DELIVERY SYSTEM TRANSFORMATION CONCEPT PAPER

Introduction

General Objective

Arizona has long been a leader in serving its 1.85 million Medicaid beneficiaries through creative and effective use of managed care delivery systems. Acute managed care organizations (MCOs), Regional Behavioral Health Authorities (RBHAs), and Arizona Long-Term Care System (ALTCS) plans (together, "the health plans") are the foundation of Arizona's management of its Medicaid program in a cost-effective and value-based manner. In 2015, Arizona was awarded a State Innovation Model (SIM) planning grant to facilitate system transformation. The agency responsible for the Medicaid program, Arizona Health Care Cost Containment System (AHCCCS), is also responsible for managing the SIM. The goal of AHCCCS is to provide comprehensive, quality health care for those in need by: (i) bending the cost curve while improving members' health outcomes; (ii) pursuing continuous quality improvement; (iii) reducing fragmentation in health care delivery to develop an integrated system of healthcare, and (iv) maintaining core organizational capacity, infrastructure, and workforce. To effectuate this goal, AHCCCS understands that payment modernization is a critical component. Indeed, there are numerous payment reform efforts already underway in the State with commercial carriers and Medicaid health plans shifting away from traditional fee-for-service (FFS) models towards alternative payment model (APM) arrangements. AHCCCS has been a national leader among Medicaid agencies as one of the first in the nation to implement health plan contractual requirements with quantitative targets for value-based payment model adoption.[1] Indeed, for the calendar year ending 2015 – the most recent data available – across all product lines, 23% of AHCCCS's health care expenditures were made under value-based arrangements. While payment transformation has begun in Arizona, AHCCCS determined, through stakeholder outreach, that there were gaps in providers' abilities to succeed under new payment methodologies, and therefore a need for AHCCCS to intervene to support delivery system transformation.

A key theme for Arizona in pursuing its delivery system payment reform initiatives and APM requirements is reducing fragmentation that occurs between the main delivery and financing systems by encouraging the development of integrated systems that provide holistic care for individuals and thereby improve efficiencies and outcomes. Reduced fragmentation and APM requirements will bend the cost curve and move providers toward models of payment that increasingly focus on quality rewards and penalties, and gainsharing and risk. In particular, Arizona seeks to invest in transformational projects to better position Medicaid providers and health plans to move more quickly toward APMs that utilize upside and downside gainsharing and comprehensive population-based payment strategies. In making these changes to the delivery system, Arizona is focusing on some of the most complex and costly members, including individuals with both behavioral and physical health needs, members transitioning from incarceration into the community, and American Indian members.

[1] For example, MCOs in the acute care program will be required to have a minimum of 35% of their total payments to providers in value-based payment arrangements in 2017.

For this reason, Arizona seeks to fund time-limited projects aimed at building necessary relational infrastructure to improve multi-agency, multi-provider care delivery for the following populations:

- Individuals transitioning from incarceration who are AHCCCS-eligible.
- Children with behavioral health needs, including children with or at risk for Autism Spectrum Disorder (ASD), and children engaged in the child welfare system.
- Adults with behavioral health needs.
- American Indians enrolled in the American Indian Health Program (AIHP) (both adults and children), including both those served through the Indian health delivery system (e.g., Indian Health Service (IHS)/Tribal 638 organizations) and those receiving some or all of their care from non-Indian health providers.

At the crux of the projects is improved care coordination and care management for these vulnerable AHCCCS members. Funding for transformational activities will target infrastructure investment and incentives for providers to collaborate on the development of shared clinical and administrative protocols to enable patient care management across provider systems and networks. AHCCCS has developed initial project components and milestones and is actively working with stakeholders to validate and refine these project strategies. Initially, AIHP projects were also developed within this framework. Based on recent guidance received from CMS, AHCCCS will continue to work with its stakeholders to develop strategies that strengthen systems of collaborative care among Indian health and non-Indian health providers and improve care coordination and care management capability for AIHP members. AHCCCS will seek to implement these strategies through the American Indian Medical Home waiver, State Plan Amendments and other means that support care management and patient-centered medical home service delivery.

Current State of Affairs

Arizona's Approach to Delivery System Transformation:

Arizona's publicly-funded health care system has historically been splintered, primarily due to the fragmented system of care in existence prior to the state's participation in Medicaid, beginning in 1982, as well as the way the program evolved once authorized by the legislature. In particular, the Medicaid program was implemented under 1115 demonstration authority and was envisioned as a partnership between the state and acute care health plans. After a disappointing two-year period using a contractor to run the program, Arizona directly administered the Medicaid program through a cabinet level department utilizing MCOs. This turn around in acute care delivery allowed Arizona to launch a new component to the program, Arizona Long-Term Care System (ALTCS) in 1988. This new component utilized capitated comprehensive benefits through various program contracts serving both the disabled and the elderly. Finally, in 1995, AHCCCS completed a five-year phase-in of behavioral health services that were implemented through a separate contract with RBHAs and Tribal RBHAs.

For most Medicaid populations, services have been administered by these separate systems dependent on the needs of the populations: acute care plans for physical health and RBHAs for behavioral health. For individuals requiring long-term care, separate plans are responsible for all services: acute physical health, behavioral health and long-term services and supports. These systems have developed and functioned, for the most part separately, as the state added care components over time — unique providers, unique information and data systems, and unique strategies to develop care protocols. The system for providing care to American Indians has evolved alongside these delivery systems, similarly with limited systematic integration.

Recently, however, Arizona has taken steps towards reducing these siloes by integrating payers for its Medicaid populations. In one example, AHCCCS has made one contractor responsible for all services for specialized populations, including children with chronic health conditions served by Children's Rehabilitative Services and individuals with serious mental illness (SMI). These modifications offered a new approach to integrated care, enhancing care- and case-management services at the payer level. For other populations, Arizona has required data sharing among its acute care plans and RBHAs to reduce blind spots in data that each plan faced and allow the MCOs to see data regarding utilization across the entire continuum of care. In addition, AHCCCS has Medicaid suspension agreements with the majority of counties such that individuals who become incarcerated (for less than one year) while enrolled in AHCCCS have their Medicaid eligibility suspended and then reinstated upon release rather than having to complete a new eligibility application upon release. AHCCCS is also planning to require (beginning in October 2016) the MCOs to have reach-in policies to prepare for an individual's release. These activities are critical foundational steps to ensure that individuals transitioning into the community from incarceration have immediate access to health care.

Finally, Arizona has been a national leader in aligning care for dual eligibles. AHCCCS requires its health plans to serve as Medicare dual eligible special needs plans and promotes enrollment of dual eligible members into the same health plan for both Medicare and Medicaid with over 45% of all dual eligible members aligned in the same health plan for their Medicare and Medicaid benefits. In addition, acute plans are now responsible for the general mental health/substance abuse services for their dual eligible members.

These improvements represent important change. However each of these integration efforts has exposed gaps in the overall delivery system and identified additional opportunities for facilitating integration throughout the care delivery and prevention continuum. While the State's Innovation Plan under SIM is focusing on efforts to address these gaps, in order for those changes to be sustainable in the Medicaid program, the State believes that investments must be made across the system, particularly at the provider level, to ensure that real delivery system change occurs. This will mean positioning providers to participate and succeed under new value-based APMs that will hinge on provider collaboration across the delivery system and on information exchange and analysis. In addition to integrating payers, AHCCCS is challenged with developing provider networks that have the critical capabilities to provide whole person care that focuses on overall health and creating partnership across all aspects of health in order to improve patient outcomes.

In order to continue progress toward delivery system and payment reform and to further bring current initiatives to scale, AHCCCS seeks to develop a program that will incentivize both providers and MCOs to collaborate more effectively, leverage available data, and develop standard clinical and administrative protocols that more effectively engage patients and caregivers and ultimately provide more effective care for the defined program populations. Funding available through the incentive payments will provide fiscal support for providers electing to be participating Delivery System Reform Incentive Payment Program (DSRIP) entities. The structure of the projects and the payment attribution and distribution will provide the catalyst for providers to jointly develop strategies and approaches to care that are beneficial to all of their patients and, in particular, AHCCCS enrollees. This is a critical investment strategy as some of the providers serving these vulnerable populations may not otherwise be positioned to partner with AHCCCS health plans as they scale their APM initiatives, as well as participate

in larger national initiatives, spearheaded under Medicare (such as Merit-based Incentive Payments or APMs) because of their patient mix, size or practice type. This is particularly true in the case of behavioral health and pediatric providers.

The common theme of transformation for all projects, providers, and populations will be integration, coordination, and data exchange and analytics applied to care delivery within the participating provider entities. The existing provider entities will determine how best to leverage the strengths of their systems to connect and work with other systems and the health plans to achieve the core competencies described by AHCCCS. In addition, AHCCCS will be encouraging provider entities to form relationships with community-based social service resources to participate in the transformation projects, including but not limited to, self-help referral connections, community group resources, peer professionals, and housing and employment support services. However, specific tactics, providers, and services will be highly dependent on the targeted populations that the DSRIP provider entities seek to engage.

Behavioral Health and Physical Health Integration:

Historical Background

In 1990, AHCCCS began phasing in comprehensive behavioral health services, starting with seriously emotionally disturbed (SED) children under the age of 18 who required residential care. Over the next five years, other populations were added, including non-SED children in 1991, adults with serious mental illness in 1992, and adults needing general mental health and/or substance abuse services in 1995. The State supported a separate system of care for the treatment of behavioral health conditions instead of “carving-in” those services in the benefit plan administered by the acute health plans. This separation of behavioral health and physical health services was the desired approach of the behavioral health advocacy community at the time. The challenge for the State is balancing this long-held view with current health data and research showing health care disparities for persons with behavioral health conditions that could be addressed through system integration. Accordingly, and out of respect for the partnership with the behavioral health advocacy community, the State has taken incremental steps to move closer to an integrated behavioral and physical health delivery system but only after extensive stakeholder engagement. In 2014, AHCCCS shifted Medicaid-funded physical health services for individuals with SMI living in the State’s largest county and largest urban center to the RBHA administering services in that geographic area. In 2015, the remainder of the State moved to this integrated model for Arizonans with SMI.

In addition, state structural design utilized separate state agencies to oversee Medicaid health services exacerbating fragmentation. Historically, the Division of Behavioral Health Services within the Arizona Department of Health Services managed the behavioral health services and AHCCCS managed the physical health services. Effective July 1, 2016, the Division of Behavioral Health Services has been successfully merged with AHCCCS so that both physical and behavioral health services are now administered through AHCCCS.[2] The differing state administration means separate contracts for physical and behavioral health services for the same members. This resulted in the development of entirely separate provider networks and delivery systems, where behavioral and physical health providers worked separately with limited collaboration.

[2] The merger took place over several months and was completely finalized on July 1, 2016.

With this historical background, it is not surprising that, in spite of these progressive changes toward integrated care, Arizonans with both behavioral health and physical health needs still struggle to receive the best care because of the lingering fragmentation throughout the delivery system. The lack of care coordination and integration between the two systems can hamper optimal care and result in an inadequate identification of and response to a person's total health needs. The adverse effect of uncoordinated care can have a particularly profound impact on the physical health of those with serious behavioral health conditions as further addressed below.

AHCCCS has care coordination requirements in its acute managed care contracts, including the following:

- The health plan must provide care coordination to members with special health care needs or chronic health conditions. In addition, the health plan is encouraged to develop specific strategies to promote care integration activities through contracting with behavioral health providers and consideration of members' behavioral health needs.
- The health plan is required to proactively provide care coordination for members with both behavioral health and physical health needs, including the requirement to meet regularly with the RBHAs.
- The health plan is required to develop a short- and long-term strategy to improve care coordination for individuals with behavioral health needs.

However, the ability for the managed care plans to effectively coordinate care and provide integrated care is limited by the providers' ability to participate in that process. The providers are directly delivering care and are in a better position to coordinate care in real time, but for them to do so effectively, many need infrastructure support to assist with data sharing, utilizing data analytics, having processes in place to support team-based care, and establishing the ability to make connections to social services. These areas represent fundamental changes in practice operational processes. In addition, it is difficult for providers to make these changes individually without transformation support and a common framework of clinical and administrative protocols designed and administered in coordination with the health plans. The DSRIP program provides the opportunity to support, facilitate and align this kind of delivery system evolution and thereby achieve a new level of integration and improved outcomes.

Impact of Fragmented Care for Children with Behavioral Health Needs, Children with and At-Risk for ASD, and Children Engaged with the Child Welfare System

Children with behavioral health needs, children with and at–risk for ASD, and children engaged with the child welfare system and their families have found that insufficient and inconsistent linkages between community-based health and behavioral care, social service resources, and hospital care can leave them frustrated.

In addition to responding to Arizona children and families, there are multiple compelling reasons to focus upon these pediatric populations, based on national research:

- Behavioral health care accounts for approximately 38% of Medicaid expenditures for children.
- Children in child welfare system and those on Supplemental Security Income/disability represent one-third of the Medicaid child population using behavioral health care but represent 56% of total pediatric behavioral health expenses.

- Almost 50% of children in Medicaid prescribed psychotropic medications receive no accompanying identifiable behavioral health services, such as medication management.[3]

As in the rest of the U.S., Medicaid-enrolled children with behavioral health needs often receive fragmented care from multiple public systems leading to poor health outcomes and costly utilization. A December 2013 report recommended that efforts be made nationally to improve care coordination for these children, including collaboration between child-serving systems**,** especially the child welfare, behavioral health, and primary care systems.[4]

Impact of Fragmented Care for Adults with Behavioral Health Needs

Adults with behavioral health needs too 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.[5] That report also observed that "Although individuals with mental health conditions have some of the greatest health care needs (including complex polypharmacy regimens) the health care system is often too fragmented to effectively and efficiently serve them."

Individuals Transitioning from the Justice System:

Historical Background

On average, 9,000 Arizona Medicaid beneficiaries are incarcerated in a given month. In fiscal year 2015, of the approximately 120,000 individuals that transitioned from incarceration into the community, approximately 42,000 were enrolled (or re-enrolled if eligibility was suspended) in AHCCCS. AHCCCS analysis shows that there are a significant number of individuals who are eligible for Medicaid but not enrolled upon release.

Many individuals begin their incarceration with undiagnosed or underdiagnosed behavioral health conditions.[6] In addition, research on recidivism indicates that three out of four incarcerated individuals are re-incarcerated over the course of five years.[7] The inability to access behavioral health services, including treatment to address substance use disorder, is a contributing factor to recidivism. Further compounding the issue in Arizona is the significant shortage of behavioral health providers within the State's counties and federal correctional facilities.[8]

When these individuals transition out of incarceration, there is a need to ensure they have access to the needed services and social supports without a break in care. Individuals transitioning out of incarceration experience significant gaps in care. While incarcerated, these

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[3] Rires SA et al. Examining Children's Behavioral Health Service Utilization and Expenditures**.** Center for Health Care Strategies, Inc. Hamilton, NJ December 2013.
[4] Ibid.
[5] General Accounting Office (GAO). A Small Share of Enrollees Consistently Accounted for a Large Share of Expenditures. GAO 15-460 May 2015.
[6] See www.tacreports.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf TAC—The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey.
[7] 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.
[8] See Arizona State Health Assessment April 2014 at page 113, available at http://www.azdhs.gov/documents/operations/managing-excellence/az-state-health-assessment.pdf.

individuals generally receive health care services from the counties or the state's Department of Corrections (depending on whether they are incarcerated in a jail or prison). The providers within the jail and prison systems typically do not have access to an individual's health history (unless the individual is a repeat offender) and may not be aware of chronic conditions, treatment plans, or medications. Similarly when the individual transitions out of incarceration, community providers are not privy to the treatment the individual received while incarcerated. To further complicate the issue, often when leaving a prison or jail individuals (particularly those with chronic physical and/or behavioral health conditions) have no warm hand-off to transition their care and ensure continuity.

Impact of Fragmented Care for Individuals Transitioning From the Justice System

While AHCCCS has taken steps to keep members attached to their health plans through suspended enrollment during incarceration, and has established early intervention and outreach activities to enroll newly released individuals, additional strategies are needed to effectively engage previously incarcerated individuals with health care providers in their communities. National research has found that 80% of released individuals have chronic medical, psychiatric, or substance abuse problems, yet only 15% to 25% report visiting a physician outside of the emergency department (ED) in the first year post release.[9] It has also revealed that there is little care coordination between prison/jail and community health systems. For example, few individuals are released with a sufficient supply of chronic medications or primary care follow-up.[10] In addition, individuals leaving prison/jail may not fully understand the scope of Medicaid benefits available to them or how to appropriately access services. Given their additional need for support as they transition into the community, this population is likely to need a higher, more intense level of care coordination by providers as they are settled in the community.

American Indians:

Historical Background

The location of services for American Indians varies to a large extent. American Indians (including those who are enrolled in Medicaid), regardless of whether they live on or off tribal lands, can receive services at any Indian health facility, including IHS sites, Tribal 638 programs and facilities, and Urban Indian Health Programs. While the issue of provider choice is important, the lack of care coordination among providers and across the care continuum challenges service delivery for American Indians. Each of these settings provides care to individual members without visibility into the care the members may receive from other providers, making care coordination and whole-person care challenging.

Within the Medicaid program, American Indians may enroll in either the FFS AIHP or one of the AHCCCS-contracted managed health plans. For American Indian Medicaid eligible residents who live on tribal lands and do not elect a Medicaid enrollment choice, enrollment defaults to AIHP. In contrast, if the American Indian Medicaid eligible resident does not live on tribal lands, and does not make a Medicaid enrollment choice, the individual is auto-assigned to a managed care plan based on factors such as family participation in the plan. Choice is key; American

[9] Mallik-Kane K, Visher CA. Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration. Washington, DC: The Urban Institute; 2008 and Mallik-Kane K. Returning Home Illinois Policy Brief: Health and Prisoner Reentry. Washington, DC: Urban Institute Justice Policy Center; 2005.

[10] Wakeman SE, McKinney ME, Rich JD. Filling the gap: the importance of Medicaid continuity for former inmates. *J Gen Intern Med*. 2009; 24(7):860---862 and Flanagan NA. Transitional health care for offenders being released from United States prisons. *Can J Nurs Res*. 2004; 36(2):38---58.

Indian Medicaid enrolled individuals can change enrollment from AIHP to a managed care plan at any time and vice-versa. These enrollment options have created churn between managed care and AIHP. In general, however, one third of Arizona's American Indian population is enrolled in AIHP and as of May 2016, the program had approximately 120,000 members.

This fragmented system of care is evident both (i) among Indian health providers and (ii) between Indian health providers and non-Indian health providers. For example, it is a common occurrence that primary care providers caring for individuals in Indian health organizations are not aware of their patients' admission to or discharge from a hospital outside their communities. Consequently, appropriate discharge planning and follow–up care does not routinely occur, sometimes resulting in avoidable ED visits or hospital re-admissions. Likewise, the attending hospital or ED provider who is seeing the patient for the first time is faced with providing care without complete knowledge of the patient's medical history, including medications. This significant fragmentation of services is believed to contribute to observed health disparities and present challenges in improving outcomes for American Indians in Arizona.

American Indians with chronic or complex conditions, including those with SMI, are often most negatively impacted by system fragmentation. Continuity of care, including medication and other therapies, are critical for those with serious health conditions. However, the current delivery system does not provide the infrastructure to support appropriate care management.

A key contributor to care fragmentation stems from inadequate health information technology (HIT) connectivity and interoperability. Health information for American Indians resides in different electronic health record (EHR) systems, with limited exchange of information needed to coordinate care. As described in the HIT section of Arizona's Innovation Plan, IHS, Tribal 638 facilities, ITUs, and non-Indian health providers often utilize distinct HIT/EHR systems and databases that do not presently communicate with each other, prohibiting the exchange of information needed to provide appropriate services and coordinate care.

The limited resources across the IHS and Tribal 638 facilities present another barrier to reducing fragmentation in the system. Generally, these organizations do not have the resources to hire additional staff to perform care coordination or care management or resources to enable interoperability that would support improved coordination.

In spite of significant resource limitations, IHS has been working across its national system to increase coordination of care through its Improving Patient Care (IPC) Program, a patient-centered medical home model. The IPC Care Model is based on the Chronic Care Model developed by the MacColl Center for Health Care Innovation. The IPC model modified the original Chronic Care Model to reflect the unique features of health care in the Indian health system. The model also has been adapted to address the strong role of family and the need to fully integrate the community and the Tribes into the vision for health care. Robust therapeutic relationships are a key element in this IPC model.

In summary, the delivery system and provider networks for American Indian Health Program members are often fragmented and fail to address the needs and care of the "whole" person across the care continuum. AHCCCS with its stakeholders has identified goals and accompanying tasks that will help bridge existing gaps in care for the State's American Indian population through enhanced care coordination, care management and HIT interoperability.

Delivery System Transformation

Future State of Affairs

Arizona believes the initiatives described below will help the State take a critical step towards achieving true delivery system reform by reducing fragmentation and developing an integrated system that provides holistic care for individuals that bends the cost curve. Detail on each of the initiatives is further described throughout this section.

Behavioral and Physical Health Integration for Adults:

Specific Objective for Adults

There is a need for a comprehensive approach to integrated care in any care setting in which an AHCCCS member may receive either physical or behavioral health services to better address mental and physical health and addiction disorders. There are four projects in this strategic focus area, all of which are mandatory for providers that seek to participate in DSRIP projects targeting this focus area. The projects are designed to foster collaboration between providers in these unique systems through joint development of information sharing tools, data analysis, clinical and administrative protocols, and preparing providers to more effectively manage population health as reimbursement systems move toward shared accountability and shared risk. The projects are further described below.

Providers Involved and Role of Acute Health Plans and RBHAs

Providers interested in participating in the adult behavioral and physical health integration projects must collaborate with other providers in order to enable the creation of collaborative clinical and financial relationships that can most effectively impact care delivery. Successful entities must engage a minimum array of providers needed to address core health and social needs of this target population. Providers forming a participating entity must consider historical patterns of care for targeted patients and must include provider partners to address:

- Acute inpatient care needs.
- Behavioral health care needs, including substance abuse disorders.
- Primary care.
- Social and community supports, as needed.
- Access to care.

AHCCCS is not dictating a governance structure for the participating entities beyond a requirement that the participating entities have executed an agreement that defines how providers will work together to accomplish the projects. These agreements must describe, at a minimum:

- Which providers will act as ‘leads’ for purposes of reporting performance on DSRIP milestones and measures, convening meetings, and disbursing incentive payments.
- How the entities will engage in data sharing and data analytics, including clinical and financial measures.
- How entities will collaborate to develop shared clinical and administrative protocols.
- How acute health plans and RBHAs and Arizona Health-e Connection (AzHeC) will participate in the partnership and projects.
- Geographic reach of entity.

Prospective participating entities will submit applications to the State that address how the entities will develop and implement projects. The applications will be scored, selected, and approved prior to any project activities starting or funding being released.

In addition to being involved in the participating entities, AHCCCS expects its acute health plans and RBHAs to not only participate as members of the participating DSRIP entities, but also to:

- Provide the DSRIP entities with analytic support to inform their strategy development and implementation.
- Participate in joint planning and implementation of care coordination protocols and activities, particularly in light of existing care management and care coordination functions that the health plans operate, and thereby define the respective roles of the acute health plans, RBHAs, and participating providers.
- Participate in the DSRIP learning collaboratives.
- Play a substantive role in relevant projects.

Description of Adult Behavioral and Physical Health Integration Projects

Project 1: Integration of primary care and community behavioral health services (primary care site). The objective of this project is to integrate behavioral health services (some of which are paid for by RBHAs) into the primary care site. This project would include both SMI and non-SMI individuals. There are many core components for successful participation in this project that include, among many others: (i) utilizing a commonly accepted behavioral health integration practice self-assessment instrument; (ii) conducting a root cause analysis to determine why certain practice patients are frequent ED and/or inpatient service utilizers and identifying the barriers to reducing the frequency of ED and inpatient use, including those that may be practice-based; and (iii) enhancing EHR capabilities between physical health providers and behavioral health providers to support coordination, foster efficient clinical practice and reduce administrative duplication.

Project 2: Integration of primary care and community behavioral health services (community behavioral health site). The objective for project 2 is to integrate primary care services into the community behavioral health care site for the purposes of better care coordination of the preventive and chronic illness care for individuals who primarily receive their services at community behavioral health sites. The core components of project 2 are similar to project 1 except this project is within a community behavioral health care site and project 1 is within a primary care site.

Project 3: Integration of primary care and behavioral health services (co-located site). The objective of project 3 is to achieve maximum impact from integration of primary care and behavioral health services to realize the potential and maximize the impact of service co-location to better address mental and physical health and addiction disorders. The core components of this project are the same as projects 1 and 2 except that this project takes place in a co-located care site where higher levels of integration are possible.

Project 4: Care coordination for adults with behavioral health conditions being discharged from an inpatient stay (hospital). The objective of project 4 is to more effectively coordinate the care for adults with behavioral health conditions who are being discharged from an inpatient stay. Hospitals participating in this project will be required to focus on care coordination with outpatient providers upon a patient's admission, and upon discharge, medication management

and communication with the RBHA. There are many core components for successful participation in this project that include, among many others: (i) developing protocols with high-volume community behavioral health providers and primary care providers to solicit their input into their patient's health history upon admission, seven days per week; (ii) providing a discharge summary to the community primary care provider and community behavioral health provider within 24 hours of discharge, which includes reason for hospitalization, principle discharge diagnosis, discharge medications and next level of care recommendations; and (iii) following-up with the patient within 48 hours of discharge for medication reconciliation and to help with any questions or problems related to transitioning care for his/her condition to the community.

Incentive Payments and Financial Sustainability

DSRIP entities that participate in the adult behavioral and physical health integration projects will be expected to meet each of the core components for each project, as well as provide required process and outcome reports on their progress. It is expected that payments made to DSRIP entities in the first two years will be related to meeting process measures (i.e., achieving milestones). It is anticipated that DSRIP entities meeting these process measures and receiving payments will utilize those payments to further build infrastructure that will facilitate and enhance integration efforts. In the later years of the demonstration, DSRIP entities will only receive payments if they demonstrate improvement or high performance on clinical measures. Throughout the process, AHCCCS will be able to further evaluate the proposed integration and care coordination strategies, and review whether additional changes to further encourage the effective integration and care coordination strategies are necessary.

At the conclusion of the demonstration, AHCCCS expects the necessary infrastructure changes will have been supported, and the model will be sustainable through APMs. Currently, AHCCCS has requirements for its health plans to have a certain percentage of its payments in value-based arrangements with that percentage increasing every year. AHCCCS may decide to add requirements to its contracts around value-based arrangements or refine existing contractual requirements to reflect the infrastructure changes implemented under DSRIP for specific projects to ensure the integration efforts are sustainable. For example, participating DSRIP entities could contract with health plans as an entity and negotiate APMs that include investments in integrated care for adults with physical and behavioral health needs.

Measurement of Transformation

DSRIP entities will be expected to meet certain performance measures to receive payments under the DSRIP proposal. AHCCCS has been meeting with stakeholders to discuss the measures. A discussion of how AHCCCS will measure the change at the system level is provided further below.

Behavioral and Physical Health Integration for Children:

Specific Objective

There is a need for a comprehensive approach to integrated care (physical and behavioral health) in any care setting in which an AHCCCS member under the age of 21 may receive either physical or behavioral health services (for example, from a primary care provider or a community behavioral health provider) to better address mental and physical health and addiction disorders. There are six projects for this strategic focus area, all of which are mandatory for DSRIP participating entities, and are focused on children with behavioral health needs, children with or at-risk for ASD, and children engaged with the child welfare system.

Providers involved and Role of Acute Health Plans and RBHAs
AHCCCS anticipates that the provider characteristics and role of the health plans will be the same as described in the adult section.

Description of Behavioral and Physical Health Integration Projects for Children
Project 1: Integration of primary care and behavioral health services for children with behavioral health needs and their families (primary care site). This project is for primary care practices to integrate behavioral health services for children (some of which are paid for by the RBHAs) within the primary care site. This project focuses on the actions necessary to fully integrate care, including managing high-risk patients using an integrated treatment plan where both physical health and behavioral health providers give input, developing referral, consultation, and warm hand-off protocols and integrating patient records. There are many core components for successful participation in this project that are similar to the core components for the adult project 1.

Project 2: Integration of primary care and behavioral health services for children with behavioral health needs and their families (community behavioral health site). This project is for community behavioral health sites to better integrate primary care services for the purposes of better care management of the preventive and chronic illnesses for children. This project focuses on the actions necessary to fully integrate care in a manner similar to project 1 and the core components are similar to the core components for the adult project 2.

Project 3: Improving treatment for the care of children with and at-risk for ASD. The objectives of this project is to improve the identification and care of Medicaid-enrolled children at-risk for Autism Spectrum Disorders or diagnosed with Autism Spectrum Disorder, and create sufficient and consistent linkages between primary care, behavioral health, and social service resources. This project would begin in DSRIP Year (DY) 2 and all participating providers would need to first successfully complete project 1 in this strategic focus area, as this project builds upon the foundation for care provided in an integrated setting addressed in project 1. This project focuses specifically on care coordination with autism treatment teams, early intervention programs, and schools to improve the care outcomes of children with Autism Spectrum Disorder. There are many core components for successful participation in this project that include, among many others: (i) utilizing a commonly accepted toolkit for caring for children with ASD as a guide for clinical management; (ii) developing procedures for referring children with positive screening to ASD treatment teams or programs; and (iii) routinely documenting family history of autism.

Project 4: Improving treatment for the care of children engaged in the child welfare system (primary care site). The objective of this project is to improve the care of Medicaid-enrolled children who are involved in the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in the child welfare system. This project would begin in DY 2, and all participating DSRIP entities would need to complete project 1 in this strategic focus area, as it builds upon the care provided in an integrated setting. This project specifically focuses on developing clinical protocols to help identify and address medical or behavioral health issues a child engaged in the child welfare system may have and to conduct care using Trauma-Informed Care principles. There are many core components for successful participation in this project that include, among many others: (i) ensuring that all practice pediatricians, family physicians, advanced-practice clinicians, and case managers who treat children engaged in the child welfare system complete a training program in Trauma-informed Care and in Child and Family Team Practice that offers continuing education credits, unless

having done so in the past three years; (ii) developing and implementing policies that allow for patients, in particular teens, to participate in shared decision making using the skills and techniques developed through Trauma-Informed Care training; and (iii) completing a comprehensive after-visit summary that is shared with the foster parents/guardians and the child welfare case worker, which can assist in guiding the foster parents/guardians and case worker in following-up on referrals and recommendations.

Project 5: Improving treatment for the care of children engaged in the child welfare system (community behavioral health site). The objective of this project is to improve the care of Medicaid-enrolled children who are engaged in the child welfare system and ensure continuity of care across providers over the continuum of the child's involvement in the child welfare system. This project would begin in DY 2 and all participating DSRIP entities would need to successfully complete project 2 in this strategic focus area prior to starting this project, as it builds upon the foundation for care provided in an integrated treatment setting addressed in project 2. This project focuses on the actions to coordinate care specifically for children engaged in the child welfare system in a similar manner to project 4. There are many core components for successful participation in this project that include, among many others, (i) conducting a comprehensive behavioral health assessment within the timeframe established by AHCCCS for patients referred by the RBHA, a primary care provider, or when a case worker, patient or a patient's parent/guardian requests an appointment, and (ii) actively outreaching to any known past and current medical and behavioral health providers to obtain and share records for the purposes of better care management.

Project 6: Care coordination for children with behavioral health conditions being discharged from an inpatient behavioral health stay (hospital). The objective of this project is to more effectively coordinate the care for children with behavioral health conditions who are being discharged from an inpatient stay. Hospitals participating in this project will be required to focus on care coordination with outpatient providers upon a patient's admission, and upon discharge, medication management and communication with the RBHA. There are many core components for successful participation in this project that include, among many others: (i) developing protocols with high-volume community behavioral health providers and primary care providers to solicit their input into their patient's health history upon admission, seven days per week; (ii) providing a discharge summary to the community primary care provider and community behavioral health provider within 24 hours of discharge, which includes reason for hospitalization, principle discharge diagnosis, discharge medications and next level of care recommendations; and (iii) following-up with the patient within 48 hours of discharge for medication reconciliation and to help with any questions or problems related to transitioning care for his/her condition to the community.

Incentive Payments and Financial Sustainability

DSRIP entities that participate in the child behavioral and physical health integration projects will be expected to meet each of the core components for each project, as well as provide required process and outcome reports on their progress. It is expected that payments made to DSRIP entities in the first two years will be related to meeting process measures (i.e., achieving milestones). It is anticipated that DSRIP entities meeting these process measures and receiving payments will utilize those payments to further build infrastructure that will facilitate and enhance integration efforts. In the later years of the demonstration, DSRIP entities will only receive payments if they demonstrate improvement or high performance on clinical measures. Throughout the process, AHCCCS will be able to further evaluate the proposed integration and care coordination strategies particular to the specific projects and target populations. Analysis of

alternative payments strategies will be necessary to support and leverage the infrastructure changes through health plan contracts.

At the conclusion of the demonstration, AHCCCS expects that language will be added to the health plan contract requirements to embed and support the care coordination activities developed through the waiver. AHCCCS has requirements for its health plans to have a certain percentage of its payments in value based arrangements with that percentage increasing every year, and this language may be modified to reflect these new models. AHCCCS may decide to add requirements to its contracts around value-based arrangements to ensure the integration efforts are sustainable. For example, participating DSRIP entities could contract with health plans as an entity and negotiate alternative payment models that include investments in integrated care for children with behavioral health needs, children with or at-risk for ASD and children engaged with the child welfare system.

Measurement of Transformation

DSRIP entities will be expected to meet certain performance measures to receive payments under the DSRIP proposal. AHCCCS has been meeting with stakeholders to discuss the measures. A discussion of how AHCCCS will measure the change at the system level is provided further below.

Individuals Transitioning from the Justice System:

Specific Objective for Individuals Transitioning from the Justice System

There is a need to facilitate better provider, community, and justice system coordination to ensure individuals transitioning out of incarceration are (i) enrolled in AHCCCS (and a health plan) if eligible for AHCCCS, and (ii) have timely appropriate access to physical and behavioral health services. There is one project for this strategic focus area for adults, described below.

Providers Involved and Role of Acute Health Plans and RBHAs

For the Justice project, AHCCCS believes that RBHAs are best positioned to lead in this effort and as such, is proposing that RBHAs will organize providers interested in this project and provide support throughout the project. RBHAs will be expected to have agreements with providers to deliver, among other things, the following services:

- Behavioral health care services, including services for substance use.
- Primary care services.
- Social and community supports services, as needed.

The RBHAs will be expected to submit an application to AHCCCS that explains arrangements with providers and how the entities will effectively implement the project. Among other things, the RBHA will need to ensure its agreement with providers explains:

Description of the Justice Project

Develop an integrated health care setting within county probation offices or Department of Corrections (DOC) parole offices to address beneficiary health care needs upon release and throughout the term of probation/parole for individuals transitioning out of incarceration. The objective of this project is to develop an integrated health care setting within selected probation and parole offices to: (i) coordinate eligibility and enrollment activities to maximize access to services; (ii) assist with health care system navigation; (iii) perform health care screenings; (iv) provide physical and behavioral health care services; (v) provide care coordination services to

assist the individual in scheduling initial and follow-up appointments with necessary providers within or outside of the integrated setting; and (vi) assist individuals with arranging and coordinating continuing care once the individual is no longer required to participate in probation/parole activities. There are many core components for successful participation in this project that include, among many others: (a) establishing an integrated health care setting(s) co-located within select county probation offices and/or DOC parole offices, the number to be determined by the RBHA and AHCCCS; (b) developing an education strategy in cooperation with the probation and parole offices to encourage individuals pre-release to utilize the integrated health care setting post-release; and (c) enhancing relationships with community-based social service resources, including self-help referral connections, community group resources, specialty mental health and substance use services, peer professionals, housing and employment support services by identifying the resources in the community, and creating protocols of when to engage or refer patients to these community-based resources.

A project targeting youth transitioning from the juvenile justice system was under consideration, but is no longer proposed based on AHCCCS' assessment that there is existing funding supporting ongoing delivery system capacity development in this area.

Incentive Payments and Financial Sustainability

DSRIP entities that participate in the Justice project will be expected to meet each of the core components for the project, as well as provide required process and outcome reports on their progress. It is expected that payments made to participating providers and plans in the first two years will be related to meeting process measures (i.e., achieving milestones). It is anticipated that providers and RBHAs meeting these process measures and receiving payments will utilize those payments to further build infrastructure that will facilitate and enhance integration efforts. In the later years of the demonstration, providers and RBHAs will only receive payments if they meet specific outcome measures. Throughout the process, AHCCCS will be able to further evaluate the proposed integration and care coordination strategies and evaluate options for alternative payment strategies to RBHAs and providers or develop plan incentives to support the transformation achieved through the DSRIP.

AHCCCS expects the necessary infrastructure changes will have been supported, and the model will be sustainable through value-based payment strategies targeting both providers and plans for this focus area. Currently, AHCCCS has requirements for its health plans to have a certain percentage of its payments in value-based arrangements with that percentage increasing every year and additional options could be identified associated with this specific project. AHCCCS may decide to add requirements to its contracts around plan incentives tied to outcomes associated with justice-involved individuals and/or the inclusion of value-based arrangements or care coordination payments to providers to ensure the integration efforts are sustainable. For example, RBHAs could implement provider pay for performance payments for successful transitions of individuals from the probation clinic to community providers or reward outcomes associated with wellness activities or treatment adherence successes by plans.

Measurement of Transformation

DSRIP entities will be expected to meet certain process performance measures to receive payments under the DSRIP proposal. AHCCCS has been meeting with stakeholders to discuss the measures. A discussion of how AHCCCS will measure the change at the system level is provided further below.

American Indians

Specific Objective for American Indians Receiving Services from AIHP

There is a need to improve health outcomes for American Indians by creating more robust care coordination and care management for American Indian Health Program (AIHP) members, through collaborations that seek to improve infrastructure, communication, use of data, consistent outcome measures, and application of operational and clinical protocols. Four projects have been developed for this strategic area. Each project is summarized below. Based on recent CMS guidance, AHCCCS will be exploring with stakeholders ways to achieve these projects through the American Indian Medical Home and American Indian Medical Home + waiver, a State Plan Amendment or other means and will not be pursuing this initiative under the DSRIP. However, it is important to note that these projects and their core components have undergone extensive stakeholder review and the descriptions below reflect that feedback. Nonetheless, AHCCCS will be making adjustments to the descriptions below based on CMS feedback but will continue to push for improved care management system development through regional collaboratives and expanded medical homes capability.

Description of Projects

Project 1: Provider Role in Care Management Collaboratives (CMCs) Formation, Governance and Management. Three regional CMCs are proposed to advance care management collaboration among Indian health and non-Indian health provider organizations. Providers will participate in CMC activities to ensure that commonly understood and shared care management strategies are developed and implemented. This project focuses on the activities in which providers will engage and collaborate constructively in the formation of the CMCs, participate in training developed by the CMCs, and implement protocols created collaboratively by the CMCs and providers.

Project 2: Care Management. The goal of this project is to develop a care management system for American Indian populations enrolled in AIHP and receiving treatment through Indian health and non-Indian health provider organizations participating in the CMC. This project focuses on the development and implementation of specific care management protocols, including standard care plan development, member engagement in care management, availability of care management services, and appropriate and timely communication of records for care management activities.

Project 3: Care Management and Data Infrastructure. The goal of this project is to develop a data infrastructure that can support data analytics using both clinical data and claims data for CMC participating providers. This project focuses on accessing and utilizing data analytics, requirements for which data must be shared/reported, and use of state-based resources, including the Controlled Substances Prescription Monitoring Program and the Network, the state's health information exchange.

Project 4: Transformation of primary care sites serving AIHP members into Patient-Centered Medical Homes (PCMH). The goal of this project is to train primary care practices and community behavioral health practices on core PCMH skills and track their increased skill level over time. This project focuses on the core requirements to develop PCMH functionality, including adopting a quality improvement strategy, conducting care management activities, using evidence-based care, enhancing access, and integrating portions of behavioral health into

the primary care setting, among other attributes. The project is built around the eight Qualis change concepts for safety net medical homes.[11]

Delivery System Transformation Assessment

In order to assess transformation at the system level, AHCCCS will focus on aspects of clinical performance that should improve as a result of better integrated care for enrollees with behavioral health needs. In addition, AHCCCS will track evolution towards increased use of risk-bearing value-based payment models.

AHCCCS has identified the following candidate measures for assessing delivery system transformation with the intention that two measures will ultimately be selected for each of the three strategic focus areas. Because AHCCCS is currently in the process of calculating baseline rates for these measures and other measures to identify where opportunities for improvement exist, final proposed measures will be presented to CMS by November 2016 and may include measures other than those presented below.

DSRIP Strategic Focus	Candidate Measure #1	Candidate Measure #2	Candidate Measure #3
Justice transition: Individuals released from Incarceration	Adults access to preventive/ambulatory health services (HEDIS)	Follow-up after emergency department visit for alcohol and other drug dependence (HEDIS)	Adult body mass index assessment, (HEDIS)
Children: behavioral/physical health integration	Well-child visits in the third, fourth, fifth and sixth years of life for children with a behavioral health diagnosis (HEDIS, modified)	Follow-up after emergency department visit for mental illness (HEDIS)	Mental health utilization (HEDIS)
Adults: behavioral/physical health integration	Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (HEDIS)	Follow-up after emergency department visit for mental illness (HEDIS)	HbA1c poor control >9% for adults with diabetes and a behavioral health diagnosis (HEDIS measure component, modified)

For the purpose of assessing adoption of risk-based APMs, AHCCCS proposes to track contracted health plan performance relative to the following targets, all defined using the Health Care Payment Learning and Action Network (HCP-LAN) framework[12]:

[11] www.safetynetmedicalhome.org/change-concepts
[12] See https://hcp-lan.org/groups/apm-fpt/apm-framework/

Measure #1: Percentage of overall managed care spend in alternative payment models (2016 baseline = 23%)

DSRIP Year	Percentage spend in HCP-LAN Categories 2, 3 and 4
1	30%
2	40%
3	50%
4	60%
5	70%

Measure #2: Percentage of overall managed care spend in HCP-LAN Category 3 or 4 (assumes CYE 2018 MCO VBP contract requirements modified to HCP-LAN APM framework)

DSRIP Year	Percentage spend in HCP-LAN Categories 3 and 4
2	5%
3	10%
4	20%
5	40%

Once again, AHCCCS will consult with an invited group of providers and evaluate alternative payment model contract requirements before making a final selection(s).

Funding

AHCCCS proposes to fund the DSRIP activities through waiver savings and finance those payments through a combination of intergovernmental transfers and state funds made available through federal matching of a limited number of designated state health programs (DSHP). Funding will scale down throughout the final years of the waiver period ending in demonstration year five of the current renewal request.

Funding for transformational activities will target infrastructure investment and incentivize providers to collaborate on the development of shared clinical and administrative protocols to enable patient care management across provider systems and networks. AHCCCS has developed initial project components and milestones and is actively working with stakeholders to validate and refine these project strategies. Development of incentive payment methodologies will follow finalization of projects and their associated metrics.

Projects focusing on Individuals Transitioning from Incarceration will require the actual development of care coordination infrastructure, data analytics, and provider collaboration where little or no capabilities exist. AHCCCS is in a unique position to act as an agent for change and a convener of critical providers to leverage existing systems, as well as establish care coordination capabilities and data exchange capabilities. Additionally, AHCCCS may need to invest in state infrastructure to support this and other proposed projects. Such investments would be limited and might include expenses associated with certain administrative expenses, management information systems, health information exchanges and IT systems, medical management, policy and procedure development and data analytics. DSRIP investments at the state level will be limited to 5% of total DSRIP expenditures annually and will phase out by demonstration year 4.

Projects focused on behavioral health for adults and children will leverage existing provider infrastructure and health plan data and networks to build capacity to complete projects within those categories. Payments would be based on development of joint care coordination and care management plans, data sharing, and data analytics capabilities. In all cases, as providers implement and actively utilize care coordination, payments would transition to support those activities ultimately leading to alternative payment strategies.

AHCCCS has identified the total potential funding under the waiver for these projects at the following levels:

Programs	DY 1	DY 2	DY 3	DY 4	DY 5	Totals
Transitioning from Incarceration	$22 m.	$22 m.	$22 m.	$18 m.	$16 m.	$100 m.
Adult BH Integration	$156.99 m.	$156.99 m.	$156.99 m.	$116 m.	$92 m.	$678.97 m.
Pediatric BH Integration	$156.99 m.	$156.99 m.	$156.99 m.	$116 m.	$92 m.	$678.97 m.
Totals	$335.98 m.	$335.98 m.	$335.98 m.	$250 m.	$200 m.	$1,457.94 m.

Most funds would be paid to providers directly, including health plans as appropriate, though a small, annual percentage may be made available to coordinating entities to support transformational activities and potentially social support services as appropriate within project networks. It is important to note that the total dollars available through this program are not large relative to the value of services provided; total funding for this program represents less than 3% of the AHCCCS Medicaid expenditures. This was a strategic decision to emphasize that this funding is transitional, enough to catalyze change but also at a level that can be absorbed within longer term payment reform.

Funding for these payments would rely on (i) intergovernmental transfers from eligible providers, and (ii) state dollars associated with Designated State Health Programs (DSHP) matched at Arizona's federal medical assistance percentage rate for all projects. Arizona expanded coverage in 2014 and recently restored children's health insurance program coverage up to 200% of the federal poverty level. It is critical that Arizona be able to effectively provide coverage, ensure access, and manage these additional populations. Absent investment through these transformation efforts, it is unlikely that providers would be able to self-fund such coordination and collaboration nor would those transformations likely be made to encompass providers that currently have little interaction.

The State has focused significant resources in on expanding and restoring coverage, and the use of DSHP investments would enable this critical component allowing providers to move toward taking more accountability for care delivery. Absent the utilization of DSHP, reliance for the non-federal share would fall entirely on government providers (of which there is only one), local jurisdictions, such as universities (which have only limited resources to devote to these efforts) or counties. Arizona has a very limited public provider infrastructure. Relying on locally generated funding often limits a state's ability to invest in projects that are most ready for transformation or most likely to make an impact immediately on system change and beneficiaries' lives. Utilizing DSHP allows the state to target investments to the most appropriate providers, networks and plans rather than simply those that can provide the non-federal share.

AHCCCS has identified several state-only health programs for which it seeks federal matching funding.

State Only Programs

Program	Amount	Source
Smoking Cessation	$16.9 m.	Tobacco Tax
Prevention Services	$19.6 m.	Tobacco tax
Trauma Services	$25.0 m.	Indian Gaming
DD/HCBS Funding	$16.1 m.	General Fund
Individuals with SMI	$50.0 m.	General and County Funds

In addition, the state would receive $15 m. in inter-governmental transfers from providers to support DSRIP payments annually.

The transformational payments would support infrastructure and development payments in demonstration year's one and two and outcomes and quality measures in years two through five. AHCCCS would work with stakeholders, health plans and the Centers for Medicare & Medicaid Services to develop alternative payment methodologies during demonstration year five to transition to sustainable financing strategies focused on the value added through these projects post-transformation. In particular, AHCCCS would leverage health plan contracting opportunities to increase the use of reimbursement strategies that include provider entities in both financial risk and reward and recognize increased quality and health outcomes (category 3 and 4 alternative payment models within the HCP-LAN APM framework). In addition, through extensive stakeholder engagement and using its procurements, the State will continue to facilitate opportunities for integration. AHCCCS will be conducting a significant procurement in 2018 and will seek stakeholder support to pursue additional payor integration. State share for this post-waiver period would rely on general fund dollars achieved through efficiencies and achievements in population health outcomes.

AHCCCS intends that this Medicaid investment will accelerate the transformation of the delivery system, resulting in sustainability through outcomes and value-based payment strategies, as well as to develop state accountability milestones to measure progress of the transformational program. AHCCCS is currently working on identifying the appropriate statewide measures that both have a high correlation to the transformation efforts and are measureable. AHCCCS is proposing to be subject to a one percent reduction in DSHP funding if it does not meet these defined goals.