AHCCCS
Arizona Health Care Cost Containment System

AHCCCS Update

SIM Sustainability
Delivery System Reform Incentive Payment - DSRIP

Arizona State Innovation Model Vision

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

SIM Strategies

Focus on Complex High Needs High Cost members

1. Physical Health/Behavioral Health Integration
2. Justice System Transitions
3. American Indian Members

Leverage Value Based Payments

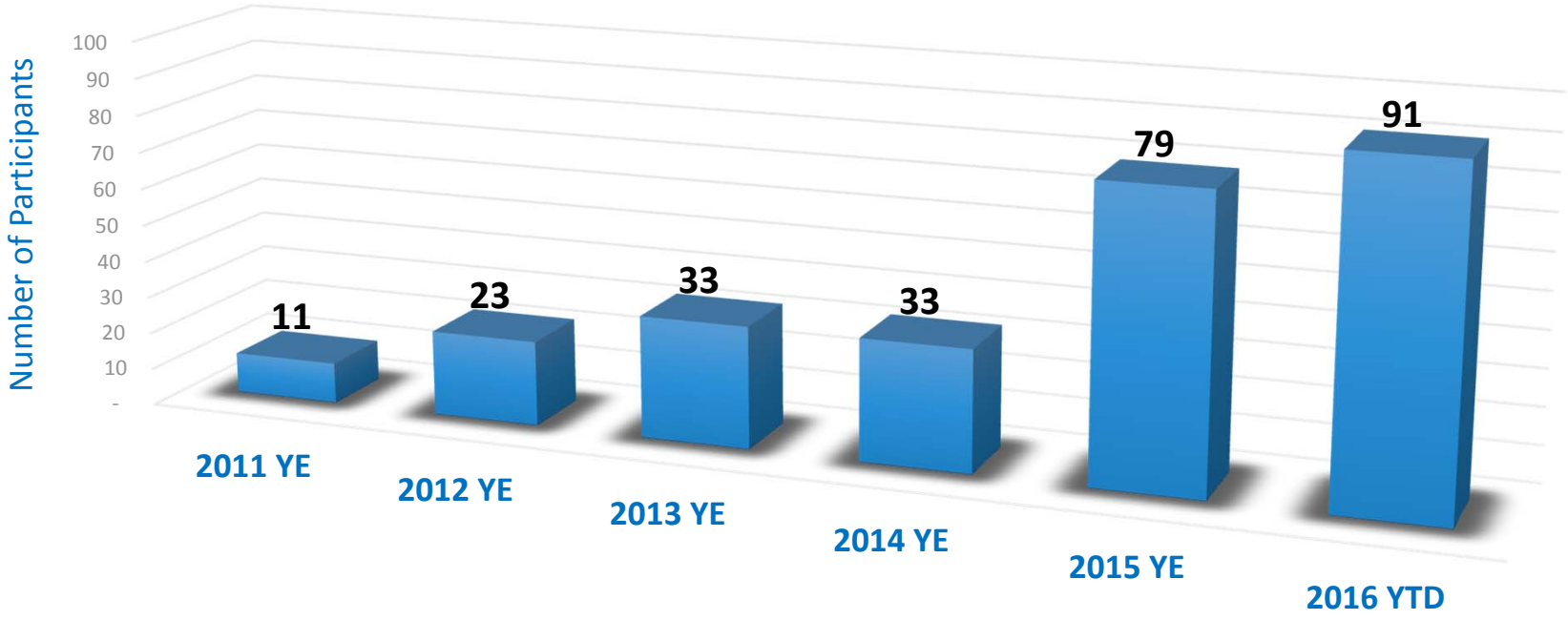
Leverage HIE and Data sharing

DSRIP now seen as vehicle to leverage Medicaid Venture Capital

Arizona's Application

- Arizona's application for a new 5-year waiver includes:
  - Part I: Governor Ducey's vision to modernize Medicaid: The AHCCCS CARE program
  - Part II: The Legislative Partnership
  - Part III: DSRIP: Arizona's Approach
  - Part IV: HCBS Final Rule
  - Part V: American Indian Medical Home
  - Part VI: Building Upon Past Successes
  - Part VII: Safety Net Care Pool

The Network – Growth
All Participants



88% of the 2015/2016 growth occurred after the implementation of the new HIE Infrastructure.

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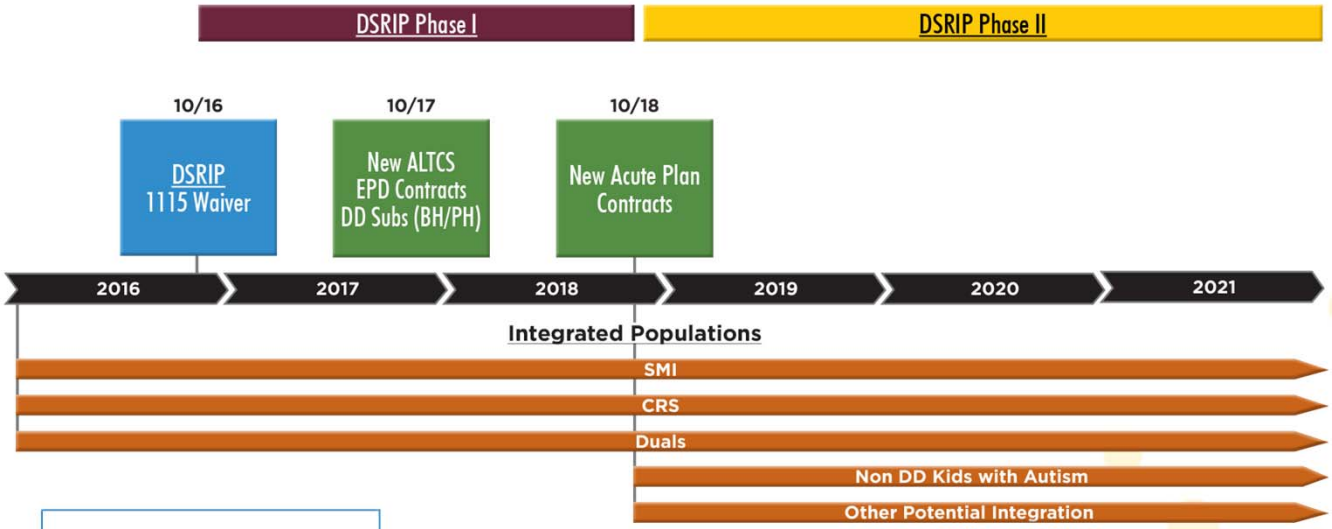
Summary of State DSRIP Programs

State	Current Federal Match	Approximate Maximum Federal Funding	Approximate Maximum State and Federal Funding	Number of Participating Providers
California	50%	$3,336,000,000	$6,671,000,000	21
Texas	58.05%	$6,646,000,000	$11,418,000,000	309 providers (organized into 20 RHPs)
Massachusetts	50%	$659,000,000	$1,318,000,000	7
New Mexico	69.65%	$21,000,000	$29,000,000	29
New Jersey	50%	$292,000,000	$583,000,000	50
Kansas	56.63%	$34,000,000	$60,000,000	2
New York	50%	$6,419,000,000	$12,837,000,000	64,099 estimated providers (organized into25 PPSs)
Oregon	64.06%	$191,000,000	$300,000,000	28
TOTAL		**$17,598,000,000**	**$32,216,000,000**	

DSRIP Timeline



MCO ROLE

- Establish Network
  - Providers Required
  - Provider Competencies
  - Care Managment Protocols
- How Providers Work Together
- Tie APMs to Value
- Drive Members to Value
- Care Management
  - Identification of complex/HNHC
  - Transitions (EX: Justice)
  - Data/Analytics
  - Infrastructure (Staff, Systems)

DSRIP Phase I

- SMI/RHBA
- AI/AN
- Behavioral Health Readiness/ HIT
- Kids
  - Autism
  - CRS
  - Foster

DSRIP Phase II

- MCOs Form DSRIP Entities Based on Provider Network Requirements Serving Broader Populations

DSRIP Projects

1. American Indian Care Management Collaborative
2. Physical Health - Behavioral Health integration
    a. Adults
    b. Children
3. Justice System Transitions

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.

CMC DSRIP

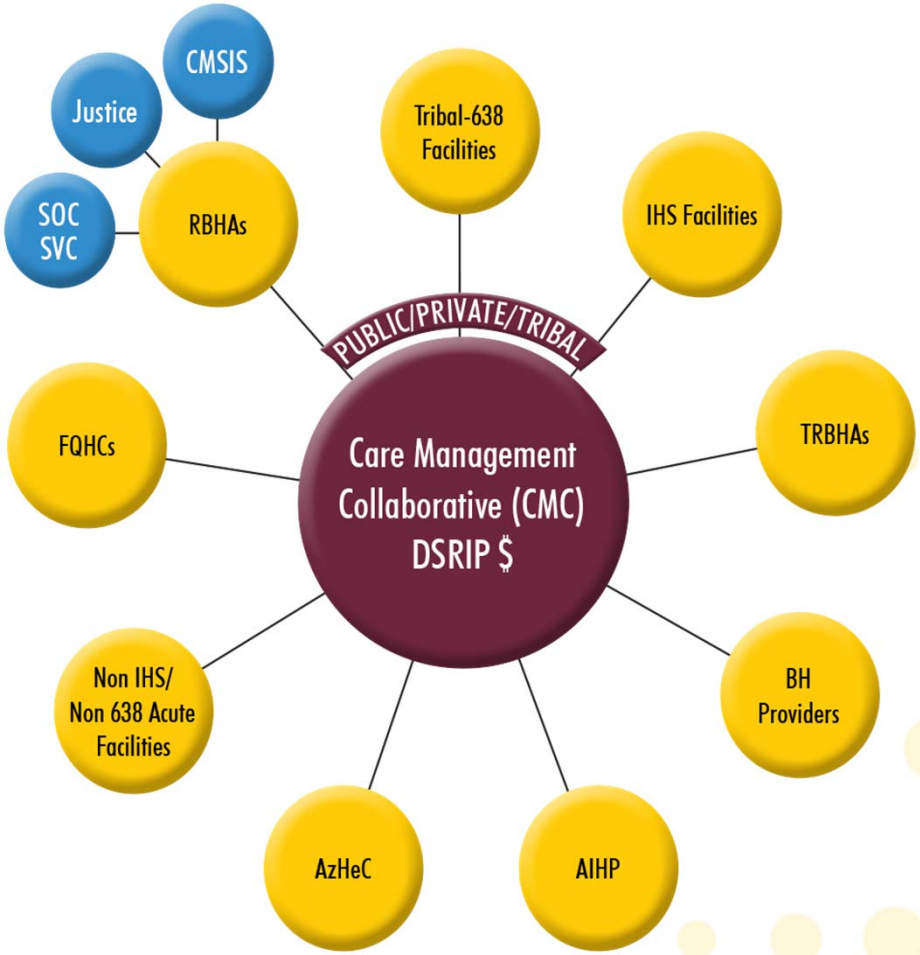
American Indian Health Program

- 120,000 Americans Enrolled in FFS – one-third of Arizona American Indian population
- $1 billion per year - $650 m tribal providers
- Limited care management infrastructure – compared to MCO capacity – staffing and payment
- Vast geography – majority of members in 3 counties – Coconino – Apache – Navajo – 33,638 square miles – 2 MA and Maryland
- Healthcare disparities – American Indians 4 times more likely to die from diabetes than non-American Indians AZ

Care Management vs Care Coordination

- Care Management activities are person-focused, ensuring individuals at high risk get care and services they need
- Care Coordination activities are system-focused, ensuring that care is seamless and consistent across providers and transitions.

AIHP DSRIP Framework



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

CMC DSRIP Proposal

Create 3 Regional Care Management Collaboratives

- CMCs will have centralized data analytics and care management platform to support providers with complex members
- CMCs will have limited staffing
- CMC Steering Committees
  - Track Progress of CMC in meeting goals
  - Identify ways to improve support for providers
  - Track progress of providers in CMC

CMC DSRIP Aligns with Medical Home Waiver

- 1115 waiver proposal includes Medical Home waiver which would pay a PMPM to qualifying facilities
- Current tribal workgroup is working to update formal proposal
- DSRIP is focused on building care coordination and care management across system (tribal and non-tribal providers)
- Medical Home waiver is focused on building internal facility capacity

CMC DSRIP Proposal

- Funding targeted towards High Volume providers
- Would be available to limited number of providers
- Would include limited number of non-tribal providers
- Vast majority of funding targeted to Tribal providers (I.H.S – 638 – Urban Clinics)
- Would include both PH and BH Providers
- Requesting 100% federal participation
- Funding would also help support CMC Infrastructure
- Funding would complement Medical Home Waiver

CMC DSRIP Projects

Project 1 – Care Management Collaboration Formation

1. Join CMC through executing MOU – One Time Payment
2. Regularly participate in CMC meetings with appropriate staff – ongoing

CMC DSRIP Projects

Project 2 – Care Management Execution

1. Regular Care Management staffings of memebers with CMC and other providers as appropriate – ongoing
2. Establishment and Maintain Attribution Model for Complex Members – ongoing
3. Complex Member Engagement – Transition to Medical Home Waiver PMPM - onetime
4. Establish and Execute Transition Planning for IP – Justice System - Crisis - ongoing

CMC DSRIP Projects

Project 3 Data Infrastructure

1. Tribal Providers submit more robust claim detail – onetime
2. Dedicated support of CMC Data analytics tools - ongoing
3. Ability to identify complex members hitting internal/external delivery system - ongoing
4. AZHEC Connectivity – receive data – push data- onetime
5. Register and use CSPMP - ongoing

CMC DSRIP Projects

Potential Project #4 – Justice System Transitions – CMC and providers partner on strategies to engage members involved in justice system transitions

1. CMC works with Justice system on transition Treatment plan
2. CMC works with providers on appt availability
3. CMC works with providers on services needed as part of transition – meds etc..
4. CMC works with providers on peer services
5. CMC and providers partner on training for staff
6. CMC and providers partner with justice system on data transitions

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.

DSRIP Requires Measures for Projects

Metrics

- Avoidable ED – PH and BH
- Avoidable Re-hospitalization – PH and BH
- Follow-up hospitalization for Mental Illness
- Antidepressant Medication
- Utilization of Primary Care Services
- Movement to some differential Value Based Payment

DSRIP State Match

Source of Non-Federal Share

State	State General Revenue	Provider Taxes	IGTs from Public Entities	DSHP	Entities Supplying Non-Federal Share Dollars
California			√		Designated public hospitals
Texas			√		Public hospitals, local government
Massachusetts	√		√		State for private hospitals, public hospital self-funded
New Mexico	√		√		State for private hospitals, public hospital self-funded
New Jersey	√				State
Kansas			√		Public hospitals
New York			√	√	Mostly public hospitals, supplemented by some state (DSHP)
Oregon		√			Hospitals

State Match Options

1. Current IGTs – DSH and GME
    1. Univ. of Arizona
    2. MIHS
    3. City of Tucson/Pima County
    4. Northern Cochise Hospital District
    5. Mohave County Hosp. District
    6. Mount Graham Hosp. District
    7. City of Tempe

Designated State Health Programs

1. Tobacco Cessation - $17m voter protected
2. First Things First - $20m voter protected
3. State Only non-TXIX BH - SAMSHA MOE
4. DES/DHS State only spending
5. County public health spending

Issues for Consideration

1. Are these the right projects?
2. Does a regional approach make sense?
3. Are there providers/stakeholders missing?

Next Steps

- First Week March - Region Meetings
- March 17th – Hope to meet with Medical Home tribal workgroup
- End of March – Tribal Consultation
- Early April – review DSRIP concepts with CMS
- End of April – early May – post DSRIP waiver for public comment

Thank You.