
# Targeted Investments Program Renewal Request (TI Program 2.0) Concept Paper

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AHCCCS proposes a renewal of the Targeted Investments Program for the 2021-2026 waiver period. The program renewal will support and incentivize providers who did not participate in the original TI Program to better integrate care for AHCCCS members, and enable participants from the original TI Program to further develop more comprehensive whole person care with systems that effectively address the social risk factors that adversely affect health. The Program aligns and supports the AHCCCS 2021 Strategic Plan.

## OVERVIEW OF THE CURRENT TARGETED INVESTMENTS PROGRAM (2016-2021)

Arizona's health care system has historically been fragmented, due to a siloed system of care prior to the state's participation in Medicaid and the establishment of a delivery system model within the Medicaid program in which members accessed physical health services through an acute care health plan and behavioral health services through a behavioral health care plan, known in Arizona as a Regional Behavioral Health Authority (RBHA). As a result of this delivery system division, AHCCCS members often interacted with multiple managed care entities and received care from myriad providers who were funded from different sources. This fragmentation has historically hindered effective care coordination, impacted members' health status, and resulted in increased costs for members with complex behavioral and physical health needs.

Over the past decade, Arizona has taken significant steps to reduce these silos by addressing integration at the administrative, payer, and provider levels. In 2016, the administration of behavioral health services that was formerly under the Arizona Department of Health Services merged with AHCCCS. In 2018, AHCCCS transitioned to the AHCCCS Complete Care model which placed payment and provider network responsibility for AHCCCS members' physical and behavioral health under a single managed care plan.AHCCCS' effort to integrate care and improve health outcomes for members relies on the unique partnership between the managed care organizations (MCOs) and AHCCCS providers. The ability for the MCOs to effectively coordinate care and provide integrated care is directly linked with the providers' ability to participate in that process. The TI Program is an important component of AHCCCS's initiative to integrate physical and behavioral health at the provider level. The providers who deliver services are in a better position to coordinate care in real time, but to do so effectively, many need infrastructure support to build data sharing and analysis capabilities, to integrate team-based care, and to create workflows that connect members to social services.

Through its Targeted Investments (TI) Program, AHCCCS supports participating providers in moving toward more integrated and coordinated care.The program aims to reduce fragmentation between physical and behavioral health providers, increase efficiencies in integrated service delivery, and improve health outcomes for targeted populations.The TI Program has incentivized requirements aimed at building the necessary infrastructure to enable an integrated and high-performing health care delivery system that enhances care coordination and improves health and financial outcomes. Targeted populations include adults and children with behavioral health needs who are at high risk for complex care, including justice involved individuals.

In the first three years of the five-year, $300 million program, participating providers received payments for achieving milestones focused on development of infrastructure, and implementation of processes and policies, that support behavioral health and physical health integration and coordination.In years four and five, providers are eligible to receive performance-based incentive payments based on quality measures for specific populations. Figure 1 illustrates the number of participating providers, by area of concentration, at the end of year four of the Demonstration.

**Figure 1: TI Program Providers:**

| Figure 1 Participating Area of Concentration | Number of Sites |
|---|---|
| Adult Behavioral Health | 153 |
| **Adult Primary Care** | 163 |
| **Pediatric Behavioral Health** | 117 |
| **Pediatric Primary Care** | 91 |
| **Hospital** | 21 |
| **Justice Co-located Clinics** | 13 |

The TI Program has achieved noteworthy accomplishments in several areas of concentration, as discussed below.

**JUSTICE INVOLVED INDIVIDUALS**

Numerous studies have shown that individuals who are incarcerated have a high prevalence of undiagnosed or underdiagnosed behavioral health conditions.In addition, research on recidivism indicates that three out of four incarcerated individuals are re-incarcerated over the course of five years.[1] The inability to access behavioral health services, including treatment to address substance use disorder, is a contributing factor to recidivism.

Recognizing the unique circumstances and needs of this population, in addition to incentivizing integrated care within traditional clinic settings, the TI Program supported the establishment of 13 co-located, integrated clinics where primary care and behavioral health providers deliver services to justice-involved individuals. The co-located clinics are located with, or adjacent to, probation and/or parole offices that collaborate with providers to meet the members' health and social needs. The co-located justice clinics prioritize access to appointments for individuals with complex health conditions, with a specialized focus on ensuring that this population has same-day access to appointments on the day of release and during visits to a probation or parole office. AHCCCS non emergency medical transportation (NEMT) coverage for medically necessary services available at these clinics offers the added benefit of supporting members' ability to keep appointments with probation and parole officers thus contributing to efforts to reduce recidivism.In FFY 2019, 4,272 formerly incarcerated members received services through the integrated justice clinics.

In addition, AHCCCS has established Medicaid suspension agreements with the majority of counties such that individuals who become incarcerated (for less than one year) while enrolled in AHCCCS are suspended from Medicaid eligibility and then reinstated upon release from incarceration,rather than having to complete a new eligibility application.These individuals are automatically re-enrolled with the MCO they were enrolled in at the time of the suspension. AHCCCS requires the MCOs to have reach-in policies, mandating that they engage these individuals with complex health conditions and high criminogenic needs prior to release, ensuring that they are able to access care immediately upon

[1] Durose, Matthew R., Alexia D. Cooper, and Howard N. Snyder, Recidivism of Prisoners Released in 30 States in 2005: Patterns from 2005 to 2010 (pdf, 31 pages), Bureau of Justice Statistics Special Report, April 2014, NCJ 244205.

transition back into the community. Many of the members identified through these processes are referred to TI justice clinics. This is a critical foundational step to ensure that individuals transitioning into the community from incarceration have immediate access to health care including substance use and behavioral health services.

**IMPROVEMENTS IN PHYSICAL AND BEHAVIORAL HEALTH INTEGRATION FOR TI PARTICIPATING PROVIDERS**

To address the challenges associated with fragmentation at the point of service, the TI Program incentivizes and supports a comprehensive approach to integrated care in any care setting in which an AHCCCS member may receive either physical or behavioral health services. For that reason, TI Program participants are financially incentivized to establish numerous protocols, policies, and systems of care that support the provision of person centered integrated care, such as:

- Integrated care plans for members with behavioral health needs,
- Primary care screening for behavioral health using standardized tools for depression, SUD, anxiety, and suicide risk,
- Primary care screening, intervention and treatment for children with developmental delays, including early childhood cognitive and emotional problems,
- Protocols for behavioral health providers to identify physical health concerns and to effectively connect the member to appropriate physical health care,
- High risk registries, health risk assessment tools, predictive analytic systems, and other data mining structures to identify individuals at high risk of a decline in acute and/or behavioral health status,
- Trauma-Informed care protocols including screening for adverse childhood events (ACEs), referral processes for children that screen positive, and use of evidence-based practices and trauma-informed services, and
- Protocols to send and receive core Electronic Health Record (EHR) data with the state's Health Information Exchange (Health Current) and receipt of Admission, Discharge, and Transfer (ADT) alerts to notify providers when their patients are in the hospital

Additionally, TI Program participants (except hospitals) are required to complete the Integrated Practice Assessment Tool (IPAT) to assess their level of integration on the Substance Abuse and Mental Health Services Administration (SAMHSA) Levels of Integrated Healthcare continuum at the end of each program year. SAMHSA defines six levels of coordinated/integrated care grouped into three broad categories, ranging from minimal collaboration to co-located care to fully integrated care (Figure 2).

| Figure 2 SAMHSA Six Levels of Collaboration/Integration | | | | | |
|---|---|---|---|---|---|
| Coordinated Care<br>Key Element: Communication | | Co-Located Care<br>Key Element: Physical Proximity | | Integrated Care<br>Key Element: Practice Change | |
| **LEVEL 1**<br>Minimal Collaboration | **LEVEL 2**<br>Basic Collaboration at a Distance | **LEVEL 3**<br>Basic Collaboration On site | **LEVEL 4**<br>Close Collaboration On site with Some Systems Integration | **LEVEL 5**<br>Close Collaboration Approaching an Integrated Practice | **LEVEL 6**<br>Full Collaboration in Transformed/ Merged Integrated Practice |

Early results indicate the TI Program funding was important in increasing the levels of integrated care for participating providers. The majority of TI Program participants reported having a higher level of integration after implementing the protocols associated with the TI Program between demonstration years (DYs) two and three. Sixty percent of unique provider sites reported an increase in integration by at least one IPAT level, and 38 percent of provider sites reported an increase by at least two IPAT levels. Most notably, nearly 25 percent (46 clinics) of PCP participants attested to increasing their IPAT scores by four or more levels—transitioning from levels one or two (minimal coordination) to levels five or six (fully integrated care), within one year. This higher level of integration among participating PCPs means members are able to consistently access behavioral health services when the PCP's screening identifies a need within the integrated practice setting.

In addition, many participating behavioral health providers successfully transitioned to a higher level of integration. The number of providers that reported successfully transitioning to co-located care (levels three or four) or fully integrated care (levels five or six) increased by threefold in year three. AHCCCS anticipates that additional providers will achieve greater levels of integration by years four and five.

These results illustrate the important role the TI Program has played in incentivizing and supporting providers to transform their practices. Some TI providers have transitioned to offering primary care and behavioral health services in their participating sites.

The TI Quality Improvement Collaborative (QIC) assisted participants with improving processes that support integration. The QIC was established in program year four in partnership with the College of Health Solutions and the Center for Health Information and Research at Arizona State University. It provides TI participants with data driven performance improvement strategies and peer learning through monthly virtual collaboratives, current performance-measure dashboards, and tailored technical assistance. QIC attendance is included in the years four and five participant milestones.

**Opportunities and Challenges Going Forward**

The Targeted Investments Program is now in its fifth and final year. The program participants regularly report that they have changed "how they do business" due to the systems of care they have established as a result of implementing TI Program requirements and the resources they have earned through meeting required milestones. Processes such as universal behavioral health screening and

intervention by primary care participants have been embraced, and are being continued even after milestone incentives for the protocol are no longer in place. Participants also report improved quality in service delivery and coordination as a result of required high risk registries, exchanging data with the health information exchange, and enhanced communication protocols with their primary care and behavioral health counterparts. Many participants working toward more integrated practices prior to Targeted Investments report that the structure and deadlines required by the program accelerated and improved their integration efforts.

With the increased focus on the comprehensive needs of the AHCCCS members they serve, program participants have identified opportunities to achieve greater integration and coordination particularly related to the identification of social risk factors and the establishment of corresponding interventions. The healthcare environment, particularly health information systems capabilities, has evolved since implementation of the TI Program. This has increased the potential for TI participants to sustain and enhance the delivery of more comprehensive, whole person care.

The TI Program's impact has been limited to members served by TI participating providers. Many AHCCCS providers who were either not ready or unable to participate in the original TI Program have expressed the desire to achieve improved coordination and integration for their patients through the opportunity to access the TI Program blueprint and resources. Expanding provider participation in the TI Program will enable more AHCCCS members to receive the greater levels of point of care coordination and integration currently available from the program's existing providers. The ongoing public health emergency has intensified the need to effectively address, as one of the program's PCP participants noted, this "epidemic of anxiety and depression."

**TARGETED INVESTMENTS PROGRAM 2.0 PURPOSE AND GOALS**

Original TI Program Goals:

- Reduce fragmentation between acute and behavioral health care.
- Increase efficiencies in service delivery for members with behavioral health needs by improving integration at the provider level.
- Improve health outcomes for members with physical and behavioral health needs.

AHCCCS's multi-year strategic priorities align with TI:

- Pursue and implement long-term strategies that bend the cost curve while improving member health outcomes.
- Pursue continuous quality improvement.
- Reduce fragmentation driving toward an integrated and sustainable healthcare system.

TI Program Renewal Proposal Goals:

- Sustain: TI participants' point of care integration achievements.
- Expand: the opportunity to implement the program's integrated care systems to new providers that did not participate in the original program.
- Improve: the program requirements to more comprehensively provide whole person care through enhanced social risk screening and intervention with milestone updates that reflect developments since the advent of the original TI Program.

The TI Program Renewal (2.0) proposal supports Arizona's goal to fully transform the Medicaid delivery system to an integrated whole person care structure. AHCCCS can achieve this goal by

adding providers to a renewed TI Program, and by supporting initial TI Program participants in their efforts to sustain the integration systems and protocols they've built, using these foundations to further the whole person care model. This will be achieved by:

- Sustaining integrated point of care infrastructure that improves care coordination and drives better health and financial outcomes for high-risk AHCCCS members, such as care management for high risk members, behavioral health screening and intervention, and effective use of telehealth services.
- Expanding AHCCCS members' accessibility to more fully integrated, whole person care through additional TI Program participants.
- Further extending point of care integration systems that include enhanced capabilities to successfully identify and address social risk factors.
- Developing and supporting strategies for effective and efficient use of technology including the health information exchange and closed loop referral systems that facilitate the information sharing needed to provide whole person care and to identify and address social determinants of health.
- Supporting provider and other stakeholder peer learning and sharing of process improvement strategies through a quality improvement/learning collaborative.
- Engaging stakeholders from community based organizations, managed care organizations, and public and private sector subject matter experts to provide input on systems and strategies that enable comprehensive and coordinated whole person care integration opportunities and strategies.

**TI PROGRAM RENEWAL STRUCTURE AND CONTENT**

In order to continue progress toward delivery system and payment reform, and to bring the current TI Program initiatives to scale, AHCCCS proposes renewing the TI Program from 2021 through 2026 to include two distinct participant cohorts –the "extension" and "expansion" cohorts.

The "extension" cohort will include current TI Program providers. As the transition to integrate behavioral health and primary care continues for this cohort, their next step will be to incorporate non-clinical or social needs into point of care systems to provide a more holistic, person-centered approach to care. TI Program 2.0 requirements for this cohort will be designed to foster collaboration between providers and community based organizations (CBOs), particularly those crucial to addressing social risk factors such as housing, food, employment, and non-medical transportation for AHCCCS members, while retaining high value physical-behavioral health integration requirements from the original program. The incentive payments for this group of participants will be based on the continuation of high impact practices, establishment of additional systems and infrastructure that support advancing whole person care, and the achievement of outcome measures. Participation eligibility requirements will include established HIE connectivity and successful implementation of previous TI integration systems and protocols.

The "expansion" cohort will include primary care practices, behavioral health providers, and integrated clinics with no prior TI participation that wish to participate in the TI Program 2.0. Qualified participants will meet requirements such as a certified EHR that is capable of bi-directional data exchange, minimum volume thresholds, and a commitment to participate in the Learning/Quality Improvement Collaborative established to support TI program participants. The structure of the program for this cohort will be modeled on the original TI Program, including

milestones such as establishment of a high risk registry, implementation of behavioral health screening and intervention, and active engagement with the HIE. These requirements will be updated to emphasize SDOH screening, adverse childhood event screening and intervention, telehealth, data sharing, and cultural competency. Milestones in the fourth and fifth years of the Program will be based on performance against an established set of measures.

The expansion cohort will also include co-located justice clinics. Eligibility will generally align with the original program requirements, with enhanced emphasis on: justice partner commitment, co-location flexibility, development in areas of the state currently underserved by this resource (e.g. rural counties), and inclusion of AHCCCS members adjudicated through diversion programs such as drug courts and veterans courts.

AHCCCS proposes that the TI Program's original five-year structure be utilized for both cohorts in the TI Program renewal. Annual Requirements:

| Program Year | Extension Participants | Expansion Participants |
|---|---|---|
| **Year 1** | Re-Establish TI 1.0 Systems and Processes<br>Establish New Systems and Processes that support Whole Person Care | Application & Onboarding |
| **Year 2** | Establish New Systems and Processes | Establishment of Systems & Processes |
| **Year 3** | Implementation and Evaluation of Systems and Processes | Implementation and Evaluation of Systems & Processes |
| **Year 4** | Performance/Outcome Measures | Performance/Outcome Measures |
| **Year 5** | Performance/Outcome Measures | Performance/Outcome Measures |

**PARTICIPANTS AND STAKEHOLDERS**

Consistent with the original program, AHCCCS anticipates participation in both the extension and expansion cohort will be site specific. This means a multi-site provider practice or organization will apply separately for each of the sites that participate with milestone achievement based on site specific performance. Original program participants' sites that did not participate will not be eligible to participate in the expansion cohort. Contingent on available funding, these sites could be eligible to participate in the extension cohort.

**Participants**

Similar to the original program, participation will be limited to specific provider types:

- Primary Care: includes pediatric, adult, and family practice MDs, DOs, and nurse practitioners (both cohorts).
- Behavioral Health: includes outpatient behavioral health clinics and providers that serve children, adults, or both children and adults (both cohorts).
- Integrated Clinics: provider organizations that provide both primary care and behavioral health care, licensed by the Arizona Department of Health Services as integrated clinics, and registered with AHCCCS as integrated clinic provider type (both cohorts).
- Co-located Justice Clinics: licensed and registered integrated clinics co-located with or adjacent-to probation and/or parole facilities, or probation and/or parole offices are located with or adjacent to the integrated clinic (both cohorts).
- IHS and Tribal 638 Ambulatory Facilities: AHCCCS is exploring including this participant category. This would be a new provider category to the TI Program (expansion cohort only).
- Community Based Organizations (CBOs): AHCCCS is exploring options for engaging CBOs in the structure of the Program and to support their participation in the closed loop referral system (extension cohort only).
- Peer Run Organizations: AHCCCS is exploring options for including organizations that provide peer support services (each cohort).

**Partners/Collaborators**

The provider transformation supported by the TI Program also requires the support and collaboration of additional stakeholders to achieve program goals.

- Quality Improvement/Learning Collaborative (QIC): Partnership with the Arizona State University College of Health Solutions to continue support of program participants with process improvement guidance, data analysis support, and peer learning facilitation.
- Managed Care Organizations: As reflected in the 2019 TI sustainability plan, MCOs will continue to seek alignment of value based arrangements with program participants in their networks to help sustain systems and protocols established through TI participation. AHCCCS contracted health plans will continue processing incentive payments to their respective network of TI participating providers. In addition, MCOs will continue to support and coordinate with participants in areas such as risk assessment, vetting of community resources, and QIC participation. Discussions between AHCCCS and MCOs will continue regarding additional TI 2.0 engagement opportunities.
- Health Information Exchange (Health Current): Health Current, the state HIE, is administering the statewide closed loop referral system and will support and collaborate with TI 2.0 participants involving the closed loop referral system requirements. Health Current partnered with AHCCCS to support TI participants' ability to meet the original program data exchange

capabilities including bi-directional data exchange with the HIE. Health Current will maintain this function.

- Community Based Organizations: AHCCCS is exploring CBO collaboration and engagement options , as well as means to incentivize and support their closed loop referral system participation.

- Public Agencies: Engagement with county probation departments, courts, the Arizona Department of Child Safety, the Arizona Department of Corrections Rehabilitation and Reentry, and others is underway to ensure there is effective coordination and leveraging of established systems and resources that interface with AHCCCS members who are served by TI Program participants.

- Other stakeholders/Subject Matter Experts: AHCCCS is engaged with advocacy groups such as the Autism Advisory Council, professional associations such as the Arizona Council of Human Service Providers, and AHCCCS subject matter experts to further inform program requirements.

**FUNDING**

TI 2.0 Program funding will direct incentive payments to participating providers to improve performance and increase physical and behavioral health care integration and coordination for individuals, and to identify and address social risk factors that affect health status of AHCCCS members.

AHCCCS anticipates funding TI 2.0 through a combination of state and federal sources. AHCCCS has identified the availability of $24 million in Designated State Health Programs (DSHP) funds to cover the state contribution over the five year program period. AHCCCS proposes federal financial participation through the matching of permissible DSHP funds at the FMAP rate.

AHCCCS proposes that the maximum total funding for the program not exceed $250 million over five years including state and federal match contributions. This is contingent on the amount of allowable DSHP expenditures, with funds distributed in proportion to the level of effort required of participants in each of the five years. AHCCCS proposes 6 percent of the total funding be allocated to administrative expenses, eligible for federal financial participation at the administrative match rate of 50 percent.