PART V

The American Indian Medical Home

Supporting Arizona's Commitment to Addressing Health Care Disparities
for American Indians/Alaska Natives

Overview

AHCCCS administers Medicaid to over 1.8 million members through a mandatory managed care delivery system. This system operates managed care insurance programs that establish each member with a Primary Care Physician (PCP) upon enrollment. Case management is provided as an administrative service to those members identified by their health plan to require care coordination or assistance in managing a chronic illness. Health plans also offer call lines staffed by medical professionals as an administrative service.

The AHCCCS model requires every Medicaid beneficiary to enroll with a managed care organization (MCO). The only exception to this requirement is for the American Indian/Alaska Native (AI/AN) population, which has the option of enrolling with an MCO or receiving services in the AHCCCS fee-for-service (FFS) program, known as the American Indian Health Program (AIHP). American Indians and Alaska Natives who enroll in the American Indian Health Program receive their care largely through Indian Health Services (IHS) facilities and Tribal facilities operated under Public Law (PL) 93-638. IHS and Tribal facilities do not have the administrative dollars to support case management functions or call lines to assist members in coordinating their care.

In addition, there is significant fragmentation of care for AIHP members. This fragmented system of care is evident both (i) among IHS/Tribal 638 providers and (ii) between IHS/Tribal 638 providers and non-IHS/Tribal 638 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 Emergency Department (ED) visits or hospital re-admissions. Likewise, if a patient presents for specialty care without an authorized Purchased Referred Care (RC) referral, 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. IHS/Tribal 638 providers lack the resources necessary to engage in robust sharing of information and coordination of care across the spectrum of facilities where AIHP members receive healthcare. IHS and Tribal 638 sites do not have the resources to hire additional staff to perform care coordination nor the resources to enable information system interoperability that would support improved care coordination. The clinical leadership of Indian health provider organizations recognizes that fundamental changes in their system are required in this time of fewer resources and health reform.

The IHS Improving Patient Care (IPC) program goal is to engage IHS, Tribal, and Urban Indian health programs to improve the quality of, and access to, care for AI/AN members through the development of a system of care called the American Indian Medical Home Program (Medical Home). The IPC program is focusing on patient-and-family-centered care while ensuring access to primary care for all AI/AN people. High-quality care will be delivered by health care teams who will be making sustainable and measurable improvements in care. Medicaid is IHS' biggest payor/partner. Therefore, AHCCCS would like to align its efforts in Arizona with the efforts being made by IHS and the federal government to modernize and improve the health care delivery system for the AI/AN population.

The most recent U.S. Census figures state the AI/AN population is approximately 350,000 in Arizona.[1] Almost half of the AI/AN population in Arizona is enrolled in AHCCCS, and approximately 75 percent of AI/AN AHCCCS members are enrolled in the American Indian Health Program. Significant health disparities exist between the AI/AN population and the general population of Arizona, including the average age of death (17.5 years lower for American Indians), and higher death rates from many preventable diseases. AHCCCS proposes an American Indian Medical Home that aligns with the IHS IPC program in order to address some of these disparities and to support the ability of IHS, Tribal, and Urban Indian health programs, as well as non-IHS facilities with high AI/AN patient volumes, to better manage the care for American Indians and Alaska Natives enrolled in the American Indian Health Program.

Accordingly, to accomplish these goals AHCCCS seeks the following authority:

- **Comparability** - Waiver from §1902(a)(10)(B) and corresponding regulations at 42 CFR §§440.240, to allow the State to provide services that support a medical home for AI/AN members enrolled in FFS who receive services provided through the IHS and Tribal facilities. These services are Primary Care Case Management, diabetes education, after-hospital care coordination, 24-hour call lines staffed by medical professionals, sharing of electronic health data in the Arizona health information exchange, and participation in regional Care Management Collaboratives.
- **Reimbursement CNOM-** Expenditure authority to allow the State to pay for services that support a medical home for AI/AN members enrolled in FFS who receive services provided through the IHS and Tribal facilities. Expenditure authority to allow the State to pay non-IHS/Tribal facilities a shared savings payment to support the Indian Health Medical Home Program.

Developing the American Indian Medical Home through Consultation

Originally, this concept was proposed and brought to AHCCCS by the Tucson Area IHS. Verbal notification on the development of this proposal as well as notification that a future consultation meeting would be held to further discuss this topic was provided at an AHCCCS Consultation Meeting with Tribes and IHS, Tribal, and Urban Indian health programs (l/T/U) on March 31, 2011.

[1] Current tribal enrollment numbers collected by survey taken by AHCCCS estimate the AI/AN population in Arizona to be approximately 443,000.

AHCCCS also obtained information related to medical home activities from the Navajo Area IHS, Phoenix Area IHS, Tucson Area IHS, and certain Tribal Facilities. This information was used in the development of the first waiver proposal. AHCCCS formally consulted with tribes and I/T/Us in Arizona on the components of the original waiver proposal in accordance with the AHCCCS Tribal Consultation Policy and Medicaid State Plan on August 4, 2011. The amendment was also placed on the AHCCCS website for public comment around that time.

Since then, AHCCCS has embarked upon a Tribal Care Coordination effort of its own. AHCCCS revised this proposal to align this amendment with the IPC and AHCCCS Tribal Care Coordination efforts. The AHCCCS Tribal Care Coordination initiative strives to improve the quality of care for its members by increasing the efficiency of the multiple systems of care in which members can access services. While there are various care coordination models being implemented across the nation, as well as here in Arizona, AHCCCS adopted the Indian Health Service's IPC Care Model to avoid creating duplication in the system and confusion amongst the various efforts being implemented to improve the care for AI/AN members. Furthermore, the Agency recognizes the importance of promoting a shared message in working toward a common goal - improve the quality, connectivity, and accessibility of care in the American Indian healthcare delivery system. AHCCCS works toward that goal in its role as a facilitator of data exchange to inform providers of utilization trends among members empaneled to them. As a major payor, AHCCCS provides this data so that the medical home can develop interventions that will assist patients empaneled to them to better manage their health. I/T/Us, however, need additional resources to build their capacity to act as medical homes that can be held accountable for reducing emergency department utilization, admissions or readmissions, and improve outcomes.

Anticipated updates to the draft proposal were presented verbally at tribal consultation on August 15, 2013. AHCCCS has also posted the revision to its website for public comment. The revised amendment was also presented to the State Medicaid Advisory Committee on April 9, 2014. Subsequently, representatives from the three IHS Area offices made revisions to the proposal for consideration requiring additional review. Revisions were incorporated here and presented for comment at the tribal consultation in August 21, 2015.Subsequent to receiving comment from CMS, a Tribal workgroup was established in 2016 to review the proposal and offer further revisions. Following an extensive review conducted by the workgroup, an updated proposal was re-presented at Tribal consultation on April 21, 2016. The workgroup's recommendations were finalized in May, 2016 for submission to CMS.

Based on CMS's review of a separately developed proposal for a DSRIP waiver, and recommendation made by CMS that AHCCCS consider service payment methodology for collaborative care management for AIHP members, the workgroup reconvened in September, 2016 and made additional recommendations for the American Indian Medical Home proposal.

Arizona expects that the oversight and payment for Medical Home service delivery will necessitate close working relationships between the State and the IHS, Tribal, Urban Indian health program, and non-IHS facilities with AI/AN patient volumes greater than 30%, and that this process will enhance collaboration toward similar goals of reducing health disparities and delivering cost-effective care.

Provider Payments

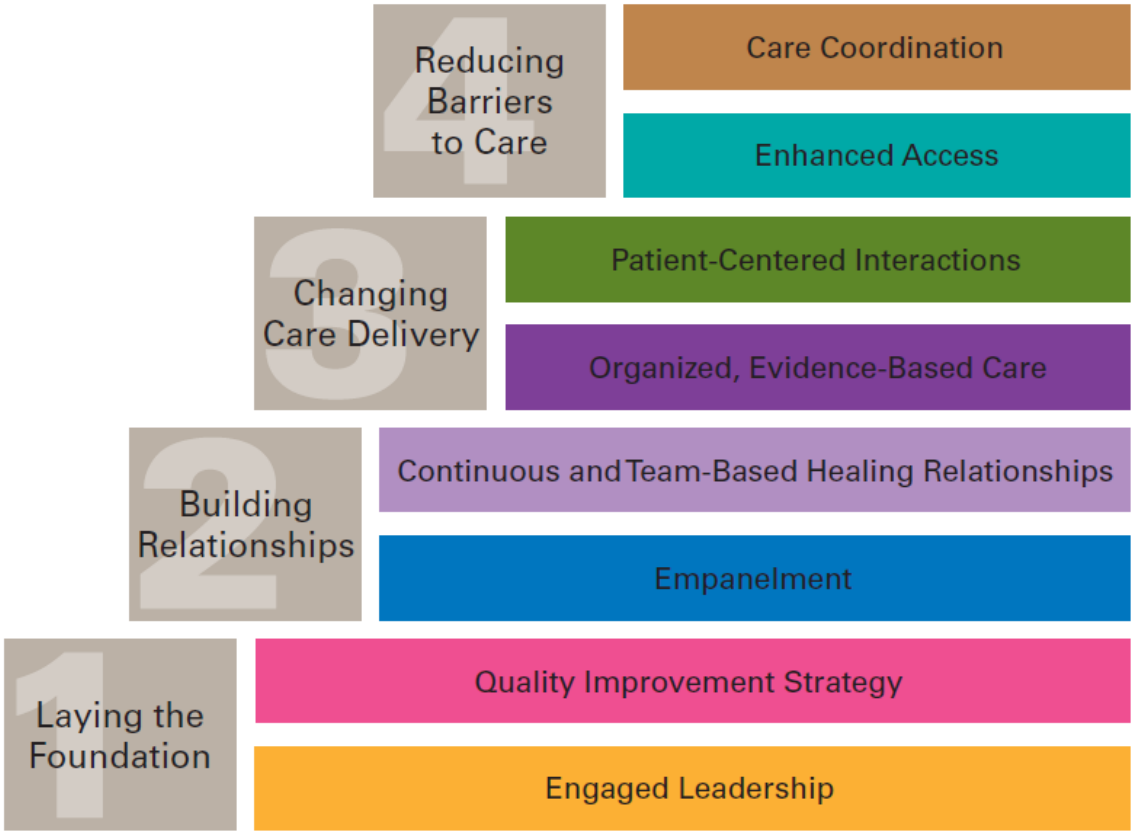
The American Indian Health Program has worked in conjunction with tribes and IHS facilities to determine the cost of delivering a Medical Home, which would reimburse for Primary Care Case Management, a 24-hour call line and care coordination among sites. IHS and tribal facilities who elect to participate in the Medical Home would receive payments based on a per member per month (PMPM) payment structure. The American Indian Health Program cost data from IHS and tribal facilities in Arizona were evaluated to determine a baseline PMPM payment amount of $13.26 with an annual increase of 4.6%, which is based upon the average annual increase of the outpatient all-inclusive rate over the past ten years. For approved Medical Homes providing diabetes education pursuant to guidelines established within that model and herein, an additional $2.00 PMPM with an annual increase of 4.6% would be available. For sites engaged in Medical Home "Plus" described herein (i.e. participation in the state HIE and in regional CMCs), an additional $7.50 PMPM with an annual increase of 4.6% would be available.

The medical home services for which AHCCCS proposes to reimburse are currently not reimbursed through the all-inclusive rate and will therefore be billable by IHS and Tribal facilities only on a monthly basis to AHCCCS. PMPM payments will be made with 100% FFP dollars and will only be available for IHS and tribally operated 638 facilities for FFS members in order to avoid duplicative payment. Facilities will be required to submit a Medical Home claim for each member that is empanelled in their medical home on a monthly basis. Empanelment will be determined by AHCCCS based on the criteria discussed below.

Overview of Medical Home Criteria Development

IHS and Tribal facilities may choose whether or not to provide an American Indian Medical Home Program (Medical Home) for their members. In order to receive the PMPM rate for services provided by their Medical Home, facilities must submit evidence of meeting Medical Home criteria annually to AHCCCS. Fee for Service (FFS) AHCCCS members will have the option to not be empaneled so as not to restrict choice; reimbursement will be based upon only those members that are formally part of the medical home. To ensure there is choice given, the AHCCCS FFS member must sign a form at the facility stating they are agreeing to be empaneled to that particular facility.

The Indian Health Service Patient Centered Medical Home (PCMH) is adapted from the Safety Net Medical Home Initiative (SNMHI) change package and is widely recognized and tested. There is a high degree of overlap between the SNMHI and the National Committee for Quality Assurance (NCQA) 2014 PCMH Recognition Standards.



LAYING THE FOUNDATION

ENGAGED LEADERSHIP

- *Provide visible and sustained leadership to lead overall culture change as well as specific strategies to improve quality, and spread and sustain change.*
- *Visibly support improvement at all levels of the organization, beginning with senior leaders and extending throughout the organization.*
- *Ensure that the PCMH transformation effort has the time and resources needed to be successful.*
- *Ensure that providers and other care team members have protected time to conduct activities beyond direct patient care that are consistent with the medical home model.*
- *Build the practice's values of creating a medical home for patients into staff hiring and training processes.*
- *Use practice resources strategically.*

QUALITY IMPROVEMENT STRATEGY

- *Use the Model for Improvement as a formal model for quality improvement.*
- *Establish and monitor metrics to evaluate improvement efforts and outcome; ensure all staff members understand the metrics for success.*

- *Build capability in all staff to support improvement and ensure that patients, families, providers, and care team members are involved in quality improvement activities.*
- *Ensure opportunities for community members to engage in the improvement process, program development, and policy.*
- *Optimize use of health information technology (e.g. RPMS).*
- *Use data to continuously improve performance, quality, and service (e.g. iCare).*
- *Build practice analytic capability.*

<u>BUILDING RELATIONSHIPS</u>

EMPANELMENT AND POPULATION MANAGEMENT
- *Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis.*
- *Assess practice supply and demand; balance patient load accordingly.*
- *Use panel data and registries to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.*
- *Use a formal data-driven approach to stratify level of risk for all empaneled patients.*

CONTINUOUS AND TEAM-BASED HEALING RELATIONSHIPS
- *Establish and provide organizational support for care delivery teams accountable for the patient population/panel.*
- *Link patients to a provider and care team so both patients and provider/care team recognize each other as partners in care.*
- *Ensure that patients are able to see their provider or care team whenever possible.*
- *Define roles and distribute tasks among multidisciplinary care team members to reflect the skills, abilities, and credentials of team members.*

<u>CHANGING CARE DELIVERY</u>

ORGANIZED, EVIDENCE-BASED CARE
- *Use planned care according to patient need.*
- *Ensure high risk patients are receiving appropriate care and case management services.*
- *Use point-of-care reminders based on clinical guidelines.*
- *Enable planned interactions with patients by making up-to-date information available to providers and the care team at the time of the visit.*
- *Support alternative and complementary medicine approaches, including traditional healing.*

PATIENT-CENTERED INTERACTIONS
- *Respect patient and family values and expressed needs.*
- *Encourage patients to expand their role in decision-making, health-related behaviors, and self-management.*
- *Communicate with patients in a culturally appropriate manner, in a language and at a level that the patient understands.*
- *Engage patients and families in goal setting, action planning, problem-solving, and follow action plans.*
- *Provide self-management support at every visit through goal setting and action planning.*
- *Obtain feedback from patients/family about their healthcare experience and use this information for quality improvement.*

REDUCING BARRIERS TO CARE

ENHANCED ACCESS

- *Enhance efficiency and access to care and services.*
- *Promote and expand access by ensuring that established patients have 24/7 continuous access to their care team via phone, email or in-person visits.*
- *Provide scheduling options that are patient- and family-centered and accessible to all patients.*

COORDINATE CARE ACROSS THE MEDICAL NEIGHBORHOOD

- *Link patients with community resources to facilitate referrals and respond to social service needs.*
- *Integrate behavioral health and specialty care into care delivery through co-location or referral protocols.*
- *Track and support patients when they obtain services outside the practice.*
- *Follow-up with patients within a few days of an emergency room visit or hospital discharge.*
- *Perform medication reconciliation at every office visit and care transition.*
- *Communicate test results and care or treatment plans to patients/families.*

With this change package in mind and in conjunction with the IHS, tribally operated 638 programs and the American Indian Health Program, AHCCCS has developed the following mandatory criteria for Medical Home designation when provided by IHS and tribally owned or operated 638 facilities in Arizona.

Medical Home Program Mandatory Criteria:

1. The site has achieved Patient Centered Medical Home recognition through NCQA, Accreditation Association for Ambulatory Health Care, The Joint Commission PCMH Accreditation Program, or other appropriate accreditation body, OR
2. IHS IPC attests annually that the site has completed the following in the past year:
    a. Submitted the SNMHI Patient-Centered Medical Home Assessment (PCMH-A) to IHS IPC with a score of 7 or greater.
    b. Submitted monthly data on the IPC Core Measures to the IPC Data Portal; AND
    c. Submitted narrative summaries on IPCMH improvement projects to IHS IPC quarterly.

Diabetes Education Mandatory Criteria:

National Standards for Diabetes Self-management Education in support are defined by the American Association of Diabetes Educators. These standards address program organizations, stakeholder input, program planning and coordination, staff qualifications, curriculum, quality assurance and improvement. Medicare reimburses Diabetes Education services, Diabetes Education accreditation through American Associations of Diabetes Educator. To qualify for the additional per member, per month for Diabetes Education, Medical Homes must have Diabetes Education Accreditation through a recognized accreditation agency.

Medical Home "Plus" Mandatory Criteria:

1. Data Infrastructure: Sites must demonstrate evidence of meaningful sharing of electronic health information through participation in the AZ state health information exchange, evidenced by a signed agreement with the Arizona Health e Connection and active participation in the "Network" (the Arizona HIE).
2. Care Management Collaboratives (CMCs): Three regional CMCs would be formed to advance care management collaboration among Indian health and non-Indian health provider organizations. Medical Home "Plus" providers would execute a participation agreement with a regional CMC and participate in CMC activities related to care management protocols, standard care plans, and health information communication to ensure that commonly understood and shared care management strategies are developed and implemented. As part of CMC participation, Medical Home "Plus" providers would execute Care Coordination Agreements as indicated with non-IHS/Tribal 638 providers, as per CMS State Health Official guidance #16-002. CMCs would identify and track specific medical home outcome measures (e.g. NCQA or IHS IPC Core Measures) and, for all Medical Home Plus providers, AHCCCS would monitor efforts across CMCs to reduce avoidable ED visits to non-IHS/Tribal 638 providers for AIHP members

Patient Empanelment

While an AHCCCS member retains the right to seek care from any AHCCCS registered provider, AHCCCS may only pay for one Medical Home per member. In order to avoid reimbursement to two different Medical Homes for the same member, AHCCCS will recognize patient empanelment to a specific Medical Home by the receipt of a signed patient attestation form identifying the patients' medical home of record. A Medical Home will not be able to be reimbursed for PMPM claims until the empanelment process has been completed.

After a facility is approved as a medical home by AHCCCS, the facility must submit to AHCCCS Division of Fee-for-Service Management (DFSM) a file of empaneled members. Members submitted that already have been empaneled in a medical home will be rejected back to the facility; in this case, the facility or member can request a transfer through the transfer process.

All empanelment files and transfers must be submitted to AHCCCS by the 22nd of the month for the facility to be able to submit a claim for the following month. Information received after the 22nd of the month will not be able to be claimed until the following month.

The AHCCCS transfer process can be utilized when a member is empaneled with another facility. In this case, the facility that would like the member to be transferred must complete the AHCCCS approved transfer form. This form must be signed by the requesting facility, the currently empaneled facility and the member.

Non-IHS/Tribal facilities Shared Savings Payment: Supporting the IHS Indian Health Medical Home Model American Indian members are not limited to using only IHS/Tribal facilities. They access care from non-IHS/Tribal facilities particularly in areas where a non-IHS/638 facility is more readily available than an IHS/Tribal facility. Additionally, AI/AN members often access non-IHS/638 facilities and providers for specialty care that may not be accessible at an

IHS/Tribal facility. As a result, there are a number of non-HIS/Tribal facilities with high AI/AN patient volumes that can help support the American Indian Medical Home. These facilities are grappling with issues of care coordination, hospital readmissions and non-emergent use of the emergency department related to the AI/AN population.

Facilities with high AI/AN inpatient enrollment in AIHP, specialty care (e.g., OB/GYN) or emergency department patient volumes can help support the Medical Home model by allowing an IHS/Tribal facility to embed an IHS/Tribal care coordinator within their facility. Non-IHS/Tribal facilities that meet or exceed 30% AI/AN patient volumes such as Urban Indian Programs are eligible to receive shared savings payments through structured arrangements with AHCCCS that, among other measures: reduce emergency department use; reduce readmissions, coordinate with behavioral health; and share data with AHCCCS. These initiatives will be arranged on a case-by-case basis depending on the specialty of the provider type.

By supporting the model in this way, the non-IHS/Tribal facilities will be partnering with the Medical Home to connect AIHP enrolled members with the services necessary to address the health disparities that exist within the population, thereby, reducing the rate of hospital readmissions and non-emergent use of the emergency department. These facilities should be rewarded for the improvements in care delivery and in savings achieved for their efforts in supporting this model. Addressing healthcare disparities for the AI/AN population is not possible without the participation of non-IHS/Tribal facilities.

Summary

Arizona is proposing to offer services that support an American Indian Health Medical Home Program for its acute care FFS Population. The American Indian Medical Homes will be charged with addressing health disparities between American Indians and other populations in Arizona, specifically by enhancing case management, care coordination, timely sharing of health information, and regional collaborations for care management. In tracking the successes of Medical Homes across the state, Arizona expects to see trends indicating cost savings through the prevention of hospital readmissions and improved control of non-emergent use of the emergency department. Non-IHS/Tribal facilities will also share in those savings as critical players in addressing healthcare disparities for the AI/AN population.

Collectively, these efforts represent an expanding strategy to advance population health for AIHP members through innovation in service delivery. The American Indian Medical Home "Plus" tier of participation also represents a type of alternative payment methodology for IHS/Tribal 638 provider organizations that incentivizes quality and value, is consistent with MACRA and emerging CMS programs, and preserves the uniquely important fee-for-service reimbursement methodology that is nationally established for IHS/Tribal 638 facilities.

Summary of Public Comments
American Indian Medical Home 1115 Waiver Proposal

AHCCCS accepted public comments during a 30 day comment period on the American Indian Medical Home proposal starting September 26, 2016 through Monday, October 26, 2016. During this time the public had the opportunity to review and comment on the proposal in writing via email to publicinput@azahcccs.gov or send comments to: AHCCCS, c/o of Office of Intergovernmental Relations, 801 E. Jefferson Street, MD 4200, Phoenix, AZ 85034. Three (3) comments were received during this time and are summarized below.

Organization:	Comments:

Inter-Tribal Council of Arizona (ITCA)
2214 North Central Avenue
Phoenix, AZ 85004
	• Comments represent 21 tribes in State of Arizona
	• Supports the AIMH revised proposal and seeks approval by CMS
	• Supports the alignment of AHCCCS AIMH with IHS Improving Patient Care (IPC) program
	• Supports AHCCCS request to reimburse IHS/638s for MH care management and associated services on a monthly basis, based on a PMPM payment calculation
	• Recommend:
	  ○ On-going discussions with ITUs in regard to AIMH implementation
	  ○ Further discussion between IHS Information Technology divisions at Navajo Area, Tucson Area and Phoenix Area IHS with AHCCCS and Tribes

Tuba City Regional Health Care Corporation (TCRHCC) 167 North Main Street Tuba City, AZ 86045	• Strongly supports approval of a PMPM rate for ITUs that meet Medical Home criteria • Has concerns about non-ITUs qualifying for reimbursement under this program for shared savings payment • Would like further clarification from AHCCCS on proposed shared savings payment to non-ITUs • Has concern about the Medical Home "Plus" Care Management Collaborative participation, oversight and outcome measures. Would like to be engaged in further development.
Tohono O'odham Nation Health Care (TONHC) San Xavier Health Center 7900 South J Stock Road Tucson, AZ 85746	• Supports the AIMH proposal • TONHC has been working, over the past 8 years, to implement a medical home for their patients through the national IHS IPC program. • Approval of AIMH by CMS would support TONHC efforts to further improve quality, access to care and services for their patients.

Submitted Via: PublicInput@azahcccs.gov

October 26, 2016

AHCCCS
Attn: Office of Intergovernmental Relations
801 E. Jefferson St., MD 4200
Phoenix, AZ 85034

Re: Inter Tribal Council of Arizona, Inc. Comments on AHCCCS New Section 1115 Waiver Demonstration American Indian Medical Home Proposal

The Inter Tribal Council of Arizona, Inc. (ITCA) representing twenty one (21) Tribes in the State of Arizona is pleased to provide comments on the revised American Indian Medical Home (AIMH) proposal for the Arizona Section 1115 Waiver Demonstration. The proposal is pending as a result of additional discussion between AHCCCS and the Centers for Medicare and Medicaid Services (CMS) that resulted in reconvening AHCCCS AIMH Tribal Workgroup with the charge of incorporating some of the elements of another proposed Waiver initiative titled, Delivery System Reform Incentive Payment (DSRIP). Overall, the ITCA is supportive of the AIMH revised proposal and seeks its approval by CMS. The Medical Home services that AHCCCS is proposing to reimburse are not currently reimbursed through the all-inclusive rate that facilities receive for providing Medicaid covered services. AHCCCS is now seeking to reimburse IHS and Tribal facilities for Medical Home care management and associated services on a monthly basis, based on a per member per month (PMPM) payment calculation.

Background

The goal of this proposal is to align the AHCCCS AIMH with the Indian Health Service (IHS) Improving Patient Care (IPC) program. IPC requires a facility to meet the needs of patients that are assigned to Care Teams that actively coordinate health care to meet the needs of their patients. The AHCCCS AIMH Medical Home criteria require the assignment of patients to a Care Team in addition to other requirements. AHCCCS is seeking CMS approval to make available payments based on a *per member per month* (PMPM) payment structure to IHS or Tribal facilities that meet the Medical Home criteria. The PMPM payments will be made with 100% FFP dollars for Primary Care Case Management, a 24-hour call line and care coordination among sites. Based on the analysis conducted by the AIMH Tribal Workgroup, AHCCCS is endorsing the recommended baseline PMPM payment of $13.26 with an annual increase of 4.6%. Medicaid eligible and enrolled patients will have the option to register in the AIMH at their health care facility. The empanelment of these patients will trigger the PMPM payment to the facility. Additional payments may be obtained for Medicaid Homes that provide diabetes education at $2.00 PMPM with an annual increase of 4.6%.

For AIMH sites that participate in Medical Home "Plus," an additional $7.50 PMPM with an annual increase of 4.6% would be available. To recoup these dollars, the facility must have a signed agreement with the Arizona Health-e-Connection and participate in the Arizona Health Information Exchange (HIE) Network. Further the facilities would have to execute a participation agreement with Care Management Collaboratives (CMC's). CMC's would be comprised of Indian and non-Indian providers that participate in CMC activities related to care management protocols, standard care plans, and health information communication. Direct agreements with non IHS/Tribal facilities and urban Indian programs may include the provision of shared savings payments if they meet or exceed 30% AIAN patient volume. Shared savings payments may assist these facilities improve AIAN patient care coordination.

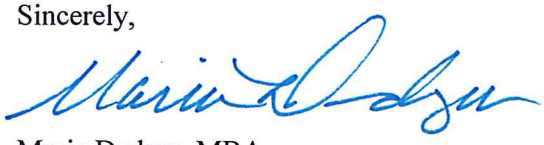
Recommendations

ITCA advises that ongoing discussion occur with the IHS, Tribal and urban Indian health program facility representatives with regard to AIMH implementation. AHCCCS and CMS should be cognizant that IHS, Tribal and Urban facilities are entrenched in efforts to maintain the IHS Improving Patient Care (IPC) designation and will now endeavor to meet the Medical Home mandatory criteria required by AHCCCS. This would require substantial efforts especially at the onset of the program. The parties should be aware that in terms of implementation, the resolution of issues may require flexibility. For example, the facilities should have additional input on any required time frames for submitting evidence of meeting the Medical Home and Medical Home "Plus" Criteria and the submission of patient empanelment files that must be submitted to AHCCCS each month.

ITCA recommends that further discussion between the principals at the IHS Information Technology divisions at the Navajo Area, Tucson Area and Phoenix Area IHS offices take place with AHCCCS and the Tribes. IHS advisement on data sharing, data security and agreements that pertain to participation on the AZ HIE was not relayed during recent AHCCCS Tribal Consultations when the AIMH topic was discussed. These meetings may have taken place internally, but it is still unclear why no IHS/638 facilities participate in the HIE, except for one urban Indian health program in the state. AHCCCS has indicated that some of the technical aspects could be overcome with the infusion of the AIMH "Plus" incentive payments. ITCA seeks more information on barriers that may exist with regard to sharing data or on matters pertaining to the signing of agreements with the state HIE. These topics should be a focus of a future meeting of interested parties, such as the AIMH Tribal Workgroup along with IHS and AHCCCS staff. While 638's may have the ability to move ahead more quickly to enter into signed agreements with Arizona Health-e-Connection, it is still unclear if IHS facilities will be able to prioritize and engage in this activity any time soon.

ITCA appreciates this opportunity for its Member Tribes to elaborate on the issues and concerns in order to institute an effective Medicaid Demonstration for the period of 2016 – 2021. If you have further questions, please contact me directly or Ms. Alida Montiel, Health Systems Director, at (602) 258-4822. Thank you for your consideration of these comments.

Sincerely,



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Or Bonnie.talakte@azahcccs.gov

RE: Tuba City Regional Health Care Corporation (TCRHCC) Public Comments on the Revised American Indian Medical Home (AIMH) Section of the 1115 Waiver Proposal

TCRHCC has been very involved in the AIMH workgroup. TCRHCC will meet all criteria for the AIMH criteria in the waiver proposal by the fourth quarter of FY17. As a Title V Tribal 638 healthcare provider, TCRHCC provides case management functions including care coordination for our patients. This includes coordinating with other I.H.S./638 and non-I.H.S./638 providers and receiving timely notification when patients are in need of care coordination services. At this time AHCCCS **does not provide** reimbursement for a 24 patient call line or case management services and we strongly support the approval of a PMPM rate for I/T/Us that meet the Medical Home criteria.
TCRHCC has concerns about **non**-I/T/Us also qualifying for reimbursement under this program under the shared savings payment. Currently, TCRHCC employs its own employees whose salaries are paid with healthcare facilities revenue to coordinate and manage care. TCRHCC would like further clarification from AHCCCS on the proposed shared savings payment to **non**-I/T/U facilities. To the extent that a **non**-I/T/U facility does care coordination for AI/AN on its own, TCRHCC believes they should meet the same metrics as the I/T/Us. While AHCCCS expects that the proposal will necessitate a close working relationship between I/T/Us and **non**-I/T/Us, it does not indicate how the **non**-I/T/Us will communicate back to the I/T/Us that meet the medical home criteria. This appears to be only addressed in the *optional* Medical Home "*Plus*" criteria of participation in the state Health Information Exchange, Care Coordination Agreements, and regional Care Management Collaborative'. TCRHCC has concerns about the Medical Home "*Plus*" Care Management Collaborative participation, oversight, and outcome measures and would like to be engaged in the further development of this.

Tuba City Regional Health Care (TCRHCC) is pleased AHCCCS sought Tribal consultation and input for these sections of the 1115 waiver demonstration through the tribal workgroups.

TCRHCC, like many other tribes that have compacted I.H.S. healthcare services, have adopted more modern reporting programs, (TCRHCC will implement ALLSCRIPTS Electronic Health Record), and the proposed AIMH criteria **should be flexible** enough to allow reporting using more than one Electronic Health Record reporting system.

Sincerely,

Lynette Bonar

Lynette Bonar, RN, MBA, BSN
Chief Executive Officer, TCRHCC

Cc: T. Betlach
Bonnie Talakte

From: Speakman, Ronald R (IHS/TUC) [mailto:Ronald.Speakman@ihs.gov]
Sent: Wednesday, November 02, 2016 3:47 PM
To: Public Input
Cc: Carroll, Mark; chester.antone@tonation-nsn.gov; Fallon, Angela B (IHS/TUC); Geronimo, Veronica (TONHC)
Subject: American Indian Medical Home proposal comment

As the Acting Facility Director of the Tohono O'odham Nation San Xavier Health Center, I support the American Indian Medical Home proposal. Tohono O'odham Nation Health Care (TONHC), formerly Sells Service Unit, has been working over the past eight years to implement a medical home for our patients. This was largely done through participation in the national IHS Improving Patient Care (IPC) program. Our mission was "to create a patient-centered environment that provides the care our patients deserve and need when they need it. We will empower patients to take an active role in improving their health by providing care that emphasizes prevention and healthy lifestyles. Using a care team approach we will partner with the Tohono O'odham Nation, local communities, families, and patients to enhance the health of all eligible persons in harmony with their cultural values and customs." We began this work by empaneling our patients to multidisciplinary Family Practice Primary Care Teams and tasked these team with implementing change utilizing the Model for Improvement and clinical measures.

Initially, we started slow with a single Care Team at two sites. Today, 95% of the patients receiving care at any Tohono O'odham Nation Health Care facility are empaneled to a team. Care Team composition has also grown from not only the Primary Care Physician, Nurse Team Leader (RN), Medical Assistant (or LPN), and Medical Clerk, but now also include a Pharmacist, Clinical Nurse Case Management, Social Work Services, Public Health Nursing, Health Education, Nutritional Education as well as business and support functions of Purchased and Referred Care, Benefits Coordination, and Medical Records Management. Through this work we have developed improvements in appointment reminders, preventative screening, care coordination and case management, and have even implemented a 24/7 Nurse Call Line available to all of our patients.

These improvements do not come without expense. It was recently calculated that TONHC expends over $1.5 million to provide care coordination services not covered under the AHCCCS fee-for-service program to our American Indian Health Program (AIHP) enrolled patients. At TON SXHC alone we have increased our Ambulatory Care Visits from 49,993 in FY 2009 to 71,125 in FY 2016. Our nurse visits have risen from 546 in FY 2009 to 4348 in FY 2016. Despite this expansion of services, we still struggle meet the needs of our ever growing population with appointments and related care coordination services. The American Indian Medical Home section of the 1115 Waiver that AHCCCS is proposing to the Centers for Medicare and Medicaid Services (CMS) would greatly support our efforts to further improve the quality of, and access to, care and services that we strive to provide to our patients.

Respectfully,

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28. American Indian Medical Home Services

A. Provider Qualifications

The American Indian Medical Home will enhance service payments for Indian Health Service (IHS) and Tribal 638 facilities delivering primary care case management, 24 hour nurse call line support, and after-hospital care coordination to American Indian enrolled in the AHCCCS American Indian Health Program (AIHP), the AHCCCS fee-for-service program. The American Indian Medical Home "Plus" will expand service payments for IHS/Tribal 638 facilities designated as an American Indian Medical Home that actively participate in regional Care Management Collaboratives and in the state Health Information Exchange. Optional service payments will be available for American Indian Medical Home-designated facilities that provide comprehensive diabetes education services.

(i) Medical Home Qualifications

A. The site has achieved Patient Centered Medical Home (PCMH) recognition through NCQA, Accreditation Association for Ambulatory Health Care, The Joint Commission PCMH Accreditation Program, or other appropriate accreditation body, OR
B. IHS IPC program attests annually that the site has completed the following in the past year:
    1. Submitted the SNMHI Patient-Centered Medical Home Assessment (PCMH-A) to IHS IPC with a score of 7 or greater;
    2. Submitted monthly data on the IPC Core Measures to the IPC Data Portal; AND
    3. Submitted narrative summaries on IPCMH improvement projects to IHS IPC quarterly.

(ii) Medical Home "Plus" Qualifications

A. All criteria listed above for a Medical Home, AND
B. Data Infrastructure
    1. Sites must demonstrate evidence of meaningful sharing of electronic health information through participation in the AZ State Health Information Exchange (HIE), evidenced by a signed agreement with the Arizona Health-e-Connection and active participation in the "Network," Arizona's HIE
C. Care Management Collaboratives (CMCs)
    1. Medical Home "Plus" providers must execute a participation agreement with one of the three regional CMCs and participate in CMC activities related to care management protocols, standardized care plans, and high risk patient registry development and health information communication protocols to ensure that commonly understood and shared care management strategies are developed and implemented.
    2. As indicated by CMC protocols and collaborative regional priorities, Medical Home Plus providers will voluntarily execute Care Coordination Agreements with non-IHS/Tribal 638 providers, as per CMS State Health Official guidance #16-002.
    3. CMCs will identify and track specific medical home outcome measures (e.g. NCQA or IHS IPC Core Measures, such as the Comprehensive Diabetes Care Bundle). These focused measures will be monitored in addition to measure reporting that is required as part of non-"Plus" medical home designation and will be aligned as appropriate by CMC participants with other emerging quality measure sets (e.g. MIPS and APMs). In addition, at the system level, AHCCCS will monitor efforts across CMCs to reduce avoidable ED visits for non-emergent and primary care treatable conditions by AIHP members to non-IHS/Tribal 638 providers.

(iii) Diabetes Education Qualifications

A. National standards for diabetes self-management education and support are defined by the American Association of Diabetes Educators. These standards address program organizations, stakeholder input, program planning and coordination, staff qualifications, curriculum, quality assurance and improvement. To qualify for the additional per member per month for Diabetes Education, American Indian Medical Homes must have Diabetes Education Accreditation through a recognized accreditation agency.

B. Service Description:

The American Indian Medical Home (AIMH) is designed to support a medical home model for AHCCCS members who are American Indian/Alaska Natives and receive their care on a fee-for-service basis. Most qualified members receive their care at Indian Health Services and/or Tribal 638 Facilities operated under Public Law 93-638 ("IHS/Tribal 638 Facilities"). These facilities should serve as the medical home for AIHP members, but lack the needed capacity and service capability. The goal of the AIMH program is to further efforts to develop Patient Centered Medical Home capability within IHS/Tribal 638 Facilities, reducing fragmentation in service delivery and improving outcomes for AIHP AHCCCS members. AIMH services will align with national efforts within the IHS and Indian health system (e.g. the IHS Improving Patient Care Medical Home model) and result in demonstrable change in service delivery capability for qualifying facilities serving American Indian AHCCCS members.

C. Covered Population

The American Indian Medical Home will be open to American Indian members enrolled in AHCCCS Acute fee-for-service (FFS).

D. Core Services

All AIHP members have access to the full array of AHCCCS covered benefits under the State Plan and 1115 waiver for acute care enrollees. Members receiving their care at facilities that qualify as an AIMH will also be able to access the following services.

1. Primary Care Case Management
2. Diabetes Education.
3. 24-Hour Call Lines staffed by medical professionals.
4. After-Hospital Care Coordination.

Members receiving their care at facilities that qualify as an AIMH Plus will benefit from the utilization of standardized protocols, collaborations, and secure health information sharing that supports care transitions for members with complex conditions following hospitalization, transfer for specialty evaluation, or emergency department evaluation.

28. American Indian Medical Home Services.

American Indian Medical Home Services for members enrolled in the Federal Emergency Services program are not covered.

American Indian Medical Home Services are not covered for members enrolled in the Hospital Presumptive Eligibility (HPE) program.

American Indian Medical Home Services are not covered for members receiving long term services supports through Tribal ALTCS as they are duplicative of services covered in other sections.

- **American Indian Medical Homes**

Facilities achieving AIMH status receive payments using an Alternative Payment Model that reimburses on a prospective per-member per-month (PMPM) structure. Facilities will be required to submit a Medical Home claim on a monthly basis for each member that is empaneled in their medical home.

a. Medical Home: A baseline PMPM payment amount with an annual increase of 4.6%, which is based upon the average annual increase of the outpatient all-inclusive rate over the past ten years.
b. Medical Home "Plus": An additional PMPM (above the baseline) with an annual increase of 4.6%.
c. Diabetes Education: An additional PMPM (above the baseline) with an annual increase of 4.6%.

Patients will be empaneled using the following methodology.

b. Attestation process. AHCCCS will recognize patient empanelment to a specific Medical Home by receipt of a signed patient attestation form identifying the patient's medical home of record. A Medical Home will not be able to be reimbursed for PMPM claims until the empanelment process has been completed.
c. Submission of empanelment file. The Medical Home must submit to AHCCCS Division of Fee-for-Service Management (DFSM) a file of empaneled members. Members submitted that already have been empaneled in a different medical home will be rejected back to the submitting facility; in this case, the facility or member can request a transfer through the transfer process.
d. Transfer process. The AHCCCS transfer process can be utilized when a member is empaneled with another facility. In this case, the facility that would like the member to be transferred must complete the AHCCCS approved transfer form. This form must be signed by the requesting facility, the currently empaneled facility, and the member.

The Traditional Healing

Waiver List

Add paragraphs to current #3 **Amount, Duration, Scope of Services Section 1902(a)(10)(B) (42 CFR 440.240 and 440.230)**
To the extent necessary to enable the State to offer traditional health services to beneficiaries receiving care at an IHS or Tribal 638 Facility.

Costs Not Otherwise Matchable (CNOMs)

Add new CNOMs:

20. Expenditures for payments to IHS and Tribal 638 Facilities for traditional healing services.

STCs – Traditional Healing

1. **General Description**. Traditional Healing practices are offered as part of an integrated service delivery within IHS/Tribal 638/Urban Indian Facilities (I/T/Us) to support care coordination and improved health outcomes.
2. **Definition**. A system of culturally appropriate healing methods developed and practiced by generations of Tribal healers who apply methods for physical, mental and emotional healing. The array of practices provided by traditional healers shall be in accordance with an individual Tribe's established and accepted traditional healing practices as identified by the Qualifying Entity.
3. **Extent of Covered Benefit**. I/T/Us shall adopt policies and procedures and determine the array of covered traditional healing services that may be offered. The services may be conducted within the physical structure or on the grounds of the facility, such as in a prayer or healing room or sweat lodge developed for this purpose. The covered traditional services, limitations, exclusions and insurance liability shall be described by each facility seeking to participate in this program upon the approval of CMS and shall be detailed by facility within Attachment H.
4. **Provider Types**. The training and qualifications of Traditional Healing Providers may vary widely depending on the Tribe served. For this reason, a facility governing body may serve as the Qualifying Entity or designate another Qualifying Entity from the Tribe(s) served to endorse qualified Traditional Healing Providers. The details and membership of the Qualifying Entity shall be outlined in Attachment H.
5. **Federal Financial Participation**. It is recognized that traditional healing services meeting the criteria in the STCs and Attachment H shall be reimbursed at 100% FFP in accordance with IHS policy that requires IHS facilitate access to traditional medicine practices.
6. **Operational Protocol**. The Operational protocol in Attachment H will also:
    a. Identify policies in place by which traditional healing and the clinical and preventive allopathic health care providers consult each other and refer members.
    b. Establish the Facility system of performance evaluation or a customer service satisfaction survey that provides information on the effectiveness of the traditional healing program.

c. Include the policies/procedures of the facility to obtain a signed release of liability by a member and member consent.
d. Reimbursement methodology.
    i. Option A: **Per Encounter payment.** AHCCCS to reimburse the IHS, Tribal and Urban health facilities (through arrangements), at the All-Inclusive per encounter rate available for Medicaid inpatient and outpatient hospital services for covered traditional healing services. The hospital services are billed on a UB 04 at the OMB All-Inclusive Rate (AIR) with the current rate published in the Federal Register.
    ii. Option B: Fee-for-Service Payment. Fee for Service reimbursement to be based on traditional healing services provided to an individual patient. Reimbursement will be identified based upon AHCCCS HCPCS code for traditional services.
    iii. Option C. Member Benefit Allowance. This would be provided as an added value benefit to an eligible AI/AN through AHCCCS. A traditional healer recommends a ceremony that the patient needs and they are eligible for a determined benefit allowance each year. The practitioner will be paid upon completion of the service. The purpose of the reimbursement is to cover costs of conducting such services for the benefit of the patient.
e. Identification of need of service as part of the member's care plan, which includes individualized goals.
f. Types of services determined by facility.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
AMERICAN INDIAN MEDICAL HOME BUDGET MODEL

INPUTS: 119,601 AIHP Acute Care enrollment as of 11/1/16

80% Total Enrollment Presentation Rate over 5 years

10%	20%	50%	60%	80%
Year 1	Year 2	Year 3	Year 4	Year 5

65% Total AIMH+ Achievement Rate over 5 years

0%	20%	33%	50%	65%
Year 1	Year 2	Year 3	Year 4	Year 5

80% Total Diabetes Eduction rate over 5 years

10%	20%	50%	60%	80%

PMPMs:	Year 1	Year 2	Year 3	Year 4	Year 5
AIMH Base	13.26	13.87	14.51	15.18	15.88
AIMH with Diabetes	15.26	15.96	16.69	17.46	18.26
AIMH Plus	20.76	21.71	22.71	23.75	24.84
AIHM Plus with Diabetes	22.76	23.81	24.91	26.06	27.26

Enrollment Phase:	Year 1	Year 2	Year 3	Year 4	Year 5
AIMH Base	10,764	15,309	20,033	14,352	6,698
AIMH with Diabetes	1,196	3,827	20,033	21,528	26,791
AIMH Plus	-	3,827	9,867	14,352	12,439
AIHM Plus with Diabetes	-	957	9,867	21,528	49,754
	11,960	23,920	59,800	71,760	95,682

Estimated Costs:	Year 1	Year 2	Year 3	Year 4	Year 5
AIMH Base	1,712,800	2,548,000	3,488,100	2,614,400	1,276,400
AIMH with Diabetes	219,000	732,900	4,012,200	4,510,500	5,870,400
AIMH Plus	-	997,000	2,689,000	4,090,300	3,707,800
AIHM Plus with Diabetes	-	273,400	2,949,400	6,732,200	16,275,500
	1,931,800	4,551,300	13,138,700	17,947,400	27,130,100
Federal	1,931,800	4,551,300	13,138,700	17,947,400	27,130,100
State	-	-	-	-	-