



## TRIBAL CONSULTATION MEETING

July 28, 2016

10:00 a.m. – 1:00 p.m. (Arizona Time)

Flagstaff Medical Center, McGee Auditorium

Conference Bridge: 1-877-820-7831, Participant Passcode: 108903#

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### NOTIFICATION TO TRIBES:

Good Morning,

I'm pleased to announce the third quarterly AHCCCS Tribal Consultation meeting scheduled for July 28, 2016 from 10:00 a.m. – 1:00 p.m. The meeting will be held at the Flagstaff Medical Center, McGee Auditorium, 1200 N. Beaver St., Flagstaff, AZ 86001. The draft agenda and FMC campus map are attached. If you plan to participate by phone, please dial **1-877-820-7831** and enter participant code, **108903#**. Meeting materials will be posted to the AHCCCS website the day before the meeting at:

<https://www.azahcccs.gov/AmericanIndians/TribalConsultation/meetings.html>. A meeting reminder will also be sent to the tribal listserv a couple of days before the meeting.

Don't hesitate to contact me if you have questions. Thank you for participating in this important meeting.

*Bonnie*

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**Bonnie Talakte**

Tribal Relations Liaison

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# AGENDA

## AHCCCS TRIBAL CONSULTATION MEETING

With Tribal Leaders, Tribal Members, Indian Health Services, Tribal Health Programs Operated Under P.L. 93-638  
and Urban Indian Health Programs

Date: July 28, 2016

Time: 10:00 a.m. – 1:00 p.m. (Arizona Time)

Location: Flagstaff Medical Center, McGee Auditorium, 1200 N. Beaver St., Flagstaff, AZ 86001

Conference Call-In: **1-877-820-7831** Participant Passcode: **108903#**

TIME	TOPIC	PRESENTER
10:00–10:15 a.m.	Welcome  Opening Prayer  Introductions	Beth Kohler, <i>AHCCCS Deputy Director</i>  Mr. Larry Curley, <i>Director of Program Development</i> <i>Rehoboth McKinley Christian Health Care Services</i>  Beth Kohler
10:15-11:00 a.m.	Best Practice Presentation: • Tucson Area Medical Home Model	Ron Speakman, <i>Acting Facility Director,</i> <i>TON San Xavier Health Center,</i> <i>Tohono O’odham Nation Health Care</i>
11:00-11:45 a.m.	AHCCCS Updates: • Free Standing Emergency Departments • KidsCare Implementation • Access to Care for Fee-for-Service (CMS Rule) • Fee-for-Service Rates • Medicaid Managed Care Final Rule: Impact of Reimbursement for Institutions for Mental Disease (IMD) Services • CMS Guidance on 100% FMAP: Claiming and State Legislative Report	Beth Kohler
11:45-11:55 a.m.	<b>10 Minute Break</b>	
11:55-12:15 p.m.	Delivery System Reform Incentive Payment (DSRIP)	Dr. Mark Carroll, <i>Physician Program Consultant</i>
12:15-12:30 p.m.	Draft Policy: Hepatitis C Virus (HCV) Prior Authorization Requirements	Suzanne Berman, <i>Director of Pharmacy Services</i>
12:30-12:50 p.m.	Presentation by Senator Caryle Begay: Addressing Care Coordination Strategies for AIHP	Caryle Begay, <i>Arizona State Senator-District 7</i> <i>Arizona State Senate</i>
12:50-1:00 p.m.	Announcements/Wrap-Up/Adjourn	Beth Kohler

**Next Meeting: October 20, 2016 - White Mountain Apache Tribe**

## ATTENDEES:

Tribes	<p><u>Gila River Indian Community</u>: Alma Carillo, Felicia Begay</p> <p><u>Hopi Tribe</u>: R. Johnson</p> <p><u>Navajo Nation</u>: Theresa Galvan, Marie Keyonnie, Gen Holona</p> <p><u>Pascua Yaqui Tribe</u>: Reuben Howard</p> <p><u>Salt River Pima Maricopa Indian Community</u>: Chris Christy</p> <p><u>Tohono O’odham Nation</u> – Joni Jim</p>
I/T/Us	<p><u>Fort Defiance Indian Health Board</u>: Terrilynn Chee, Brochelle Shirley,</p> <p><u>Native Connections</u>: Janel Striped Wolf</p> <p><u>Navajo Area IHS</u>: KL Dempsey, Nan Totsoni, Priscilla Whitethorne, Lorraine Willie; Juanita Jeff, Gloria John, Laurie VanWinkle</p> <p><u>Phoenix Area IHS</u>: Carol Chicharello</p> <p><u>Tohono O’odham Nation Medical Center</u>: Ron Speakman</p> <p><u>Tuba City Regional Health Care Corporation</u>: Selena Simmons, Violet Skinner, Kirk Shim, Yolanda Burke, Melverta Barlow</p> <p><u>Winslow Indian Health Care Corp.</u>: Jacquanna Kurlachecuy, Kelly Saganey, Carol Chitwood, Jolene Bitsui, Katie Peshlekai, CeCelia Jackson, Alutha Yellowhair, Jolene Yazzie, Mary Billie</p>
Other	<p><u>Cenpatico</u>: Sheina Yellowhair, Julia Chavez</p> <p><u>Flagstaff Medical Center</u>: Richard Mese</p> <p><u>Health Choice Integrated Care</u>: Holly Figueroa</p> <p><u>Inter-Tribal Council of Arizona</u>: Alida Montiel</p> <p><u>Native Resource Development</u>: Jermiah Kanuho</p> <p><u>Mercy Maricopa Integrated Care</u>: Faron Jack</p> <p><u>Rehoboth McKinley Christian Health Care Services</u>: Larry Curley, Cindy Curley</p> <p><u>Salina Valley Home Care</u>: Amanda Begay, Lisa Woody, Avial Begay</p>
AHCCCS Representatives	Bonnie Talakte, Beth Kohler, Elizabeth Carpio, Anne Dye, Markay Adams, Valerie Jones

## MEETING SUMMARY

All meeting materials and presentations can be found at the AHCCCS Tribal Consultation website:  
<https://www.azahcccs.gov/AmericanIndians/TribalConsultation/meetings.html>

TOPICS	SUMMARY
<p><b>Best Practice Presentation: Tohono O’odham Nation San Xavier Health Center Medical Home</b></p>	<p><b>Background:</b> In 2014 the AHCCCS Office of Intergovernmental Relations established a page on the AHCCCS website titled, <i>Promising/Best Practices</i>. The purpose of the page is to encourage tribal communities, tribal health facilities and others to share programs and practices that have a positive impact on the health of tribal members that others can learn from and adapt to their needs. Starting in 2015, AHCCCS began to feature a <i>promising</i> or <i>best practice</i> at one of the quarterly tribal consultation meetings. In 2015 AHCCCS selected the Tucson Area IHS San Xavier Health Center’s medical home model as a <i>Best Practice</i>. In 2009, the health center started collecting clinical data and implementing evidence based best practices.</p>

	<p><b>Ron Speakman, San Xavier Health Center Acting Facility Director</b>, provided an overview of the San Xavier Health Center Medical Home model. The medical home concept of care was implemented in 2009 by the former Tucson Area IHS San Xavier Health Center. Effective July 1, 2016, the Tohono O’odham Nation signed a self-governance compact and funding agreement with IHS. With this compact, the Nation will directly manage and provide services for their tribal members. The health center has been re-named the Tohono O’odham Nation San Xavier Health Center.</p> <p>The medical home concept of care was developed to improve access to care and improve care coordination. The model focuses on the following implementation plan:</p> <ul style="list-style-type: none"> <li>• Empanelment of all SXHC patients</li> <li>• Complete formation of Care Teams</li> <li>• Scheduling guidelines/planning for same day appointments</li> <li>• Maximize space utilization</li> <li>• Notification to patients/community</li> </ul> <p>Successes include:</p> <ul style="list-style-type: none"> <li>• Improved care coordination and access to care</li> <li>• Utilization of clinical data to guide and improve care coordination</li> <li>• Improved communication with patients and health center staff</li> <li>• Improved distribution of administrative responsibilities</li> <li>• Effective use of health center space</li> </ul>
<p><b>AHCCCS Updates</b></p>	<p><b>Beth Kohler, AHCCCS Deputy Director</b>, began her presentation by highlighting 2016 AHCCCS accomplishments, 2017 opportunities, and ongoing opportunities.</p> <p><b>2016 accomplishments:</b> 1) The BHS/AHCCCS merger. BH staff have been transitioned, 2) transitioned Greater AZ RBHAs and dual BH integration, 3) Initiative expansions of; CRN-SMI determination statewide, DES Medicaid in HEAPlus, added 152 AIHP members to active care coordination, 4) avoided a 5% provider rate reduction, 5) clinical system improvements analysis in ASD and CMDP, 6) submission of the 1115 Waiver, and 7) completion of 4-TRBHA IGAs.</p> <p><b>2017 opportunities:</b> 1) complete formal BH transition merger by 7/1/16, 2) implement new 1115 Waiver by 10/1/16, 3) work on managed care procurement for ALTCS and DD sub-contractors and acute managed care contracts, 4) integration 2.0 planning-stakeholder engagement, 5) value based purchasing, 6) health information exchange, 7) support justice systems initiatives, 8) clinical initiatives; ASD and substance use disorder, 9) new federal MCO regulations-access requirements, 10) continue AIHP care coordination and DSRIP.</p> <p><b>Ongoing Opportunities:</b> 1) Achieving sustainability of the AHCCCS programs 2) maintaining sufficient staff to achieve initiatives and ongoing work with stakeholders, 3) working to better integrate and align efforts for children engaged in the child welfare system, 4) integration efforts with BH and physical health, 5) improving care coordination, 6) facilitating access for members to social services and economic support important to achieving good health care outcomes, 7) CMO efforts surrounding the opioid crisis.</p> <p><b>Fee-for-Service Rates:</b> All rates, with general descriptions, are posted on the AHCCCS website and are available for public comment. The description of each rate under consideration for increase or realignment is too lengthy to include in this summary but can be found at the AHCCCS website under the American Indian tab, <i>Meetings with Tribes and ITUs, AHCCCS Updates:</i> <a href="https://www.azahcccs.gov/AmericanIndians/TribalConsultation/meetings.html">https://www.azahcccs.gov/AmericanIndians/TribalConsultation/meetings.html</a>. Ms. Kohler’s rates presentation included the following:</p> <ul style="list-style-type: none"> <li>• Value Based Purchasing (VBP) Differential Adjusted</li> <li>• Free Standing Emergency Departments</li> </ul>

- Treat and Refer
- Long-Acting Reversible Contraception
- Behavioral Health Outpatient
- AZ Early Intervention Program (AZEIP) Speech Therapy
- 340-B
- Home and Community Based Services (HCBS)
- Nursing Facilities (NF)
- Hospice – updated to Medicare rate
- Diagnostic Related Group (DRG)
- Federally Qualified Healthcare Centers (FQHC) Prospective Payment System (PPS)
- Stakeholder Driven realignment:
  - Air ambulance realignment
  - Dental realignment
  - Long Term Acute Care (LTAC) and Rehab
- Physician Drug Schedule
- Ground Ambulance:
  - ADHS
  - Non-ADHS FFS
- Other 0% aggregate updates:
  - Ambulatory Surgical Centers (ASC)
  - Outpatient Hospital
  - Physician
  - Lab
  - Durable Medical Equipment (DME) Place Of Service (POS)
- Adult Dental - \$1000 per member begins 10/1/16
- Licensed Podiatrist
- Board Certified Behavior Analysts (BCBA) Provider Type
- Nursing Facility Supplemental Payments
  - Increase in FFS NF supplemental payment
- Assessment increases:
  - Medicare day
  - Non-Medicare day for certain high-Medicaid facilities
  - **IHS/638 facilities continue to be exempt from assessment**

**Managed Care Institute for Mental Diseases (IMD) Provisions:**

What is an IMD?

- Definition found in 42 C.F.R. 435.1010

“a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases.”

There has been a long standing statutory prohibition on paying for IMD’s with Medicaid money. The statutory prohibitions are In federal statute so CMS can’t change this. Only Congress can change. Through the managed care programs, AHCCCS has been able to pay for some IMD services through a provision called the “in-lieu” process. New managed care regulations allow only for IMD stays less than 15 days for adults aged 21-64. This eliminates the existing in-lieu option. If the stay is longer than 15 days, the state must recoup the ENTIRE capitation payment to the MCO for the month (not just amount associated with IMD stay). Member is still enrolled with plan – the plan is still responsible for care.

	<p><u>Next Steps include:</u></p> <ul style="list-style-type: none"> <li>• Working to identify complete list of IMDs</li> <li>• Options include, for managed care members (but are not limited to): <ul style="list-style-type: none"> <li>• Prohibit IMD stays at all</li> <li>• Prohibit IMD stays more than 15 days</li> </ul> </li> <li>• Need to assure network capacity</li> <li>• Have solution for TRBHAs</li> </ul> <p><b>Access Monitoring Review Plan:</b> Monitoring Access to Care for Fee-for-Service Populations. Every time AHCCCS performs a rate change an analysis has to be done.</p> <p><u>CMS amended 42 CFR Part 447</u></p> <p>Requires Medicaid agencies to establish an Access Monitoring Review Plan to ensure adequate access to care for the FFS population. The Plan must be updated annually and is subject to a 30-day public comment period. AHCCCS must complete analysis of services included in the review plan at least once every three years and provide mechanisms for ongoing beneficiary and provider input.</p> <p><u>Service Categories to Evaluate:</u></p> <ul style="list-style-type: none"> <li>• Primary care Services</li> <li>• Physician specialist services</li> <li>• Behavioral health services</li> <li>• Pre-and post-natal obstetric services (including labor and delivery)</li> <li>• Home health services</li> <li>• Additional types of services with a higher than usual volume of access complaints</li> <li>• Additional types of services selected by the state- AHCCCS has chosen to include Durable Medical Equipment</li> <li>• Additional types of services with a higher than usual volume of access complaints</li> <li>• Additional types of services selected by the state- AHCCCS has chosen to include Durable Medical Equipment</li> </ul> <p><u>Provider Rate Reductions/Restructuring:</u></p> <p>When a state proposes to reduce or restructure provider payments in circumstances where the changes could result in diminished access, the state must submit access monitoring analysis for each service potentially affected and show sufficient service access and must review access for those services at least annually for at least three years.</p> <p><u>Measure to Analyze Access to Care</u></p> <p>For each of the service categories AHCCCS will: 1)Discuss fee schedules and recent changes, 2) Evaluate number of AHCCCS-enrolled providers trended over time, broken out by urban &amp; rural areas, 3) Compare AHCCCS enrolled providers to cumulative changes in AHCCCS fee schedules, 4) Analyze number of AHCCCS claims trended over time, 5)When available, compare to Medicare rates, Medicaid rates of western states, and AHCCCS MCOs</p> <p><u>FFS Access to Care Input:</u></p> <p>States must have ongoing mechanisms for beneficiary and provider input on access to care for FFS population. AHCCCS has begun developing a page on the website for reporting access to care issues that will allow beneficiaries, providers, and stakeholders the opportunity to submit access to care concerns. The page will be available by October 1, 2016 and will provide mailing address and phone number to submit access to care concerns</p> <p><u>Final Comments:</u></p> <p>Limitations include access to available data. The Access Monitoring Plan is scheduled to be published on our website soon and will be open to 30-day public comment period.</p> <p><a href="https://www.azahcccs.gov/AHCCCS/PublicNotices/">https://www.azahcccs.gov/AHCCCS/PublicNotices/</a>. The final report is due to CMS on October 1, 2016.</p>
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<p><b>Questions/Answers Comments/Response</b></p>	<p><b>CMS Guidance on 100% FMAP</b>  Currently, if the service is provided by an IHS/638 facility (whether it be an agent, employee, and contracted provider) <b>and</b> the service is billed by the IHS/638 facility, the State claims 100% match. The current criteria is as follows:</p> <ul style="list-style-type: none"> <li>• The service must be furnished to a Medicaid-eligible AI/AN;</li> <li>• The service must be a “facility service” – i.e., within the scope of services that a facility (e.g., inpatient hospital, outpatient hospital, clinic, Federally Qualified Health Center/Rural Health Clinic, nursing facility) can offer under Medicaid law and regulation;</li> <li>• The service must be furnished by an IHS/Tribal facility or by its contractual agent as part of the facility’s services; and  The IHS/Tribal facility must maintain responsibility for the provision of the service and must bill the state Medicaid program directly for the service.</li> </ul> <p>New CMS guidance reinterprets what it means for a service to be “received through” an IHS/638 facility to include when:</p> <ul style="list-style-type: none"> <li>• An IHS/638 facility practitioner requests the service for his or her patient from a non-IHS/638 provider (outside of the IHS/Tribal facility)</li> <li>• The non-IHS/638 provider is a Medicaid provider</li> <li>• The IHS/638 provider and non-IHS/638 provider have a care coordination agreement in place.</li> </ul> <p>Under the circumstances, non-IHS/Tribal providers may bill directly for these services and the State may receive a 100% federal match.</p> <p><u>Care Coordination Agreement:</u>  A written agreement between an IHS/638 facility practitioner and a non-IHS/638 facility practitioner must be established. The IHS/638 facility practitioner remains responsible for overseeing patient’s care and retains control over medical records.</p> <p><u>Care Coordination Agreement Requirements:</u>  Care coordination must include:</p> <ol style="list-style-type: none"> <li>1. IHS/638 facility practitioner requests the specific service and providers relevant information to the non-IHS/Tribal provider;</li> <li>2. The non-IHS/638 provider sends patient care information and results to the IHS/638 facility practitioner;</li> <li>3. IHS/638 facility practitioner takes appropriate action with that information</li> <li>4. IHS/638 facility incorporates the patient’s information in the medical record.</li> </ol> <p><u>Billing Options:</u></p> <ul style="list-style-type: none"> <li>• Non-IHS/638 facility practitioner bills directly</li> <li>• IHS/638 facility practitioner bills</li> <li>• In either case it must be documented/separately identified</li> </ul> <p><u>Next Steps</u>  AHCCCS is working through internal operational issues and will schedule stakeholder discussions. A Legislative report is due by December 1, 2016 on financial implications and strategies to encourage care coordination agreements</p> <p><b>Kids Care:</b>  KidsCare went live on Monday, July 25<sup>th</sup>. People can apply through a HEAPlus application. AHCCCS has approved 229 applications and most are renewals. Just a reminder this KidsCare is not new. For children enrolled in MCOs, IHS and 638 should bill MCOs directly. That’s the standard practice.</p>
	<p><u>IMD Provisions</u>  <b>Q:</b> “How do the IMD Provisions affect Tribes”?  <b>A:</b> “We’re working through the final implications, what our options are so we can support the facilities that provide care services”.</p> <p><b>Q:</b> “In an earlier IMD provisions slide you mentioned 16 beds or more. Most tribal facilities are smaller than 16 beds”.</p>

<p><b>Delivery System Reform Incentive Payment (DSRIP)</b></p>	<p><b>A.:</b> “Those are non-IMD’s. These changes do not apply to those facilities”.</p> <p><b>C:</b> “There aren’t many facilities here in Arizona that can take care of adolescents who are sexual predators so we are forced to send them out of state. That doesn’t allow for a continuum of care. So would that be one of the complaints that could be submitted as part of the public comments? In the RBHA RFP that went out, we specifically requested those kind of services be established here in Arizona. Some of the adolescents are aging out and are coming back to our communities”.</p> <p><b>R:</b> “Yes, that is something you can definitely submit. We are working to have regular conversations on this to increase access to care because we are hearing that challenge. We have to look into the transitions. It’s a very complex issue for a complex population”.</p> <p><u>CMS Guidance on 100% FMAP</u></p> <p><b>Q.</b> “Would this then apply in the case of non-IHS/non 638 providers? We’ve had a coordination agreement with urban Indian health facilities”.</p> <p><b>A.</b> “Yes, it does apply”.</p> <p><b>Q:</b> “With the care coordination document, is there a template that is going to be provided and who is going to see it”?</p> <p><b>A:</b> “It’s my understanding that IHS has developed a template and is available for use. AHCCCS is working through how to operationalize this because there are options for billing. There has to be documentation, we have to assure CMS that these agreements are in place”.</p> <p><b>Q.</b> “Right now with the TRBHAs, we’re required, in our IGA agreements, to have contracts with non-IHS providers. You’re not going to ask us to do double work are you”?</p> <p><b>A:</b> “This is not a requirement of the IGA because they are a part of the FFS network. This is voluntary. IHS and 638s do not have to participate or engage in this”.</p> <p><b>C:</b> “I work with a hospital in Gallup, NM. We have many AZ Medicaid patients who come through our facility. We are a provider under the AHCCCS network as a hospital. NM is also going through the process of addressing this issue. I’m wondering how different this will be in AZ as compared to NM. How many referrals are being made currently at IHS and 638 facilities to non-IHS facilities that if an agreement were in place there would be the 100% match coming into the both AZ and NM? Seventy percent (70%) of our clients are Navajo and they come from the AZ side. The facility would be saving the state of NM a lot of money. The problem is that whatever money NM saves is going to end up in Hobbs and Artesia and not coming back and increasing access to care at our hospital. It would be in the best interest of the IHS and 638 facilities in AZ to look at how the coordination of care agreements are implemented and structured. These are just my comments”.</p> <p><b>Dr. Mark Carroll, AHCCCS Physician Program Consultant,</b> provided a definition of DSRIP: “Federal funds administered by the Centers for Medicare &amp; Medicaid Services (CMS). DSRIP initiatives provide states with funding that can be used to support providers in changing how they provide care to Medicaid beneficiaries. DSRIP initiatives are part of broader Section 1115 Waiver programs”.</p> <p><u>DSRIP Initiatives:</u></p> <p>The initiative has been in existence since 2010. It is a five year long waiver if approved by CMS. There are no official federal criteria for DSRIP program qualification. States have taken varying approaches. There are more states like AZ who are interested in this current year. Federal funds are matched to state funding for certain qualifying health programs, which means that States have a match requirement. DSRIP is an incentive program where payment incentives are distributed for meeting performance outcome requirements. It’s not a grant program. Providers (organizations) can use funds to develop systems, infrastructure, and/or processes. DSRIP is a great opportunity for capital investment to come into States to transform healthcare.</p> <p><u>Arizona’s DSRIP Proposal:</u></p> <p>Focuses on populations of vulnerable Medicaid members where care integration, coordination of care, and data exchange will likely have an immediate positive impact for enrollees and providers.</p>
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<p><u>Arizona’s 4 DSRIP Focus Areas:</u></p> <ul style="list-style-type: none"> <li>• Adults with Behavioral Health Needs</li> <li>• Children with Behavioral Health Needs, Children with and at-Risk for Autism Spectrum Disorder, and Children Engaged in the Child Welfare System</li> <li>• Members Transitioning from the Justice System</li> <li>• Individuals enrolled in the American Indian Health Program (AIHP)</li> </ul> <p><u>Integrated Care for Adults:</u> DSRIP proposed projects include:</p> <ol style="list-style-type: none"> <li>A. Integration of behavioral health services within primary care sites</li> <li>B. Integration of primary care within community behavioral health sites</li> <li>C. Integration of primary care &amp; behavioral health services within co-located sites.</li> <li>D. Care coordination for adults with behavioral health needs following hospital discharge</li> </ol> <p><u>Integrated Care for Children:</u> Proposed projects include:</p> <ol style="list-style-type: none"> <li>A. Integration of behavioral health services within primary care sites</li> <li>B. Integration of primary care within community behavioral health sites</li> <li>C. Improving treatment for the care of children with and at-risk for Autism Spectrum Disorder</li> <li>D. Improving treatment for the care of children engaged in the child welfare system (at both primary care and behavioral health sites)</li> <li>E. Integration of behavioral health services within primary care sites</li> <li>F. Integration of primary care within community behavioral health sites</li> <li>G. Improving treatment for the care of children with and at-risk for Autism Spectrum Disorder</li> <li>H. Improving treatment for the care of children engaged in the child welfare system (at both primary care and behavioral health sites)</li> </ol> <p><u>Members Transitioning from Justice:</u> Two proposed projects include:</p> <ol style="list-style-type: none"> <li>A. Development of an integrated health care setting within county probation offices or Department of Corrections parole offices to address beneficiary health care needs upon release and throughout the term of probation/parole for individuals transitioning out of incarceration.</li> <li>B. An integrated care project (TBD) for youth transitioning from the juvenile justice system</li> </ol> <p><u>American Indian Health Program (AIHP):</u> Proposed projects include:</p> <ol style="list-style-type: none"> <li>A. Shared care management strategy development via regional collaboratives</li> <li>B. Improvement of care management systems via protocols and structured care plans</li> <li>C. Development of data infrastructure and analytics capability for care management</li> <li>D. Transformation to Patient Centered Medical Homes (PCMH) of primary care sites serving AIHP members</li> </ol> <p><u>DSRIP Required Measures:</u></p> <ul style="list-style-type: none"> <li>• Process measures <ul style="list-style-type: none"> <li>○ Draft measures proposed for DY 1 and 2</li> </ul> </li> <li>• Outcome measures: Is a collaborative effort so measures have not been finalized <ul style="list-style-type: none"> <li>○ “Candidate pool” identified for each project</li> <li>Intent is to align as much as possible with other measure sets, such as CMS core measures, GPRA, PCMH measures, etc.</li> </ul> </li> </ul> <p><u>Preliminary Feedback from CMS:</u> CMS indicated that support for collaborative care management of AIHP members should be structured as payments for services rather than payments for projects. <b>Note:</b> If DSRIP is authorized by CMS, other DSRIP focus areas (i.e. justice transitions, adult and pediatric behavioral health integration) will remain structured as projects</p> <p><u>Potential New Service Payments:</u></p> <ul style="list-style-type: none"> <li>• For the care of AIHP members, provider organizations will be potentially eligible for new care management service payments: <ul style="list-style-type: none"> <li>○ Such service payments would be separate from &amp; in addition to services currently eligible for reimbursement and at current rates (i.e. all-inclusive rate for IHS/Tribal 638 providers)</li> </ul> </li> </ul>
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<p><b>Questions/Answers Comments/Response</b></p>	<ul style="list-style-type: none"> <li>○ New care management service payments for AIHP members will need to be approved by CMS</li> <li>○ The care management service payment methodology will need to be coordinated with: <ul style="list-style-type: none"> <li>▪ Proposed American Indian medical home waiver payments</li> <li>▪ CMS guidance related to care coordination agreements</li> </ul> </li> </ul> <p><u>Timeline:</u></p> <ul style="list-style-type: none"> <li>● The AZ DSRIP proposal was submitted to CMS on July 15 <ul style="list-style-type: none"> <li>○ Comments and suggestions received during the stakeholder process guided the proposal development</li> <li>○ Continued refinement of proposed projects and their core components will occur, based on CMS feedback and stakeholder input</li> </ul> </li> <li>● Based on approval authority from CMS: <ul style="list-style-type: none"> <li>○ DSRIP projects will begin after October 1, 2016</li> <li>○ Care management service/AI medical home payments will begin following CMS review and finalization of a new methodology via a non-DSRIP waiver and/or state plan amendment</li> </ul> </li> </ul> <p><b>Q:</b> “This is a two-part question. Earlier in DSRIP discussions there had been mentioned the possibility of steering committees for stakeholders to participate in further development of the focus areas projects and core components. If AIHP is to be removed from the project methodology and goes to the service payment methodology route, is there still opportunity for such steering committees or workgroups and the second part is, will AHCCCS invite Indian health AHCCCS providers input into the development of the service payment methodology?”</p> <p><b>A:</b> “Yes, we will continue gathering input. Moving forward we will bring back the methodology for review and consultation. This whole process has been and will continue to be stakeholder driven. We are still determining what that path forward will be”.</p> <p><b>C:</b> “With regard to the justice transitions, the Navajo Nation has been working with the U.S. Attorney’s office and U.S. Federal Probations office on a re-entry program called New Path. One of the things we’ve been looking at is if traditional healing is available in federal facilities. There is 30M in grants available for projects. We like to bridge with AHCCCS on the project you’re working on”.</p> <p><b>R:</b> “Thank you for that information. Michel Rudnick leads this particular issue at AHCCCS. We will connect Michal to your project”.</p> <p><b>Q:</b> “Can you provide us any additional insight into discussions with CMS on both the AIHP portion of the DSRIP and the medical home model?”</p> <p><b>A:</b> “We have not heard from CMS on the medical home waiver proposal. The only thing we have received is the preliminary feedback from CMS on AIHP within the DSRIP projects on care management service payments”.</p> <p><b>Q:</b> “Given the quick turnaround time to 10/1, do you anticipate it is possible this will be approved by 10/1?”</p> <p><b>A:</b> “The State’s renewal application has multiple components. We hope that many of the components are approved and authorized by 10/1 but it is possible that some of this will go beyond 10/1. There is a fair amount in AZ’s renewal application and DSRIP is just one part of the application. Also, this is an election year with expected change in administration. Based on CMS’s ability to get to certain things will influence our ability to it done by 10/1”.</p>
<p><b>Draft Policy: Hepatitis C Virus (HCV) Prior Authorization Requirements</b></p>	<p>No presentation on this topic at this time. Awaiting approval from Governor Ducey’s office.</p>

<b>Presentation by Senator Caryle Begay: Addressing Care Coordination Strategies for AHIP</b>	No presentation by Senator Begay at this time. The presentation will be re-scheduled to another tribal consultation meeting.
<b>1:00 p.m.</b>	Meeting Adjourned