DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

August 12, 2019

Jami Snyder
Director
Arizona Health Care Cost Containment System
801 E. Jefferson Street
Phoenix, AZ 85034

Dear Ms. Snyder:

The State of Arizona submitted to the Centers for Medicare & Medicaid Services (CMS) a report titled "AHCCCS Targeted Investment Sustainability Plan", dated March 29, 2019. The report was submitted in fulfillment of the requirement for a plan for ongoing support for the sustainability of increased behavioral health care integration and care coordination as described in the Special Term and Condition (STC) #67 of the state's section 1115 demonstration, Arizona Health Care Cost Containment System (Project No. 11-W-00275/9), dated January 18, 2019. CMS has reviewed the final sustainability plan and determined that it is consistent with the requirements outlined in the applicable STCs; therefore, with this letter, CMS is accepting the final sustainability plan for completeness.

CMS will publish the sustainability plan to Medicaid.gov, and the state may also make the plan available on its state Medicaid website.

If you have any questions, please contact your project officer, Ms. Kelsey Smyth, at 410-786-7915 or by email at Kelsey.Smyth@cms.hhs.gov.

Sincerely,

/s/

Andrea J. Casart
Director
Division of Medicaid Expansion Demonstrations

Enclosure
cc: Richard Allen, Director of Field Operations West

AHCCCS TARGETED INVESTMENTS PROGRAM SUSTAINABILITY PLAN

March 29, 2019
Jami Snyder, Director

This Report is submitted to CMS in accordance with the AHCCCS 1115 Waiver, Special Terms and Conditions, item 67, which states: "Because funding (for the Targeted Investments Program) will decrease each year after year 3 and end after year 5, the state must submit a plan for ongoing support for the sustainability of increased behavioral health care integration and care coordination. The state must submit a draft sustainability plan for CMS comment by March 31, 2019. The sustainability plan should include, but is not limited to, the following elements:

a) The scope of the behavioral health care integration activities that the state wants to maintain including analysis of alternative integration models like Integrated Care models or health homes under sections 1905(t)(1) or 1915(g) of the Act; and

b) The strategy to secure resources to maintain the integration activities."

Scope of the behavioral health integration activities that the state wants to maintain

The Targeted Investments (TI) Program participating providers are establishing numerous protocols, policies and systems of care that support the provision of whole person care through the integration of physical and behavioral health, and the screening and intervention for Social Determinants of Health (SDOH) and other psychosocial factors affecting health status. The following are integration activities being established by TI Program participants that are expected to be continued and sustained system wide by the newly established AHCCCS Complete Care (ACC) Managed Care Organizations (MCOs) that are accountable for whole person systems of care.

Assessment of level of integration on the SAMHSA Levels of Integrated Healthcare continuum- All TI Program participants (except hospitals) that participate for the five year duration of the Program will complete the Integrated Practice Assessment Tool (IPAT) at the beginning, midway, and end of the Program to assess their level of integration on the SAMHSA Levels of Integrated Healthcare continuum. Progression toward greater degrees of integration are planned to be measured by AHCCCS following the conclusion of the Program as the providers continue to participate in the ACC MCO networks.

Outside of the TI Program, AHCCCS has implemented payment incentives via directed payments permitted under 42 CFR 438.6 to providers which are operating integrated care clinics. Since the start of these directed payments, in place for approximately two years, AHCCCS has seen an explosion in the number of integrated care clinic providers. AHCCCS expects to monitor physical and behavioral health utilization of these clinics over time to determine the success of the delivery of integrated care services, and further expects to modify incentives/payments if and when it is determined necessary to improve integration at the provider level.

Identification of members with, or at risk for, a behavioral health condition at high risk of near-term acute and behavioral health service utilization and/or a decline in health status- The ACC MCOs are employing health risk assessment tools, predictive analytic systems, and other data mining structures to identify individuals at high risk of a decline in acute and/or behavioral health status. This MCO data, which is also utilized by many TI participants, will continue to be coupled with the additional methods implemented by the TI Program participants such as routine screening for mental health conditions and Social Determinants of Health (SDOH), ensuring individuals at high risk are identified at the provider and payer level. TI participants were provided with screening tool examples and were permitted to use the tool of their choice if it included the common elements in the example tools. The example tools include

the Patient-Centered Assessment Method (PCAM), the Health Leads Screening Toolkit, the Hennipin County Medical Center Life Style Overview, and the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE). ACC plans recognize the value of the additional practice-based methods for identifying high risk individuals and it is expected the MCOs will support these tools following the conclusion of the TI Program.

Establishment of primary care practice level care management functions for individuals identified as high risk- ACC MCOs have contractual requirements for care management systems, and historically have had accountability for care management functions (with historical behavioral health case management functions performed at the provider level). The care management functions established by the TI participants at the practice level have afforded the practitioners and ACC plans the opportunity to develop collaborative and complementary care coordination protocols for AHCCCS members. This includes completion and sharing of member needs assessment, integrated care plan development and implementation, support of transitions of care, coordination of members' medical and behavioral health services, and facilitating linkages with community organizations to address SDOH needs [primary care providers]. The TI Program is expected to inform development of effective system wide care management systems with MCOs and providers working in a complementary, collaborative, and integrated manner, following conclusion of the TI Program. The TI Program has brought a new focus to integrated care management approaches for both physical and behavioral health care/case coordination of needs at the point of care level. Care management systems that include providers beyond those participating in the TI Program are anticipated to grow and enhance the overall coordination efforts of the physical and behavioral providers that care for AHCCCS members.

Screening for SDOH and intervention for identified needs- Implementation of the TI requirements relative to SDOH has prompted a range of considerations that are serving to inform the system-wide implementation of SDOH screening, and effective intervention systems. With the end of the TI Program approaching in 2021, and the understanding that medical services address only 20% of a member's health outcomes[1], AHCCCS is focusing efforts on identifying effective SDOH tools, in part via the Medicaid Innovation Challenge occurring throughout the spring of 2019. A short-list of national vendors was selected to offer on-site presentations of various tools to AHCCCS, its MCOs, and interested stakeholders that should enable access to social needs of members to address whole-person care. AHCCCS is committed to finding ways not only to connect members to services, but to ensure that these connections occur.

In addition to these efforts, with the implementation of the ACC Program in October 2018, AHCCCS has expanded its requirement that its MCOs direct 6% of profits on its AHCCCS lines of business to community reinvestment. While there is no direct requirement today that those community reinvestment dollars be earmarked for SDOH activities, most MCOs previously participating in community reinvestment have directed their dollars in such a manner. Community Reinvestment expenditures are reported in the quarterly MCO financial statements and are included in a separate footnote. MCO Community Reinvestment expenditures are detailed in an annual report deliverable which includes an indicator for whether the expenditure represents a Social Determinant of Health (SDoH). Examples of SDoH activities with Community Reinvestment funding over the last three years include:

- Transitional and Sober Living Housing

[1] https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/

- Food Insecurity –Fresh Express
- Community and School Gardens
- Food/Financial Literacy Training
- Veteran Resource Center
- Jail transition planning
- Libraries, Community Centers
- Adult Center Exercise Room
- Community Fitness Project
- Development of Park Playground/Skate Park

AHCCCS has already signaled its intent that community reinvestment funding will be mandated to be so-directed.

Primary care screening for behavioral health using standardized tools for depression, drug/alcohol misuse, anxiety, suicide risk and, additionally for children, developmental delays in early childhood cognitive, emotional problems with procedures for intervention and treatment- The TI requirement for screening for behavioral health conditions in primary care settings is a foundational component of the overall efforts to integrate physical and behavioral health. The screening requirement calls for the routine screening of all members using standardized tools such as the Patient Health Questionnaire (PHQ-2 and PHQ-9), the Generalized Anxiety Disorder (GAD 7), and the Parents' Evaluation of Development Status (PEDS). Following completion of Year 3 (September 30, 2019) of the Program the aggregate screening rate for the TI participant practices can be computed for the first time. Most important, the requirement for appropriate intervention in cases of a positive screen is resulting in the establishment of collaborative relationships among primary care and behavioral health providers. The ACC plans are supporting these new network connections for TI participants, and utilizing lessons learned system wide. Prior to implementation of the ACC Program, these interconnections between behavioral health (BH) providers and primary care physicians (PCPs) were not strong in part due to the fragmentation of the payment system. The experience of the TI participants is facilitating the development of improved integration and provider collaboration that is being supported by ACC MCOs and expected to be sustained long term.

Use of Trauma-Informed care protocols including screening for adverse childhood events (ACEs), referral process for children that screen positive, and use of evidence-based practices and trauma-informed services-The TI Program includes requirements for both pediatric BH providers and PCPs to attend education on ACEs and trauma-informed Care. Additionally they are required to utilize evidence-based trauma-informed screening and care practices. These care practices are informed by the SAMSHA 6 Guiding Principles for trauma informed care based on the recommendation of key stakeholders including ACC MCO medical directors. The ACC MCO plans are supporting and integrating trauma systems and expectations modeled on the TI requirements in their networks. It is anticipated that these systems will continue to evolve and mature following the conclusion of the TI Program.

Screening for autism spectrum disorder [ASD] protocols and ensuring an effective referral- Pediatric primary care TI participant providers are required to have completed continuing education units (CEUs) on ASD, to provide parents with resources for families and other caregivers of children/youth with ASD. These providers are also required to have policies and procedures that facilitate the transition of care for teenagers and young adults with ASD who will be aging out of pediatrics and seeking care from adult primary care and/or behavior health providers. Pediatric behavioral health TI participants are required

to screen for ASD and establish protocols that ensure referral to appropriate providers for those who screen positive using Arizona established pathways.

The development and implementation for both sets of requirements has been guided by key stakeholders and subject matter experts, including the AHCCCS ASD Advisory Committee. The ASD Advisory Committee is comprised of providers, community advocates, and AHCCCS health plan representatives. The work of the ASD Advisory Committee is expected to continue after the conclusion of the TI Program. The experience and knowledge gained by the TI participants will inform the system wide strategies and priorities of AHCCCS, its MCOs, and other stakeholders beyond the conclusion of the Program.

Protocols for Behavioral health providers that help identify a member's need for follow-up physical health care with his/her primary care provider, and conduct a warm hand-off if necessary-The TI Program requirement for prompting BH providers to identify physical health concerns and to effectively connect the member to appropriate physical health care is resulting in the forging of new protocols and relationships. As challenges are identified by TI participants to effectively implement these new care integration strategies, they are shared with ACC MCOs to inform their integration implementation strategies. For example, upon relating one of these challenges to an ACC MCO medical director regarding a provider in the MCO's network, the medical director responded that he would follow up with the practice to learn more because "these types of situations are canaries in the coal mine for us as we move ahead on integration." The lessons learned by TI participants are being used by the MCOs for their long term provider network protocols and expectations.

Hospital protocol for conducting a community-based, post-discharge medication review within 48 hours of discharge, for members with a primary diagnosis of mental illness and for members with complex medication regimens-The coordination of care for high risk persons transitioning from inpatient to community based care has high potential for care fragmentation. A particularly significant risk for members with behavioral health conditions is the availability and effectiveness of medication in the transition to the community setting. ACC MCOs recognize this and are increasingly looking to inpatient and community care managers to implement, coordinate, and collaborate to ameliorate these types of fragmentation points, based in part on the experience of the TI Program participants. The TI participating hospitals' experience with this process will inform whether it will be adopted system wide.

Co-located justice clinics prioritize access to appointments for individuals listed in the high-risk registry, with a specialized focus on ensuring that adults transitioning from the Criminal Justice System have same-day access to appointments on the day of release and during visits to a probation or parole office-The AHCCCS contracted MCOs have contractual requirements for meeting the unique needs of justice system involved individuals. They have been among the key stakeholders in development and implementation of the TI Program co-located justice clinics, along with key behavioral health providers and the government agencies, which manage the probation and parole activities. The TI Program has been instrumental in providing the funding to create the infrastructure to establish these one-stop service options for members reintegrating into society. AHCCCS and its key participants strongly believe that members, who likely have not interacted with the health delivery system in years, will find the convenience and access of the co-located clinics too difficult to ignore. It is anticipated that these clinics will continue to be supported and sustained by the AHCCCS MCOs as a means to ensure the unique needs and risks of this population are addressed.

The strategy to secure resources to maintain the integration activities

AHCCCS has been on the integration journey for approximately 10 years. That journey can be described by three stages: (1) administrative Integration, (2) payer integration, and (3) provider integration. AHCCCS has been working to address each of these stages, sometimes concurrently. Administrative integration occurred, officially, on July 1, 2016, with the merger of AHCCCS and the Arizona Department of Health Services/Division of Behavioral Health Services – the sister-state agency which managed the Medicaid behavioral health service benefit for most AHCCCS members. Provider integration has been occurring over the last several years, in part due to the payment incentive previously described, and in great part due to the TI Program. And payer integration took its most transformational step on October 1, 2018, when the ACC MCO Program was implemented.

The ACC Program offers a natural sustainability pathway to maintain the integration activities occurring at the provider level due to the TI Program. Single payers are authorizing and paying for whole person healthcare, and are eager for the delivery system to offer providers addressing whole person healthcare. For providers who are not integrated, the care coordination activities and tools established under TI should improve the health outcomes of members seeking care offered by multiple providers.

Other AHCCCS initiatives can also be leveraged to sustain the integration activities created under the TI Program. AHCCCS has had value based purchasing (VBP) initiatives as part of its contractual requirements of MCOs for six years, including the withholding of capitation payments contingent on their effective implementation of value based strategies with their provider networks. VBP has clearly proven that, when incentives for payers and providers are aligned, positive outcomes are attainable.

One strategy to sustain the integration activities initiated under the Targeted Investments Program utilizing the VBP initiative is for AHCCCS to align future VBP goals for MCOs with, and drive the MCOs toward alternative payment models (APMs) addressing, the systems and infrastructure established under the TI Program that have demonstrated effectiveness.

Examples of the types of VBP strategies that could be employed by AHCCCS MCOs after conclusion of the TI Program include:

- Provider payments based on total cost of care coupled with performance measures that are enabled by whole person systems of care
- Shared savings arrangements with upside and downside risk for combined behavioral health, primary care, and post inpatient follow-up based on effective integration arrangements
- Expanded adoption of ACO and network arrangements that enable alignment of payer and provider accountability for population health that are possible under effective integrated and coordinated whole person care systems

Examples of the types of APM related measures MCOs could apply to their provider networks Program to support the integration of behavioral and physical health care include:

- VBP outcome measures based on effective care coordination
- Payment associated with addressing SDOH

- Payment incentives for effective BH screening and follow up
- VBP requirements tied to provider care management indicators

Summary

The timing of the Targeted Investments (TI) Program enactment coincided with numerous AHCCCS initiatives focused on integrated care, most notably the establishment of the AHCCCS Complete Care Program, which requires ACC MCOs to be responsible for integrated, whole person care. The ACC MCOs have been among the primary stakeholders helping to inform the implementation of the TI Program. Challenges and opportunities identified through the experience of TI Program participants in the MCOs' networks have afforded the MCOs the chance to learn first-hand about strategies and systems that are most effective in providing whole person integrated care.

This understanding of best practices in integrated care and lessons learned are seen by the ACC MCOs as opportunities to enhance and accelerate the implementation of integrated systems of care with their provider networks and their associated contractual performance. To the extent that TI Program requirements and systems are effective, the MCOs are incentivized to sustain those TI Program initiatives after the conclusion of the Program. Program participants are also incentivized to maintain effective integration activities and strategies at the conclusion of the Program to enhance their value in the MCOs' networks.