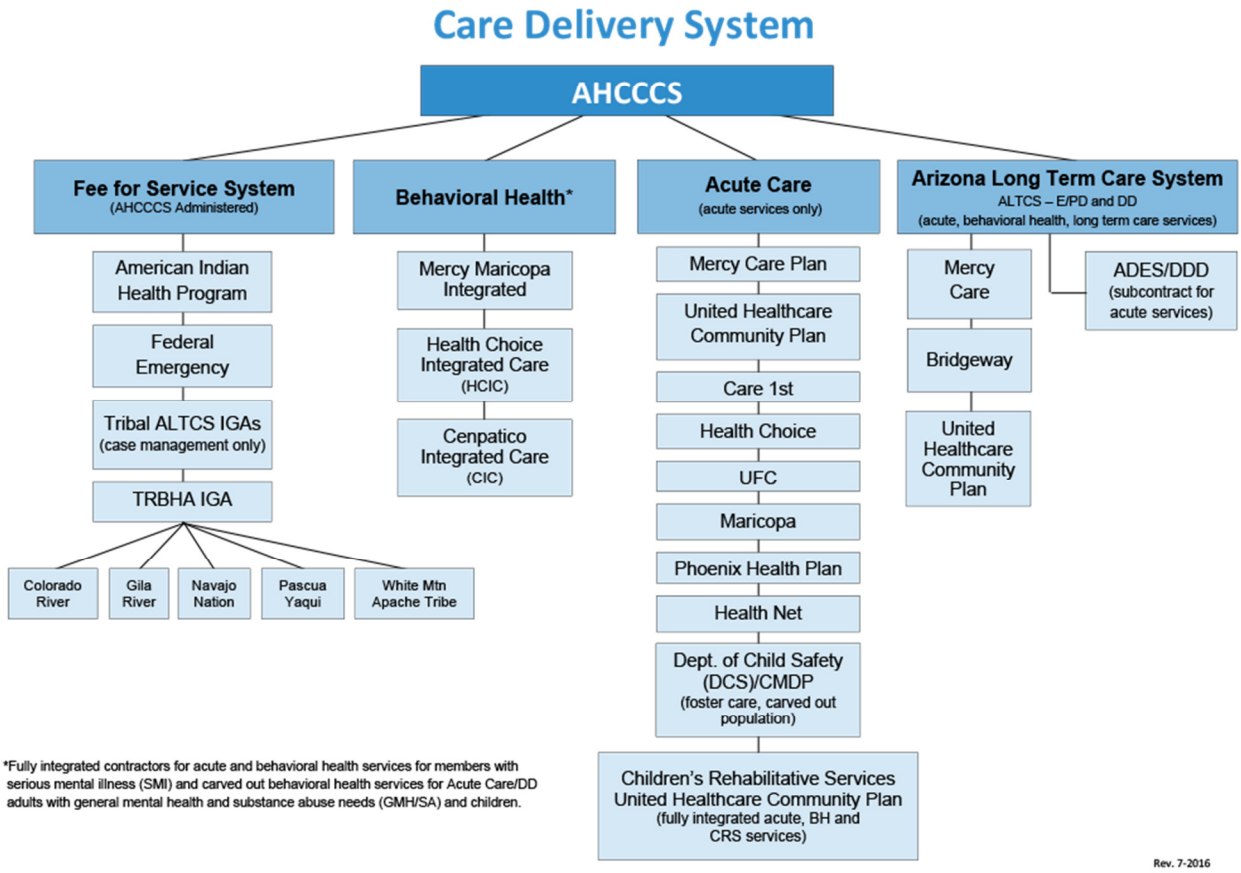
Nearly half of the State's population is enrolled in either Medicaid or Medicare. Today, approximately 27% of Arizonans are enrolled in AHCCCS.[13] As of 2015, approximately 16% were covered by Medicare (1,134,774 total enrollees).[14] Of those enrolled in Medicare, 31% were enrolled in Medicare Advantage (353,354).[15]

In 2014, the State elected to restore and expand Medicaid in an effort to improve uninsured rates and provide comprehensive care to newly qualifying individuals. In 2013, the State's uninsured rate was higher than the national average (14.5% nationally, versus 17.1% in Arizona).[16] While the uninsured rate was still higher than the national average in 2014 according to the same Census report (11.7% nationally, versus 13.6% in Arizona), the gap has decreased. Some residents obtained coverage by purchasing private insurance; as noted above approximately 3% of the state's population obtained private insurance from the health insurance exchange. Many others gained coverage through restored AHCCCS eligibility. In fact, 41% of uninsured Arizonans at the time of restoration qualified for Medicaid.[17] Medicaid enrollment has increased by approximately 40% between 2013 and 2016, which amounts to over 480,000 newly enrolled members over this short period of time.[18]

Medicaid Delivery System

Arizona's Medicaid care delivery system is comprised of four main systems, 1) Managed care for acute services, 2) Managed care for long-term care services (known as the Arizona Long-Term Care System – ALTCS), 3) Behavioral Health, and 4) Fee-for-service (FFS). The care delivery system and health care contractors are shown in the graphic below.

[13] https://azahcccs.gov/Resources/Downloads/PopulationStatistics/2016/May/AHCCCS_Population_Highlights.pdf
[14] http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/
[15] http://kff.org/medicare/state-indicator/total-enrollment-2/
[16] http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf
[17] http://kff.org/health-reform/fact-sheet/state-profiles-uninsured-under-aca-arizona/
[18] https://www.medicaid.gov/medicaid-chip-program-information/by-state/arizona.html



The majority of Arizona's Medicaid population is enrolled in managed care (almost 85%). The table below shows the distribution of Arizona's Medicaid population across the State's Health Care Contractors.

Arizona Medicaid Program Enrollment[19]

Medicaid Program	Medicaid Population as of 5/1/2016
Managed Care Acute Care Services	1,489,327
Managed Care Long-Term Care Services (Arizona Long Term Care System, ALTCS)	58,034
Fee-for-service	233,853
Medicare Savings Program	51,938
TOTAL	1,833,152

Health plans with the most enrollment (acute care and ALTCS combined) include UnitedHealthcare (416,906 enrollees, 22% of the Medicaid population), Mercy Care Plan (355,241 enrollees, 19% of the Medicaid population), Health Choice (240,709 enrollees, 13% of the Medicaid population), University Family Care (132,541 enrollees, 7% of the Medicaid population), and Care 1st Arizona (106,185 enrollees, 6% of the Medicaid population).[20] Medicaid health care

[19] Enrollment numbers include those receiving care through the RBHAs.
[20] AHCCCS Report "AHCCCS Population By Health Care Contractor" found at https://www.azahcccs.gov/Resources/Downloads/PopulationStatistics/2016/May/Members_by_Contractor_Report.pdf

contractors and enrollment information for Arizona's managed care programs are outlined below.[21]

Arizona Medicaid Enrollment by Acute Health Plan and ALTCS Health Care Contractor

Acute Health Plans	Medicaid Enrollment as of 5/1/2016
UnitedHealthcare	407,005
Mercy Care Plan	344,052
Health Choice Arizona	235,298
University Family Care	132,541
Care 1st Arizona	106,185
Maricopa Health Plan	80,491
Health Net Access	58,356
Phoenix Health Plan	52,955
DES Foster Care	17,701
Children's Rehabilitative Services (CRS)	16,724

Integrated RBHA Plans	Medicaid Enrollment as of 5/1/2016[22]
Mercy Maricopa Integrated Care	19,691
Cenpatico Integrated Care	12,917
Health Choice Integrated Care	5,411

ALTCS Health Care Contractors	Medicaid Enrollment as of 5/1/2016
Dept. of Economic Security/Division of Developmental Disabilities (DES/DDD)	29,093
Mercy Care LTC	11,189
UnitedHealthcare	9,901
Bridgeway Health Solution	5,325
Tribal IGAs[23]	2,526

Under the FFS system, the State administers the American Indian Health Program (AIHP) to provide medical coverage to enrolled American Indian members. Qualifying American Indians and Alaska Natives (AI/AN) enrolled in AHCCCS or Children's Health Insurance Program (KidsCare) may elect to receive their coverage through the AHCCCS AIHP or one of the AHCCCS managed health care plans. As of May 2016, approximately 120,000 American Indians were enrolled in the AIHP program.

In 2015, there were 1,134,774 Arizonans enrolled in Medicare,[24] 31% of which participated in a Medicare Advantage program (353,354 individuals).[25] In 2016, the options for Medicare

[21] Ibid.
[22] In addition, individuals with behavioral health needs who are enrolled in the acute health plans receive behavioral health services through the RBHAs.
[23] Includes aggregate number of tribal members from all of the tribal IGAs.
[24] http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/
[25] http://kff.org/medicare/state-indicator/total-enrollment-2/

Advantage Plans across the State's counties range from a low of five in three counties to thirty plan options available to Maricopa County residents (includes Phoenix area).

In calendar year ending 2015, 234,991 Medicaid enrollees (Title XIX and Title XXI) received behavioral health services through Arizona's Division of Behavioral Health Services' (DBHS) programs. An additional 30,665 non-Medicaid enrollees also received services through the DBHS system.

AHCCCS contracts with Regional Behavioral Health Authorities (RBHAs) to have a network of providers, clinics and other appropriate facilities and services to deliver behavioral health services to eligible members in their contracted geographic service area (GSA). AHCCCS has Intergovernmental Agreements for Tribal RBHAs with five of Arizona's American Indian Tribes to provide behavioral health services to persons living on tribal land.[26]

As of July 1, 2016, the DBHS merger with AHCCCS will be complete. As further discussed below in the Innovation Plan, the change in the organizational structure at the State level supports the overall efforts to further integrate physical health and behavioral health services for Medicaid members.

Private Health Coverage

Arizona's private health care market is a multi-faceted system that includes a wide range of self-insured and fully-insured plans. As of 2014, 43% of Arizonans were enrolled in employer-sponsored coverage (2,835,200 total enrollees) and 5% were enrolled in non-group coverage (333,500 total enrollees).[27] Of those enrolled in employer-sponsored coverage, 59% of enrollees are covered by self-insured plans.[28] Self-insured plans are much more prevalent among larger firms. In firms with fewer than 50 employees, 15% of enrollees are covered by self-insured plans, compared to 64.9% of enrollees in firms with 50 or more employees.

2013 Self-Insured Coverage: % of Private Sector Enrollees by Firm Size[29]

Total	Fewer than 50 employees	50 or more employees	100–999 employees	1,000 or more employees
59%	15%	64.9%	32.3%	80.2%

In Arizona's fully-insured market, Blue Cross Blue Shield covers the largest number of enrollees (132,940 enrollees in the individual market, 50,711 enrollees in the small group market, and 181,842 in the large group market).[30,31,32] UnitedHealthcare is the second largest carrier based on the total number of enrollees (68,963 in the individual market, 47,662 in the small group market, and 177,174 in the large group market). Humana, Aetna, and Health Net. Inc. fill the role of the third largest carrier in the individual, small group, and large group market, respectively.

The table below identifies the market share by largest insurers in Arizona for the self-insured, individual, small group, and large group markets.

[26] Prior to the merger of AHCCCS and DBHS, DBHS contracted with RBHAs and T/RBHAs.
[27] http://kff.org/other/state-indicator/total-population/
[28] https://www.ebri.org/pdf/notespdf/ebri_notes_06_june15_si-autoiras.pdf
[29] https://www.ebri.org/pdf/notespdf/ebri_notes_06_june15_si-autoiras.pdf
[30] http://kff.org/other/state-indicator/market-share-and-enrollment-of-largest-three-insurers-individual-market/
[31] http://kff.org/other/state-indicator/market-share-and-enrollment-of-largest-three-insurers-small-group-market/
[32] http://kff.org/other/state-indicator/market-share-and-enrollment-of-largest-three-insurers-large-group-market/

2013 Individual Market[33]

Carrier	Market Share
BCBS of Arizona	50% (132,940 enrollees)
UnitedHealthcare	26% (68,693 enrollees)
Humana	6% (16,147 enrollees)

2013 Small Group Market[34]

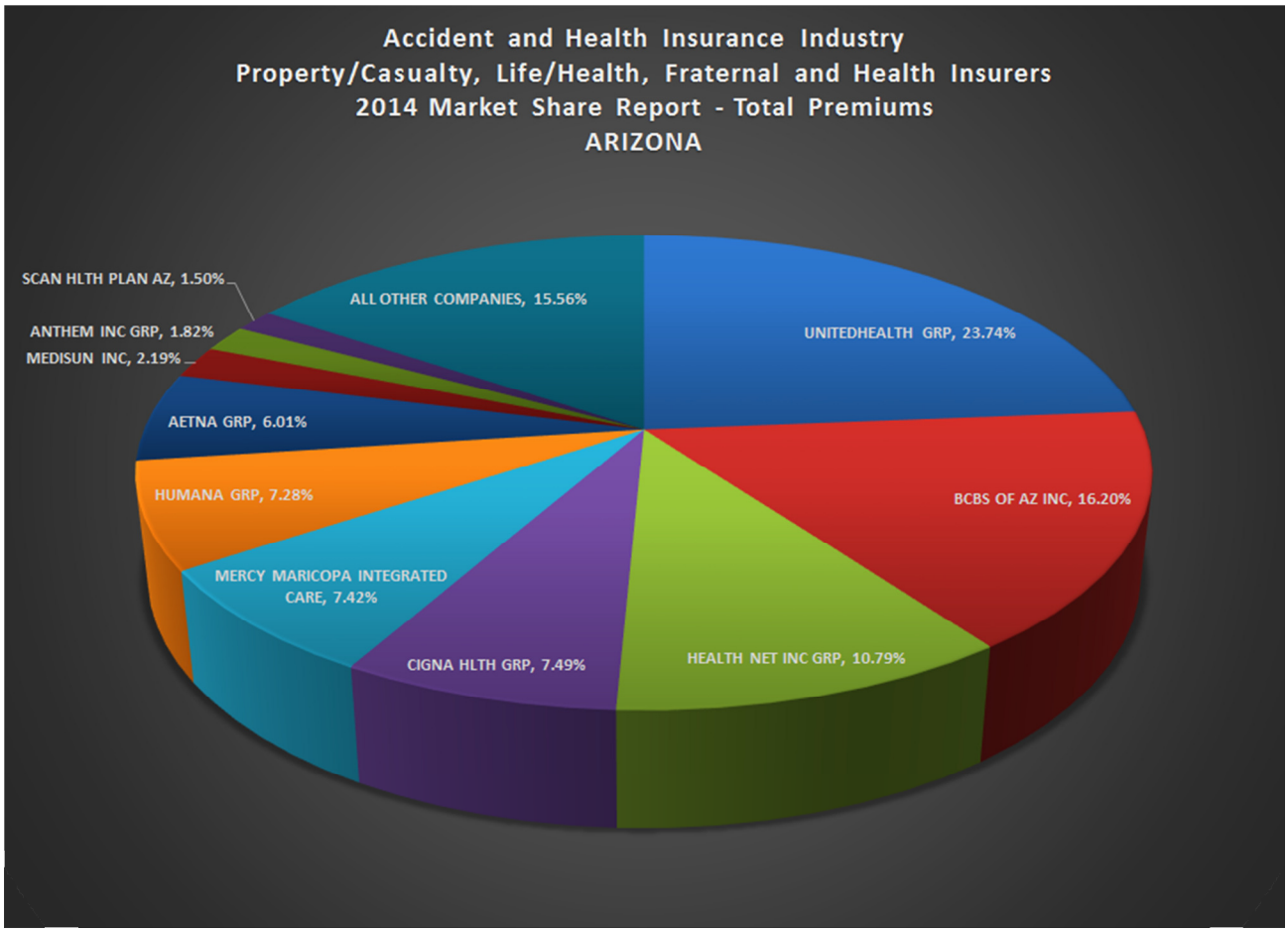
Carrier	Market Share
BCBS of Arizona	23% (50,711 enrollees)
UnitedHealthcare	22% (47,662 enrollees)
Aetna	21% (46,531 enrollees)

2013 Large Group Market[35]

Carrier	Market Share
BCBS of Arizona	32% (181,842 enrollees)
UnitedHealthcare	32% (177,174 enrollees)
Health Net Inc.	13% (72,064 enrollees)

Based on industry information from 2014, the largest private health carriers based on premiums is outlined in the graphic below:

[33] http://kff.org/other/state-indicator/market-share-and-enrollment-of-largest-three-insurers-individual-market/
[34] http://kff.org/other/state-indicator/market-share-and-enrollment-of-largest-three-insurers-small-group-market/
[35] http://kff.org/other/state-indicator/market-share-and-enrollment-of-largest-three-insurers-large-group-market/



Providers in the State

Arizona is home to several health systems; however despite the presence of leading hospital systems, there is still access to care barriers across the State. In order to, among other things better understand access to care for the State's population and to identify primary and secondary health issues of concern in Arizona, the Arizona Department of Health Services composed a report: the State Health Assessment.[36] The following information provides greater detail from the State Health Assessment on the number and type of providers throughout the State.

While this report provides a summary of providers in the State, it is also important to understand perspective. Arizona has relatively low provider-to-population ratios, which has translated to hundreds of HPSA designations. Nationally, there are was an average of 265 active physicians per 100,000 individuals in 2014, compared to an average of 234 active physicians per 100,000 residents in Arizona.[37] Among all states, Arizona ranked 32nd nationally in physician-to-population ratio. A 2013 report from the Health Resources Services Administration found similar trends in low nurse-to-population ratios. Nationally, there was an average of 921 nurses per 100,000 residents, compared to an average of 801 RNs per 100,000 residents in Arizona.

[36] See generally, Arizona State Health Assessment, April 2014 at p. 4.
[37] http://members.aamc.org/eweb/upload/2015StateDataBook%20%28revised%29.pdf

Number and Types of Arizona Providers

Category	Sub-category	# Providers
Physicians		Over 23,000
	Allopathic Physicians (MD)	13,769
	Osteopathic Physicians (DO)	1,936
	Naturopathic Physicians (ND)	1,675
	Physician Assistants (PA)	2,015
	Nurse Practitioners (NP)	4,299
Registered Nurses (RN), Licensed Practical Nurses (LPN) and Certified Nursing Assistances		92,968
Outpatient Treatment Centers		1,043
	Behavioral Health Outpatient	637
FQHCs		139
Pharmacies		1,681
	Chain Pharmacies	930
	Government Pharmacies	6
	Limited Service Pharmacies	70
	Hospital Pharmacies	115
	Other	396
	Individual Pharmacies	164
Pharmacists		9,828
Licensed Behavioral Health Professionals		8,546
	Licensed Professional Counselors	2,340
	Licensed Associated Counselors	791
	Licensed Marriage and Family Therapists	316
	Licensed Associate Marriage and Family Therapists	122
	Licensed Clinical Social Workers	227
	Licensed Master Social Workers	1,207
	Licensed Bachelor Social Workers	118
	Licensed Independent Substance Abuse Counselors	1,406
	Licensed Associate Substance Abuse Counselors	184
	Licensed Substance Abuse Technicians	35
State Licensed Paramedics		6,438
Licensed Emergency Medical Technicians (EMT)		12,689

Category	Sub-category	# Providers
Ground Ambulance Providers		85
Air Ambulance		17 using 102 registered aircraft
Hospitals		129
	Children's Hospitals	2
	Critical Access Hospitals	14
	Long-Term Hospitals	10
	Federal Hospitals	11
	Acute Psychiatric Hospitals	14
	Rehabilitation Hospitals	7
	Short-Term Acute Hospitals	71
Accountable Care Organizations		10

As mentioned, the geographic realities are such that every county has a health professional shortage area designated by the Health Resources and Services Administration. These shortages are outlined below.

Arizona Health Professional Shortage Areas

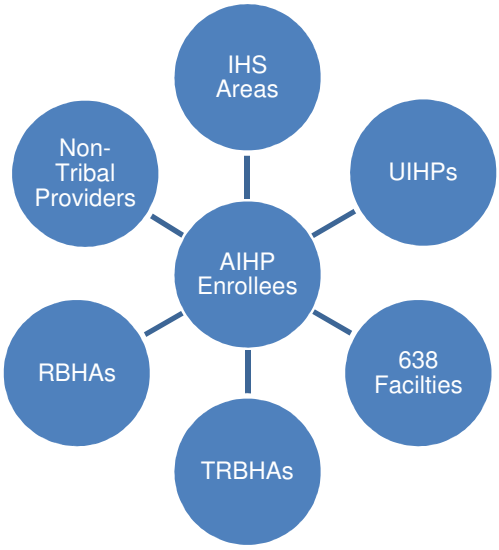
Health Professional Shortage Areas (HPSAs)			
	Primary Medical Care	Dental	Mental Health
Apache	13	13	11
Cochise	11	12	6
Coconino	11	14	10
Gila	5	8	4
Graham	7	7	4
Greenlee	1	2	1
La Paz	3	6	3
Maricopa	36	34	21
Mohave	7	8	3
Navajo	13	14	10
Pima	18	21	13
Pinal	21	18	15
Santa Cruz	2	4	2
Yavapai	9	10	4
Yuma	4	11	4
Total	161	182	111

Indian Health

Arizona is the sixth largest state in the nation based on its geographic size and home to 22 State and federally recognized tribes. There are three Indian Health Service (IHS) areas located in Arizona: the Navajo Area, the Phoenix Area, and the Tucson Area. The Navajo Area Indian

[38] http://datawarehouse.hrsa.gov/topics/HrsaInYour/HrsaInYourState.aspx?geocd=04#

Health Service (NAIHS) covers American Indian health service delivery in the Four Corners area, which includes northeastern Arizona, New Mexico, and Utah. The Phoenix Area Indian Health Service (PAIHS) oversees the delivery of American Indian care throughout most of Arizona, including in parts of Nevada and Utah. The Tucson Area is the smallest in the IHS system, serving the Tohono O'odham Nation and the Pascua Yaqui Tribe in southcentral Arizona.



There are also at least 12 Compact Health Centers (638 Tribal facilities) located around the State. All 638 facilities provide physical health services, and some provide both physical and behavioral health care. Additionally, there are three Urban Indian Health Program (UIHP) grantees in Arizona. The UIHP grantees include Native Americans for Community Action (NACA) located in Flagstaff (northern Arizona), Native Health located in Phoenix (central Arizona), and the Tucson Indian Center located in Tucson (southeastern Arizona).

For behavioral health services, AHCCCS has intergovernmental agreements with Tribal Regional Behavioral Health Authorities (TRBHAs).[39] In total, there are five intergovernmental agreements with Arizona's Tribes to deliver behavioral health services to AI/AN Medicaid enrollees living on tribal land. Agreements have been established for Colorado River Indian Tribes, Gila River Indian Community, the Navajo Nation, the Pascua Yaqui Tribe, and the White Mountain Apache Tribe of Arizona. Behavioral health services to other Tribes are provided and covered by the Regional Behavioral Health Authorities (RBHAs).

Summary Population Health

The Arizona Department of Health Services (ADHS) conducted a State Health Assessment (the "SHA") to identify public health issues. The SHA, released in April of 2014, serves as a surveillance tool to provide an analysis of qualitative and quantitative data to determine the public health status of Arizonans and to identify the State's leading public health issues. The SHA is critical to outlining a comprehensive strategy to better understand the State's health concerns and address gaps within the health care system.[40]

The SHA utilized a combination of the Community Health Status Indicator Project Model and the Healthy People 2020 Map-IT Model. Sixty national health indicators for data reliability, availability, and comparability throughout the State were evaluated. Of those 60 indicators, 30 were chosen as "priority indicators." Further, the SHA utilized the 30 priority indicators to determine high-risk populations in underserved areas.

The SHA was conducted by gathering data from multiple sources, including all 15 county health departments. Community-level data was collected through stakeholder engagement and the development of an assessment for each respective county. The county-level health assessment (CHA) was a two-fold analysis. The primary data analysis required participation from local community members in surveys, focus groups, and strategy meetings. The secondary data analysis acquired data for each respective county through the ADHS Data Advisory Board. Data

[39] As of July 2016, the merger between DBHS and AHCCCS became final.
[40] The SHA is available at http://www.azdhs.gov/documents/director/managing-excellence-program/az-state-health-assessment.pdf. The source for this section is the SHA unless otherwise indicated.

acquired from the CHA identified public health priority issues within each county and served as framework for the development of the county health improvement plan and the SHA, respectively.

Approximately 10,000 people statewide were engaged in identifying the local community health priorities:

- 623 participants in 73 focus groups.
- 8,156 respondents to surveys.
- 318 participants in community forums.
- 297 participants in key stakeholder meetings.

Based on this outreach and resulting data collection, Arizona was able to identify 15 critical public health issues impacting the health and quality of life of a significant number of Arizonans. The Center for Medicare & Medicaid Innovation and the Centers for Disease Control and Prevention core measures of (i) tobacco use, (ii) obesity, and (iii) diabetes emerged as critical public health issues for Arizona.

15 Leading Public Health Issues in Arizona[41]

Leading Public Health Issues	Selected Indicators
Obesity	• One in four Arizona adults (25.2%) is obese. • Income is a driving factor in the rate of obesity. The rate of obesity in low income children has increased from 12% in 2004 to 14.5% in 2011. • Since 1993, Arizona has seen a 19% increase in individuals who are overweight or obese, which is the largest increase in the nation.
Tobacco Use	• Trends in adult smoking decreased from 2002 to 2010 (23.1% to 15%), placing Arizona below the national rate of 17.2%. • Use of tobacco products by youth increased slightly from 6.9% in 2009 to 7.1% in 2011.
Substance Abuse	• Fourteen percent (14%) of Arizona adults and 15.7% of Arizona youth reported binge drinking in 2010. • From 2006 to 2010, the number of deaths where prescription drugs are listed on death certificates has increased significantly, almost doubling for oxycodone/hydrocodone (from 91 to 180), and almost tripling for benzodiazepines (from 56 to 155). • Rates of youth illegal drug use deceased over the past few years, including marijuana use. • Marijuana use by youth is more than twice the US baseline (14.3% compared to 6.7%). There has been a decrease in the number of youth who view smoking marijuana regularly as harmful, from 55.8% in 2008 to 45% in 2012.
Teen Pregnancy	• Arizona has had a dramatic decline of 29% in the teen pregnancy rate since 2007. • There were 30,000 children born to mothers younger than age 20 from 2008 through 2010.
Creating Healthy Communities and Lifestyles	• Since 2002, there has been only minimal improvement in the number of people eating the recommended number of servings of fruits and vegetables a day from 22.7% to 25.2%. • Twenty percent (20%) of Arizonans indicated they have no social-emotional supports.
Health care-Associated Infections (HAI)	• At least one in three HAIs is preventable. • Patients in Arizona hospitals had 42% fewer central line-associated bloodstream infections in 2011 than would have been predicted.
Suicide	• The rate of intentional self-harm as a leading cause of death has continued to increase from 14.6 per 100,000 in 2000 to 16.7 per 100,000 in 2010. • The population age 65 and older has a significantly higher rate of suicide at 21.2%.
Diabetes	• The percentage of adults told by a doctor they have diabetes increased from 7.5% in 2005 to 9.1% in 2010. • In 2010, American Indians in Arizona were four times more likely to die from diabetes than the average Arizonan.
Heart Disease	• Heart disease is the second leading cause of death in Arizona. • The mortality rate (per 100,000) for heart disease decreased by 30% from

[41] Leading Public Health Issues Table: Arizona State Health Assessment, 2014.

Leading Public Health Issues	Selected Indicators
	206.1 in 2000 to 143.3 in 2010. • While the mortality rate decreased for both men and women during this time period, the rate for men remains substantially higher (179.8 per 100,000).
Other Chronic Disease (Cancer, Respiratory Disease & Asthma)	• Cancer was the leading underlying cause of death to Arizona residents in 2010, accounting for 10,423 deaths (22.7%). • Chronic lower respiratory disease was the third leading underlying cause of death in 2010, accounting for 2,892 (6.3%) of total deaths.
Oral Health	• Children ages 2 through 4 have tooth decay rates far beyond national targets. Arizona is the third worst in the nation for children ages 2 through 4: 30% have untreated tooth decay. • More than 54% of children age 3 have never visited a dentist. • The rate of Arizona adults receiving a dental visit within the previous year has improved only slightly from 1999 at 68.3% to 2010 at 69.5%.
Unintentional Injury	• Unintentional injuries are the leading cause of death for Americans and for Arizonans age 1 to 44 and a leading cause of disability for all ages, regardless of sex, race/ethnicity, or socioeconomic status. • In 2010, more Arizonans died from poisoning and falls than from motor vehicle crashes. • In 2011, the Arizona Child Fatality Review Teams determined that 292 child deaths (35% of all child fatalities) were probably preventable.
Access to Health Insurance Coverage	• In 2010, 18.5% of adults had no health insurance coverage.[42] • More than 18% of adults indicated they could not afford needed health care; a dramatic increase from 11.8% in 2003 and more than the national rate of 16.9%. • In 2011, 11.3% of Arizona children did not have health insurance (more than 200,000).
Access to WellCare	• More than 22% of Arizona adults reported they did not have a personal doctor or health care provider.[43] • Arizona rates for preventive care related to prostate cancer screening, routine mammography, and routine PAP smears are higher than national rates.
Behavioral Health Services	• More individuals with serious mental illness (SMI), through Medicaid Restoration, now have increased benefits that include peer and family support, Assertive Community Treatment/Case Management, living skills and personal care, supported employment, residential room and board, respite, transportation, and crisis services. • Overall satisfaction with the services provided through our public behavioral health system has improved significantly in the past five years with more than 90% of our consumers liking the services they receive and willing to recommend to a friend or family member. • Between 7,500 and 9,000 individuals with SMI (with incomes between 100% and 133% of the federal poverty level) are projected to begin receiving public mental health services this year as a result of the

[42] Please note that the data included is taken from the SHA that relied on information from 2010. Arizona did expand its Medicaid program in 2014.
[43] Please note that the data included is taken from the SHA that relied on information from 2010. Arizona did expand its Medicaid program in 2014.

Leading Public Health Issues	Selected Indicators
	Governor's Medicaid Restoration Plan.

Upon completion of the SHA, ADHS began working with stakeholders to identify health priorities among the numerous health issues identified in the SHA, and to establish measurable objectives for each priority health area and strategies to achieve the objectives. This work was accomplished through stakeholder workgroups convened for the task of developing high-impact evidence-based strategies targeted at improving their assigned health priority.

In April 2016, this collaborative work across state agencies, health care providers, community representatives, and other stakeholders culminated in the Arizona Department of Health Services issuance of the Arizona Health Improvement Plan (AzHIP). The plan identifies strategic issues and desired health and public health system outcomes to be achieved through the coordinated activities of the many partners who provided input throughout the process. Fourteen health priorities were identified. Ten health priorities and strategies have been targeted for achieving measureable success over the next five years, with implementation beginning in 2016. AzHIP strategies targeting the remaining four health priorities: Access to Care, Mental Health, Suicide Prevention, and Substance Abuse will be released in late summer 2016.

Arizona's Leading Health Priorities	
Access To Care	Maternal & Child Health
Behavioral Health Services	Obesity
Cancer	Oral Health
Cardiovascular Disease & Stroke	Substance Abuse
Chronic Lower Respiratory Disease (CLRD) & Asthma	Suicide
Diabetes	Tobacco
Healthcare-Associated Infections (HAIs)	Unintentional Injury (UI)

Many of the leading health priorities are prevalent in the focus populations associated with SIM Innovation Plan strategies.

Outlined below is an assessment of gaps in access to care and health care disparities identified through the SHA and AzHIP for these populations and the relevant strategies noted in the AzHIP to improve health across these areas.

American Indians

Arizona is home to 22 federally-recognized tribes making up approximately 5.2% of the State's population (based on the 2010 Census). As of 2010, 30.6% of Arizona's American Indian population identified as uninsured. American Indians between the ages 18 and 64 had a higher uninsured rate of 37%. Approximately 42% of the American Indian population in Arizona is enrolled in Medicaid.[44] Health disparities within Arizona's American Indian population remain a chronic problem despite efforts to help bridge gaps in care.

One of the primary health problems with a disproportionate impact on American Indians is diabetes, with approximately 9% of Arizona's American Indian population having a diabetes

[44] Based on U.S. Census and information provided by AHCCCS.

diagnosis. While approximately 9% of all Arizonans are diagnosed with diabetes, American Indians are more likely to develop diabetes than non-Hispanic Whites.[45] Further, the diabetes mortality rate for Arizona American Indians was nearly four times greater than the overall death rate of the average Arizonan (79.3 per 100,000 people compared to 20.1 per 100,000 people).[46]

As the diabetes rate continues to increase across Arizona,[47] co-morbidities, such as obesity and cardiovascular disease are becoming more prevalent. American Indians report the highest incidence of obesity in Arizona at 33.2% compared to 8.4% Asian/Pacific Islanders, 22.6% other, 24.4% White Non-Hispanic, 26.6% Black, and 31.2% Hispanic. In addition, heart disease is identified as the leading cause of death among the American Indian population.

In 2009, the national benchmark for the incidence of cancer rates in the American Indian population was 279.3 per 100,000 people, as compared to the American Indian population in Arizona, which was 306.8 per 100,000 people, making cancer the second leading cause of death for American Indians in Arizona. As of 2011, approximately 20% of the American Indian community engaged in tobacco use[48], which is higher than the current rate of adults statewide engaged in tobacco consumption (15.65%). In addition, 93% of American Indian children have tooth decay (as compared to 66% of non-Hispanic White children and 80% Hispanic children).

Moreover, the rate of unintentional injuries occurring in the American Indian population is higher when compared to other populations. American Indian children and young adults (up to age 24) are more likely to die from motor vehicle crashes when compared to other populations. Unintentional injury is identified as the third leading cause of death among American Indians in Arizona.

Similarly, for the American Indian population, as well as other minority populations, behavioral health conditions are frequently inadequately addressed.[49] Individuals may experience symptoms that are undiagnosed, under-diagnosed, or misdiagnosed due to cultural, linguistic, or historical reasons.[50] As of 2010, the American Indian population had the youngest median age of death by intentional self-harm at 27 years old, delineating a large discrepancy between the American Indians and their White non-Hispanic counterparts, for whom 51 years was the median age of death by intentional harm. Throughout Arizona, American Indians reported the highest rate of incidents in which they felt psychological distress (24%) in the past thirty days, when compared to their counterparts (Hispanics 22%; African Americans 21%; non-Hispanic Whites 15%; and Asian/Pacific Islanders/Native Hawaiians 14%).[51]

Mental health conditions strongly correlated with substance use disorder among the American Indian population. According to the Arizona Health Survey[52], 10% of American Indians reported consuming alcohol prior to the age of 12; this number was considerably higher when compared to their counterparts (non-Hispanic Whites 8%; Hispanics 5%; African Americans 4%, Asian/Pacific Islanders 2%).[53] Various efforts are underway to address these population health issues as further described in Section IV of the Innovation Plan.

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[45] See Arizona State Health Assessment, April 2014 at p. 60.
[46] Ibid.
[47] See Arizona State Health Assessment, April 2014 at p. 59.
[48] CC State Highlights on Smoking & Tobacco Use available at http://www.cdc.gov/tobacco/data_statistics/state_data/state_highlights/2012/states/arizona/index.htm
[49] See, *American Psychological Associations:* http://www.apa.org/about/gr/issues/health-care/disparities.aspx
[50] Ibid.
[51] See http://www.arizonahealthsurvey.org/wp-content/uploads/2010/12/ahs-2010-SubstanceUse-Dec10.pdf
[52] See http://www.arizonahealthsurvey.org/wp-content/uploads/2010/12/ahs-2010-SubstanceUse-Dec10.pdf
[53] See http://www.arizonahealthsurvey.org/wp-content/uploads/2010/12/ahs-2010-SubstanceUse-Dec10.pdf

Justice Involved Individuals

National research has found that 80% of individuals released from incarceration have chronic medical, psychiatric, or substance use disorders, yet only 15% to 25% report visiting a physician outside of the emergency department in the first year post release.[54] Chronic disease is prevalent among the population with higher rates of tuberculosis, HIV, Hepatitis B and C, arthritis, diabetes, and sexually transmitted disease compared to the general population.[55] Over half of prison and jail inmates have a mental health disorder, with local jail inmates experiencing the highest rate (64%).[56] These disorders include mania, major depression, and psychotic disorders.[57] Incarcerated individuals who have a mental health disorder are more likely than those without a disorder to have been homeless in the year prior to their incarceration, less likely to have been employed prior to their arrest, and more likely to report a history of physical or sexual abuse. Moreover, the majority of inmates with a mental health disorder also have a substance or alcohol use disorder.[58]

National Prevalence of Behavioral Health Conditions Across Prisons and Jails

Facility	% Female Inmates with Behavioral Health Conditions	% Male Inmates with Behavioral Health Conditions
Federal Prison	61%	44%
State Prison	73%	55%
Local Jails	75%	63%

In looking at current data being collected across the state, the number of individuals incarcerated with serious mental illness (SMI) and individuals with behavioral health conditions is overwhelming and further highlights the need for action.

- As of March 2016, the Arizona Department of Corrections had 42,681 inmates with 26% requiring ongoing mental health services.[59]
- In Pima County of those in detention, 51% were on a mental health caseload, and 8% were designated as SMI.[60]
- In Maricopa County individuals diagnosed with SMI comprise nearly 10% of the jail population.[61]

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[54] 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.
[55] National Institute of Corrections, "Solicitation for a Cooperative Agreement—Evaluating Early Access to Medicaid as a Reentry Strategy," Federal Register 76, no. 129 (2011): 39438-39443; Ingrid Binswanger, Nicole Redmiond, and LeRoi Hicks, "Health disparities and the criminal justice system: an agenda for further research and action," *Journal of Urban Health 89, no. 1* (2012): 98–107; and Laura Maruschak, *Medical Problems of Prisoners* (Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, April 2008),
[56] *See* KiDeuk Kim, Miriam Becker-Cohen, and Maria Serakos, "The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System: A Scan of Practice and Background Analysis", March 2015 at pgs. 8-9, Urban Institute.
[57] Ibid.
[58] Ibid.
[59] See The Arizona Department of Corrections, "Corrections at a Glance" February 2016, available at https://corrections.az.gov/reports-documents/reports/corrections-glance
[60] *Briefing Paper on Insurance Status of Individuals in Criminal Justice System Profile of Individuals Released from PCADC, prepared on November 25, 2013.*
[61] Maricopa County Proclamation "Stepping Up Initiative to Safely Reduce the Number of People with Serious Mental Illnesses in Jails", May 4, 2015.

- In Maricopa County Adult Probation, approximately 54% of probationers under active supervision have an identified need for mental health and/or substance use disorder treatment.[62]

Further complicating the high prevalence of behavioral health conditions in the justice system population is the fact that even with Medicaid expansion in the State, many individuals either have no health care coverage or are unsure of their health insurance status upon release. A recent report based on self-reported information from Maricopa County probation is that 16% of probationers were uninsured and 4% were unaware of their health insurance status.

On average, 9,000 Arizona Medicaid beneficiaries are incarcerated in a given month. In fiscal year 2015 of the approximately 120,000 individuals that transitioned from incarceration into the community, approximately 42,000 were enrolled (or re-enrolled if eligibility was suspended) in AHCCCS. AHCCCS analysis shows that there are a significant number of individuals who are eligible for Medicaid but not enrolled upon release. Indeed, Pima County probation recently estimated that approximately 30% of its probationers appeared to be Medicaid eligible but had not been covered by Medicaid prior to incarceration. In addition, traditionally there has been very little care coordination effort between the jail/prison system and the Medicaid delivery system for various reasons including but not limited to the Medicaid payment rules related to incarcerated individuals. As such, individuals often are released without proper medications, follow-up appointments and a true understanding of how to appropriately access the system. Various efforts are underway to address these population health issues as further described in Section IV of the Innovation Plan.

Individuals with Behavioral Health Needs

On a national level according to the U.S. Government Accountability Office, the most common conditions and services among high expenditure Medicaid-only enrollees (the top 5% with the highest expenditures within each state), are mental health conditions. Nationally, the percentage of Medicaid individuals with behavioral health conditions and co-occurring conditions based on fiscal year 2011 data is as follows:[63]

Condition	Asthma	Diabetes	HIV/AIDS	Mental Health	SUD	Delivery/ Childbirth	LTC	None
Mental Health	11.92	7.03	.76	-	15.2	3.81	4.06	65.92
Substance Use Disorder	12.90	10.48	2.12	51.41	-	5.14	3.83	37.35

Among high expenditure Medicaid-only enrollees, the percentage of individuals with behavioral health conditions and co-occurring conditions based on fiscal year 2011 data is as follows:[64]

Condition	Asthma	Diabetes	HIV/AIDS	Mental Health	SUD	Delivery/ Childbirth	LTC	None
Mental Health	17.57	18.71	2.83	-	26.73	4.02	11.85	42.94

[62] Maricopa County Adult Probation Department, Probationers with GMHSA Needs, November 2015.
[63] See GAO 15-460, Medicaid: A Small Share of Enrollees Consistently Accounted for a Large Share of Expenditures, May 2015 at page 13.
[64] Ibid.

Condition	Asthma	Diabetes	HIV/AIDS	Mental Health	SUD	Delivery/ Childbirth	LTC	None
Substance Use Disorder	20.84	22.57	6.14	70.83	-	4.52	10.23	15.56

Behavioral health conditions are also prevalent among Medicaid high-cost individuals in Arizona. Of the high expenditure Medicaid-only enrollees in Arizona (defined as the 5% with the highest expenditures within Arizona), 39.23% have mental health conditions and 14.07% have a substance use disorder.[65,66]

Arizona's population of over 40,000 individuals with a serious mental illness (SMI) die an average of 31.8 years earlier than the general population. Premature deaths are attributed largely to i) the impact of co-morbid chronic physical health conditions that are not adequately managed, and ii) the loss of life from suicide.[67] Other issues related to co-morbid conditions for this population include:

- Tobacco consumption in individuals diagnosed with a behavioral health condition is three-times higher as compared to the general population (75% versus 15%, respectively).
- Obesity is a prevalent co-morbidity associated with behavioral health condition. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), nearly half of the individuals suffering from binge-eating problems had a history of depression.
- High prevalence of cardiovascular disease risk factors can be explained in part by unfavorable psychiatric side effects.
- Binge drinking is often associated with numerous health problems, including damage to liver cells, inflammation of the pancreas, various cancers, high blood pressure, and psychological disorders.
- Additional risk factors include other substance use, poverty, and social isolation.

The acknowledgment of issues stemming from a fragmented delivery system is not new to Arizona. However, as the State has moved towards value based payments, it has become clear that strategies to address the system fragmentation differ throughout the State. Arizona continues to believe that pursuit of VBPs will facilitate movement along the coordinated care continuum, and, through the SIM Model Design, Arizona has developed specific goals and strategic initiatives to test different methods of advancing integrated care. Various efforts are underway to address these population health issues as further described in Section IV of the Innovation Plan.

Value Based Purchasing Pursuit

To fully appreciate how Arizona has narrowed its SIM planning design to specific initiatives, it is important to first understand some of the State's delivery system efforts that have laid the groundwork for Arizona's Innovation Plan. In 2014, AHCCCS released a payment modernization plan (the "SFY 2014 Payment Modernization Plan") that outlined the current Medicaid and D-SNP health care delivery and payment system in Arizona and the actions needed to transform the system.[68] The SFY 2014 Payment Modernization Plan identified three broad-based goals:[69]

[65] United States Government Accountability Office, A Small Share of Enrollees Consistently Accounted for a Large Share of Expenditures, May 2015, see page 33.
[66] Note that to the extent individuals receiving long-term care services were not included in this calculation, the percentages of high cost individuals with behavioral health conditions would be significantly higher.
[67] Arizona Health Improvement Plan, page B15 at http://www.azdhs.gov/documents/operations/managing-excellence/azhip.pdf
[68] AHCCCS Payment Modernization Plan SFY 2014 available at https://www.azahcccs.gov/reporting/Downloads/PaymentModernizationPlan_SFY2014.pdf.

- AHCCCS must promote and facilitate a culture of learning and growth around payment modernization both internally and externally.
- AHCCCS must leverage its position among Arizona health care payers to promote increased cost and outcome transparency in the health care delivery system.
- AHCCCS must deploy a variety of strategies that leverage health plans and other stakeholders, resulting in value-based purchasing advancing up the payment modernization continuum.

In addition, the SFY 2014 AHCCCS Payment Modernization Plan outlined payment modernization initiatives including, but not limited to, the following:[70]

- Determining the ongoing structure and methodologies by which AHCCCS will further incentivize, support, and prescribe the contracted MCOs' adoption of value-based models of care delivery and payment, while continuing to foster MCO and provider competitive innovation.
- Supporting increased development of patient-centered care models, which improve care access and involve patients in their health decisions and options. Patient-centered care leads to better outcomes, lower costs, and an enhanced care experience.
- Leveraging and developing AHCCCS' data analytics capabilities to enable effective design, development, and measurement of new care delivery models.

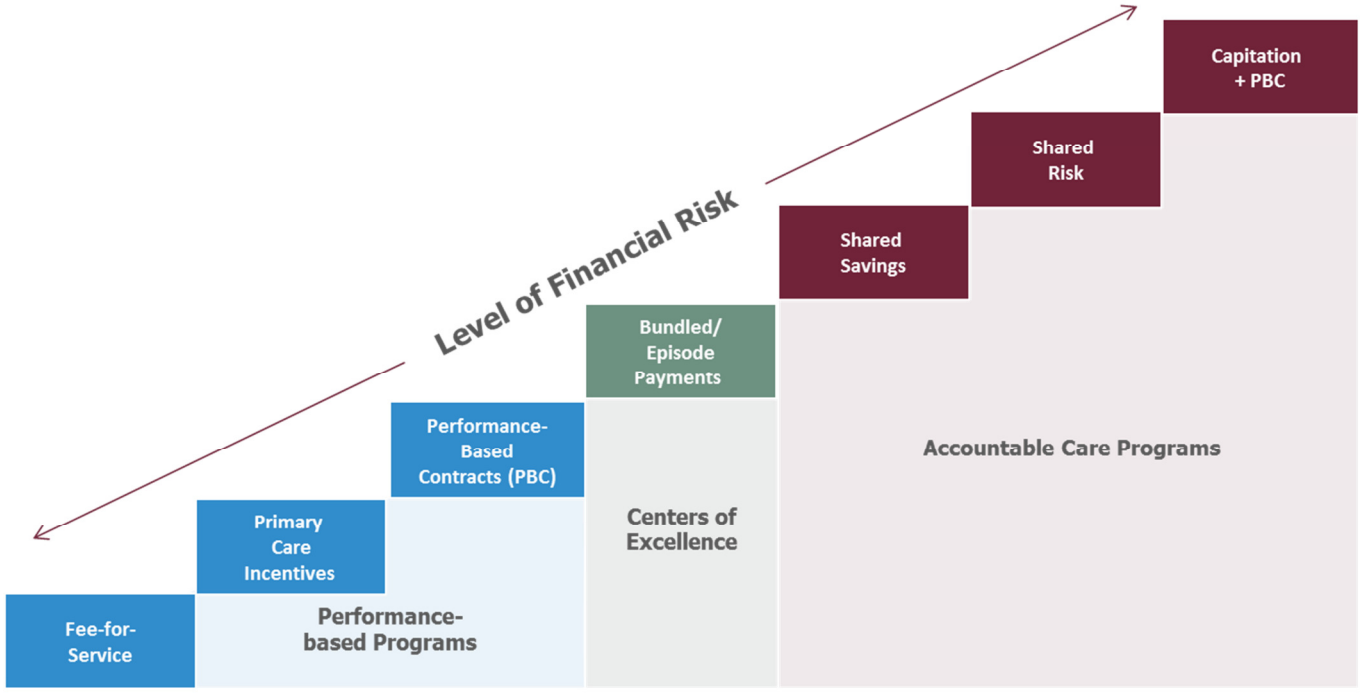
The SFY 2014 Payment Modernization Plan recognized that transformation will be a long-term process, and that AHCCCS will continue to maintain an open dialogue with stakeholders and a commitment to continuous learning and improvement for payment modernization strategies. Similarly, the AHCCCS Strategic Plan for 2015-2019 (that outlines goals and strategies that are critical to AHCCCS' continued success) also identifies payment reform strategies specific to the State's goal "to pursue and implement long-term strategies that bend the cost curve while improving member health outcomes." The strategies identified include the following:[71]

- Implement value based payment (VBP) requirements for AHCCCS contractors measured by percentage of medical spending on value-based arrangements.
- Modernize hospital payments to better align incentives, increase efficiency, and improve the quality of care provided to members.
- Establish robust payment modernization stakeholder input opportunities.

AHCCCS has taken on the role of establishing broad goals for the system and incentivizing and encouraging its contractors to be creative in implementing alternative payment model arrangements to best meet the needs of their own unique populations, provider mix, and regional/geographic differences. As such, AHCCCS has developed general contract language to ensure its contractors have the ability to pursue many different strategies along the value-based continuum illustrated below.

AHCCCS is advancing value based payment along a continuum of increasing accountability and risk

[69] See SFY 2014 Payment Modernization Plan at page 3.
[70] The full list of initiatives is described on page 5 of the SFY 2014 Payment Modernization Plan.
[71] Please note that these initiatives have further developed over time and have been slightly revised from how they were proposed in the Strategic Plan.



Degree of Care Provider Integration and Accountability

A summary of the current contract language that demonstrates the requirements and permitted flexibility for AHCCCS contractors in utilizing alternative payment model arrangements is provided in Exhibit C.

AHCCCS also maintains a Contractor Operations Manual (the "ACOM") that includes further detail regarding its expectations and requirements for alternative payment model arrangements.[72] The contractors have the flexibility to utilize different VBP strategies outlined in the ACOM. The ACOM defines possible VBP strategies as follows:

- Value based payment — A reimbursement model that aligns payment more directly to the quality and efficiency of care provided by rewarding providers for measured performance across the dimensions of quality.
- Performance-Based Contract — A purchasing strategy in which a portion of provider's total potential payment is tied to performance on cost-efficiency and quality performance measures. While providers may still be paid fee-for-service for a portion of their payments, they may also be paid a bonus or have payments withheld. The bonus is not paid unless the provider meets cost-efficiency and/or quality targets.
- Bundled Episode Payments — A purchasing strategy in which the provider is reimbursed on the basis of expected costs for clinically defined episodes that may involve several practitioner types, several settings of care, and several services or procedures over time. The provider receives a lump sum for all health services delivered for a single episode of care.
- Shared Savings – A purchasing strategy, which provides an incentive for providers or provider entities to reduce unnecessary health care spending for a defined population of patients, or for an episode of care, by offering providers a percentage of any realized net savings (e.g., upside risk only).

[72] AHCCCS Contractor Operations Manual (ACOM) is available at http://www.azahcccs.gov/shared/ACOM/Chapter300.aspx.

- Shared Risk — A purchasing strategy in which payer and provider share upside and downside risk against an agreed-upon budget after meeting quality and experience thresholds. This model refers to arrangements in which providers accept some financial liability for not meeting specified financial or quality targets.
- Capitation + Performance — A purchasing strategy in which a provider or group of providers are reimbursed a set amount for each enrolled person assigned to them, rather than paying providers for individual services. Providers, or groups of providers, are expected to assume a certain level of financial risk under a capitated payment system. The provider is responsible for the quality, cost, and experience outcomes of a specific population of patients and receives payments based on per member per month, rather than fee-for-service. To be considered as a value based purchasing strategy, payment adjustments must be made based on measured performance and patient risk. It is intended to promote efficient and high quality care and coordination among providers for population health management.

AHCCCS has outlined its expectations for VBP model arrangements through contract year 2019. Specifically, the AHCCCS contractors will be required to meet the percentages of VBP as described in the chart below. Similar to the Centers for Medicare & Medicaid's (CMS) goals for Medicare for 2019 (to reach 50% of alternative payments and 90% if including fee-for-service linked to quality), Arizona is requiring its acute and long-term care contractors to also reach 50% VBP by 2019.

Value Based Payment Contractual Requirements

Program	CYE 15	CYE 16	CYE 17	CYE 18	CYE 19
Acute	10%	20%	35%	50%	50%
ALTCS EPD	5%	15%	25%	35%	50%
RBHA		5%	15%	25%	35%

Failure to meet the VBP contract terms results in the MCOs not being able to participate in the quality distribution payments available for meeting quality performance measures, and the associated financial incentives.

Since establishing the VBP initiative, AHCCCS has revised each subsequent contract year informed by MCO and provider experience with delivery system and payment transformation initiatives using the following principles:

- AHCCCS' role is to establish broad goals for systems; not to define specific alternative payment methodologies.
- Goals and progress are incremental.
- Pursuing VBP requires resources and leadership commitment.
- It is necessary to create a culture of learning.
- Improved access to actionable data is required.

- Defining measures is challenging.

As described above, AHCCCS has developed a framework for its contractors to pursue VBPs with providers through contractual language and policy. This approach has resulted in AHCCCS' contractors developing arrangements with providers that are tailored to their unique populations and geographic differences. In support of this innovation and to begin identifying successes and best practices, during quarterly meetings with AHCCCS leadership and other contractors, AHCCCS contractors present one of their VBP arrangements, share lessons learned from the arrangement, and report on the level of success. Agendas and materials from these meetings (including the specific details presented on payment transformation) are posted on the AHCCCS website.[73] Some examples of current VBPs being used by AHCCCS contractors with providers include the following:

- Adding a shared savings component based on total cost of care for a provider on a case rate payment.
- Utilizing bundled payments for lower extremity joint replacements and expanding to cardiac bundles.
- Using a shared-risk contract where the shared amount depends on the provider's performance compared to the plan's other provider groups' performance in the county.
- Having patient-centered medical home (PCMH) agreements with certain provider groups where there is a PMPM incentive for PCMH support [which is non-encounterable] and a quality incentive payment funded by savings resulting from decreased ED visits and hospitalization.
- Utilizing multiple FQHC agreements with a combination of shared savings [budget vs. actual MLR] and quality incentives tied to performance against target. If the threshold of actual MLR better than budget is met, the incentive payment amount is tiered according to quality results.
- Having a hospital re-admission incentive method by measuring actual readmissions against the goal. The average cost per admission is calculated, then a shared savings incentive amount is tied to a tiered percentage of the actual savings resulting from the decrease in readmissions.

While AHCCCS has emerged as a leader in Arizona's efforts to reform the payment system in support of better health care and improved health outcomes, the State believes that the efforts used in the Medicaid program will expand to other payers in the State health care system as providers and health plans become more experienced with VBP arrangements and as data sharing improves. Moreover, the Medicaid program currently covers over 25% of the State's population (and is growing), so reforms implemented by AHCCCS will impact over 1.8 million people. The number of individuals impacted by the reforms (including the 60,000 providers that are registered with AHCCCS as Medicaid providers) will likely influence the overall health care payment system. In addition, AHCCCS has found that its policies have in the past impacted more than just the Medicaid program. For example, AHCCCS' contractual requirement for health plans to increase e-prescribing is expected to result in statewide improved adoption statewide of e-prescribing. AHCCCS expects the same results with VBP implementation throughout the State.

In addition to the VBP contractual requirements in the Medicaid program, the State is implementing a VBP adjustment to FFS payments made to (i) hospitals that participate in The Network by June 1, 2016 and achieve Meaningful Use Stage 2 for Program Year 2015 (a .5% fee increase), (ii) nursing facilities that meet or exceed the statewide average for administrative of pneumococcal vaccinations (a 1% fee increase), and (iii) providers who are registered as

[73] This information is available at http://www.azahcccs.gov/commercial/.

Integrated Clinics (10% increase for certain services). The purpose of these VBP payments are to distinguish facilities that have committed to supporting designated actions to improve patients' care experience, improve members' health, and reduce cost of care growth.[74]

It should also be noted that all of AHCCCS Acute and EPD plans have a Medicare dual eligible special needs plan (D-SNP) and the ALTCS/EPD contractors are required to meet minimum VBP arrangements in their D-SNP plan. For calendar year ending 2016, the contractors are required to have 15% of their D-SNP payments in VBP arrangements. In addition, some of the Medicaid contractors also offer qualified health plans on the federally-facilitated marketplace. It is expected that the contractors will apply lessons learned from VBP models to these product lines as well.

[74] See Public Notices for these payments available at https://azahcccs.gov/shared/Downloads/News/ValueBasedPaymentRateDifferentialPublicNotice1232015Final.pdf and https://azahcccs.gov/AHCCCS/Downloads/PublicNotices/rates/ValueBasedPaymentRateDifferentialPublicNoticeForICs04222016Final.pdf

IV. Proposed Payment and Delivery System Initiatives

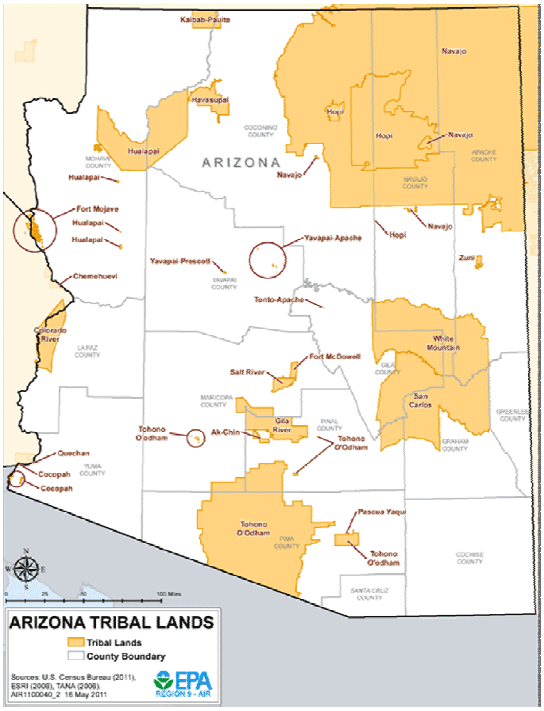
As highlighted previously in Section III, the State's population health assessment and initial experience with VBPs further highlighted gaps in the current health care delivery system for vulnerable populations. In order to close those gaps and realize improved health care outcomes, the Arizona SIM Model Design focuses on strategic implementation of delivery system reform initiatives.

Care Coordination for Individuals Served by the American Indian Health Program

Current Delivery System Gaps

Arizona is home to 22 State and federally recognized tribes in locations ranging from very rural, frontier areas to urban centers. Tribal lands are diverse as is the American Indian population, and the delivery system infrastructure is spread over a geographically large area, making access to care difficult or disjointed in many cases.

The map below shows the location and size of tribal lands in Arizona.



The point of services for American Indians varies to a large extent. American Indians (including those who are enrolled in Medicaid), regardless of whether they live on or off tribal land, can receive services at any Indian health facility, including IHS sites, Tribal 638 programs and facilities, and Urban Indian Health Programs. While the issue of provider choice is important, the lack of care coordination among providers and across the care continuum challenges service delivery for American Indians. This fragmented system of care is evident both (i) among Indian health providers and (ii) between Indian health providers and non-Indian health providers. For example, it is a common occurrence that primary care providers caring for individuals in Indian health organizations are not aware of their patients' admission to or discharge from a hospital outside their communities. Consequently, appropriate discharge planning and follow–up care does not routinely occur, sometimes resulting in avoidable emergency department (ED) visits or hospital re-admissions. Likewise, the attending hospital or ED provider who is seeing the patient for the first time is faced with providing care without complete knowledge of the patient's medical

history, including medications. This significant fragmentation of services is believed to be a major barrier to solutions that address health disparities and improved outcomes for American Indians in Arizona.

American Indians with chronic or complex conditions, including those with serious mental illness, are often most negatively impacted by system fragmentation. Continuity of care, including medication and other therapies, are critical for those with serious health conditions. However, the current delivery system does not provide the infrastructure to support appropriate care coordination.

A key contributor to care fragmentation stems from inadequate HIT infrastructure and connectivity. Health information for American Indians resides in different electronic health record (EHR) systems, with limited exchange of information needed to coordinate care. As described in the HIT section of the Innovation Plan, IHS, Tribal 638 facilities, ITUs, and non-Indian health providers often utilize distinct HIT/EHR systems and databases that presently do not communicate with each other, prohibiting the exchange of information needed to provide appropriate services and coordinate care.

The limited resources across the IHS and Tribal 638 facilities present another barrier to reducing fragmentation in the system. Generally, these organizations do not have the resources to hire additional staff to perform care coordination or funds to purchase upgrades to their HIT/EHR systems that would support improved coordination.

In spite of significant resource limitations, IHS has been working across its national system to increase coordination of care through its Improving Patient Care (IPC) Program, a patient-centered medical home model. The IPC Care Model is based on the Chronic Care Model developed by the MacColl Center for Health Care Innovation. The IPC model modified the original care model to reflect the unique features of health care in the Indian health system. The model also has been adapted to address the strong role of family and the need to fully integrate the community and the Tribes into the vision for health care. Robust therapeutic relationships are a key element in this IPC model.

Within the Medicaid program, American Indians may enroll in either the FFS AIHP or one of the AHCCCS-contracted managed health plans. For American Indian Medicaid eligible residents who live on tribal land and do not elect a Medicaid enrollment choice, enrollment defaults to AIHP. In contrast, if the American Indian Medicaid eligible resident does not live on tribal land, and does not make a Medicaid enrollment choice, the individual is auto-assigned to a managed care plan based on factors such as family participation in the plan. Choice is key; American Indian Medicaid enrolled individuals can change enrollment from AIHP to a managed care plan at any time and vice-versa. These enrollment options have created churn between managed care and AIHP. In general, however, one third of Arizona's American Indian population is enrolled in AIHP and, as of May 2016, the program had approximately 120,000 members.

Approximately two-thirds of AIHP's $1 billion service budget is spent at IHS and Tribal 638 facilities. In AIHP, any AHCCCS-registered provider who has not opted out of FFS can also provide services to American Indian Medicaid members. AHCCCS does not contract with individual providers in FFS, and members do not need referrals prior to receiving care from a registered provider.

Given these realities in the delivery system and provider networks for American Indian Health Program members, the resulting care is often fragmented and fails to address the "whole" person.

AHCCCS with its stakeholders has identified goals and accompanying tasks that will help bridge existing gaps in care for the State's American Indian population through enhanced care coordination and HIT.

The State and Tribes believe a key approach to reduce the health disparities for the American Indian population in Arizona is to enhance care coordination efforts, particularly for high needs/high cost individuals, and decrease system fragmentation for those served by the AIHP. Specifically, AHCCCS seeks to expand care integration and decrease system fragmentation through enhanced care coordination and expanded use of HIT in AIHP. AHCCCS has instituted care coordination processes for individuals with the very highest needs. But this needs to be brought to scale. This delivery system reform will have an immediate impact on approximately 42% of the American Indian population in Arizona and it is expected to be leveraged to reach other American Indian individuals in the community who may receive care from IHS or other Indian health providers who also participate in Medicaid.

Stakeholder Efforts

AHCCCS has a robust stakeholder engagement process with its Indian health partners as described in the Tribal Consultation Policy developed in 2006.[75] As further detailed in the Tribal Consultation Policy, AHCCCS engages in both formal tribal consultation and other meetings with Indian health partners to maintain continual discussions with Tribal leaders and partners regarding issues impacting tribal communities. All materials presented during Tribal Consultations and meetings are also provided on the AHCCCS website.[76] During the SIM Model Design planning, AHCCCS met with its Indian health partners and held tribal consultations on the following dates to discuss the following items pertinent to the SIM initiative:

Tribal Consultations and Meetings with Indian health Partners	Topics Discussed
• January 20, 2016 — Tribal Consultation Meeting • February 24, 2016 - Special AIR Tribal Consultation Teleconference • March 8-9, 2016 — Meetings with Indian health Partners • March 29-30, 2016 — Meetings with Indian health Partners • March 23, 2016 — Special DSRIP Tribal Consultation • April 5-7, 2016 — Meetings with Indian health Partners • April 21, 2016 — Tribal Consultation Meeting • May 12, 2016 — Meetings with Indian health Partners • May 25, 2016 — Meetings with Indian health Partners	• Care coordination strategies, • Claims submission and processing, • Sustainability options, • Alternative payment models, and appropriate measures and metrics.

Stakeholders working to improve the delivery system for American Indians reflected on the lessons learned and accomplishments of other initiatives. For example, Tucson IHS has worked with stakeholders to share its experience with medical home development and electronic health systems so that others can benefit from the lessons they have learned. IHS providers have worked with AHCCCS, Tribal leaders and community members, and other Indian health providers and non-Indian health providers to share information on the IPC program, including its goals, structure, and challenges. The information from these and other stakeholders contributed

[75] The Tribal Consultation Policy is available at https://azahcccs.gov/AmericanIndians/Downloads/consultations/AHCCCSTribalConsultationPolicy.pdf.
[76] Tribal Consultation materials are available at https://azahcccs.gov/AmericanIndians/TribalConsultation/meetings.html.

significantly in stakeholders' deliberations regarding health system transformation goals impacting American Indians.

Through tribal consultation and meetings with Indian health partners, the transformation goals identified in the following section were developed. The goals were then shared with the SIM Steering Committee and Executive Leadership for feedback. The goals described in this section of the Innovation Plan remain subject to change and additional stakeholder feedback particularly for how these goals will be tested. As noted throughout this Innovation Plan, much of the information contained in the Innovation Plan continues to evolve and, as such, the Innovation Plan represents a snapshot in time of the planning and design of these models.

Transformation Goals

AHCCCS with its Indian health partners has established three primary goals to achieve the underlying objective of improving care integration and decreasing system fragmentation in AIHP. As noted previously, the goals and action steps described in this section remain subject to change and further discussion with stakeholders and CMS. The descriptions included in this section of the Innovation Plan are continuing to evolve and are not final.

Goal 1	Goal 2	Goal 3
Improve care coordination for AIHP members by developing care coordination models that integrate physical and behavioral health care, leveraging assistance from IHS sites, Tribal 638 facilities, ITUs, TRBHAs, RBHAs, and non-Indian health providers.	Improve connectivity and use of HIT in AIHP.	Test delivery system model.

AHCCCS has already taken steps to prepare for the AIHP transformation objectives and has involved the full stakeholder continuum from Tribal leaders and Tribal community members to local providers and federal agencies. Specific activities taken to prepare for each goal are outlined in further detail below. Beyond these specific activities, it should be noted that AHCCCS has worked to build better care coordination for its American Indian FFS members. AHCCCS' recent submission of its 1115 Waiver application to CMS includes a key strategy to improve care coordination for its AIHP members. Specifically, the application seeks to create an American Indian medical home for AIHP members, the Indian Health Medical Home Program (IHMHP), which is included as part of the first task of Goal 1. As proposed in the 1115 Waiver, the IHMHP would be reimbursed for primary care case management, a 24-hour call line, diabetes education, and care coordination. The IHMHP was originally proposed by the Tucson Area IHS in 2011 and has since been refined through work with Tribes, IHS, Tribal 638 facilities, and other Indian health stakeholders. AHCCCS has detailed many of the IHMHP components in the 1115 Waiver application, including what services will be covered in the medical home, how providers will be enrolled as medical homes, and reimbursement for medical home services.

Activities Currently Underway Related to Goal 1

Better care coordination is the crux of Goal 1, and AHCCCS has been laying the foundational groundwork to establish an effective care coordination program such as IHMHP. Much of this IHMHP groundwork is described in the American Indian medical home proposal included in the State's 1115 Waiver application. Over the past five years, AHCCCS has worked with Tribes and Indian health organizations in the Navajo Area IHS, Phoenix Areas IHS, and Tucson Area IHS to build the IHMHP model described in the 1115 Wavier.

- ✓ 1115 Waiver to create IHMHP.
- ✓ Adoption of IHS's Improving Patient Care (IPC) care model.
- ✓ Bi-weekly stakeholder meetings on care coordination models.
- ✓ Workshops to identify champions to enhance care coordination.

AHCCCS has also adopted principles of the IHS's IPC care model, which is complementary to the IHMHP. The IPC care model (as described above) identifies the necessary components of a health system to support safe, efficient, patient-centered, effective, timely, and equitable care. The model leverages relationships between a prepared and proactive care team and informed and engaged patient.

While the 1115 Waiver was the starting point for stakeholder engagement and other activities necessary to create the IHMHP, stakeholder work has continued after the Waiver was submitted and has focused on opportunities presented in the SIM Model Design grant. Specifically, AHCCCS has been hosting bi-weekly meetings with acute and behavioral health stakeholders to coordinate care for high priority AIHP members. AHCCCS has also been working with all IHS Area and Tribal 638 facilities to share FFS information.

Activities Currently Underway Related Goal 2

As noted, there are many HIT gaps in the American Indian systems of care, both within AHCCCS and between the various Indian health providers and non-Indian health providers. There are also varying HIT priorities in different regions around the State, which sometimes reflect the practical barriers like connectivity. AHCCCS has started the groundwork for implementing these various tasks, which has focused on engaging local, statewide, the statewide HIE, and national stakeholders. Additionally, the groundwork described here and the subsequent steps necessary to operationalize the goals, tasks, and action steps align with the broader HIT objectives described in this Innovation Plan. For example, AHCCCS' aforementioned meetings with IHS Areas and Tribal 638 facilities have focused on breaking down HIT barriers by discussing data sharing methods.

- ✓ Meetings with IHS Areas and 638 facilities on data sharing methods.
- ✓ Regular contact with the statewide HIE on AIHP HIT activities.

AHCCCS has a longstanding connection to AzHeC, stemming from its participation in the exchange to its partnership in providing incentives for safety net providers to enroll in the HIE. AzHeC has also participated in regular stakeholder meetings on HIT expansion and connectivity in AIHP. As of the date of submission of the Innovation Plan, the contract has been established for AIHP to receive real-time information for AIHP members from the HIE.

The success of AHCCCS' overall objective for AIHP proposed here — to expand care integration and decrease system fragmentation through enhanced care coordination and expanded use of HIT in the program — is mapped by specific action steps outlined for each goal. The action steps

to meet the goals further illuminate a path to improve care coordination and integration for AIHP members. The goals and action steps are outlined in detail below and are also included in Exhibit D.

Goal 1 — Improve Care Coordination

As described, the systems of care for Arizona's American Indian Medicaid population are fragmented and care coordination is limited across the numerous points of care available to them. Due to the lack of coordinated care, patient care outcomes are less than optimal and health care resources are not used as efficiently as possible.

Arizona has identified three action steps to advance improved care coordination for members served by the American Indian Health Program.

GOAL 1 ACTION STEPS	
1.	Establish an IHMHP for AIHP members.
2.	Work with Indian health providers to identify champions to develop best practices that support care coordination for high cost/high needs individuals and coordinate with non-Indian health providers.
3.	Identifying effective Care Coordination Strategies for High Needs/High Cost Members to address their needs and later be expanded to other AIHP populations.

Action Step 1: Establish an IHMHP for AIHP members.

Much of the planning work for the IHMHP has already been completed, including support from Tribes, IHS, Tribal 638 facilities, and Urban Indian Health programs. As discussed in the 1115 Waiver, the IHMPH would reimburse for primary care case management, a 24-hour call line, diabetes education, and care coordination. The 1115 Waiver also outlines a process for designating Indian health providers and non-Indian health providers' facilities as medical homes for AIHP members, including mandatory criteria, such as assignment of the individual to a primary care team, coordination of medically necessary primary and preventive services, and maintenance of a system to track referrals. A reimbursement model has also been developed, including a per member per month (PMPM) payment for case management and care coordination, and an additional PMPM for medical homes offering diabetes education.

To a large extent, a plan for creating an IHMHP exists and the action steps needed to operationalize these activities have already been set in motion. However, additional testing funds would be necessary to, among other things, (a) continue robust stakeholder conversations; (b) ensure development of core components to operationalize the medical home, including the specific medical home activities, requirements for medical home participation that supports meaningful provider participation, and the PMPM rates; and (c) measure the success of this medical home model in delivering effective care to American Indian members.

Action Step 2: Work with Tribes to identify champions to develop best practices that support care coordination for high cost/high needs individuals and coordinate with non-Indian health providers.

As part of ongoing stakeholder engagement, AHCCCS has already started discussions with Tribes and Indian health providers on a number of related care coordination ideas. Additional funding would assist in (a) engagement with the Tribes and others to identify champions — those in the Tribal and Indian health system community who are knowledgeable, connected and engaged in building care coordination — to form a best care practice workgroup, and (b) infrastructure system costs to be able to apply best practices. Once the champions have been identified and agree to participate in the workgroup, AHCCCS would convene a summit to begin

long-term engagement with the champions to develop care coordination, best care practices in the American Indian community and to build workable solutions to bridging gaps in care between Indian health providers and non- Indian health providers.

Action Step 3: Identifying effective Care Coordination Strategies for High Needs/High Cost Members to address their needs and later be expanded to other AIHP populations.
AHCCCS is working to increase behavioral health care services to AIHP members, particularly for those identified as having high cost and high needs. Working with RBHAs and TRBHAs, the State is developing additional strategies to close the care gaps for high needs/high cost members. One such strategy currently implemented is joint case staffing model. In the joint case staffing models, the outcomes for high needs/high cost members are recorded and tracked to better identify successful models and apply the lessons learned to other populations.

Additional funding would allow AHCCCS to further engage the RBHAs and TRBHAs by convening them to: a) inform and build further interest in the IHMHP program and b) work with the TRBHAs to further develop care coordination strategies for high needs high/cost members. Test grant funds would also assist AHCCCS with developing a specific method to record and track outcomes of these high needs/high cost members and apply lessons learned more broadly in AIHP, and where appropriate, in the general AHCCCS population.

The universe of providers impacted by the Goal 1 activity to establish an IHMHP will involve IHS and Indian health facilities that choose to implement an IHMHP, which would potentially include all sites. The impacted provider universe also includes primary care providers at IHS and Indian health facilities. These primary care providers will form medical homes, which are the fulcrum of the IHMHP model, and will coordinate care with other Indian health providers and non- Indian health providers, including specialty care.

Goal 2 — Improve Connectivity and Use of HIT
To help resolve the challenges related to limited use of HIT across providers serving American Indians, Arizona identified six action steps related to Goal 2.

GOAL	ACTION STEPS
1.	Connect AHCCCS' Division of Fee for Service Management (DFSM) — the agency that operates AIHP — to the State Health Information Exchange (HIE).
2.	Connect TRBHAs, IHS, and Tribal 638 facilities and Urban Indian Health Programs to the State HIE.
3.	Identify data sharing concerns from State IHS sites and Tribes and developing mitigation suggestions.
4.	Coordinate with Indian Health organizations and other HIT partners to share lessons learned and develop best practices for secure health information sharing.
5.	Work to build an automated process to generate case management notes for AIHP members.

The universe of providers impacted by Goal 2 tasks overlap with those impacted by Goal 1 and include, specifically, TRBHAs, IHS Areas, and Tribal 638 facilities, and primary care providers participating in IHMHP case management services.

Action Step 1: Connect AHCCCS' DFSM to the State HIE.
Despite efforts at AHCCCS to increase participation in the HIE among health care providers and payers in the State, DFSM, the agency that operates AIHP, is not yet connected to The Network. Connecting DFSM is a fundamental step to bridge HIT use and connectivity gaps in AIHP and a

priority of Goal 1 action steps. AHCCCS intends to work with AzHeC and leverage its own experience in connecting to the HIE, to connect DFSM to The Network. As of the date of submission of the Innovation Plan, the contract to connect DFSM to The Network has been executed.

Action Step 2: Connect TRBHAs, IHS, 638 facilities and Urban Indian Health Programs to the State HIE.

The path to connecting TRBHAs, IHS, and 638 facilities to the state HIE involves a number of variables including:

- Connectivity capacity.
- Receptivity of the facilities in connecting to the HIE.
- Facility adoption of ONC-certified EHR systems and staff training on those systems.
- HIE implementation.

AHCCCS will work with these entities to first assess HIT connectivity capacity and to build interest in connecting to the HIE. Once capacity is assessed and interest is secured, AHCCCS will work with the providers to assess current use of ONC-certified EHR systems. Where gaps in these systems exist, AHCCCS would develop a plan to finance EHR technology adoption and training for staff.

Action Step 3: Identify data sharing concerns from State IHS sites and Tribes and developing mitigation suggestions.

An oft-cited obstacle to expanding HIT use and connectivity in AIHP, identified in early stakeholder engagement activities, involves cultural and organizational sensitivities of data sharing in American Indian communities. As stated earlier, AHCCCS will convene a workgroup with appropriate representation from IHS Areas and Tribes to identify particular concerns about data sharing, and clarify potential misunderstanding about data sharing processes. AHCCCS will host regular meetings with this workgroup while barriers are identified, and possible solutions to mitigate those concerns are formulated.

Action Step 4: Coordinate with Indian Health organizations and other HIT partners to share lessons learned and develop best practices for secure health information sharing.

AHCCCS has engaged in productive dialogue with Indian health organizations on care coordination and connectivity opportunities. This planning is vital for the proposed creation of the IMHMP; multiple Indian health organizations, including Tribal 638 organizations and the IHS Tucson Area, have been key stakeholders throughout the IMHMP development process. Additional discussions at the national level with IHS Office of Information Technology leadership have identified an architecture for secure data-sharing between the Arizona HIE and Indian health organizations in Arizona using the IHS EHR and the national IHS HIE. AHCCCS will convene a workgroup of interested IHS, Tribal, and Urban Indian health organizations to identify lessons learned from recent experience and develop a strategy that will bridge gaps in health information sharing to facilitate timely, patient-centered care for members of the American Indian Health Program.

Action Step 5 Work to build an automated process to generate case management notes for AIHP members.

While the connection between Goal 1 and Goal 2 is implicit, an automated process to generate case management notes is a tangible product of this connection. Automated case management notes reflects an essential part of the IHPMH case management service proposed by AHCCCS

and is a fundamental step in expanding HIT use. Like other HIT tasks, developing an automated process for case management notes will require buy-in from Indian health providers and non-Indian health providers, connectivity capacity of the case management note system, and funding for infrastructure needs and ongoing operating costs, including staff training.

Additional details surrounding the HIT/HIE tasks related to this initiative can be found in the HIT/HIE section of the Innovation Plan.

Goal 3 — Test Delivery System Models

With this background, AHCCCS and its stakeholders set out to construct delivery system reform models to address coordinated care for American Indians participating in the AIHP. The projects to test care coordination models for American Indians participating in AIHP stem from a need to improve health outcomes through a multi-provider collaboration that seeks to improve infrastructure, communication, use of data, consistent outcome measures, and application of operational and clinical protocols. The core of the model is based on the establishment of Care Management Collaboratives (CMCs). AHCCCS will support the development and operation of the CMCs, but the participating providers will inform the operational structure of the CMCs. The State anticipates there will be three CMCs that will be regionally based. The model is dependent on providers participating in the first three projects described below with participation in the fourth project as optional.

Project 1: 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 that commonly understood and shared care management strategies are developed and implemented, including participation in the CMC steering committee. 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.

Project 2: Care Management.

The goal of this project is to develop a care management system for the population enrolled in the AIHP and receive treatment through Indian health 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.

Project 3: 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 the state's health information exchange.

Project 4: Transform primary care sites serving AIHP members into PCMH.

The goal of this project is to train primary care practices on core PCMH skills and track their increased capabilities 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.[77]

The goal is to align this project with the Indian Health Service's IPC Care Model as much as possible and practical. The IHS IPC program goal is to engage IHS, Tribal, and Urban Indian health programs to improve the quality of, and access to, care for American Indian members through the development of the IHMHP system of care model. The IPC program is focusing on patient-and-family-centered care while ensuring access to primary care for all American Indians. High-quality care will be delivered by health care teams who will be making sustainable and measurable improvements in care. Medicaid is IHS' biggest payer/partner. Therefore, AHCCCS will align its IHMHP program with the efforts being made by IHS and the federal government to modernize and improve the health care delivery system for the American Indian population.

Quality/Performance Metrics

The State is currently working on finalizing quality and performance metrics related to (i) relevant population health and clinical metrics and (ii) measures to track the projects that will be tested. Regarding the first group, the Arizona Department of Health Services is leading the effort to finalize population health measures related to American Indians that will be incorporated in the Innovation Plan. Stakeholders and AHCCCS are working together to finalize measures that will track the progress of the model designed to improve care coordination for AIHP members. These draft measures under consideration can be found in Exhibit E.

Alignment with Other Initiatives

AHCCCS, specifically through AIHP, has been working with Flagstaff Medical Center to develop a care coordination process for high needs/high cost members. AIHP identified the high needs/high cost members through claims data and shared that information with Flagstaff Medical Center who designated care coordination staff to work with those members. This collaboration has helped create some other initiatives such as the CMC concept, the medical home waiver and changes made to the health plan contracts around high need/high cost members. This care coordination collaboration is continuing today and is providing lessons learned that will assist the State in further developing and implementing the projects and action steps under this initiative in the Innovation Plan. In addition, AHCCCS will continue to work with its Indian health partners to identify other opportunities that align with the goals of this initiative.

Planning for improving care coordination for individuals served by the American Indian Health Program has been with consideration of other health care initiatives occurring in the State and with Tribes and Indian health. AHCCCS serves on the Arizona Advisory Council on Indian Health Care (ACOIHC) whose mission is to advocates for increasing access to high quality health care programs for all American Indians in the State. The ACOIHC lists its duties as the following:[78]

- Develop a comprehensive health care delivery and financing system, specific to each Arizona Indian tribe that uses title XIX funds and builds on currently available private, state and federal funds.
- Develop new title XIX demonstration projects, specific to each Arizona Indian tribe, both on and off reservations in cooperation with this state and the federal government.
- Facilitate communications, planning and discussion among tribes, the state and federal agencies regarding operations, financing, policy and legislation relating to Indian health care.

[77] www.safetynetmedicalhome.org/change-concepts
[78] Available at https://acoihc.az.gov/about-acoihc

- Recommend and advocate tribal, state and federal policy and legislation that supports the design and implementation of health care delivery and financing systems specific to each Arizona Indian tribe.
- Notwithstanding section 36-2903.01, subsection B, in conjunction with the administration, request a federal waiver from the United States department of health and human services that allows tribal governments that perform eligibility determinations for temporary assistance for needy families programs to perform the Medicaid eligibility determinations for persons who apply for services pursuant to section 36-2901, paragraph 6, subdivision (a). If the waiver is approved, the state shall provide the state matching monies for the administrative costs associated with the Medicaid eligibility based on federal guidelines. As part of the waiver, the administration shall recoup from a tribal government all federal fiscal sanctions that result from inaccurate eligibility determinations.
- Perform other duties as requested by the legislature.

AHCCCS serves on the 23 member Council, of which 20 members are Tribal members representing health care agencies, social service agencies, tribal organizations or metropolitan Indian centers, agencies serving individuals with intellectual/developmental disabilities and tribal members at large. The Council meets at least six times a year to carry out their duties to identify and address the unique health care needs of the Indian population living in Arizona. The information obtained through participation in the ACOIHC informed the development of the SIM Model Design Planning related to Indian Health.

Justice System Transitions

Current Delivery System Gaps

Incarcerated individuals often suffer from various health problems and may enter the justice system with serious health conditions. The poor health status of many individuals prior to incarceration is often due to homelessness, HIV/AIDS, asthma, diabetes, hepatitis, serious mental illness, substance use, limited education, and trauma. A national study found inmates returning to home communities faced the following health challenges:

- One-half of men and two-thirds of women had been diagnosed with chronic physical health conditions such as asthma, diabetes, hepatitis, or HIV/AIDS.
- 15% of men and over one-third of women reported having been diagnosed with depression or another mental illness; the actual prevalence of mental health conditions is likely to be double the self-reported amount.
- About two-thirds of men and women reported active substance abuse in the six months before the incarceration.[79]

A study published in 2009 of more than 20,000 adult jail inmates across five local jails found that 14.5% of the men and 31% of women, a total of 16.9%, had serious mental illness.[80] Substance use disorders have been found to be even more prevalent among incarcerated adults. One study documented substance dependence and alcohol abuse as high as two-thirds of prison inmates

[79] Mallik-Kane, K., Visher, C.A. Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration. Research Report. 2008. Urban Institute Justice Policy Center, p. 21-31.
[80] Henry Steadman, Fred Osher, Pamela Robbins, Brian Case, and Steven Samuels, "Prevalence of Serious Mental Illness among Jail Inmates," *Psychiatric Services* 60, no. 6 (June 2009): 761-65, http://www.consensusproject.org/publications/prevalence-of-serious-mental-illness-among-jail-inmates/PsySJailMHStudy.pdf.

across both males and females.[81] Research specific to the jail population found that jail inmates had a history of substance use disorder seven times more than that of the general population.[82] Co-occurring disorders of mental health and substance use is also prevalent among the jail population, with estimates as high as 72% of jail inmates with mental disorders having a co-occurring substance use disorder.[83]

Many individuals begin their incarceration with undiagnosed or underdiagnosed behavioral health conditions.[84] Further compounding the issue in Arizona is the significant shortage of behavioral health providers within the State's counties and federal correctional facilities.[85]

When these individuals' transition out of incarceration, there is a need to ensure they have access to the needed services and social supports without a break in continuity of care. Individuals transitioning out of incarceration experience significant gaps in care. While incarcerated, these individuals generally receive health care services from the counties and the state's department of corrections (depending on whether they are incarcerated in a jail or prison). The providers within the jail and prison system typically do not have access to the individuals' health history (unless the individual is a repeat offender) and may not be aware of chronic conditions, treatment plans, or medications. Similarly when the individual transitions out of incarceration, community providers are not privy to the treatment the individual received while incarcerated. To further complicate the issue, often when leaving a prison or jail individuals (particularly those with chronic physical and/or behavioral health conditions) have no warm hand off to transition their care and ensure continuity. Therefore, these individuals may not be released with sufficient medication or follow-up appointments. To address these issues, AHCCCS gathered interested stakeholders in the beginning of 2015 to discuss how these different government and community resources could work together to ensure that these vulnerable individuals receive necessary health care with the hope that improved care coordination and access to services would also impact recidivism rates in the State.

Stakeholder Efforts

With the restoration of coverage for childless adults through Arizona's Medicaid program in January 2014, many individuals transitioning out of incarceration who previously did not have health care coverage became eligible for Medicaid upon their release. Recognizing the volume and the churn on and off Medicaid (members losing eligibility when incarcerated) of these individuals, AHCCCS convened a work group that included other state agencies, community partners both from the criminal justice system, as well as the health care system, and county departments, including probation and courts. This diverse workgroup began to address, among other issues (i) how to ensure these individuals were enrolled in AHCCCS as soon as they were eligible (i.e. no longer incarcerated), and (ii) how to provide continuity of care for these individuals particularly given the high prevalence of SMI and other mental health and substance use disorder treatment needs. The SIM Model Design grant provided an opportunity to expand Arizona's focus on this vulnerable population. As a result, AHCCCS invited additional stakeholders and expanded the objective of these meetings to, among other things, (i) develop statewide goals; (ii) share best

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[81] The National Center on Addiction and Substance Abuse at Columbia University, "*Behind Bars II: Substance Abuse and America's Prison Population*," Feb 2010 at 25; available at http://www.centeronaddiction.org/newsroom/press-releases/2010-behind-bars-II.

[82] Aileen B. Rothbard, "Effectiveness of a Jail-Based Treatment Program for Individuals with Co-Occurring Disorders," *Behavioral Sciences & the Law* 27 (2009): 643-54.

[83] Center for Mental Health Services GAINS Center, "The Prevalence of Co-Occurring Mental Illness and Substance Use Disorders in Jails," http://www.gainscenter.samhsa.gov/pdfs/disorders/gainsjailprev.pdf

[84] *See* *http://www.tacreports.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf* TAC—The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey.

[85] *See* Arizona State Health Assessment April 2014 at 113.

practices and lessons learned from across the State; (iii) share data and analytics regarding this population; and (iv) continue to brainstorm and refine strategies with the ultimate goal of improving health outcomes, reducing health care costs and impacting recidivism rates. The following is a summary including the dates, participants, and agenda topics for these stakeholder meetings.

The stakeholder work group for the justice system includes representatives from the following organizations:

- AHCCCS.
- AzHeC.
- Arizona Department of Corrections.
- Health Plans.
- RBHAs.
- Apache County.
- Cochise County.
- Coconino County.
- Gila County.
- Graham County.
- Greenlee County.
- La Paz County.
- Maricopa County.
- Mohave County.
- Navajo County.
- Pima County.
- Pinal County.
- Santa Cruz County.
- Yavapai County.
- Yuma County.
- Courts System.
- Maricopa Probation.
- Pima Probation.
- David's Hope (Peer Run).

The following meetings were held during the SIM Model Design period. The agenda items are also provided:

Meeting	Agenda
September 4, 2015 — Quarterly Meeting	Data Sharing Application and Enrollment Process Description and Use of the OST/FROST Collaboration Between DES and Maricopa County Jail for Eligibility Determinations MMIC and Jail Diversion Services SIM Stakeholder Workgroup Ohio Initiative
October 16, 2015 — SIM Focus Group	Development of State Goals and Specific Aims Identification of Barriers and Resource Needs Development of Baseline Measures and Performance Metrics

Meeting	Agenda
November 12–16, 2015 (Meetings were held with the three regions (Maricopa County, Northern and Southern) to cover the same topics)	Review of Desired Outcomes Review of Data Available Review of Mercy Maricopa Coordination Process Review of Goals
December 4, 2015 — Quarterly Meeting	Update on Progress of Regional SIM Workgroups RBHA Process Flows Maricopa County Jail and DES Enrollment Collaboration Data Sharing Update from AzHeC Overview of AHCCCS Eligibility and Enrollment Processes for the Juvenile Justice System Service Capacity Concerns Medication Assisted Treatment (MAT)
March 4, 2016 — Quarterly Meeting	SIM Update Expansion of Pre-Release Applications Behavioral Health Presentation — Pima County Managed Care Organization Justice Data Analytics Housing Overview Review of Draft Managed Care Contract Language Assessment of Treatment Needs Available Resources
May 12, 2016	Justice Transition Strategy Milestone & Metrics AHCCCS Stakeholder Discussion
May 25,' 2016 — Specialized Meeting on Testing Metrics	Discussion of Testing Project Discussion of Testing Project Measures
June 3, 2016 — Quarterly Meeting	Updates Since our March Meeting State Innovation Model Update Update on final MCO contract language RBHA Presentations on Data Analytics Discussion of Probation/Parole data feed(s) and sharing DOC updates AzHEC (HIE) update Potential use of Michigan data sharing form

This stakeholder workgroup held quarterly meetings with the stakeholders and also held a series of regional workgroup meetings to specifically discuss how the workgroup's overall state goals could be implemented within each region. From each stakeholder meeting, notes were gathered and formatted into a summary of goals. Within each goal there were stated action steps, responsible parties, recognized barriers and challenges, and initial deadlines to measure progress. Once compiled, the draft goals were shared with the entire stakeholder workgroup and both written and oral feedback was received. The goals were updated based on the feedback and then shared with the SIM Steering the Committee and Executive Leadership for final approval.

Transformation Goals

A summary of the stakeholder workgroup's goals can be found in Exhibit F. Each of the goals is also in detailed below. The workgroup believes that achievement of these goals will be the

foundational building blocks to improving health outcomes and decreasing recidivism rates for individuals transitioning out of incarceration. For many of these goals; however, additional funding and resources will be necessary to ensure among other things continued stakeholder engagement and system infrastructure requirements.

AHCCCS, with its stakeholders, has established five goals to reduce the service gaps and improve care coordination for individuals transitioning from incarceration.

Goal 1	**Goal 2**
Medicaid Enrollment for Eligible Justice-System Involved Individuals.	Coordination of Physical and Behavioral Health Care
Goal 3	**Goal 4**
Share Clinical Data and Incarceration Information	Identify and Implement Support for Other Social Determinants of Health
Goal 5	
Test Delivery System Model	

Goal I — Enrollment

To ensure continuity of care, an individual transitioning out of incarceration needs to be enrolled and eligible to access services immediately upon release. As such, the first goal is to ensure that individuals who are AHCCCS eligible are enrolled with AHCCCS prior to release. There are two crucial steps the stakeholders identified as necessary to achieve this goal: (i) ensuring each county has implemented processes for AHCCCS enrolment suspension and (ii) establishing eligibility and enrollment processes with each county and the Department of Corrections (DOC). Each of these steps comes with challenges as further described below.

Arizona has identified two action steps to support continuity in Medicaid enrollment for eligible individuals.

GOAL 1 ACTION STEPS	
1.	Expand Medicaid enrollment suspension across Arizona's counties.
2.	Support Medicaid eligibility and enrollment for eligible justice-system involved individuals.

Action Step 1: Medicaid Enrollment Suspension.

AHCCCS does not pay for individuals in incarcerated status. Where Medicaid suspension is available, an individual who is incarcerated for less than a year has his/her eligibility suspended upon incarceration and then reinstated upon release. This process avoids requiring the individual to complete an eligibility application and ensures that the individual is enrolled with an AHCCCS contracted managed care organization and is eligible for services immediately upon release. The process works as follows: the DOC and the county jails submit a file to AHCCCS that allows AHCCCS to match the incarcerated member and share that information with the impacted health plan on a daily basis. As of today, the majority of the 15 counties in Arizona (including the largest counties) have a process in place for Medicaid suspension. In state fiscal year 2015, the State avoided $26,066,071 in capitation costs because of Medicaid enrollment suspense.

The goal is to have enrollment suspense processes implemented statewide. Implementing an enrollment suspense process in the remaining counties will require capital and technical expertise. Because these counties are small, it has been difficult for them to invest in obtaining the necessary technology and staff for this process to be effective. Stakeholders recognized this

barrier and suggested that AHCCCS work with these counties to assist them in engaging local community colleges and universities to lend technical support and expertise to develop a Medicaid suspense process. In addition, the stakeholders suggested engaging Arizona Justice Alliance as a potential resource to assist in this initiative. The stakeholders have identified a goal of statewide Medicaid suspension processes to be in place by December 2016.

Action Step 2: Eligibility and Enrollment Processes.

Medicaid suspension is critical to ensuring individuals have continuity of care and seamless access to needed services; however, there are still many individuals incarcerated in Arizona who are eligible for Medicaid but have not yet completed an application. For these individuals to have access to services upon release, they would need to complete an application and enroll in a health plan to be effective upon the date of release. In practice, this concept is not easy to implement. As explained by the counties, there is limited funding and personnel to assess Medicaid eligibility and enroll clients into AHCCCS. Moreover, as of now, the Arizona Department of Economic Security (DES) only accepts applications in hard copy. As such, the counties can only implement this process for individuals with known release dates that are at least 30 days out. Given that many individuals do not have known release dates, and there is a lack of resources at the county level to assist individuals in completing and submitting their Medicaid applications, this process has been challenging. While there have been community organizations that have been assisting some of the larger counties with these processes, reliance on these organizations to continue to provide this service without charge is not sustainable; a long-term plan is necessary.

The State is making enhancements to its HEAplus eligibility system, which will allow for applications to be submitted online. The system is currently being tested and it is expected to be up and running soon. The ability to submit online eligibility applications for incarcerated individuals has become even more crucial with the passage of HB 2701. This legislation permits DOC to require individuals to apply for health care benefits through AHCCCS before being released. It will likely result in an influx in applications, and the ability to submit online will assist with the ease of completing the application but also with the ability to make timely eligibility determinations.

AHCCCS recognizes that the volume of incarcerated individuals and available resources to assist with the eligibility application process varies by county. As such, AHCCCS is working with each county to identify existing processes and determine what resources and changes are necessary to effectively enhance these processes. The current processes to identify eligible clients are redundant, and manual and system changes and links between AHCCCS, DES, county jails, DOC, probation and parole are necessary to develop a streamlined process. Even with the enhancements to HEAplus, implementing eligibility and enrollment processes will continue to vary by county depending on the size of the incarcerated population and the resources available to assist with inmates with eligibility and enrollment forms.

Goal 2 — Coordination of Physical and Behavioral Health Care

Obtaining eligibility and enrollment information prior to release is a critical step in ensuring physical and behavioral health care can be coordinated early and continuously for individuals transitioning from incarceration. Having eligibility suspense systems and processes in place to identify Medicaid eligibility for those not previously AHCCCS enrolled, incarcerated individuals, provides some lead time to be able to identify health care needs, make appointments for the individual to attend immediately upon release, and further cultivate a physical and behavioral health-related safety net for the member. An individual transitioning out of incarceration faces many changes and obstacles including receiving necessary health services. To be able to provide coordinated care early and continuously, the workgroup identified eight critical actions steps, each with their own barriers and challenges.

Arizona has identified eight action steps to support coordination of physical and behavioral health care for individuals transitioning from incarceration.

GOAL 2 ACTION STEPS	
1.	834 Transaction Files & Activities Prior to Release.
2.	Connect to the HIE.
3.	Streamline Discharge Planning.
4.	Establish a Care Coordination Process for Adults with Short Incarceration.
5.	As appropriate, ensure the SMI Determination Process occurs.
6.	Explore options to increase transportation services.
7.	Expand Focus of workgroup to Juveniles.
8.	Expand Focus of workgroup to American Indians.

Action Step 1: 834 Transaction Files & Activities Prior to Release.

During stakeholder discussions, it became clear that not all of the health plans and the RBHAs understood that Medicaid eligibility suspension status is indicated in the 834 transaction file that is provided to them by AHCCCS on a daily basis. The 834 Enrollment Transaction File is "[a] nightly transaction file provided by AHCCCS to its Contractors. The file identifies newly enrolled members and changes to existing members."[86] With the information on the 834 file, the health plans and RBHAs can, among other things: (i) track the number of their members who are incarcerated; (ii) identify if those members have SMI, GMH/SA or chronic health condition needs; and (iii) begin to coordinate care for those individuals prior to release.

At one of its quarterly meetings with justice stakeholders including the health plans, AHCCCS explained where the incarceration indicator was located on the 834 transaction file and worked with individual RBHAs and health plans that were having technical difficulties. In addition, AHCCCS determined it was necessary to include contract language for both the health plans and the RBHAs to, among other things: (i) utilize the 834 transaction file, (ii) and undergo early care coordination activities through a "reach in" process. In some of the counties, the RBHAs already had processes in place to begin reach in and coordination activities for their SMI members and these discussions were the basis for establishing requirements for reach in activities for the health plans. Given that "reach in" activities are dependent on having known release dates and time for planning, the requirements in the contract are for adult members with an anticipated release date within 30 days. The contract language requires the health plans to coordinate reach in activities with justice partners (including jails, Arizona Department of Corrections, probation, and courts) and to focus the reach in efforts for high needs and high risk members. The contract also requires the health plan to develop a reach in plan for AHCCCS approval to meet minimum requirements. The reach in contract language has been shared with the health plans and the RBHAs and is currently being finalized based on their feedback. It will then be submitted to CMS for approval as part of the next contract amendment effective October 1, 2016.

AHCCCS recognizes that approval of the contract language by CMS is not guaranteed given the limitations on Medicaid funding for incarcerated individuals. Specifically, Medicaid, (with the exception of certain inpatient services), cannot pay for services for incarcerated individuals. While this serves as a barrier, the expectation is that the health plans and the RBHAs will see the long

[86] *See* AHCCCS Contractor Operations Manual – Chapter 433 – Member Identification Cards for further explanation of the 834 file.

term benefit of providing early coordinated care for these members (e.g., fewer visits to the emergency room, decrease in crisis intervention services, and effective disease management for chronic conditions). By "reaching-in", the health plans and the RBHAs will be able to appropriately plan for the individual's release with, for example, a care coordinator meeting the individual prior to release, addressing transportation needs, and scheduling necessary appointments for the individual to attend immediately following release. The workgroup's expectation is that the individual will receive better coordinated care immediately and that these interactions will improve health outcomes, decrease costs, and ultimately impact recidivism rates in the State.

Action Step 2: Connect to the HIE.

As further discussed in the HIE/HIT section of the Innovation Plan, the HIE will also be a resource for health plans and RBHAs to collect information to plan for an individual's transition out of incarceration. It is anticipated that the health plans and RBHAs will be able to see not only services provided prior to incarceration but also services provided while incarcerated. This information will be critical in identifying high risk and high needs members and for planning for their release. The work group recognized that for justice partners connecting to the HIE, and being able to appropriately utilize the information on the HIE, will likely require some technical expertise, staffing, and training. The work group set a goal for all county jails to implement EHRs by October of 2016 and for all justice partners (i.e., DOC, ADJC, county jails, RBHAs and health plans) to be connected to the HIE by April 2017. Additional discussion on stakeholder work and next steps is provided in the HIE/HIT section of the innovation plan.

Action Step 3: Streamline Discharge Planning.

As indicated above, having information on individuals transitioning out of incarceration prior to release allows the health plans and RBHAs to appropriately plan and anticipate the individual's health care needs upon release. The workgroup discussed the possibility of establishing a statewide discharge planning process for adults incarcerated for more than 30 days with (i) SMI, (ii) GMH/SA, and (iii) chronic health care needs. Given that the makeup of the incarcerated population varies significantly across the State and the fact that the RBHAs are regional entities, it became clear through work group discussions that mandating a single statewide process would not be an effective approach. Rather, as noted above, establishing minimum criteria for care coordination and discharge planning and allowing the health plans and RBHAs, together with the justice partners to develop an approach that works best for these populations, was the ultimate recommendation from the workgroup. The work group also recognized that separate processes for DOC and county jails would likely be necessary.

Even with permitting different discharge planning approaches based on regions and whether the individual is in jail or prison, the workgroup also identified additional challenges. First, currently there is only funding for SMI individuals to coordinate discharge and arrange for services while the individual is incarcerated. The recommendation was to have a discharge process for not only SMI but also GMH/SA and those with chronic conditions. Despite the lack of funding, the expectation (as described above) is that the health plans and RBHAs will see the value in the upfront investment in developing discharge planning and coordinate care for these individuals prior to release.

In addition to funding concerns, there was also a concern that it can be difficult to place individuals transitioning out of incarceration into substance use disorder residential treatment centers (RTCs) in certain regions in the State. A subset of the workgroup has been meeting to identify the underlying cause of the problem (e.g., lack of providers, sentencing that requires release to an RTC, etc.). Since identifying this issue through work group discussions, RBHAs have been working actively with justice partners to connect members to RTCs when medically

necessary. The justice partners have reported that they have established a collaborative and effective relationship with the RBHAs that has dramatically improved this issue.

Lastly, the workgroup identified that the treatments for opioid addicted individuals are not necessarily the same for individuals who are incarcerated because DOC and county jails do not have the resources to offer the full range of Medication Assisted Treatments. The workgroup is continuing to have discussions around this policy.

Action Step 4: Establish a Care Coordination Process for Adults with Short Incarceration.
Once the eligibility, enrollment, HIE connectivity, and reach-in/discharge planning activities have been implemented and there has been an opportunity to make any additional changes to the processes that are identified with experience, the work group intends to propose that the health plans and RBHAs develop care coordination processes for individuals with short incarceration (i.e., less than 30 days). Providing any reach-in coordination and discharge planning is difficult for stays that are less than 30 days. Nonetheless, with access to health information from the HIE and coordinated efforts with justice partners to begin identifying incarcerated individuals in real time, the work group believes that a coordination processes would improve. The workgroup intends to revisit this step in October of 2016.

Action Step 5: Ensure SMI Determination Process Occurs as Appropriate.
During the workgroup discussions on the SMI population, it was identified that individuals who have been identified with SMI while incarcerated with DOC but who has not had a community assessment for SMI prior to incarceration, is still required to undergo a community assessment for SMI by the single statewide entity that makes SMI determinations upon release. As a result, individuals designated as SMI while incarcerated may have a delay in receiving services in the community until the individual receives an SMI determination from the statewide entity. The work group discussed possible ways to make the DOC, SMI determination accepted in the community. After investigating the issue further, the work group reached consensus that the jail or prison assessment that identifies SMI needs will send the medical records to the statewide entity for SMI determination. The State is working on education and training on this process and have made these documents available on its website.[87]

Action Step 6: Explore Options to Increase Transportation Services.
Even with reach-in processes and some lead time to appropriately prepare for an individual's release, these efforts will be negated if the individual is unable to get to the appointment. Arizona's size and geography inevitably creates transportation concerns. Even in the metropolitan areas, these individuals can struggle with obtaining timely transportation. As explained by a representative of Maricopa County, the number one reason probationers are sent back to jail is failure to appear in court, (which is often the result of unavailable transportation). As a result, transportation is a huge concern not only for continuity of care for these individuals but also in recidivism rates. While there are some grants providing transportation and the State does provide non-emergency medical transportation as a service for members enrolled in AHCCCS, it is evident that the transportation need is not being met for everyone. Pending these findings, it is likely that funding is currently the largest barrier for this action item. The workgroup intends to continue discussions around this issue and explore additional ways to address the funding issue; for example, by including transportation as part of an alternative payment model for care provided to an individual transitioning out of incarceration.

[87] Enrolling in AHCCCS and Behavioral Health Services for Individuals Releasing from the Criminal Justice System
Available at https://www.azahcccs.gov/AHCCCS/Downloads/Initiatives/CJSResourcesInformation.pdf

Action Steps 7 & 8: Expand Focus of Workgroup to Juveniles and American Indians.
The workgroup has so far focused on the adult incarcerated population. In October of 2016, the work group intends to explore additional options for leveraging the above stated care coordination processes for juveniles and the American Indian incarcerated populations. Additional stakeholders have been engaged and discussions with juvenile justice representatives have begun to take place. Initial meetings were held on May 2, 2016, May 16, 2016 and June 1, 2016.

Goal 3 — Sharing Clinical Data and Incarceration Information
A theme in the goals developed by the workgroup is the need for real-time and reliable data. The workgroup anticipates that this need can be met by The Network (operated by AzHeC that links heath care organizations across the state through a single connection). Participation in The Network allows bidirectional exchange of an individual's electronic health information by all authorized Network users. Below is a summary of the steps identified by the work group with respect to sharing clinical and incarceration data. A more detailed description can be found in the HIT/HIE section of the Innovation Plan.

Arizona has identified two action steps to advance the sharing of clinical data and incarceration information for justice system involved individuals.

GOAL 3 ACTION STEPS	
1.	Increase participation in The Network.
2.	Support appropriate usage of The Network.

Action Step 1: Increase Participation in The Network.
Becoming an authorized user of The Network requires signing with AzHeC as a Network participant to be able to share patient health information. Currently, AHCCCS requires Network participation for the health plans and RBHAs. However, for the workgroup's goals to be met, additional justice partners must also be connected to the HIE. The work group recognizes that participation in The Network will require some expense and technical expertise. However, one cost barrier was eliminated for the justice partners when The Network eliminated participation fees for community partners, (including correctional facilities and first responders).[88]

To encourage Network participation and in collaboration with AHCCCS, AzHeC reached out to all of the workgroup members in February of 2016 with (i) a participant form, (ii) a sample workflow assessment, and (iii) offered to provide a demonstration and additional support as requested. As of the date of submission of the Innovation Plan, Maricopa County and Pima County corrections were listed as participants in the Network.

Action Step 2: Support Appropriate Utilization of The Network.
While not all of the workgroup members have completed a participation agreement, the work group did begin to identify types of information it would like to see available through The Network that could be used in assisting with the eligibility and care coordination goals. Specifically, the workgroup identified the following:

- AHCCCS, acute care and RBHA enrollment information.
- DOC and county jail incarceration information (to be further defined but could include release date, probation status, pre-trial status).

[88] *See Arizona's Statewide HIE Eliminates Participation Fees for Community Providers,* September 2, 2015, available at http://c.ymcdn.com/sites/www.azhec.org/resource/resmgr/Docs/NewsRelease_Statewide_HIE_El.pdf

- Court date(s).
- Clinical information (medication, allergies, etc.).
- SMI designation.
- Probation agency.
- Probation officer contact information.

To further define the data needs, AzHeC is reaching out to these stakeholders on a regional basis. The work group also recognized that after connection and identifying data needs, many of the stakeholders would need assistance in streamlining work flows using the HIE data and determining the most effective processes to utilize the information. This goal will be further explored in the beginning of 2017; however, some members of the work group raised concerns around funding needs for additional staff and HIE training needs.

Additional details on this goal can be found in the HIE/HIT section of the Innovation Plan.

Goal 4 — Identifying and Implementing Support for Other Social Determinants of Health

Individuals transitioning out of incarceration have a variety of needs and targeting health care alone will not be sufficient in causing a reduction in recidivism. The workgroup identified a need for continued collaboration with community partners who can assist with provider social support services, such as housing, employment and peer/family support to ensure a holistic approach to meeting an individual's needs upon release. An immediate barrier is funding for housing and employment services. Medicaid funding is not available to pay directly for housing and employment services. The RBHAs, however, can provide vocational services and living skills to all title XIX members with GMH/SA and SMI. Non-Medicaid funded housing services are primarily limited to members with SMI, but there are still challenges finding available housing options.

While funding will continue to be an issue in providing these services to individuals transitioning out of incarceration, the workgroup did identify recommendations to educate individuals about what potential social support services may be available.

- First, the work group recommended providing education for RBHAs and health plans for them to better understand the services and supports that Medicaid can assist with (e.g., education and referrals to housing and employment resources).
- Second, identifying opportunities within the correctional system to provide education and information to incarcerated individuals. Specifically, using video visitation or probation officers to provide information on available social supports.
- Third, using targeted case managers from various organizations to make and track referrals to the social support services.

The workgroup plans to revisit this goal in October of 2016 to begin to further implement strategies and develop some performance measures. The priority of the work group was to focus on eligibility/enrollment and care coordination efforts over the next year.

Goal 5: Test Delivery System Model

With this background, AHCCCS and its stakeholders set out to construct a delivery system reform model to address coordinated care efforts for individuals transitioning out of incarceration. A model for adults is further described below. As of the date of submission of the Innovation Plan, the stakeholders are discussing testing a model for the juvenile justice system.

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 physical and behavioral health services, the State will pursue the following model.

The RBHAs will develop an integrated health care setting located within county probation offices or DOC parole offices to address beneficiary health care needs of individuals transitioning out of incarceration upon release and throughout the term of probation/parole. The objective of this model 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.

Quality/Performance Metrics

The State is currently working on finalizing quality and performance metrics related to (i) relevant population health and clinical metrics and (ii) measures to track the projects that will be tested. The Arizona Department of Health Services is leading the effort to finalize population health measures related to individuals involved with the justice system that will be incorporated in the Innovation Plan. The measures that are being considered to track the progress of the justice system transition model can be found in Exhibit G.

Alignment with Other Initiatives

Given the overwhelming health disparities — particularly behavioral health conditions — for the incarcerated population, addressing health care transitions for individuals upon release has recently become a widely discussed topic. In developing these goals and action steps, AHCCCS and its stakeholders considered efforts occurring in other states.

For example:

- Ohio's pre-release enrollment program that includes an enrollment class, assignment to a case manager, and video conferencing to develop a transition plan.
- The Transition Clinic Network Primary Care Medical Home and Community Health Worker Model used in seven states that locates clinics that are "most impacted by incarceration" and include community health workers with history of incarceration as part of the clinical team to perform reach-in activities and act as a health navigator.
- NASHP's Toolkit: State Strategies to Enroll Justice-Involved Individuals in Health Coverage that describes enrollment process and examples of strong community partnerships to support such efforts.[89]

In addition, Arizona Department of Corrections received a Second Chance Act Grant award in 2015. This grant funding is to be used to reduce recidivism, provide community re-entry services, conduct research, and evaluate the impact of re-entry programs. The efforts around this grant will align with the efforts of the SIM.

2014 Second Chance Act Grantees[90]

[89] Available at http://www.nashp.org/toolkit-state-strategies-to-enroll-justice-involved-individuals-in-health-coverage/
[90] http://www.naco.org/sites/default/files/documents/SCA-Grantees-State09-14.pdf

Second Chance Act Grant Activities	Grantee	Funding
Adult Mentoring	Epidaurus/Amity Foundation	$300,000
Smart Supervision	Maricopa County Adult Probation Department	$749,998
Adult-Mentoring-Comprehensive	Old Pueblo Community Service	$1,000,000
Adult Co-Occurring	Pima County Office of Medical Services	$599,998

AHCCCS and the stakeholders will continue to discuss additional opportunities that arise and will work together to ensure that the all opportunities are being pursued in a way that can leverage and accelerate the ultimate goals of this initiative.

Physical and Behavioral Health Coordination

Current Service Delivery Gaps

When Arizona launched the State's Medicaid program in 1982, the State chose to maintain a separate system of care for the treatment of behavioral health conditions instead of "carving-in" those services in the managed care benefit plan. This separation of behavioral health and physical health services reflected the then views that a system focused solely on behavioral health could better meet the needs of individuals with serious behavioral health conditions. Since that time, Arizona's health care delivery system has continued to evolve and mature, and the State has taken incremental steps to move closer to an integrated behavioral and physical health delivery system. In 2014, AHCCCS shifted Medicaid-funded physical health services for individuals with SMI living in the State's largest county and largest urban center to the RBHA administering services in that geographic area. In 2015, the remainder of the State moved to this integrated model for Arizonans with SMI.

Historically, Medicaid health services have been overseen by separate state agencies, with the DBHS managing the behavioral health services and AHCCCS the physical health services. The two agencies have merged and both physical and behavioral health services are now administered through AHCCCS.[91]

In spite of these progressive changes toward integrated care, Arizonans with both behavioral health and physical health needs still struggle to receive the best care because of the lingering fragmentation throughout the delivery system. The lack of care coordination between the two systems results in inadequate care and poor response to the person's total health needs. The adverse effect of uncoordinated care can have a particularly profound impact on the physical health of those with serious behavioral health conditions. A study by the Patient-Centered Primary Health Collaborative[92] reported that uncoordinated behavioral and physical health systems contribute to inadequate care as noted below:

- 67% of people with a behavioral health disorder do not get behavioral health treatment.
- 30-50% of patient referrals from primary care to an outpatient behavioral health clinic do not make the first appointment.
- Two-thirds of primary care physicians report not being able to access outpatient behavioral health for their patients. Shortages of mental health care providers, health plan barriers, and lack of coverage or inadequate coverage were all cited by primary care providers as critical barriers to mental healthcare access.

[91] The merger took place over several months and will be completely finalized as of July 1, 2016.
[92] https://www.pcpcc.org/content/benefits-integration-behavioral-health

Behavioral health services, substance use issues, suicide, and chronic disease management were identified as leading health priorities for Arizona. Integrated behavioral and physical health care must be part of the solution for these priority areas. Through the SIM Model Design, AHCCCS worked with stakeholders to identify additional care models and payment strategies that will advance behavioral and physical health integration across the State.

Stakeholder Efforts

Striving towards integrated care in Arizona is not a new goal. Indeed, there has been a long history of stakeholders and state agencies working together to determine best practices for integration. AHCCCS and DBHS have worked collaboratively to procure integrated health plans for a variety of populations such as individuals with Serious Mental Illness, children with chronic conditions, and dual eligible who do not have a Serious Mental Illness designation. In addition, AHCCCS has facilitated information sharing across plans regarding common members to allow for better coordinated care. AHCCCS has also established care coordination requirements for high-cost, high-need members, to facilitate better integration of care for members with complex needs. As discussed above, AHCCCS is also establishing a VBP rate differential for integrated clinics. Specifically, stakeholder work groups have focused on developing ways to share information electronically given the different legal requirements on confidentiality and provider access to electronic health records.

During the SIM Model Design planning, AHCCCS sponsored a stakeholder meeting on November 18, 2015 with health plans, RBHAs, and behavioral health providers to discuss, among other things, the status of integration in the State and specific lessons learned from the health plans, RBHAs, and a panel of providers. The agenda for the forum was as follows:

- AHCCCS Overview.
- RBHA Panel: VBP Strategy and Integrated Structures.
- Provider Panel: VBP and Integrated Care Successes and Challenges.
- AHCCCS Acute Plans Plan: VBP and Integration Strategies.

Each of the panels was moderated by the AHCCCS Director or Deputy Director with a set of predetermined questions. The questions were selected in the spirit of supporting a culture of learning, providing clarity to stakeholders and providing a platform for stakeholders to share experiences and lessons learned. Questions were also taken from the audience during each of the panels.

After the forum, AHCCCS also distributed a survey through Survey Monkey with a list of questions to gain an appreciation for how providers would characterize their current integration efforts. Approximately 83 individuals completed the survey, and a summary of the results of the survey are provided as Exhibit H. Of note, 11% of the respondents are fully integrated (shared EHR, care plan, and facility) and 74% were not in any VBP arrangement as of the date of the forum.

A summary of additional stakeholder meetings and agenda topics is listed in the chart below.

Meeting	Agenda
December 8, 2015	DSRIP National Overview New York's DSRIP Arizona SIM Sustainability Proposal Goals & Strategy

Meeting	Agenda
February 25, 2016	Proposed Arizona SIM Sustainability Model Overview Sustainability Strategies High Need Members Served by the American Indian Health Program Behavioral Health and Physical Health Integration High Need Children Served by Children's Hospital Individuals Transitioning from the Justice System
May 12, 2016	Behavioral and Physical Health Integration Strategy and Milestones & Metrics — Pediatric and Adult Stakeholder Discussion
May 24, 2016	Pediatric Metrics Discussion Adult Metrics Discussion

Integration efforts are also addressed at monthly meetings with the health plans and RBHAs.

Transformation Goals

Working together, providers, payers, health care advocates, AHCCCS, and other state agencies have established a goal to accelerate behavioral and physical health integration across care settings throughout the State.

Goal 1	Goal 2
Establish a comprehensive approach to integrate care (physical and behavioral health) across care settings to better address mental and physical health and addiction disorders.	Test Arizona's nine specific delivery models designed to achieve better patient outcomes and more efficient cost-effective care.

Goal 1 — Establish a Comprehensive Approach to Integration

Arizona's goal regarding behavioral and physical health integration reflects the belief that individuals should be able to receive integrated services, regardless of the care setting in which they are seen. Achievement of this goal will require establishing a network of providers sufficient to provide integrated care across multiple settings, (e.g., primary care, community behavioral health center). Arizona intends to encourage providers (by focusing first on Medicaid providers) to move along the integrated care continuum and to facilitate that move through value based payment (VBP) models. To further define this goal and begin to outline next steps to encourage reform in the delivery system, the State developed the following action steps: (i) define integrated care, (ii) achieve administrative simplification, and (iii) encourage movement along the integrated care continuum.

GOAL 1 ACTION STEPS	
1.	Define integrated care.
2.	Achieve administrative simplification.
3.	Encourage movement along the integrated care continuum.
4.	Assess HIT needs

Action Step 1: Define Integrated Care.

AHCCCS turned to its health plan and RBHA medical directors to come up with an agreed upon definition of integrated care to level the playing field around expectations for integrated care. The medical directors reviewed various definitions and have agreed to the following working definition from Agency for Health care Research and Quality (AHRQ):

> **Integrated behavioral health care is:**
> The care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance use conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

This working definition will allow the health plans, RBHAs and State agencies to appropriately message expectations and requirements for integrated care in a uniform manner.

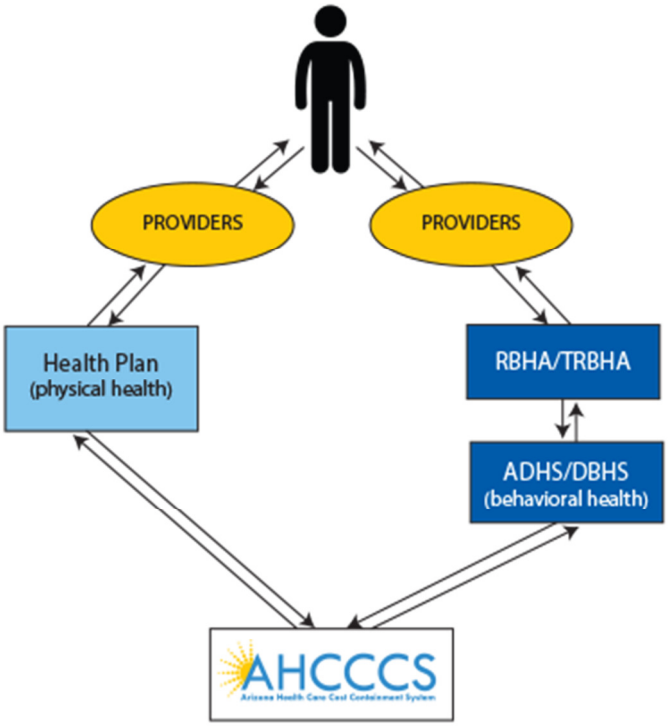
Action Step 2: Administrative Simplification.

To further encourage achieving integrated care (in line with the agreed upon definition), there is an obvious need for integration on three levels: (i) from a state policy perspective (see discussion of merging DBHS with AHCCCS below), (ii) braiding the various funding streams available for various services (see example of the integrated RBHA), and (iii) integration at the provider level. AHCCCS believes the best way to encourage integration at the provider level and true team-based collaborative care is through VBP models (further discussed below).

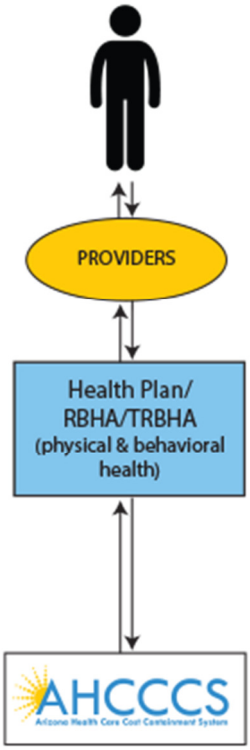
In the 2015 legislative session, Laws 2015, Chapter 195, formally merged DBHS with AHCCCS and as of July 1, 2016, AHCCCS will directly oversee both the physical health and behavioral health contracts for its members. This is one critical step in breaking down the silos of care and promoting integration and treatment of the whole person. Nonetheless, as noted previously, this change alone will not be sufficient to ensure an individual receives integrated care.

AHCCCS' vision for integration is pictured below. Previously, the separate state administration resulted in distinct contracts for physical and behavioral health and distinct provider groups who did not communicate effectively on member care. Under the streamlined configuration, AHCCCS will oversee integrated contractors that will work with provider networks that collaborate and integrate care for its members. Physical and behavioral health providers will work as an integrated team and be responsible for (either directly or indirectly) the continuum of care for AHCCCS members.

PRIOR CONFIGURATION



CURRENT STREAMLINED CONFIGURATION



Action Step 3: Encourage Movement along the Care Continuum Through VBPs.

To determine a baseline of AHCCCS behavioral health providers' understanding and implementation of value based purchasing and integration, the providers that participated in the stakeholder forum on November 18, 2015 were sent a survey. The results of the survey were telling — the level of integration between behavioral health providers and primary care providers varies significantly. Of the 61 respondents to the question of "What is your organization's level of integration with regards to primary care services?":

- 18% stated that clients are referred to a primary care provider at another practice site, and the behavioral health provider and primary care provider have no communication with respect to shared patients.
- 54.1% stated that clients are referred to a primary care provider at another practice site and periodically communicate about shared clients.
- 8.2% stated that the behavioral health care providers and primary care providers **share the same facility but maintain** separate cultures, separate records and develop separate treatment plans for clients.
- 8.2% stated that the behavioral health care providers and primary care providers **share the same facility and health record but maintain** separate cultures and develop separate treatment plans for clients.
- 11.5% stated that the behavioral health care providers and primary care providers share the same facility, health record, maintain cohesive cultures and develop and implement collaborative treatment planning for shared patients.

Barriers identified in the survey related to integrating behavioral health services with primary care services include, but are not limited to:

- Unwillingness to serve members with SMI.
- Different organizational cultures and licensing requirements.
- Long wait times for appointments.
- Data is not current.
- Facility limitations and lack of EHR.
- Member resistance.
- Reimbursement.

This information was a baseline measure to gauge system-level integration. Given that the RBHA contracts were amended to include language around integration and value based payments effective October 2015, AHCCCS will now be able to assess these integration questions against the baseline results to measure progress and determine if additional actions are necessary. AHCCCS' intent is that the contract requirements around integration, and value based payments will help align incentives to help negate some of these barriers and will create a natural progression along the integrated care continuum. In addition, AHCCCS is planning to increase fee schedules for integrated providers by paying a premium over the existing fee schedule for physical health services to align integrated providers' payment structures. The State believes this is an additional strategy to encourage and incentivize the provision of integrated services.

In addition to the contractual requirements, a key piece of successful system level integration is the ability to share data and health care information through The Network. The HIT/HIE section of the Innovation Plan provides additional detail around specific stakeholder efforts, data needs, and next steps.

Action Step 4: Assess HIT Needs.

As explained throughout the Innovation Plan and further stressed here, assessing HIT needs and expanding utilization of advanced HIT tools is a critical component to the success of Arizona's initiatives and specifically, to achieving integrated behavioral and physical health care. A major obstacle to date in achieving system integration is the use of incompatible HIT system among providers in the State. The State believes that expansion of HIT capabilities, such as advanced EHR systems that exchange information across health care providers and systems, is critical to the success of this initiative. A further description of the assessment of HIT needs, and the plan to address those needs, is described in the HIT/HIE section of the Innovation Plan.

Goal 2: Test Delivery System Models

With this background, AHCCCS and its stakeholders set out to construct delivery system reform models to address integrated care. This process identified a need for a comprehensive approach to integrated care (meaning both physical and behavioral health) in any care setting in which an AHCCCS member may receive either physical or behavioral health services (e.g., from a primary care provider, community behavioral health provider) to better address mental and physical health and addiction disorders. Nine specific models are in development to test Arizona's strategic initiative to achieve better patient outcomes and more efficient cost-effective care.

Model 1: Integration of Primary Care and Behavioral Health Services in a Primary Care Site for Adults.

This model integrates behavioral health services (some of which are paid for by the RBHAs) into the primary care sites (where services are paid by the health plans). This model would be available to all individuals, including those individuals who are enrolled in the integrated RBHA. This model is dependent on the ability of physical and behavioral health providers to, among other things, share health information electronically, utilize integrated treatment plans, develop protocols to screen for behavioral health conditions, and enhance relationships with community-based providers. In this model, providers will be required to adopt and utilize an evidenced-based practice assessment and integration toolkit. The State believes this model will be an effective approach to addressing coordination of care issues.

Model 2: Integration of Primary Care and Behavioral Health Services in a Community Behavioral Health Site for Adults.

This model is similar to the first model except that it applies to providers in a behavioral health setting. As explained above and highlighted in the State's Health Assessment, with the prevalence of co-morbidities in individuals with behavioral health conditions, this model ensures that individuals with behavioral health conditions have an integrated treatment plan that addresses all of their needs.

Model 3: Integration of Primary Care and Behavioral Health Services in a Co-Located Site for Adults.

Where primary care and behavioral health services are already co-located, the State believes more can be achieved to maximize the impact from integration of primary care and behavioral health services. This model focuses on the development of an evidence-based practice assessment and integration toolkit. In addition, this model requires the providers' ability to develop analytic capability to evaluate data obtained from the RBHAs, health plans, and the HIE. By having a one-stop shop to address members' needs, members may be more likely to adhere to treatment plans, and providers have the advantage of proximity when providing integrated care. Nonetheless, co-locating can require significant investment and capital requirements by providers to engage in this model.

Model 4: Care Coordination for Adults with Behavioral Health Conditions Being Discharged from an Inpatient Behavioral Health Stay.

To more effectively coordinate care for adults with behavioral health conditions who are being discharged from an inpatient behavioral health stay, hospitals would develop protocols with community behavioral health providers and primary care providers to ensure appropriate care transitions from inpatient to outpatient settings. This model is dependent on, among other things, protocols between the hospitals and the RBHAs to communicate member-specific social and economic determinants of health that are important to prevent or delay readmission. AHCCCS believes this model will be effective in ensuring continuity of care resulting in decreased readmission rates. AHCCCS is discussing with stakeholders whether this model should be expanded to apply to discharge from both an inpatient behavioral health stay and an inpatient physical health stay.

Model 5: Integration of Primary Care and Behavioral Health Services for Children with Behavioral Health Needs and Their Families in a Primary Care Site.

This model integrates behavioral health services (some of which are paid for by the RBHAs) into the primary care sites (where services are paid by the health plans). This model would be available to all children with behavioral health needs, including those children who are enrolled in the integrated RBHA. This model is dependent on the ability of physical and behavioral health providers to, among other things, share health information electronically, utilize integrated treatment plans, develop protocols to screen for behavioral health conditions, and enhance relationships with community-based providers. In this model, providers will be required to adopt and utilize an evidenced-based practice assessment and integration toolkit. The State believes a co-location model will be an effective approach to addressing coordination of care issues.

Model 6: Integration of Primary Care and Behavioral Health Services for Children with Behavioral Health Needs and Their Families in a Community Behavioral Health Site.

This model 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 AHCCCS acute care health plan. This project focuses on the actions necessary to fully integrate care in a manner similar to project 5.

Model 7: Improving Treatment for Care of Children with Autism Spectrum Disorders in a Primary Care Site.

To improve identification and care of Medicaid-enrolled children at risk for Autism Spectrum Disorders (ASD), or diagnosed with ASD, and create sufficient and consistent linkages between primary care, behavioral health and social service resources, primary care providers would be required to have an integration model (as described above) but also develop appropriate toolkits for caring for children at risk for or diagnosed with ASD. According to the 2016 Community Report on Autism, approximately 1.5% of eight-year old children (1 in 66) in Arizona were identified with an ASD in 2012 — approximately the same as the national average.[93] According to the same report, boys were 4.2 times more likely than girls to be identified with an ASD. The rate of ASD identification was also highest among African American and Caucasian children. Additionally, the average age of diagnosis was four years and seven months, even though ASD can be diagnosed in children as young as two years of age.

[93] http://www.cdc.gov/ncbddd/autism/documents/community_report_autism_arizona_web.pdf

Model 8: Improving Treatment for the Care of Children Engaged in the Child Welfare System in Primary Care Sites.

The objective of this model is to improve the care of Medicaid-enrolled children who are involved 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. To participate, providers would need to participate in model 5 as a pre-condition, as it builds upon the care provided in an integrated setting. This model specifically focuses on developing clinical protocols to help identify and address physical or behavioral health issues a child engaged in the child welfare system may have and to provide care using Trauma-Informed Care principles.

Model 9: Improvement Treatment for the Care of Children in the Child Welfare System in Community Behavioral Health Sites.

The objective of this model 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. To participate, providers would need to participate in model 6 as a pre-condition, as it builds upon the foundation for care provided in an integrated treatment setting. This model focuses on the actions to coordinate care specifically for children engaged in the child welfare system in a similar manner to model 4.

For these models to be tested, additional funding will be needed to address, among other things, co-location infrastructure and system and analytic capabilities. However, once implemented, Arizona believes these models will be sustained through the more effective care and aligned payment afforded through alternative payment model structures.

Quality/Performance Metrics

The State is currently working on finalizing quality and performance metrics related to: (i) relevant population health and clinical metrics and (ii) measures to track the projects that will be tested. The Arizona Department of Health Services is leading the effort to present population health measures related to individuals with physical and behavioral health needs that will be incorporated in the Innovation Plan. The measures that are being considered to track the progress of the physical and behavioral health coordination model can be found in Exhibit I.

Alignment with Other Initiatives

The University of Arizona Center for Rural Health has developed a project to review the current status of rural behavioral health care in Arizona. *On the edge of opportunity: A review of the public behavioral health system in rural Arizona* represents the first phase of that project. The report provides important views on ways in which the rural Arizona public behavioral health care system is working well and where there are challenges and opportunities for improvement. It ends with nine recommendations that require policy formation or change, additional study, or more education and training. The review combined extensive interviews with state and local key informants, a focus group with behavioral health providers from Arizona Community Health Centers, and significant review of existing public documents. Future phases of the project will address other rural populations, including those with private health care insurance, inmates of rural prisons, American Indians covered by the Indian Health Service, and rural veterans.

AzHeC is also a recipient of the Transforming Clinical Practice Initiative (TCPI) grant — a four-year model test grant from CMS. Through the TCPI grant, AzHeC, Southwest Catholic Health Network, and Mercy Maricopa Integrated Care are sponsoring the Practice Innovation Institute (Pii). The goals of the Pii are similar to the goals of SIM in that it is seeking to support delivery system reform. As such, Arizona is seeking to align the goals and objectives of both the SIM initiatives outlined in the Innovation Plan and those developed through the TCPI grant.

In addition, in support of efforts to encourage information sharing and the use of the statewide HIE, AzHeC has changed the HIE platform to accept and handle behavioral health information in compliance with 42 CFR Part II. This change is crucial to the HIT and HIE goals described within this initiative and throughout the Innovation Plan.

V. Foundation of Delivery System Initiatives

AHCCCS will continue to be a leader in delivery system transformation, but the ability to address gaps in the system and develop targeted initiatives to address those gaps is critical to the overall success of the State's transformation goals. Central to the effective implementation of the delivery transformation models and initiatives outlined above is (i) effective VBP models, (ii) access and use of HIE, (iii) a work-force that can adapt to the delivery system changes, (iv) an understanding of the applicable policy levers, and (v) a plan to ensure the sustainability of the delivery system.

Payment Transformation

Arizona believes that payment transformation is a critical component to achieving the State's goals to reach across Arizona to provide comprehensive, quality health care for those in need by (i) bending the cost curve while improving members' health outcomes, (ii) pursuing continuous quality improvement, (iii) reducing fragmentation in health care delivery to develop an integrated system of health care, and (iv) maintaining core organizational capacity, infrastructure and workforce.[94] Arizona's payment transformation initiatives have identified care coordination and integration gaps in the delivery system that needed additional focus. To continue to accelerate payment transformation efforts, the State's approach is to:

- Leverage existing reforms underway in the State;
- Request information from stakeholders on barriers and resource needs to effectuate payment reform;
- Optimize the utilization of the health information exchange (HIE) to facilitate payment transformation; and
- Determine the right approach for sustainability of the proposed payment reform.

Arizona's approach to statewide payment modernization will continue to be shaped by stakeholder input in the design and feedback on strategies implemented. A summary of payment reform and the approach to value based payment (VBP) models in Medicaid is described in the background section of the Innovation Plan above. This section explains specific stakeholder efforts around payment transformation, importance of HIE/HIT for successful payment reform, and reiterates the expectation that payment transformation efforts will continue in Medicaid as required by AHCCCS and begin to filter into payers' other lines of business.

Stakeholder Meetings Related to Payment Transformation

Several stakeholder meetings were held to discuss VBP pertaining to specific components of the Innovation Plan, including sustainability strategies. AHCCCS also met individually with many health systems, ACOs, health plans and others to discuss their VBP initiatives, the State's strategy, and opportunities for further VBP development. A key stakeholder meeting that occurred was the Value Based Payment Model Forum as further discussed below.

Value Based Payment Models Forum

As addressed above, on November 18, 2015, AHCCCS convened a statewide behavioral health stakeholder forum with approximately 250 individuals representing acute care plans, RBHAs, and behavioral health providers in attendance. One of the goals of the forum was to obtain stakeholder feedback regarding experiences with current integration and alternative payment model approaches and identify implementation barriers and resource needs. Panel discussions elicited information on challenges and successes of existing integrated and VBP model

[94] As stated in Arizona Health Care Cost Containment System's (AHCCCS) Strategic Plan for State Fiscal Years 2015-2019 available at https://www.azahcccs.gov/reporting/Downloads/StrategicPlans/StrategicPlan_15-19.pdf.

arrangements, as well as sharing lessons learned to support providers as they prepare to embrace VBP strategies in the future.

A critical takeaway from the discussion and an identified lesson learned was the need to measure the readiness of providers to participate in VBP arrangements. For example, RBHAs and the acute care plans noted the importance of undergoing a full readiness review with providers before entering into VBP models. Stakeholders expressed that providers should be financially stable, able to provide services based on evidenced-based practices, and able to provide data needed to measure quality metrics.

As part of the forum, the RBHAs had an opportunity to explain their vision on VBP models and the quality metrics that would be the focus for these arrangements. The RBHAs discussed strategies to progress up the value-based scale and specifically touched on the following topics:

- Emerging community issues that could be considered in the context of VBP models, including inappropriate use of the emergency department and the interaction of the crisis system and first responders with members.
- Evolving models to support and encourage integrated physical and behavioral health care.
- Importance of technology, use of electronic health records, utilizing provider portals, and expanding telemedicine.
- Importance of providers communicating with the RBHAs to identify resource needs, barriers, and concerns about VBP models.
- Determining strategies to address workforce shortages and making related policy changes (e.g., addressing provider licensure requirements).
- Discussion of publicly-posted individual provider report cards on VBP models, performance measures to encourage competition, and member choice.

Given that AHCCCS initiated VBP first in the acute care contracts, the acute care plans shared VBP lessons learned with the RBHAs and behavioral health providers that included the following:

1. The need to explain managed care vernacular to providers when entering into these arrangements (e.g., explaining medical loss ratios, shared savings, pay for performance, etc.).
2. The importance of short term and long-term incentives.
3. The need to explore and identify aligned incentives between the plan and the provider.
4. The value of striving for a short, simple, and streamlined VBP contract or contract language — avoiding incorporating too many measures and overcomplicating the arrangement.
5. The importance of allowing room for innovation rather than being prescriptive on all details of a VBP model program.

In a follow up to the forum, participants were sent a survey to which approximately 83 individuals provided anonymous responses. The results of the survey indicated that some providers are engaged in integrated organizations and VBP model arrangements, but most do not currently have the capability for transformation.[95]

Justice System Stakeholder Meetings

In developing a delivery system transformation model for transitioning individuals from incarceration into the community, the State has engaged stakeholders that include representatives from RBHAs, acute care plans, the Arizona Department of Corrections, county jails, county probation departments, and others. Stakeholder discussions have included

[95] A summary of the survey results are available at Exhibit H.

considering how VBP strategies can be utilized to help achieve the statewide goals related to these community transitions. RBHAs have been exploring the use of VBP arrangements to encourage coordination for justice system involved individuals. Through the discussions, specific issues have been noted and will continue to be explored further with stakeholders including:

- Bundled payments for assessments and transportation for individuals transitioning into the community.
- Quality metrics for VBP models including (i) measuring recidivism rates by providers, (ii) missed appointments, and (iii) following treatment plans.
- Education and training efforts for providers, first responders, judges, probation officers, and other players involved in the justice system.
- Barriers related to data collection and Medicaid rules around payments for services received while incarcerated.

These meetings with stakeholders have reinforced how vital stakeholder input is to the success of payment transformation. Key themes from the meetings with stakeholders on VBP models include the need for additional resources to further pursue VBP objectives and make sure that everyone from the State, the health plans, the RBHAs, and the individual providers has the tools they need for success. As such, the State is investigating how best to use health information technology to support payment reform, exploring ways to address resource needs, and preparing and educating providers to ensure that the payment reform efforts are sustainable in the future. The State will continue to seek input from its stakeholders on these topics.

Health Information Technology for Effective Payment Transformation

Health information technology (HIT) is a critical component of an effective care delivery and payment transformation plan. As was made clear during stakeholder discussions, having accurate and real-time data not only at the health plan and State level, but also for individual providers, will be necessary, as the delivery system reforms are implemented and VBP arrangements become the norm. In recognition of its importance and in a step towards encouraging participation on the Health Information Exchange (HIE), the statewide HIE eliminated participation fees for community providers as of October 1, 2015. Community providers, including federally qualified health centers, rural health clinics, behavioral health providers, primary care and specialty care providers in private practices, public health, correctional facilities and first responders, are now able to participate in the HIE for free.[96]

While providing free access is an important first step, meaningful information and educating providers on its use are necessary to, among other things, assist plans and providers with VBP arrangements specifically related to reporting and tracking quality measures. AzHeC conducted key informant interviews with a wide range of stakeholders, including interviews with behavioral health providers, physical health providers, federally qualified health centers, rural health clinics, RBHAs, TRBHAs, Arizona Department of Corrections, and county corrections departments. The interviews focused on identifying current capabilities and challenges related to a variety of topics, including payment reform. Identified HIT/HIE considerations related to payment reform include:

- How and what data is currently captured and identification of gaps that need to be addressed;
- How to utilize clinical, claims, and operational data to support integration and VBP models; and
- How to make appropriate information available to both providers and payers.

[96] http://c.ymcdn.com/sites/www.AzHeC.org/resource/resmgr/Docs/NewsRelease_Statewide_HIE_EI.pdf

A detailed description of AzHeC's meetings with stakeholders to discuss these issues is included in the HIT/HIE section of the Innovation Plan. Arizona believes that as VBP models mature and providers and payers become accustomed to paying for value, the sharing of data will be a critical component, and the HIE will be the necessary link to successful achievement of such efforts.

Next Steps for Payment Transformation

AHCCCS will continue to increase its contractual requirements and expectations on payment transformation with its contractors. Through continued stakeholder discussion, including quarterly meetings with its contractors, AHCCCS will determine additional opportunities to facilitate VBP. This will include tracking the successes of various contractor initiatives and evaluating the success of particular strategies as well as opportunities to scale arrangements that demonstrate significant value. The new delivery system initiatives will continue to advance payment transformation and the expectation is that value based payments and alternative payment models will be a natural necessity in order to (i) create a successful implementation of the initiatives and (ii) meet AHCCCS requirements on payment transformation.

Workforce

Arizona Workforce Needs and Challenges

In 2010, more than 21.4% of Arizonans reported not having access to a personal physician or health care provider. According to the U.S. Department of Health and Human Services, as of 2012 in Arizona, there were 36 medically underserved areas, 10 medically underserved population areas, 142 primary care health professional shortage areas, 95 mental health professional shortage areas, and 155 dental health professional shortage areas.[97] In addition to the shortage of providers, people with behavioral health conditions lack health insurance coverage at far higher rates than the general population. Nonetheless, in the first quarter of 2013, 89% of adults and 92.9% of children served by the public behavioral health system received case management services.

The State Health Assessment (SHA) focused on identifying access disparities and identifying health care provider shortages. The SHA relied on information from the US Department of Health and Human Services, Health Resources and Services Administration's (HRSA) guidelines regarding the level of health services support needed in communities.

Arizona has 142 Primary Care Health Professional Shortage Areas (HPSA).[98] To meet the standard of one primary care practitioner for every 2,000 people, Arizona needs an additional 202 health professionals; nationally 15,970 practitioners are needed to meet the needs of populations living in the 5,846 HPSAs. The primary care physician shortages by county (based on 2012 data) are as follows:

[97] US Department of Health and Human Services, Health Resources and Services Administration (HRSA).
[98] See page 109 of SHA.

County	Primary Care Physicians Needed
Apache	3
Cochise	13
Coconino	3
Gila	2
Graham	4
Greenlee	1
La Paz	2
Maricopa	100
Mohave	11
Navajo	16
Pima	51
Pinal	70
Santa Cruz	1
Yavapai	17
Yuma	9

Source: Health Resources and Services Administration Shortage Areas: HPSA by State and County as of May 2013. http://hpsafind.hrsa.gov/HPSASearch.aspx

While Arizona has 16 outpatient treatment facilities per 100,000 residents, they are not evenly distributed throughout the State. Rural areas, such as Navajo County, Yuma County and Apache County, have the lowest ratios of licensed outpatient treatment centers to population.

There is an evident shortage of behavioral and physical health providers in Arizona with the entire state designated as a mental health shortage area. Behavioral health shortage areas have, in particular, a significant impact on populations with low-incomes, those living in rural areas, and incarcerated individuals receiving services through correctional facilities. The table below indicates the numbers of physicians needed per designated area to reconcile the mental health professional statewide shortages.[99]

HPSA Name	County	# Needed
Northern Arizona Catchment Area	Apache Coconino Navajo Mohave Yavapai	20
Southeast Arizona Catchment Area	Cochise Graham Greenlee Santa Cruz	5
Pinal/Gila Catchment Area	Pinal Gila	13
Southwest Arizona Catchment Area	La Paz Yuma	6
Maricopa County	Maricopa	10
Pima County	Pima	15

An additional 143 mental health professionals, particularly psychiatrists, would be needed to meet the desired ration of one practitioner for every 10,000 people living in the HPSA.

The bulk of the HPSA designation stems from correctional facilities as demonstrated in the chart below:

Correctional Facilities	County	# Needed
Arizona State Prison		
• Douglas	Cochise	5
• Safford	Graham	3
• Lewis	Maricopa	12
• Phoenix	Maricopa	1
• Perryville	Maricopa	5
• Winslow	Navajo	3
• Tucson	Pima	9
• Eyman	Pinal	9
• Florence	Pinal	7
• Yuma	Yuma	4
Federal Corrections Facilities		
• Safford	Graham	1
• Phoenix	Maricopa	2
• Immigration	Pinal	13

Source: Health Resources and Services Administration, Shortage Areas: HPSA by State and County as of May 3, 2013. http://hpsafind.hrsa.gov/HPSASearch.aspx

[99] See page 113 of the SHA.

Arizona is home to four accredited medical schools: University of Arizona College of Medicine (Tucson and Phoenix campuses), Arizona College of Osteopathic Medicine of Midwestern University, and the A.T. Still University School of Osteopathic Medicine. While in-state retention of medical school graduates is higher than the national average (43.2% retained, compared to 38.7% average nationally), the aggregate number of graduates is lower.[100] In 2012, 1,700 of the 3,931 medical school graduates in Arizona went on to practice in the State. Despite the relatively high retention rate, the aggregate number of new practitioners was among the lowest nationally. The limited number of in-state medical graduates is systemic. The State has taken steps to address health workforce shortages, which has focused, in part, on increasing the number of nurse practitioner-led practices. Over 15 years ago, the scope of practice laws were changed to allow nurse practitioners (NP) to practice independently of physicians. However, a study by the National Institute for Health Care Reform found that the autonomous scope of practice law has not increased the number of NP-led practices because reimbursement rates have been too low to sustain these practices.[101]

Arizona Workforce Development Strategies

Western Interstate Commission for Higher Education (WICHE)

A key workforce development strategy for Arizona has been its participation in the Western Interstate Commission for Higher Education (WICHE) since 1953. Over the years, Arizona has benefited from numerous WICHE initiatives but, in particular, the WICHE's Student Exchange Programs. The Student Exchange Program has saved Arizona students and families millions of dollars in reduced tuition rates. Through the Professional Student Exchange Program, 2,558 Arizona students have studied in professional programs that include health care professional fields, such as medicine, pharmacy, physician assistant, osteopathic medicine, occupational therapy, physical therapy, optometry, and dentistry. WICHE reports that 83% of students from Arizona participating in this program returned to Arizona to pursue their career.[102] In addition, Arizona participates in WICHE's Western Regional Graduate Program, which offers Arizonans access to graduate programs at 60 institutions across WICHE states. Advanced educational degrees can be obtained across a wide variety of health care professional fields, such as public health, psychology, and social work.

The Network

As described in the HIE/HIT section of the Innovation Plan, The Network plays a pivotal role in creating efficiencies and improved productivity for health care professionals by providing access to patient health information. The availability of complete and up-to-date health information about a patient at the point of their care has multiple benefits to both the provider and patient. With complete and current information, providers can more effectively and quickly diagnosis their patients, coordinate care, reduce medical errors, and provide safer care.

The information available to providers through The Network includes, but is not limited to, the following:

- Patient and family health history;
- List of medications;
- List of accessed providers; and
- Emergency department visits.

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[100] https://www.aamc.org/download/362168/data/2013statephysicianworkforcedatabook.pdf
[101] http://www.nihcr.org/pcp-workforce-nps
[102] http://www.wiche.edu/wiche-region/az

For additional information on The Network, please see the HIT/HIE section of the Innovation Plan.

Telehealth

AHCCCS and private health systems are using telehealth services as a strategy to increase access to care and the quality of care in response to workforce shortages. Accountable Care Organizations (ACOs) in Arizona are expanding their utilization of telehealth services. The federal final rule "Medicare Shared Savings Program: Accountable Care Organizations," which will offer a telehealth waiver of the billing and payment requirements for telehealth services to ACO sometime after January 1, 2017, offers further incentives for ACOs to continue expansion of telehealth services.

Legislation recently enacted in Arizona will enable further expansion of telehealth services throughout the State. SB 1363 is described below under "Impact of legislative efforts on workforce."

Higher Education Efforts

Arizona State University has programs specifically focused on integration and applied behavioral health. For example, the College of Nursing and Health Innovation has cohorts of students being trained at the Mayo Clinic and Veterans' Administration. There are also Doctorate of Nursing Practice students training in a variety of health care venues. The Center for Applied Behavioral Health Policy uses evidence-based research to support organizational effectiveness in human services programs including: a) research and development of evidence-based treatment interventions; b) external monitoring and evaluation of programs; c) workforce enhancement and training; and d) organizational change process. The College of Health Solutions (CHS) has an applied doctorate program in integrated behavioral health which focuses on graduating licensed clinicians trained to provide evidence-based integrated care. The School for the Science of Health Care Delivery within CHS is focused on the development of patient-centered cost effective care systems. CHS could be leveraged to develop an integrated behavioral health workforce and training for a variety of providers, including community-based behavioral health providers. These programs are well-positioned to support the proposed Innovation Plan workforce efforts to analyze and assess the effectiveness of various models and expand provider training and education opportunities. Community Colleges that train significant numbers of clinicians and extender positions can also support these efforts.

Impact of Strategic Delivery System Reforms on Workforce

While the delivery system initiatives introduced in the Innovation Plan will not directly increase the number of providers in the State, the intent is that through these initiatives, providers will be able to work efficiently through data sharing and connection to The Network and create partnerships and collaborations to maximize the workforce available in the State.

By creating teams of professionals to provide integrated care across HPSAs, Arizona's planned delivery system reform will result in maximizing the available work force. Arizona's integrated models promote team-based care coordination, joint case staffing and a multi-disciplinary approach that supports each healthcare professional practicing at the top of their license.

Impact of Legislative Efforts on Workforce

A key component of Arizona's delivery system reform is expanding telehealth services throughout the State. For Arizona's HPSAs, utilization of telehealth services is particularly critical to overcome access barriers created by the State's workforce shortage. An important step forward in telehealth

expansion for Arizona was the enactment of Laws 2016, Chapter 278 on May 17, 2016. Laws 2016, Chapter 278 expands existing private insurance coverage requirements for health care services provided through telemedicine to apply to services received anywhere in the State. Previously, State law required commercial health insurers to cover telemedicine services only in rural regions of the State. The new law, which is effective January 1, 2018, requires private health plans to cover telehealth services for the following services:

- Trauma;
- Burn;
- Cardiology;
- Infectious Diseases;
- Mental Health Disorders;
- Neurologic Diseases, including Strokes;
- Dermatology; and
- Pulmonology (added by SB 1363).

In addition, States have been increasingly looking to reciprocity of out-of-state medical licensure as an option to help alleviate workforce shortages. In May 2016, the Arizona legislature passed Laws 2016, Chapter 137 that establishes Arizona's participation in the Federation of State Medical Boards' Interstate Medical Licensure Compact.[103] The Compact allows for reciprocity agreements among member states to enable qualified physicians an expedited pathway for licensure. Governor Ducey signed the bill, making Arizona the 13th state to join the Compact. Since enactment of Laws 2016, Chapter 137, three additional states have joined the Compact making a total of 16 states currently participating. Ten additional states have introduced Compact legislation.

Lastly, the Arizona Community Health Worker (AzCHOW) and the Arizona Community Health Worker Workforce Coalition (AzCHW) have been urging statewide recognition of community health workers and educating law makers in the State. On February 2, 2016, AzCHOW and AzCHW lead an informational session that presented numerous topics, including the current CHW scope of practice, the cost effectiveness of using CHWs within health care delivery system, and the potential benefits for recognizing the voluntary CHW credentialing program established by AzCHOW.[104] AzCHOW and AzCHW are promoting standardized voluntary credentialing to ensure that community health workers meet established competencies while at the same time creating a career path for the community health workers in the State. It is estimated that there are 1,000 community health workers employed in Arizona serving all 15 counties and 19 Tribes. Establishing a voluntary credentialed process and developing a career path for individuals interested in becoming a community health worker could have immediate impacts on improving access to services and enhancing navigation of the delivery system.

Behavioral Health Workforce Development

Behavioral health workforce development has long been, and continues to be, a primary focus for Arizona. As noted previously, Arizona's participation in WICHE has provided numerous benefits to the State, including in the area of behavioral health workforce development. WICHE has contracted with the National Technical Assistance Center to analyze the behavioral health workforce in Arizona and eight other states to identify individual state needs and find ways to help develop strategies and resources to create a stable workforce.[105] This analysis is expected to

[103] http://www.azleg.gov/DocumentsForBill.asp?Bill_Number=HB2502&Session_ID=115
[104] *See* Arizona Community Health Worker Association Press Release, Jan. 21, 2016.
[105] http://wiche.edu/mentalHealth/10926

provide information that will enhance Arizona's strategy and action to recruit and retain a stable, qualified behavioral health workforce.

Arizona's RBHAs, with the support of AHCCCS, are taking significant action to support the behavioral health workforce through administrative simplification and streamlining. Working with behavioral health administrators and clinicians, the RBHAs are evaluating contractual requirements to determine what administrative and training requirements can be consolidated in order to reduce administrative burden and free up behavioral health professionals' time to provide clinical care. For example, there are re-training requirements for health professionals when they switch their employment to a behavioral health program under contract with a different health plan. This requires duplicative training instead of providing clinical care. Likewise, clinicians are required to devote much of their time to administrative requirements are of limited value and interferes with the patient time. There is an effort to standardize administrative, reporting, and training requirements across the State to streamline processes and enable efficient use of clinician's time.

In another change to improve workforce efficacy, changes are underway on providing training to behavioral health staff with limited professional credentials to ensure competency. Moving from the "one size fits all" training model to a training model that focuses on individualized competency needs will both improve the quality of Arizona's behavioral health workforce and free up clinicians' time from non-beneficial training time to spend more time providing patient services.

Policy Levers

As explained previously, Arizona does not typically develop mandated reform through legislative activity. As such, this Innovation Plan does not recommend or seek legislative changes to assist with the delivery system initiatives outlined in this Innovation Plan. Nonetheless, as further explained above, there are currently some issues that have garnered legislative attention and could result in statutes that impact areas discussed in this Innovation Plan (see for example, Senate Bill regarding telehealth services and consideration of the Interstate Medical Licensure compact).

At this point in time, it is unlikely that a SIM Test Model opportunity test grant funds will be available to Arizona to test the effectiveness of the proposed delivery system initiatives. Despite this, the implementation of these initiatives and models is extremely important to Arizona, and the State will continue to seek alternatives to be able to test the initiatives and models developed during the SIM Model Design period. Arizona believes that Test Model funds would provide the State with the best avenue to test its delivery system reforms; however, Arizona will pursue all other federal opportunities to be able to sustain the efforts initiated through the Model Design process.

As noted earlier, AzHeC is a recipient of the Transforming Clinical Practice Initiative (TCPI) grant — a four-year model test grant from the Centers for Medicare & Medicaid Services. Through the TCPI grant, AzHeC, Southwest Catholic Health Network, and Mercy Maricopa Integrated Care are sponsoring the Practice Innovation Institute (Pii). The Pii is another initiative designed to reform and improve Arizona's delivery system through technical assistance support to clinicians who are not otherwise participating in a Medicare Shared Savings Program, a Pioneer Accountable Care Organization, or other CMS innovative program, (including SIM). However, given that the goals of the TCPI grant similar to the transformational goals of the SIM Model Design grant, Arizona is seeking to align the program goals.

The State will also continue to pursue a renewal of its current 1115 Demonstration that includes a request for an American Indian Medical Home and a Delivery System Reform Incentive Payment (DRSIP) program. While the State will still seek Model Test funds to the extent third round SIM funding is available, the State will also be seeking matching federal funds to support the initiatives outlined in the Innovation Plan through its 1115 Demonstration (whether as initially requested through a DSRIP or another vehicle). The State will continue to explore these options with CMS and its stakeholders.

Health Information & Technology

Note as of the date of submission of the Innovation Plan, the State is awaiting ONC's review and comment on its Health Information and Technology Plan. Any additional feedback received from ONC will be later included in this document.

The success of Arizona's plan to transform the State's health care system and improve the health of Arizonans, particularly the vulnerable populations of American Indians, those involved in the justice system, and those with behavioral health conditions, depends on expanding the HIT needed to implement and support Arizona's SIM model. Arizona has long recognized the importance of HIT and has been investing in evolving and expanding technology to support improvements in the health care system. In order to implement the State's SIM model, Arizona will build on the State's HIT roadmap, identifying the policy, infrastructure, technology, and technical assistance needed to support implementation of the model. The State of Arizona has long recognized the value of health information exchange (HIE) and the use of electronic health records (EHRs) by health care providers in achieving the triple aim.

There is now a convergence of these two separate HIE and EHR efforts. The statewide HIE, The Network, has grown in both its technical capacity and number of participants under AzHeC leadership, which provides statewide collaborative leadership towards the goal of improving health care and public health in Arizona through HIE and HIT. In addition, CMS's Meaningful Use initiative has led to large numbers of physical health providers and hospitals increasing their use of EHR technology, innovating in workflow and utilizing data for outcome measures. Behavioral Health (BH) providers, which are excluded from the federal Medicaid EHR Incentive Program, have not shown the same level of EHR adoption. There is an increasing awareness of the need for data exchange across organizations to facilitate care coordination and improved outcomes.

Exchanging data includes a drive toward interoperable information technology – a drive to connect disparate systems by electronic means. This drive will increase as providers become increasingly responsible based on the outcomes of the patients they treat, even when their patients receive care at the hands of providers whose workflows they do not control. An important outcome of interoperability is aggregated data from providers, payers, and even patients. The ultimate goal also includes enhanced care coordination and communication among providers across the health care continuum.

Arizona's SIM model is dependent on HIT policies, governance, and a statewide technology infrastructure to support a data-driven evidence-based approach to care, to increase access to care and timeliness of care, to drive quality improvement at the point of care, and to support the transition to value based purchasing (VBP). Without a solid HIT plan and the right tools, including a strong and flexible infrastructure both at the point of care, as well as across the spectrum of care, these goals cannot be fully realized.

In 2005, Arizona began the development of its statewide health IT strategic plan or "Roadmap." Developed with the input of hundreds of Arizona individuals and organizations, it was published in 2006 under the moniker of "Arizona Health-e Connection Roadmap (Roadmap 1.0)." In 2014, the State published an updated version of its plan (*Health IT Roadmap 2.0*) to reflect the continuous refinement of the State's planning and direction for HIT and HIE advancement, as informed by Arizona's ongoing dialogue with stakeholders. *Health IT Roadmap 2.0* identified three essential strategies to guide the adoption and advancement of HIT/HIE in Arizona:

- Continue to support providers, across the community, in their adoption and successful use of technology.
- Accelerate the secure sharing of health information among health care providers.
- Continue to provide opportunities where health care stakeholders can come together and develop HIT/HIE strategies to meet their evolving business needs.

Through the SIM Model Design development, Arizona has sharpened its focus on the State's HIT policies and infrastructure needs to support new delivery system and payment models impacting American Indians, justice system involved individuals, and behavioral health and physical health integration. AHCCCS engaged AzHeC to assist the State with obtaining input from stakeholders, payers, and other county and state agencies on how to improve the coordination and delivery of care for the three SIM target populations through the 1) expansion of exchange of clinical information on a real time basis, and 2) the provision of data and analytical capability to support providers practices, payers, and other relevant organizations as the State works to improve the health of all Arizonans.

In order to develop and expand the appropriate HIT infrastructure to support data exchange and analytics, Arizona understood that an essential activity was working with stakeholders to understand the barriers to HIT infrastructure development. The tables below summarize the challenges that stakeholders identified for each of the SIM target areas and that require solutions to move forward with successful implementation of Arizona's delivery system and payment models.

Barriers to HIT/HIE for Indian health Entities

Barriers to Health IT and HIE Utilization Impacting Indian health Entities		
	Policy Issues	**Technical Issues**
EHR Adoption	The IHS EHRS (RPMS) is certified but work continues to ensure the providers continue to meet MU functionality.	High level of EHR adoption by physical health; low to medium adoption by behavioral health.
Readiness for HIE Utilization	The Network has achieved Healtheway Certification and is in ongoing discussions with IHS to ensure participation in The Network.	AHCCCS is working to establish connectivity between The Network and its Fee-for-Service Area to be able to coordinate care better for its American Indian Health Program (AIHP) members.
Level of Integrated care	The AHCCCS AIHP program is currently working to establish a contract that would allow it access to The Network for care coordination. At this point, most of the coordination is done through fax.	
Special Consideration:	Coordination with processes like Healtheway federal certification will need to occur to ensure availability of Indian Health Services data, and participation at state level HIE discussions is also needed.	Technical implementation of interfaces and data sharing between The Network and IHS are currently limited with discussions ongoing with IHS.

Key HIT/HIE Justice System Issues

Barriers to Health IT and HIE Utilization Impacting Justice System Care Coordination		
	Policy Issues	Technical Issues
EHR Adoption	Both Maricopa County and Pima County have made investments in Certified CEHRS; but smaller counties may not be able to afford.	County correctional health providers are varied in their capabilities to capture clinical information.
Readiness for HIE Utilization	With CEHRS correctional health providers can participate in The Network; need to explore barriers to sharing with non-health providers, e.g. probation and parole.	More sophisticated correctional health providers will be able to utilize The Network for HIE connectivity.
Level of Integrated care	Justice System providers deliver BH and PH services to members and currently, contract language is limited to requiring care coordination for incarcerated individuals with significant BH and SUD needs. By October 2016, contract requirements will extend to complex PH needs.	Justice system providers may be able to share BH and PH information under their roof, but their ability to share this information with providers outside of their justice system is limited at this time.

Barriers to HIT/HIE to support Behavioral Health and Physical Health Integration

Barriers to Health IT and HIE Utilization Impacting Behavioral Health and Physical Health Integration		
	Policy Issues	**Technical Issues**
EHR Adoption	Behavioral health providers who have transitioned from paper records to an EHR found the process difficult and time consuming.	High level of EHR adoption by physical health; low to medium adoption by behavioral health.
Readiness for HIE Utilization	Most BH Providers are at the low to medium adoption of EHRS or have non-certified systems that will make readiness for HIE utilization more challenging	High level by physical providers; low level by behavioral health providers.
Level of Integrated care	Due to challenges in being able to technically separate 42 CFR Part 2 SUD information from other data, interferes with provides being able to share non–sensitive clinical information.	Low level of HIE adoption, which facilitates integrated, particularly by physical health
Special consideration Privacy for BH Data	Establishing privacy and consent policies for behavioral health around 42 CFR Part 2 that protect privacy and ensure optimal integrated care are needed.	Technical implementation of policies by the HIE and practices that support privacy and enable data exchange.

AHCCCS, AzHeC, and stakeholders statewide are working together to design innovative solutions to overcome the barriers identified. The important work done previously and during the SIM Model Design grant phase continues. The SIM HIT plan outlines in detail the governance, policy, infrastructure, and technical assistance needs of providers that is required to implement the delivery system and payment reform described in this Innovation Plan. The SIM HIT plan is included in Exhibit M.

Sustainability

A key theme for Arizona in pursuing its strategic delivery system reform initiatives is reducing fragmentation and developing an integrated system that provides holistic care for individuals that bends the cost curve. In making these changes to the delivery system, Arizona is focusing on populations with the greatest need for improved care coordination, including American Indian members, members transitioning from incarceration and into the community, and individuals with behavioral health and physical health needs.

As of the date of submission of the Innovation Plan, Arizona is currently working with its stakeholders and with CMS to explore options to ensure that the necessary infrastructure and support is in place to test the plans and initiatives outlined above and to sustain the resulting delivery system changes once implemented. AHCCCS is proposing to use its 1115 Demonstration waiver to pursue these options.

As this document continues to evolve, additional information on sustainability will be provided.

VI. Financial Analysis

At the time of required submission of the Innovation plan, the State was unable to complete updating the financial analysis that was submitted as part of the State's SIM application. As such, the financial analysis that was submitted as part of the State's SIM application is reproduced here. Accordingly, some of the terminology and concepts discussed in this financial analysis are not addressed throughout the Innovation Plan.

Optumas was engaged by the AHCCCS to complete Section iii. Financial Analysis of AHCCCS' 2014 SIM Model Test Application. The table below is a subset of the initiatives AHCCCS plans to fund with the SIM monies, focusing on those initiatives where Optumas, as the State's independent actuarial consultant, can provide estimated savings. Base data summarized by category of service was provided by AHCCCS covering Federal Fiscal Year (FFY) 2011, 2012, and 2013. Optumas chose to utilize a blend of FFY11 and FFY12 as its base and then trended that data forward by 2.1% annually, consistent with AHCCCS' historical overall trend rate for the past 3 years, to the midpoint of the project period, January 2017. The savings estimates provided use research conducted by Optumas to identify applicable studies published in peer-reviewed journals for similar interventions.

Optumas was unable to complete in-depth actuarial analyses or financial modeling due to the lack of claims level data and the short timelines associated with the SIM application process. AHCCCS, currently in the midst of a data warehouse transition, began processing data for Optumas in early June but was unable to provide detailed claims. As a result, Optumas is unable to provide an actuarial certification for the savings estimates below. To support the required financial analysis for this application, AHCCCS and Optumas invested significant time and resources in literature searches to identify clinical trials and systematic reviews of clinical trials that met the University of York Centre for Reviews and Dissemination's Scientific Quality Criteria. The savings estimates are conservative and should be considered illustrative and are based on applying savings figures achieved by similar initiatives as described in published studies from peer-reviewed journal articles. No actuarial judgment was applied in the determination of the savings estimates.

A. Populations Addressed

Optumas has grouped the initiatives together below into categories where we have summary level per member per month (PMPM) expenditure estimates for the project time period. Where possible, we have identified the populations addressed, PMPM costs, the associated member months, and the savings estimates as a percentage, as well as total dollars on an annual basis and for the project period.

Summary and Description by Initiative	PMPM, MMs, and Savings % and $'s*
• Integrated Care — Grants to major providers that partner with community-based behavioral health providers to integrate care. • Best Practices — Determine best practices for provider and payer activities to integrated care that can be replicated statewide. • Whole Person Care — Develop programs to train clinicians and health systems on effective interventions in integrated, whole person care. • SMI Care Coordination — Develop care coordination infrastructure between QHPs and RBHAs for members with behavioral health needs, including connecting QHP members with serious mental illness to state-only resources. • Value-Based Contracting — Funding for Medicaid and Commercial plans to support providers that partner with plans and RBHAs on value-based contracting tied to integration and care coordination.	PMPMandMMs $272.65 16,225,165 TotalDollars $4,423,774,643 SavingsEstimates 0.75% (midpoint) Total Savings $33,178,310 *All figures annual
• Population Health – Develop training programs for peers and other behavioral health providers to also include population health opportunities like obesity, diabetes care, and smoking cessation.	PMPMandMMs Not Available (N/A)
• Emergency Department (ED) Diversion – Explore partnerships with plans and EMS providers for delivery of low-acuity services and care coordination activities to avoid ED utilization and hospital readmissions.	PMPMandMMs N/A

Summary and Description by Initiative	PMPM, MMs, and Savings % and $'s*
• Super-Utilizers — Announce funding to develop infrastructure and capacity to accelerate care coordination for high-cost physical health and GMH/SA individuals (upper 5% or super utilizers) through RBHA and plans.	PMPMandMMs $4,530.87, 24,226 TotalDollars $109,767,174 SavingsEstimates 1.50% (midpoint) TotalSavings $1,646,508
• American Indian — Enhance and expand AHCCCS American Indian care coordination infrastructure and data sharing capacity. • Care Coordination — Enhance and develop four regionally-based care coordination models for the American Indian Health Program, including collaboration with IHS, 638 facilities and non-tribal providers, creating provider infrastructure and reducing fragmentation. • Literacy — Create member health literacy materials for American Indians to explain what members can do to access care appropriately (to be used with care coordination models.)	PMPMandMMs $489.52, 1,742,654 TotalDollars $853,071,339 SavingsEstimates 0.75% (midpoint) TotalSavings $6,398,035
• Corrections — Develop HIT infrastructure and health plan interfaces to coordinate coverage and care with the ADOC, jails, and probation systems.	PMPMandMMs $1,321.48, 62,538 TotalDollars $82,643,059 SavingsEstimates 1.75% (midpoint) TotalSavings $1,446,254

Totals:	Annual:	Project Period (Annual x 4):
• To adjust for any potential overlap, all expenditure estimates are mutually exclusive by population and therefore are additive. • FMAP assumed to be constant 2015 levels = 68.46%	TotalClaimsSpend $5,469,256,214 TotalSavings FederalSavings $42,669,106 $29,211,270 RequestedFederalFunds Yr 1: $9,218,925 Yr 2: $37,918,925 Yr 3: $19,318,925 Yr 4: $19,318,925 ReturnonInvestment N/A	TotalClaimsSpend $21,877,024,858 TotalSavings Federal Savings $170,676,424 $116,845,080 RequestedFederalFunds $87,775,700 ReturnonInvestment N/A

B. Anticipated Cost Savings and Documentation for Source of Savings Estimates

Individuals with behavioral and physical health conditions present a unique challenge to the health care industry[106][107]. Delivery of necessary services is frequently complicated due to the lack of communication between behavioral health and primary care providers[108]. In the current system of delivering physical and behavioral health in a non-integrated setting, sometimes duplicative or overlapping services are received by individuals or conditions remain undiagnosed[109]. The interventions proposed by Arizona will generate savings not only for Medicaid expenditures for other payers as well as Medicaid providers will change their practice in response to the incentives, so the commercial and Medicare populations seen by these providers will reap the benefits.

Initiatives 3/4/5/10/15: Integration

Studies have shown that including behavioral health and physical health services under the same managed care contract can reduce costs and improve patient outcomes[110]. In addition to generating savings, the integration of physical and behavioral health services has been shown to improve patient outcomes[111]. By integrating physical health services under the behavioral health capitation rate, providers will be able to decrease the overlap between services, efficiently diagnose conditions, and improve outcomes. Studies have further shown that providers with an increased awareness of psychological afflictions can reduce the overuse of medical and surgical services[112]. Additionally, the increased coordination of care between physical and behavioral health providers has led to better outcomes for patients[113]. The available literature supports the position that further coordination between physical health and behavioral health services will allow Arizona to achieve cost reductions and improve patient outcomes[114]. For the impact of these

[106] Mechanic D, "Seizing Opportunities under the Affordable Care Act for Transforming the Mental and Behavioral Health System", Health Affairs, Feb 2012.
[107] Mauer B and Druss B, "Mind and Body Reunited: Improving Care at the Behavioral and Primary Healthcare Interface", Am College Mental Health Administration, Mar 2007.
[108] Correll JA Cantrell P Dalton WT, "Integration of Behavioral Health Services in a Primary Care Clinic Serving Rural Appalachia: Reflections on a Clinical Experience", Fam Syst Health, Dec 2011.
[109] Mauer B and Druss B, "Mind and Body Reunited: Improving Care at the Behavioral and Primary Healthcare Interface", Am College Mental Health Administration, Mar 2007.
[110] Saunders RC, "Physical and Behavioral Health of Medicaid Children in Two Southern States", Southern Medical Journal, Apr 2005.
[111] Levent RF et al, "Cost Offset: Past, Present, and Future", Psychological Services, Aug 2006.
[112] Ibid.
[113] Saunders RC, "Physical and Behavioral Health of Medicaid Children in Two Southern States", Southern Medical Journal, Apr 2005.
[114] Correll JA Cantrell P Dalton WT, "Integration of Behavioral Health Services in a Primary Care Clinic Serving Rural Appalachia: Reflections on a Clinical Experience", Fam Syst Health, Dec 2011.

initiatives, Optumas applied an overall savings of 0.5–1.0% of total health expenditures per year for the target populations; all enrollees.

Initiative 6: Population Health

There is a significant body of research showing the positive impact that behavioral health interventions can have on population health issues like obesity, diabetes, and smoking[115][116] with no negative impacts on their mental health[117]. Without detailed data, Optumas was unable to apply a savings percentage.

Initiative 7: ED Diversion

Multiple studies have shown mostly positive results for pre-emergency department interventions to reduce inappropriate or inefficient use of the ED[118][119]. Without detailed data, Optumas was unable to apply a savings percentage.

Initiatives 10: Super-Utilizers

Studies on integrated care for super-utilizers, which may include behaviorally intensive individuals like the SMI, shows significant opportunities for savings and material improvements in functioning, quality of life and patient satisfaction while maintaining or slightly reducing costs[120]. For these initiatives, Optumas applied an overall savings of 1.0–2.0% of total expenditures per year for the super-utilizers.

Initiatives 11/12/13: American Indians

There is a significant gap in research regarding the efficacy of integrated care or health literacy for American Indians. American Indians have significantly worse access to integrated care and health literacy than the general population. For those studies on Medicaid and low-incomes populations similar to American Indians that lack access to integrated care, the evidence is clear that improvements in care integration and health literacy do reduce overall health expenditures[121]. For these initiatives, Optumas applied an overall savings of 0.5–1.0% of total expenditures per year for American Indians.

Initiative 14: Corrections

Significant opportunities exist to implement strategies to coordinate coverage and care for individuals exiting the correction systems[122] and associated improvement in care and savings have been demonstrated[123]. For the impact of these initiatives, Optumas applied an overall savings of 1.5–2.0% of total expenditures per year.

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[115] Kitzman KM and Beech BM, "Family-Based Interventions for Pediatric Obesity: Methodological and Conceptual Challenges from Family Psychology", Journal of Family Psychology, Vol 20 2006.
[116] Stead LF and Lancaster T, "Combined pharmacotherapy and behavioural interventions for smoking cessation (Review)", The Cochrane Library, Issue 12 2012.
[117] Piper ME et al, "Psychiatric diagnoses among quitters versus continuing smokers 3 years after quit day", Drug Alcohol Depend, Feb 2013.
[118] Infinger A et al, "Implementation of Prehospital Dispatch Protocols that Triage Low-acuity Patients to Advice- line Nurses", InformaHealthCare, Oct-Dec 2013.
[119] Morgan SR et al, "Non-emergency department interventions to reduce ED utilization: a systematic review", Academic Emergency Medicine, Vol 20 2013.
[120] Schottle D et al, "Integrated care in patients with schizophrenia: results of trials published between 2011 and 2013 focusing on effectiveness and efficiency", Current Opinion in Psychiatry, Jul 2013.
[121] Williams JW Jr, "Integrative Care: What the Research Shows", N C Med J, 2012.
[122] Patel K et al, "Integrating Correctional And Community Health Care For Formerly Incarcerated People Who Are Eligible for Medicaid", Health Affairs, Mar 2014.
[123] Morrissey JP et al, "Medicaid Enrollment and Mental Health Service Use Following Release of Jail Detainees With Severe Mental Illness", Psychiatric Services, Jun 2006.

C. Total Federal Cost Savings and Return on Investment (ROI)

To determine the savings percentage used in the calculations, Optumas used the midpoint in the savings range. To ensure that there is no overlap in our savings estimates, all expenditure figures are mutually exclusive by population and service (e.g., no expenditures for American Indians, SMI super-utilizers, or individuals with previous incarcerations are included in any of the other expenditure estimates). All savings estimates are done on an annual basis and converted to the project period by multiplying by four. Where possible, we provided estimated Federal cost savings estimates by applying the Federal Medical Assistance Percentage (FMAP) for FY2015 for the State of Arizona of 68.46%. For purposes of our savings calculations, we assumed a constant FMAP for the four year project. While savings will accrue to the Medicare program as a result of these initiatives, we have not included those savings here. It was not possible to calculate a ROI by initiative, as requested Federal funds were not available by initiative, nor was it possible to calculate an aggregate ROI as each initiative did not have a savings estimate available.

Actuarial Certification

It is not possible to provide an actuarial certification at this time. With sufficiently detailed claims and adequate time to support identification of 1) each the specific populations covered by the initiatives listed above, 2) the proposed interventions, and 3) development of an actuarial model to complete the financial analysis. Optumas could provide an independent actuarial certification in the future.

VII. Roadmap to Transformation

Implementation Roadmap

The implementation roadmap described herein is based on implementing the test goals described in Section IV of this Innovation Plan.

As described in the sustainability section of the Innovation Plan, Arizona is working with CMS to determine any necessary waivers the State will need to appropriately test each of its delivery system reform initiatives. In addition, among other things, Arizona is discussing implementation topics with its stakeholders, such as (i) what provider entities should be permitted to participate in testing the SIM initiatives, (ii) how provider entities apply to participate in testing the SIM initiatives, (iii) what funding is available to incentivize participation in testing the initiatives, and (iv) what measures and metrics will the participating providers be required to report.

While all of the SIM delivery system initiatives described in this Innovation Plan share a common theme of integration, coordination, and data exchange, the State anticipates that the entities participating in each initiative will vary based on the needs of the different vulnerable populations on which the specific initiative is focused.

At this time, the intent is that interested providers will collaborate with other providers to establish a collaborative arrangement that can most effectively impact care delivery and meet the goals of the specific initiative. Entities will not be required to participate in all of the initiatives. Providers forming a collaborative arrangement will 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 use disorders.
- MCOs (except for American Indians).
- Primary and specialty care.
- Social and community supports, as needed.
- Access to care.

AHCCCS is not dictating governance structures for the participating entities beyond a requirement that the participating providers have executed an agreement that defines how they will work together to accomplish selected projects.

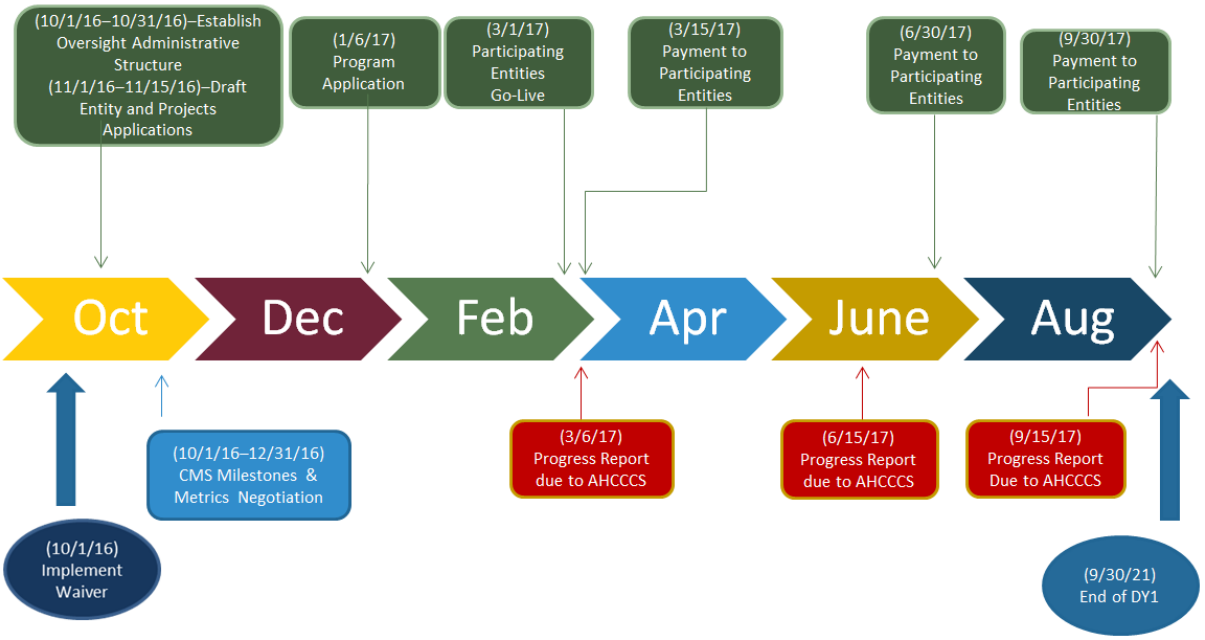
AHCCCS will support the development and operation of regional Care Management Collaboratives (CMCs) that will support the American Indian strategic focus. The participating providers will inform the operational structure of the CMCs through a steering committee. In the case of the justice system strategic focus, RBHAs will organize the providers and provide support throughout the project, as they are best positioned to initiate projects in this category. Successful entities will submit applications to the State that address how they will develop and implement projects.

AHCCCS intends to leverage its managed care infrastructure to make these initiatives a success. For that reason, Arizona intends to ask that its MCOs and RBHAs not only participate as members of the participating provider entities, but also:

- Provide the 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.
- Participate in learning collaboratives.
- In the case of the RBHAs, organize and support the entities participating in the justice system strategic focus area.

Arizona has developed the following timeline for the first year to engage participating providers and begin developing the necessary infrastructure to test the specific projects described in the initiatives above. Arizona is still working its stakeholders to review and finalize the year one timeline and developing the timeline for the next years.

Implementation Timeline - Year 1



Monitoring & Evaluation of Delivery System and Payment Model Transformation

To measure the success of the delivery system reform initiatives described throughout this Innovation Plan, the State must look at (i) the health of the population, (ii) the quality of care, and (iii) the cost of care. With respect to population health, the State has identified 14 health priorities and has developed specific strategies that it believes will improve these measures. The strategies to improve these measures are described in the Arizona Health Improvement Plan: Healthy People, Healthy Communities. The Arizona Department of Health Services (ADHS) is still refining its specific strategies for the following health priorities: (i) access to care, (ii) mental health, (iii) suicide prevention, and (iv) substance use. ADHS expects these strategies to be released by late summer 2016, and they will be incorporated into the Innovation Plan.[124]

With respect to measuring quality of care and cost of care, it is not possible at this juncture to finalize the monitoring and evaluation strategy because of continuing discussions with both stakeholders and CMS. As explained throughout this document, Arizona has spent a considerable amount of time with its stakeholders and with CMS in determining and developing the best strategy to implement and test its delivery system reform initiatives. The ability to monitor and evaluate the success of the delivery system reform initiatives is a critical step to ensure that the State is achieving its overall goals for delivery system reform in the State. However, as of the date of release of the Implementation Plan, the strategy to monitor and evaluate the delivery system reform initiatives is still evolving. Indeed, the State is still reviewing the quality measures and metrics that will be reported on during the testing of these initiatives. Drafts of these metrics that are being discussed with stakeholders are included in Exhibits D, F and I.

Moreover, the discussions with CMS continue to evolve and, as such, the monitoring and evaluation strategy will continue to evolve. To the extent that the State utilizes its 1115 Demonstration to implement testing the initiatives, reporting, monitoring and evaluating the

[124] The Arizona Health Improvement Plan: Healthy People, Healthy Communities is available at http://www.azdhs.gov/documents/operations/managing-excellence/azhip.pdf.

initiatives will have to align with special terms and conditions under the 1115 Demonstration and as of now, that is currently under discussion with CMS.

ARIZONA STATE HEALTH CARE INNOVATION PLAN

Exhibits

Exhibit A: Master Stakeholder List

Stakeholder Organizations

Abrazo Community Health Network

Adelante Healthcare

Apache Behavioral Health Services

Arizona Administrative Office of the Court

Arizona Advisory Council on Indian Health Care

Arizona Alliance for Community Health Centers

Arizona Association of Health Plans

Arizona Behavioral Care Homes

Arizona Behavioral Health Center PC

Arizona Care Network

Arizona Connected Care

Arizona Council of Human Service Providers

Arizona Department of Child Safety (DCS), Comprehensive Medical and Dental Plan (CMDP)

Arizona Department of Child Safety, Comprehensive Medical and Dental Program (CMDP)

Arizona Department of Economic Security (DES), Division of Developmental Disabilities (DDD)

Arizona Department of Juvenile Correction

Arizona Health Care Association

Arizona Health Care Cost Containment System

Arizona Health-e Connection

Arizona Hospital and Healthcare Association

Arizona Mentor

Arizona State Courts

Arizona State University - Center for Health Information and Research

Arizona's Children Association

Avalon Healthcare

Avalon Southwest Health & Rehabilitation

AZ Recovery Housing Association

Banner Health

Bay Area Addiction Research and Treatment

Bayless Healthcare Group

Behavioral Health Services

Benson Hospital

Bentley's Transition Living

Bridgeway Health Solutions

Brummet Consulting

Canyon Vista Medical Center

Canyonlands Healthcare

Care1st Health Plan Arizona

Caring Connections for Special Needs

Casa de los Ninos

Cenpatico Integrated Care

CHEEERS Recovery Center

Child & Family Services of Yuma

Child and Family Support Services

Chinle Comprehensive Healthcare Facility

Chiricahua Community Health Services

Christian Family Care Agency

Circle the City

Cochise County

CODAC Health, Recovery & Wellness

Community Counseling Centers

Community Health Associates

Community Intervention Associates

Community Medical Services

Community Partners Inc.

Community Provider Enrichment Services, Inc.

Copper Queen Community Hospital

CORIZON

Court Administrator for Navajo County

Covenant Health

Cradles to Crayons

Crestline Advisors

Crisis Preparation and Recovery

Crossroads Mission

David's Hope

Department of Corrections

Department of Economic Security (DES)

Department of Economic Security (DES), Division of Developmental Disabilities (DDD)

Desert Senita Community Health Center

Devereux Advanced Behavioral Health

Dignity Health Chandler Regional Medical Center

Dignity Health, AZ Service Area

District Medical Group

Easter Seals Blake Foundation

El Rio Community Health Center

Encompass Health Services

Encompass Integrated Care, A Division of PPEP

Family Involvement Center

Flagstaff Medical Center

Focused Family Services

Ft. Defiance Indian Health Board

Gila County

Gila River Health Care

Health Choice Arizona

Health Choice Integrated Care

Health Net

Health System Alliance of Arizona

Higher Ground a Resource Center

Honor Health

HOPE Group

Hope Inc.

Hope Lives - Vive la Esperanza

HOPE Medical Transportation

Hopi Tribe

IASIS Healthcare

IHS Navajo Area

IHS Phoenix Area

IHS Sells Service Unit

IHS Tucson Area

Indian Health Services

Integrity Counseling Services

Intensive Treatment Systems

Inter-Tribal Council of Arizona

Jewish Family and Children Services

Kaibab Paiute Tribe

Keogh Health Connection

La Frontera/EMPACT

La Frontrera Arizona

Lateef Behavioral Care Homes

Lifewell Behavioral Wellness

Luminaria

Maricopa County Adult Probation Department

Maricopa County Correctional Health Services

Maricopa County Juvenile Court

Maricopa Integrated Health System

Mariposa Community Health Center

Mercy Care Plan

Mercy Maricopa Integrated Care

MHC Healthcare

MIKID

Mountain Park Health Center

Mountain Top Behavioral Health Services

Native Americans for Community Action (NACA)

Native Health

Navajo County

Navajo Nation Department of Health

Navajo Social Services

Navajo Tribe

Neighborhood Outreach Access to Health

New Hope of Arizona

North Country HealthCare

Northern Arizona Healthcare

Oasis Behavioral Health

Partners in Recovery

Pasadera

Pascua Yaqui Tribe

Pathfinder Accountable Care Organization

People Empowering People of AZ

Phoenix Children's Hospital

Phoenix Health Plan

Phoenix Indian Medical Center

Phoenix Shanti Group

Pima County Health Department

Pima Prevention Partnership

Pinal County

Pinal Hispanic Council

Portable Practical Educational Preparation, Inc.

Practice Innovation Institute (Pii)

Providence of Arizona

PSA Beahvioral Health Agency

Quail Run Behavioral Health

Rabideau Consulting, PLLC

Recovery Empowerment Network

Regional Center for Border Health

Rio Salado Behavioral Health Systems

S.E.E.K. Arizona

S.T.A.R. - Stand Together And Recover Centers, Inc.

Safe Wing

Salt River Pima Maricopa Indian Community

San Carlos Apache Health Care Corporation

San Luis Walk-In Clinic

Sonora Behavioral Health Hospital

Southeastern Arizona Behavioral health Services, Inc.

Southwest Behavioral Health

Southwest Network

Spectrum Healthcare

St. Luke's Behavioral Health Center

Strategic Mental Health

Summit Healthcare

Sun Life Family Health Center

Sunset Community Health Center

Tenet Healthcare

Terros

The Guidance Center

The U-turn Foundation

Tohono O'odham Department of Health Services

Total Transit

Touchstone Behavioral Health

Tsehootsooi Medical Center

Tuba City Regional Health Care Corporation

Tucson Medical Center

United Healthcare Community Plan

University of Arizona Health Plan

University of Arizona RISE Health and Wellness Center

Valle del Sol

Valley Hospital

VALLEYLIFE

Vitalyst Health Foundation

Wedco Employment Center

Wesley Community and Health Center

Winslow Indian Health Care Center

Yavapai County

Youth and Familes First

Youth ETC

Yuma County Sheriff’s Office

Yuma County-Adult Probation

Yuma Regional Medical Center

Zarephath

Exhibit B: Steering Committee Meeting and Agenda Topics

The Steering Committee met on the following days and discussed the noted agenda topics:

Meeting Date	Agenda Topics
August 25, 2015	SIM Overview Steering Committee Charter Steering Committee's Role 11 Components of the Innovation Plan Arizona's SIM Initiatives Operational Plan Timeline Draft Stakeholder Engagement Plan
November 19, 2015	Quarter 3 (August–October) progress summary Arizona's SIM Components: Justice System Transition American Indian Care Coordination Models Behavioral and Physical Health Integration Alternative Payment Models HIT Plan Upcoming CMS Deliverables
January 27, 2016 (virtual meeting)	CMS Deliverable Status: Draft Value-Based Health Care Delivery and Payment Methodology Transformation Plan Deliverable Population Health Plan Quarter 4 Progress Report Office of the National Coordinator for Health Information Technology's Feedback on the Health Information Technology (HIT) Plan Updates on initiatives Justice System American Indian

Exhibit C: Summary Payment Contract Language

Acute Care Health Plan	Regional Behavioral Health Authority (RBHA)	Arizona Long-Term Care System (ALTCS)-Elderly & Physical Disability Program (EPD)	Comprehensive Medical & Dental Program (CMDP)	Children's Rehabilitative Services	ALTCS-Developmental Disabilities
Value-Based Purchasing (VBP) is a cornerstone of AHCCCS' strategy to bend the upward trajectory of health care costs. AHCCCS is implementing initiatives to leverage the managed care model toward value-based health care systems where members' experience and population health are improved, per capita health care cost is limited to the rate of general inflation through aligned incentives with managed care organization and provider partners, and there is a commitment to continuous quality improvement and learning. The Contractor shall participate in payment VBP efforts.	[Same as Acute Care Contract]	[Same as Acute Care Contract]	[Same as Acute Care Contract]	[Same as Acute Care Contract]	[Same as Acute Care Contract]
The purpose of the VBP initiative is to encourage Contractor activity in the area of quality improvement by aligning the incentives of the Contractor and provider through VBP strategies, as delineated by ACOM Policy 315 CYE 16 and as specified in Attachment F3, Contractor Chart of Deliverables. Quality distributions to Contractors will be funded by assessing 1 percent from Prospective Gross Capitation (Quality Contribution) exclusive of Delivery Supplemental, KidsCare and State Only Transplant payments. One hundred percent (100%) of the Quality Contributions will be distributed to one or more Contractors according to the Contractors' performance on selected Quality Management Performance Measures relative to minimum performance standards established by CQM and the Contractors' ranking on QMPMs. Quality contributions and quality distributions will be	The purpose of a VBP initiative is to encourage Contractor activity in the area of quality improvement by aligning the incentives of the Contractor and provider through VBP strategies, as delineated by ACOM Policy 322 CYE16.	The purpose of the VBP initiative is to encourage Contractor activity in the area of quality improvement by aligning the incentives of the Contractor and provider through VBP strategies, as delineated by ACOM Policy 318 CYE 16 and as specified in Attachment F3, Contractor Chart of Deliverables. Quality distributions to Contractors will		The purpose of the VBP Initiative is to encourage Contractor activity in the area of quality improvement by aligning the incentives of the Contractor and provider through VBP strategies, as delineated by ACOM Policy 319 CYE16 and as specified in Attachment F3, Contractor Chart of Deliverables.	The purpose of a VBP initiative is to encourage Contractor activity in the area of quality improvement by aligning the incentives of the Contractor and provider through VBP strategies. For CYE 16, the Contractor shall implement a VBP initiative focused on decreasing quality of care concerns related to transportation

Acute Care Health Plan	Regional Behavioral Health Authority (RBHA)	Arizona Long-Term Care System (ALTCS)-Elderly & Physical Disability Program (EPD)	Comprehensive Medical & Dental Program (CMDP)	Children's Rehabilitative Services	ALTCS-Developmental Disabilities
settled through a reconciliation performed annually on a contract year basis.		be funded by assessing 1 percent of Prospective Gross Capitation (Quality Contribution) exclusive of Acute Care Only payments. One hundred percent (100%) of the Quality Contribution will be distributed to one or more Contractors according to the Contractors' performance on selected Quality Management Performance Measures relative to minimum performance standards established by CQM and the Contractors' ranking on QMPMs. Quality contributions and quality distributions will be settled through a reconciliation performed annually on a contract year			services. Also during CYE 16, the Contractor shall continue development of its strategy regarding value-based purchasing for long term care services for employment for CYE 17 implementation.

Acute Care Health Plan	Regional Behavioral Health Authority (RBHA)	Arizona Long-Term Care System (ALTCS)-Elderly & Physical Disability Program (EPD)	Comprehensive Medical & Dental Program (CMDP)	Children's Rehabilitative Services	ALTCS-Developmental Disabilities
		basis.			
The Contractor shall develop strategies that ensure that members are directed to providers who participate in VBP initiatives and who offer value as determined by measureable outcomes. The Contractor shall submit by October 31, 2015, an Executive Summary describing its strategies to direct members to valued providers.	[Same as Acute Care Contract]	[Same as Acute Care Contract]		[Same as Acute Care Contract]	

Exhibit D: Goals and Action Steps for American Indians

Desired outcome: Improved care integration and decreased system fragmentation in the AIHP through enhanced care coordination and use of health information technology (HIT).

Goals	Actions Needed to Achieve Goals	Responsible Entity	Barriers/Challenges	Resources Needed	Measures
1	**Improve care coordination for AIHP enrollees by developing care coordination models that integrate physical and behavioral health care, leveraging assistance from IHS sites, Tribally-Operated 638 Health Programs, Urban Indian Health Programs (collectively, ITUs), Tribal Regional Behavioral Health Agencies (TRBHA), Regional Behavioral Health Authorities (RBHAs) and non-tribal providers.**				
1a	Establish the Indian Health Medical Home Program (IHMHP) for AIHP members.	AHCCCS DFSM IHS Tribally-Operated 638 Health Programs Urban Indian Health Programs Non-Indian health providers	Approval from CMS. Funding to support the medical homes. Recruitment of practices that can meet or enhance their practice to meet the IHMHP mandatory criteria. Establishing IHMPHs in geographic areas with healthcare provider workforce shortages	Participation in medical home model by providers. Training for providers and members. Medicaid funding to pay for specific services for AI members enrolled in FFS who receive services through IHS and Tribal health programs. Medicaid funding to pay non-IHS/Tribal health programs, a shared savings payment to support the Indian Health Medical Home Program.	Receive approval from CMS to pursue by October 2016. Improvement in the following measures: -Hospital readmissions within 30 days; -Number of hospital admissions within 30 days of discharge with a behavioral health diagnosis; -Average number of ED visits per empaneled patient per year; and GPRA measure regarding childhood immunizations and additional GPRA measures in future years.

1b	Work with Tribes to identify champions to develop best practices that support care coordination for high cost/high needs individuals and coordinate with non-Tribal providers.	AHCCCS DFSMIHS638 facilitiesTRBHAsRBHAsTribes and Tribal championsNon-Indian health Providers	Availability of culturally competent and linguistically appropriate health care services.Challenges in defining a high cost high need population.High staff turnover among IHS and 638 facilities. Healthcare provider workforce shortages, particularly in BH.Funding necessary to support the development of care coordination models.Participation among physical and behavioral health providers.Lack of detail on an IHS/638 claim because of how they are able to bill.	Participation among AHCCCS, tribes, and tribal champions.Funding.Expertise on care coordination models of care for high cost high needs models.	Identify champions for each tribal service area.Develop best practices in care coordination by September 2017.
1c	Identifying effective Care Coordination Strategies for High Needs/High Cost Members to address their needs and later be expanded to other AIHP populations.	AHCCCS DFSM TRBHAs	Staffing resources.		In progress.
2	**Improve connectivity and use of HIT in AIHP.**				
2a	Connect AHCCCS DFSM to State Health Information Exchange (HIE).	AHCCCS DFSM AzHeC		Training on HIE usage and workflow.	AHCCCS DFSM connected to HIE.

2b	Connect TRBHAs, IHS, and 638 facilities to State HIE.	TRBHAs IHS 638 Facilities AzHeC	Training on HIE usage, workflow, and benefits of connection to HIE. Funding to connect to HIE.	Funding to train staff. Funding to connect to HIE.	All TRBHAs connected to HIE.
2c	Identify data sharing concerns from state IHS sites and Tribes and develop suggestions on ways to mitigate.	AHCCCS DFSM AzHeC Tribes and Tribal champions IHS	Concerns regarding privacy and security. Technical obstacles. Quality and completeness of data.	Funding for training and establishing workflow. Discuss issue of technology barriers and potential solutions with AzHeC Board and academic institutions.	Identify data sharing concerns. Provide recommendations and work plan to mitigate concerns.
2d	Coordinate with Indian Health organizations and other HIT partners to share lessons learned and develop best practices for secure health information sharing	AHCCCS DFSM AzHeC IHS 638 Facilities Other Indian health organizations with HIT experience	Lack of interest from potential partners. Lack of common EHR systems. Competing priorities that requires leadership buy-in and prioritization.	Identification of sites to partner with.	Develop a learning collaborative to share experiences and provide guidance to providers who are struggling to develop and use electronic health information.
2e	Work to build an automated process to generate case management notes for AIHP members.	AHCCCS DFSM TRBHAs RBHAs IHS 638 Facilities Non-Indian health Providers	IT barriers. Funding. Training.	Health IT systems and HIE work flows. Training for staff.	Implement automated processes.

3	**Test delivery system model.**				
3a	Providers need to participate in care management collaborative (CMC) activities to ensure commonly understood and shared care management strategies are developed and implemented, including participation in the CMC steering committee.	AHCCCCS DFSM Indian health providers Non-Indian health providers	Defining appropriate regions for CMCs.	Development of CMCs.	Currently being discussed with stakeholders.
3b	Develop a care management system for the population enrolled in the AIHP and receiving treatment through Indian health and non-Indian health provider organizations participating in the CMC.	AHCCCCS DFSMIndian health providers	Funding and training on protocols.Funding to employ care managers.	Developing protocols.Funding for care management activities.Funding for training.	Currently being discussed with stakeholders.
3c	Develop a data infrastructure that can support data analytics using both clinical data and claims data for CMC participating providers.	AHCCCCS DFSM Indian health AzHeC	Participation in EHR and HIE.	Funding for training and establishing workflow. Discuss issue of technology barriers and potential solutions with AzHeC Board and academic institutions.	Currently being discussed with stakeholders.

3d	Train primary care practices on core PCMH skills and track their increased capabilities 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.	AHCCCS DFSM IHS Indian health providers	Coordination with IHS IPC Care Model.	Funding for training.	Currently being discussed with stakeholders.

Exhibit E: Draft Quality Performance Metrics for American Indians

Strategic Focus Area: Members Served by the American Indian Health Program - DRAFT

Project 1: Provider Role in CMC Formation, Governance and Management

Objective: Participate in collaborative CMC activities to ensure commonly understood and shared care management strategies are developed and implemented, resulting in improved care for high-risk AIHP members in need of structured care management support.

		Year 1
CC #	Core Component	Provider Reporting Requirement
1	Participate in the Steering Committee and any work groups developed by the CMC.	Identify the executive(s) from its organization who will participate on the CMC Steering Committee and any CMC-organized work groups.
2	Develop an agreement with the CMC to participate and collaborate in CMC-organized activities.	*N/A: The CMC will document that an agreement has been signed between the participating provider and the regional CMC.*
3	The executive assigned to the Steering Committee will attend all meetings, or send a designated representative when the executive is unable to attend, and will participate in collaborative work (with the CMC) to develop protocols for comprehensively identifying and prioritizing AIHP members for whom care management resources would be beneficial. Such work should also include the development of a standardized approach to care plan development, which includes consumers, and defining the respective care management roles of the CMC and participating providers, and to define the respective care management roles of the CMC and participating providers.	*N/A: The CMC will document that all Steering Committee meetings have been attended by a provider executive, or by a designated representative.*
4	The participating provider will implement the care management protocols, as collaboratively developed through and documented by the CMC.	Document that the participating provider is working to implement a care management model designed in collaboration with the CMC.
5	The participating provider will report progress on Core Components of projects in this strategic focus area to the CMC.	*N/A: Evidence of this Core Component will be measured in other Projects.*
6	The participating provider will participate in education and training offered by the CMC.	*N/A: The CMC will document that a clinician affiliated with the participating provider attended the CMC's education and training offerings over the course of the year.*

Strategic Focus Area: Members Served by the American Indian Health Program - DRAFT

Project 2: Care Management

Objective: To develop a care management system that will support the care delivered to American Indian populations enrolled in AIHP and receiving treatment through Indian health provider organizations and non-Indian health provider organizations participating in the CMC.

		Year 1
CC #	**Core Component**	**Provider Reporting Requirement**
1	**For primary care practices and community mental health practices:** Implement the protocols established through CMC-coordinated efforts (Project 1, Core Component #3), including engaging AIHP members who have been prioritized for care management, and developing individualized care plans.	Document that the provider has implemented the established protocols; Document that the provider has the capability to implement the protocols, consistent with Core Component 4.
2	**For primary care practices and community mental health practices:** Utilize the predictive modeling software employed by the CMC for improved population health.	*N/A*
3	**For primary care practices and community mental health practices:** Utilize the care plans for all care management activity. Utilize the standardized care plan template to be developed collaboratively with the CMC in Project 1, Core Component #3 when available.	Document that care managers a) have been trained in how to develop a standardized care plan, and b) are utilizing care plans for all care managed AIHP members.
4	**For primary care practices and community mental health practices:** Participate in collaborative work (with the CMC) to define how to attribute AIHP members in need of care management to a participating provider organization.	*N/A: The CMC will report the participation levels of participating providers.*
5	**For primary care practices and community mental health practices:** Providers of a certain size, to be determined by AHCCCS, must have a care manager(s) employed by the practice. The number and full-time status of the care manager(s) should be directly correlated with the number of high-risk patients attributed to the provider. Providers that are smaller than the size set forth by AHCCCS must develop care management agreements with the regional care management support consistent with Core Component 6.	Identify the name of at least one care manager serving site and the hours for which the care manager is available. Provide documentation of a job description. Document that the care manager has been trained to educate patients, how to promote patient engagement, and when/how to facilitate linkages to community-based organizations.

6	**For regional care management support organizations designated by AHCCCS:** Care management services must be available during 24/7 to a) support AIHP member evaluation during ED visits; b) answer after-hour and weekend questions from providers regarding member care plans; and c) coordinate follow-up post-ED evaluation / after-hour clinical interventions with primary care or community mental health practice; d) support practices too small to support a care manager during regular business hours.	Develop agreements with small primary care and community mental health providers to provide care management services to the practice. Agreements should have protocols for accessing medical records. Document the staffing plan for 24/7 care management coverage. Develop agreements with any primary care and community mental health providers to provide care management services outside of non-traditional business hours. Agreements should have protocols for accessing medical records. Document the staffing plan for 24/7 care management coverage.
7	**For hospitals, primary care practices and community mental health practices:** Develop protocols for transition planning and collaborative care management for AIHP members:	Document that policies and procedures have been developed to provide transition planning and collaborative care management for AIHP members.
	(a) leaving the justice system. (This protocol should, in part, state that upon notification from the criminal justice system that an AIHP member is transitioning back to the community, actively outreach to the AIHP member to schedule a well-visit.)	
	(b) being discharged from inpatient care. (This protocol should, in part, state that shortly after hospital notification of an outpatient primary care practice (or a community behavioral health provider, when appropriate) that an AIHP member will soon be discharged, actively outreach to the AIHP member to schedule a post-discharge visit within 3 days after hospital discharge and conduct 3) medication reconciliation within 7 days of hospital discharge. Prior to the post-discharge appointment, obtain the discharge summary.)	

	(c) being discharged from crisis stabilization services. (This protocol should, in part, state that upon notification that an AIHP member is being or has been discharged, actively outreach to the AIHP member to schedule a post-discharge appointment. Prior to the post-discharge appointment obtain the discharge summary.)	
	(d) entering the foster care system or transitioning from the foster care system (due to family reunification, adoption or aging-out). (This protocol should identify the actions the primary care and community mental health practices must take to ensure a) immediate care is provided to AIHP members that need care (e.g., children entering foster care); and that b) for AIHP members that might not need immediate care (e.g., adults aged-out of the foster care system), that medical and behavioral health records are transitioned to a new provider (if applicable) within a reasonable time frame.	
8	Provide all medical records to AzHeC or non-IHS / tribal provider when referring the AIHP member for any testing, treatment, or follow-up.	N/A
	Incorporate results of screening, diagnostic testing, or procedures from the non-IHS / tribal provider into the AIHP member's medical record and HIE upon receipt.	Document that the provider has a procedure for incorporating the results from secondary treatment providers into the AIHP's member's medical record and the HIE.
	Assess the information received from the non-IHS / tribal provider and take appropriate action, including when necessary, furnishing or requesting additional services.	Document the provider has a procedure for assessing the clinical information received from secondary providers and protocols for acting upon it.

Strategic Focus Area: Members Served by the American Indian Health Program - DRAFT

Project 3: Care Management and Data Infrastructure

Objective: To develop a data infrastructure capability in support of care management protocols, including data analytics for both clinical data and utilization data for CMC participating providers.

		Year 1
CC #	**Core Component**	**Provider Reporting Requirement**
1	Participate in CMC-offered coding training and education to improve the claims detail that flows to the CMC and AHCCCS.	Document participation in all CMC-offered coding training and education.
2	Establish processes and dedicate staff to update data that reside in CMC analytic tools and that are used to identify recent utilization, gaps in care and/or care management detail.	Document processes and identify staff who are responsible for updating data used by the CMC to identify AIHP members in need of care management and for tracking their care.
3	**For primary care practices and community mental health providers**: Establish processes for a) utilizing CMC analytic data and dedicate staff to identify and b) actively engaging complex needs members in care management activities.	N/A
4	**For primary care practices and community mental health providers:** Establish protocols for identifying complex members during office visits so that timely interventions and supports can be provided. Such protocols should include an assessment of medical and behavioral health needs, and of social determinants of health, including housing, employment and food security needs. Evidence-based screening tools should be used, when possible, and be consistent with Core Components 6 & 11 of Project 4. Results of assessment / screening tools must be documented in the medical record.	Document that policies and procedures are in place to identify individuals with complex medical and behavioral health needs, and that social determinants of health are identified; Demonstrate that the results are documented in the medical record, and as applicable in the CMC analytics tool.
5	**For participating hospitals:** Provide ADT notification and ED discharge summaries to the AzHeC.	*N/A: The CMC will report whether the participating hospital has provided ADT and ED discharge summaries to AzHeC.*

6	**For participating hospitals:** Establish protocols for identifying complex members during ED visits so that timely interventions and supports can be provided. Assessment information should be included on ED discharge summaries that are shared with AzHeC.	Document that policies and procedures are in place to identify individuals with complex medical and behavioral health needs, and that social determinants of health are identified; Document that the results are recorded in the medical record.
7	Register with Arizona's Controlled Substances Prescription Monitoring Program	Identify the percentage of prescribers in the organization who are registered for the CSPMP.
8	Consult Arizona's Controlled Substances Prescription Monitoring Program before prescribing a controlled substance to identify the patient's controlled substance usage history.	Document that the practice has policies and procedures in place for all prescribers of controlled substances to review the CSPMP before prescribing Schedules 2, 3, 4 and 5 controlled substances.
9	Utilize e-prescribing for Schedules 2, 3, 4, and 5 controlled substances.	Document that prescribers have the capability to e-prescribe, and that medications that are e-prescribed are documented into the electronic medical record.
10	Enter into an arrangement with AzHeC to participate in bidirectional exchange of data with the HIE (both sending and receiving data).	Document that an agreement with AzHeC has been executed.

Strategic Focus Area: Members Served by the American Indian Health Program - Optional - DRAFT

(Optional) Project 4: Transform primary care sites serving AIHP members into Patient-Centered Medical Homes.

Objective: Assist primary care practices on developing core PCMH skills, and possible certification, and track their increased skill level over three years.

		Year 1
CC #	**Core Component**	**Practice Reporting Requirement**
	Engaged Leadership	
1	Demonstrate practice leadership is committed to transforming the practice into a Patient-Centered Medical Home.	Written documentation that the practice leadership has designated staff resources and allocates time for care teams to learn, implement and manage the transformation process, including the name of the physician champion and hours designated weekly to oversee the transformation process; Written documentation of practice's transformation vision statement, and objectives.
	Quality Improvement Strategy	
2	Use an organized approach to identify, report and act on improvement opportunities, and set goals for improvement.	Written documentation of the organized QI approach (e.g., PDSAs, Model for Improvement, Lean, FMEA, Six Sigma, etc.) to be used within the practice; Written example of use of selected approach to address one quality issue.
3	Build quality improvement capacity and empower staff to innovate and improve.	Name and qualifications of clinician responsible for overseeing the practice's quality initiatives; Written curriculum used to train existing staff in QI process.
4	Regularly produce and share reports on performance at both the organizational and provider/care team level, including how performance compares to goals.	Examples of reports the practice intends to implement on a regular basis; Written plan for sharing report results within the practice, including to whom and how frequently.
	Empanelment and Population Health Management	

5	Maintain a process to measure and promote continuity between a patient and his/her care team so that patients and care teams recognize each other as a partner in care.	Written protocol for assigning patients to a care team.
6	Track high-risk patients to assist efforts to address their needs and coordinate their care. High-risk patients include, but are not limited to: those with patterns of frequent emergency department use, frequent inpatient use for behavioral health conditions; recent use of residential services; recent involvement with law enforcement; children and youth in foster care; individuals with multiple chronic conditions. *Complementary to Project 2.*	Written evidence that the practice regularly receives payer-generated, gaps-in-care reports covering the top 5 chronic diagnoses within the practice's patient population and uses this information to identify gaps in care.
	Continuous & Team-based Healing Relationships	
7	Set clear expectations for each team member's functions and responsibilities to optimize efficiency, outcomes and accountability.	Written documentation of process used for identifying members of the care team; Job descriptions for each care team member; Work flow map of work required before, during and after patient visits that maximizes the skill set of the care team.
	Organized Evidence-based Care	
8	Assure well-coordinated, evidence-based care for highest-risk patients. *Complementary to Project 2.*	Written protocol detailing the content of patient assessment based on patient's specific symptoms, complaints or situation, including the patient's preferences and lifestyle goals, self-management abilities and socioeconomic circumstances contributing to high-risk designation; Written protocol for content of care plan and timeline for its development.

	Integrated Care	
9	Ensure that care addresses the whole person, including mental and physical health needs, by routinely screening adult patients for: depression, anxiety, drug and alcohol misuse using the Patient Health Questionnaire (PHQ-2 and PHQ-9) for depression, CAGE-AID for drug and alcohol use, GAD-7 for generalized anxiety disorder; and screening pediatric patients for: developmental disorders, depression, and drug and alcohol use. To assess development delays and disorders, practices may use the Parents' Evaluation of Development Status (PEDS), the Survey of Wellbeing in Young Children (SWYC), the Ages and Stages Questionnaire (ASQ), OR the Pediatric Symptom Checklist (PSC) AND must use the Modified Checklist for Autism in Toddlers (M-CHAT) at the 18- and 24-month office visits. For drug and alcohol screening of adolescents, practices should use the CRAFFT Screening Test. For depression, practices should use the Patient Health Questionnaire for Adolescents (PHQ-A).	Copy of training curriculum regarding use of screening tool and names of clinicians that have completed training.
10	Develop referral agreements with mental health and substance use providers in the community to improve the integration of care, coordination of referrals, and access. Each referral agreement must include: (a) an agreed-upon practice for regular communication and provider-to-provider consultation, and the protocols for referring a patient to a behavioral health provider when any of the screening assessments are positive. Details should include the communication modality by which the primary care clinician can reach the behavioral health provider (e.g., telephone, pager, email, etc.).	Identify the names of the behavioral health practices with which the primary care site has developed a referral and care coordination agreement.

	Patient-Centered Interactions	
11	Encourage patients and families to collaborate in goal-setting and decision-making.	Name of shared decision-making tool selected by practice; Curriculum for training all staff that interact with patients and families in shared decision-making approaches. Written protocol for consistently documenting patient/family involvement in goal setting, decision making.
12	Maintain a formal approach to obtaining patient and family feedback and incorporating this feedback into the quality improvement system and in strategic and operational decisions of the practice.	Evidence that practice has a formal approach to obtaining patient and family feedback, such as an established patient advisory group that meets regularly or a patient survey that is implemented within established timeframes.
13	Encourage patients to develop self-management skills.	List of self-management classes or educators to which practice refers patients.
14	Guide the practice by principles of patient-centered and culturally competent care.	Practice vision and mission statement include the principles of patient-centered and culturally competent care.
	Enhanced Access	
15	Maintain a system to increase patient access to their care team in order to improve continuity of care and reduce need for ED visits.	Written policy specifying the timeframes for returning patient telephone calls: a) For urgent medical/behavioral calls received during office hours, return calls are made the same day; b.) For urgent calls received after office hours, return calls are made within 1 hour; c) For all non-time-sensitive calls, return calls are made within 2 business days of receiving the call.
	Care Coordination	
16	Identify the practice's medical neighborhood to include specialists, a hospital(s), nursing homes and other organizations with which the practice or its patients interact on a regular basis.	List of specialists, hospitals, nursing homes, home health, home care and other organizations, including drug and alcohol abuse treatment programs, that are part of the practice's medical neighborhood, including key contact names, telephone numbers and email addresses.
17	Follow up via telephone, visit or electronic means with patients within a designated time interval after an emergency room visit and completes a medication reconciliation within a designated time	a) Written evidence that the practice has established a system for regularly receiving timely information from hospital partners about emergency department visits; b) Written protocol

	interval after hospital discharge. *Complementary to Project 2.*	requiring follow-up after ED visits to occur within 72 hours of visit.
18	Enhance relationships with community-based social service resources, including self-help referral connections, community group resources, specialty mental health and substance use services, and peer professionals by (a) identifying the resources in the community, and (b) creating protocols of when to engage or refer patients to these community-based resources.	Document the resources in the community, including contact information, and describe a schedule for periodically updating the resource listing with up-to-date information. Document protocols used for engaging these resources on behalf of patients and for referring patients to these resources.

Members Served by the American Indian Health Program

Exhibit F: Goals and Action Steps for Justice System

Updated: **20-May-16**

Desired Outcome: Reduced health care costs per capita associated with Justice System involved individuals impacting a reduction in recidivism.					
Goals	**Actions Needed to Achieve Goals**	**Responsible Entity**	**Barriers/Challenges**	**Resources Needed**	**Measures**
1	**Ensure individuals who are AHCCCS eligible are enrolled with AHCCCS prior to release.**				
1a	Remaining AZ counties to implement processes for AHCCCS enrollment suspension: 1. Santa Cruz 2. La Paz 3. Greenlee 4. Apache 5. Gila 6. Graham	- County Jails - AHCCCS	1) Cost and technical expertise.	1) Engage local colleges and universities for technical expertise support. 2) AZ Justice Alliance is a potential resource.	1) Have Medicaid suspension for incarcerated individuals implemented in all counties by December 2016.
1b	Establish Eligibility and Enrollment processes in each jail and prison to assist with applications for adults not already enrolled in Medicaid prior to release.	- DOC - County Jails - DES - AHCCCS - Adult Probation	1) HEAplus restriction on approving apps from jail/DOC prior to release. 2) People needed to assist applicants with completing and submitting applications. 3) Assistance from Community Organizations/Navigators not sustainable. 4) Current process to identify eligible clients in jail is redundant and manual. Expand use of jail data link to Adult Probation and other key partners for efficiency. 5) Release dates are rarely known.	1) Verify and determine AHCCCS enrollment status upfront. 2) Identify a DES worker to assist with AHCCCS application. 3) HEAplus system enhancements. 4) Consider utilizing RBHA Jail Liaisons for application assistance.	1) Establish baseline of the number of applicants approved as part of current pre-release process versus the number potentially eligible by June 2016. 2) Once HEAplus enhancements made, measure the number of people approved by jails/prisons in system by December, 2016.

2	**Coordinate physical and behavioral health care early and continuously.**				
2a	RBHAs and health plans to use 834 transaction file to identify incarcerated adults and coordinate care prior to release.	- RBHAs - Health plans - Adult probation	1) There is no contract language that requires care coordination expectation for incarcerated individuals.	1) Communication to stakeholders - Health Plans and RBHAs. 2) Adult probation to help locate and coordinate between client and RBHA/health plan.	1) RBHAs and Health Plans to begin using 834 in December 2015 to develop processes to identify incarcerated individuals and begin to collect baseline data on utilization from January 2015 to September 2016. Utilization measures include: (i) Number of ED use per 1,000. (ii) Number of ED visits per 1,000. (iii) Total number of care coordination touches per 1,000. (iv) Number of individuals who were referred to BH services and completed an intake assessment. 2) Collect jail recidivism rates.
2b	RBHAs and health plans to use the HIE to identify incarcerated adults and coordinate care prior to release.	- AzHeC - DOC - ADJC - County Jails - RBHAs - Health plans	1) Cost and technical expertise. 2) Adopt and implement EHR. 3) HEC vendor resources to complete work	1) County jails may need human and capital resources to implement EHR and connect to the HIE. 2) Communication to stakeholders - RBHAs, health plans, DOC, County Jails, and adult probation	1) By October 2016, all county jails will implement EHR. 2) By April 2017, all entities will be connected to HIE.

2c	Develop a streamlined statewide requirement for discharge planning for adults who are sentenced and incarcerated for more than 30 days and with: (i) SMI (ii) GMH/SA (iii) Chronic healthcare needs.	- DOC - AHCCCS - RBHAs - Health Plans - County Jails - Probation/Parole	1) May need a separate processes for: (i) DOC (statewide approach) (ii) County jails (regional approach) 2) SA RTC shortage. 3) For non-SMI individuals, there is no funding to coordinate discharge and arrange for services while an individual is incarcerated.	1) Need contract language for both the RBHAs and health plans with minimum requirements for care coordination processes. 2) Research evidence-based practices in transitioning care from the justice system to the community setting to inform RBHAs and health plans in effective continuity of care (e.g. early intervention, provide members with appointments and treatment plans when necessary prior to release, health care education, peer support). RBHAs could already have this knowledge and be supporting providers with EBP and re-entry planning. 3) Also, there are state-wide coalitions, summits and other efforts that include participation from RBHAs and the health plans currently to address streamlining and enhancing re-entry planning and transitional services. AHCCCS should participate. 4) Standardized assessment tool for BH and PH needs.	1) By October 2016 , contract language will be approved by CMS and incorporated as amendment. 2) Reporting requirements i.e., education, training, meetings or collective plan addressing these items. 3) Determine needs around capacity concerns and make recommendation by March 2016.

			4) Currently DOC and county jails provide only methadone as MAT to treat opioid addicted inmates regardless of drug efficacy.	5) Depending on what services can be delivered prior to the release, may require a State Plan Amendment, AHCCCS rule changes, AHCCCS and contractor requirements, and communication to stakeholders. 6) Include Peer Support requirements for RBHAs and Health Plans as part of discharge planning.	
2d	RBHAs and health plans to develop care coordination processes for those adults with short incarceration (less than 30 days).	- Health Plans - County Jails - Community Providers - Probation/Parole - AOC	1) Lack of incarceration information from DOC and county jails. 2) Inmates with very short stays are difficult to do early reach-in as timing can be as short as 48 hours.	1) More real time data through the HIE. 2) Standardized assessment tool for BH and PH needs. 3) Depending on what services can be delivered prior to the release, may require a State Plan Amendment, AHCCCS rule changes, AHCCCS and contractor requirements, and communication to stakeholders.	N/A at this time. Will revisit this goal in October 2016.

2e	Streamline the SMI determination process and develop a reciprocity process for accepting the SMI determination completed by DOC.	- DOC - AHCCCS - RBHAs - County Jails - Probation/Parole - AOC	1) Possible statutory or regulatory restrictions on use of DOC SMI determination vs community.	1) Depending on the review of the current DOC's SMI determination process and the SMI rules, statutory changes may be needed.	1) By February 2016, review the DOC's SMI assessment process and compare to the assessment done in the community. **COMPLETE-See 1-page communication from AHCCCS dated 3/1/16** 2) By April 2016, finalize a decision related to use of DOC's SMI assessment for members transitioning into the community. Where possible, utilize DOC SMI assessment for transfer to community. **COMPLETE - See 1-page communication from AHCCCS dated 3/1/16**
2f	Assist with transportation for individuals to attend court hearing, legal, and health related appointments.	RBHA Health Plans	1) Transportation to court hearing. 2) Non-medically necessary transportation services cannot be paid through federal dollars.	1) RBHAs and health plans could elect to expand transportation services to include legal appointments, and broaden partnerships with CBOs/other organizations that provide case management and transportation services. 2) Waiver request, if appropriate.	1) By April 2016, number of members who receive NEMT services to health appointments. 2) By April 2016, number of members that health plans and RBHAs elect to assist with non medical transportation.

2g	Expand focus to juveniles - RBHAs and health plans to coordinate discharge and provide follow up services upon release.	- ADJC - Health plans - RBHAs - Juvenile Probation/Parole - AOC	Juveniles in a detention setting may or may not be able to continue Medicaid services. Need to ensure the system for Medicaid determinations is effective for counties.	Eligibility determination system that is effective for counties to use with juveniles.	N/A at this time. Will revisit this goal in October 2016.
2h	Expand focus to American Indians - IHS, 638 tribal facilities, and T/RBHAs to coordinate discharge and provide follow up services upon release.	- DOC - IHS and 638 tribal facilities - T/RBHAs - Probation/Parole - AOC	1) EHR adoption and implementation. 2) HIE connectivity. 3) Regional variations in processes.	To be determined.	N/A at this time. Will revisit this goal in October 2016.
3	**Share clinical and incarceration information via HIE.**				
3a	Sign up with AzHEC as a Network participant to share patient health information.	- DOC - County Jails - Community Providers. - AHCCCS - RBHAs - Health plans - Probation/Parole - AOC	1) Cost and technical expertise. 2) Adopt and implement EHR. 3) Vendor resources to complete work.	1) Communication to stakeholders.	1) Number of entities signed up with AzHEC by April 2016.

3b	Utilize HIE for the following, including but not limited to: (i) AHCCCS, acute care, and RBHA enrollment information. (ii) DOC and County Jail incarceration information (to be further defined i.e., release date, probation status, pre-trial status) (iii) Court date. (iv) Clinical information i.e., medication, allergies. (v) SMI designation. (vi) Probation. (vii) Probation agency. (viii) Probation officer contact info.	- DOC - County Jails - Community Providers. - AHCCCS - RBHAs - Health plans - Probation/Parole - AOC	1) Lack of financial and/or IT resources to upgrade and/or set up the system to participate in the HIE.	1) Communication to stakeholders.	1) Data sub-team to develop proposal for current and future data requirements and needs (to include specific data measures required for this model) by June 2016.
3c	Assist with workflow using HIE data.	- AzHEC	1) Entities with the HIE connectivity may need assistance in streamlining workflow using HIE data.	1) Communication to stakeholders.	Will revisit this goal in beginning of 2017

4	**Identify and implement support for additional social determinants of health (housing, employment, peer support).**				
4a	Collaboration with community partners that can assist with providing social support services i.e., housing, employment and peer/family support for individuals.	- RBHAs - Health plans - Probation/Parole - County Human Services Departments - Municipal human service agencies	1) Medicaid funding cannot directly pay for housing or employment services but funding is available to pay for education related to these services. Through the RBHAs Vocational services and living skills are available to all TXIX GMH/SA and SMI members. Housing services are available to SMI members;	1) Funding for housing. 2) Employment support. 3) Access to community resources. 4) Education for RBHAs and Health Plans to better understand the services and supports that Medicaid can assist with (e.g. education and referral to housing, employment resources). 5) If in jail, use video visitation or probation officer to help reach client. 6) Use targeted case managers from various orgs (RBHAs, health plans, etc.) to make and track referrals.	N/A at this time. Will revisit this goal in October 2016.

5	**Test delivery system model**				
5a	The RBHAs will develop an integrated health care setting located within county probation offices or DOC parole offices to address beneficiary health care needs of individuals transitioning out of incarceration upon release and throughout the term of probation/parole.	- RBHAs - MCOs - Probation/Parole - County Human Services Departments - County Jails - DOC - AOC - AzHeC	1) Administrative issues in developing a co-located space such as having physical space to set up a clinic within probation offices. 2) Geographic concerns. 3) Requiring entities to execute agreement with non-traditional partners.	1) Funding for developing integrated space. 2) Providers to be located within probation clinics. 3) Access to community resources. 4) Education for RBHAs and Health Plans to better understand the services and supports that Medicaid can assist with (e.g. education and referral to housing, employment resources). 5) Use targeted case managers from various orgs (RBHAs, health plans, etc.) to make and track referrals.	Currently being discussed with stakeholders.

Exhibit G: Draft Quality Performance Metrics for Justice System

Strategic Focus Area: Adults Transitioning from the Justice System – DRAFT

Project 1: Develop an integrated health care setting within select 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.

Objective: 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.

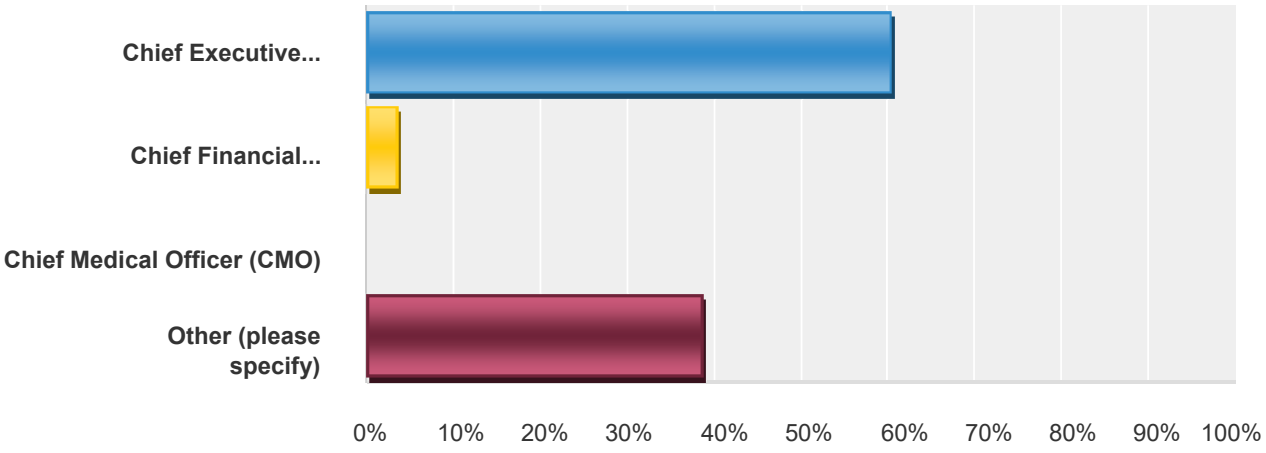
		Year 1
CC #	Core Component	Practice Reporting Requirement
1	Upon the request of the RBHA, participate in the RBHA-convened process designed to identify opportunities consistent with the objectives of this project for integrated care in select county probation office or DOC settings, and develop a strategy for addressing identified opportunities.	Document collaborative participation with the RBHA and work in good faith to identify opportunities for developing an integrated health care setting within probation and/or DOC parole offices.
2	Establish an integrated health care setting(s) co-located within select county probation offices and/or DOC parole offices, the number to be determined by the RBHA and AHCCCS.	N/A
3	Develop a marketing plan in cooperation with the probation and parole offices to encourage individuals pre-release to utilize the integrated health care setting post-release.	Document a marketing plan developed in cooperation with probation and parole offices.
4	For individuals who have suspended Medicaid eligibility while incarcerated with a known release date within 30 days for those in jail and within 90 days for those in prison, develop protocols with probation and parole offices to coordinate health care assessments and care management meetings with probation/parole pre-release visits and schedule appointments in the integrated co-located health care setting upon release.	Document protocols with agreement from the probation and/or parole office(s) for coordinating health care assessments and care management meetings at the integrated site pre-release and scheduling appointments upon release.

5	The practice should conduct a screening and assessment for both physical and behavioral health needs (including substance use disorder needs) during the individual's first visit to probation/parole unless the beneficiary declines a request from the practice.	Demonstrate that the practice has a protocol for performing and assessment and screening during the first visit.
6	Develop protocols to ensure that prior to the conclusion of a visit, (i) a follow-up appointment has been made at a mutually convenient time, (ii) that the individual has a plan to access transportation to the follow-up appointment, and if not, that the care manager or a peer support assists the beneficiary in developing a plan to access transportation and (iii) that the practice has obtained contact information to reach the individual.	Demonstrate that the practice has developed protocols consistent with all three elements of this Core Component.
7	Peer support staff are part of the co-located staff to assist formerly incarcerated individuals with, including but not limited to, eligibility and enrollment applications, health care education / system navigation, and information on other support resources.	Demonstrate that peer support staff have been hired and have participated in training provided by the RBHA; Provide evidence of job descriptions.
8	Enhance relationships with community-based social service resources, including self-help referral connections, community group resources, specialty mental health and substance use services, peer professionals, housing and employment support services by (a) identifying the resources in the community, and (b) creating protocols of when to engage or refer patients to these community-based resources.	Document the resources in the community, including contact information, and describe a schedule for periodically updating the resource listing with up-to-date information. Document protocols used for engaging these resources on behalf of patients and for referring patients to these resources.
9	Assess patient satisfaction with integrated practice services and identify what the practice might do to attain higher utilization of practice services among those on probation and parole and traveling to the probation or parole office per the terms of their release. Develop and implement changes in response to patient satisfaction assessment findings.	N/A
10	Enter into an arrangement with AzHeC to participate in bidirectional exchange of data with the HIE (both sending and receiving data).	Document that an agreement with AzHeC has been executed.
11	Participate in RBHA training and education.	Demonstrate that the practice participated in RHBA-provided training during the DY.

Exhibit H: VBP Forum Survey Results

Q1 What is your title/position at your organization?

Answered: 83 Skipped: 0



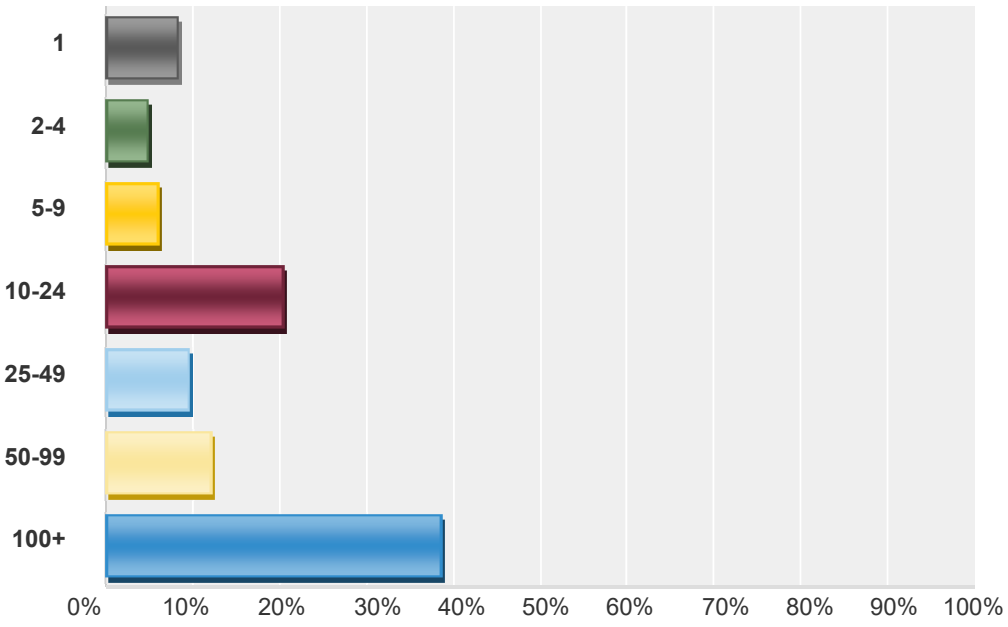
Answer Choices	Responses	
Chief Executive Officer (CEO)	**60.24%**	50
Chief Financial Officer (CFO)	**3.61%**	3
Chief Medical Officer (CMO)	**0.00%**	0
Other (please specify)	**38.55%**	32
Total Respondents: 83		

#	Other (please specify)	Date
1	Clinical Director/Area Director	12/17/2015 10:49 PM
2	Clinical Director	12/17/2015 5:14 PM
3	Accounts Recievable Manager	12/17/2015 4:28 PM
4	Program Director	12/17/2015 1:44 PM
5	Chief Programs Officer	12/17/2015 1:05 PM
6	Executive Director	12/17/2015 1:01 PM
7	Licensed Professional Counselor Individual Provider	12/17/2015 11:19 AM
8	Chief Clinical Officer	12/17/2015 10:35 AM
9	Chief Program Officer	12/17/2015 10:23 AM
10	Chief Nursing Officer	12/17/2015 9:53 AM
11	Program Direvctor	12/17/2015 9:29 AM
12	Program director	12/17/2015 9:10 AM
13	Director of Operations	12/14/2015 11:58 AM
14	Executive Vice President	12/13/2015 1:31 PM
15	Program Director	12/12/2015 7:52 AM

16	Clinical Director	12/10/2015 10:37 AM
17	Owner /sole practitioner	12/10/2015 10:10 AM
18	Clinical Director	12/10/2015 7:58 AM
19	Clinical social worker	12/10/2015 7:47 AM
20	Director	12/9/2015 8:06 PM
21	self employed	12/9/2015 6:55 PM
22	Owner	12/9/2015 6:51 PM
23	Director of Operations	12/9/2015 5:37 PM
24	VP of Behavioral Health	12/9/2015 4:36 PM
25	Executive Director	12/9/2015 3:53 PM
26	office manager	12/9/2015 3:46 PM
27	psychologist	12/9/2015 3:45 PM
28	Program Supervisor	12/9/2015 3:37 PM
29	Director	12/9/2015 2:07 PM
30	Senior Program Manager	12/8/2015 8:43 AM
31	Clinical Director	12/7/2015 11:46 PM
32	Director	12/7/2015 2:10 PM

Q2 Please select the number of full time employees at your organization

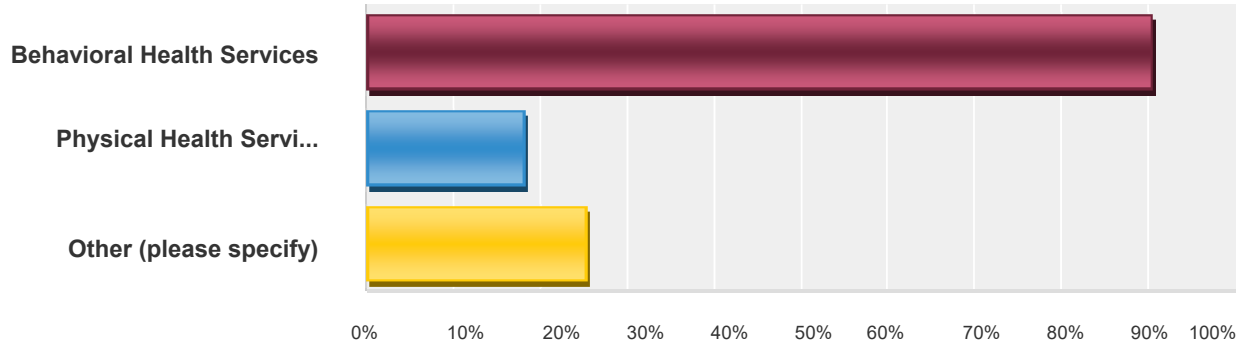
Answered: 83 Skipped: 0



Answer Choices	Responses	
1	**8.43%**	7
2-4	**4.82%**	4
5-9	**6.02%**	5
10-24	**20.48%**	17
25-49	**9.64%**	8
50-99	**12.05%**	10
100+	**38.55%**	32
Total		**83**

Q3 What service does your organization provide?

Answered: 83 Skipped: 0

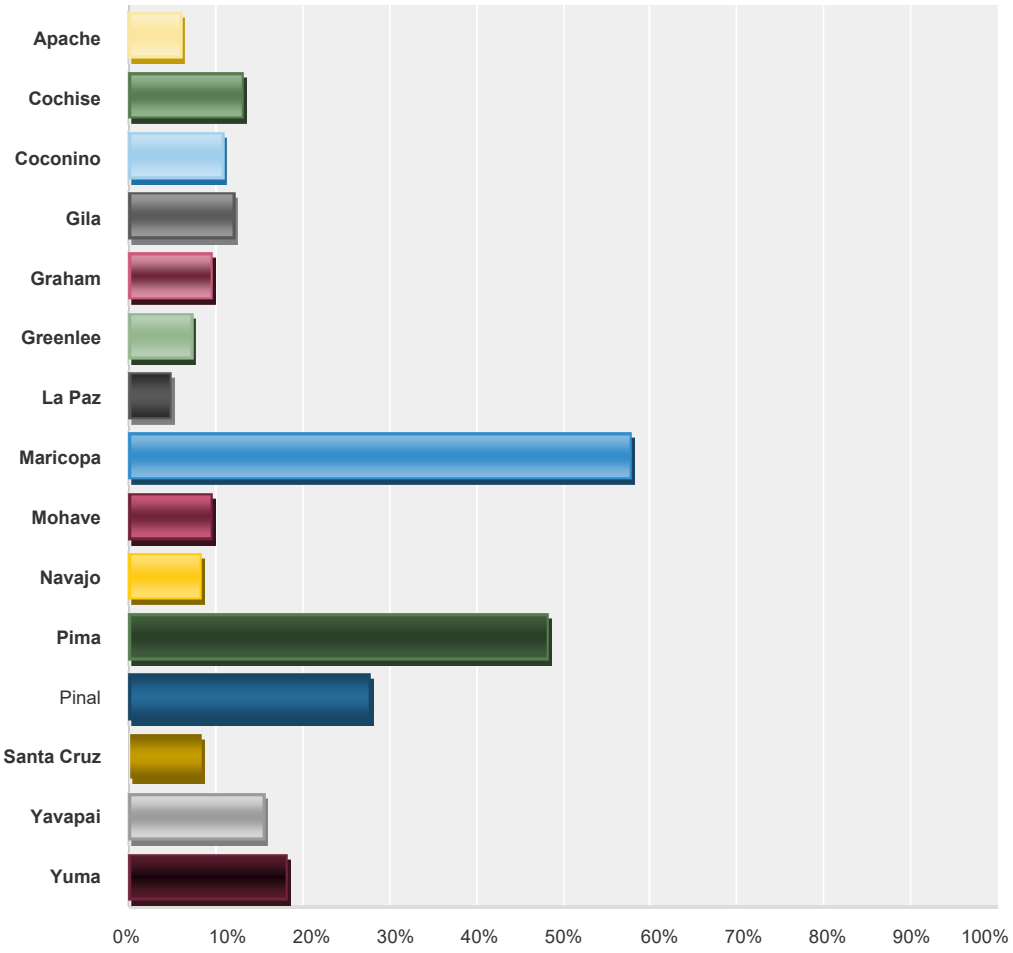


Answer Choices	Responses	
Behavioral Health Services	**90.36%**	75
Physical Health Services	**18.07%**	15
Other (please specify)	**25.30%**	21
Total Respondents: 83		

#	Other (please specify)	Date
1	Work Adjustment Program	12/17/2015 1:44 PM
2	Foster Care and Adoption	12/17/2015 1:05 PM
3	Developmental Disabilities	12/17/2015 12:32 PM
4	Developmental Disability	12/17/2015 11:43 AM
5	child welfare services	12/17/2015 10:18 AM
6	Skilled Nursing	12/17/2015 9:53 AM
7	Methadone Maintenance	12/12/2015 7:52 AM
8	MAT, HIV	12/10/2015 10:48 AM
9	Neuropsychological and psychological evaluation	12/10/2015 10:10 AM
10	Specialty Services for Addiction Disorders, DD, Families FIRST, Crisis, Depart of Child Welfare, and more	12/10/2015 9:18 AM
11	Transportation	12/10/2015 9:09 AM
12	Psychiatric NP services	12/10/2015 7:58 AM
13	Residential for SMI adults	12/9/2015 6:51 PM
14	Transportation	12/9/2015 5:37 PM
15	Forensic Peer Support and Suicide Intervention and Prevention	12/8/2015 12:46 PM
16	Substance Use Disorder services	12/8/2015 9:16 AM
17	Employment Related Services - SMI	12/8/2015 8:43 AM
18	Outpatient PTSD/Trauma Treatment Center	12/7/2015 11:46 PM
19	Early Intervention, Child Care , Family Support, Services for individuals with developmental disabilities, supported employment, residential supports, Head start/Early Head Start	12/7/2015 3:30 PM
20	Prevention	12/7/2015 2:58 PM
21	Health home	12/7/2015 2:03 PM

Q4 Please select counties in which services are primarily provided (check all that apply)

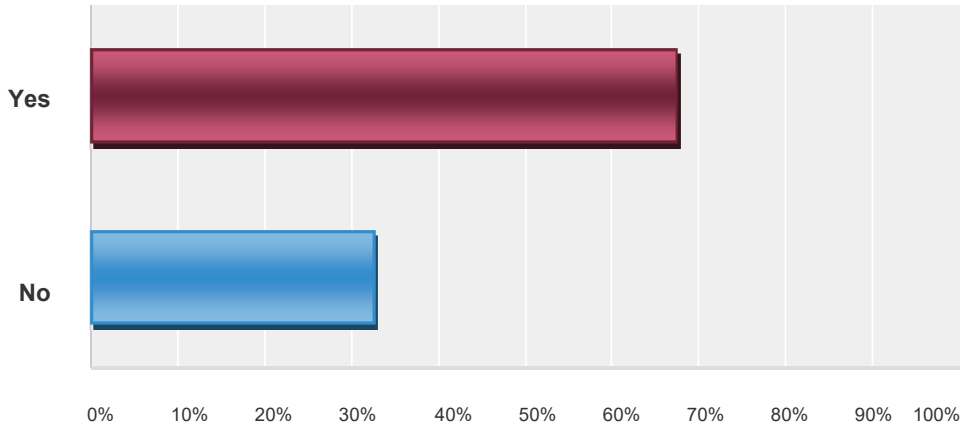
Answered: 83 Skipped: 0



Answer	Responses	
Apache	**6.02%**	5
Cochise	**13.25%**	11
Coconino	**10.84%**	9
Gila	**12.05%**	10
Graham	**9.64%**	8
Greenlee	**7.23%**	6
La Paz	**4.82%**	4
Maricopa	**57.83%**	48
Mohave	**9.64%**	8
Navajo	**8.43%**	7
Pima	**48.19%**	40
Pinal	**27.71%**	23
Santa Cruz	**8.43%**	7
Yavapai	**15.66%**	13
Yuma	**18.07%**	15
Total Respondents: 83		

Q5 Does your organization have electronic health records (EHRs)?

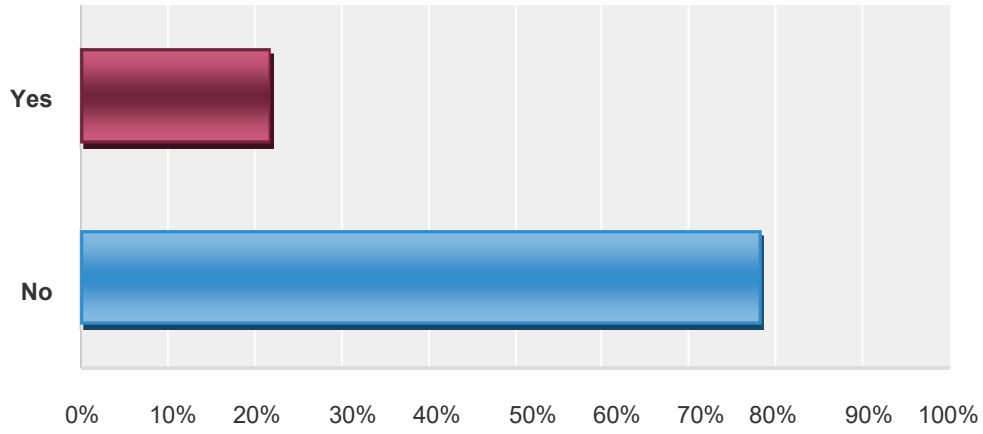
Answered: 83 Skipped: 0



Answer Choices	Responses	
Yes	**67.47%**	56
No	**32.53%**	27
Total		**83**

Q6 Is your organization connected to a Health Information Exchange (HIE) such as the Arizona Health-e Connection (AZHeC) or Behavioral Health Information Network of Arizona (BHINAZ)?

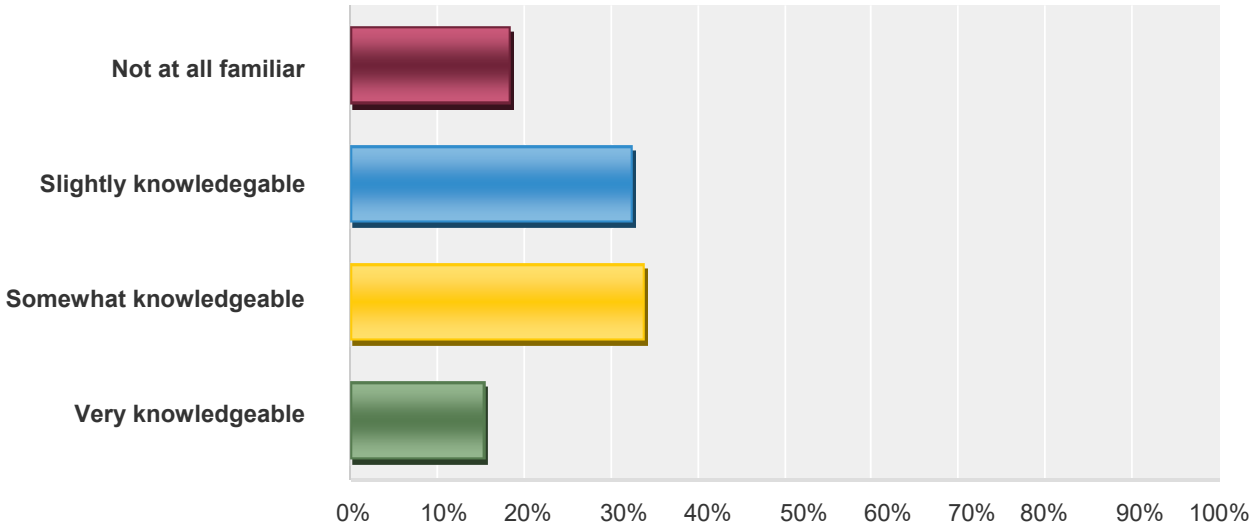
Answered: 83 Skipped: 0



Answer Choices	Responses	
Yes	**21.69%**	18
No	**78.31%**	65
Total		**83**

Q7 How would you rate your knowledge on value based payment?

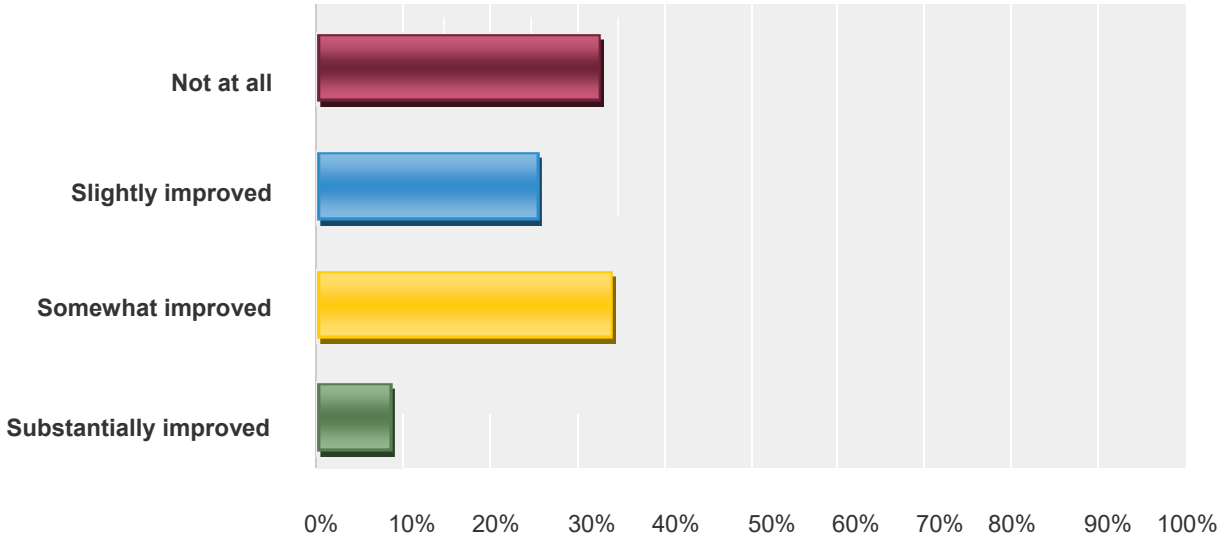
Answered: 71 Skipped: 12



Answer Choices	Responses	
Not at all familiar	**18.31%**	13
Slightly knowledgeable	**32.39%**	23
Somewhat knowledgeable	**33.80%**	24
Very knowledgeable	**15.49%**	11
Total		**71**

Q8 Has your knowledge on value based payments improved as a result of the behavioral health forum?

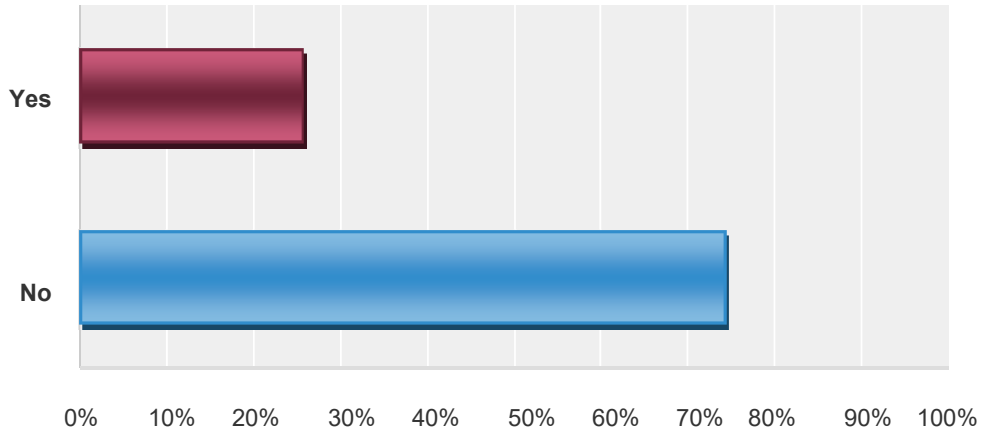
Answered: 71 Skipped: 12



Answer Choices	Responses	
Not at all	**32.39%**	23
Slightly improved	**25.35%**	18
Somewhat improved	**33.80%**	24
Substantially improved	**8.45%**	6
Total		**71**

Q9 Does your organization currently participate in value based contract arrangements?

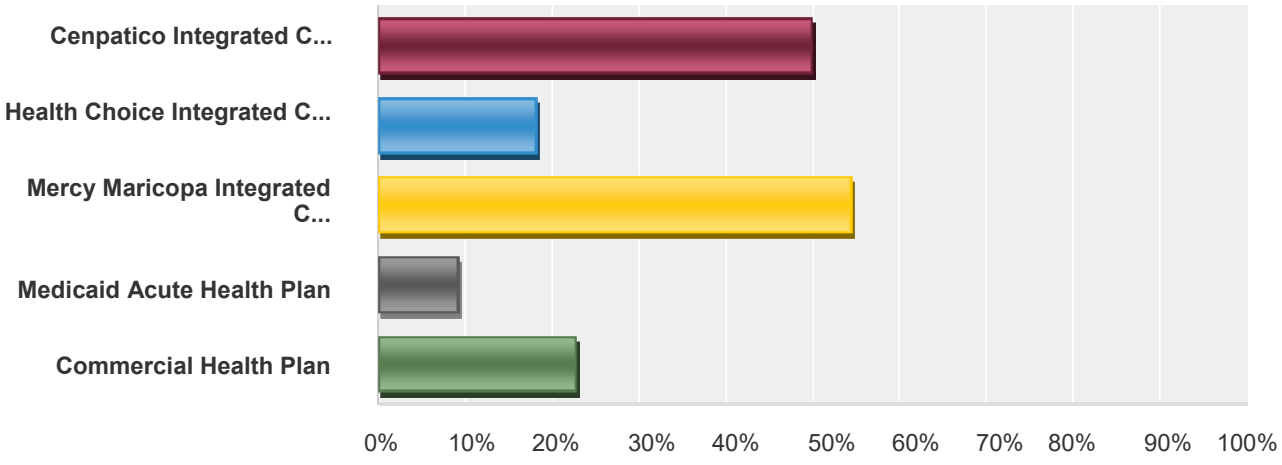
Answered: 70 Skipped: 13



Answer Choices	Responses	
Yes	**25.71%**	18
No	**74.29%**	52
Total		**70**

Q10 Which health plan do you have value based contracts with? (Check all that apply)

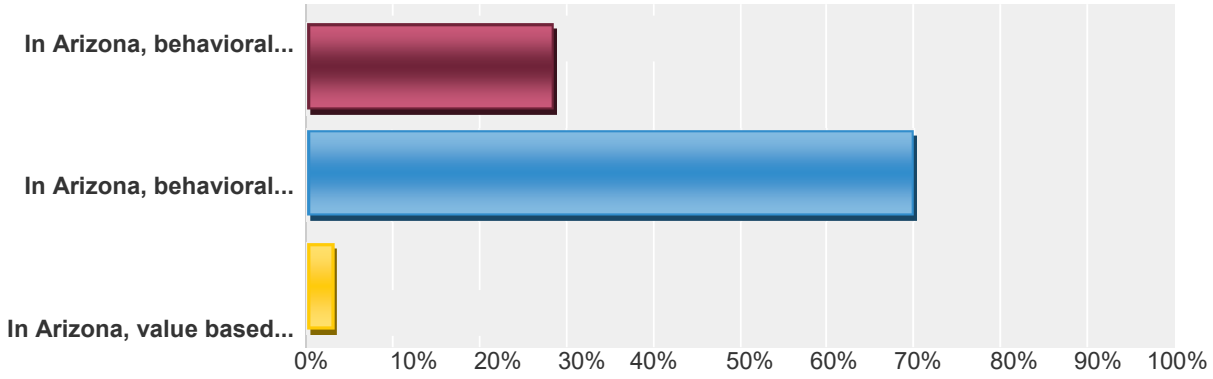
Answered: 44 Skipped: 39



Answer Choices	Responses	
Cenpatico Integrated Care (CIC)	**50.00%**	22
Health Choice Integrated Care (HCIC)	**18.18%**	8
Mercy Maricopa Integrated Care (MMIC)	**54.55%**	24
Medicaid Acute Health Plan	**9.09%**	4
Commercial Health Plan	**22.73%**	10
Total Respondents: 44		

Q11 Which statement best describes your awareness of what is happening around the state in regards to value based payment for behavioral health in Arizona?

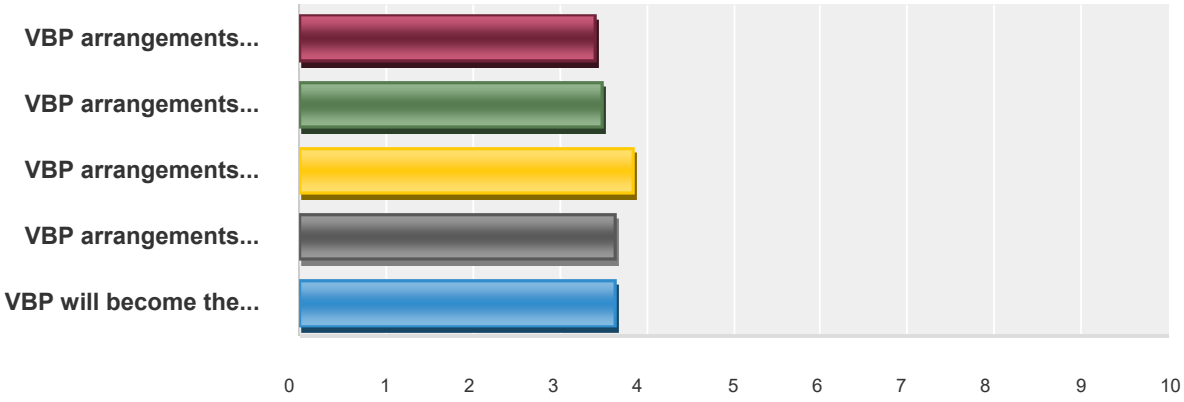
Answered: 67 Skipped: 16



Answer Choices	Responses
In Arizona, behavioral health providers are advancing rapidly towards value based reimbursement. My organization is/plans to embrace value based payment.	**26.87%** 18
In Arizona, behavioral health providers are just beginning to adopt value-based reimbursement and are moving slowly. I am open to learning more about value based payment arrangements.	**70.15%** 47
In Arizona, value based reimbursement programs are experimental and will not play a major role for behavioral health services. My organization is hesitant to enter value based payment arrangements at this time.	**2.99%** 2
Total	**67**

Q12 Please indicate how much you agree or disagree with each of the following statements about value based payment (VBP).

Answered: 69 Skipped: 14



	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Total	Weighted Average
VBP arrangements improve overall quality of care for patients.	**1.45%** 1	**7.25%** 5	**46.38%** 32	**39.13%** 27	**5.80%** 4	69	3.41
VBP arrangements improve care coordination for behavioral health and physical health services.	**1.45%** 1	**5.80%** 4	**44.93%** 31	**39.13%** 27	**8.70%** 6	69	3.48
VBP arrangements require data exchange amongst behavioral health providers, physical health providers and payers.	**2.90%** 2	**1.45%** 1	**26.09%** 18	**47.83%** 33	**21.74%** 15	69	3.84
VBP arrangements can increase quality transparency for behavioral health services.	**2.94%** 2	**1.47%** 1	**38.24%** 26	**44.12%** 30	**13.24%** 9	68	3.63
VBP will become the dominant payment model for behavioral health services in the future.	**2.90%** 2	**2.90%** 2	**40.58%** 28	**34.78%** 24	**18.84%** 13	69	3.64

Q13 What are your greatest concerns with value based payment models?

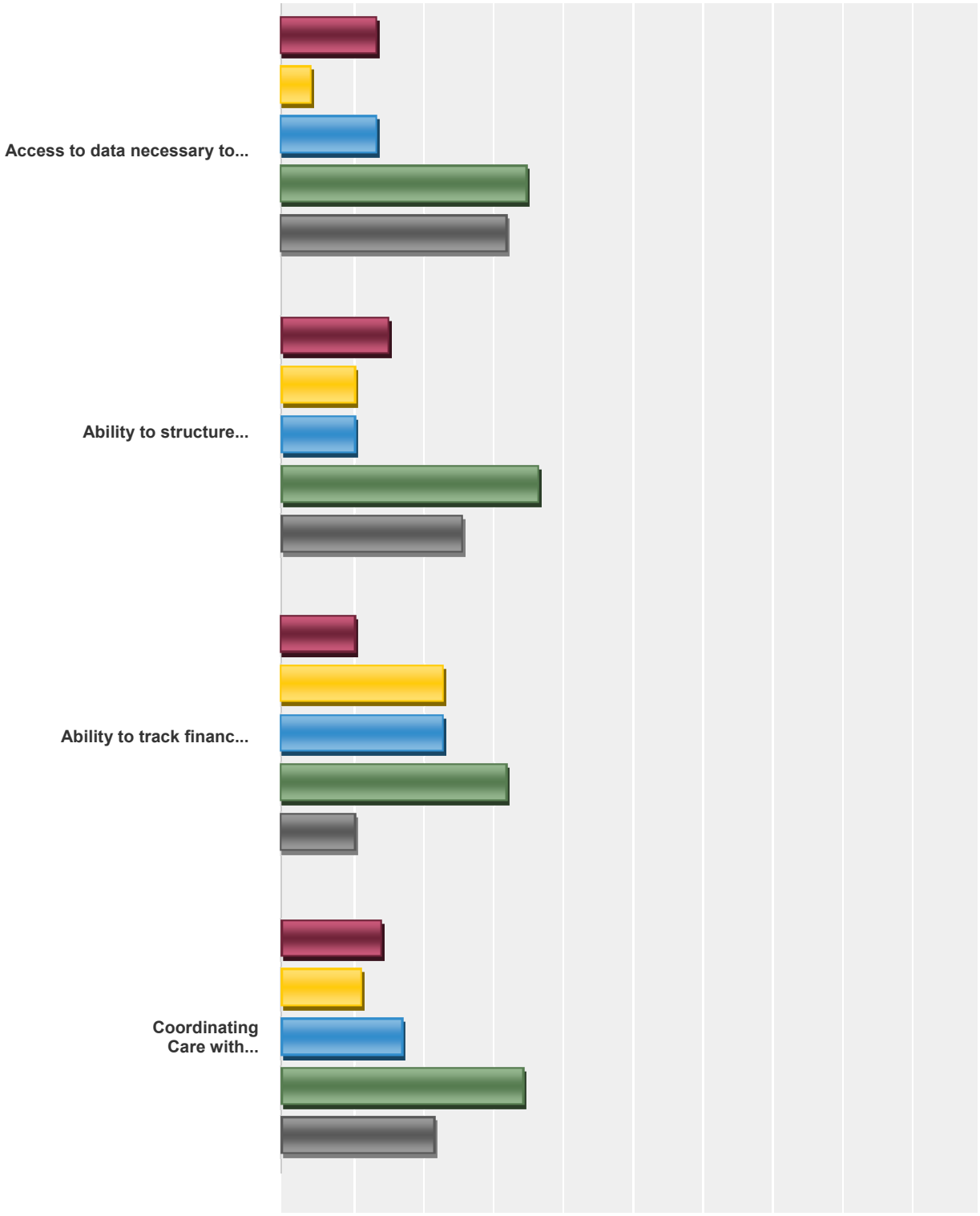
Answered: 37 Skipped: 46

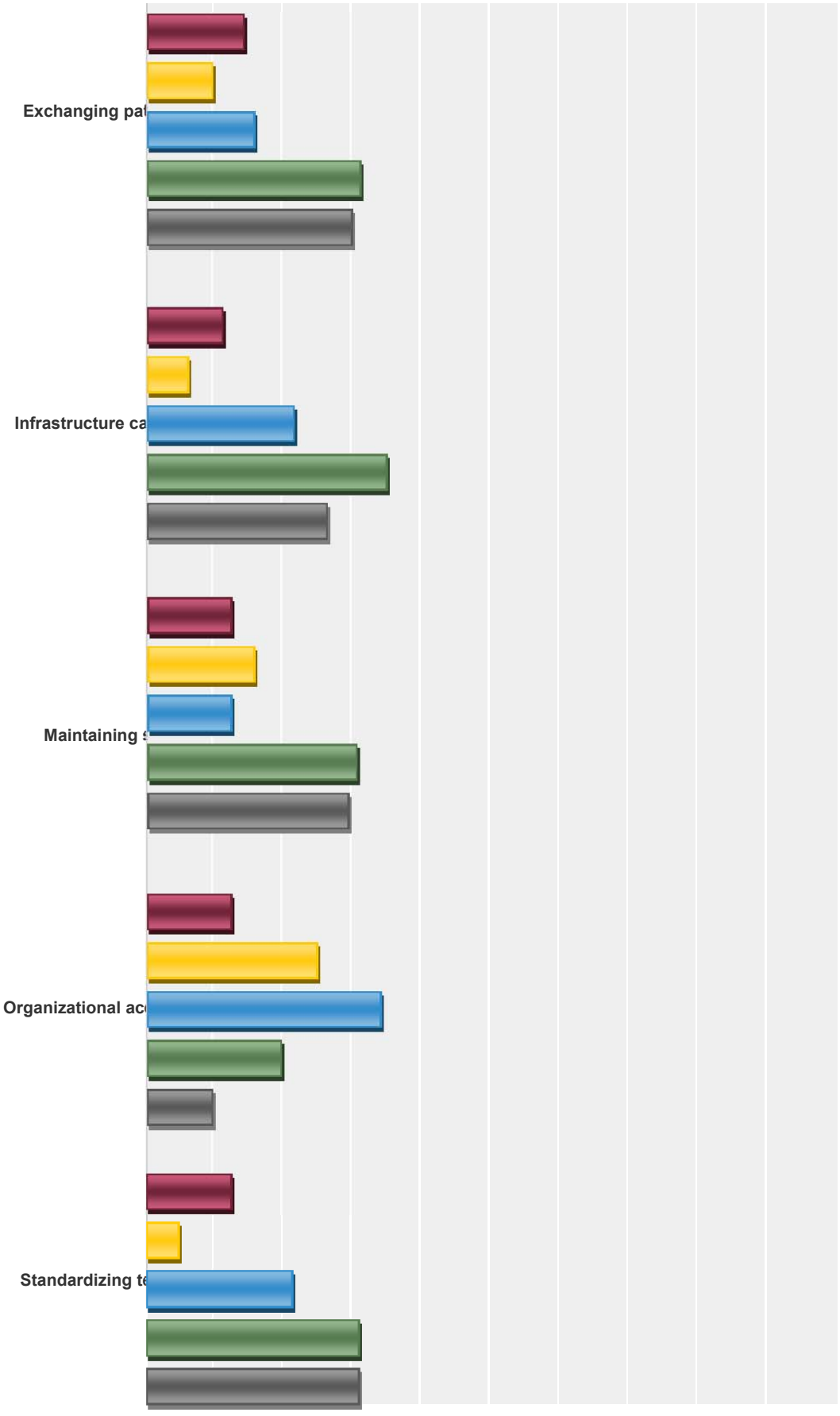
#	Responses	Date
1	There is concern that the outcomes being measured may lead some providers/professionals/staff to not seek hospitalizations or utilize emergency services even though they are appropriate or necessary. The rates are not currently paid at a high enough rate to cover all of the increased costs of integrated care and to cover the staff costs for those positions we would have to add to begin tracking outcomes/costs vs. benefits, etc.	12/17/2015 10:58 PM
2	As with many things, VBP arrangements run the risk of being instituted without rigorous research to establish what the benefits and pitfalls of such arrangements might be, and how to resolve pitfalls before such arrangements are instituted.	12/17/2015 5:14 PM
3	outcomes that are designed to measure quality or services not just quantity or clean claims	12/17/2015 1:08 PM
4	That they will not actually result in better outcomes and that payers will not be willing to continue paying long enough to see the outcomes.	12/17/2015 1:07 PM
5	none at this time	12/17/2015 12:44 PM
6	That it is just a risk withhold and offers no upside to providers.	12/17/2015 11:46 AM
7	Lack of communications/willingness across providers to work with each other. There seems to be a major lack of understanding about the physical results of childhood trauma and how they interact or influence behavioral health. It is very hard to get behavioral health providers to work with medical providers, due to lack of understanding.	12/17/2015 11:23 AM
8	Transition process	12/17/2015 10:34 AM
9	balancing risk data integrity ensuring staff understand shift	12/17/2015 10:22 AM
10	Complexity	12/17/2015 9:32 AM
11	No idea about them	12/17/2015 9:30 AM
12	The reimbursement to agencies when the VBP starts. Agencies do not all have the working capital to sustain funding payments when process first rolls out	12/15/2015 4:58 PM
13	I believe it will take some time to truly see the quality of coordination of care improve. The old way of thinking " keep it all in house " will not change overnight, but I	12/15/2015 9:23 AM
14	The burden of administrative cost to capture outcomes. Collaboration between providers	12/13/2015 1:35 PM
15	Unable to continue to receive monies necessary to maintain required work force to maintain compliance.	12/12/2015 7:55 AM
16	Not enough information.	12/10/2015 12:02 PM
17	Our affiliation options as a very small population-specific provider, should the RHBA network system be eliminated.	12/10/2015 11:32 AM
18	The seemingly arbitrary number of billable units allowed for services changes from RBHA to RBHA. It appears that the "one-size fits all" approach is being utilized at times.	12/10/2015 10:14 AM
19	The initial investment entering the new environment. Having sufficient medical provider workforce both psychiatric and physical.	12/10/2015 9:35 AM
20	One size fits all models will not work. Maintaining cash flow and sustainable fiscal reserves to remain solvent between the periods of time until the value based benchmarks are reconciled and payment is made.	12/10/2015 8:22 AM
21	I am concerned that the RBHA doesn't understand that some providers serve a more complex population. I am also concerned about the RBHA's ability to provide accurate data. I am also concerned about the process measures currently in place and the number of PIPs, CAPs and Notice to Cures that occur because of process measures (number of case managers, caseload size, face to face visits, etc). When we are on corrective action we focus on those items and it is difficult to focus on quality of clinical care. Workforce is a huge concern. We are also competing for a small pool of staff. The lack of psychiatrists in the system is difficult.	12/10/2015 8:19 AM

22	We are a specialty provider under a Direct Services Provider Contract, and the type of services we provide are not well understood or valued yet by the larger, more traditional provider organizations, and we have to rely on these agencies for referrals. Providing parent-to-parent (peer) support in the children's behavioral health system for MMIC and HCIC. Parents/primary caregivers who need our services do not have an easy way to access our services, nor are there effective approaches for parents/families to learn about or access our services. Parents would benefit if if they could receive info when first coming into services and be able to request on their own this service - not after program approaches have to fail multiple times before the topic of support for the parent comes into discussion. In order for us to prove the value base of our services, the manner in which parents can access our services needs to be re-=designed. Do we have to become an in-take agency, or are there other routes to make this happen. Research shows that parents/primary caregivers who seek services for their child on their own are more likely to "own" their child's treatment plan and feel more confident in the arduous journey of addressing their child's mental health diagnosis and problems in navigating fo the needs of both the child and family.	12/9/2015 11:33 PM
23	Government control	12/9/2015 7:11 PM
24	Measures for residential care	12/9/2015 4:37 PM
25	encounter requirements, micromanaging process, different models with different payers	12/9/2015 4:14 PM
26	Getting a fair based payment for services rendered	12/9/2015 4:05 PM
27	Small and effective providers may not be able to survive due to contracting constraints and FTE needed to manage information. It is also very hard for small providers to contract with medical based insurance companies due to the complexity regardless of United Health reps perspective regarding is "simple" current contracts.	12/9/2015 3:56 PM
28	The technology and resources required for implementation.	12/8/2015 9:37 AM
29	Cash Flow during the transition	12/8/2015 9:22 AM
30	Making sure that the tracking system is sound and able to ensure that reported information is accurate and verifiable.	12/8/2015 8:44 AM
31	Payment	12/8/2015 12:00 AM
32	none we like the idea, we encounter all our contracts and have great services, we think this will get the $ to the best providers, hopefully smaller innovative providers will have a seat at the table and not just the majors as they will not be able to morph and change as much as smaller ones, in other words invest in the NEW up and coming non- traditional providers willing and ready to change the system	12/7/2015 6:39 PM
33	RBHA policies that don't align. For example specific caseload or location requirements by the RBHA. The provider should do what is best for the client to get the best results; how the provider achieves that can't be dictated under a value based arrangement.	12/7/2015 5:24 PM
34	Excessive standardization of care practices.	12/7/2015 3:33 PM
35	Agencies that serve children only need contract modifications TODAY to allow services to Young Transition Age Adults and Guardians to serve ages 0-100+ as experience, expertise and quality performance allows.	12/7/2015 3:05 PM
36	The lack of access to data that the payors currently and will have in the future.	12/7/2015 2:51 PM
37	1. Since we are unable to establish emergency reserves, that we and other good organizations may be forced out of the market. 2. That some organizations may be inclined to deny services to people who need them in an effort to attain good outcome measures.	12/7/2015 2:17 PM

Q14 Below is a list of potential barriers to adopting value based reimbursement. Please rate the significance of each barrier for your organization.

Answered: 65 Skipped: 18

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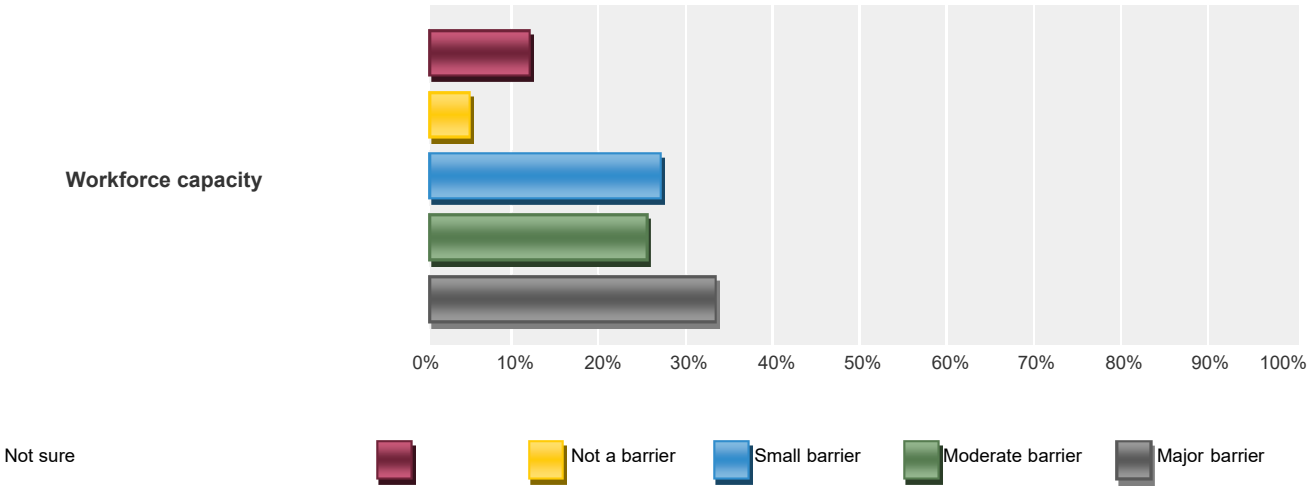


	Not sure	Not a barrier	Small barrier	Moderate barrier	Major barrier	Total
Access to data necessary to manage payment and care delivery.	**13.85%** 9	**4.62%** 3	**13.85%** 9	**35.38%** 23	**32.31%** 21	65
Ability to structure affiliated provider arrangements.	**15.38%** 10	**10.77%** 7	**10.77%** 7	**36.92%** 24	**26.15%** 17	65
Ability to track financial performance.	**10.77%** 7	**23.08%** 15	**23.08%** 15	**32.31%** 21	**10.77%** 7	65
Coordinating care with physical health providers	**14.29%** 9	**11.11%** 7	**17.46%** 11	**34.92%** 22	**22.22%** 14	63
Exchanging patient health information with providers	**14.06%** 9	**9.38%** 6	**15.63%** 10	**31.25%** 20	**29.69%** 19	64
Infrastructure capacity to implement value based payment.	**10.77%** 7	**6.15%** 4	**21.54%** 14	**35.38%** 23	**26.15%** 17	65
Maintaining sufficient volume of patients to ensure financial viability.	**12.31%** 8	**15.38%** 10	**12.31%** 8	**30.77%** 20	**29.23%** 19	65
Organizational acceptance and/or resistance to change.	**12.31%** 8	**24.62%** 16	**33.85%** 22	**20.00%** 13	**9.23%** 6	65
Standardizing terms and conditions for value based payment with different payers.	**12.31%** 8	**4.62%** 3	**21.54%** 14	**30.77%** 20	**30.77%** 20	65
Workforce capacity	**10.94%** 7	**4.69%** 3	**26.56%** 17	**25.00%** 16	**32.81%** 21	64

#	Other (please specify)	Date
1	Caseloads are too large in behavioral health agencies to provide proper focus on each client.	12/17/2015 11:25 AM
2	You really need to allow us to explain the above "Barriers". Most are barriers because we do not have enough information regarding the expectations of the RBHA and AHCCCS systems regarding VBP.	12/10/2015 12:02 PM
3	encounter requirements	12/9/2015 4:14 PM
4	We are not able to build a "risk corridor", are not permitted to open a line of credit, etc.	12/7/2015 2:17 PM

Q15 What kind of technical support or educational material would be beneficial to you with regards to implementing value based payment models or contracts?

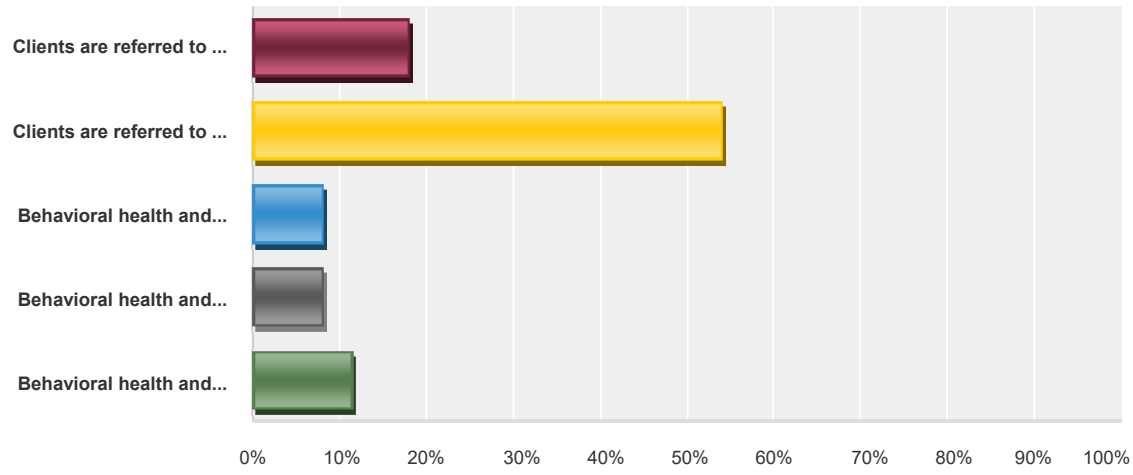
Answered: 32 Skipped: 51

#	Responses	Date
1	what outcomes would behavioral health residential homes be able to track to be a part of VBP contracts? Are we looking at keeping rates as they are and making additional incentive payments for outcomes or would we possibly looking at cuts or owing back money if outcomes are not adequate?	12/17/2015 11:04 PM
2	Everything	12/17/2015 5:14 PM
3	on site consultations	12/17/2015 1:10 PM
4	How clients will get referred.	12/17/2015 1:09 PM
5	not sure at this time	12/17/2015 12:45 PM
6	Evidenced based practices and tools which could be deployed to increase overall member functioning.	12/17/2015 11:49 AM
7	Overall understanding of how I would fit into the arrangements.	12/17/2015 11:25 AM
8	Technical support with data needs	12/17/2015 10:35 AM
9	Any updated information that is released	12/17/2015 10:31 AM
10	training for all levels of staff - direct care to management	12/17/2015 10:23 AM
11	Scenarios to ensure we understand what value based actually means in practice.	12/17/2015 10:14 AM
12	Step by step requirements of VBP	12/17/2015 9:35 AM
13	training is a key--also any educational materials would be great	12/15/2015 4:59 PM
14	Overall information on VBP	12/12/2015 7:55 AM
15	INFORMATION. Most all of the expectations that were presented at the AHCCCS forum have been met by our agency for years, coordination of care, reducing hospitalization and getting SMI/GMH/SA patients back to work.	12/10/2015 12:02 PM
16	Provider organizational models that are showing successful outcomes and financial viablility	12/10/2015 11:32 AM
17	data analysis, health data, analytics, value measurements	12/10/2015 9:35 AM
18	clear, concise and objective measurement of what the value based objectives will be for community based provider agencies.	12/10/2015 8:22 AM
19	Make sure the RBHA has accurate data	12/10/2015 8:19 AM
20	Education that would apply for specialty providers such as family-runs and peer-runs and how they fit in the continuum of providers in a network.....there are many questions around how to maintain the integrity of the parent-to-parent peer support services .....who is listening to the parents who are really a big part of the services and support a child receives ---they are a constant provider of services and support	12/9/2015 11:33 PM
21	EMR for residential services	12/9/2015 4:37 PM
22	Need data on medical spend of high utilizers	12/9/2015 4:14 PM
23	Webinar CEs,	12/9/2015 4:05 PM
24	I think it would be helpful to see some examples of that have already been in place and are working in other behavioral health companies.	12/9/2015 3:56 PM
25	Suggested implementation plan and list of prerequisites.	12/8/2015 9:37 AM
26	Ensuring that there is transparency during the transition with payers and providers.	12/8/2015 9:22 AM
27	1:1 training and explanations based on the type of services that Arizona Behavioral health Center provides.	12/8/2015 12:00 AM

28	have AHCCCS hold the client record, forget the integration of the providers and just have 1 client file at AHCCCS, would save millions of dollars and could guarantee the valid documentation prior to service delivery and payment, we have the ability to provide this platform to AHCCCS, then we all plug into the 1 client file via the web. You decrease rates for all services because we no linger need to spend the huge amount of time and money maintaining the client record, and by the way that one client has numerous files with every agency that provides service, thus duplicating the efforts and wasting time and money that could be spent of services that the clients desperately need, look at our recovery rates, look at how many children are going SMI, these all have been proven to be preventative with the right services in place, again we need a new system!! Make AZ the innovative leader in the USA!!!	12/7/2015 6:39 PM
29	Statewide Health Information Exchange available to all providers, with all types of Electronic Health Records systems.	12/7/2015 3:33 PM
30	Affordable HIE connectivity, required of all AHCCCS providers, with Opt -in/out for management of CFR 42 Privacy issues while Congress works on legislation to remove bumps in sharing clinical data.	12/7/2015 3:05 PM
31	Standardizing the metrics used by the plans.	12/7/2015 2:51 PM
32	Support to get our EHR on the HIE and to access the HIE. Support to navigate the above mentioned barriers.	12/7/2015 2:17 PM

Q16 What is your organization's level of integration with regards to primary care services?

Answered: 61 Skipped: 22



Answer Choices	Responses
Clients are referred to a primary care provider at another practice site. The behavioral health provider and primary care providers have no communication with respect to shared patients.	18.03% 11
Clients are referred to a primary care provider at another practice site, and periodically communicate about shared clients	54.10% 33
Behavioral health and primary health care providers share the same facility but maintain separate cultures, separate records, and develop separate treatment plans for clients.	8.20% 5
Behavioral health and primary health care providers share the same facility and health record; but maintain separate cultures and develop separate treatment plans.	8.20% 5
Behavioral health and primary care providers share the same facility, health record, maintain a cohesive cultures and develop and implement collaborative treatment planning for shared patients.	11.48% 7
Total	**61**

Q17 What barriers has your organization encountered in integrating with primary care services?

Answered: 32 Skipped: 51

#	Responses	Date
1	contradictions in prescribing medications. Refusal to discontinue or refill medications that the other professional originally wrote (often at a hospital setting). lack of availability for quick appointments. Refusal to do simple physical and TB tests that are requirements. Unwillingness to complete the med eval records that we bring to each appointment.	12/17/2015 11:07 PM
2	N/A	12/17/2015 5:14 PM
3	We are a specialty provider within the behavioral health system and not all clients will access our services	12/17/2015 1:11 PM
4	Not a material concern for us.	12/17/2015 1:10 PM
5	not aware of any at this time.	12/17/2015 12:45 PM
6	Many primary care clinicians have no interest in treating severe and persistent mentally ill members.	12/17/2015 11:53 AM
7	None, work well with some PCP's, I do not have a need to work with all of them, depends on client's issues.	12/17/2015 11:27 AM
8	Different cultures, licensing requirements	12/17/2015 10:36 AM
9	No barriers	12/17/2015 10:32 AM
10	We are a children's provider - the system is focused on SMI pop. Waiting for the conversation to shift to kids.	12/17/2015 10:25 AM
11	Limited coordination of care with behavioral health providers and long wait time for appointments	12/17/2015 9:42 AM
12	Rural areas have limited capacity--FQHC's already exist which serve a majority of our clients	12/15/2015 5:00 PM
13	Data is not current and is share on a limited basis.	12/13/2015 1:36 PM
14	Ensuring that proper releases of information are maintained due to substance abuse history	12/12/2015 7:56 AM
15	We are currently looking at becoming an Integrated Care Facility, however we have a high degree of working with PCPs and PNOs including attending meetings with PCPs and Rxs as clinically indicate.	12/10/2015 12:04 PM
16	Receiving acute clinical data in a timely way.	12/10/2015 11:34 AM
17	Having primary care services be financially viable. Volume on behavioral health side greater than funding therefore very high caseloads for psychiatric providers and difficulty for them to keep up with the volume and coordinate care with physical health providers.	12/10/2015 9:37 AM
18	Individuals in BH services across the valley/State have freedom of choice with their PCP. Our agency is assuming an "navigator model" using a Chronic Care Professional Health Coaching and Population health model. Clear definition of the benchmarks and value based contracting objectives for community based services will help structure this initiative.	12/10/2015 8:26 AM
19	There is a lack of understanding int he primary care services arena about parent peer support.	12/9/2015 11:35 PM
20	difficult to recruit and keep primary care providers; very difficult to maintain viable panel size	12/9/2015 4:16 PM
21	Space availability for new staff integration.	12/9/2015 4:07 PM
22	Primary care providers have not been interested in communicating with us in the past, we found it difficult to obtain information or coordinate services unless the primary makes the initial contact for their own purposes.	12/9/2015 3:57 PM
23	licensure, infrastructure and funding.	12/8/2015 12:50 PM

24	Facility limitations and lack of EHR	12/8/2015 9:38 AM
25	Follow-up and no call back from psychiatrists or Primary care physicians despite the several attempts by AzBHC to communicate live not by voice mail or emails.	12/8/2015 12:02 AM
26	none at this time Thanks for the opportunity to share	12/7/2015 6:40 PM
27	We communicate with the PCP however hear very little from the PCP back to us. There are so many different groups, private practices, etc. that it is difficult to create an arrangement with ALL primary care physicians especially for children.	12/7/2015 5:27 PM
28	Volume of clients, new systems being put in place, member resistance	12/7/2015 3:35 PM
29	Simultaneously as we are allowed by contract to serve adult population we will expand to include our own FP/NP-PCP at 2 or more of our sites. We are also working with 2 large Peds/Family Practice Groups to coordinate care and share patients and clinical data.	12/7/2015 3:15 PM
30	Reimbursement rates on physical health side do not support the expense. we are structurally integrated and run primary care as a separate line of business and it has been losing money since conception.	12/7/2015 2:47 PM
31	We rarely receive return calls from PCP's	12/7/2015 2:27 PM
32	We are not an intake agency, just a specialty agency/CSA so are not considered a priority for integration. Integration would require we get licensed as a provider, which would require capital to make building renovations to meet licensure requirements. This has not been deemed a priority by our current RBHA or by our affiliate health care organization.	12/7/2015 2:21 PM

Exhibit I: Draft Quality Performance Metrics for PH/BH Integration

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT

Project 1: Integration of Primary Care and Community Behavioral Health Services (primary care site)

Objective: To integrate behavioral health services (some of which are paid for by Regional Behavioral Health Authorities (RBHAs)) into the primary care site. This project would include seriously mentally ill (SMI) individuals enrolled in an integrated RBHA and non-SMI individuals receiving services from both the RBHA and the assigned acute care health plan.

		Year 1	
CC#	**Core Component**	**Practice Reporting Requirement**	**Reporting Requirement to AHCCCS**
	Taking Steps Toward Integration		
1	Utilize a commonly accepted behavioral health integration practice self-assessment instrument.	Identify the names of the self-assessment instruments the practice has employed and report the practice's top three opportunities for improvement identified based on the assessments.	Percentage of practices with documented completion of an assessment; Frequency distribution of practice-employed self-assessment instruments by assessment type; Frequency distribution of practice opportunities for improvement by assessment type.
2	Utilize the behavioral health integration toolkit to develop a practice-specific course of action to improve integration.	Identify the names of the integration toolkit the practice has adopted and document a practice-specific action plan informed by the self-assessments, with measurable goals and timelines.	Percentage of practices that have identified the toolkit they have adopted; Frequency distribution of practice-employed integration toolkit; Summary description of practice action plan areas of focus and goals.
	Management of High-Risk Patients		
3	Utilize care coordinators to, in part, help develop integrated care plans, work with patients and facilitate linkages to community organizations and social service agencies.	Identify the name of at least one care coordinator serving at the primary care site.	Percentage of practices that have identified a care coordinator for each practice site; List of names of care coordinators by practice site.

		Document that care coordinators have been trained in development of integrated care plans, how to educate patients, how to promote patient engagement, and when/how to facilitate linkages to community-based organizations.	Percentage of practice care coordinators that have received care coordination training; Evidence of training agenda and training materials.
		Document that care coordinators have been trained to engage and educate patients who are frequent ED utilizers to utilize the behavioral health practice, instead of the ED, when appropriate.	
4	Track-high risk patients to assist efforts to address their needs and coordinate their care. High-risk patients include, but are not limited to: those with patterns of frequent emergency department use, frequent inpatient use for behavioral health conditions; recent use of residential services; recent involvement with law enforcement.	Develop a) a registry of high-risk patients and b) processes for routinely screening for high-risk status indicators.	Percentage of practices that have developed a high-risk registry; Percentage of practices that have implemented processes for routinely screening for high-risk status indicators.
5	Include relevant data from all sources in the high-risk registry.	Demonstrate the functionality to incorporate data shared by acute plans and RBHAs into the high-risk registry.	Percentage of practices that can demonstrate that relevant data shared with them can and is incorporated into the high-risk registry.

6	Implement the use of integrated care plans to be managed by a clinical care manager.	Demonstrate that all patients and identified as high-risk have been referred to a care coordinator for the development of an integrated care plan consistent with this Core Component.	Percentage of practices that have implemented integrated care planning consistent with the requirements of this Core Component. AHCCCS will conduct an audit of sample of practices to confirm that high-risk patients have care plans consistent with the required elements.
		Demonstrate that all patients identified as high-risk have an integrated care plan consisting of: problem identification, risk drivers, and barriers to care, including social determinants of health, and assessing physical, functional, cognitive, and psychological status, medical history, medication history, use of support systems, and transportation issues. The care plan should also identify the patient's goals, desired outcomes, and objectives and readiness to address any individual needs.	
		Document that behavioral health care providers provide input into the integrated care plan when the primary care provider is the originator of the plan, consistent with Core Component 8.	

7	Conduct a root cause analysis to determine why certain practice patients are frequent ED and / or inpatient service utilizers and identify the barriers to reducing the frequency of ED and inpatient use, including those that may be practice-based.	List the adopted practice strategies to address the barriers, and engage the patients with high ED and / or IP use to access the primary care practice or their principal behavioral health provider in lieu of an ED visit, when appropriate, and with measurable goals and timelines.	Percentage of practices that developed strategies for addressing high ED and / or inpatient use; Summary categorization of practice strategies and goals with frequency distribution.
	Relationships with Community Behavioral Health Providers		
8	Develop referral agreements with mental health and substance use providers in the community to improve the integration of care, coordination of referrals, and access. Each referral agreement must include: (a) an agreed-upon practice for regular communication and provider-to-provider consultation. Details should include the communication modality by which the primary care clinician can reach the behavioral health provider (e.g., telephone, pager, email, etc.); (b) protocols for referrals, crisis, information sharing, and obtaining consent; (c) protocols for incorporating a "warm hand-off" between primary care providers and behavioral health providers; (d) protocols for ongoing and collaborative-team-based care, including for behavioral health providers to provide input into an integrated care plan, and (e) protocols for ensuring same-day availability for a behavioral health visit on the day of a physical health visit.	Identify the names of the behavioral health practices with which the primary care site has developed a referral and care coordination agreement.	Percentage of practices with referral and care coordination agreements; A listing of mental health and substance use providers with which each practice has completed a referral and care coordination.
	Clinical Care within the Primary Care Office		
9	Routinely screen patients for depression, anxiety, drug and alcohol misuse using the Patient Health Questionnaire (PHQ-2 and PHQ-9) for depression, CAGE-AID for drug and alcohol use, GAD-7 for generalized anxiety disorder.	Confirm that the results of all screening tool assessments are contained in the electronic health record.	Percentage of practices that report inclusion of the results of all specified screening tool assessments into the electronic health record.

10	Develop procedures for intervention or referrals as the result of a positive screening.	Document policies and procedures for intervention or referrals as the result of a positive screening. Referrals to behavioral health providers should be consistent with protocols established in the Core Component 8 of the project.	Percentage of practices that have documented procedures for interventions and for referrals that are consistent with the protocols established in Core Component 3 of the project.
	Integrated clinical records		
11	Establish and implement integrated access to clinical information from BH providers in primary care records, as appropriate and permissible.	To be defined	To be defined
12	Enhance electronic health record (EHR) capabilities between physical health providers and behavioral health providers to support coordination, foster efficient clinical practice, and reduce administrative duplication.	To be defined	To be defined
	Community-based Supports		
13	Enhance relationships with community-based social service resources, including self-help referral connections, community group resources, specialty mental health and substance use services, and peer professionals by (a) identifying the resources in the community, and (b) creating protocols of when to engage or refer patients to these community-based resources.	Document the resources in the community, including contact information, and describe a schedule for periodically updating the resource listing with up-to-date information. Document protocols used for engaging these resources on behalf of patients and for referring patients to these resources.	Percentage of practices that have community-based resources lists with contact information, a schedule for updating the resource and protocols for engaging the resources and/or referring patients.

	E-Prescribing		
14	Consult Arizona's Controlled Substances Prescription Monitoring Program before prescribing a controlled substance to identify the patient's controlled substance usage history.	Document that the practice has policies and procedures in place for all prescribers of controlled substances to review the CSPMP before prescribing Schedules 2, 3, 4 and 5 controlled substances.	Percentage of practices that have policies and procedures in place for routine use of the CSPMP prior to prescribing a controlled substance.
15	Utilize e-prescribing for Schedules 2, 3, 4, and 5 controlled substances.	Document that prescribers have the capability to e-prescribe, and that medications that are e-prescribed are documented into the electronic medical record.	Percentage of providers that demonstrated the ability to e-prescribe and that medications that are e-prescribed are documented into the electronic medical record.
	Involvement with SIM Entity		
16	Participate in SIM entity-offered training and education.	N/A	Percentage of practices that participated in a) all, and b) each SIM entity provided training during the year; Evidence of training agenda and training materials.

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT

Project 2: Integration of Primary Care and Behavioral Health Services (community behavioral health care site)

Objective: To integrate primary care services into the community behavioral health care site for the purposes of better care coordination of the preventive and chronic illness care for SMI individuals.

		Year 1	
CC#	**Core Component**	**Practice Reporting Requirement**	**Reporting Requirement to AHCCCS**
	Taking Steps Toward Integration		
1	Utilize a commonly accepted behavioral health integration practice self-assessment instrument.	Identify the names of the self-assessment instruments the practice has employed and report the practice's top three opportunities for improvement identified based on the assessments.	Percentage of practices with documented completion of an assessment; Frequency distribution of practice-employed self-assessment instruments by assessment type; Frequency distribution of practice opportunities for improvement by assessment type.
2	Utilize the behavioral health integration toolkit to develop a practice-specific course of action to improve integration.	Identify the names of the integration toolkit the practice has adopted and document a practice-specific action plan informed by the self-assessments, with measurable goals and timelines.	Percentage of practices that have identified the toolkit they have adopted; Frequency distribution of practice-employed integration toolkit; Summary description of practice action plan areas of focus and goals.
	Management of High-Risk Patients		
3	Utilize care coordinators to, in part, help develop integrated care plans, work with patients and facilitate linkages to community organizations and social service agencies.	Identify the name of at least one care coordinator serving at the primary care site.	Percentage of practices that have identified a care coordinator for each practice site; List of names of care coordinators by practice site.

		Demonstrate that the care coordinator(s) has been trained in development of integrated care plans, how to educate patients, how to promote patient engagement, and when/how to facilitate linkages to community-based organizations.	Percentage of practice care coordinators that have received care coordination training; Evidence of training agenda and training materials.
		Demonstrate that care coordinator(s) have been trained to engage and educate patients who are frequent ED utilizers to utilize the behavioral health practice, instead of the ED, when appropriate.	
4	Track-high risk patients to assist efforts to address their needs and coordinate their care. High-risk patients include, but are not limited to: those with patterns of frequent emergency department use, frequent inpatient use for behavioral health conditions; recent use of residential services; recent involvement with law enforcement.	Develop a registry of high-risk patients and processes for routinely screening for high-risk status indicators.	Percentage of practices that have developed a high-risk registry; Percentage of practices that have defined and implemented processes for routinely screening for high-risk status indicators.
5	Include relevant data from all sources in the high-risk registry.	Demonstrate the functionality to incorporate data shared by acute plans and RBHAs into the high-risk registry.	Percentage of practices that can demonstrate that relevant data shared with them can be and is incorporated into the high-risk registry.

6	Implement the use of integrated care plans to be coordinated by a clinical care coordinator.	Demonstrate that all patients and identified as high risk have been referred to a clinical care coordinator for the development of an integrated care plan consistent with this Core Component.	Percentage of practices that have implemented integrated care planning consistent with the requirements of this Core Component. A sample audit of high-risk patients to identify whether their care plans consistent of the required elements may occur.
		Demonstrate that all patients identified as high-risk have an integrated care plan consisting of: problem identification, risk drivers, and barriers to care, including social determinants of health, and assessing physical, functional, cognitive, and psychological status, medical history, medication history, use of support systems, and transportation issues. The care plan should also identify the patient's goals, desired outcomes, and objectives and readiness to address any individual needs.	
		Document that primary care providers provide input into the integrated care plan, when the behavioral health provider is the originator of the plan, consistent with Core Component 3.	

	Relationships with Primary Care Providers and Hospitals		
7	Develop referral agreements with primary care providers in their community to improve the integration of care, coordination of referrals, and access. Each referral agreement must include: (a) an agreed-upon practice for regular communication and provider-to-provider consultation. Details should include the communication modality by which the behavioral health provider can reach the primary care clinician (for example, telephone, pager, email, etc.). (b) protocols for referrals, crisis, information sharing, and obtaining consent. (c) protocols for incorporating a "warm hand-off" between primary care providers and behavioral health providers. (d) protocols for ongoing and collaborative-team-based care, including for primary care providers to provide input into an integrated care plan that originated with the behavioral health provider. (e) protocols for ensuring same-day availability for a physical health visit at the time of a behavioral health visit.	Identify the names of the primary care practices with which the community behavioral health care site has developed a referral and care coordination agreement.	Percentage of practices with referral and care coordination agreements; A listing of primary care providers with which each practice has completed a referral and care coordination.
8	Develop protocols with local hospitals to provide input into a patient's health history upon admission, 7 days per week.	Identify the hospitals with whom formal protocols have be established.	Percentage of behavioral health providers with protocols to provide meaningful input into their patient's health history upon admission, 7-days per week.
9	Develop protocols with local hospitals to improve the post-discharge coordination of care that cover communication, consultation, medical record sharing, medication reconciliation, for discharges 7 days per week.	Identify the hospitals with which formal protocols have been established.	Percentage of behavioral health providers with protocols to provide meaningful input into their patient's health history upon admission, 7 days per week.

	Clinical Care within the Behavioral Health Office		
10	Routinely screen patients receiving psychotropic medications for tobacco use, body mass index (BMI), metabolic syndrome, diabetes, and cardiovascular conditions, and document results in the medical record.	Confirm that the results of the screening tool assessments are contained in the electronic health record.	Percentage of practices that report inclusion of the results of all specified screening tool assessments into the electronic health record.
11	Develop procedures for intervention or referrals as the result of a positive screening, consistent with protocols established in Core Component 5.	Document policies and procedures for intervention or referrals as the result of a positive screening. Referrals to behavioral health providers should be consistent with protocols established in the Core Component 8 of the project.	Percentage of practices that have documented procedures for interventions and for referrals that are consistent with the protocols established in Core Component 3 of the project.
12	Establish and implement integrated access to clinical information from primary care providers in BH records, as appropriate and permissible.	To be defined	To be defined
	Enhance electronic health record (EHR) capabilities between physical health providers and behavioral health providers to support coordination, foster efficient clinical practice, and reduce administrative duplication.	To be defined	To be defined
	E-Prescribing		
13	Consult Arizona's Controlled Substances Prescription Monitoring Program before prescribing a controlled substance to identify the patient's controlled substance usage history.	Document that the practice has policies and procedures in place for all prescribers of controlled substances to review the CSPMP before prescribing Schedules 2, 3, 4 and 5 controlled substances.	Percentage of practices that have policies and procedures in place for routine use of the CSPMP prior to prescribing a controlled substance.

14	Utilize e-prescribing for Schedules 2, 3, 4, and 5 controlled substances.	Document that prescribers have the capability to e-prescribe, and that medications that are e-prescribed are documented into the electronic medical record.	Percentage of providers that demonstrated the ability to e-prescribe and that medications that are e-prescribed are documented into the electronic medical record.
	Involvement with SIM entity		
15	Participate in SIM entity-offered training and education.	N/A	Percentage of practices that participated in a) all, and b) each SIM entity provided training during the year; Evidence of training agenda and training materials.

Note:

[1] Tools include: the Organizational Assessment Toolkit for Primary and Behavioral Healthcare Integration (OATI), a Standard Framework for Level of Integrated Healthcare, the Integrated Practice Assessment Tool, the Behavioral Health Integration Capacity Assessment, the Maine Health Access Foundation Site Assessment (SSA), the University of Washington's Advancing Integrated Mental Health Solutions (AIMS) Center Checklist, the Integrated Behavioral Health Project Tool, the Dual Diagnosis Capability in Health Care Settings, the Massachusetts Patient Centered Medical Home Behavioral Health Toolkit.

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT

Project 3: Integration of Primary Care and Behavioral Health Services (co-located care site)

Objective: 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.

		Year 1	
CC #	**Core Component**	**Practice Reporting Requirement**	**Reporting Requirement to AHCCCS**
	Taking Steps Toward Further Integration		
1	Utilize a commonly accepted behavioral health integration practice self-assessment instrument. [1]	Identify the names of the self-assessment instruments the practice has employed and report the practice's top three opportunities for improvement identified based on the assessments.	Percentage of practices with documented completion of an assessment; Frequency distribution of practice-employed self-assessment instruments by assessment type; Frequency distribution of practice opportunities for improvement by assessment type.
2	Utilize the behavioral health integration toolkit to develop a practice-specific course of action to improve integration.	Identify the names of the integration toolkit the practice has adopted and document a practice-specific action plan informed by the self-assessments, with measurable goals and timelines.	Percentage of practices that have identified the toolkit they have adopted; Frequency distribution of practice-employed integration toolkit; Summary description of practice action plan areas of focus and goals.
	Management of High-Risk Patients		
3	Utilize care coordinators to, in part, help develop integrated care plans, work with patients and facilitate linkages to community organizations and social service agencies.	Identify the name of at least one care coordinator serving at the primary care site.	Percentage of practices that have identified a care coordinator for each practice site; List of names of care coordinators by practice site.

		Demonstrate that the care coordinator(s) has been trained in development of integrated care plans, how to educate patients, how to promote patient engagement, and when/how to facilitate linkages to community-based organizations.	Percentage of practice care coordinators that have received care coordination training; Evidence of training agenda and training materials.
		Demonstrate that care coordinator(s) have been trained to engage and educate patients who are frequent ED utilizers to utilize the behavioral health practice, instead of the ED, when appropriate.	
4	Track-high risk patients to assist efforts to address their needs and coordinate their care. High-risk patients include, but are not limited to: those with patterns of frequent emergency department use, frequent inpatient use for behavioral health conditions; recent use of residential services; recent involvement with law enforcement.	Develop a registry of high-risk patients and processes for routinely screening for high-risk status indicators.	Percentage of practices that have developed a high-risk registry; Percentage of practices that have defined and implemented processes for routinely screening for high-risk status indicators.
5	Include relevant data from all sources in the high-risk registry.	Demonstrate the functionality to incorporate data shared by acute plans and RBHAs into the high-risk registry.	Percentage of practices that can demonstrate that relevant data shared with them can be and is incorporated into the high-risk registry.

6	Implement the use of integrated care plans to be managed by a clinical care manager.	Demonstrate that all patients and identified as high risk have been referred to a clinical care coordinator for the development of an integrated care plan consistent with this Core Component.	Percentage of practices that have implemented integrated care planning consistent with the requirements of this Core Component. A sample audit of high-risk patients to identify whether their care plans consistent of the required elements may occur.
		Demonstrate that all patients identified as high-risk have an integrated care plan consisting of: problem identification, risk drivers, and barriers to care, including social determinants of health, and assessing physical, functional, cognitive, and psychological status, medical history, medication history, use of support systems, and transportation issues. The care plan should also identify the patient's goals, desired outcomes, and objectives and readiness to address any individual needs.	
		Document that primary care providers provide input into the integrated care plan, when the behavioral health provider is the originator of the plan, consistent with Core Component 3.	

7	Conduct a root cause analysis to determine why certain practice patients are frequent ED and / or inpatient utilizers and identify the barriers to reducing the frequency of ED use, include those that may be practice based.	Develop strategies to address the barriers, and engage the patients with high ED and / or inpatient use to access the primary care practice or their principle behavioral health provider in lieu of an ED visit, when appropriate.	Percentage of practices that developed strategies for focus; Summary description of practice action plan areas of focus and goals.
	Integrated Clinical Functions		
8	Routinely screen patients for depression, anxiety, drug and alcohol misuse using the Patient Health Questionnaire (PHQ-2 and PHQ-9) for depression, CAGE-AID for drug and alcohol use, GAD-7 for generalized anxiety disorder.	Demonstrate the results of the screening tool are documented in the electronic health record, and that behavioral health providers and primary care providers are using the same screening tools.	Percentage of practices that have documented that the same screening tools are routinely used by all provider types, that they are documented in the electronic record.
9	Develop procedures for warm hand-offs with behavioral health providers when the results of a positive screening warrant intervention or referrals to the behavioral health provider.	Demonstrate that there are procedures and protocols in place for a warm hand-off.	Percentage of practices that conduct warm hand-offs.
10	Integrate chart notes for primary care providers and behavioral health providers, as appropriate and permissible.	Document that the behavioral health service provider chart notes (related to clinical information relevant to the assessment and treatment of the patient) are placed in the same location as the PCP chart notes. (Psychotherapy / personal notes should be kept separately).	The percentage of practices that can demonstrate the use of an integrated chart.

11	Ensure same-day availability for a behavioral health visit at the time of a physical health visit, and a physical health visit at the time of a behavioral health visit.	Document that the practice has the ability to provide same-day behavioral health care when the need arises during a primary care visit, and that a primary care visit can occur when the need arises during a behavioral health care visit.	Percentage of practices that demonstrate that immediate behavioral health needs, or physical health needs, can be accessed at the point of care.
12	Integrate physical space in the practice site.	N/A	N/A
13	Develop protocols with local hospitals to provide appropriate post-discharge follow-up care for empaneled patients.	Identify the hospitals with which the practices have developed protocols to assist the hospital in discharge planning, to receive the hospital discharge summary, and to provide appointments for patients within 7 days of discharge.	Percentage of practices with documented protocols.
	E-Prescribing		
14	Consult Arizona's Controlled Substances Prescription Monitoring Program before prescribing a controlled substance to identify the patient's controlled substance usage history.	Document that the practice has policies and procedures in place for all prescribers of controlled substances to review the CSPMP before prescribing Schedules 2, 3, 4 and 5 controlled substances.	Percentage of practices that have policies and procedures in place for routine use of the CSPMP prior to prescribing a controlled substance.

15	Utilize e-prescribing for Schedules 2, 3, 4, and 5 controlled substances.	Document that prescribers have the capability to e-prescribe, and that medications that are e-prescribed are documented into the electronic medical record.	Percentage of providers that demonstrated the ability to e-prescribe and that medications that are e-prescribed are documented into the electronic medical record.
	Involvement with SIM Entity		
16	Participate in SIM entity-offered training and education.	N/A	Percentage of practices that participated in a) all, and b) each SIM-entity provided training during the year; Evidence of training agenda and training materials.

Footnotes

[1] Tools include: the Organizational Assessment Toolkit for Primary and Behavioral Healthcare Integration (OATI), a Standard Framework for Level of Integrated Healthcare, the Integrated Practice Assessment Tool, the Behavioral Health Integration Capacity Assessment, the Maine Health Access Foundation Site Assessment (SSA), the University of Washington's Advancing Integrated Mental Health Solutions (AIMS) Center Checklist, the Integrated Behavioral Health Project Tool, the Dual Diagnosis Capability in Health Care Settings, the Massachusetts Patient Centered Medical Home Behavioral Health Toolkit.

Strategic Focus Area: Adults with Behavioral Health Needs - DRAFT

Project 4: Care Coordination for Adults with Behavioral Health Conditions Being Discharged from an Inpatient Behavioral Health Stay (Hospital)

Objective: To more effectively coordinate the care for adults with behavioral health conditions who are being discharged from an inpatient behavioral health stay.

		Year 1	
CC #	**Core Component**	**Practice Reporting Requirement**	**Reporting Requirement to AHCCCS**
	Care Coordination with Outpatient Behavioral Health and Primary Care Providers Upon Admission		
1	Develop protocols with high-volume community behavioral health providers and primary care providers to solicit their input into their patient's health history upon admission, 7-days per week.	Identify the names of the behavioral health providers and primary care providers with whom formal protocols have be established.	Percentage of hospitals with documented protocols, allowing behavioral health providers and primary care providers to provide meaningful input into their patient's health history upon admission, 7-days per week.
	Medication Management		
	Provide direct medication management support and education to patients prior to discharge by:		
2	(a) providing (either through a hospital-based outpatient pharmacy, or through collaboration with a local outpatient pharmacy) medication required for post-discharge care in amounts at least sufficient to cover the patient until their first scheduled outpatient follow-up appointment;	Document policies and procedures for discharging patients with medication required for post-discharge through a hospital-based pharmacy or local outpatient pharmacy.	Percentage of hospitals with the specified policies and procedures in place for medication provision.

3	(b) reconciling medications received in the hospital to what may be taken (or available) at home;	Document that a medication reconciliation took place immediately prior to discharge.	Percentage of hospitals with documented policies and procedures for performing medication reconciliation.
4	(c) educating on how and when to take the medications.	Document that the patient received education on all medications.	Percentage of hospitals with documented policies and procedures for performing medication education.
	Care Coordination with Outpatient Behavioral Health and Primary Care Providers Upon Discharge		
5	Develop protocols with high-volume **community behavioral health providers** to improve post-discharge coordination of care. The protocols cover communication, consultation, medical record sharing, and medication reconciliation for discharges 7 days per week. If a patient is discharged on multiple antipsychotics, protocols for communicating plans to transition the patient to monotherapy.	Identify the names of the behavioral health providers with whom formal protocols have be established.	Percentage of hospitals with documented protocols, containing all of the required elements.
6	Develop protocols with high-volume **community primary care providers** to improve the post-discharge coordination of care. The protocols cover communication, consultation, medical record sharing, and medication reconciliation for discharges 7 days per week.	Identify the names of the primary care providers with whom formal protocols have be established.	Percentage of hospitals with documented protocols, containing all of the required elements.

7	Provide a discharge summary to the **community primary care provider** and **community behavioral health provider** within 24 hours of discharge which includes reason for hospitalization, principle discharge diagnosis, discharge medications and next level of care recommendations.	Document the policies and procedures by which discharge summaries are shared with primary care providers and community behavioral health providers in the required timeframe, and with the required elements.	**NQF Measure 0557: HBIPS-6 Post-discharge continuing care plan created.** Psychiatric inpatients for whom the post-discharge continuing care plan is created and contains all of the following: reason for hospitalization, principal discharge diagnosis, discharge medications and next level of care recommendations. Report hospital rates using The Joint Commission HBIPS-6 measure specifications. (http://tinyurl.com/j8hsyjy)
8	With input from the patient, schedule follow-up appointments with a community behavioral health provider(s).	Document the policies and procedures that govern the process for setting up post-discharge follow-up appointments with the patient's input.	**RBHA will report on the following measure and SIM entity will be held accountable. NQF Measure 0576: Follow-Up After Hospitalization for Mental Illness.** The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: - The percentage of discharges for which the patient received follow-up within 30 days of discharge - The percentage of discharges for which the patient received follow-up within 7 days of discharge.

9	Follow-up with the patient within forty-eight hours of discharge for medication reconciliation and to help with any questions or problems related to transitioning care for his/her condition to the community.	Document the policies and procedures that govern the process for following-up with the patient within forty-eight hours of discharge.	Percentage of hospitals with documented policies and procedures.
	Care Coordination with RBHAs		
10	Develop protocols with RBHAs to communicate identified member-specific social and economic determinants of health (e.g., housing) that will be important to address to support the member upon transition to a community setting and prevent or delay the need for a readmission.	Document a protocol for contacting the RBHA prior to patient discharge in the event that the hospital has identified a social determinant of health that the RBHA may be able to address in order to support community tenure post-discharge.	Percentage of hospitals with a protocol for communicating member-specific social determinants pre-discharge in order to facilitate transition to the community.
	Involvement with SIM Entity		
11	Participate in SIM entity-offered training and education.	N/A	Percentage of hospitals that participated in a) all, and b) each SIM-entity provided training during the DY; Evidence of training agenda and training materials.

Exhibit I: Quality Performance Metrics for PH BH Integration Child - Part 2

Strategic Focus Area: Children with Behavioral Health Needs, Including Children with and At-risk for Autism Spectrum Disorder, and Children Engaged in the Child Welfare System - DRAFT

Project 1: Integration of primary care and behavioral health services for children with behavioral health needs and their families (primary care site)

Objective: To integrate behavioral health services (some of which are paid for by Regional Behavioral Health Authorities (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.

		Year 1	
CC #	Core Component	Practice Reporting Requirement	Reporting Requirement to AHCCCS
	Taking Steps Toward Integration		
1	Utilize a) a commonly accepted behavioral health integration practice self-assessment instrument and b) a family-centered care self-assessment instrument.	Identify the names of the self-assessment instruments the practice has employed **and** report the practice's top three opportunities for improvement identified based on the assessments.	Percentage of practices with documented completion of both assessments; Frequency distribution of practice-employed self-assessment instruments by assessment type; Frequency distribution of practice opportunities for improvement by assessment type.

2	Utilize the behavioral health integration toolkit and the family-centered care toolkit to develop a practice-specific course of action to improve integration and family-centered care efforts.	Identify the names of the integration and family-centered care toolkits the practice has adopted **and** document a practice-specific action plan informed by the self-assessments, with measurable goals and timelines.	Percentage of practices that have identified the two toolkits they have adopted; Frequency distribution of practice-employed integration and family-centered care toolkits; Summary description of practice action plan areas of focus and goals.
	Management of High-Risk Patients		
3	Utilize care managers [1] to, in part, help develop integrated care plans, work with families and facilitate linkages to community organizations, social service agencies and schools.	Identify the name of at least one care manager serving at the primary care site.	Percentage of practices that have identified a care manager for each practice site; List of names of care managers by practice site.
		Demonstrate that the care manager(s) has been trained in development of integrated care plans, how to educate patients, how to promote patient engagement, and when/how to facilitate linkages to community-based organizations.	Percentage of practice care managers that have received care management training; Evidence of training agenda and training materials.

4	Track high-risk patients to assist efforts to address their needs and coordinate their care. High-risk patients include, but are not limited to: those with patterns of frequent emergency department use, frequent inpatient use for behavioral health conditions; recent use of residential services; recent disciplinary action in schools; recent involvement with law enforcement; involvement with the child welfare system; with or at risk for ASD.	Develop a registry of high-risk patients and processes for routinely screening for high-risk status indicators.	Percentage of practices that have developed a high-risk registry; Percentage of practices that have defined and implemented processes for routinely screening for high-risk status indicators.
5	Include relevant data from all sources in the high-risk registry.	Demonstrate the functionality to incorporate data shared by acute plans and RBHAs into the high-risk registry.	Percentage of practices that can demonstrate that relevant data shared with them can be and is incorporated into the high-risk registry.
6	Implement the use of integrated care plans to be managed by a clinical care manager.	Demonstrate that all patients and their parents / guardians identified as high-risk have been referred to a care manager for the development of an integrated care plan consistent with this Core Component.	Percentage of practices that have implemented integrated care planning consistent with the requirements of this Core Component. AHCCCS will conduct an audit of sample of practices to confirm that high-risk patients have care plans consistent with the required elements.

	Demonstrate that all patients and their parents / guardians identified as high-risk have an integrated care plan consisting of: problem identification, risk drivers, and identified barriers to care, including social determinants of health, and assessing physical, functional, cognitive, and psychological status, medical history, medication history, use of support systems, and transportation issues. The care plan should also identify the patient and parent/guardian goals, desired outcomes and objectives, culture, and readiness to address any individual needs.	
	Demonstrate that behavioral health providers provide input into the integrated care plan when the behavioral health provider is the originator of the plan, consistent with Core Component 7.	

7	Conduct a root cause analysis to determine why certain practice patients are frequent ED and / or inpatient service utilizers and identify the barriers to reducing the frequency of ED and inpatient use, including those that may be practice-based.	List the adopted practice strategies to address the barriers, and engage the parents and guardians of children with high ED and / or inpatient use to access the primary care practice or their principal behavioral health provider in lieu of an ED visit, when appropriate, and with measureable goals and timelines.	Percentage of practices that developed strategies for addressing high ED and / or inpatient use; Summary categorization of practice strategies and goals with frequency distribution.

	Relationships with Behavioral Health Providers		
8	Develop referral agreements with mental health and substance use providers in the community to improve the integration of care, coordination of referrals, and access. Each referral agreement must include: (a) an agreed-upon practice for regular communication and provider-to-provider consultation. Details should include the communication modality by which the primary care clinician can reach the behavioral health provider (e.g., telephone, pager, email, etc.); (b) protocols for referrals, crisis, information sharing, and obtaining consent; (c) protocols for incorporating a "warm hand-off" between primary care providers and behavioral health providers; (d) protocols for ongoing and collaborative-team-based care, including for behavioral health providers to provide input into an integrated care plan, and (e) protocols for ensuring same-day availability for a behavioral health visit on the day of a physical health visit; (f) expectations for what information will be shared between providers, with the intention that at a minimum problem lists (in ICD-10 and lay terms), comprehensive medication lists, care plan and follow-up schedules will be shared after each visit.	Identify the names of the behavioral health practices with which the primary care site has developed a referral and care management agreement.	Percentage of practices with referral and care management agreements; A listing of mental health and substance use providers with which each practice has completed a referral and care management.

	Clinical Care within the Primary Care Office		
9	Routinely screen patients (at the age-appropriate time) for developmental disorders, depression, and drug and alcohol use. To assess development delays and disorders, practices may use the Parents' Evaluation of Development Status (PEDS), the Survey of Wellbeing in Young Children (SWYC), the Ages and Stages Questionnaire (ASQ), OR the Pediatric Symptom Checklist (PSC) **AND** must use the Modified Checklist for Autism in Toddlers (M-CHAT) at the 18- and 24-month office visits. For drug and alcohol screening of adolescents, practices should use the CRAFFT Screening Test. For depression, practices should use the Patient Health Questionnaire for Adolescents (PHQ-A).	Identify the practice's adopted developmental screening tool, and policies and procedures for administration of that tool(s) and of the M-CHAT, CRAFFT and PHQ-A.	Percentage of practices that have adopted all of the required screening patients for developmental delay and disorders, depression, drug and alcohol use; Frequency distribution of developmental screening tools used by practices.
		Confirm that results of all specified screening tool assessments are documented in the electronic health record.	Percentage of practices that report inclusion of the results of all specified screening tool assessments into the electronic health record.
10	Develop procedures for intervention or referrals as the result of a positive screening.	Document policies and procedures for intervention or referrals as the result of a positive screening. Referrals to behavioral health providers should be consistent with protocols established in the Core Component 3 of the project.	Percentage of practices that have documented procedures for interventions and for referrals that are consistent with the protocols established in Core Component 3 of the project.

11	Follow the American Academy of Pediatrics clinical guidelines for the treatment of children with ADHD, anxiety and mild depression, including the use of psychotropic medications and appropriate consultation with behavioral health providers to assist with diagnosing.	Document that all primary care clinicians and any behavioral health providers in the practice have undergone training on the guidelines.	Percentage practices where all primary care providers, advance-practice clinicians and behavioral health providers in the practice were trained on the American Academy of Pediatrics clinical guidelines by a SIM-provided event, or documentation of CME course completion.
	Integrated Clinical Records		
12	Establish and implement integrated access to clinical information from behavioral health providers in primary care records, as appropriate and permissible.	To be defined	To be defined
13	Enhance electronic health record (EHR) capabilities between primary care providers and behavioral health providers to support coordination, foster efficient clinical practice, and reduce administrative duplication.	To be defined	To be defined
	Community-based Supports		
14	Enhance relationships with Arizona Early Intervention Program (AzEIP), schools, community-based social service resources, including self-help referral connections, community group resources, family support services (including Family Run Organizations) by (a) identifying the resources in the community, and (b) creating protocols of when to engage or refer patients to these resources.	Document the resources in the community, including contact information, and describe a schedule for periodically updating the resource listing with up-to-date information. Document protocols used for engaging these resources on behalf of patients and for referring patients to these resources.	Percentage of practices that have community-based resources lists with contact information, a schedule for updating the resource and protocols for engaging the resources and/or referring patients.

	E-Prescribing		
15	Consult Arizona's Controlled Substances Prescription Monitoring Program before prescribing a controlled substance to identify the patient's controlled substance usage history.	Document that the practice has policies and procedures in place for all prescribers of controlled substances to review the CSPMP before prescribing Schedules 2, 3, 4 and 5 controlled substances.	Percentage of practices that have policies and procedures in place for routine use of the CSPMP prior to prescribing a controlled substance.
16	Utilize e-prescribing for Schedules 2, 3, 4, and 5 controlled substances.	Document that prescribers have the capability to e-prescribe, and that medications that are e-prescribed are documented into the electronic medical record.	Percentage of providers that demonstrated the ability to e-prescribe and that medications that are e-prescribed are documented into the electronic medical record.
	Involvement with SIM Entity		
17	Participate in SIM entity-offered training and education.	N/A	Percentage of practices that participated in a) all, and b) each SIM entity provided training during the year; Evidence of training agenda and training materials.

Notes:

[1] Care managers are individuals that "link children and families to services and resources in a coordinated manner to maximize the potential of children and provide them optimal health care." They are responsible for assessing and identifying the needs of the child, developing, in part, integrated plans of care, implementing the plan of care and periodically reassessing the needs of the child and care plan to address new or emerging needs.

Strategic Focus Area: Children with Behavioral Health Needs, Including Children with and At-risk for Autism Spectrum Disorder, and Children Engaged in the Child Welfare System - DRAFT

Project 2: Integration of primary care and behavioral health services for children with behavioral health needs and their families (community behavioral health care site)

Objective: To integrate primary care services into the community behavioral health care site for the purposes of better care management of the preventive and chronic illness care 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.

		Year 1	
CC #	**Core Component**	**Practice Reporting Requirement**	**Reporting Requirement to AHCCCS**
	Taking Steps Toward Integration		
1	Utilize a) a commonly accepted behavioral health integration practice self-assessment instrument and b) a family-centered care self-assessment instrument.	Identify the names of the self-assessment instruments the practice has employed **and** report the practice's top three opportunities for improvement identified based on the assessments.	Percentage of practices with documented completion of both assessments; Frequency distribution of practice-employed self-assessment instruments by assessment type; Frequency distribution of practice opportunities for improvement by assessment type.
2	Utilize the behavioral health integration toolkit and the family-centered care toolkit to develop a practice-specific course of action to improve integration and family-centered care efforts.	Identify the names of the integration and family-centered care toolkits the practice has adopted **and** document a practice-specific action plan informed by the self-assessments, with measurable goals and timelines.	Percentage of practices that have identified the two toolkits they have adopted; Frequency distribution of practice-employed integration and family-centered care toolkits; Summary description of practice action plan areas of focus and goals.
	Management of High-Risk Patients		
3	Utilize care managers [1] to, in part, help develop integrated care plans, work with families and facilitate linkages to community organizations, social service agencies and schools.	Identify the name of at least one care manager serving at the behavioral health care site.	Percentage of practices that have identified a care manager for each practice site; List of names of care managers by practice site.

		Demonstrate that the care manager(s) has been trained in development of integrated care plans, how to educate patients, how to promote patient engagement, and when/how to facilitate linkages to community-based organizations.	Percentage of practice care managers that have received care management training; Evidence of training agenda and training materials.
4	Track high-risk patients to assist efforts to address their needs and coordinate their care. High-risk patients include, but are not limited to: those with patterns of frequent emergency department use, frequent inpatient use for behavioral health conditions; recent use of residential services; recent disciplinary action in schools; recent involvement with law enforcement; involvement with the child welfare system; with or at risk for ASD.	Develop a registry of high-risk patients and processes for routinely screening for high-risk status indicators.	Percentage of practices that have developed a high-risk registry; Percentage of practices that have defined and implemented processes for routinely screening for high-risk status indicators.
5	Include relevant data from all sources in the high-risk registry.	Demonstrate the functionality to incorporate data shared by acute plans and RBHAs into the high-risk registry.	Percentage of practices that can demonstrate that relevant data shared with them can be and is incorporated into the high-risk registry.
6	Implement the use of an integrated care plans to be coordinated by a clinical care manager.	Demonstrate that all patients and their parents / guardians identified as high-risk have been referred to a clinical care manager for the development of an integrated care plan consistent with this Core Component.	Percentage of practices that have implemented integrated care planning consistent with the requirements of this Core Component. AHCCCS will conduct an audit of sample of practices to confirm that high-risk patients have care plans consistent with the required elements.

	Demonstrate that all patients and their parents / guardians identified as high-risk have an integrated care plan consisting of: problem identification, risk drivers, and identified barriers to care, including social determinants of health, and assessing physical, functional, cognitive, and psychological status, medical history, medication history, use of support systems, and transportation issues. The care plan should also identify the patient and parent/guardian goals, desired outcomes, and objectives, culture, and readiness to address any individual needs.
	Demonstrate that primary care providers provide input into the integrated care plan, when the behavioral health provider is the originator of the plan, Consistent with Core Component 7.

7	Conduct a root cause analysis to determine why certain practice patients are frequent ED and / or inpatient service utilizers and identify the barriers to reducing the frequency of ED and inpatient use, including those that may be practice-based.	List the adopted practice strategies to address the barriers, and engage the parents and guardians of children with high ED and / or inpatient use to access their primary care practice or their principal behavioral health provider in lieu of an ED visit, when appropriate, and with measureable goals and timelines.	Percentage of practices that developed strategies for addressing high ED and / or inpatient use; Summary categorization of practice strategies and goals with frequency distribution.

	Relationships with Primary Care Providers

8	Develop referral agreements with primary care providers in the community to improve the integration of care, coordination of referrals, and access. Each referral agreement must include: (a) an agreed-upon practice for regular communication and provider-to-provider consultation. Details should include the communication modality by which the primary care clinician can reach the behavioral health provider (e.g., telephone, pager, email, etc.); (b) protocols for referrals, crisis, information sharing, and obtaining consent; (c) protocols for incorporating a "warm hand-off" between primary care providers and behavioral health providers; (d) protocols for ongoing and collaborative-team-based care, including for primary care providers to provide input into an integrated care plan, when the integrated care plan is initiated by the behavioral health provider, (e) protocols for ensuring same-day availability for a physical health visit on the day of a behavioral health visit; and (f) expectations for what information will be shared between providers, with the intention that at a minimum problem lists (in ICD-10 and lay terms), comprehensive medication lists, care plan and follow-up schedules will be shared after each visit.	Identify the names of the primary care practices with which the community behavioral health care site has developed a referral and care management agreement.	Percentage of practices with referral and care management agreements; A listing of primary care providers with which each practice has completed a referral and care management.
	Clinical Care within the Primary Care Office		

9	Routinely screen patients (at the age-appropriate time) for developmental disorders, depression, and drug and alcohol use. To assess development delays and disorders, practices may use the Parents' Evaluation of Development Status (PEDS), the Survey of Wellbeing in Young Children (SWYC), the Ages and Stages Questionnaire (ASQ), OR the Pediatric Symptom Checklist (PSC) **AND** must use the Modified Checklist for Autism in Toddlers (M-CHAT) at the 18- and 24-month office visits. For drug and alcohol screening of adolescents, practices should use the CRAFFT Screening Test. For depression, practices should use the Patient Health Questionnaire for Adolescents (PHQ-A).	Identify the practice's adopted developmental screening tool, and policies and procedures for administration of that tool(s) and of the M-CHAT, CRAFFT and PHQ-A.	Percentage of practices that have adopted all of the required screening patients for developmental delay and disorders, depression, drug and alcohol use; Frequency distribution of developmental screening tools used by practices.
		Confirm that results of all specified screening tool assessments are documented in the electronic health record.	Percentage of practices that report inclusion of the results of all specified screening tool assessments into the electronic health record.
10	Develop procedures for intervention or referrals as the result of a positive screening.	Document policies and procedures for intervention or referrals as the result of a positive screening. Referrals to behavioral health providers should be consistent with protocols established in the Core Component 3 of the project.	Percentage of practices that have documented procedures for interventions and for referrals that are consistent with the protocols established in Core Component 3 of the project.
11	Follow the American Academy of Pediatrics clinical guidelines for the treatment of children with ADHD, anxiety and mild depression, including the use of psychotropic medications and appropriate consultation with behavioral health providers to assist with diagnosing.	Document that all behavioral health providers and primary care clinicians in the practice have undergone training on the guidelines.	Percentage practices where all primary care providers, advance-practice clinicians, and behavioral providers were trained on the American Academy of Pediatrics clinical guidelines by a SIM-provided event, or documentation of CME course completion.

	Integrated Clinical Records		
12	Establish and implement integrated access to clinical information from primary care providers in behavioral health records, as appropriate and permissible.	To be defined	To be defined
13	Enhance electronic health record (EHR) capabilities between behavioral health and primary care providers to support coordination, foster efficient clinical practice, and reduce administrative duplication.	To be defined	To be defined
	Community-based Supports		
14	Enhance relationships with Arizona Early Intervention Program (AzEIP), schools, community-based social service resources, including self-help referral connections, community group resources, family support services by (a) identifying the resources in the community, and (b) creating protocols of when to engage or refer patients to these resources.	Document the resources in the community, including contact information, and describe a schedule for periodically updating the resource listing with up-to-date information. Document protocols used for engaging these resources on behalf of patients and for referring patients to these resources.	Percentage of practices that have community-based resources lists with contact information, a schedule for updating the resource and protocols for engaging the resources and/or referring patients.
	E-Prescribing		
15	Consult Arizona's Controlled Substances Prescription Monitoring Program before prescribing a controlled substance to identify the patient's controlled substance usage history.	Document that the practice has policies and procedures in place for all prescribers of controlled substances to review the CSPMP before prescribing Schedules 2, 3, 4 and 5 controlled substances.	Percentage of practices that have policies and procedures in place for routine use of the CSPMP prior to prescribing a controlled substance.

16	Utilize e-prescribing for Schedules 2, 3, 4, and 5 controlled substances.	Document that prescribers have the capability to e-prescribe, and that medications that are e-prescribed are documented into the electronic medical record.	Percentage of providers that demonstrated the ability to e-prescribe and that medications that are e-prescribed are documented into the electronic medical record.
	Involvement with SIM Entity		
17	Participate in SIM entity-offered training and education.	N/A	Percentage of practices that participated in a) all, and b) each SIM entity provided training during the year; Evidence of training agenda and training materials.

Notes:

[1] Care managers are individuals that "link children and families to services and resources in a coordinated manner to maximize the potential of children and provide them optimal health care." They are responsible for assessing and identifying the needs of the child, developing, in part, integrated plans of care, implementing the plan of care and periodically reassessing the needs of the child and care plan to address new or emerging needs.

Strategic Focus Area: Children with Behavioral Health Needs, Including Children with and at-risk for Autism Spectrum Disorder, and Children Engaged in the Child Welfare System - DRAFT

Project 3: Improving Treatment for the Care of Children with and At-risk for Autism Spectrum Disorders (ASD) (primary care site)

Objective: To improve the identification and care of Medicaid-enrolled children at-risk for ASD or diagnosed with ASD and create sufficient and consistent linkages between primary care, behavioral health and social service resources for improved care.

		Year 2	
CC #	**Core Component**	**Practice Reporting Requirement**	**Reporting Requirement**
	Prerequisite Requirements for Project 2		
	Working toward an integrated primary care practice is a critical first component of improving the care of children with and at risk for Autism Spectrum Disorder. Practices must successfully complete Project 1 Core Components 2-4, 5, 7-8 in DY 1. Project 2 will begin in DY 2.	N/A	Listing of practices that successfully completed Project 1 Core Components 2-4 and are starting on Project 2 in DY2.
	Clinical Care within the Primary Care Office		
1	Utilize a commonly accepted toolkit for caring for children with ASD as a guide for clinical management. One such tool is "Caring for Children with Autism Spectrum Disorder: A Resource Toolkit for Clinicians" from the American Academy of Pediatrics.	Identify the name of the ASD toolkit the practice has adopted **and** document a practice-specific action plan informed by the toolkit, with measurable goals and timelines.	Percentage of practices that have identified the ASD toolkit they have adopted; Frequency distribution of practice-employed ASD toolkits; Summary description of practice action plan areas of focus and goals.
2	Develop procedures for referring children with positive screening to ASD treatment teams or programs, consistent with Core Component 5. If a child is referred to a behavioral health provider (or team) trained to evaluate autism, develop procedures for simultaneously referring the child to:	Document that policies and procedures have been established for referring patients to an audiologist, and depending on age of patient, AzEIP or the local school district, and DDD.	Percentage of practices with policies and procedures that meet this requirement.

	a. An audiologist to determine whether hearing loss is an etiology of the developmental delay; b. The Arizona Early Intervention Program (AzEIP) using the online referral system: https://extranet.azdes.gov/azeip/AzeipREF/Forms/Categories.aspx, if the child is between birth and 36 months. c. The local school district through Arizona's FIND program (www.azed.gov/special-education/az-find/), if the child is over three years of age. d. The Division of Developmental Disabilities (DDD) for eligibility determination.		
3	Routinely document family history of autism.	Document that the family history of the patient is being asked, and documented in the electronic medical record.	Percentage of practices that have documented that the family history of the patient is being asked, and documented in the electronic medical record.
4	Ensure that all pediatricians, family physicians, advanced-practice clinicians and case managers complete a training program in ASD that offers continuing education credits unless having done so within the past 3 years. This training should include support for a comprehensive assessment to ascertain the need for often co-existing conditions, such as speech and language delay or environmental hypersensitivity which can benefit from occupational therapy recommendations for parents and classrooms.	Identify names of pediatricians, family physicians, advance-practice clinicians and case managers who have completed an ASD training program for CEUs in the last three years, the percentage of such practice clinicians that they represent and the training program sponsor(s).	Percentage of practices in which all eligible staff received ASD training in the last three years; Listing of training programs.
	Relationships with ASD Treatment Providers / Team		
4	Develop referral agreements with ASD treatment teams, programs,	Identify the names of the	Percentage of practices with referral

	or providers who are trained to evaluate children for autism and provide early intensive behavioral therapy to families and children. Each referral agreement must include: (a) agreed-upon practice for regular communication and provider-to-provider consultation; details should include the communication modality by which the primary care clinician can reach the behavioral health provider (for example, telephone, pager, email, etc.), and (b) protocols for referrals, crisis, information sharing and obtaining consent; (c) protocols for incorporating a "warm hand-off" between primary care providers and behavioral health providers; (d) protocols for ongoing and collaborative-team-based care, including for behavioral health providers to provide input into an integrated care plan.	ASD treatment team(s) or program(s) with which the primary care site has developed a referral agreement.	agreements; A listing of ASD treatment teams/programs with whom agreements have been executed.
	Community-based Supports		
6	Provide families and other caregivers of children with ASD information regarding parent support and other resources available to them. This should be done by offering specific information to families on local, state and national organizations that offer resources to families caring for children with ASD. Specific information can be delivered in the form of a hand-out listing the names of relevant organizations, the resources they provide, and telephone numbers and websites of the organizations.	Identify what resources are being shared with the parents and caregivers, and develop policies and procedures for ensuring that parents and caregivers receive the information regarding available resources.	Percentage of practices with policies and procedures for ensuring that parents and caregivers receive information regarding available resources.

7	Participate in SIM entity-offered training and education to understand the unique needs of children with ASD.	N/A	Percentage of practices that participated in SIM entity provided training; Evidence of training agenda and training materials.

Strategic Focus Area: Children with Behavioral Health Needs, Including Children with and at-risk for Autism Spectrum Disorder, and Children Engaged in the Child Welfare System - DRAFT

Project 4: Improving Treatment for the Care of Children Engaged in the Child Welfare System (primary care site)

Objective: To improve the care of Medicaid-enrolled children who are engaged 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.

		Year 2	
CC #	**Core Component**	**Practice Reporting Requirement**	**Reporting Requirement to AHCCCS**
	Prerequisite Requirements for Project 3		
		N/A	Listing of practices that have completed the required Project 1 Core Components and are starting on Project 4.
	Be part of the Comprehensive Medical & Dental Program's (CMDP) Preferred Provider Network, and care for the minimum number of foster children required for participation in this project, as defined by AHCCCS.	N/A	Percentage of practices participating in Project 4 that are part of the CMDP Preferred Provider Network.
	Clinical Care within the Primary Care Office		
1	Actively outreach to any known past and current medical and behavioral health providers to obtain and share records for the purposes of better care management. If current and prior provider are not known, outreach should occur through contacting CMDP and the RBHA, or if the child is under 6 years old, the primary care provider should utilize the Arizona State Immunization Information System (ASIIS) to identify any past providers. If the child has ongoing psychotropic medications, expedite contact with the prescribing physician, if known, to gather correct information about dosing and intended goals, as well as about any side effects.	Document a process for identifying medical and behavioral health providers that have served or do serve the child, and for obtaining information from those providers.	Percentage of practices with documented processes for working with the child protection worker and gathering data from providers, with an expedited procedure for children on psychotropic medications.

2	Offer patients and families consent forms to ensure that consent is obtained (when willing and within applicable state and federal laws). [1]	Document policies and procedures to obtain consent from patients / families when they are willing, and within applicable state and federal laws.	Percentage of practices with policies and procedures in place to obtain consent from patients / families when they are willing, and within applicable state and federal laws.
3	Ensure that all practice pediatricians, family physicians, advanced-practice clinicians and case managers who treat children engaged in the child welfare system complete a training program in Trauma-informed Care, and in Child and Family Team Practice that offers continuing education credits[2] unless having done so in the past 3 years.	Identify the names of pediatricians, family physicians, advance-practice clinicians and case managers who have completed a Trauma-Informed Care training program and / or a Child and Family Team Practice for CEUs in the last three years.	Percentage of practices in which all eligible staff received training; Listing of training programs.
4	Develop and implement policies that allow for patients, in particular teens, to participate in shared decision making using the skills and techniques developed through Trauma-Informed Care training.	Document that policies have been developed and implemented to allow for adolescents to participate in shared care decision making.	Percentage of practices with implemented policies for teen shared decision making.
5	After the initial office visit with the foster child, the practice must proactively schedule or outreach to the foster parent / guardian to schedule EPSDT appointments on a schedule as follows: visits are required 10 times in the first 2 years of life (ages 3-5 days, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months and 24 months-of-age) and at least annually after age 2 per the Arizona Department of Child Safety policy. The initial and annual EPSDT/well care medical examinations must include:	Document policies and procedures to a) schedule and perform complete medical examinations consistent with EPSDT requirements and b) schedule and perform additional EPSDT visits consistent with the enhanced periodicity schedule defined by DCS policy.	Percentage of practices with policies and procedures to schedule and perform timely and comprehensive EPSDT visits with children placed in out-of-home care consistent with DCS requirements.

a. Complete health history & physical exam.
b. Developmental and behavioral health screening.
c. Growth and nutrition check.
d. All medically necessary Immunizations.
e. Vision and hearing tests.
f. Assessment of vision and hearing related to eyeglasses and hearing aids.
g. Dental care.
h. Blood and urine tests.
i. Follow-up and referral of any medically-necessary health and mental health care services.
Even if the initial assessment does not indicate active concerns, practices must schedule office visits on an enhanced schedule for children engaged in the child welfare system (monthly for infants birth to 6 months; every 3 months for children between 6 and 24 months; bi-annually for children 24 months to 21 years of age) to help:
a. Monitor developmental milestones and any signs and symptoms of abuse and/or neglect,
b. Monitor a youth's emotional adjustment to the child welfare system and visitation,
c. Ensure the child has all necessary academic supports, clinical or community based referrals, medical equipment, and medications; and
d. Support and educate foster parents/guardians.[3]

6	At every visit, conduct a comprehensive child abuse and neglect screening, including through an interview (being sensitive to the child's fears and anxieties), observing the child's affect, height, weight and head circumference (if younger than 3 years), skin examination, range of motion in joints and extremities, and genital survey. Upon each visit, if any signs of child abuse or neglect are found, follow reporting practices established by AHCCCS.	Document a protocol for conducting a comprehensive child abuse and neglect screening at every visit.	Percentage of practices with required screening protocols in place.
7	Complete a comprehensive after-visit summary that is shared with the foster parents/guardians and the child welfare case worker which can assist in guiding the foster parents/guardians and case worker in following-up on referrals and recommendations.	Document a protocol for developing and sharing comprehensive after visit summaries with foster parents/guardians that contain referrals, recommendations and protocols for assessing risk and monitoring the child's needs.	Percentage of practices with required comprehensive visit summary practice and protocols.
8	This comprehensive after visit summary should include protocols for foster parents/guardians to use to assess safety risk and monitor the child's medical or behavioral health issues at home. The first such parenting strategies should include education about the child's physical and emotional needs at the time of the initial visit, and repeatedly as required to assist the child and family in understanding their remaining care plan.		
9	Develop and implement a policy that comprehensive after visit summary should not divulge confidential information between the patient and provider, particularly for teens engaged in the child welfare system.[4]	Demonstrate that a policy has been developed to ensure confidentiality between the patient and provider.	Percentage of practices with an appropriate confidentiality policy in place.

10	Coordinate care management with the RBHA. Treatment of medical conditions that may be affected by co-occurring behavioral health conditions should be done in consultation and coordination with the treating behavioral health provider, or the RHBA.	Document an effort to collaborate with each welfare system child's behavioral health provider(s), and/ or the RBHA in order to collaborate in care planning and treatment.	Percentage of practices routinely initiating communication with each child welfare child's behavioral health provider(s) and/or the RBHA in order to collaborate in care planning and treatment.
	Involvement with SIM Entity		
11	Participate in SIM entity-offered training and education to understand the unique needs of children engaged in the child welfare system.	N/A	Percentage of practices that participated in SIM entity provided training; Evidence of training agenda and training materials.

Notes:

[1] Per ARS Article 7.1.,Medical Records: a health care provider is permitted to disclose medical records without the written authorization of the patient or the patient's health care decision maker to health care provider who are currently providing health care to the patient for the purposes of diagnosis or treatment of the patient. Written consent is needed to obtain the medical records of past providers.

[2] Examples of organizations offering CEU credit courses on Trauma-informed Care include the Arizona Trauma Institute (http://aztrauma.org/classes/) and the National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint (NCTIC) (www.samhsa.gov/nctic).

[3] Standards which are recommended by the American Academy of Pediatrics and Child Welfare League of America.

[4] See "Consent & Confidentiality in Adolescent Health Care: A Guide for the Arizona Health Practitioner. https://azmed.org/wp-content/uploads/2014/09/2011Adol_Consent_Conf_Booklet.pdf

Strategic Focus Area: Children with Behavioral Health Needs, Including Children with and at-risk for Autism Spectrum Disorder, and Children Engaged in the Child Welfare System - DRAFT

Project 5: Improving Treatment for the Care of Children Engaged in the Child Welfare System (behavioral health site)

Objective: To improve the care of Medicaid-enrolled children who are engaged 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.

		Year 2	
CC #	**Core Component**	**Practice Reporting Requirement**	**Reporting Requirement to AHCCCS**
	Prerequisite Requirements for Project 4		
	Working toward an integrated behavioral health care practice is a critical first component of improving treatment for the care of children engaged in the child welfare system. Practices must successfully complete all Project 2 Core Components. Project 5 will begin in year 2.		
	Clinical Care within the BH Provider Office		
1	Conduct a comprehensive behavioral health assessment within the timeframe established by AHCCCS for patients referred by the RBHA, a PCP, or when a case worker, patient or a patient's parent/ guardian requests an appointment. The assessment must directly involve the child and include developmentally and culturally appropriate screening tools and assessments for the child's age and cognitive level. The assessment must also include the parent'(s)/family's strengths and needs to effectively address the child's needs – with the family of origin and/or foster parent(s), as applicable.[1]	Document policies and procedures to a) schedule and perform an assessment consistent the DBHS Practice Tool and AACAP guidelines following notification by the CMDP and within 30 days of out-of-home placement, and b) schedule and provide services monthly for at least the first six months of out-of-home placement.	Percentage of practices with policies and procedures to schedule and perform a) timely assessment visits with children placed in out-of-home care consistent with DCS requirements, and b) monthly visits for the six months of out-of-home placement.

2	Actively outreach to any known past and current medical and behavioral health providers to obtain and share records for the purposes of better care management. If current and prior provider are not known, outreach should occur through contacting CMDP and the RBHA, or if the child is under 6 years old, the primary care provider should utilize the Arizona State Immunization Information System (ASIIS) to identify any past providers. If the child has ongoing psychotropic medications, expedite contact with the prescribing physician, if known, to gather correct information about dosing and intended goals, as well as about any side effects.	Document a process for identifying medical and behavioral health providers that have served or do serve the child, and for obtaining information from those providers.	Percentage of practices with documented processes for working with the child protection worker and gathering data from providers, with an expedited procedure for children on psychotropic medications.
3	Ensure that all clinicians and case managers who treat children engaged in the child welfare system complete a training program in Trauma-informed Care, Child and Family team Practice (CFT), in Transition to Adulthood, and the Transition to Independence Process (TIP) model that offers continuing education credits unless having done so in the past 3 years. [3]	Identify the names of clinicians and case managers who have completed the training programs for CEUs in the last three years.	Percentage of practices in which all eligible staff received training; Listing of training programs.
4	Adopt the AACAP's policy statement on "Prescribing Psychoactive Medications for Children and Adolescents"[4] and implement its prescribed practices.	Document that all behavioral health clinicians have undergone training on the AACAP's policy statement and that the policy statement has been incorporated into policy and practice.	Percentage of practices in which all behavioral health care clinicians were trained on the AACAP's policy statement by the SIM entity or the practice itself, or documentation of relevant CME course completion.
	Involvement with SIM Entity		
5	Participate in SIM entity-offered training and education to understand the unique needs of children engaged in the child welfare system.	N/A	Percentage of practices that participated in SIM entity provided training; Evidence of training agenda and training materials.

Notes:

[1] For more information see the DBHS Practice Tool (www.azdhs.gov/bhs/guidance/unique_cps.pdf) and the AACAP Practice Parameter for the Assessment and Management of Youth Involved with the Child Welfare System. (www.jaacap.com/article/S0890-8567(15)00148-3/pdf)

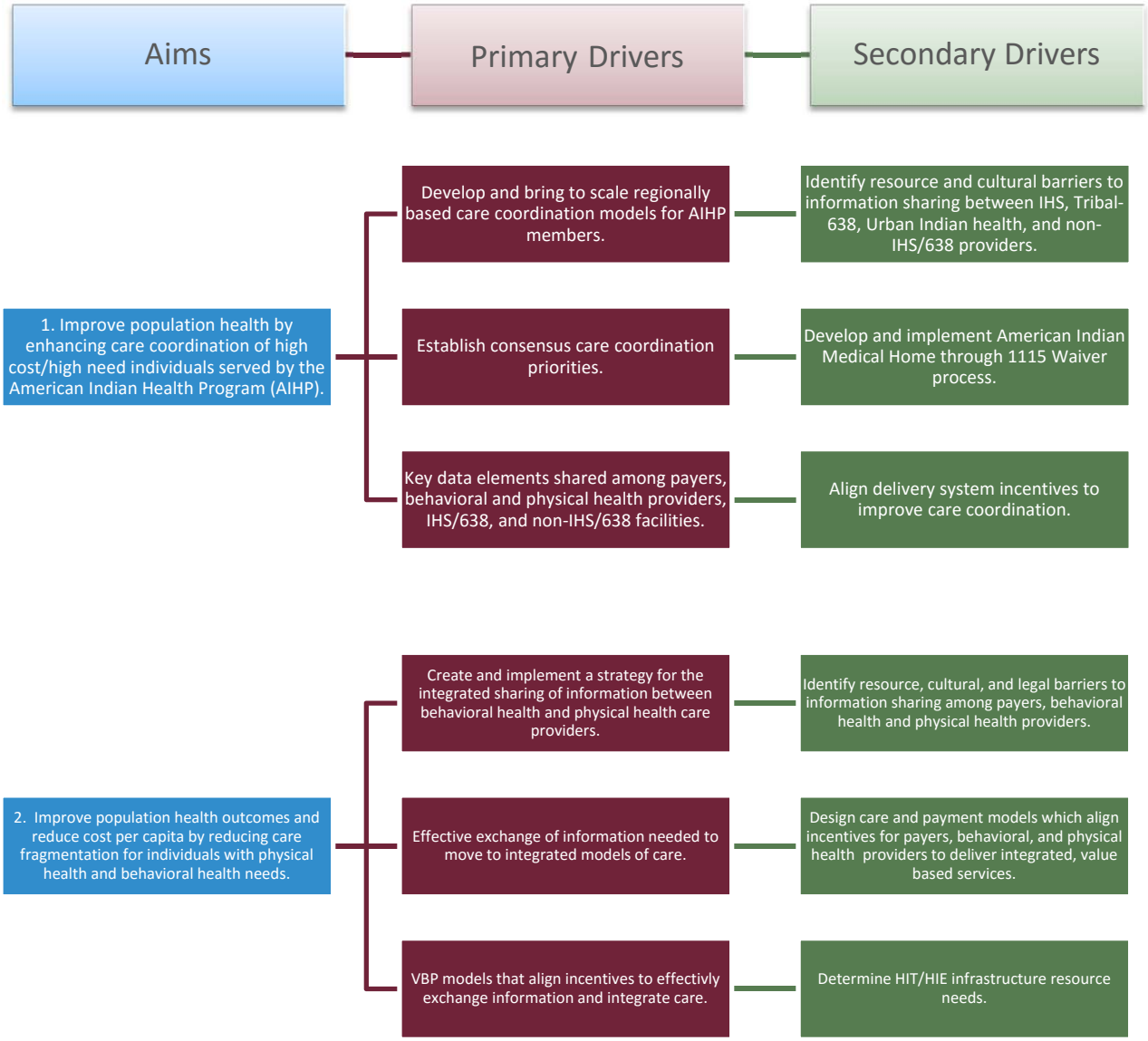
[2] Per ARS Article 7.1.,Medical Records: a health care provider is permitted to disclose medical records without the written authorization of the patient or the patient's health care decision maker to health care provider who are currently providing health care to the patient for the purposes of diagnosis or treatment of the patient. Written consent is needed to obtain the medical records of past providers.

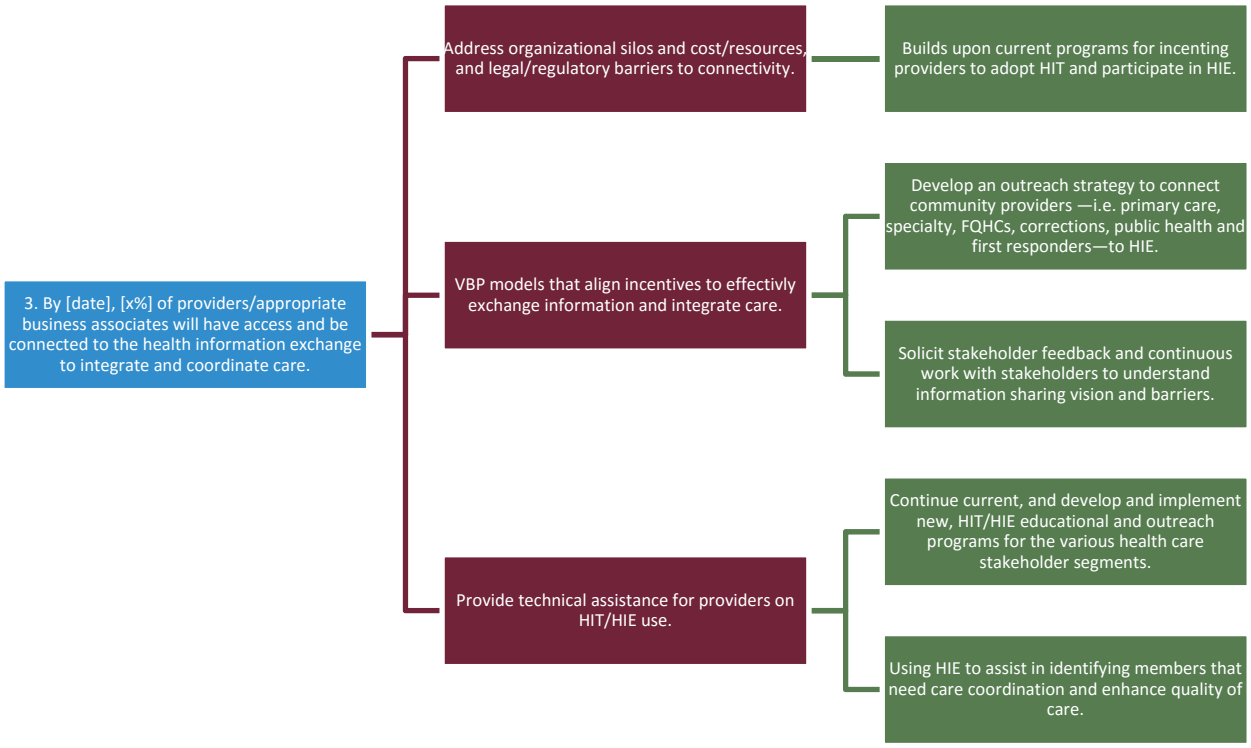
[3] Examples of CEU credit courses on trauma informed care include: the Arizona Trauma Institute (http://aztrauma.org/classes/) and the National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint (NCTIC) (www.samhsa.gov/nctic).

[4] www.aacap.org/AACAP/Policy_Statements/2001/Prescribing_Psychoactive_Medication_for_Children_and_Adolescents.aspx

Exhibit J: Driver Diagram

As required in the SIM Design Model grant, AHCCCS developed a driver diagram to assist in the development and design of its initiatives.




3. By [date], [x%] of providers/appropriate business associates will have access and be connected to the health information exchange to integrate and coordinate care.
Address organizational silos and cost/resources, and legal/regulatory barriers to connectivity.
Builds upon current programs for incenting providers to adopt HIT and participate in HIE.
VBP models that align incentives to effectivly exchange information and integrate care.
Develop an outreach strategy to connect community providers —i.e. primary care, specialty, FQHCs, corrections, public health and first responders—to HIE.
Solicit stakeholder feedback and continuous work with stakeholders to understand information sharing vision and barriers.
Provide technical assistance for providers on HIT/HIE use.
Continue current, and develop and implement new, HIT/HIE educational and outreach programs for the various health care stakeholder segments.
Using HIE to assist in identifying members that need care coordination and enhance quality of care.

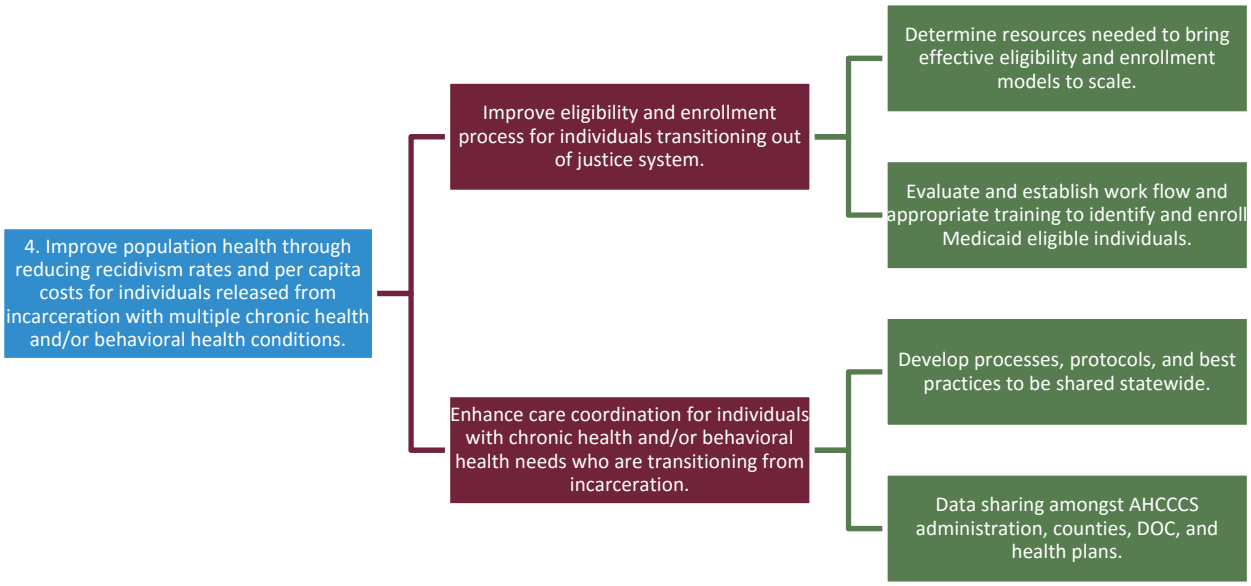

4. Improve population health through reducing recidivism rates and per capita costs for individuals released from incarceration with multiple chronic health and/or behavioral health conditions.
Improve eligibility and enrollment process for individuals transitioning out of justice system.
Determine resources needed to bring effective eligibility and enrollment models to scale.
Evaluate and establish work flow and appropriate training to identify and enroll Medicaid eligible individuals.
Enhance care coordination for individuals with chronic health and/or behavioral health needs who are transitioning from incarceration.
Develop processes, protocols, and best practices to be shared statewide.
Data sharing amongst AHCCCS administration, counties, DOC, and health plans.

Exhibit K: SIM Checklist

SIM Round 2 Model Design Check-list for State Health System Innovation Plan

Ref#	SIM Round 2 Model Design State Health System Innovation Plan Development Guidance Reference	Requirement	Section of AZ Innovation Plan Where the Requirement is Located
1.	I.C.8.a II.C.6	Description of State Health Care Environment Knowledge of the state's current health care delivery and payment environment will inform the goals for the overall health care delivery and financing transformation and serve as an input to the Driver Diagram and the selection of a state health care transformation model. Identify the current number of health care provider organizations in the State using the categories defined in Appendix D. Identify the payers in the state with more than 5% of the market share with the number of members/beneficiaries that they cover: BlueCross/Blue Shield plans Other commercial plans Employer self-funded ERISA plans Medicaid Medicare Model Design awardees will have three options for accessing Medicare data: The Public Use Files (PUF) and dashboards at no cost (data is limited); A Limited Data Set (LDS) request, which will require CMS review and approval, at no cost; or Apply for access to Medicare Research Identifiable Files via a state agency Data Use Agreement (DUA) request and pay the charges that apply. Visit www.RESDAC.org for assistance.	Section III: Description of Arizona's Health Care Environment
2.	I.C.8.b	Report on Stakeholder Engagement and Design Process Deliberations Description of how stakeholder engagement plan was operationalized Incorporate best practice recommendations by addressing: The state's strategy to advance the health of the entire population as part of the health care transformation efforts; A health care delivery system transformation model(s) and value-	Section II: "Approach to Stakeholder Engagement" Section IV: • AIHP Stakeholder Efforts, Quality/

Ref#	SIM Round 2 Model Design State Health System Innovation Plan Development Guidance Reference	Requirement	Section of AZ Innovation Plan Where the Requirement is Located
		based payment methodology; Quality and performance measures to be developed or adopted and monitored in the model; A description of how the plan aligns with other federal, state, regional and local innovation models; and How the transformation will be organizationally and financially sustained.	Performance Metrics, Alignment with other Initiatives; and • Justice System Transitions Stakeholder Efforts, Quality/ Performance Metrics, Alignment with other Initatives. Section V: • Physical & Behavorial Health Coordination Stakeholder Efforts, Quality/Performance Metrics, Alignment with other Initatives. Section VI: Sustainability
3.	I.C.8.c	Health System Design and Performance Objectives (Overarching goals and performance objectives over the 4 initiatives) Incorporate best practice recommendations by addressing: The associated driver diagram defining the state aims, primary and secondary drivers; A health care delivery system transformation model(s) and value-based payment methodology; A description of how the plan aligns with other federal, state, regional and local innovation models; and How the transformation will be organizationally and financially sustained.	Section II: Introduction & Overview of Innovation Plan Exhibits/Appendices: Driver Diagram Section VI: Payment Transformation Section IV: • AIHP Alignment with other Initiatives; and • Justice System Transitions Alignment with other Initatives. Section V:

Ref#	SIM Round 2 Model Design State Health System Innovation Plan Development Guidance Reference	Requirement	Section of AZ Innovation Plan Where the Requirement is Located
			• Physical & Behavorial Health Coordination Alignment with other Initatives. Section V: Sustainability
4	I.C.8.d II.D.2	Value-Based Payment and/or Service Delivery Model Incorporate best practice recommendations by addressing: A description of the state regulatory and policy levers available and any federal waiver or state plan amendment requirements and their timing to enable key strategies for transformation; The associated driver diagram defining the state aims, primary and secondary drivers; A health care delivery system transformation model(s) and value-based payment methodology; A description of how the plan aligns with other federal, state, regional and local innovation models; and How the transformation will be organizationally and financially sustained. Identify a value-based payment methodology to support the delivery model Define the number of providers and beneficiaries impacted Explain how it will aim to move over 80% of payments to providers from all payers from FFS alternatives to value-based payment Identify value-based strategies including intended scale and impact of the model. To document these impacts, the following groups should be identified: Employers or payers who will participate, The providers who will receive each type of reimbursement, and The patients or beneficiaries whom they serve.	Section VI: Payment Transformation Section VI: Policy Levers Exhibits/Appendices: Driver Diagram

Ref#	SIM Round 2 Model Design State Health System Innovation Plan Development Guidance Reference	Requirement	Section of AZ Innovation Plan Where the Requirement is Located
5.	I.C.8.e II.D.1	Plan for Health Care Delivery System Transformation Incorporate best practice recommendations by addressing: • The state's strategy to advance the health of the entire population as part of the health care transformation efforts; • A description of the state regulatory and policy levers available and any federal waiver or state plan amendment requirements and their timing to enable key strategies for transformation; • The associated driver diagram defining the state aims, primary and secondary drivers; • A health care delivery system transformation model(s) and value-based payment methodology; • A description of how the plan aligns with other federal, state, regional and local innovation models; and • How the transformation will be organizationally and financially sustained. Selecting care delivery transformation models • Define the range of models, their goals, impacts and advantages/disadvantages • Define one or more health care delivery model(s) • Define the range and number of health care professionals and organizations involved • Define the range of social determinants of health	Section IV: Proposed Payment and Delivery System Initatives Section VI: Policy Levers Exhibits/Appendices: Driver Diagram Section VI: Payment Transformation
6.	I.C.8.f	Plan for Improving Population Health Incorporate best practice recommendations by addressing: • The state's strategy to advance the health of the entire population as part of the health care transformation efforts; • A description of the state regulatory and policy levers available and any federal waiver or state plan amendment requirements and their timing to enable key strategies for transformation; • The associated driver diagram defining the state aims, primary and secondary drivers; • A health care delivery system transformation model(s) and value-	Section VIII: Monitoring & Evaluation of Delivery System and Payment Model Transformation Exhibits/Appendices: Driver Diagram Section IV:

Ref#	SIM Round 2 Model Design State Health System Innovation Plan Development Guidance Reference	Requirement	Section of AZ Innovation Plan Where the Requirement is Located
	II.C.4	based payment methodology; • Quality and performance measures to be developed or adopted and monitored in the model; • A description of how the plan aligns with other federal, state, regional and local innovation models; and • How the transformation will be organizationally and financially sustained. The plan for improving population health should: • Identify gaps in access and disparities in the health status of state residents. • Leverage and build upon interventions and strategies included in an existing public health State Health Improvement Plan; • Create an inventory of the current efforts to advance the health of the entire state population, including efforts to integrate public health and health care delivery; • Leverage existing health care transformation efforts to advance population health; Include a data-driven implementation plan that identifies measurable goals, objectives and interventions that will enable the state to improve the health of the entire state population.	• AIHP Alignment with other Initiatives and Quality/Performance Metrics; and • Justice System Transitions Alignment with other Initatives and Quality/Performance Metrics. Section V: • Physical & Behavorial Health Coordination Alignment with other Initatives and Quality/Performance Metrics. Section V: Sustainability Section III: Description of Arizona's Health Care Environment
7.	I.C.8.g II.D.3	Health Information Technology Plan Incorporate best practice recommendations by addressing: • A description of the state regulatory and policy levers available and any federal waiver or state plan amendment requirements and their timing to enable key strategies for transformation; • The associated driver diagram defining the state aims, primary and secondary drivers; • A description of how the plan aligns with other federal, state, regional and local innovation models; and • How the transformation will be organizationally and financially	Section VI: Health Information Technology Section VI: Policy Levers Exhibits/Appendices: Driver Diagram Section IV: • AIHP

Ref#	SIM Round 2 Model Design State Health System Innovation Plan Development Guidance Reference	Requirement	Section of AZ Innovation Plan Where the Requirement is Located
		sustained. Awardees should provide detailed descriptions for health information technology plans in the following domains: • Rationale: How the specified HIT elements and/or programs, in combination, will achieve state-wide health transformation • Governance: Describe how state leadership will direct the planning and oversight during future implementation; supply a comprehensive plan for future implementation of infrastructure that leverages existing assets and aligns with federally-funded programs and state enterprise IT systems; and explain how the governance structure will incorporate and expand existing public/private health information exchanges, including those operated by ACOs. • Policy: Describe policy and regulatory levers that will be used to accelerate standards based health information technology adoption to improve care; describe methods to improve transparency and encourage innovative uses of data; offer a plan for promotion of patient engagement and shared-decision making; and propose multi-payer strategies to enable and expand the use of health information technology. • Infrastructure: Describe how the state will implement analytical tools and use data driven evidence based approach to coordinate and improve care across the state; offer plans to utilize telehealth and perform remote patient monitoring to increase access to care and the timeliness of care; articulate plans to use standards based health IT to enable electronic quality reporting; explain how public health IT systems (such as clinical registry systems) will be integrated; and describe how support of electronic data will drive quality improvement at the point of care. • Technical Assistance: Define how the state will provide technical assistance to providers; identify targeted provider groups that will receive assistance and what services will be delivered; and identify how the state intends to extend resources to providers ineligible for Meaningful Use incentive payments, if applicable.	• Justice System Transitions Section V: • Physical & Behavorial Health Coordination Section V: Sustainability

Ref#	SIM Round 2 Model Design State Health System Innovation Plan Development Guidance Reference	Requirement	Section of AZ Innovation Plan Where the Requirement is Located
8.	I.C.8.h II.D.3	Workforce Development Strategy • The state's strategy to advance the health of the entire population as part of the health care transformation efforts; • A description of the state regulatory and policy levers available and any federal waiver or state plan amendment requirements and their timing to enable key strategies for transformation; • The associated driver diagram defining the state aims, primary and secondary drivers; • A health care delivery system transformation model(s) and value-based payment methodology; • Quality and performance measures to be developed or adopted and monitored in the model; • A description of how the plan aligns with other federal, state, regional and local innovation models; and • How the transformation will be organizationally and financially sustained. The state should consider data collection to address current supply and modeling methods that allow for projections of future demand for health workforce, and specify actions that will be taken to ensure an adequate and trained workforce will be available to deliver care under transformed models.	Section VI: Workforce Development Section VI: Policy Levers Exhibits/Appendices: Driver Diagram Section IV: Proposed Payment and Delivery System Initatives Section IV: • AIHP Alignment with other Initiatives and Quality/Performance Metrics; and • Justice System Transitions Alignment with other Initatives and Quality/Performance Metrics. Section V: • Physical & Behavorial Health Coordination Alignment with other Initatives and Quality/Performance Metrics. Section V: Sustainability

Ref#	SIM Round 2 Model Design State Health System Innovation Plan Development Guidance Reference	Requirement	Section of AZ Innovation Plan Where the Requirement is Located
9.	I.C.8.i	**Financial Analysis**	Section VII: Financial Analysis
10.	I.C.8.j.	**Monitoring and Evaluation Plan** The state's strategy to advance the health of the entire population as part of the health care transformation efforts; The associated driver diagram defining the state aims, primary and secondary drivers; A health care delivery system transformation model(s) and value-based payment methodology; Quality and performance measures to be developed or adopted and monitored in the model; How the transformation will be organizationally and financially sustained.	Section VIII: Monitoring & Evaluation of Delivery System and Payment Model Section IV: • AIHP Quality/Performance Metrics; and • Justice System Transitions Quality/Performance Metrics. Section V: • Physical & Behavorial Health Coordination Quality/Performance Metrics. Section V: Sustainability
11.	I.C.8.k.	Operational Plan • The state's strategy to advance the health of the entire population as part of the health care transformation efforts; • A description of the state regulatory and policy levers available and any federal waiver or state plan amendment requirements and their timing to enable key strategies for transformation; • The associated driver diagram defining the state aims, primary and secondary drivers; • A health care delivery system transformation model(s) and value-based payment methodology; • Quality and performance measures to be developed or adopted	Section VIII: Roadmap to Transformation Section VI: Policy Levers Exhibits/Appendices: Driver Diagram Section IV: Proposed Payment and Delivery System Initatives Section IV:

Ref#	SIM Round 2 Model Design State Health System Innovation Plan Development Guidance Reference	Requirement	Section of AZ Innovation Plan Where the Requirement is Located
		and monitored in the model; • A description of how the plan aligns with other federal, state, regional and local innovation models; and • How the transformation will be organizationally and financially sustained.	• AIHP Alignment with other Initiatives and Quality/Performance Metrics; and • Justice System Transitions Alignment with other Initatives and Quality/Performance Metrics. Section V: • Physical & Behavorial Health Coordination Alignment with other Initatives and Quality/Performance Metrics. Section V: Sustainability

Exhibit L: List of Helpful Links

1. AHCCCS: www.azahcccs.gov
2. AHCCCS Payment Modernization Plan SFY 2014: https://www.azahcccs.gov/AHCCCS/Downloads/Plans/PaymentModernizationPlan_SFY2014.pdf
3. AZ Health Survey: http://www.arizonahealthsurvey.org/wp-content/uploads/2010/12/ahs-2010-SubstanceUse-Dec10.pdf
4. AzHeC: www.azhec.org
5. Arizona Health Improvement Plan: http://www.azdhs.gov/documents/operations/managing-excellence/azhip.pdf
6. State Health Assessment: http://www.azdhs.gov/documents/operations/managing-excellence/az-state-health-assessment.pdf

Health Information Technology (HIT) Plan

Introduction

The success of Arizona's plan to transform the State's health care system and improve the health of Arizonans, particularly the vulnerable populations of American Indians, those involved in the justice system, and those with behavioral health conditions, depends largely on the State's ability to develop and expand the HIT needed to implement and support Arizona's SIM model. Arizona has long recognized the importance of HIT and has been investing in evolving and expanding technology to support improvements in the health care system. In order to implement the State's SIM model, Arizona will build on the State's HIT roadmap, identifying the policy, infrastructure, technology, and technical assistance needed to support implementation of the model.

Over the last decade, through consistent statewide planning around health improvement, health services, payment modernization, and technology planning and fueled by visionary leadership by the State of Arizona and its citizens, widespread acceptance in the health care community of the triple aim has grown. The State of Arizona has long recognized the value of health information exchange (HIE) and the use of electronic health records (EHRs) by health care providers in achieving the triple aim. HIE is the electronic exchange of health related information among organizations. HIT is the storage and use of health information for communication and decision-making.

There is now a convergence of these two separate HIE and EHR efforts. The statewide HIE, The Network, has grown in its technical capacity and participation and is now under the Arizona Health-e Connection (AzHeC) leadership, which provides statewide collaborative leadership towards the goal of improving health care and public health in Arizona through HIE and HIT. In addition, driven by CMS's Meaningful Use initiative in recent years, this focus has led to large numbers of health care providers, namely physical health provider and hospitals, notably improving their use of EHR technology, innovating in workflow, and moving towards outcomes measures. Behavioral Health (BH) providers, which are excluded from the federal Medicaid EHR Incentive Program, have not shown the same level of EHR adoption. As providers' capacity to innovate independently moves forward, there is now a greater awareness of the need for data exchange across organizations to facilitate care coordination and improved outcomes.

Exchanging data includes a drive toward interoperable information technology – a drive to connect disparate systems by electronic means. This drive only increases as providers become increasingly responsible (and soon financially rewarded or penalized) based on the overall health of the patients they treat, even when their patients receive care at the hands of providers whose workflows they do not control. While one important outcome of interoperability is aggregated data from providers, payers, and even patients, the ultimate goal also includes enhanced team-based care and communication, especially when it takes place among providers across the health care continuum.

Moving in this direction, Arizona's SIM model requires HIT policies, governance, and a statewide technology infrastructure to support a data driven evidence based approach to care, to increase access to care and timeliness of care, to drive quality improvement at the point of care, and to support value-based purchasing (VBP). Without a solid HIT plan and the right tools, including a strong and flexible infrastructure both at the point of care, as well as across the spectrum of care, these goals will be difficult, if not impossible, to actualize.

In 2005, Arizona began the development of its statewide health IT strategic plan or "Roadmap." Developed with the input of hundreds of Arizona individuals and organizations, it was published in 2006

under the moniker of "Arizona Health-e Connection Roadmap (Roadmap 1.0)." In 2014, the State published an updated version of its plan (*Health IT Roadmap 2.0*) to reflect the continuous refinement of the State's planning and direction for HIT and HIE advancement, as informed by Arizona's ongoing dialogue with stakeholders. *Health IT Roadmap 2.0* identified three essential strategies to guide the adoption and advancement of HIT/HIE in Arizona:

- Continue to support providers across the community in their adoption and successful use of technology.
- Accelerate the secure sharing of health information among health care providers.
- Continue to provide opportunities where health care stakeholders can come together and develop HIT/HIE strategies to meet their evolving business needs.

Through the SIM Design Model, Arizona sharpened its focus on how the State's HIT policies and infrastructure must be developed to support new delivery system and payment models impacting American Indians, justice system involved individuals, and behavioral health and physical health integration. AHCCCS engaged AzHeC to assist the State with obtaining input from stakeholders, payers, and other county and state agencies on how to improve the coordination and delivery of care for the three SIM target populations through the 1) expansion of exchange of clinical information on a real time basis, and 2) the provision of data and analytical capability to support providers' practices, payers, and other relevant organizations as the State works to improve the health of all Arizonans.

This section of the Arizona SIM Health Innovation Plan summarizes the discussions with stakeholders and State leadership and outlines the HIT strategic plan to develop the governance, policy, infrastructure, and technical assistance necessary to support Arizona's SIM Model goals.

Governance

Organizational Structure and Capacity

Arizona's approach to development and oversight of statewide HIT planning has been through public-private partnerships. The State's long-standing multi-stakeholder governance structure has served well over many years in addressing HIT and HIE governance and policy issues. Arizona's public-private governance model involves State agencies sitting on the boards of directors of community-wide organizations. Stakeholder participation from multiple private and public organizations has been voluntary and collaborative. This structure enables it to address issues around data contributors, data sources and data types, data standards, and data access. Arizona has successfully balanced meeting the current needs of its stakeholders with an eye toward what stakeholders may need in the future.

The State, through its Medicaid agency, has established a public-private governance model that is supported by many of Arizona's health care stakeholders. Key to the governance model is three State agencies – AHCCCS, Arizona Department of Administration - Arizona Strategic Enterprise Technology Office (ADOA-ASET), and the Arizona Department of Health Services (ADHS).

AHCCCS plays a strong leadership role in the governance of Arizona's HIT system supporting health care. The State HIT Coordinator is part of AHCCCS' leadership team and is responsible for leading the State's HIT/HIE strategy development. The State HIT Coordinator communicates with other state agencies to increase their knowledge about Health IT and ensures they evaluate the services being offered by The Network to ensure coordination and alignment between Medicaid, public health, and other state agencies. The State HIT Coordinator also communicates and facilitates planning with ADHS for the purpose of ensuring providers can comply with Public Health Meaningful Use requirements. In addition, the State of Arizona has a presence on the Board of Directors of AzHeC, the organization that operates the statewide HIE. Today the State continues to support the public-private governance model created and supported by Arizona's health care stakeholders.

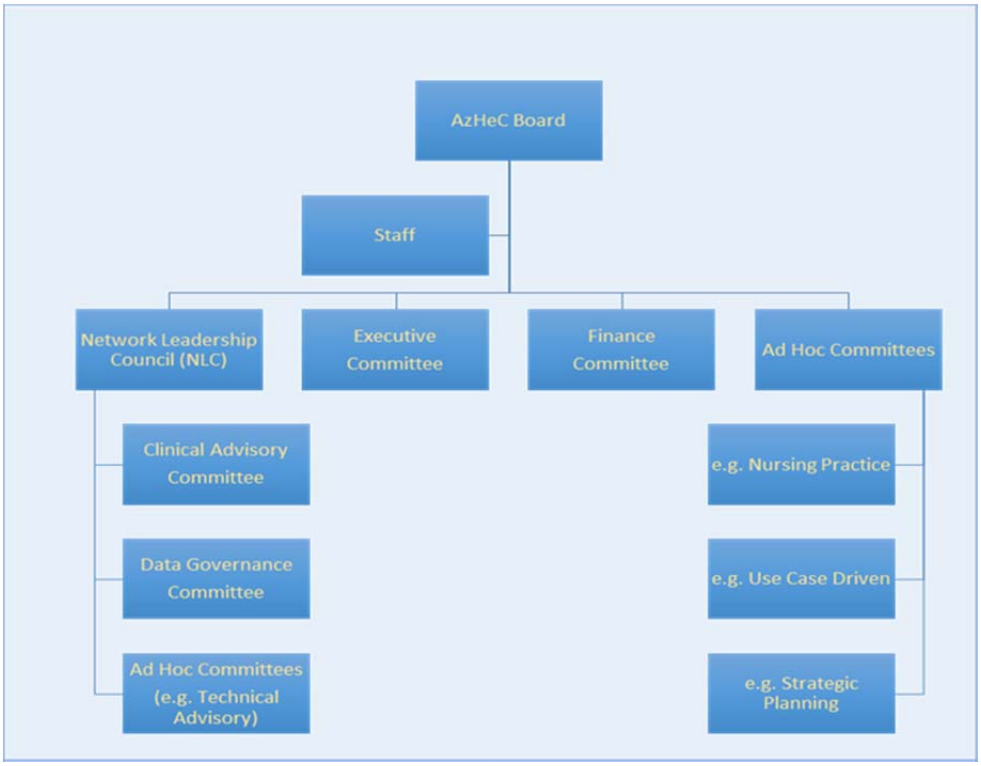
Also key to the governance model is AzHeC, the non-profit, public-private partnership organization that manages and operates “The Network,” Arizona’s statewide HIE. The Network provides secure access to patient health information, as well as the secure exchange of patient health information between The Network and its participants. Through the secure sharing of health information among authorized participants, The Network is enabling Arizona’s health care community to improve health care coordination, quality, and safety, and to reduce costs. The Network is Arizona’s largest and only statewide HIE. Participants include over 100 hospitals, physicians, health plans, reference labs, and other providers.

Since 2007, AzHeC has been the coordinator of community HIT and HIE initiatives in Arizona by:

- Serving as an educator and clearinghouse for HIT information.
- Researching, developing, and advocating statewide HIT policies.
- Leading and supporting provider adoption of HIT and HIE across Arizona.

AzHeC also operates the Arizona Regional Extension Center (REC), which has assisted more than 3,000 providers in adopting EHRs and achieving Meaningful Use. AzHeC’s other programs have included statewide e-prescribing advancement and education, the Arizona HIE Marketplace, and spearheading health IT consumer education and awareness.

Figure 1 - AzHeC Governance Structure



AzHeC's governance structure includes the AzHeC Board of Directors, its Executive Committee, the Finance Committee, and Health Information Network Leadership Council (NLC). The Executive Committee oversees The Network's three standing committees (Clinical Advisory, Technical Advisory, and Data Governance) plus Ad Hoc Committees, which will be in place soon. The current governance structure provided by AzHeC provides a solid foundation upon which SIM-related governance and policy activities can be supported.

The AzHeC Board of Directors is composed of Arizona's leading health care executives and leaders, with representation from hospitals, laboratories, health plans, employers, higher education institutions, and other key health care stakeholders. Additionally, the Board has permanent seats for representation from the Office of the Arizona Governor, AHCCCS, ADHS, ADOA-ASET, Arizona Hospital and Healthcare Association (AzHHA), Arizona Medical Association (ArMA), and Arizona Osteopathic Medical Association (AOMA).

Executive Committee

The Executive Committee has full authority to act in place of the Board between meetings of the Board in all matters except for those specific matters reserved to the entire Board (including filling vacancies on, or increasing or decreasing the members of, the Board or any committee of the Board; adoption, amendment, or repeal of the AzHeC Bylaws; and fixing compensation of directors, officers, or employees). The members of the Executive Committee all must be directors and, in the case of directors affiliated with an AzHeC Member, the AzHeC Member must be in good standing as a Member. The Board Chair shall serve as the chair of the Executive Committee, either ex officio without a vote unless appointed by the Board as one of the committee members, and then with a vote. The Executive Committee, by a two-thirds vote, may designate any action as immediately effective and such immediately-effective action shall not require or be subject to Board ratification or modification, except as a separate subsequent action of the Board.

Finance Committee
The Finance Committee is responsible for monitoring the financial health of the organization, including reviewing and approving monthly financial reports, as well as financial policies, goals and budgets that support the mission, values and strategic goals of the organization. The committee's roles and responsibilities include the following:

- Review and approve all financial goals and proposals; recommend to the AzHeC board of directors for final approval.
- Review, recommend, provide feedback on and approve policies that help ensure the assets of the organization are protected and exposure to risk is lessened. These include accounting policies, internal controls, investment policies and personnel policies.
- Review and approve annual operating budget.
- Monitor adherence to the budget.
- Set long-range financial goals.
- Review the financial aspects of new programs, as well as proposals to discontinue programs.
- Review and approve annual audit report and 990 report.

Network Leadership Council
Health Information Network Leadership Council (NLC) is a standing advisory council to the AzHeC Board. Members of the NLC include representatives from Arizona health plans, hospitals, laboratories, pharmacists, professional associations, and physicians, to name a few. AzHeC also has a limited number of focused committees, which allows AzHeC to operate effectively and with appropriate oversight of finances and operations, and to respond nimbly and dynamically to emerging opportunities. (See Appendix B for a complete list of AzHeC Board members and the NLC Council.) NLC is responsible for providing strategic direction and oversight for The Network, Arizona's statewide HIE. The roles and responsibilities of the Network Leadership Council members are as follows:

- Provide feedback and input into key Network priorities and projects, as well as new business directions, new service lines, and new strategic priorities related to The Network.
- Review and approve any new services and/or Network financial/business model changes prior to review and approval by the AzHeC Board of Directors.
- Review, recommend, provide feedback on, and approve Network policies to ensure compliance with applicable laws and regulations.
- Monitor adherence to key program goals, especially as it relates to those with significant budget impact.
- Provide oversight and strategic direction for all activities that advance The Network's effectiveness and sustainability.
- Make decisions in the best interest of The Network.

The NLC oversees the Network's three standing committees (Clinical Advisory, Technical Advisory, and Data Governance).

In theory, the AzHeC Board has full operational authority to endorse or reject decisions of the NLC. However, in practice, the AzHeC Board's involvement in NLC decisions typically only concerns two areas: (1) where NLC decisions have budgetary implications and (2) where the NLC is taking a stand on an issue that has far-reaching policy or operational implications for AzHeC. Thus, the NLC's support for changes in The Network's fee structure or expansion of The Network's services that would include additional fees for participants would require adoption by the full AzHeC Board of Directors. Additionally, a modification to the definition of "Permitted Use" per The Network's participation agreement would require AzHeC Board approval, since the participation agreement clearly dictates such approval. However, changes to The Network's fee structure, such as allowing post-acute care entities to be included in the definition of "community provider" and have no fees for participation, would not require

AzHeC Board approval, as long as it would not have an impact on the annual budget approved by the Board.

In addition to the AzHeC Board and its supporting committees – the Executive Committee and the Finance Committee – AzHeC has formed various committees from time to time to support various initiatives and activities. Examples of committees that have existed in the past include:

- **E-Prescribing Steering Committee**: As part of the HIE Cooperative Agreement Program, AzHeC developed and executed an e-prescribing initiative to encourage e-prescribing use, with a particular focus on e-prescribing of controlled substances. An e-prescribing committee was created to provide feedback and expertise in support of the program.
- **Consumer Connections Task Force:** Also as part of the HIE Cooperative Agreement Program; AzHeC managed a consumer ehealth campaign. As part of this activity, AzHeC developed a broad-based community task force, called the Consumer Connections Task Force, which included representatives from more than 50 health care organizations, hospitals, health plans, government agencies and non-profit organizations.
- **Roadmap 2.0 Executive Council:** In support of Arizona's Health IT Roadmap 2.0 development, the Roadmap 2.0 Executive Council was appointed. The Council provided executive level oversight and guidance for the Roadmap 2.0 process and final report.

AHCCCS and AzHeC have continued their close working relationship during the SIM Design Model planning phase. AzHeC leadership serves on the SIM Steering Committee and the Justice System Workgroup. AzHeC provides subject matter expertise regarding Arizona's current HIT/HIE systems and its vision for the future during discussions with stakeholders, providers, payers, and other organizations across the three SIM focus areas. The AzHeC Chief Executive Officer and Chief Operating Officer, meet bi-weekly with the SIM Project Manager and State HIT Coordinator to discuss SIM planning and coordination with statewide HIT/HIE efforts.

Health IT Stakeholder Engagement

Arizona has a strong history of collaboration between public and private health care stakeholders. The State promotes community involvement in planning and decision-making regarding the strategic approach and implementation of HIT/HIE. Arizona's SIM Design model is occurring at a critical planning step in the State's initiative to convert to a fully integrated care delivery system that uses value-based payments for health care services. The HIT/HIE related observations and findings contained in the Arizona SIM Health Innovation Plan should be understood as targeted updates to a series of environmental scans, stakeholder engagement activities, and health care system transformation planning initiatives that Arizona has been regularly conducting for over 10 years.

AzHeC Environmental Scan

To obtain specific HIT/HIE information for planning purposes related to SIM's three focus areas, AHCCCS contracted with AzHeC to conduct an environmental scan that included stakeholder interviews. The environmental scan provided information about current barriers to widespread health IT adoption and clinical information exchange. In particular, the scan focused on exchange of clinical information between physical health and behavioral health providers. The scan also provided an opportunity to identify opportunities that exist to accelerate data sharing, and identify resources needed to ensure that a diverse range of providers participate in robust health IT adoption and information exchange.

AzHeC's environmental scan focused on gaining an understanding of: current state technological capabilities, key stakeholder relationships, current data exchange barriers, and current and anticipated needs to improve service integration. Of special interest was garnering a greater understanding of the status of behavioral health care providers regarding access to data, the use of EHRs, and the exchange

of data to facilitate care coordination and care integration with other behavioral and physical health care providers.

Environmental Scan Methodology

Three primary data collection and analysis activities were employed.

1. Literature Review – Current, relevant literature was reviewed, referenced and assimilated into this report.
2. Stakeholder Interview Process – Beginning in October of 2015, AzHeC hosted a series of 28 documented stakeholder interviews. To select the specific stakeholders to interview, AzHeC asked each of the Regional Behavioral Health Authorities (RBHAs) to suggest candidates from organizations within their service area that (a) demonstrated outstanding understanding and execution of integration today; (b) could benefit the most from more robust information and workflow integration; or (c) lagged behind their counterparts with integration efforts but are key to the target populations' health. Final selection of interviewees was based on achieving balanced representation from:
    - Organizations that provide some level of both behavioral health and physical health services.
    - Large and small providers of physical health care who could articulate their needs for increased collaboration with their behavioral health counterparts.
    - Key stakeholders from the Justice System and Indian Health Service, to pursue the multi-institutional dimension of health data exchange.
    - Organizational leadership (clinical and business), information systems and security professionals, compliance and privacy professionals, and clinical workflow experts.

    The interviews were ninety (90) minutes long and focused on Arizona's desire to integrate physical and behavioral health information sharing functionality. The list of organizations included in the interviews can be found in Appendix A.
3. Validation with Focus Groups and Key Informants – Following the stakeholder interviews, AzHeC held focus groups with additional stakeholders to share their preliminary analysis of the interview process. During these meetings, stakeholders were able to confirm, clarify and expand on AzHeC's findings, observations and emerging solutions. Some key individuals were unable to attend the focus groups and so were contacted individually for feedback.

    The AzHeC team analyzed validated observations and findings to develop models for sharing information across organizations with complex requirements, especially in the area of consent management. These observations, findings and models are presented within the body of this report.

AHCCCS-led Stakeholder Engagement

In addition to the environmental scan and stakeholder interviews conducted by AzHeC, AHCCCS has been leading stakeholder discussions in a variety of settings, including workgroups, regional community meetings, meetings with RBHAs and health plans, meetings with Indian Health Service (IHS) and tribal health providers, and tribal consultations.

Findings from Stakeholder Interviews

The findings from stakeholder interviews below includes information obtained both from AzHeC's and AHCCCS' stakeholder communications. The information below summarizes salient issues raised by stakeholders and key barriers identified that must be addressed to support appropriate HIT/HIE utilization to achieve Arizona's SIM Model goals.

The findings from the stakeholder interviews are grouped by topic area, with the three SIM focus areas presented first.

SIM Focus Areas

Behavioral Health and Physical Health Integration

The Substance Abuse and Mental Health Services Administration (SAMHMSA) and Health Resources and Services Administration (HRSA) have developed a continuum for demonstrating various levels of care integration that can exist. This maturity model, illustrated in Table 1 below, was used as a guide to understanding stakeholders' perceptions regarding the level of integrated care that currently exists in Arizona.

The SAMHSA Maturity Model describes how a provider's health IT needs would evolve as a provider achieved higher degrees of care integration.

Table 1 - Integrated Care and Information Sharing Maturity Model

Minimal Collaboration	Basic Collaboration from a Distance	Basic Onsite Collaboration	Close Collaboration/Partial Integration	Fully Integrate
Information exchange is rare, if it happens at all.	Minimal information exchange. Fax Machines. Significant lag time before information reaches providers.	Providers use electronic medical record systems that are specific to their roles. Electronic medical records cannot share information but there is occasional face-to-face communication.	Electronic health record systems can exchange some information. Providers use face-to-face interaction to determine treatment plans.	Full information sharing Coordinated electronic clinical decision support Shared accountability for clinical quality measures generated from information in the EHR

Based on discussion with Arizona providers, AHCCCS found that providers largely mirrored the descriptions found in the SAMHSA Maturity Model. Providers that were self-reporting as minimally collaborative also tended to have limited or non-existing health information sharing practices. For stakeholders that identified themselves as being a "Basic Collaborator from a Distance" were using fax machines as a way to respond to requests for information, but were often times not initiating or sending information prior to another provider's request. If a stakeholder self-identified as a "Basic Onsite Collaborator," that provider was either using EHRs or wanted to implement EHR adoption but was experiencing challenges in being completely successful.

Based on our discussions with stakeholders, all of them understood and are very interested in moving further along the maturity continuum, but sited problems with policy, technology, cost and training as issues they would need future help with in order to become either a basic onsite collaborator, close collaborator/partial integrator, or a fully-integrated collaborator. At this time, the majority of Arizona providers considered themselves at the "Basic Collaboration from a Distance" maturity level but hope with resources they could move to a close collaborator or achieve a partial integration over the next three years.

Perceptions of what care integration means varied among the stakeholders interviewed. Behavioral health providers see integration of behavioral and physical health care as essential to integrated care; and, as a result, several of the behavioral health organizations interviewed had introduced physical health care into their organization to create an integrated care model. Fewer stakeholders reported having behavioral health care providers inside their physical health organizations.

Behavioral health and physical health providers have met with AHCCCS, AzHeC, RBHAs, and health plans to provide input on overcoming the limitations of their current EHR systems and identifying the supports needed to expand their adoption of HIT/HIE. Key barriers to HIT/HIE utilization identified by stakeholders are noted in Table 2 below.

Table 2: Barriers to HIT/HIE to support Behavioral Health and Physical Health Integration

	Barriers to Health IT and HIE Utilization Impacting Behavioral Health and Physical Health Integration	
	Policy Issues	**Technical Issues**
EHR Adoption	Behavioral health providers who had transitioned from paper records to an EHR found the process difficult and time consuming.	High level of EHR adoption by physical health; low to medium adoption by behavioral health.
Readiness for HIE Utilization	Most BH Providers are at the low to medium adoption of EHRs or have homegrown systems that will make readiness for HIE utilization more challenging.	High level by physical providers; low level by behavioral health providers.
Level of Integrated care	Due to challenges in being able to easily and technically separate 42 CFR Part 2 information from other data, interferes with provides being able to share non–sensitive clinical information.	Low level of HIE adoption, which facilitates integrated, particularly by physical health
Special consideration Privacy for BH Data	Establishing privacy and consent policies for behavioral health around 42CFR Part 2 that protect privacy and ensure optimal integrated care are needed.	Technical implementation of policies by the HIE and practices that support privacy and enable data exchange.

IHS and Tribal HIT/HIE Challenges

There is a strong American Indian health care presence in Arizona by three different agencies and programs. IHS, an agency within the Federal Department of Health and Human Services, operates six service units across the State and Navajo Nation. In addition, Tribal health programs operate twenty three (23) clinics[1] and hospitals and three (3) tribally operated Urban Indian Health federally qualified health care centers (FQHCs).

All IHS facilities use the Resources and Patient Management System (RPMS), a decentralized integrated solution for management of both clinical and administrative information in health care facilities. Despite the sophistication of RPMS, data exchange adoption outside of IHS has been slow because RPMS does not have the ability to exchange data outside of the RPMS system. With that said, other 638 clinics and hospitals have the opportunity to exchange data if they are not using RPMS. This provides an opportunity for data exchange with other providers across the state and technical assistance. To date, there has been limited exchange of health care data between IHS and non-IHS providers, and between Tribal health services and non-Tribal health services.

The ability to share information across health care systems and providers would greatly enhance care coordination for American Indians. Due to the limited availability of some specialty services available on

[1] Known as “638 clinics” for the type of contract used.

tribal land, many American Indians must travel significant distance to access specialty care and often without the appropriate clinical communication occurring between providers. Likewise, when individuals are hospitalized or receive emergency care in areas of the State where they do not receive their routine care, complete and timely information is generally not available to enable the treating health care practitioner to understand the individual's medical history, current medications, and other information that would facilitate better care.

Through discussions with tribal leaders, tribal community members, IHS, and other health care providers serving tribal members, stakeholder input has been obtained on current barriers to exchanging clinical information between health care providers serving American Indians. Table 3 below indicates barriers identified by stakeholders.

Table 3: Barriers to HIT/HIE for Tribal Health Entities

	Barriers to Health IT and HIE Utilization Impacting Tribal Health Entities	
	Policy Issues	**Technical Issues**
EHR Adoption	The IHS EHR (used by almost all IHS/Tribal 638 organizations) is certified. All providers continue work to meet MU functionality.	High level of EHR adoption exists for acute care/physical health organizations. Low to medium adoption by behavioral health providers.
Readiness for HIE Utilization	The Network has achieved Healtheway Certification and participates in the eHealth Exchange. Active planning is underway with IHS nationally to enable participation by AZ IHS/Tribal 638 facilities.	AHCCCS is working to establish connectivity between The Network and the AHCCCS American Indian Health Program (AIHP) to be able to coordinate care better for AIHP members. Participation by IHS/Tribal 638 organizations in the Network will be vital for collaborations with non-IHS/Tribal 638 providers and improved population health efforts.
Level of Integrated care	42 CFR Part 2 limitations as policy challenge related to integrated care.	The IHS is completing internal HIE capability that will enable data sharing among IHS/Tribal 638 facilities using the IHS EHR. Next step efforts are underway for the agency to establish data sharing with state-based HIE, such as The Network.
Special Consideration:	To date, the IHS has not exchanged data for participating IHS/Tribal 638 facilities with any external HIE.	Detailed dialogue with regional and national Indian health leadership is identifying specific obstacles to participation in the AZ Network.

Justice System Challenges and Opportunities

According to the Arizona Department of Corrections (ADOC), there are sixteen (16) State correctional facilities in Arizona of which ten are state-run, and six are private facilities. There are even greater numbers of county and municipal jails.

AHCCCS and DOC have both identified release/discharge coordination and planning as priorities. By the final quarter of 2016 they expect to begin using language in contracts to require more robust discharge planning. Additionally, there is a focus on getting all county jails to implement EHRs and become connected to The Network. This will greatly support more effective care coordination.

AHCCCS has partnered with state and county governments to improve coordination within the justice system and create more cost effective and efficient ways to transition people leaving the criminal justice system. A significant number of men, women and children transitioning out of jail and prison into communities are in need of services for behavioral health and physical health conditions. Approximately 120,000 Arizonians are released from jails and prisons each year. Many of these individuals are eligible for Medicaid. In FY2015, AHCCCS identified over 43,000 Medicaid beneficiaries that had been incarcerated at some point during the fiscal year.

AHCCCS is engaged with ADOC and most Arizona counties covering the majority of the State's population, including the two largest – Maricopa and Pima – in a data exchange process that allows AHCCCS to suspend eligibility upon incarceration rather than terminate coverage. This exchange also allows ADOC and counties to electronically send discharge dates, which simplifies the process of transitioning directly into care. Through this enrollment suspension process, care can be coordinated by county jails or prisons upon discharge. To support this, all RBHAs are contractually required to have a justice systems contact that can ensure a connection to needed behavioral health services. In addition, AHCCCS medical management coordinates with counties to facilitate a transition to care into acute health plans for persons being discharged with serious physical illnesses, such as cancer or other illness, that present public health concerns or require immediate attention.

Primary care in correctional facilities is often delivered by a contracted care provider who sees inmates in the correctional facility. Specialty providers, also available on a contract basis, sometimes see patients in correctional facilities, as well as in their own offices. AHCCCS and ADOC have both identified release/discharge coordination and planning as priorities. By the final quarter of 2016, both agencies expect to begin using language in contracts to require more robust discharge planning. Alongside this, the goal is that all county jails implement EHRs by October 2016 and by April 2017 all will be connected with The Network.

As a health care provider, particularly one focused on ensuring effective care coordination, the health care system within ADOC requires the same HIT/HIE infrastructure as any other health care facility. Currently, ADOC and Juvenile Probations each use a certified EHR. However, county jails often do not have an electronic means of collecting or viewing health care information. Obtaining an EHR where necessary, and connecting those entities to the HIE so that the health data contained within those EHRs and the HIE can be more widely available, is a key priority.

Per Arizona's Health Information Organization (HIO) law, incarcerated patients do not have the right to "opt out" of HIE. Therefore, even if a patient had previously opted out of participation in AzHeC, much of his/her data is available through the HIE while incarcerated. The one exception to this is that providers still require patient consent to view data covered by the Federal Substance Abuse statute (42 CFR Part 2)[2] while the patient is incarcerated, a process that will be possible as The Network implements changes consistent with its recently approved strategic direction for integrating behavioral and physical health data. Having both behavioral health and physical health data available within the correctional system would eliminate redundancy and waste in re-administering a wide range of common diagnostic tests and assessments. For recently released inmates, care delivered while incarcerated would similarly be available to community providers.

[2] 42 CFR Part 2 are part of Title 42, Federal Code of Regulations, Part 2 – Substance Abuse Confidentiality Regulations (1992). As background, the special privacy protections afforded to alcohol and drug abuse patient records are motivated by the understanding that stigma and fear of prosecution might dissuade persons with substance use disorders from seeking treatment. To add an extra layer of protection on these records, regulations outline under what limited circumstances information about a patient's treatment may be disclosed with and without the patient's consent. Arizona Health-E Connection, AzHeC SIM HIT/HIE Environmental Scan and Stakeholder Findings Report, January 2016.

The Justice System workgroup has identified obstacles to exchanging information between correctional facilities and jails with health care providers, and have identified resources that would be needed to connect with Arizona's statewide HIE. Stakeholders from various Arizona counties have shared lessons learned and solutions they have implemented to inform the development of statewide strategies for exchanging information needed to coordinate care for justice system involved individuals.

HIT/HIE utilization barriers identified through stakeholder discussions are identified in Table 4 below.

Table 4: Key HIT/HIE Justice System Issues

	Barriers to Health IT and HIE Utilization Impacting Justice System Care Coordination	
	Policy Issues	**Technical Issues**
EHR Adoption	Both Maricopa County and Pima County have made investments in Certified EHRS; but smaller counties may not be able to afford.	Correctional health providers are varied in their capabilities to capture clinical information.
Readiness for HIE Utilization	With CEHRT correctional health providers could participate in The Network; need to explore barriers to sharing with non-health providers, e.g. probation and parole.	More sophisticated correctional health providers will be able to utilize The Network for HIE connectivity.
Level of Integrated care	Justice System providers do deliver BH and PH services to members and currently, contract language limited to requiring care coordination for incarcerated individuals with significant behavioral health (BH) and substance use disorder (SUD) needs; by October 2016, contract requirements will extend to complex PH needs.	Justice system providers may be able to share BH and PH information under their roof, but their ability to share this information with providers outside of their justice system is limited at this time.
Special Consideration For Justice Systems	Many of the Justice System providers (i.e., county and state DOC) are not AHCCCS registered providers meaning they may not qualify for EHRS incentive payments or HIE onboarding payments under SMD 16 – 003. Funding for these providers may be an ongoing problem.	AHCCCS and justice partners are looking at ways to capture the total number of incarcerated to compare to Medicaid eligible members based on data sharing we currently have in place.

Additional Issues Identified to Support HIT/HIE Utilization across all SIM Areas

Data Exchange and Interoperability

Interoperability is defined by the Office of the National Coordinator for Health Information Technology (ONC) as "the ability of systems to exchange and use electronic health information from other systems without special effort on the part of the user." For most behavioral health care organizations, this is the seamless exchange of data (within or outside an organization) that enables a clinician to see data in a common view, thereby facilitating care coordination and integration.

Data exchange using print, fax, and scan is the starting point. This method moves the data from one location to the next but doesn't necessarily make the data easily accessible in a common view as with

interoperability. Currently, print, fax, and scan are the major avenues for data exchange among most of the behavioral health care providers.

EHRs for Behavioral Health[3]

Physical health care providers have a variety of certified EHRs that support their ability to achieve Meaningful Use[4] and include data storage, analytics, and data exchange. On the other hand, the same standards do not exist for behavioral health EHRs. In fact, several behavioral health EHR systems are "home-grown" electronic medical records (EMRs). There are also very few EHRs that have the capacity to integrate behavioral health and physical health data into a common view for an integrated workflow.

Behavioral health providers who had transitioned from paper records to an EHR found the process difficult and time consuming. The transition impacted revenue cycle, productivity, and staff morale. The limitations of EHRs will be more noticeable as care coordination and integration increases and requires more data exchange, differently trained employees, and more care delivery partners.

Examples of EHR and Data Exchange Innovation

Despite the limitations of EHRs for behavioral health care providers, there were notable examples of innovation.

- Partnering with a FQHC, a behavioral health organization was able to inject clinical data, using a Continuity of Care Document, into its behavioral health EHR without resorting to print, fax, or scan.
- Collaborating with the local hospital, a behavioral health organization was able to access the hospital's EHR system. With a patient relationship, the organization was able to access hospital notes.
- One behavioral health entity enabled collaborators, such as regional behavioral health authorities (RBHAs)[5] or providers, to pull data from its EHR system using log-ins. Key issues in this scenario related to appropriately managing access controls.
- One fully integrated organization enables primary care and behavioral health providers (as well as any care coordination and ancillary staff) to access all necessary data—both sensitive and non-sensitive—from one source system. However, when a patient requires specialty services (for example, orthopedics, detox, or hospitalization), staff resorts to sending and receiving patient records via fax, thus encountering the same limits as their less integrated counterparts.

Maricopa County Crisis Portal

In an effort to improve crisis response, the Mercy Maricopa Integrated Care crisis portal program was established between Mercy Maricopa Integrated Care, the Maricopa County RBHA and AzHeC. The pilot program requests information from clinics caring for the population with serious mental illness to send

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[3] The ONC differentiates between Electronic Medical Records (EMR) and Electronic Health Records (EHR) as follows: "An EMR contains the standard medical and clinical data gathered in one provider's office. EHRs go beyond the data collected in the provider's office and include a more comprehensive patient history. For example, EHRs are designed to contain and share information from all providers involved in a patient's care. EHR data can be created, managed, and consulted by authorized providers and staff from across more than one health care organization. Unlike EMRs, EHRs also allow a patient's health record to move with them to other health care providers, specialists, hospitals, nursing homes, and even across states.

[4] As defined by the CMS EHR Incentive Program at https://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives

[5] AHCCCS contracts with Regional Behavioral Health Authorities (RBHAs), and Tribal Regional Behavioral Health Authorities (TRBHAs), to administer integrated managed care delivery services in six distinct geographic service areas (GSAs) throughout the State.

their data to the HIE for access during emergencies. Due to the emergency access to protected 42 CFR Part 2 data without consent, individuals treating a patient in a crisis are able to access all of a patient's data in crisis situation (unless that individual has fully opted out). The crisis portal project is the first step in fully integrated physical and behavioral HIE functionality and once available in Maricopa County, will be expanded statewide.

Patient Consent
Though mental health data exchange without specific patient-consent is often permissible under current state and federal laws, all stakeholders interviewed require patient consent to disclose any mental health information to other organizations. These organizations feel strongly that mental health information, like the more sensitive substance use disorder treatment information covered by 42 CFR Part 2, should be subject to disclosure only with patients' explicit permission.

Policy
Planning for health care system transformation has been an ongoing, iterative process in Arizona, affording flexibility to adopt ever-improving technology and adapt to public policy drivers. In recent years, Arizona State agencies, AzHeC, and key stakeholders conducted pivotal technology planning, setting the stage to support the advancing health care transformation.

In 2013 – 2014, through the stakeholder engagement process that was used to develop Arizona's *Health IT Roadmap 2.0*, stakeholders identified multiple policy areas that they wanted to ensure were considered to ensure that the future health IT landscape could accommodate and support. This list did not change significantly during the recent SIM stakeholder engagement.

Potential Policy Levers to Support SIM Implementation
Below are policy issues that were discussed the most by stakeholders.

Ensuring functionality was available for providers and payers that were participating in Accountable Care Organizations – Providers operating under accountable care arrangements are responsible, under a contract with a payer entity (Medicare, Medicaid, commercial health plans, employer group health plans, etc.), for providing health care for a defined population group and measuring specific health outcomes and other quality metrics, such as patient satisfaction.

e-CQM Reporting to ensure that any future HIE platform could support Clinical quality measures (CQMs) as tools that help measure and track the quality of health care services provided by health professionals or facilities within the health care system.

Ability for Providers to meet Meaningful Use Requirements – The Medicare and Medicaid EHR Incentive Programs provide incentive payments to eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs), and Medicare Advantage Organizations to promote the adoption and meaningful use of interoperable health information technology (HIT) and qualified electronic health records (EHRs).

Demonstrations to Integrate Care for Dually Eligible Beneficiaries – The Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) oversees demonstrations to better serve people who are enrolled in both Medicare and Medicaid, also known as 'Medicare-Medicaid enrollees' or 'dual eligibles.' The Medicare-Medicaid Coordination Office works with the Medicaid and Medicare programs, across Federal agencies, States and stakeholders to align and coordinate benefits between the two programs more effectively and efficiently. AHCCCS currently shares data files with its plans from Medicare, but discussions are ongoing about how to do this more effectively.

Prescription Drug Monitoring Program (PDMP) – A PDMP is a statewide electronic database, which collects designated data on substances dispensed in the state, according to the National Alliance for Model State Drug Laws.

Public Health Reporting as part of the MU Program and more – Local, state, and federal public health agencies rely on immunization, syndromic surveillance, and reportable lab results data to carry out their surveillance activities under state and federal laws. Arizona has had an Executive Order since 2008 asking its state agencies to coordinate activities on improving provider use of e-prescribing activities with AzHeC.

Ensuring Coordination with Qualified Health Plan Certification Requirements – The Affordable Care Act (ACA) requires insurance companies seeking to sell products on either a federal or state insurance exchange to be certified as a Qualified Health Plan (QHP). QHPs must be licensed (typically by the state department of insurance) in the state in which they operate. Many AHCCCS Health plans also have commercial products that need to align to ensure easier administration.

Maintaining State Purchasing/Health Plans – AHCCCS purchase health care services through competitive grants and contracts. These purchasing/contracting activities generally fall into the following categories: (1) Medicaid or CHIP Managed Care Contracts: Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services. Some states are implementing a range of initiatives to coordinate and integrate care beyond traditional managed care. These initiatives are focused on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals, and building in accountability for high quality care.

AHCCCS has used progress in the Health IT space to establish several new policies like VBP and e-prescribing to create new opportunities to reward higher quality providers.

The potential policy issues noted below are those that did not generate much discussion.

- **All Payer Claims Database** – APCDs are large-scale databases that systematically collect medical claims, pharmacy claims, dental claims, and/or eligibility and provider files from private and public payers. Once aggregated, this data can provide a comprehensive picture of the total cost of care for individuals that can be used to support initiatives focused on improving health care quality and efficiency.
- **Credentialing** – Credentialing is a process used to evaluate the qualifications and practice history of a health professional. This process includes a review of certain requirements including completed education, training, residency and licenses. It also includes any certifications issued by a board in an area of specialty.
- **HIE Connectivity Requirements** – States can pass laws or create policies that mandate interoperability, require the use of health IT standards, or require connection to an HIE.

AHCCCS Policy Levers

AHCCCS has used its unique role as the single state Medicaid agency to drive Health IT adoption through a number of initiatives it has established with its contractors. The following is a list of policy levers the agency has adopted to drive better health outcomes for its members.

Establishing Contractor/MCO HIE Connectivity – AHCCCS uses contract language to require that its contractors participate with The Network to ensure that Medicaid members would benefit from real time data sharing.

Establishing HIE Connectivity for the AHCCCS AIHP – AHCCCS is executing a participation agreement with The Network to ensure the agency Division of Fee-for-Service Management can do care coordination for the High Needs/High Cost members of the AIHP program.

E – prescribing – AHCCCS has a performance improvement project underway with contractors for all lines of business, which is designed to improve member health. Under the e-prescribing performance improvement project, the goal is to increase the number of prescribers electronically prescribing at least one prescription and increase the percentage of prescriptions, which are submitted electronically in order to improve patient safety.

Value Based Payments – AHCCCS has used progress in the Health IT space to establish several new policies that link financial incentives with use and adoption of Health IT. This approach is creating new opportunities to reward higher quality providers and requires hospitals to have met Stage 2 MU and is sending ADT through the Network by June 1, 2016 in order to receive a 0.5% fee differential.

Under the Health Information Technology for Economic and Clinical Health Program, AHCCCS is currently implementing:

- **HIE Onboarding Incentive Payments to Providers** that qualify for Medicaid EHRs Incentive Payments. AzHeC is responsible for recruiting and establishing interfaces to enable the providers to get real time clinical data.

- **Education and Outreach to Providers** for providers that are eligible but have not yet joined or have joined the EHRS program, but need support to continue their HIT/HIE adoption.

Current State Statutes that Impact Health IT/HIE

Arizona Revised Statutes Title 36, Chapter 38, Article 1, Sections 3801 – 3809 (Arizona HIO Statute) (2011).

Relevance in this Context

Arizona's HIO law expressly addresses the sharing of patient information through a HIO, like AzHeC. Arizona uses an "opt-out" model, which means that an individual's health information will be available for viewing through the HIO unless the individual chooses not to participate.

The major challenge to integrating physical and behavioral health data chiefly derives from the different consent standards that are often applied to behavioral health data. Because the publically funded behavioral health sector delivers both mental health and substance abuse services, many behavioral health providers also adhere to 42 CFR Part 2, which has a higher consent standard than Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the State HIO law. Compliance with HIPAA and State HIO laws are already in place for data exchange by AzHeC. 42 CFR Part 2 requires that consent to share information name specific providers, which can be a challenge when participating in an HIE. AzHeC has developed and is in the process of implementing a policy framework that enables data to be shared with patient permission if 42 CFR Part 2 applies. This framework includes legal, policy, operational, clinical, and technology solutions.

Looking to the Future – Potential HIT Tools Hosted by AzHeC

Other future policy issues include identifying HIT/HIE tools hosted by AzHeC. Potential services could include among others:

- Data normalization.
- Data analytics and population health.

- Community-wide care planning.
- Community-wide referral system.
- Patient authentication/identity management.
- Community lab order entry and response.

Although AzHeC could deploy any of these tools or services, each would need to be evaluated to ensure it is included under current AzHeC policies, such as the "Permitted Use" definition in the Participation Agreement. In order to determine this, each technology will need to be evaluated in terms of the following questions:

- Who will have access to these tools?
- What will the data be used for?
- What entities will be accessing the data?

For example, once behavioral health and physical health data are integrated, AzHeC expects that providers, RBHAs, and payers will request new forms of data, such as cost of an encounter. Will AzHeC choose to provide this? To what degree will AzHeC engage in analytics? What roll will it play? Answers to these questions will then determine whether the AzHeC policies will require updates and if the current governance structure is capable of handling the new set of responsibilities inherent in "owning" a new service line.

Alignment with Other Federal and State Initiatives

Transforming Clinical Practice Initiative: In late 2015, AzHeC was awarded a CMS Transforming Clinical Practice Initiative (TCPI) grant, a program intended to help practices optimize their use of EHRs and align their use around outcomes based measurement, in preparation for value-based purchasing arrangements. Through 2019, TCPI calls for recruiting and assisting 2,500 providers statewide through a relationship with Mercy Care Plan and Mercy Maricopa Integrated Care. The Practice Innovation Institute – the name for the Arizona-focused program – will provide individual coaching to support adoption of alternative payment models (APMs), performance improvement, population-based health improvement, and financial and administrative efficiencies. Targeted providers include behavioral health providers, as well as traditional medical providers, especially those serving rural, underserved, and pediatric populations.

HIT Connectivity: Connecting to The Network is a core requirement for achieving success with the goals of the SIM effort. There are currently two mechanisms to support this. For Medicaid providers who participate in the Medicaid EHR Incentive Program, such as hospitals, FQHCs and rural health clinics, AHCCCS has received approval for using funding with a high federal match (i.e. 90/10 match) to support connectivity to The Network. This funding supports bidirectional exchange to The Network and includes all one-time connectivity costs. It comes with a light level of technical assistance to train providers in how to use the HIE interface and data as part of the standard on-boarding suite of training assistance available to providers.

For all community provider, including private practices, FQHCs, rural health clinics, long term and post-acute care, behavioral health providers, and others, The Network has adopted a "no fee" policy for all core HIE services. As with support from 90/10 match, this too comes with a suite of standard on-boarding efforts designed to train providers in how to access and use the data in the HIE.

Infrastructure

Overview of Current General HIT/HIE Infrastructure

Arizona has identified the technical underpinnings to support the SIM goals should include (1) a fully functioning Health Information Exchange (HIE) with analytic, workflow improvement and communications technologies, (2) high levels of EHR adoption and interoperability with the HIE, (3) practices that are well

versed in how to utilize data and technology to drive practice transformation[6], and (4) payers willing to reimburse providers for improved health outcomes.

This section of the HIT portion of the Arizona SIM Innovation Plan provides a description of both the infrastructure that exists today and what is needed to adequately support implementation of Arizona's SIM Model.

Background
Founded in 2007, AzHeC is a statewide, non-profit and public-private partnership that improves health and wellness by advancing the secure and private sharing of electronic health information. Additionally, AzHeC drives the adoption and optimization of HIT and HIE by:

- Serving as an educator and clearinghouse for HIT information.
- Researching, developing and advocating statewide HIT policies.
- Leading and supporting provider adoption of HIT and HIE across Arizona.

AzHeC plays a pivotal role in the supporting the expansion of HIT/HIE across the State. As noted previously, AzHeC's functions include:

- Operating the Arizona Regional Extension Center (REC), which has assisted more than 3,000 providers in adopting EHRs and achieving Meaningful Use.
- Managing and operating Arizona's statewide HIE that provides secure access to patient health information, as well as the secure exchange of patient health information between and among its participants. The Network has 117 participants, 150+ data sources that feed into the HIE and more than 5.9 million unique patients' records. The hospitals participating in The Network represent roughly 90% of all hospital inpatient discharges in Arizona. In the last 12 months, AzHeC processed 35.5 million Admit/Discharge/Transfer (ADT) transactions, 27.3 million lab results, 6.7 million clinical reports, 2.5 million radiology results, and in the past 4 months 0.5 million alerts and notifications.[7]
- AzHeC's other programs include statewide e-prescribing advancement and education, and spearheading health IT consumer education and awareness.

HIE Participants

Health Systems and Hospitals - from the state's largest hospitals and health systems to critical access hospitals and rural hospitals

Health Plans – including all Medicaid (AHCCCS) plans

Community Providers– including solo and group practices, clinics and community health centers

Behavioral Health Providers – including general mental health, substance abuse treatment and crisis services providers

Reference Labs – including the state's two largest reference labs

State and Local Government – including state and county government, correctional facilities and first responders

Other Health Care Organizations – including long-term care, home health, hospice, skilled nursing facilities, and rehabilitation services

ADHS is responsible for overseeing the state public health agency. As part of their agency strategic plan, ADHS is actively evaluating technical capabilities and services that are currently available at The Network. ADHS is working with The Network to determine how it may use their IT infrastructure to meet the CMS MU

[6] Practice Transformation includes the following components: 1) promoting broad payment and practice reform in primary care and specialty care; 2) promoting care coordination between providers of services and suppliers; 3) establishing community-based health teams to support chronic care management, and 4) promoting improved quality and reduced cost by developing a collaborative of institutions that support practice transformation. https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/ Retrieved March 19, 2016.

[7] AzHeC Statistics obtained from: http://www.azhec.org/?page=NetworkbytheNumbe Data retrieved on March 19, 2016.

reporting requirements, but also looking at evaluating the Network for Population Health Analytics and other clinical reporting requirements.
ADHS is a partner in the CMS EHRs Incentive Program by validating and establishing electronic reporting for Medicaid and Medicaid providers for the public health measures of the program. ADHS is currently supporting MU reporting for:

- Eligible Hospitals – Electronic Labs, Immunizations and Syndromic Surveillance.
- Eligible Professionals – Immunizations and Electronic Labs - ADHS is not currently offering Syndromic Surveillance reporting for Eligible Professionals.

As a first step in establishing connectivity with The Network, ADHS is evaluating if it can send and receive bi-directional messages with its Immunization Registry Vendor and is currently piloting this with The Network. The Network has available an ONC Certified Public Health Reporting Gateway that it can activate, when ADHS is ready to test and implement electronic reporting for immunizations and labs.

Status of Current EHR Adoption in Arizona
EHR adoption among the physical health provider community in Arizona is quite high. Of the 12,408 active physicians in Arizona who participated in a recent survey, 86% were using EHRs. Approximately 43% of physicians with EHRs are "partially" connected (minimal exchange of information typically with others in their health care organization).[8]

Given current trends in the State, it is estimated that by 2018 nearly 100% of physicians in the State will be using EHRs[9]. Even though this is just one measure of success, as practices mature, there will be a growing need to support practices who wish to switch their EHR for a variety of reasons, such as they are unhappy with their EHR, it is no longer supported by their vendor, the system cannot be upgraded, etc. These practices will require some level of support to identify requirements and evaluate new products. Subsequently, practices will need support with transition efforts as they move from one EHR to another, particularly without disrupting the delivery of care.

Even with the state nearing 100% adoption of EHRs for physicians, there is a marked gulf in those using them well, at least as measured by the providers that have attested to Stage 2 of Meaningful Use (MU). As of February 2016, 5,300 unique Eligible Medicare Providers had attested to Stage 1 and/or Stage 2 of MU. Nevertheless, providers are facing significant challenges as they seek to move from basic use of an EHR (as measured by MU Stage 1 attestations) to the more sophisticated leveraging of the EHR as tool for practice transformation (as measured by MU Stage 2 attestations).

Hospitals face similar challenges. Of the 73 hospitals that had attested to MU Stage 1, only 31 (41%) had attested to MU Stage 2 as of March 2016. Hospitals are generally better staffed with a range of supporting roles—from information technology to quality assurance. However, hospitals in more rural areas, including critical access hospitals, are struggling to make this transition.

AzHeC Participants
AzHeC currently identifies two types of entities that can participate in The Network: Data Suppliers and Data Recipients. A Participant may be *both* a Data Supplier and a Data Recipient (for example a hospital), but the Participant must be at least *one* in order to sign a Network participation agreement and participate in the HIE.

[8] *Physicians' Use, Exchange, and Evaluation of Electronic Medical Records. September 2015.* Sponsored by and Prepared for the Arizona Health Care Cost Containment System (AHCCCS) by the Center for Health Information and Research (CHIR) and College of Health Solutions, Arizona State University. http://chir.asu.edu/sites/default/files/AHCCCS%20EMR%20Report-October%202013%20Final-bj.pdf

[9] Ibid.

Figure 2 - AzHeC Participant Types

Who can contribute data, what data they can contribute, how that data will be housed and shared are all spelled out in “The Network Participation, Services and Funding Agreement” (i.e. the Participation Agreement), which includes a definition of permitted uses. Additionally, embedded in the Participant Agreement is a requirement to abide by standardized Terms and Conditions in a Data Use and Reciprocal Services Agreement (DURSA) that was developed for the Nationwide Health Information Network (NwHIN, now called the eHealth Exchange) if the Participant utilizes The Network to exchange information with other entities via the eHealth Exchange network. Currently, the definition of Permitted Use includes use of the HIE by Data Recipients for “treatment, care coordination, case or care management, transition of care planning, or other purposes approved by the AzHeC Board of Directors.”

Each participating organization must sign the Participation Agreement in order to participate in the HIE. The Participation Agreement defines the respective obligations of the contributor and AzHeC and how they are to interact with each other. For example, the agreement describes how health information may be shared based on the sharing practices contained in HIPAA.

1) Data Suppliers
   Traditional Data Suppliers include the hospitals, labs, and community providers, such as community health centers or private practices, who make data available through the HIE for access and use by other Network Participants. Among the obligations incumbent upon Data Suppliers are that the data will adequately identify the individuals whose data is being contributed. Additionally, Data Suppliers must make corrections to the source data when problems are identified.

2) Data Recipients
   Currently, only entities that participate in The Network are able to obtain data from it. To do so, the participant must agree that only authorized users will see personally identifiable data, and that all uses of data will adhere to the same trust framework. AzHeC has established a process for enabling participants to utilize health data. Access is granted in compliance with HIPAA requirements and also newly added ability to access data in compliance with 42 CFR Part 2, the substance abuse treatment privacy regulations. Care providers, such as physicians, may obtain emergency access to patient data in order to deliver high quality care. Payers, however, have different access to the health information in the HIE as specified based on the Permitted Use definition, as well as the dates of coverage of their beneficiaries. The Network has adopted policies related to access to data by health plans to clarify some aspects of data access and use.

Any changes to the permitted uses of data or the entities that are eligible to participate in the HIE would require changes to any related policies and may require approval by the NLC or the AzHeC Board. By including this information in the foundational contractual documents between The Network and its participants and/or the policies that all Network Participants are bound by as a result of signing the Participation Agreement, AzHeC makes explicit to participants how they can use data they obtain through The Network, and also how they can expect *other* participants to use their data. When dealing with sensitive personal information, the circle of trust among participating entities is essential to a well-functioning HIE. This can only be achieved by explicitly defining who can participate and how data can be used.

Current Data Available to Participants
Through its HIE, AzHeC attempts to collect and make available for viewing and distribution the following information (actual data available is dependent upon the information provided by each Participant):

- Advance directives.
- Allergies.
- Encounters.
- Family history.
- Immunizations.
- Insurance.
- Laboratory results, including microbiology and pathology.
- Medications.
- Patient demographics.
- Patient identifies (MRN, Group ID).
- Problem list.
- Procedures.
- Provider information.
- Radiology reports.
- Social history.
- Transcribed documents.
- Vital signs.

Current Core Technology Components
AzHeC has established core technical components that form the backbone of AzHeC's HIE and support the transfer of patient information. These components support the basic needs of all participants and lay the foundation for a data-driven evidence-based approach to care. Core infrastructure includes the following:

- Master Patient Index – The Master Patient Index (MPI) is a database that maintains a unique index (or identifier) for every patient whose information has been received by The Network. The index associates a patient's records from multiple Network Participants with one unique identifier for that patient.

- Provider/User Directory – The Provider/User Directory contains both individual level and entity level information on individual health care professionals and health care organizations. Each health care professional and organization listed in the Provider/User directory has a unique ID that serves as the key and consistent identifier for that individual or organization's record.

- Integration Engine – The Mirth Connect Integration Engine that enables unidirectional and bi-directional interfaces, query-response interactions with eHealth Exchange, and distribution of machine readable Alerts and Notifications. This tool set also provides the capabilities to edit and transform data, to map data to national standard code sets, and to map data between differing formats.

- Clinical Data repository – A comprehensive database that houses all patient demographic and clinical information, all entity and individual user identity information, and maintains all individual data transactions received by The Network in their original format with their original content. By quarter 2, 2016, this repository will also house sensitive behavioral health information. In that way, AzHeC will be able to continue to exchange patient data via HIPAA and State HIO sharing rules

but also include more sensitive 42 CFR Part 2 data on a provider-by-provider basis, when a patient has provided the appropriate consent.

Current Core Services
The following services are then made available to participants as a result of the above core components:

Exchange Technologies
1. Bi-directional exchange: AzHeC connects to certified EHRs allowing access to patient health information by all authorized participants. This bi-directional connection allows a Participant to automatically send patient information to the HIE, automatically push patient information to the Participant's EHR and it allows a certified EHR to query the HIE and receive information on patients.

2. E-Health Exchange: AzHeC enables a secure electronic exchange of patient information via the national eHealth Exchange certified standards. The eHealth Exchange certification allows The Network on behalf of its participants to discover patient records, query and receive patient health information, and share documents on their patients with HIEs in other states and with federal agencies, such as the Department of Veterans Affairs.

3. Integration of Behavioral Health Information: AzHeC recently expanded its core capabilities to receive, segregate and store sensitive/protected health information in its clinical data repository. This information can be accessed by authorized users who have obtained appropriate patient consent in accordance with 42 CFR Part 2, HIPAA, and Arizona HIO regulations.

4. Public Health Reporting Gateways (Quarter 4, 2016) – a set of electronic gateways for participants to submit via the HIE state and federally mandated public health information to the appropriate agency from their certified EHR system. The types of gateways supported will include:

    - Reportable Diseases Gateway (Cancer, Diabetes, etc.).
    - Immunization Registry Gateway.
    - Reportable Lab Results Gateway.
    - Syndromic Surveillance Gateway.

Messaging and Alerting Technologies
1. Alerts and Notifications: The HIE sends relevant patient data regarding a patient's emergency room registration, inpatient admission, discharge or transfer to a providers, case managers, and care coordinators to advise them of a patient's movement within the health care community. Additionally, the HIE sends notices to providers, case managers, care coordinators and others involved in the patient's care informing them of a patient's lab and radiology results and of the availability of transcribed results and reports. To setup this capability, a provider or health plan submits to AzHeC their list of current patients or beneficiaries, selects the alerts and notices they wish to receive, and designates who will receive the alerts and notices. The HIE then forwards, via Secure (Direct) messaging and/or other bi-directional exchange means, the related medical information as it is received.

2. Secure (Direct) messaging: AzHeC utilizes this HIPAA compliant, encrypted, standards-based application to send and receive clinical information to/from HIE participants. AzHeC serves as a health information service provider and can provide Secure (Direct) email accounts to all authorized Participant personnel.

Access Technologies
1. Provider Portal: Patient clinical information can be accessed via a web-based portal. This service allows an authorized user from a Participant organization to access patient records one patient at a

time via the Provider Portal over a secure Internet connection. Access to this data is based upon the patient's opt-in/opt-out choice as defined by Arizona's HIO law.

2. Payer Portal: Beneficiary clinical information can be accessed via a web-based portal. This service allows an authorized user from a health plan Participant to access beneficiary health records one beneficiary at a time via the Payer Portal over a secure Internet connection. Access to this data is based upon the patient's opt-in/opt-out choice as defined by Arizona's HIO law.
    -
3. Crisis Portal: Patient general mental health, substance abuse, and physical health information can be accessed via this web-based portal. This service allows crisis network service providers to view all relevant patient information for individuals in a medical emergency or other crisis situation. Access to this data is based upon patient consent choice as defined by 42 CFR Part 2 regulations and the patient's opt-in/opt-out choice as defined by Arizona's HIO law.

Planning for Future Infrastructure

In response to stakeholders' information and input, Arizona has identified the several infrastructure issues that may need to be addressed in support to SIM goals.

1. New or modified AzHeC operational policies and procedures may be needed in the following areas to achieve appropriate HIT/HIE utilization across the three SIM focus areas:

    - Expansion of the number and type of Data Suppliers to the Network (e.g. long-term care providers, tribal entities, etc.).
    - Expansion of Data Sources and Data Types (e.g. behavioral health assessments, prescription fill data, etc.).
    - Data Standardization.
    - Expansion of Data Recipients (probation personnel, first responders).
    - Possible expansion of HIT Tools hosted or facilitated by AzHeC.
    - Identifying data and clinical needs of providers and RBHAs.
    - Identifying and exploring ways of integrating clinically and operationally with the criminal justice system.
    - Revising the technology infrastructure to support appropriate sharing of sensitive behavioral health treatment data.
    - Modifying the patient consent mechanism.

2. AzHeC has been exploring potential changes that impact data suppliers and data recipients together. This may include, for example, who can contribute data, what data they contribute, and what data can be shared. Additionally, AzHeC and the NLC will need to explore policy and data architecture implications of the new data sources as they are acquired. For instance, greater coordination of the jail, prison, and crisis intervention systems, as intended by Arizona's SIM model, may require technology and policy changes that support more restrictive data sharing as the rules for sharing data with organizations who are not covered entities and lack Business Associate Agreements require it.
    -
3. Arizona's goals to improve care coordination and analyze and evaluate health care system performance for the three SIM focus areas will require new data types:
    a. **Care Coordination** – Effective transitions of care and care coordination involve many parties engaged with the patient and their families. While the initial focus has been on care coordination between health care providers, to effectively serve the SIM targeted populations, communication and coordination will need to be expanded to other service providers, such as human services, community-based care, and public health. Early changes may occur with the jail, prison, and crisis systems, particularly with transitions of care. More care coordination of

services will result in the demand for more data sources and data types from AzHeC, much of which may be in a non-standardized format.

b. **Performance Measures** – Value-Based Purchasing by AHCCCS and other payers and funding sources will drive providers to monitor performance and health outcomes much more closely than ever before. This may require collection of new types of data in standardized format.

c. **Analytics Data and Tools** – Both longitudinal clinical data from providers and longitudinal cost and claims data from payers to evaluate provider performance trends individually and in the aggregate will also be needed to support the transition to value-based purchasing. There will be growing demand for access to the data and to analytics services. Demand for the data and services will be by providers and payers who are engaged in APMs, value-based purchasing, and other forms of risk contracting. This can take the form of access to the data alone for use in their own tools or access to the data for use by an external analytics service provider. Some of this data is collected by payers who would bring new data contributors to AzHeC.

4. As the shift towards APMs, value-based purchasing drives interest in social determinants of health, it is likely that exploration of non-health care related data sources may need to be explored. This could include information on participation in supported housing, transportation, meal programs for the elderly, or other forms of social supports that are not traditionally part of a medical record but that impact health care outcomes.

5. Similarly, the shift toward value-based purchasing creates greater demand for information that can be integrated with health care data and made available to care providers that enter into risk-based contracts. By driving an integrated view of clinical care and outcomes based on performance measures, these providers will likely demand inclusion of more data sources and date types. In some cases, new types of data that can facilitate improved care will not be in a standardized format. This may include non-clinical data from the judicial system, community services, or patients. Personal health care devices used by patients to monitor heart rate, level of exercise, etc. have the potential to generate a considerable amount of data. Bringing this data into an HIE will require considerable dialogue among AzHeC participants to determine how much and what kind of personal health device data to allow and how and whether to create standards around the way that the data is stored in the HIE. Additionally, use and acceptance of data from these personal health devices will likely raise issues of data provenance[10], which could have a dramatic effect across the range of content coming into and made available via The Network.

6. The value-based purchasing and the trend to APMs also require that AzHeC migrate toward data standardization. Currently, AzHeC is in the process of normalizing data around medical codes, such as Logical Observation Identifiers Names and Codes, International Classification of Diseases, Revision 10, and Healthcare Common Procedure Coding System Level I and Level II codes. By normalizing data around medical codes, data can be exchanged seamlessly, embedded into EHRs, and used in metrics. Standards for language, race, and gender, essential to SIM analytics, will need to be normalized. With greater demand for more data types from data recipients, data standardization will become a very high priority.

   For example, in regards to provider EHRs, it may become necessary to obtain more information then what can currently be captured in a standard Continuity of Care Document (CCD)—the current modality of exchange in The Network. Obtaining this new EHR data will require new extraction methods, likely necessitating validation through the NLC governance process. For instance, quality for many behavioral health conditions is measured through the use of assessments, but these assessment scores are not captured either discretely, or at a sufficiently granular level to facilitate

[10] https://www.hl7.org/fhir/provenance.html

effective care coordination. Nor is the data captured in a consistent format across EHR platforms. As a result, AzHeC may need to employ some level of data transformation.

7. Regarding data access, AzHeC has an established a process for enabling participants to utilize health data. Currently, access conforms to HIPAA requirements and recently began efforts to enable access to 42 CFR Part 2 data under those requirements. AzHeC can expect greater demand for data access in light of the integration of behavioral and physical health and the push toward value-based purchasing. Some areas of expansion may require modification of the Participant Agreement—particularly the definition of "Permitted Use"—which can impact when and how non-health care entities such as law enforcement and criminal justice obtain access to the information to support seamless transitions of care. Another area of potential expansion of data use may include payers who begin to submit claims and cost data to the HIE for purposes of exploring the real costs of providing various types of care. In this case, that data would be highly proprietary and not (necessarily) available for other participants to see except, perhaps, in aggregated form.

8. The broad view of population across care settings and organizational boundaries requires a much broader dataset than that which is usually available to a given practice, clinically integrated network, integrated delivery network, ACO, etc. Arizona is looking at the possibility of making clinical data sets available to organizations that are engaged in population health management, and providing access to population health management toolsets for those organizations that may not have the financial resources to obtain access to these toolsets on their own.

   Community wide care planning tools enable providers and other care team members to support patients between and during transitions of care and within disparate care settings. In order to be effective, a wide array of users including clinicians, care coordinators, social workers, payers, and even workers at supportive services organizations like housing, employment and transportation should have access to the tool.

   The purpose of these tools is for care teams to coordinate care for the patient across time and care settings. These tools typically offer both analytic and communication services so that providers are informed as to care that has been provided and care that is needed. With this information, the provider can act "at the point of care" with the right intervention in the right setting at the right time.

   This type of coordinated workflow support can be built on top of, and leverage, AzHeC's current infrastructure with its longitudinal patient clinical record, Master Patient Index, Provider/user Directory, and ability to electronically deliver care summaries to individuals and/or EHRs. Ways in which AzHeC can contribute to population health management in Arizona is by making its' clinical data set available to organizations that are engaged in population health management, and potentially, by providing access to population health management toolsets for those organizations that may not have the financial resources to obtain access to these toolsets on their own.

In addition to the issues above, Arizona has identified several optional future technologies that could be deployed to further advance the State's SIM goals. Stakeholder feedback and cost benefit analyses will need to be conducted to determine which of these will be most beneficial and in what order they should be deployed. Priorities set will be based on need, funding, sustainability and ability to amplify outcomes for the greatest number of Arizona citizens.

Exchange Technologies

1. **Advance Consent Management**: AzHeC is building a consent management system that will enable providers to obtain consent to view a patient's protected behavioral health information through their HIE. This type of consent is at the provider level and enables the provider to see all of a person's protected information regardless of source. Some patients confronted to this "all or nothing" way of

sharing their behavioral health information may opt not to share that data with any provider. For this reason, AzHeC is exploring the technology that will enable a more granular level of sharing. With this technology, for example, a patient could select to share their "Mental Health" information but not their "Substance Abuse Treatment" records with their primary care provider. However, when in the hospital, they may elect to share the entire set of their protected data with those providers. The level of granularity for consent could even go down to the data element level so that, for instance, a patient could authorize their medication information to be shared broadly to all of their providers but then hold back the sharing of any other information including diagnosis and previous clinical encounters.

2. **Advanced Directives**: Each patient has the opportunity to provide their care provider with directives that determine how they wish to be treated if they are at end-of-life. Since, in most cases, a patient's wishes would be the same across the continuum of care providers, having to repeat these instructions at each care setting can be burdensome for patients. More likely than not, patients simply forget to notify a new care provider of their wishes and then that provider does not have access to this legal document at the time when it may be required. While personal health record (PHR) systems could solve this by enabling the patient to keep an electronic version of their advance directives in one place and then (direct) emailing it to each provider, this simply perpetuates that manual ingest of data one provider at a time.

   In the standard CCD format, a section is designated for "Advance Directives", which would be helpful if EHR systems actually collected, tracked, and then reported these directives within a CCD. However, most standard CCDs, while having a place holder for this data, do not actually transmit it as part of their standard data set.

   AzHeC is investigating the establishment of a PHR gateway that would enable bi-directional exchange between the PHR and AzHeC providers. If this were established – and the PHR had a standards based way to store Advance Directives – AzHeC could query and route the Advance Directive to any AzHeC participant through the provider portal. Of course, this requires that patient use of PHR technology increases past what is currently reported and that education about the need for patients to provide their Advance Directives within their PHR applications is important.

   Another more streamlined approach might be to work with hospitals, who typically make great effort to obtain Advance Directives upon admit, to send Advance Directives to the HIE for storage and dissemination to other care providers. The challenge with enabling this is that the patient does not have a clear and direct way to expire or change an Advance Directive in a consistent way.

3. **Claims Data Integration**: Some of the payer related data elements that AzHeC currently collects from organizations able to send data are payer and insurance information. However, full claims information, including costs, is not yet available through The Network. In order to support SIM goals, understanding not only the types of services being delivered but the true cost of providing that care, is paramount. Currently, many payers track outcomes and costs within their own organizational systems but because patients sometimes move among carriers and some patients pay privately for services, the data within a payer silo increasingly does not account for the full cost of care. Also, some types of services, (e.g., care coordination are often not reimbursable, and therefore, do not result in a claim.

   In order to get the full picture of a patient's care, encompassing both outcomes and costs, marrying payer claims data with the rich clinical data set available through AzHeC is an important lever to achieve SIM goals. Some states have chosen to setup all payer claims systems and have enacted legislation requiring payers to contribute data to those systems. Such a system does not yet exist in Arizona, and waiting for one to be built may not be feasible given the desire to move swiftly to value-based purchasing. One solution is for AzHeC to utilize its claims-ready technology infrastructure to include the storage and query of claims related data, which would be linked to the clinical data through the Master Patient Index (MPI).

One potential barrier to this type of claims level transparency through The Network is that many payers view their cost data as very proprietary and part of what helps them maintain a competitive advantage in the marketplace. However, more and more payers are recognizing that without system wide transparency to the full set of cost and services data they are increasingly at a competitive disadvantage. For that reason, in California, Blue Cross/Blue Shield recently began, under its own volition, a data exchange that it hopes will enable pairing of BCBS cost information with provider service data. They are welcoming all payers and providers to contribute to that system.

In some ways, this type of payer level transparency is already happening through AzHeC. Currently, payers (through the AzHeC payer portal) are able to see 36 months of clinical data on a patient who recently transferred into their care from another payer. With this information, they can better support the patient with seamless transitions of care between systems. This highlights the trust that AzHeC has built, and continues to build, in the Arizona health care marketplace. With this as a foundation, the competitive and policy barriers that exist with bringing claims data into The Network can be overcome over time.

4. **Data Segmentation**: Work at AzHeC is currently underway to enable ingest, segment and share data protected by 42 CFR Part 2, the federal statute that governs programs that provide substance abuse disorder treatment. As has been previously discussed, this type of data cannot be shared per the rules of HIPAA and patient consent must be obtained. Most behavioral health providers are subject, at least in part, to the 42 CFR Part 2 requirements. Only that portion of the services they provide that directly relate to the treatment of a substance use disorder are subject to the regulation. The exact language regarding the restriction against re-disclosure states that any information disclosed by a covered program that "would identify a patient as an alcohol or drug abuser" [42 CFR §2.12(a) (1)] cannot be disclosed without patient consent.

   Currently, most behavioral health organizations lack EHRs that are sophisticated in their ability to separate HIPAA protected data (for example, mental health and physical health) from 42 CFR Part 2 protected data. Therefore, as AzHeC begins to bring behavioral health data, including the 42 CFR Part 2 data into its clinical data repository, these data will be segregated within the repository from the HIPAA protected data and accessible only if consent has been granted by the patient. However, much of the information from behavioral health providers (for example, allergies, some medications, some diagnoses, care plan, etc.) does not identify someone as an alcohol or drug abuser and therefore could be shared via HIPAA regulations.

   AzHeC is considering technology that would enable it to interrogate discrete data received from providers against value sets that can be used to determine whether the information is covered by 42 CFR Part 2. If the data is covered by 42 CFR Part 2, then it would be segregated from the non-Part 2 data and accessible only with patient consent. These value sets look at information such as diagnosis, medication, procedures, Logical Observation Identifiers Names and Codes (LOINC), etc. in determining whether the code being used would reveal that someone has been diagnosed with or is receiving treatment for a substance abuse disorder. For example, if the diagnosis indicated "depression" it would be available for release to providers under the rules of HIPAA. However, if the diagnosis indicated "alcoholism," it would only be released with patient consent. The benefit to providers across Arizona is that this segmentation will "free up" mental health related information, (which can be shared in Arizona without patient consent) and therefore enhance patient care and care coordination.

5. **Identity Proofing**: Increasingly, identify theft and fraud in the health care marketplace are requiring providers to positively identify patients before providing services. Identity proofing is a set of services that enable providers, or any organization, to positively identify the person as whom they say they are. The justice system has the longest history in identify proofing with the requirement that all offenders

are fingerprinted as they enter the system. Other identity proofing technologies include retinal scans and touch IDs. As identify proofing becomes more and more important in health care, AzHeC is monitoring the market place as to the types of applications and services that are available that it could provide to aid providers in positively identifying patients.

6. **Remote Monitoring data**: Remote patient monitoring refers to technology used to continually assess a person's health. Examples could include physiological monitoring (e.g., blood pressure, glucose, weight, temperature), medication monitoring whereby the device registers each time a pill minder is opened, exercise tracking such as via a "Fit Bit" or other similar technology, and tools to manage behavioral symptoms, such as anxiety and depression, whereby the patient records current mood and activity every several hours. Typically the data is stored in the remote device and then automatically uploaded into an EHR, PHR, or other analytics or care coordination tool that can convert the raw data into aggregate (and more usable) form or into an alert for immediate intervention.

   Rarely, if ever, is the individual raw data usable on its own, which is why connecting the raw data feed into the HIE is not the goal of this added capability. Rather, AzHeC plans to work with providers to send the "snapshots" of the data that their EHR or other care management software uses to make the large volumes of remote monitoring data actionable at the point of care. For instance, the EHR may aggregate data from a blood pressure cuff into an easy to read graph that spans a certain number of days or weeks between a particularly critical time in the patient's care regimen. That data summary could be ingested into the HIE and then made available for other providers to view and use to inform their care as well.

   In many ways, this is not dissimilar to AzHeC's current integration efforts to bring CCDs from EHR systems directly into the exchange. However, these new reports that aggregate remote monitoring data into usable information do not typically come as a part of a CCD. Therefore, AzHeC will need to implement a separate, but complimentary, method of obtaining these other types of reports from provider source systems.

Messaging and Alerting Technologies

1. **Mobile Access to Alerts**: Currently, AzHeC sends alert notifications to providers, payers, and care coordinators, who sign up for that service, via direct message. Each organization interested in this alerting function provides AzHeC with a list of patients whom they would like to monitor and in what situations they would like to receive alerts. For instance, if a care coordinator is managing a caseload of patients with poorly controlled Diabetes, the coordinator could subscribe to receive an alert when a patient's A1C levels are beyond a certain threshold. Or, if someone else is managing a group of patients with serious mental illness, they can receive alerts when their patient present at the emergency room. These alerts are sent via Secure Direct Messaging and available for each care provider via their DirectTrust certified EHR inbox or other DirectTrust certified email system.

   For providers out in the community working with patients directly, the ability to receive an alert via their mobile device will result in timelier alerting and the ability for care teams to respond more immediately to, for instance, stave off a hospital admission when another more appropriate method of care exists. One option is for the provider to receive a notice to their device via SMS that simply notifies the provider that they have a direct message waiting in their inbox. This message would not contain any patient identifying information and could be transmitted via SMS. Another near term technology explored in this section is Secure Messaging. If this technology is deployed, AzHeC could send the actual text of the alert via this secure method, thereby enabling the care provider to immediately receive highly critical alerts.

2. **Secure Text Messaging**: Providers are increasingly using their cell phones and other personal devices to access data from their EHRs and other care tools. However, when communicating about patients using the built-in texting capability of any mobile device (frequently referred to as SMS), this

is not advisable as SMS does not provide the necessary security and data encryption to transmit PHI. In order to enhance communication with referring providers, and discourage the use of SMS for care coordination, many hospitals are deploying secure texting platforms. In some cases, EHRs are also building this type of real-time, two-way communication into their mobile applications. However, a barrier not dissimilar to the barrier that existed prior to the advent of the DirectTrust email protocol still exists. Providers can only use the secure text messaging system with those providers who also subscribe to that service. Therefore, if one provider wishes to communicate with another provider via secure text messaging, they would invite that provider to join their service. As a result, a single provider may end up needing two or more secure texting applications to communicate with providers across varying systems.

Access Technologies

1. **Patient and family engagement**: Traditionally, HIE's have stayed away from direct patient engagement, preferring to collaborate with providers to support patient care but not becoming directly involved in the patient relationship. One area where some HIEs are moving more directly toward supporting patients is in the area of integration with Personal Health Records (PHRs). One of the incentives for providers to offer PHRs to their patients comes from the requirement in Stage 2 of MU that providers are required to have a functioning PHR. Most PHRs are extensions of the practice's EHR, offering a seamless way for data such as test results, clinical notes and administrative information (e.g., appointments, billing) to be available for patient review and comment through the PHR.

   In cases where a patient receives care from a number of provider organizations, they have to log into multiple provider PHRs in order to see a comprehensive view of their care. Not dissimilar to the case for EHRs connecting to the HIE, the case for PHRs to connect with the HIE provides similar benefits. By creating a PHR "gateway", the HIE can create a standards based way for any PHR to connect and receive clinical information from the community health record for a patient or family member. Also, since much of the clinical data, (such as lab results and clinical notes) are already traveling into the HIE from the provider's EHR, having the PHR tethered directly to the EHR is no longer necessary. This then enables the patient to log into any of their PHRs to see a full set of their data (provided that each health care entity transmits data to the HIE). One set of data not currently provided to the HIE, which is important to patients, is information on upcoming appointments and other care alerts. Since this data can also be very important for other care providers to see as part of the comprehensive community health record in the HIE, it becomes an additional data set that the HIE can obtain from the provider organization. Once ingested in the HIE, it can then be shared with other providers and also passed through the PHR gateway and into the patient's record.

   The more sophisticated EHR/PHRs also provide the ability for patients to update demographics, cancel appointments, respond to health surveys, enter data captured from personal devices and provide specific feedback to providers on the care plans available in their PHR. In these cases, the HIE could enable the routing of PHR specific inputs back to the provider much the way that immunization data is being routed from the EHRs and into the Public Health System. The HIE would store this patient generated information in the HIE but would simply act as a "pass through" entity enabling the PHR results to make their way into the providers' EHR systems where they can be acted upon and updated as needed.

   Again, the benefit of enabling such a system is that patients will be able to select a single PHR – one that best meets their needs – and use that single platform to interact with all of their care providers. The benefit to provider organizations is that they can meet MU requirements using this architecture without the added burden of managing an independent PHR platform.

Community Tools

1. **Electronic Quality Reporting**: Providers are increasingly mandated to provide a variety of reports to various agencies to account for outcomes and operational practices. Each report requires the providers to create a separate reporting structure and follow a different transmission protocol. As previously discussed, AzHeC is growing its health care data set to the point where in the future it could create these reports on behalf of its participants. The benefit of this type of services is that the practices would no longer need to manage and maintain separate reporting protocols or manage the manual transmission of that data to the entities that require it. A further benefit to the agencies that require these reports, particularly state agencies, is that AzHeC, should it deploy data normalization services, could provide a higher quality of data to those agencies; and thus, make the data more immediately actionable. Types of reports that providers typically need to report include: Patient-Centered Medical Home (PCMH) certification; Merit-Based Incentive Payment System (MIPS), which includes PQRS; and payer-specific quality reporting requirements (BCBS Bridges to Excellence).

Future Infrastructure Priorities to meet SIM Goals and Vision

The table below summarizes the underlying technologies that will be needed to support the three SIM focus areas. Also indicated are the functionality requirements needed to bring about greater levels of interoperability and technical capacity to support the overarching SIM goals.

Table 5- Targeted Health Area Needs

Target Health Area Needs Assessment	HIT/HIE Functionality Required to Support
Integration of Behavioral Health and Physical Health	
Collection and presentation of behavioral health information that is trackable and actionable for non-behavioral health providers.	1. High functioning, MU certified, EHRs in every practice sending data to the HIE. 2. Ability to do data exchange at three levels of interoperability: • Print, fax, and scan. • Ability to receive data and interpret it using normalization tools (e.g. coding differences between data sender and receiver). • Ability to receive data and use the information as sent. 3. Ability to do analytics at the second and third levels of interoperability. 4. Use the AzHeC multi-level multi-layered consent management process.
Data exchange across organizations with the ability for data to be ingested into EHRs and ancillary tools that can then leverage this data to enhance and improve care. Transition all providers from print, fax, and scan to exchange through the HIE.	
Support for high functioning EHRs for behavioral health providers.	
Ready providers (and infrastructure) for the exchange of data in discrete format through the HIE for both patient treatment and analytics to support value-based purchasing (VBP).	
Justice System Transitions	
Access to patient data, including physical health data, behavioral health data (with patient permissions to access data) from inside and outside of the jails and prisons.	1. High functioning, MU certified, EHRs at each prison and jail that provides health care services sending data to the HIE. 2. Advanced alerts to community health care providers, case managers and payers as persons exiting incarceration transition back into the community. 3. Access, via the HIE, to a comprehensive patient record that contains information from both correctional and non-correctional facilities. 4. Access by community providers to non-health care related information, (such as
Improved transitions with community health providers and payers when an inmate is released from prison or jail.	

Target Health Area Needs Assessment	HIT/HIE Functionality Required to Support
	probation/parole information) through a justice information exchange that is paired with The Network. 5. Use the AzHeC multi-level, multi-layered consent management process.
Indian Health Service and Tribal Health Programs	
Support for Tribal 638 clinics and hospitals and FQHCs to obtain and/or use MU certified EHRs.	1. High functioning, MU certified, EHRs in every practice sending data to The Network. 2. Use the AzHeC multi-level multi-layered consent management process. 3. Data normalization tools that can convert non-standards based entry into the EHR into standards based entry (i.e. International Classification of Diseases, 10th revision (ICD-10), LOINC coding, etc.) 4. Support for Tribal health facilities to adopt and use telemedicine infrastructure to bring specialists into their communities remotely. 5. Care Coordination tools (hosted by The Network or another entity) that are directly integrated into the EHRs of the IHS clinics, hospitals and FQHCs so that providers and care coordinators can do interventions with patients at the point of care.
Data exchange with other physical and behavioral health providers through The Network	
To overcome issues of sensitive data exchange, use of a robust consent management tool to protect behavioral health patient confidentiality.	
Standardize coding such as diagnosis, encounters, etc. so that Tribal health program practices do not need to retool their workflow to participate in The Network.	
Remote care technologies such as Telemedicine and remote patient monitoring.	
Access to Care Coordination tools to enable Tribal health program providers to coordinate care with one another, as well as with non-Tribal providers, when patients need to access care at these facilities.	

Functionality Requirements for Infrastructure Solutions

The table below contains a list of technologies that could contribute, in a significant way, to the initiatives of SIM. Technologies that already exist within the AzHeC HIE are identified in the “Phase 1” column.

The “Phase 2” and “Phase 3” columns identify other technology solutions that, if deployed through the HIE, could support the various goals of SIM. The “Phase 2” column identifies the high value technologies that were referenced in Table 6. These are the primary technologies that SIM Plan implementation could focus on implementing during the first 3 years and, as such, the cost estimates associated with implementation and operation are identified in later in this document (see Table 10 on High Value Technology Solutions Annual Costs).

The “Phase 3” column identifies optional future technologies that should be monitored for advancements and improvements. These should be reviewed periodically to determine whether or not the demand has risen to a sustainable level. It is anticipated that demand for some of these could result in their implementation in years 2 and 3.

Table 6 - HIE Infrastructure Road Map

HIE Infrastructure Road Map			
Functionality	Phase 1 **Current Capabilities**	Phase 2 **High Value Technologies**	Phase 3 **Optional Future Technologies**
Exchange	1. Bi-directional exchange 2. E-Health Exchange – National data sharing 3. BH/PH Integration 4. Public Health Reporting	1. Community Order Entry 2. Data normalization 3. Data segmentation 4. Image sharing 5. Medication history 6. Prescription Drug Monitoring Program (PDMP) integration	1. Claims data integration 2. Data Segmentation 3. Remote Monitoring Data 4. Advanced Directives 5. Identity Proofing 6. Granular Consent Management
Messaging/ Alerting:	1. Alerts and Notifications 2. Direct Secure email messaging		1. Mobile Access to Alerts 2. Secure Text Messaging
Access:	1. Provider Portal 2. Payer Portal 3. Crisis Portal		1. Patient and Family Engagement
Community Tools:		1. Health Care Analytics 2. Population Health Management 3. Community Wide Care Plans 4. Community Wide Referrals	1. Electronic Quality Reporting

Of particular note in the “Phase 2 High Value Technologies” in the table above is data segmentation.With integration of behavioral and physical health care delivery and the integration of the information associated with this care, it will become increasingly important to be able to separate information protected by 42 CFR Part 2 from the non-Part 2 data. Software is available that can address this need by distinguishing between some Part 2 and non-Part 2 data categories. This will provide the means of freeing-up significant amounts of non-substance abuse related data, which can then be accessed without Part 2 based patient consent. This data falls under the control of HIPAA Privacy and Security regulations and Arizona’s HIO Law. The software was developed under the direction of the SAMSHA utilizing federal dollars and as such, is available as “open source” software. Additionally, the commercial software developers retained by SAMSHA to develop this software have programs to support its implementation and maintenance.

While this specialized software can assist with freeing-up data, it must be noted that this effort will require additional time and effort to educate the provider community on the value and benefit of segmenting the data in order to gain widespread support for its usage. Additionally, significant ongoing support from the

provider community will be necessary to reach agreement as to which data can be reclassified as non-Part 2 and to continually monitor and revise this list.

Health Care Data Analytics

Health care data analytics, also noted in the table above as a Phase 2 function, is a key requirement in Arizona's SIM Model Design. This function includes the processes of inspecting, cleaning, transforming, aggregating and modeling data to highlight useful information, suggest conclusions, and support decision-making. The first three of those five functions are currently being enabled within the AzHeC HIE platform. Adding aggregation and modeling functions, i.e., analytic capabilities, is underway and will be available in fourth quarter 2016.

AzHeC's commitment to aggregate data from a growing list of data sources will ensure that the data set available through AzHeC contains information from across as many providers as possible in the continuum of care. Currently, AzHeC has data from 72% of the hospital discharges across Arizona with more data being ingested daily from physical care providers and recently from behavioral health providers as well. Data normalization, medication and PDMP data, and the addition of claims information are potential future capabilities of AzHeC. As these evolve, AzHeC will have built a high quality, robust and actionable set of data. Connecting its own data analytics platform to that data or providing connectivity to other health care providers and ACOs will be the next step.

There are many different types of data analytic tools and purposes. Some that Arizona is considering to support the SIM model include:

- Predictive analytics – analyzing available data to determine the risk of a patient or group of patients utilizing health care resources such as ED, inpatient, or ambulatory services. This analysis is used to predict post-discharge short-term patient readmissions and ED visits.
- Clinical Effectiveness Analyses – determining the extent to which specific clinical interventions deliver the results they are intended to deliver.
- Economic Effectiveness Analyses – the evaluation of health care intervention alternatives to determine which are the most cost effective for the resulting outcomes.
- Comparative Effectiveness Analyses – the direct comparison of existing health care interventions to determine which work best for which patients and which pose the greatest benefits or pose the greatest harm.
- Metrics – the selection of nationally vetted and/or locally defined clinical and financial measures that are tracked by the analytics toolset and provide insights that help providers make more informed care decisions. Some examples of patient level metrics might include: cost per episode of care across all clinical encounters, hospital admits over the past 6 months, ED visits in the past 30 days, etc. Population level metrics might include: number of ED visits per year per 1,000 Medicaid patients, number of inpatient admissions per quarter per 1,000 Medicare beneficiaries, number of 30-day all cause readmissions per quarter per 1,000 CHF patients using ace inhibitors, etc.
- Hot-spotting – the data-driven process for the timely identification of extreme patterns in a defined region of the health.
- Care system – It is used to guide targeted intervention and follow-up to better address patient needs, improve care quality, and reduce cost. Through hot-spotting, claims and clinical data can help reveal both a community's health care problems and their solutions.

Community-wide referral management tools enable providers and other care team members to refer patients to other providers and resources for continued care, follow up care, diagnostic services, treatment, etc. Referrals are a care transition point that are well known to be difficult for providers to track and coordinate. A sufficiently robust referral tool could help reduce or eliminate this difficulty by notify the referring provider when a patient does not follow through on a referral to a specialist. The provider could

also receive an alert when a patient makes an appointment with the referred specialist and when the appointment occurs. In addition, the specialist's consult summary would be provided to the primary care practice to ensure the primary care provider has complete information.

Technical Assistance

Overview

While Arizona is encouraged by the significant strides in HIT/HIE advancement and strong stakeholder support, the State understands that providing continuous and quality technical assistance to providers throughout their transformation will be necessary to further advance HIT/HIE to support SIM Model implementation.

Through stakeholder discussions, a range of technical assistance needs have been identified to respond to the barriers described in Section Governance. Planning for technical assistance reflects a range of services and supports related to technology adoption and use that will lead to improvements in care for the SIM targeted populations and beyond, as well as better alignment with initiatives around value-based purchasing.

Technical assistance efforts will focus on the three broad areas identified by stakeholders, as well as any special considerations that may be unique to the focus area. The three broad areas are: 1) EHR adoption and utilization that impacts how a provider or organization operates and functions; 2) Readiness and extent of HIE utilization and services to improve care coordination across the range of providers an individual might see; and 3) Supporting beneficial levels of care coordination to obtain the best care and health outcomes for both the individual and the population as a whole. By providing assistance to advance intra-practice technology adoption/use and cross-practice communication tools, behavioral health, justice system, and IHS and tribal health care, organizations can quickly learn to leverage technology in order to meet the complex needs of SIM targeted populations.

Because each practice is unique in their adoption of HIE and EHR technology, each will require a practice assessment in order to identify which services will prove most beneficial. Some practices lacking an EHR or needing to change their EHR system, may need help selecting and installing the right EHR system; other, more sophisticated EHR users, however, are likely to need support around modifying workflows to achieve peak efficiency. Similarly, with HIEs, some practices will need assistance in connecting to and enabling more rudimentary HIE functions like admission alerts; others who have already routinized the use of these EHR functions may require improvements in semantic integration of HIE data.

Technical assistance related to the SIM Model will be planned and delivered through a partnership between AHCCCS, other relevant State agencies, and AzHeC. AzHeC has a long history delivering high quality and highly sought-after technical assistance supporting the adoption and use of health information technology. As the State's REC, AzHeC helped over 3,000 health care providers and 18 critical access and rural hospitals to adopt and use certified EHR technology. AzHeC support also helped over 1,800 providers achieve Stage 1 MU and qualify for reimbursements under the EHR Incentive Program.

This section of the Arizona SIM Innovation Plan HIT section is intended to support better understanding of magnitude of technical assistance needs for providers and organizations serving SIM targeted populations and to prescribe specific technical assistance services that can address those needs. In particular, this section outlines how to address existing gaps that will enable improvements in care, care coordination, and outcomes for SIM target populations.

Technical Assistance Needs for SIM Focus Areas

A. Behavioral Health and Physical Health Integration

Table 6 - Educational Needs: Behavioral Health and Physical Health Integration

Educational Needs: Behavioral Health and Physical Health Integration	
EHR Adoption	Comprehensive Technical support needs to be provided to providers on an ongoing and affordable way.
Readiness for HIE Utilization	Ongoing affordable technical support for BH providers needs to be available.
Level of Integrated Care	Preparing physical and behavioral health for Value-Based Purchasing is needed.
Special Consideration Privacy for BH Data	Educating providers and patients around policies and HIT/HIE capabilities is needed.

Currently, EHR adoption among behavioral health and justice system providers lags behind EHR adoption among physical health providers. However, behavioral health and criminal justice providers care for populations that drive significant health costs throughout Arizona and/or have substantial health-related deficits that derive from poorly coordinated care. As a result, the providers serving these populations need to improve their use of EHRs, and data exchange (HIE) tools, including how these improvements are routinized in practice workflows. Additionally, effective care coordination will require effort that occur side-by-side with physical health providers since all these groups are on the same Technical Assistance journey, even if they are at different stages.

A prior effort to develop a plan for the integration of behavioral and physical health data through The Network identified 66 priority providers of behavioral health services who were using twenty different EHRs. These EHRs range from little known products to nationally-known systems. These behavioral health providers will need support in several areas. Some of these smaller EHRs will likely require replacement in the next several years. Many of these providers will need some level of support connecting with and using information from The Network. Almost all will need assistance aligning their practices to integrate with physical health care providers and to adopt APMs and outcomes measures.

While behavioral health providers have a basic level of EHR adoption, they are not yet focused significantly on the high levels required for value-based purchasing including outcome measures. Technical assistance will focus on preparing behavioral health providers to advance to higher levels of HIT/HIE utilization.

B. Providers Serving American Indians

Table 7 - Educational Needs: Providers Serving American Indians

Education Needs: Providers Serving American Indians	
EHR Adoption	Ongoing education and support is underway to ensure adoption for all providers and continued success in the MU Program
Readiness for HIE Utilization	Most non-IHS/Tribal 638 providers serving AIHP members have joined the Network. There is growing recognition that participation by a maximum number of provider types and organizations will improve care and outcomes for AIHP members.
Level of Integrated care	Expanded discussion has identified the importance of securely sharing care plans, especially for members with both physical and behavioral health conditions.
Special Consideration for American Indians	If a member of The Network would like to have access to Federal data, each participant may need to go through the Federal HealtheWay certification process itself.

Designing and coordinating deployment of technical assistance to providers serving American Indians will only be successful if all key parties are collaboratively engaged in discussion and planning. AHCCCS is working with tribal leaders, IHS, and tribal health care providers, and non-IHS/tribal providers serving American Indians to identify technical assistance needs and opportunities.

C. Justice System

Table 8 - Educational Needs: Justice System

Educational Needs: Justice System	
EHR Adoption	Need to ensure there are tools and technical assistance that can help any provider in an affordable and ongoing way; justice partners are not as far on the continuum of adopting electronic health records or understanding the benefits.
Readiness for HIE Utilization	Needs to be ongoing low cost technical support given to ensure the ability of all correctional health providers to participate with The Network.
Level of Integrated Care	Due to high numbers of AHCCCS members in Justice System with chronic conditions and co morbidities, need to ensure care coordination can occur upon release. Could look at standardized tools across justice system partners to ensure consistent resources and care are available.
Special Consideration: For Justice Systems	Working with Justice System Workgroup to identify unique needs and approaches.

The level of adoption of HIE is high among justice system providers relative to behavioral health providers. However, the need to support providers in the adoption, use, and optimization of EHRs is

crucial since inmates are often released without adequate community re-entry planning. AHCCCS and AzHeC are working with the Justice System Workgroup to identify technical assistance needs and develop a plan for deployment of resources and assistance.

Additional Opportunities for Technical Assistance

Because EHR use radically changes practice workflows, simply installing an EHR is not sufficient to realize higher quality and safer care for patients. In fact, much of the post-implementation work of an EHR is focused on documenting and altering the workflows to ensure that the practice—including the use of the EHR—is operating at optimal efficiency. Additionally, many EHRs have capabilities that are valuable only once basic functions like documenting clinical encounters become routine. Often, practices need a range of onsite tactical support that is not forthcoming from the EHR vendor to support optimal use of the EHR tool. This might include, for example, reviewing and obtaining reports from the EHR that look at population health information like incidence of diabetes or heart failure among the practice's population. Typically, it takes up to 18 months for a practice to attain the level of comfort and familiarity with the EHR they've installed to start contemplating more sophisticated uses. The goal of this technical assistance effort will be to support these practices through this process and accelerate it as much as possible.

One specific aspect of EHR Adoption that may require specific support concerns consent management. The Network is already moving ahead with plans to integrate behavioral and physical health data into the statewide HIE. In doing so, it is planning to separate, but still ingest, data from providers who are subject to 42 CFR Part 2. In order for a provider to access this information, he or she must obtain a point-of-care consent from a patient. This would be a change from existing operations which currently require notification that the data will flow to the HIE unless the patient "opts out." As practices and hospitals transition to this new system, they are likely to need some form of technical assistance particularly around workflow.

The final level of technical assistance would concern those practices and hospitals that are now comfortable using their EHR and are in the early phases of aligning their practice with outcomes based measures. More than just looking at disease states like diabetes, this technical assistance will focus on identifying key performance measures that may be tied with payer or health system-based incentives, and aligning practice efforts to continually improve performance. For example, a practice participating in an Accountable Care Organization may be eligible for bonuses for reducing 30- and 60-day readmissions for individuals with Chronic Obstructive Pulmonary Disease (COPD). Technical Assistance might take the form of supporting alert follow-up planning and patient engagement when the practice is notified, (via the Hospital and/or HIE), that a patient is being discharged.

In addition to the EHR and the HIE, there are new, emerging technologies, such as remote monitoring devices and secure real-time conferencing that could be leveraged to support practices with better alignment around population health. As practice and hospital IT infrastructure stabilizes, leveraging these new approaches to patient monitoring and engagement could prove instrumental to on-going quality improvements.

Although EHRs provide some of the necessary infrastructure to support inter-practice coordination, this alone is inadequate to effectively align with the goals of the SIM initiative. Many of the practices that were interviewed as part of this initiative revealed that much of the exchange of information, even sometimes across divisions of the same practice delivering different kinds of care, is often transmitted via paper, scanned forms, and fax. These efforts are not only inefficient, but clearly inadequate to support the large scale coordination of care expected with SIM target populations. Care coordination may quickly expand beyond practices to skilled nursing facilities, pharmacies, home health, aging services, patient advocates, and more. As care coordination increases, the backlog created by increasing paper, scan, and fax transmissions will create its own workflow problems.

While most practices in Arizona are using relatively rudimentary means, (e.g., print, faxes, and scans) to share information, The Network offers several different approaches for practices to begin leveraging statewide HIE services, each having different implications for care coordination. These do not necessarily represent different levels of sophistication so much as different approaches that must meet the unique needs of the practice and its care coordination partners. These could include, for example, alerts, patient look-up via the Provider Portal, or even sending and/or receiving a patient record using the Direct secure email protocol. All of these are available to providers, even those using rudimentary EHR products. However, configuring them and integrating their use into standard practice workflows requires some level of technical assistance likely beyond the typical practice.

The one level of integration with The Network that does require a more sophisticated EHR is where the information available via The Network is actually integrated with the practice's EHR. Even the more limited number of practices for whom this is an option will require support to ensure the right data is flowing to the right place. Perhaps even more importantly, the practice will require training and support in how to use this information to drive quality improvements.

There are several efforts currently underway in Arizona to address the technical assistance needs of providers in the adoption and use of EHRs, but these are likely not sufficient to address the full spectrum of needs for the SIM effort or for this specific population.

As noted previously, to be most effective, any technical assistance effort should start with a comprehensive practice assessment. The assessment should address the following items since it is the first step in what services the practice will need. Ideally, such an assessment will determine:

- Level of EHR adoption and use:
  - Key pain points.
- HIE connectivity and use:
  - Key pain points.
- Populations served and key clinical issues:
  - American Indians.
  - Behavioral health.
  - Criminal Justice system.
  - Chronic disease.
- Payer mix:
  - Commercial versus Medicaid/Medicare.
  - Financial incentives:
    - VBP.
    - Quality Reports.
- Key information 'trading partners' and modes of transmitting information.

High Value Technology Solutions Costs

Some technologies, when implemented within the current AzHeC HIE infrastructure at a state and/or community level with an extensive and comprehensive data source, will provide a significantly important foundation in supporting Arizona's health care transformation. These technologies and the resulting enhanced infrastructure will: 1) enable many other technologies to be implemented including telehealth and mobile health services; 2) link providers from across all care settings; 3) link patients with their care team members regardless of care setting, and 4) provide a common comprehensive patient database all of which will enhance care coordination, care transitions, care delivery, care quality, and enable more affective cost controls.

The following tables attempt to provide some insight into the costs associated with these technologies regarding acquisition and implementation, as well as the ongoing operational costs. It must be understood that until each technology is completely evaluated for need, sequencing, timing, extent of adoption, form, and functionality it will not be possible to identify the actual costs associated with these high value technologies, or any other technology, such as those identified as “Optional Future Technologies” in Phase 3 of the HIE Infrastructure Road Map in Table 6 above. The following estimates should be viewed as order of magnitude numbers and used only in the broadest sense when estimating initial budget needs.

Table 9 depicts the costs associated with acquiring the basic technology licensing and the implementation across the subset of the health care community identified for each technology.

Table 9 - High Value Technology Solutions: One-time Costs

High Value Technology	Acquisition Costs		Implementation Costs			Total
	HIE	Provider	HIE	Provider Basis	Provider	Costs
Community Provider Order Entry (CPOE)	378,400	390,000	282,500	100 Practices and 18 Labs	475,000	1,525,900
Data Normalization	480,000	0	78,125	All data sources	0	558,125
Data Segmentation (42 CFR Part 2 data)	0	0	347,800		0	347,800
Image Sharing	66,500	0	66,500	Varies with volumes	597,700	664,200
Medication History (DrFirst)	56,000	0	66,500	All non-eRX Providers	0	122,500
Prescription Drug Monitoring Program (PDMP)	56,000	0	66,500	All Providers	0	122,500
Health Care Analytics and Population Health	0	0	656,500	1,000,000 Patients	0	656,500
Community-Wide Care Plans	0	0	0		0	0
Community-Wide Referral Management	170,800	0	180,000	All Providers	0	350,800
Total All Technologies						**4,348,325**

Table 10- High Value Technology Solutions: Annual Costs

High Value Technology	Annual Support Costs		Annual Vendor Costs			Total
	HIE	Provider	HIE	Provider Basis	Provider	Costs
Community Provider Order Entry (CPOE)	632,800	0	99,850	100 Practices and 18 Labs	98,580	831,240
Data Normalization	78,125	0	0	All data sources	360,000	438,125
Image Sharing	66,500	0	0	Varies with volumes	609,600	676,100
Data Segmentation (42 CFR Part 2 data)	93,750	0	75,000		0	168,750
Medication History	66,500	0	0	All non-eRX Providers	400,000	466,500

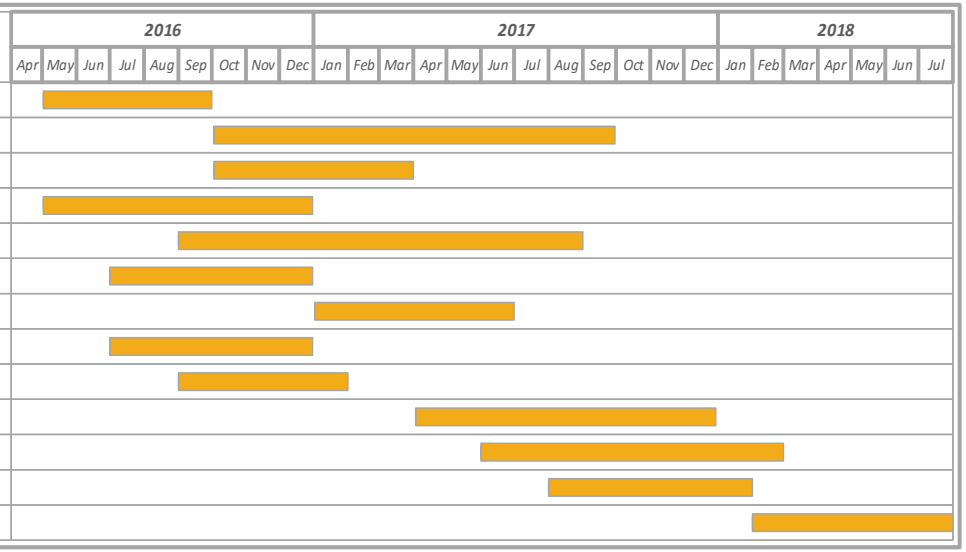
Prescription Drug Monitoring Program (PDMP)	66,500	0	0	All Providers	240,000	306,500
Health Care Analytics and Population Health	570,300	0	0	1,000,000 Patients	1,095,000	1,665,300
Community-Wide Care Plans	0	0	0		0	0
Community-Wide Referral Management	**See CPOE**	0	36,150	20,000 Referrals	20,000	56,150
Total All Technologies						**4,608,665**

High Value Technology Solutions Time Line

The following table attempts to provide some insight into the possible sequencing and implementation time lines for these technologies. This table represents the best understanding to date as to the relative importance of each technology as it relates to the sequencing of the implementations. Again, it must be understood that until each technology is completely evaluated for need, sequencing, timing, extent of adoption, form, and functionality, it will not be possible to identify the actual priorities, sequencing, or implementation time frame of each technology.

Table 11 - High Value Technology Solutions: Implementation Time Lines

ID	High Value Technology	Start	Finish	Duration
1	Health Care Analytics – Baseline Measures	5/2/2016	9/30/2016	22w
2	Health Care Analytics – Full Rollout	10/3/2016	9/29/2017	52w
3	Population Health	10/3/2016	3/31/2017	26w
4	Data Normalization	5/2/2016	12/30/2016	35w
5	Data Segmentation (42 CFR Part 2 data)	9/1/2016	8/31/2017	52.2w
6	Image Sharing - Pilot	7/1/2016	12/30/2016	26.2w
7	Image Sharing – Full Rollout	1/2/2017	6/30/2017	26w
8	Medication History	7/1/2016	12/30/2016	26.2w
9	PDMP Integration	9/1/2016	1/31/2017	21.8w
10	Community-wide Referral Management	4/3/2017	12/29/2017	39w
11	Community-wide Shared Care Plans	6/1/2017	2/28/2018	39w
12	Community Order Entry - Pilot	8/1/2017	1/31/2018	26.4w
13	Community Order Entry – Full Rollout	2/1/2018	7/31/2018	25.8w



Appendix A: Stakeholders Interviewed

Adelante Healthcare
Arizona Care Network
Arizona Center for Rural Health
Arizona Children's Association
Arizona Treatment and Counseling
Assurance Health and Wellness Center
Aurora Behavioral Healthcare, Phoenix
Chandler Fire, Health and Medical
Cigna Medical Group
City of Phoenix
ConnectionsAZ
COPE
El Rio Health Center
Encompass Health Services
Integrated Medical Services
Jewish Family and Children's Services
Marc Community Resources
Maricopa County Dept. of Corrections
Maricopa Integrated Health System
Mohave Mental Health Clinic
MomDoc
Mountain Park Health Center
Partners in Recovery
San Luis Walk in Clinic/Regional Center for Border Health
Touchstone Behavioral Health
Valle del Sol
West Yavapai Guidance Center
Yuma Regional Medical Center

Appendix B: Network Leadership Council (as of January 2016)

Banner Health
Ryan Smith, Sr. VP and CIO

Blue Cross Blue Shield of Arizona
Garrett Anderson, CTO

Care 1st Health Plan Arizona
Scott Cummings, CAO

Carondelet Health Network
Sally Zambrello, CIO

Dignity Health
Sean Turner, Sr. Director, HIE/Ambulatory Information Management

Marana Health Center
Clint Kuntz, CEO

Maricopa Integrated Health System
Kelly Summers, CIO

Mercy Care and Mercy Maricopa Integrated Care
Christi Lundeen, Chief Innovation Officer

New Pueblo Medicine
Mike Cracovaner, CEO

Northern Arizona Healthcare
Marilynn Black, VP and CIO

Pima County
Francisco Garcia, MD, Medical Director

Sonora Quest Laboratories
David A. Dexter, President and CEO (NLC Vice-Chair)

TMC HealthCare
Frank Marini, VP and CIO (NLC Chair)
UnitedHealthcare
William H. Hagan, Chief Growth Officer

Yuma Regional Medical Center
Fred Peet, Interim CIO and Director of IT

AzHeC Board of Directors (as of March 2016)

Permanent Members

Office of the Governor
Christina Corieri, Policy Advisor, Health and Human Services

Arizona Health Care Cost Containment System (AHCCCS)
Thomas J. Betlach, Director

Arizona Department of Health Services (ADHS)
Janet Mullen, Deputy Director

Arizona Hospital and Healthcare Association (AzHHA)
Greg Vigdor, President and CEO

Arizona Osteopathic Medical Association (AOMA)
Pete Wertheim, Executive Director

Non-Permanent Members

Arizona Alliance of Community Health Centers
John McDonald, CEO

Arizona Health Care Association
Kathleen Collins-Pagels, Executive Director

Arizona Nurse Practitioners Council
Erich Widemark, PhD, Director of Simulation Education, University of Phoenix

Arizona Pharmacy Association
Kelly Fine, CEO

Arizona State University
William G. Johnson, PhD, Professor, Biomedical Informatics

Barnet Dulaney Perkins Eye Center
Mark Rosenberg, CEO

Banner Health
Ryan Smith, Senior VP and CIO

Benson Hospital
Rich Polheber, CEO

Blue Cross Blue Shield of Arizona
Garrett Anderson, VP and CTO

Cambiare, LLC
Anita Murcko, MD, President and CEO

Cardiovascular Consultants
Andrei Damian, MD, President

Cenpatico Integrated Care
Sloane Steele, VP, IT and Data Operations

CIGNA Medical Group
John Parente, MD, CMIO

District Medial Group
Jeff Weil, CIO

Health Information Management Systems
Khalid Al-Maskari, CEO

Health Services Advisory Group
Mary Ellen Dalton, CEO

Independent Healthcare Consultant
Tony Fonze

Magellan Complete Care of Arizona
Shareh O. Ghani, MD, CMO

Mercy Care Health Plan
Mark Fisher, CEO

Mountain Park Health Center
Bill Kirkland, Data Manager

Regional Center for Border Health
Philip Gladney, Director of Information Technology

Sonora Quest Laboratories
David Dexter, President and CEO

UnitedHealthcare
Joe Gaudio, CEO, Community and State

University of Arizona, College of Medicine
Ronald Weinstein, MD, Founding Director, Arizona Telemedicine Program