AHCCCS Update

SIM Sustainability Delivery System Reform Incentive Payment - DSRIP

Arizona State Innovation Model Vision

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

SIM Strategies

Focus on Complex members, with an emphasis on:

1. Physical Health/Behavioral Health Integration
2. Justice System Transitions
3. American Indian Health Program Care Coordination

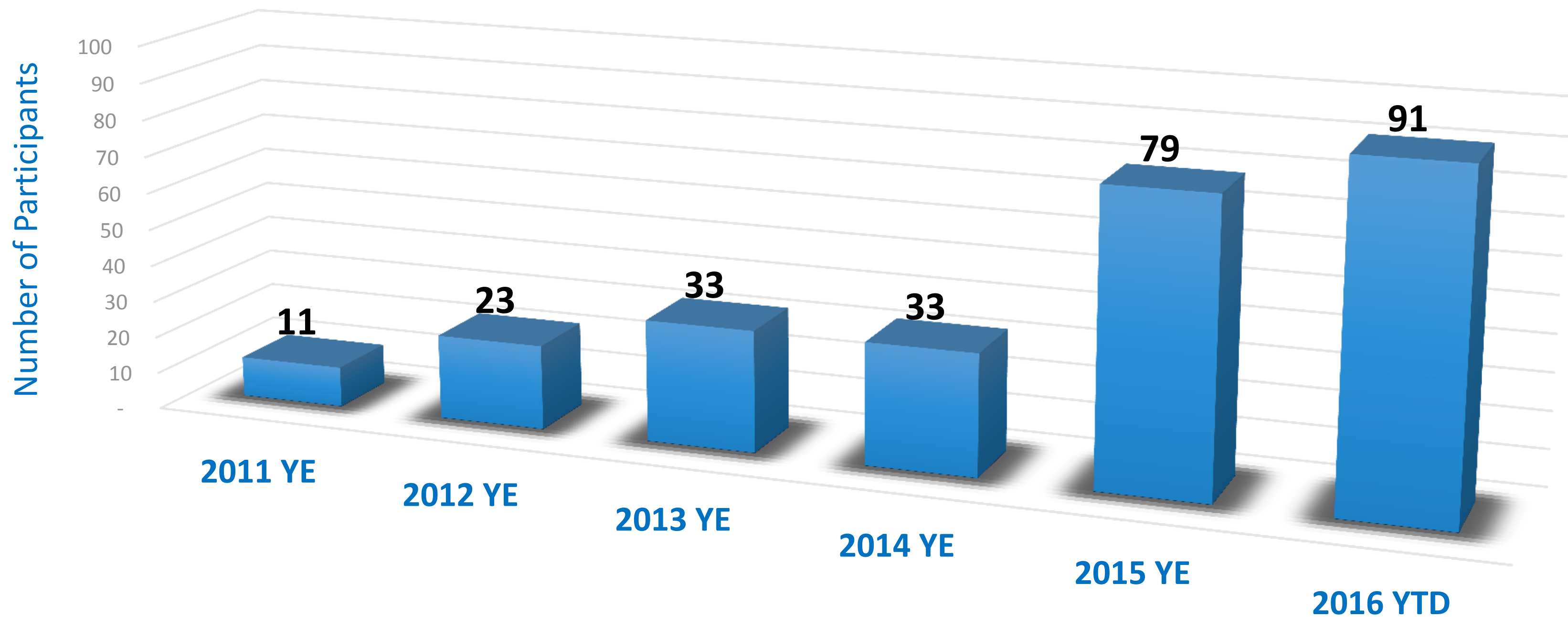
Opportunities:

- Leverage Value Based Payments
- Leverage HIE and Data sharing
- DSRIP now seen as vehicle to leverage Medicaid Venture Capital

Arizona's Application

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

The Network – Growth All Participants



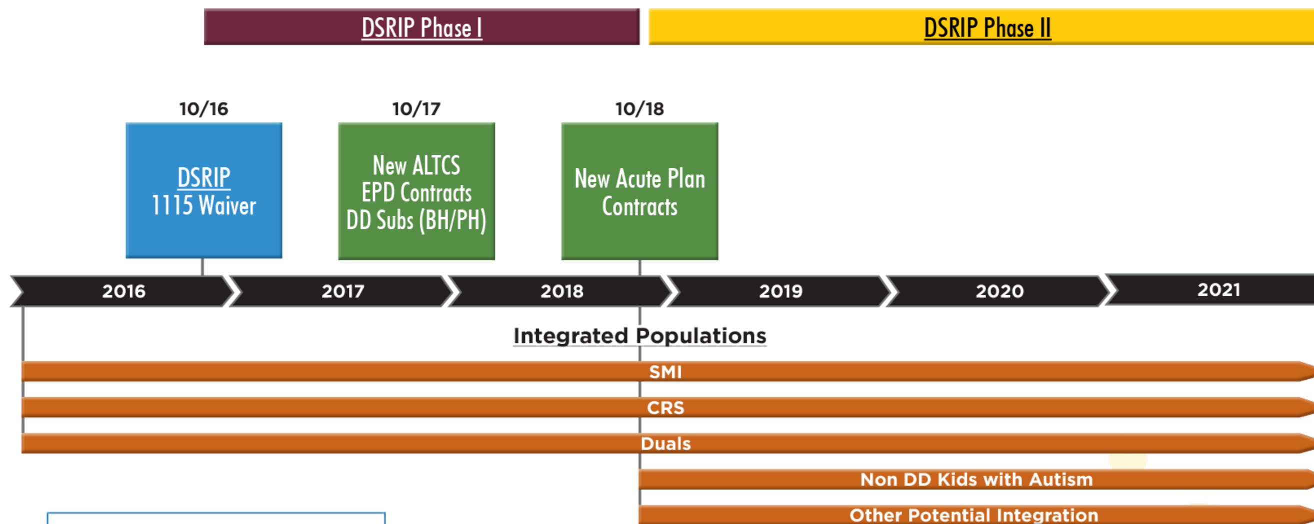
88% of the 2015/2016 growth occurred after the implementation of the new HIE Infrastructure.

AHCCCS
Arizona Health Care Cost Containment System

Summary of State DSRIP Programs

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

DSRIP Timeline



MCO ROLE

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

DSRIP Phase I

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

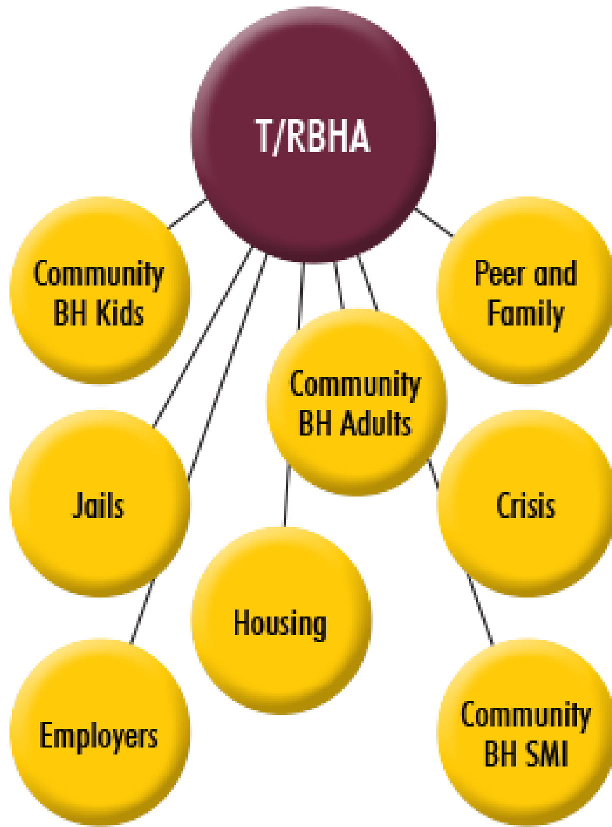
DSRIP Phase II

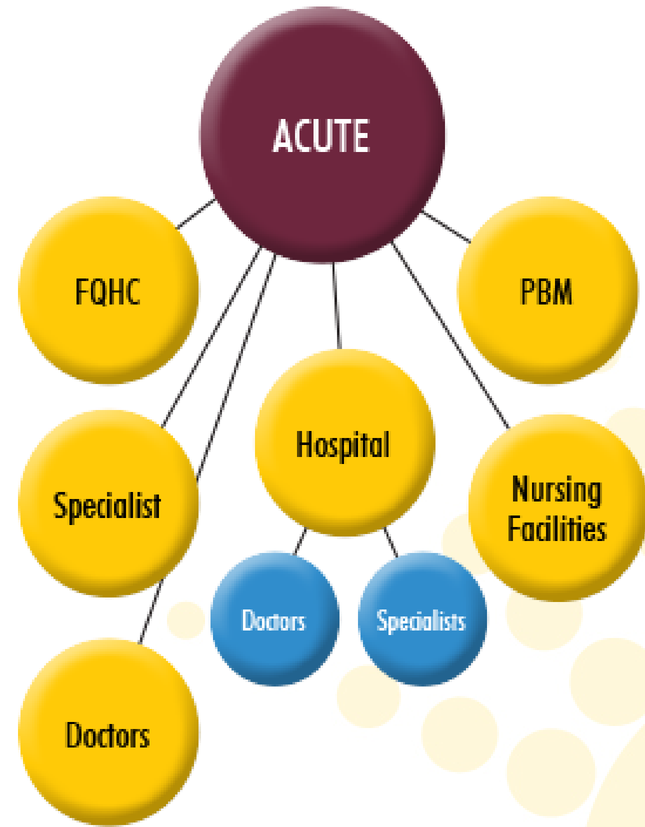
- MCOs Form DSRIP Entities Based on Provider Network Requirements Serving Broader Populations

DSRIP Projects

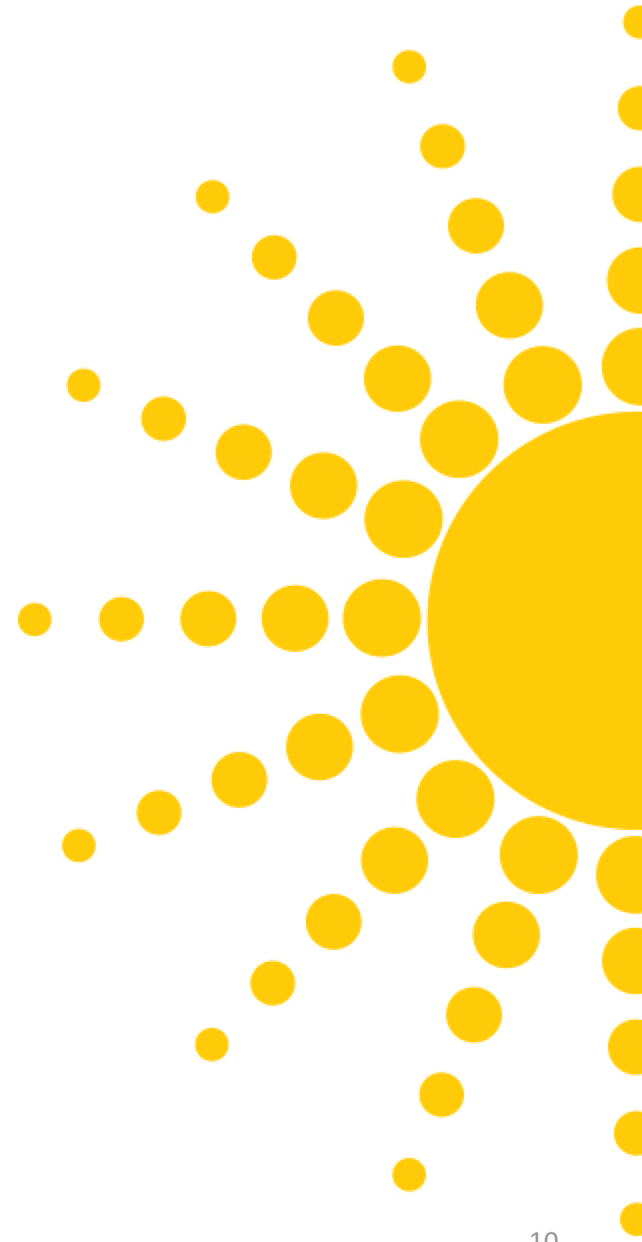
1. American Indian Care Management Collaboratives
2. Physical Health - Behavioral Health integration
   a. Adults
   b. Children
3. Justice System Transitions

Fragmented Delivery System





CMC DSRIP



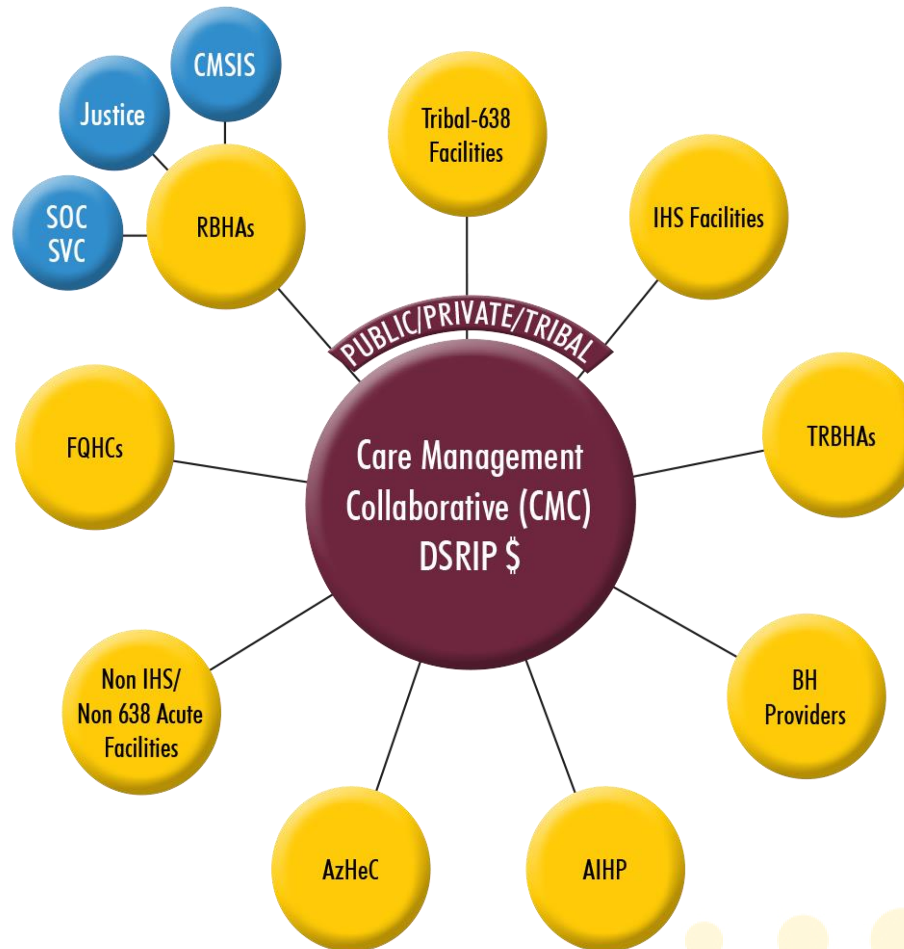
American Indian Health Program

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

Care Management vs Care Coordination

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

AIHP DSRIP Framework



CMC DSRIP Proposal

Create 3 Regional Care Management Collaboratives

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

CMC DSRIP Aligns and Complements Medical Home Waiver

- 1115 waiver proposal includes Medical Home waiver which would pay a PMPM to qualifying facilities
- Current IHS/tribal 638 workgroup is working to update formal proposal
- DSRIP is focused on building care coordination and care management across system (IHS/tribal 638 and non-IHS/tribal 638 provider~~s~~ organizations)
- Medical Home waiver is focused on building internal facility/organizational capacity

CMC DSRIP Proposal

- Funding targeted towards High Volume providers
- Would be available to limited number of providers, with a limited number of non-IHS/tribal 638 providers
- Vast majority of funding targeted to Indian health organizations (IHS/tribal 638/Urban Clinics)
- Would include both PH and BH Providers
- Requesting 100% federal participation
- Funding would also help support CMC Infrastructure
- Funding would complement Medical Home Waiver

CMC DSRIP Projects

Project 1 – Care Management Collaboration Formation

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

CMC DSRIP Projects

Project 2 – Care Management Execution

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

CMC DSRIP Projects

Project 3 Data Infrastructure

1. IHS/Tribal 638 Providers submit more robust claim detail – onetime
2. Dedicated support of CMC Data analytics tools - ongoing
3. Ability to identify complex members accessing internal/external delivery system - ongoing
4. AZHEC Connectivity – receive data & push data- onetime each
5. Register and use CSPMP - ongoing

CMC DSRIP Projects

Project #4 – Justice System Transitions –

1. CMC works with Justice system and relevant behavioral health and physical health to work with Justice involved members
2. CMC works with others to support integrated co-located clinic within probation offices and DOC parolees
3. CMC works to expand capacity to assist with eligibility
4. CMC works with partners to work on transitions for those incarcerated in jail >30 days – prison > 90 days
5. CMC works with providers on peer services
6. CMC and providers partner on training for staff
7. CMC and providers partner with justice system on data transitions

AIHP Member Scenario #1

- 59 year old male – has few positive relationships, unstable housing, has frequent medical crises and does not routinely take medications as prescribed.
- History includes uncontrolled Diabetes, advanced heart disease, and behavioral health issues related to chronic substance use.
- Past 3 months:
  - 28 ED visits. 8 IP admissions in which 3 were re-admissions.
  - Member has filled 42 prescriptions at IHS/638 facilities.
- Enrolled with the RBHA, but has not yet accessed any services.

After DSRIP Improvements:

- Member presents to the Chinle ED but has a medical home in Winslow. Care management is notified by a real-time 24 hour notification (HIE) that the member is in the ED.
- On-call care manager contacts the Chinle ED and supports the evaluation for diabetes and heart disease.
  - Transfer to Flagstaff is avoided because of access to prior records (via HIE).
- RBHA evaluation occurs via video conferencing at the Chinle ED.
  - Substance abuse education, peer support, and temporary housing are arranged.
- Follow-up appointments are scheduled, including transportation, and the member is safely discharged from the Chinle ED.
  - Care mgmt closely monitors– with CHR & PHN visits to temporary housing - to help with diabetes care and assure understanding of the treatment plan.
- Member engages with Winslow medical home and outcomes improve.

AIHP Member Scenario #2

- 39 year old female – limited mobility, has SMI, lives alone, recent loss of a friend.
- History includes PTSD, and bi-polar D/O, chest pain, shortness of breath, nausea and vomiting, open wounds.
- Past 3 months:
  - 15 ED visits due to medical symptoms and wound care.
  - 3 admissions due to anxiety and wound infections.
- 214 prescriptions filled over the last year, from over 30 different prescribers.
- Open episode of care with RBHA, but only receives meds.

After DSRIP Improvements

- Member presents to the Tucson Medical Center ED but has a medical home in San Carlos. San Carlos Care Management team is alerted by a real-time 24 hour notification (HIE).
- On-call care manager contacts the Tucson Med Ctr ED and supports member evaluation for shortness of breath
  - Access to records and medication history (via HIE) indicates member is allergic to 1 antibiotic and develops side effects to another medication
- RBHA engages on site in the ED. Interpreter, 1:1 grief counseling, transportation and behavioral health services are put in place.
- Care management team monitors care plan implementation
  - Home nursing appts are pre-scheduled for wound care (with wound specialist involved via secure video). Follow-up with behavioral health team occurs.
- Member engages with medical home/RBHA and outcomes improve.

DSRIP Requires Measures for Projects

Metrics (examples)

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

DSRIP and new 100% Guidance

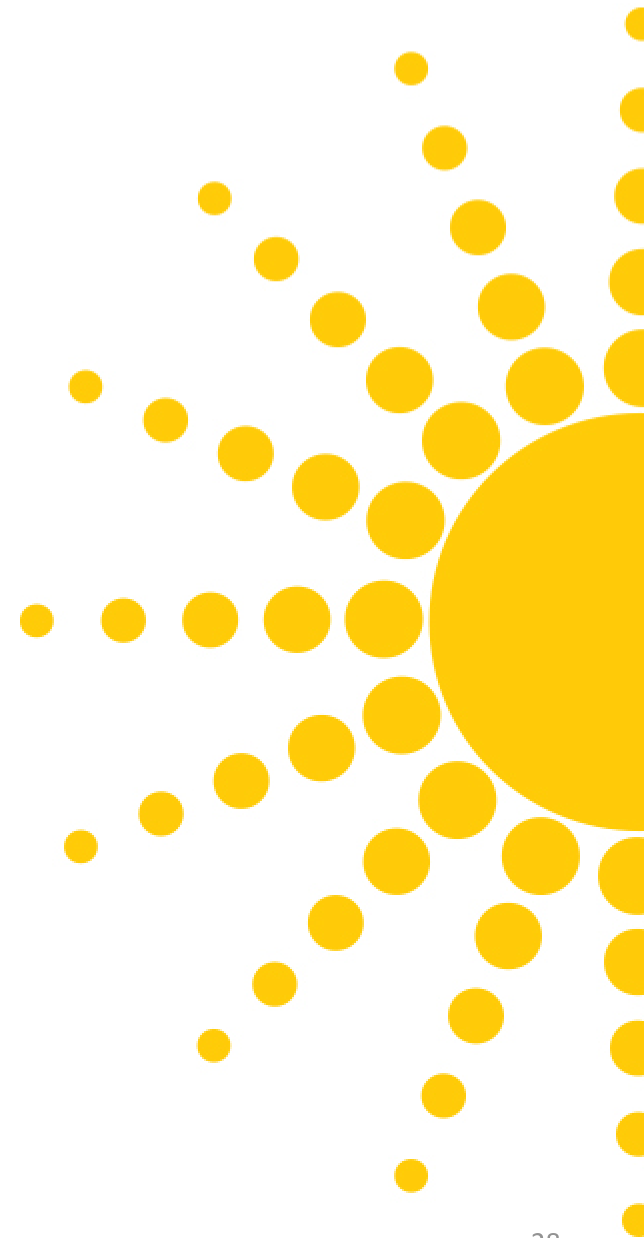
Covered Service eligible for 100% match

1. Established relationship between patient and clinician at I.H.S/Tribal facility
2. Care must be provide pursuant to a written care coordination agreement under which I.H.S/Tribal practitioner remains responsible
    1. Provide request for specific service
    2. Information provided back by non-tribal provider
3. I.H.S Tribal facility retains control of the patient's medical record

Issues for Consideration

1. Are these the right projects?
2. Does a regional approach make sense?
3. What are the regions?
    1. Mirror RBHA except Pinal goes with Central
4. Are there provider organizations & stakeholders missing?
5. How should regional funding be allocated
    1. AIHP Member Distribution
    2. HNHC Member Distribution
    3. Utilization Distribution/Spending

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

Next Steps

- March 17th – Met with Indian Health Medical Home workgroup
- March 23 – Tribal Consultation
- April 7– review DSRIP concepts with CMS
- Early May – post DSRIP waiver for public comment
- Summer 2016 – negotiate with CMS

Thank You.