AHCCCS
Arizona Health Care Cost Containment System

SIM Sustainability Strategy - Delivery System Reform Incentive Program

Potential Model Project Framework

February 25, 2016

AHCCCS DSRIP Program Design Framework

- Arizona is pursuing a DSRIP to help providers build capacity to succeed under payment reform.
  - Specifically, for the most vulnerable high cost and high need Medicaid beneficiaries.

- Many large health systems, specialty health care, and social service providers have sub-optimal operational relationships. Arizona seeks to fund time-limited projects aimed at building necessary relational infrastructure to improve multi-agency, multi-provider care delivery.

AHCCCS DSRIP Program Design Framework

The DSRIP program will focus on transformative investments for the following populations:

- American Indians, including those served through the tribal delivery system.
- Adults with behavioral health needs.
- Children with autism, children with behavioral health needs, and children engaged in the child welfare system.
- Individuals transitioning from incarceration.

Arizona seeks to ensure that as the delivery system requires accountability and the ability for providers to assume more downside risk for management of population health; these providers also possess care integration infrastructure necessary to successfully meet the needs of these beneficiaries. DSRIP will help provide funding to support transformative investments.

DSRIP Focus

American Indian Health Program (AHIP)

- There is a significant opportunity to improve care for this member population by improving the integration of services between the State's hospitals and its community providers, including those based on and off the reservations.
- Tribal members' health disparities are exacerbated by a fragmented delivery system that is difficult to navigate and provides little in the way of care coordination.
- Providers often have limited to no access to data on other settings in which the members they are seeing also seek care, making coordinated care extremely challenging.
- Potential DSRIP partners are Indian Health Service, tribally owned 638, urban Indian programs (I/T/U) , local hospitals, community providers, tribal regional health authorities (TRBHAs), as well as Care Management Collaboratives (CMCs).

DSRIP Focus

Adults with Behavioral Health Needs

- Adults, other than members living with serious mental illness, receive care through both acute care plans and regional behavioral health authorities (RBHAs), and often find that the medical care, behavioral health care, and social services sectors rarely collaborate in a way that addresses their complex needs.
- A 2015 Government Accountability Office report showed that nationally over half of the Medicaid-only enrollees in the top 5% of expenditures had a mental health condition and one-fifth had a substance use disorder.
- Potential DSRIP partners are hospitals, primary care and specialty providers, community services and support providers, RBHAs, and acute care plans.

DSRIP Focus

Children with Autism, Children with Behavioral Health Needs, and Children engaged in the Child Welfare System

- Arizona is fortunate to have three excellent children's hospitals, however, children with autism, children with behavioral health needs and their families, and children engaged in the child welfare system have found insufficient and inconsistent linkages between community-based health and behavioral care, social service resources, and hospital care.
- Medicaid-enrolled children with behavioral health needs often receive fragmented care from multiple public and community based programs leading to poor health outcomes and costly utilization.
- A 2013 report[1] recommended that efforts be made to improve care coordination for these children, including through collaboration between child-serving systems, especially the child welfare, behavioral health, and primary care systems.
- Potential DSRIP partners are children hospitals, primary care and specialty providers, community services and support providers, RBHAs, and acute care plans.

[1] Examining Children's Behavioral Health Service Utilization and Expenditures Center for Health Care Strategies, Inc. Hamilton, NJ December 2013

DSRIP Focus

Individuals Transitioning from Incarceration

- Approximately 42,000 individuals transition from incarceration to AHCCCS every year. National research has found that 80% of released individuals have chronic medical, psychiatric, or substance abuse issues, yet only 15% to 25% report visiting a physician outside of the emergency department in the first year post release.
- There is often little care coordination between prison and jails and community health systems.
- Individuals leaving prison or jail may not fully understand the scope of Medicaid benefits available to them or how to appropriately access the system.
- This population is likely to need a higher, more intense level of care coordination by providers as they are settled in the community.
- Potential DSRIP partners are hospitals, primary care and specialty providers, community services providers, substance abuse providers, mental health providers, RBHAs, and acute care plans.

DSRIP Program Structure Nationally

Providers

- States determine qualifications for participation in their DSRIP programs subject to the Centers for Medicare and Medicaid Services (CMS) approval. In recent approvals, CMS has focused on providers working as systems to deliver higher quality care producing lower health care costs and better outcomes for members.
- Providers select their partners to support the transformation by working together as DSRIP entities to select projects, develop project plans, and submit project applications for approval to the state.
- DSRIP entities select “lead” entities to manage the DSRIP process. Entities can includes partners, members, and network participants.
- DSRIP entities must have partners that can effectively deliver core services to target populations attributed to the entities.

DSRIP Program Structure Nationally

Projects

- States develop projects in support of overarching transformational goals. Projects include core components that must be addressed as part of DSRIP the project. DSRIP entities design their specific approach to achieve project implementation within the project parameters.
- Project strategies must include care coordination, data analytics, and data exchange strategies. It is important to remember that projects are implemented over the five year period of the waiver and all elements are not required to be in place at the beginning of the project period.
- Generally, DSRIP entities must select a minimum number of projects.
- DSRIP entities develop strategies to measure required metrics and report those metrics to the state to support incentive payments.

DSRIP Program Structure Nationally

Metrics

- Metrics are standardized for specific projects. Regardless of the structure of the project, all metrics can be compared across projects and DSRIP entities.
- Metrics are developed across a variety of critical components and progress from process and reporting to clinical outcome measures.
- Payments are tied to metric achievement.

Payments

- Payments are developed to be tied to value of the project, but not the cost of the transformation strategy.
- Payments are developed to incentivize projects investment.
- Payments can be made to DSRIP entities which develop payments distribution structures to partner and member entities.
- Recent approvals have tied metric reporting and payments to population attribution strategies across DSRIP entities.

AHCCCS DSRIP

Providers

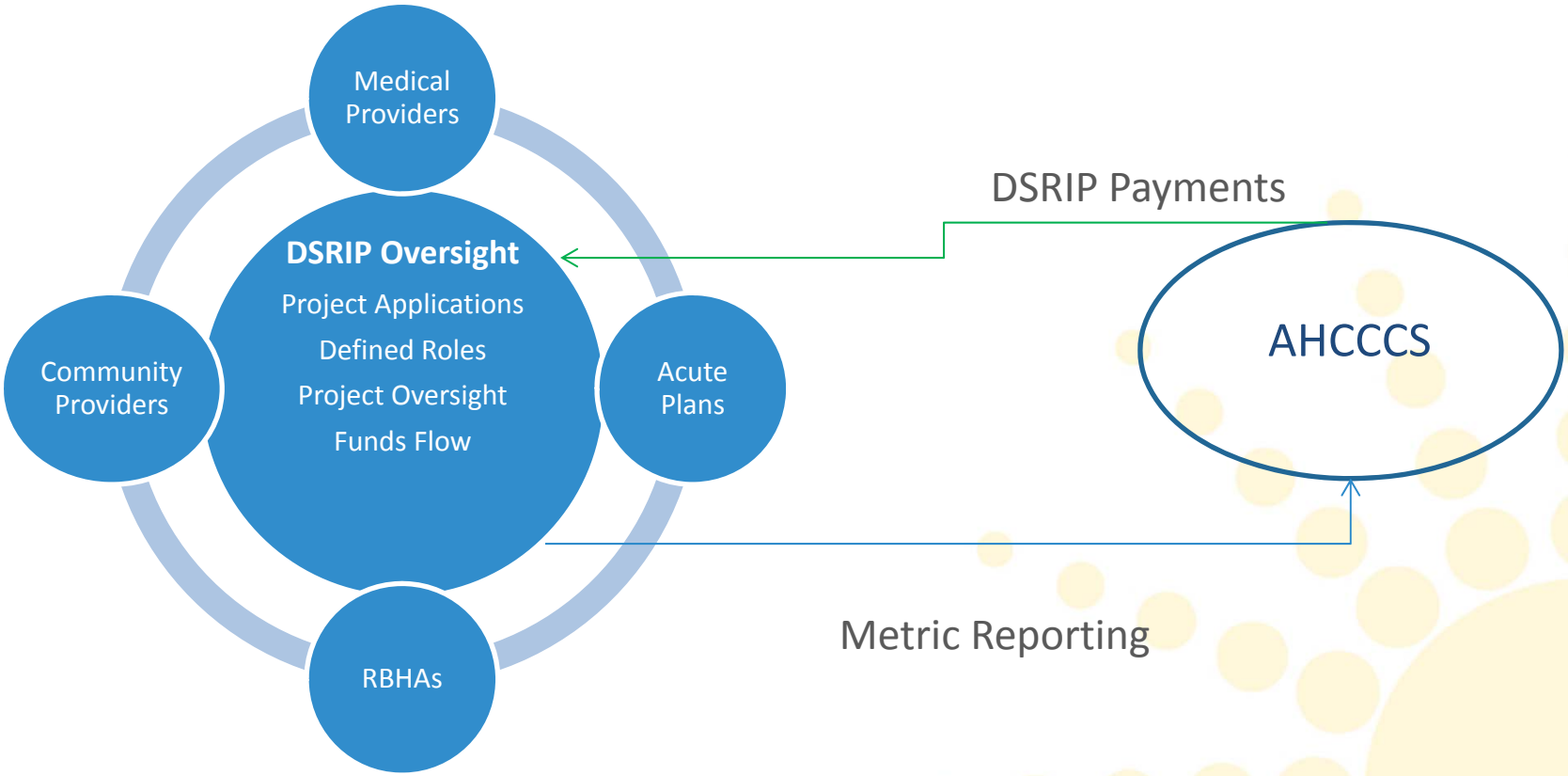
- Create a network of providers — health care, behavioral health care, and social services, as appropriate, to the selected projects. Governance parameters have not been fully developed.
- Develop formal integration agreements and implement care planning and coordination processes for its DSRIP target population and all other high cost, high need AHCCCS members.
- Select a lead provider that will receive DSRIP payments and distribute them among its DSRIP network consistent with an AHCCCS-approved approach.
- Include AHCCCS contracted plans operating in the DSRIP provider entity's market to participate as a member of the DSRIP provider entity, although not to receive DSRIP funding.
- Provider organizations will have the opportunity to participate as a member of multiple DSRIP provider entities.
- Participate in the AHCCCS DSRIP learning collaborative.

AHCCCS DSRIP

Role of Managed Care Organizations

- AHCCCS contracted plans are the foundation for Arizona's management of its Medicaid program. As a result, AHCCCS intends these partners play an active role in the DSRIP provider entities' work.
- AHCCCS intends to leverage its managed care infrastructure to make DSRIP a success. Contracted plans will provide the DSRIP provider entities with analytic support to inform their strategy development and implementation
- Play a substantive role in each DSRIP project including participation in joint planning and implementation of care coordination protocols and activities. Contracted plans must be part of the DSRIP entity infrastructure such as memorandum of understandings (MOUs) or other organizational agreements to implement DSRIP.

DSRIP Entities



AHCCCS DSRIP Projects

Projects

Selected DSRIP provider applicants will be required to select a minimum number of projects to be determined.

AHCCCS will develop detailed information on projects as part of the DSRIP development, but will negotiate with CMS throughout the approval and likely the post-approval process.

Population attribution methodology to DSRIP entities has not been fully designed.

The following slides illustrate examples of projects within the four targeted populations. These projects, core components, and metrics are *not* final but are representative of the level of detail that will be needed to effectively define the projects.

Adults with Behavioral Health Needs

Purpose: There is a need for a comprehensive approach to integrated care (physical and behavioral health) in any care setting in which an AHCCCS member may receive either physical or behavioral health services (for example, from a primary care provider, community behavioral health provider) to better address mental and physical health and addiction disorders.

DSRIP Entity Composition:

- Hospitals, primary care and specialty providers, community behavioral health, community support services, RBHAs, health plans, and AzHeC.
- Providers organize to support care coordination, implementation of clinical protocols, data analytics, development, and support of DSRIP projects.
- AHCCCS contracted plans are required participants in structural/organization constructs for DSRIP entities.

Adults with Behavioral Health Needs

Project #1: Integration of primary care and behavioral health services (primary care site)

Integrate behavioral health services (some of which are paid for by RBHAs) into the primary care site. This project would include individuals living with serious mental illness enrolled in an integrated RBHA and individuals with general mental health and/or substance abuse (GMH/SA) issues receiving services from both the RBHA and the assigned acute care health plan.

Core Components

- Develop a practice-specific course of action for integration by adopting and utilizing an evidence-based practice assessment and integration toolkit.
- Develop expectations and processes for routine screening for behavioral health conditions, including procedures for intervention or referrals as the result of a positive screening.

Adults with Behavioral Health Needs

Core Components

- Develop and implement processes for obtaining information from acute plans, RBHAs and the health information exchanges (HIE) to identify practice members with patterns of frequent emergency department (ED) and inpatient use for behavioral health conditions, and engaging those members with high ED use to come to the practice or their principle behavioral health provider in lieu of an ED visit when appropriate.
- Facilitative support from acute plans and RBHAs, enhance relationships with behavioral health providers in their community by establishing:
  - An agreed-upon practice for regular communication and provider-to-provider consultation, and
  - Team-based protocols for referrals, crisis, information sharing and obtaining consent.

Adults with Behavioral Health Needs

Core Components

- Implement the use of integrated treatment plans to be coordinated by a clinical care manager. Integrated treatment planning includes identifying the highest risk members, conducting an intake assessment that will identify problems, risk drivers and barriers to care, and includes assessing physical, functional, cognitive and psychological status, medical history, medication history, use of support systems and transportation issues.
- Integrate clinical functions with behavioral health providers by ensuring same-day availability for a behavioral health visit at the time of a physical health visit and integrating chart notes.
- 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.

Adults with Behavioral Health Needs

Core Components

- 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:
  - Identifying the resources in the community, and
  - Creating protocols of when to engage or refer members to these community-based resources.
- Participate in DSRIP training and education to understand the unique needs of persons with SMI and to mitigate stigma associated with mental illness and substance use disorders.
- Utilize e-prescribing for Class 2 controlled substances.

Adults with Behavioral Health Needs

Project #2: Integration of primary care and behavioral health services (behavioral health care site)

Integrate primary care services into the behavioral health site for the purposes of better care coordination of the preventive and chronic illness for complex members including members living with serious mental illness.

Core Components

- Develop a provider-specific course of action for integration by utilizing an evidence-based practice assessment and integration toolkit.
- Develop and implement processes for obtaining information from RBHAs, acute plans, and the HIE to identify practice members with patterns of frequent ED and inpatient use for behavioral health conditions, and engaging those members with high ED use to come to the practice in lieu of an ED visit when appropriate.

Adults with Behavioral Health Needs

Core Components

- Facilitative support from RBHAs and acute plans, enhance relationships with primary care providers in their community by establishing:
  - An agreed-upon practice for regular communication and provider-to-provider consultation, and
  - Protocols for referrals, crisis, information sharing, and obtaining consent.
- Develop expectations and processes for routine screening for medical conditions, including procedures for intervention or referrals as the result of a positive screening. Referrals to primary care providers should be consistent with protocols established in the first core component. Screening must be done for tobacco use, body mass index (BMI), and for common chronic conditions in the behavioral health provider's population, for example, asthma, diabetes, and cardiovascular conditions.

Adults with Behavioral Health Needs

Core Components

- Implement the use of integrated treatment plans to be coordinated by a clinical care manager.
  - Integrated treatment planning includes identifying the highest risk members, conducting an intake assessment that will identify problems, risk drivers and barriers to care, and includes assessing physical, functional, cognitive and psychological status, medical history, medication history, use of support systems and transportation issues.
- Integrate clinical functions with primary care providers by ensuring same-day availability for a primary care visit at the time of a behavioral health visit and integrating chart notes.
- Enhance EHR capabilities between physical health providers and behavioral health providers to support coordination, foster efficient clinical practice, and reduce administrative duplication.
- Develop protocols with local hospitals to provide appropriate post-discharge follow-up for empaneled members.

Adults with Behavioral Health Needs

Project #3: Integration of primary care and behavioral health services (co-located care site)

To achieve maximum impact from integration of primary care and behavioral health services to realize the potentials and maximize the impact of service co-location to better address mental and physical health and addiction disorders.

Core Components

- Develop a provider-specific course of action for integration by utilizing an evidence-based practice assessment and integration toolkit, and demonstrate improved integration over time relative to baseline unless the baseline score exceeds a threshold for best practice integration.
- Develop and implement processes for obtaining information from acute plans, RBHAs, and the HIE to identify practice members with patterns of frequent ED and inpatient use for behavioral health conditions, and engaging those members with high ED use to come to the practice in lieu of an ED visit when appropriate.

Adults with Behavioral Health Needs

Core Components

- Develop expectations and processes for routine primary care screening for behavioral health conditions, including procedures for intervention or referrals as the result of a positive screening.
  - Potential tools to employ include:
    - The Patient Health Questionnaire (PHQ-2 and PHQ-9) for depression,
    - CAGE-AID for drug and alcohol use,
    - GAD-7 for generalized anxiety disorder.
  - For a partial list of screening tools, see www.integration.samhsa.gov/clinical-practice/screening-tools.

Adults with Behavioral Health Needs

Core Components

- Implement the use of integrated treatment plans.
  - Integrated treatment planning includes identifying the highest risk members, conducting an intake assessment that will identify problems, risk drivers and barriers to care, and includes assessing physical, functional, cognitive and psychological status, medical history, medication history, use of support systems and transportation issues.
- Integrate clinical functions by ensuring 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.
- Develop protocols with local hospitals to provide appropriate post-discharge follow-up for empaneled members.
- Utilize e-prescribing for Class 2 controlled substances.

Adults with Behavioral Health Needs

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

To more effectively coordinate the care for adults with behavioral health conditions who are being discharged from an inpatient behavioral health stay (Consider including physical health stays, that is, members being discharged who have diagnosed behavioral health conditions).

Core Components

- Develop protocols with high-volume community behavioral health providers and primary care providers for communication, consultation, medical record sharing, and medication reconciliation.
  - Including protocols that allow for the outpatient providers to give input into health history of the member and for hand-off of care from inpatient to outpatient, including on weekends.

Adults with Behavioral Health Needs

Core Components

- Develop protocols with RBHAs to communicate identified member-specific social and economic determinants of health 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.
- Provide direct medication management support and education to members by providing at least a 30-day medication supply (for non-narcotic prescription drugs) for discharged members, reconciling medications received in the hospital to what may be taken (or available) at home, and provide education on how and when to take the medications.

Adults with Behavioral Health Needs

Core Components

- With input from the member, schedule follow-up appointments with the member's community behavioral health provider(s) and primary care provider. Provide a discharge summary to the primary care provider and community behavioral health provider within 24 hours of discharge, which includes medication, treatment plan for follow-up testing, or for any physical or behavioral health needs.
- Follow-up with the member within two days of discharge to help with any problems related to transitioning care for his/her condition to the community.
- Coordination of member records (EHR) between hospitals and community providers.

Adults with Behavioral Health Needs

Goals and Metrics (examples from other states)

Organization	a. Signed Agreements or MOUs with Providers b. Protocols for Referrals c. Protocol for Information Exchange d. Shared Training Protocols
Clinical Improvement	a. Use of behavioral health screens, including PHQ-9, CAGE-AID, AUDIT, GAD-7, DAST-10, and/or another screening tool specific to the needs of the population served b. Use of physical health screening tools, including for tobacco use, BMI and common chronic conditions in the practice (e.g., diabetes, cardiovascular conditions). c. Completion of discharge summary within 24 hours d. Follow-up after hospitalization within 2, 7 and 30 days
Outcomes	a. ED visits b. Statin use by members with diabetes and cardiovascular conditions c. Hospital behavioral health readmissions within 30 days
Integration	a. Measures to be identified from the Atlas of Integrated Behavioral Health Care Quality Measures

Adults Transitioning from Incarceration

Purpose: The aim of the following projects is to facilitate better provider, community, and justice system coordination to create a care coordination strategy specifically tailored for individuals transitioning from incarceration into the community that addresses their mental health, physical health, and addiction disorder needs.

DSRIP Entity Composition:

- AHCCCS contracted plans, hospitals, primary care and specialty providers, community behavioral health, community support services, county justice system, state justice system, RBHAs, and AzHeC.
- Providers organize to support care coordination, access to care, implementation of clinical protocols, community support services, data analytics, development, and support of DSRIP projects.
- AHCCCS contracted plans are required participants and would be organizing entities in coordination with a lead medical provider to form DSRIP entities.

Adults Transitioning from Incarceration

Projects associated with this targeted population are still under development. Project areas of focus include:

- Ensuring smooth transitions into community providers.
- Development of additional social support networks and infrastructure to support high cost/high need enrollees.
- Provider strategies to increase peer support and community health workers.
- Strategies to increase provider capacity to serve this population.

Children with Autism, Children with Behavioral Health Needs, and Children Engaged in the Child Welfare System

Purpose: There is a need to facilitate better coordination between providers for children with behavioral health needs, autism, and children engaged in the child welfare system. Their families have found insufficient and inconsistent linkages between community-based health and behavioral care, social service resources, and hospital care that causes frustration and sub-optimal care delivery.

DSRIP Entity Composition:

- Children's Hospitals, primary care and specialty providers, community behavioral health, community support services, RBHAs, health plans, and AzHeC (similar to adult behavioral health DSRIP entities).
- Providers organize to support care coordination, implementation of clinical protocols, data analytics, development, and support of DSRIP projects.
- AHCCCS contracted plans are required participants in structural/organization constructs for DSRIP entities.

Children with Autism, Children with Behavioral Health Needs and Children Engaged in the Child Welfare System

Projects #1: Care Coordination focusing on children with autism.

Core Components - Under development.

Project #2: Integration of Behavioral Health and Physical Health for high cost/high need children.

Core Components - Under development.

Project #3: Care Coordination focusing on Children Engaged in the Child Welfare System

Core Components - Under development.

Next Steps

Refine draft DSRIP model over the next several weeks. Feedback is sought in the following areas:

- Are there high need/high cost populations that we missed?
- Are there core components or key providers that should be included?
- Are there data/metrics that correlate strongly with the target areas that can be incorporated to measure success? Data elements to avoid?
- Are there projects that could be included to support the program goals – particularly for:
  - Individuals Transitioning from Incarceration
  - Children with Autism, Behavioral Health Needs, and Children Engaged in the Child Welfare System
- Comments on proposed DSRIP entities or payments?

Next Steps

AHCCCS would appreciate any feedback in writing. Comments and ideas should be sent by March 16, 2016 to George Jacobson, George.Jacobson@azahcccs.gov

AHCCCS is meeting with tribal leadership next week to discuss the program.

AHCCCS plans to meet with CMS in early April to present the DSRIP concept and to determine if the program is approvable and what, if any, changes are needed for final submission as part of the 1115 waiver renewal.

A follow-up meeting with stakeholders will be held after the meeting with CMS.

Questions?

Thank You.