## Learning Collaborative

Providers will participate in a learning collaborative related to the DSRIP projects. The learning collaborative will be designed to promote the following objectives:

- Encouraging the principle of continuous quality improvement
- Collaborating based on shared ability and experience
- Sharing DSRIP project development including data, challenges, and best practices

# PART IV

## Home and Community Based Services (HCBS) Final Rule:

### Arizona's Assessment and Transition Plan

Arizona's successful Home and Community Based Services program for persons enrolled in the Arizona Long Term Care System (ALTCS) has had a long history as part of the State's 1115 Waiver. To conform with the final rule that defines HCBS qualifying settings, Arizona conducted an assessment of its settings, as well as a draft transition plan. Extensive stakeholder meetings and public forums have already been held to seek input and engage in dialogue around the state's Assessment and Transition Plan.

Due to the length of the Assessment and Transition Plan, it will be incorporated by reference here. All materials, including the Assessment and Transition Plan, the schedule of community forums, the presentation that is being reviewed at the forums and other materials can be found on the AHCCCS website at: http://www.azahcccs.gov/hcbs/default.aspx.

# PART V

## The American Indian Medical Home

### Supporting Arizona's Commitment to Addressing Health Care Disparities for American Indians/Alaska Natives

## Overview

AHCCCS administers Medicaid to over 1.7 million members through a mandatory managed care delivery system. This system operates managed care insurance programs that establish each member with a Primary Care Physician (PCP) upon enrollment. Case management is provided as an administrative service to those members identified by their health plan to require care coordination or assistance in managing a chronic illness. Health plans also offer call lines staffed by medical professionals as an administrative service.

The AHCCCS model requires every Medicaid beneficiary to enroll with a managed care organization (MCO). The only exception to this requirement is for the American Indian/Alaska Native (AI/AN) population, which has the option of enrolling with an MCO or receiving services in the AHCCCS fee-for-service (FFS) program, known as the American Indian Health Program (AIHP). American Indians and Alaska Natives who enroll in the American Indian Health Program receive their care largely through Indian Health Services (IHS) facilities and Tribal facilities operated under Public Law (PL) 93-638. IHS and Tribal facilities do not have the administrative dollars to support case management functions or call lines to assist members in coordinating their care. The clinical leadership of IHS recognizes that fundamental changes in their system are required in this time of fewer resources and health reform.

The IHS Improving Patient Care (IPC) program goal is to engage IHS, Tribal, and Urban Indian health programs to improve the quality of, and access to, care for AI/AN members through the development of a system of care called the Indian Health Medical Home Program (IHMHP). The IPC program is focusing on patient-and-family-centered care while ensuring access to primary care for all AI/AN people. High-quality care will be delivered by health care teams who will be making sustainable and measurable improvements in care. Medicaid is IHS' biggest payor/partner. Therefore, AHCCCS would like to align its efforts in Arizona with the efforts being made by IHS and the federal government to modernize and improve the health care delivery system for the AI/AN population.

The most recent U.S. Census figures state the AI/AN population is approximately 350,000 in Arizona.[1] Almost half of the AI/AN population in Arizona is enrolled in AHCCCS, and approximately 75 percent of AI/AN AHCCCS members are enrolled in the American Indian Health Program. Significant health disparities exist between the AI/AN population and the general population of Arizona, including the average age of death (17.5 years lower for American Indians), and higher death rates from many preventable diseases. AHCCCS proposes an IHMHP that aligns with the IPC program in order to address some of these disparities and to support the ability of IHS, Tribal, and Urban Indian health programs, as well as non-IHS facilities with high AI/AN patient volumes, to better manage the care for American Indians and Alaska Natives enrolled in the American Indian Health Program.

Accordingly, to accomplish these goals AHCCCS seeks the following authority:

- Comparability - Waiver from §1902(a)(10)(B) and corresponding regulations at 42 CFR §§440.240, to allow the State to provide services that support a medical home for AI/AN members enrolled in FFS who receive services provided through the IHS and Tribal facilities. These services are Primary Care Case Management, diabetes education, after-hospital care coordination and 24-hour call lines staffed by medical professionals.

[1] Current tribal enrollment numbers collected by survey taken by AHCCCS estimate the AI/AN population in Arizona to be approximately 443,000.

- **Reimbursement CNOM-** Expenditure authority to allow the State to pay for services that support a medical home for AI/AN members enrolled in FFS who receive services provided through the IHS and Tribal facilities. Expenditure authority to allow the State to pay non-IHS/Tribal facilities a shared savings payment to support the Indian Health Medical Home Program.

## Developing the American Indian Medical Home through Consultation

Originally, this concept was proposed and brought to AHCCCS by the Tucson Area IHS. Verbal notification on the development of this proposal as well as notification that a future consultation meeting would be held to further discuss this topic was provided at an AHCCCS Consultation Meeting with Tribes and IHS, Tribal, and Urban Indian health programs (I/T/U) on March 31, 2011.

AHCCCS also obtained information related to medical home activities from the Navajo Area IHS, Phoenix Area IHS, Tucson Area IHS, and certain Tribal Facilities. This information was used in the development of the first waiver proposal. AHCCCS formally consulted with tribes and I/T/Us in Arizona on the components of the original waiver proposal in accordance with the AHCCCS Tribal Consultation Policy and Medicaid State Plan on August 4, 2011. The amendment was also placed on the AHCCCS website for public comment around that time.

Since then, AHCCCS has embarked upon a Tribal Care Coordination effort of its own. AHCCCS revised this proposal to align this amendment with the IPC and AHCCCS Tribal Care Coordination efforts. The AHCCCS Tribal Care Coordination initiative strives to improve the quality of care for its members by increasing the efficiency of the multiple systems of care in which members can access services. While there are various care coordination models being implemented across the nation, as well as here in Arizona, AHCCCS adopted the Indian Health Service's IPC Care Model to avoid creating duplication in the system and confusion amongst the various efforts being implemented to improve the care for AI/AN members. Furthermore, the Agency recognizes the importance of promoting a shared message in working toward a common goal — improve the quality, connectivity, and accessibility of care in the American Indian healthcare delivery system. AHCCCS works toward that goal in its role as a facilitator of data exchange to inform providers of utilization trends among members empaneled to them. As a major payor, AHCCCS provides this data so that the medical home can develop interventions that will assist patients empaneled to them to better manage their health. I/T/Us, however, need additional resources to build their capacity to act as medical homes that can be held accountable for reducing emergency department utilization, admissions or readmissions, and improve outcomes.

Anticipated updates to the draft proposal were presented verbally at tribal consultation on August 15, 2013. AHCCCS has also posted the revision to its website for public comment. The revised amendment was also presented to the State Medicaid Advisory Committee on April 9, 2014. Subsequently, representatives from the three IHS Area offices made

revisions to the proposal for consideration requiring additional review. These revisions have been incorporated here and will be presented for comment at the tribal consultation in August 21, 2015.

Arizona expects that the oversight and payment for IHMHP service delivery will necessitate close working relationships between the State and the IHS, Tribal, Urban Indian health program, and non-IHS facilities with AI/AN patient volumes greater than 30%, and that this process will enhance collaboration toward similar goals of reducing health disparities and delivering cost-effective care.

## Provider Payments

The American Indian Health Program has worked in conjunction with tribes and IHS facilities to determine the cost of delivering an IHMHP, which would reimburse for Primary Care Case Management, a 24-hour call line and care coordination. In order to simplify claiming and payment, AHCCCS has elected not to offer a tiered payment structure, but to combine requirements and payment into one flat rate. The American Indian Health Program cost data from IHS and tribal facilities in Arizona were evaluated to determine a PMPM payment of $13.26 with an annual increase of 4.6%, which is based upon the average annual increase of the outpatient all-inclusive rate over the past ten years. For approved medical homes providing diabetes education pursuant to guidelines established within that model and herein, an additional $2.00 PMPM will be available.

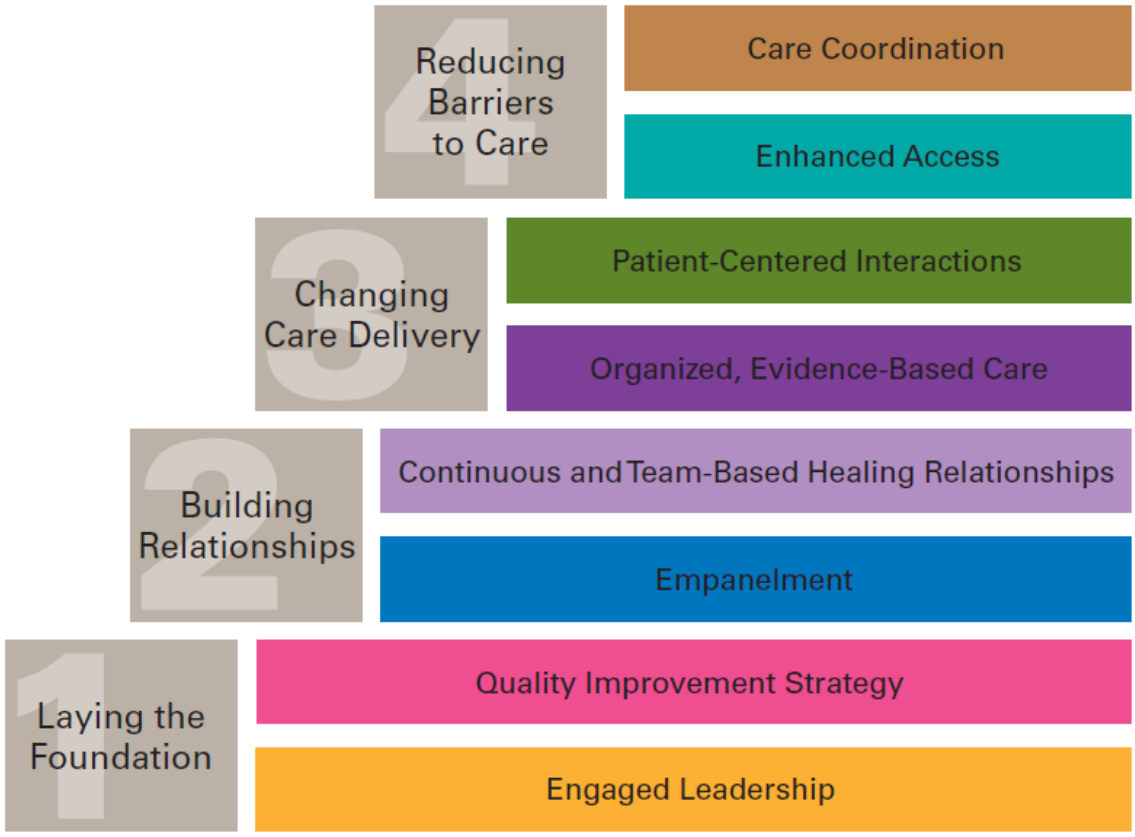
The medical home services for which AHCCCS proposes to reimburse are currently not reimbursed through the all-inclusive rate and will therefore be billable by IHS and Tribal facilities only on a monthly basis to AHCCCS. PMPM payments will be made with 100% FFP dollars and will only be available for IHS and tribally operated 638 facilities for FFS members in order to avoid duplicative payment. Facilities will be required to submit an IHMHP claim for each member that is empanelled in their medical home on a monthly basis. Empanelment will be determined by AHCCCS based on the criteria discussed below.

## Overview of Medical Home Criteria Development

IHS and Tribal facilities may choose whether or not to provide an Indian Health Medical Home Program (IHMHP) for their members. In order to receive the PMPM rate for services provided by their IHMHP, facilities must submit evidence of meeting IHMHP criteria annually to AHCCCS. FFS AHCCCS members will have the option to not be empaneled so as not to restrict choice; reimbursement will be based upon only those members that are formally part of the medical home. To ensure there is choice given, the AHCCCS FFS member must sign a form at the facility stating they are agreeing to be empaneled to that particular facility.

The Indian Health Service Patient Centered Medical Home (PCMH) is adapted from the

Safety Net Medical Home Initiative (SNMHI) change package and is widely recognized and tested. There is a high degree of overlap between the SNMHI and the National Committee for Quality Assurance (NCQA) 2014 PCMH Recognition Standards.




*LAYING THE FOUNDATION*

*ENGAGED LEADERSHIP*

- *Provide visible and sustained leadership to lead overall culture change as well as specific strategies to improve quality, and spread and sustain change.*
- *Visibly support improvement at all levels of the organization, beginning with senior leaders and extending throughout the organization.*
- *Ensure that the PCMH transformation effort has the time and resources needed to be successful.*
- *Ensure that providers and other care team members have protected time to conduct activities beyond direct patient care that are consistent with the medical home model.*
- *Build the practice's values of creating a medical home for patients into staff hiring and training processes.*
- *Use practice resources strategically.*

*QUALITY IMPROVEMENT STRATEGY*

- *Use the Model for Improvement as a formal model for quality improvement.*
- *Establish and monitor metrics to evaluate improvement efforts and outcome; ensure all staff members understand the metrics for success.*
- *Build capability in all staff to support improvement and ensure that patients, families, providers, and care team members are involved in quality improvement activities.*
- *Ensure opportunities for community members to engage in the improvement process, program development, and policy.*
- *Optimize use of health information technology (e.g. RPMS).*
- *Use data to continuously improve performance, quality, and service (e.g. iCare).*
- *Build practice analytic capability.*

*<u>BUILDING RELATIONSHIPS</u>*

*EMPANELMENT AND POPULATION MANAGEMENT*

- *Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis.*
- *Assess practice supply and demand; balance patient load accordingly.*
- *Use panel data and registries to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.*
- *Use a formal data-driven approach to stratify level of risk for all empaneled patients.*

*CONTINUOUS AND TEAM-BASED HEALING RELATIONSHIPS*

- *Establish and provide organizational support for care delivery teams accountable for the patient population/panel.*
- *Link patients to a provider and care team so both patients and provider/care team recognize each other as partners in care.*
- *Ensure that patients are able to see their provider or care team whenever possible.*
- *Define roles and distribute tasks among multidisciplinary care team members to reflect the skills, abilities, and credentials of team members.*

*<u>CHANGING CARE DELIVERY</u>*

*ORGANIZED, EVIDENCE-BASED CARE*

- *Use planned care according to patient need.*
- *Ensure high risk patients are receiving appropriate care and case management services.*
- *Use point-of-care reminders based on clinical guidelines.*
- *Enable planned interactions with patients by making up-to-date information available to providers and the care team at the time of the visit.*
- *Support alternative and complementary medicine approaches, including traditional healing.*

*PATIENT-CENTERED INTERACTIONS*

- *Respect patient and family values and expressed needs.*
- *Encourage patients to expand their role in decision-making, health-related behaviors, and self-management.*
- *Communicate with patients in a culturally appropriate manner, in a language and at a level that the patient understands.*
- *Engage patients and families in goal setting, action planning, problem-solving, and follow action plans.*

- *Provide self-management support at every visit through goal setting and action planning.*
- *Obtain feedback from patients/family about their healthcare experience and use this information for quality improvement.*

*<u>REDUCING BARRIERS TO CARE</u>*

*ENHANCED ACCESS*

- *Enhance efficiency and access to care and services.*
- *Promote and expand access by ensuring that established patients have 24/7 continuous access to their care team via phone, email or in-person visits.*
- *Provide scheduling options that are patient- and family-centered and accessible to all patients.*

*COORDINATE CARE ACROSS THE MEDICAL NEIGHBORHOOD*

- *Link patients with community resources to facilitate referrals and respond to social service needs.*
- *Integrate behavioral health and specialty care into care delivery through co-location or referral protocols.*
- *Track and support patients when they obtain services outside the practice.*
- *Follow-up with patients within a few days of an emergency room visit or hospital discharge.*
- *Perform medication reconciliation at every office visit and care transition.*
- *Communicate test results and care or treatment plans to patients/families.*

With this change package in mind and in conjunction with the IHS, tribally operated 638 programs and the American Indian Health Program, AHCCCS has developed the following mandatory criteria for IHMHP designation when provided by IHS and tribally owned or operated 638 facilities in Arizona.

Medical Home Program Mandatory Criteria:

1. The site has achieved Patient Centered Medical Home recognition through NCQA, Accreditation Association for Ambulatory Health Care, The Joint Commission PCMH Accreditation Program, or other appropriate accreditation body, <u>OR</u>
2. IHS IPC attests annually that the site has completed the following in the past year:
    a. Submitted the SNMHI Patient-Centered Medical Home Assessment (PCMH-A) to IHS IPC;
    b. Submitted monthly data on the IPC Core Measures to the IPC Data Portal; <u>AND</u>
    c. Submitted narrative summaries on IPCMH improvement projects to IHS IPC quarterly.

## Patient Empanelment

While an AHCCCS member retains the right to seek care from any AHCCCS registered provider, AHCCCS may only pay for one medical home per member. In order to avoid reimbursement to two different IHMHPs for the same member, AHCCCS will recognize patient empanelment to a specific IHMHP by the receipt of a signed patient attestation form identifying the patients' medical home of record. An IHMHP will not be able to be reimbursed for PMPM claims until the empanelment

process has been completed.

After a facility is approved as a medical home by AHCCCS, the facility must submit to AHCCCS Division of Fee-for-Service Management (DFSM) a file of empaneled members. Members submitted that already have been empaneled in a medical home will be rejected back to the facility; in this case, the facility or member can request a transfer through the transfer process.

All empanelment files and transfers must be submitted to AHCCCS by the 22nd of the month for the facility to be able to submit a claim for the following month. Information received after the 22nd of the month will not be able to be claimed until the following month.

The AHCCCS transfer process can be utilized when a member is empaneled with another facility. In this case, the facility that would like the member to be transferred must complete the AHCCCS approved transfer form. This form must be signed by the requesting facility, the currently empaneled facility and the member.

### Diabetes Education Mandatory Criteria

IHMHPs providing diabetes education must provide an evidence-based curriculum designed to enhance regular treatment and disease-specific education, such as diabetes instruction. The Diabetes Education Program provides individuals with the skill sets necessary to coordinate all the things needed to manage their health, which is particularly helpful for individuals with more than one chronic condition. Subjects covered by an IHMPP Diabetes Education Program must include:

1. Education on techniques to deal with problems such as frustration, fatigue, pain and isolation
2. Education on appropriate exercise for maintaining and improving strength, flexibility, and endurance
3. Education on the appropriate use of medications and medication compliance
4. Education on how to communicate effectively with family, friends, and health professionals
5. Nutrition Education
6. Education on decision making
7. Education on how to evaluate new treatments

IHMHPs using a diabetes education curriculum and receiving an additional PMPM for these services must separately report the following:

- Hospital readmissions within 30 days of discharge with a diabetes diagnosis
- Number of ED visits with a diabetes diagnosis

Non-IHS/Tribal facilities Shared Savings Payment: Supporting the IHS Indian Health Medical Home Model American Indian members are not limited to using only IHS/Tribal facilities. They access care from non-IHS/Tribal facilities particularly in areas where a non-IHS/638 facility is more readily available than an IHS/Tribal facility. Additionally, AI/AN members often access non-IHS/638 facilities and providers for specialty care that may not be accessible at an IHS/Tribal facility. As a result, there are a number of non-HIS/Tribal facilities with high AI/AN patient volumes that can help support the IHMHP. These

facilities are grappling with issues of care coordination, hospital readmissions and non-emergent use of the emergency department related to the AI/AN population.

Facilities with high AI/AN inpatient enrollment in AIHP, specialty care (e.g., OB/GYN) or emergency department patient volumes can help support the IHMHP model by allowing an IHS/Tribal facility to embed an IHS/Tribal care coordinator within their facility. Non-IHS/Tribal facilities that meet or exceed 30% AI/AN patient volumes such as Urban Indian Programs are eligible to receive shared savings payments through structured arrangements with AHCCCS that, among other measures: reduce emergency department use; reduce readmissions, coordinate with behavioral health; and share data with AHCCCS. These initiatives will be arranged on a case-by-case basis depending on the specialty of the provider type.

By supporting the model in this way, the non-IHS/Tribal facilities will be partnering with the IHMHP to connect AIHP enrolled members with the services necessary to address the health disparities that exist within the population, thereby, reducing the rate of hospital readmissions and non-emergent use of the emergency department. These facilities should be rewarded for the improvements in care delivery and in savings achieved for their efforts in supporting this model. Addressing healthcare disparities for the AI/AN population is not possible without the participation of non-IHS/Tribal facilities.

Arizona is proposing to offer services that support an Indian Health Medical Home Program – Primary Care Case Management, 24-hour call line, diabetes education and care coordination – to its acute care FFS Population. IHMHPs will be charged with addressing health disparities between American Indians and other populations in Arizona, specifically by enhancing case management and care coordination. In tracking the successes of IHMHPs across the state, Arizona expects to see trends indicating cost savings through the prevention of hospital readmissions and improved control of non- emergent use of the emergency department. Non-IHS/Tribal facilities will also share in those savings as critical players in addressing healthcare disparities for the AI/AN population.

## PART VI
## Building upon Arizona's Past Successes

While Arizona has had a longstanding 1115 Waiver through which the State has operated its Medicaid program, the demonstration has not remained stagnant. In fact, through over 33 years of Medicaid managed care experience, the State of Arizona has learned that Medicaid managed care is an evolutionary process. Existing demonstrations are modified, adjustments are continually made, and the program is further refined, modernized and streamlined. The result is a Medicaid managed care operation that is continually seeking opportunities to improve and build upon past successes to achieve greater health outcomes for its members and long-term sustainability for the program.

As part of this refinement, this new demonstration will reflect modifications to the following programs:
*The merger between AHCCCS and the Division of Behavioral Health Services.* As part of the 2015 legislative session, Governor Ducey proposed and the Arizona.