AHCCCS
Arizona Health Care Cost Containment System

AHCCCS Update

SIM Sustainability
Delivery System Reform Incentive Payment - DSRIP

Arizona SIM 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

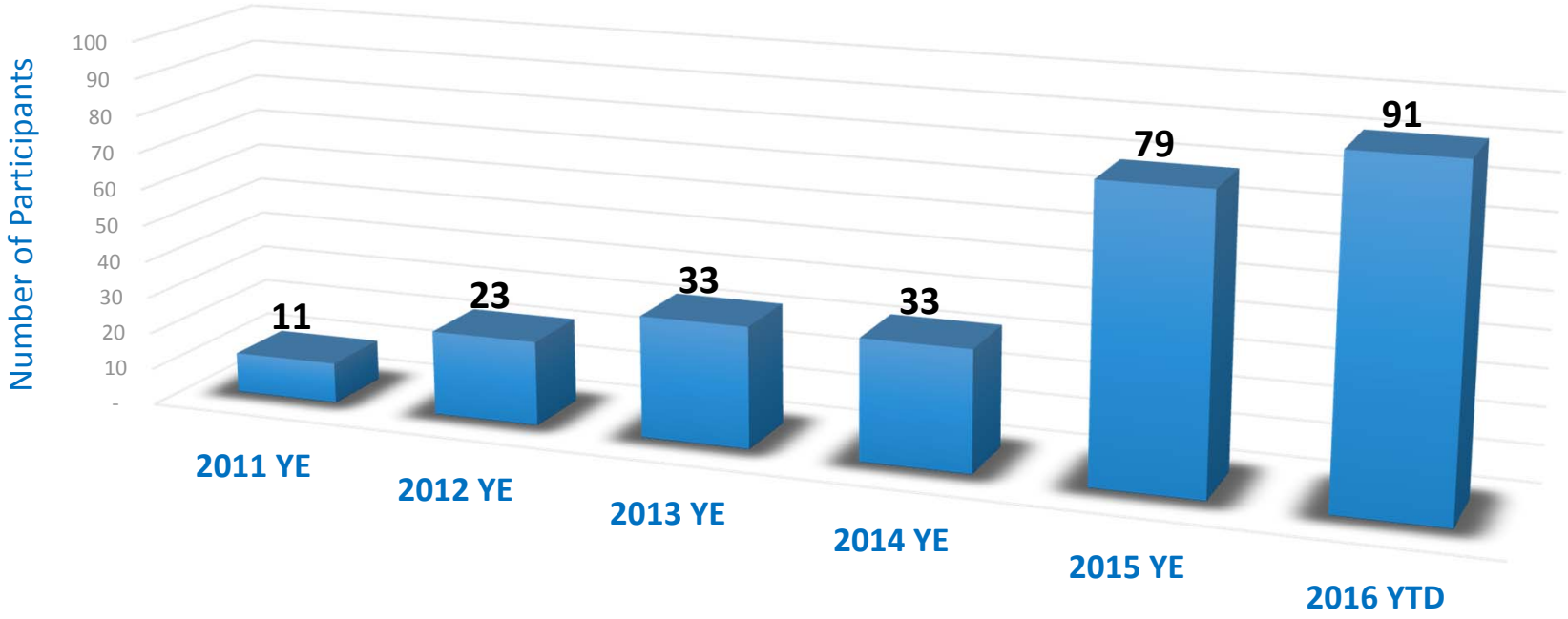
1. Physical Health/Behavioral Health Integration
2. Justice System Transitions
3. American Indian Members

Leverage Value Based Payments

Leverage HIE and Data sharing

DSRIP now seen as vehicle to leverage Medicaid Venture Capital

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**	

Delivery Reform Programs in DSRIP States

Delivery System Reform	California	Texas	Massachusetts	New Mexico	New Jersey	Kansas	New York	Oregon
State Innovation Model (SIM) Round 1 Design Award	√	√						
SIM Round 1 Testing Award			√					√
SIM Round 2 Design Award	√			√	√			
SIM Round 2 Testing Award							√	
Medicaid Expansion State	√		√	√	√		√	√
Medicaid Managed Care Expansion	√	√	√	√	√	√	√	√
State Accountable Care Organization Activity	√	√	√		√		√	√

DSRIP Challenges

1. Role of the MCO
2. Project Focus
3. Strong competitive markets for 80% of state population
4. State Match
5. Limit Administrative Infrastructure

Role of the MCO

CA DSRIP Goals

- PRIME – Public Hospital Redesign and Incentives in Medi-Cal
- Increasing the capabilities of participating PRIME entities to furnish **patient centered data driven team based care** especially those who are high utilizers or at risk
- Improve the capacity of the PRIME entities to provide **point of care services, complex care management and population health management by strengthening their data analytic capacity** to drive system-level improvement and culturally competent care

CA DSRIP Goals

- **Improve population health and health outcomes for Medi-Cal beneficiaries** served by PRIME entities as evidenced by the achievement of performance goals related to clinical improvements
- Improving the ability of participating PRIME entities to furnish in the most appropriate setting high quality care that **integrates physical and behavioral health** services
- Move participating PRIME entities towards **value based payments**

California DSRIP

- *PRIME Program Objective –PRIME entities **assuming responsibility for the overall healthcare needs of a population** of the Medi-Cal beneficiaries*
- *Integration Across Settings – Create strong links between different settings in which care is provided including inpatient outpatient institutional and community based settings and importantly behavioral and physical health providers. **The PRIME will support coordination and the provision of care for patients across the spectrum of settings in order to promote health and better outcomes***

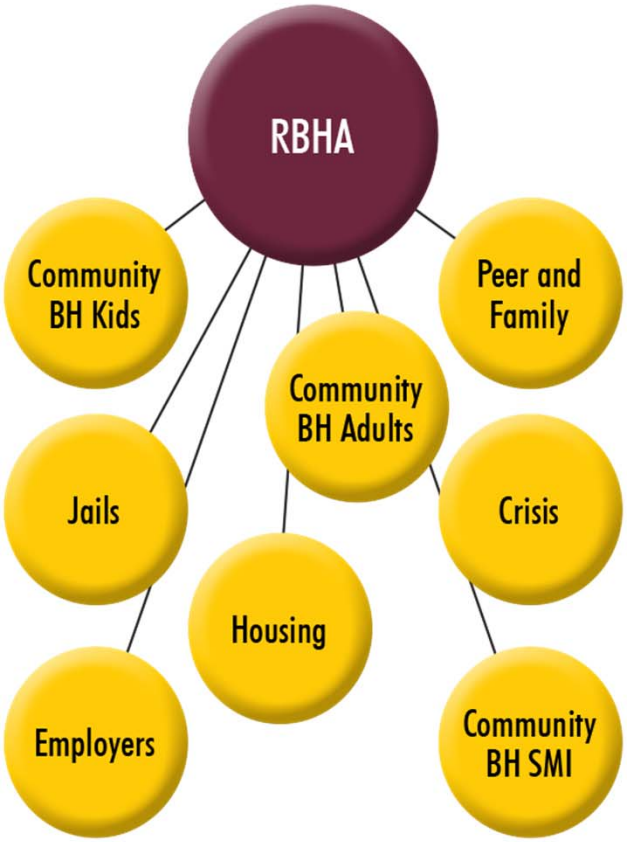
Minor role of MCO in CA DSRIP

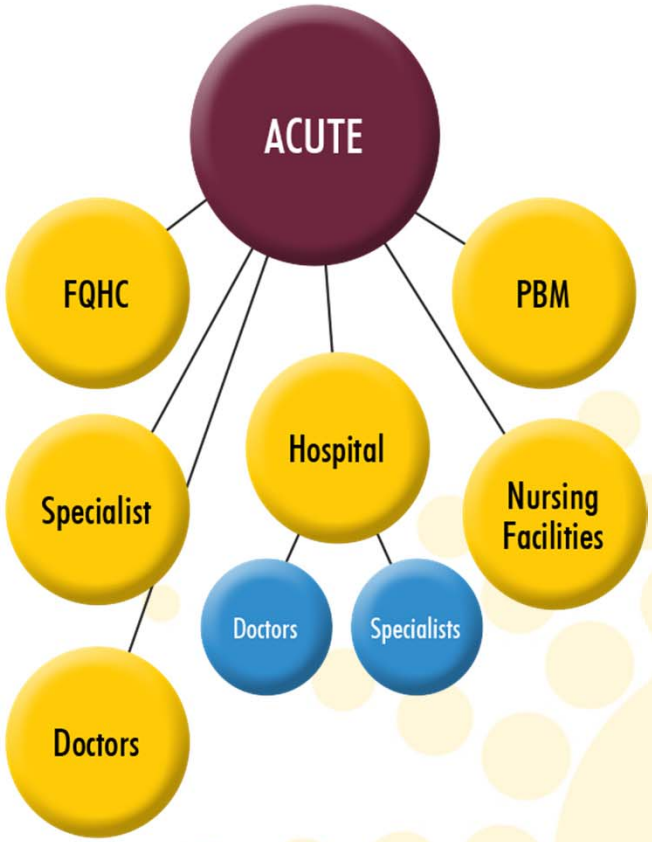
- *50% of all Medi-Cal managed care beneficiaries assigned in a DPH by their MCP in aggregate will receive all or a portion of their care under a contracted APM*
- *Statewide APM targets – This will be evidenced by an increasing shift of managed care payments for DPHs towards APMs which include full or partial cap..*
- *Since Managed care is primary delivery mode DPHs will be required to strengthen data and information sharing with MCPs under the PRIME.*
- *The State will develop a draft MCP and DPH APM activities plan consistent with APMs as defined by waiver.*

AZ Role of MCO

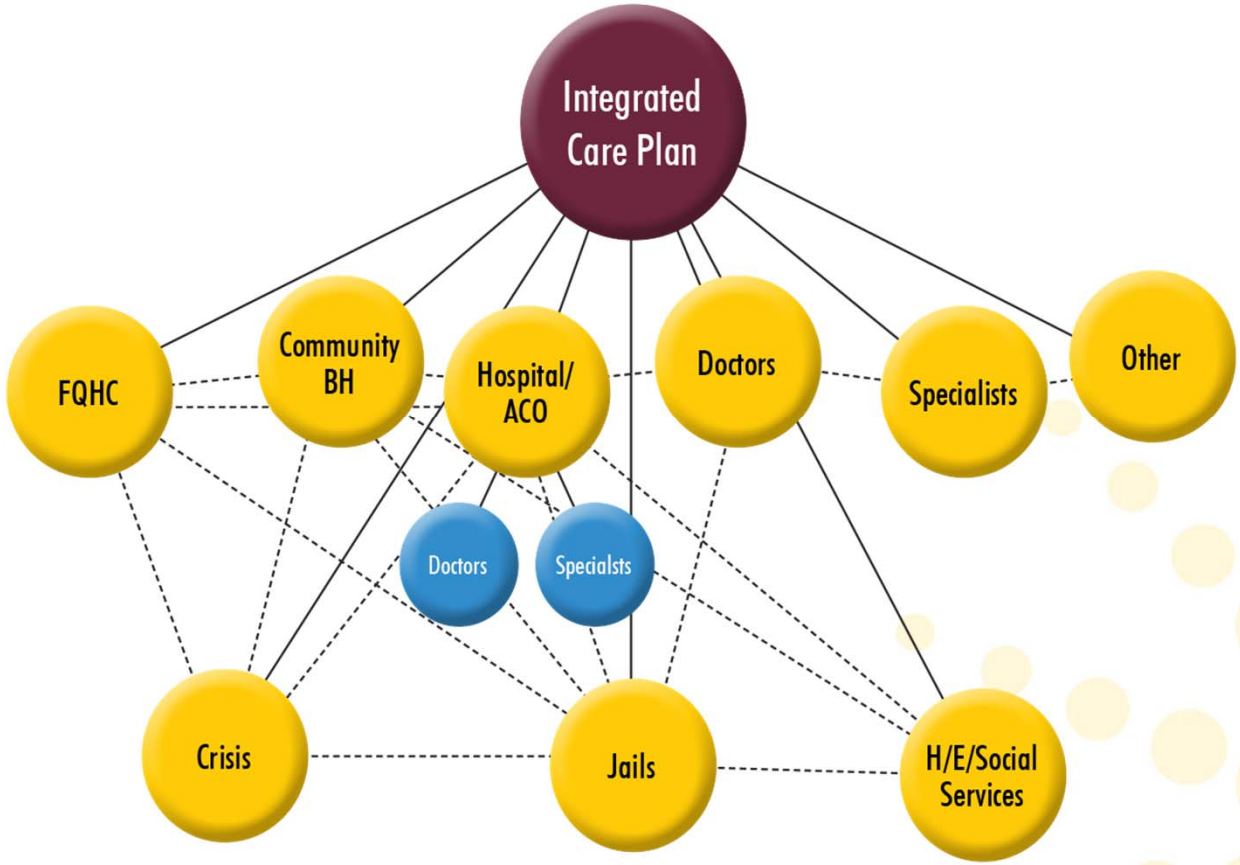
- ***AHCCCS Vision - Shaping tomorrow's managed care from today's experience, quality, and innovation***
- ***Leverage MCO to Establish DSRIP network that will have increased care management requirements and expectations to serve Complex populations***

Integrated Care Plan-Before





Integrated Care Plan-After



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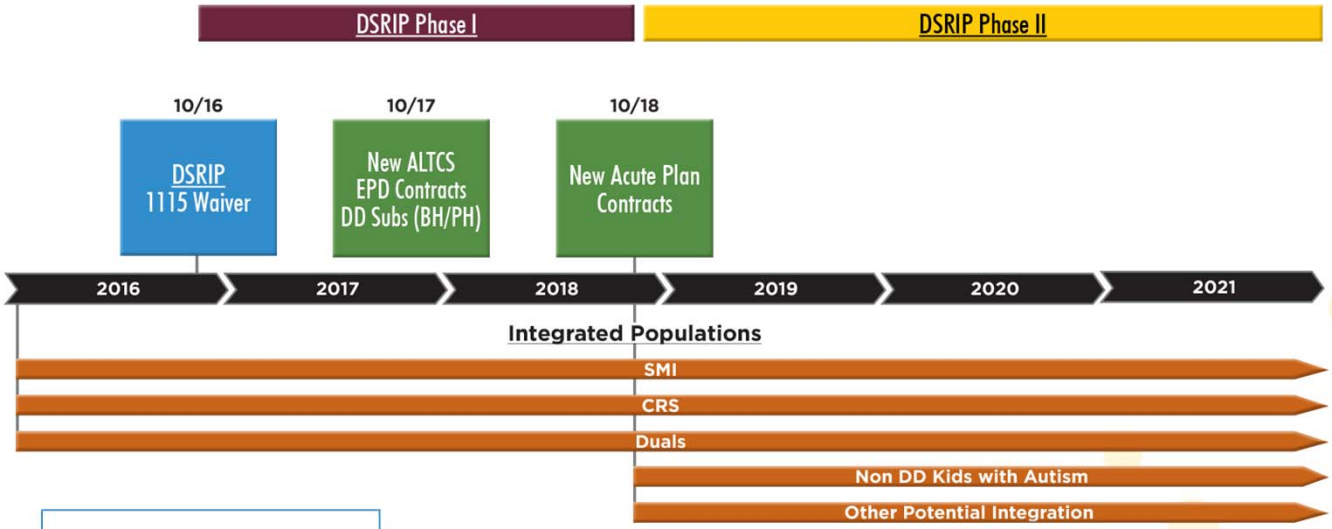
Reaching across Arizona to provide comprehensive quality health care for those in need

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

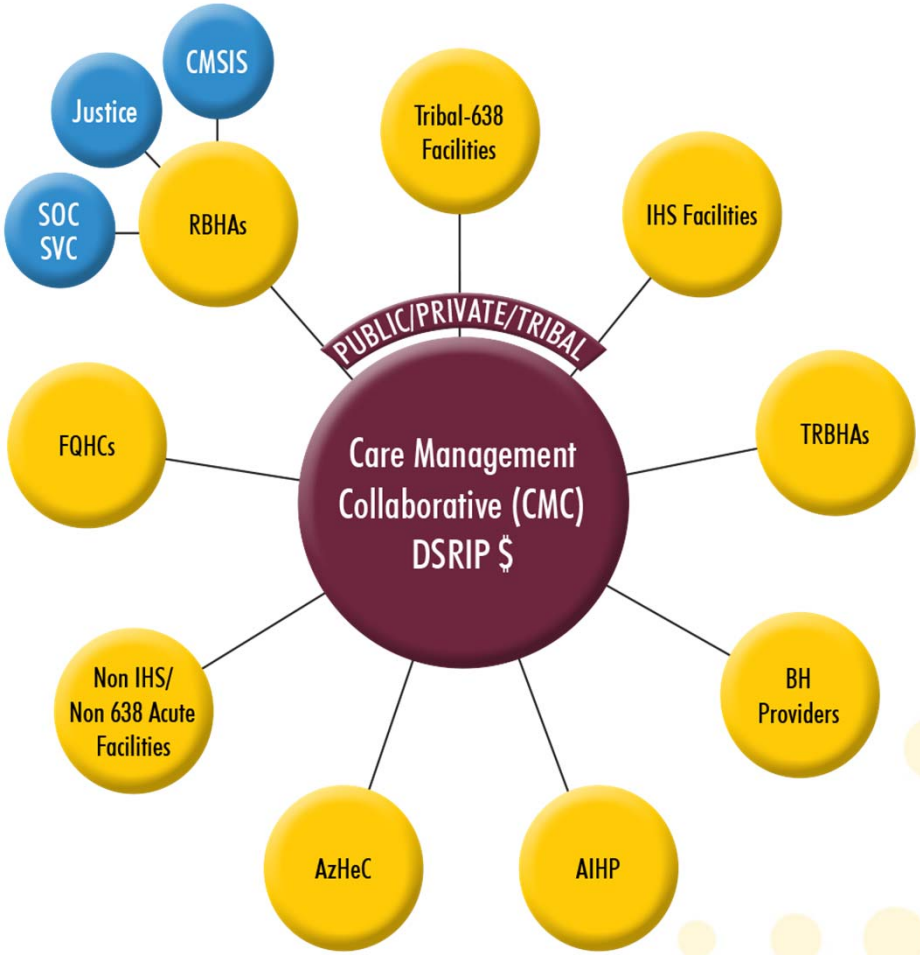
- MCOs Form DSRIP Entities Based on Provider Network Requirements Serving Broader Populations

AIHP 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
- 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-native AZ

AIHP DSRIP Framework



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AIHP DSRIP Proposal

Creates 3 Regional Care Management Collaborative

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

AIHP 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

AIHP 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

AIHP 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

AIHP 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

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

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