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2019 Arizona Mental Health System Guidebook

March 2019 MRC2.CORP.D.00407

This resource is provided for informational purposes only and is not intended as reimbursement or legal advice.

Please seek independent, qualified, professional advice to ensure that your organization is in compliance with the complex legal and regulatory requirements governing health care services, and that treatment decisions are made consistent with the applicable standards of care.

Except as otherwise indicated, the information provided is accurate to the best of Otsuka's knowledge as of March 2019. PsychU provides this information for your convenience. In order to obtain the most up-to-date information about a state or its programs, please contact the organization listed within this state's Mental Health System Guidebook.

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A. Executive Summary

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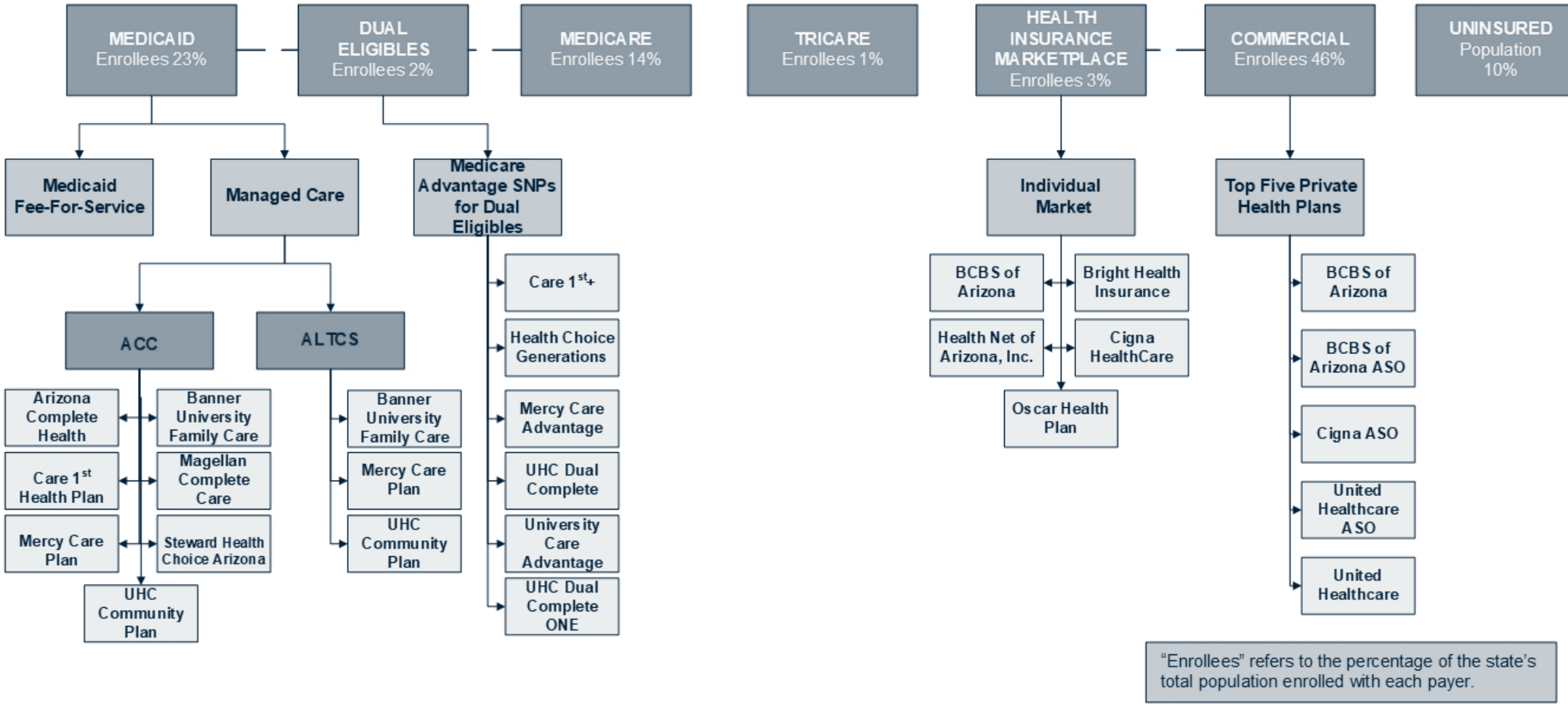
A.1. Physical Health Care Coverage Map

Total Arizona Population- 7,016,270
Estimated SMI Population- 327,020



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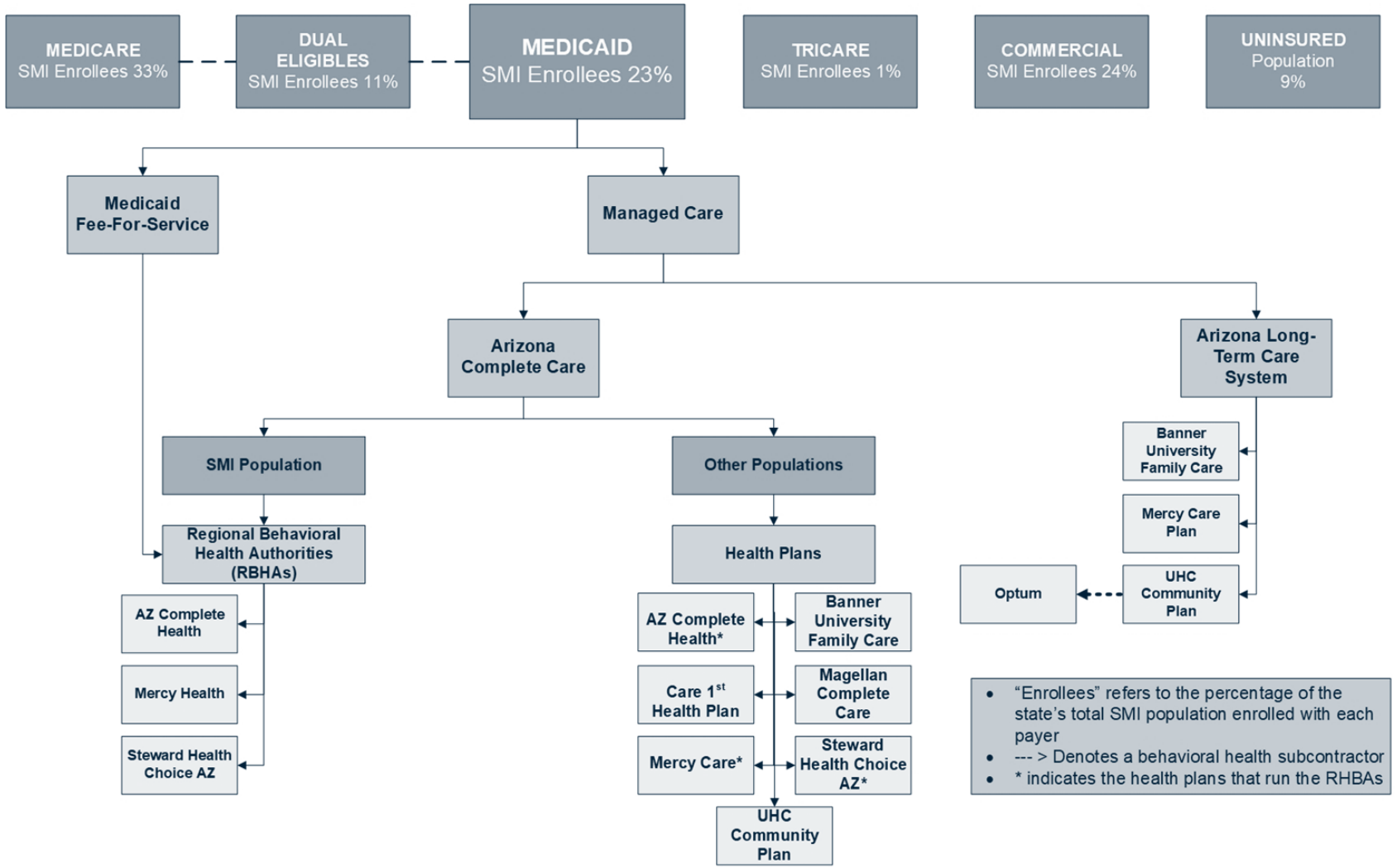
A.2. Physical Health Care Coverage Map

Medicaid Managed Care Programs



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A.3. Medicaid System Overview

Medicaid Financial Delivery System Enrollment	
Total Medicaid Population Distribution	• As of January 2019: 7% in FFS, 93% in managed care
SMI Population Inclusion In Managed Care	• Arizona's only managed care exemption criterion is membership in an American Indian Tribe, with or without the presence of an SMI diagnosis; therefore the majority of the SMI population is enrolled in managed care • Eligible individuals are automatically enrolled in specialty health plans for persons with SMI • Estimated 8% of SMI population in FFS, 92% in managed care
Dual Eligible Population Inclusion In Managed Care	• Managed care is mandatory for full-benefit dual eligibles • Estimated 7% of population in FFS, 93% in managed care

Medicaid Financing & Risk Arrangements: Behavioral Health		
Service Type	**FFS Population**	**Managed Care Population**
Traditional Behavioral Health **Specialty Behavioral Health**	• Individuals Without SMI: FFS • Individuals With SMI: RBHAs or T/RBHAs	• Included in the health plan's capitation rate • The state also operates integrated health plans for the SMI population; all services are included in the RBHA's capitation rate
Pharmaceuticals	Covered FFS by the state	Included in the health plan's capitation rate
LTSS	Covered FFS by the state	Individuals in need of a nursing facility or ICF/IDD level of care receive all services – including LTSS – through the ALTCS health plans

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A.4. Medicaid Care Coordination Initiatives

Medicaid Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	**Active Program**	**Description**
Managed Care Health Plan	✓	Health plans are responsible for care coordination.
PCCM	✓	The AIMH program provides care coordination under a PCCM model
ACO Program		None
ACA Model Health Home		None
PCMH	✓	AIMH participating organizations operates at PCMHs

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A.5. Behavioral Health Safety-Net Delivery System

Overview

State Agency Responsible For Uninsured Citizens & Delivery System Model

Physical Health Services

- Arizona's primary care office the Bureau of Health Systems Development within the Department of Health Services, has no service delivery mandate; sliding fee clinics throughout the state and county health departments provide physical health services to the safety-net population

Mental Health Services

- AHCCCS provides mental health treatment services to the safety-net population through contracts with T/RBHAs

Addiction Treatment Services

- AHCCCS also provides addiction treatment services to the safety-net population through contracts with T/RBHAs

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B. Health Financing System Overview

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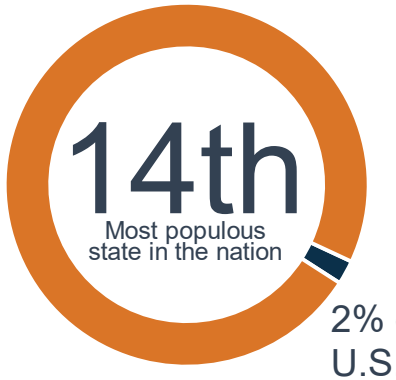
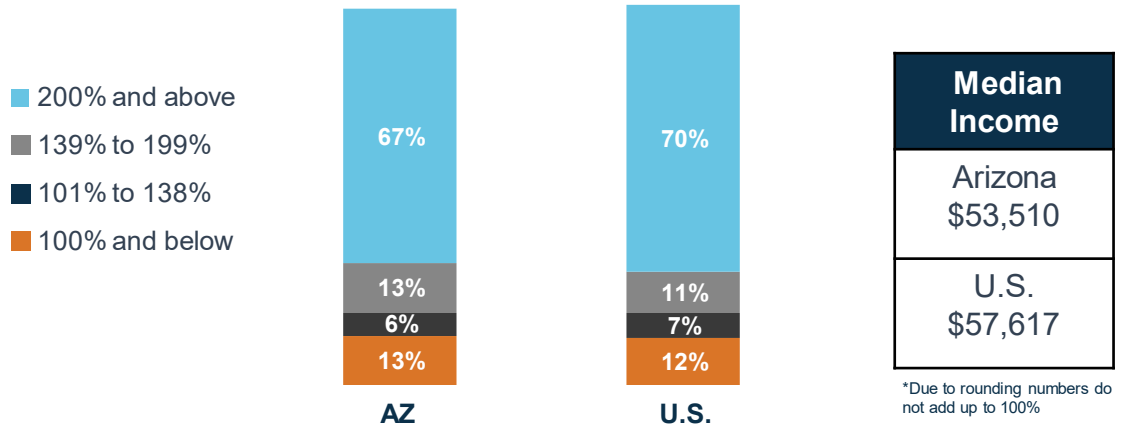
B.1. Population Demographics

Total Arizona Population- 7,016,270
Estimated SMI Population- 327,020



2% of the U.S. population

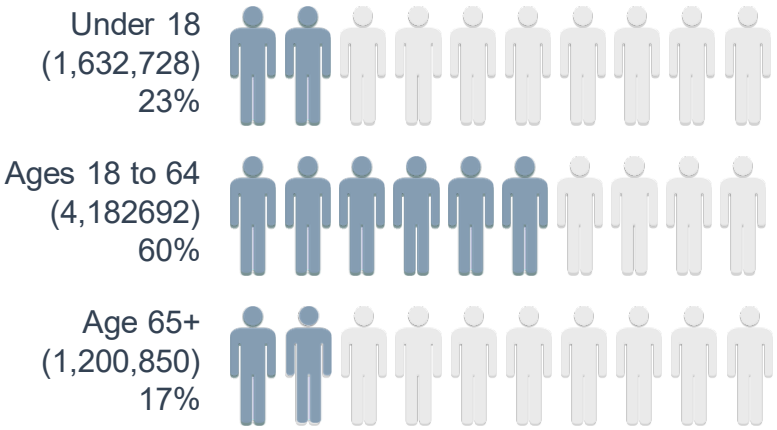
Population Distribution By Income To Poverty Threshold Ratio



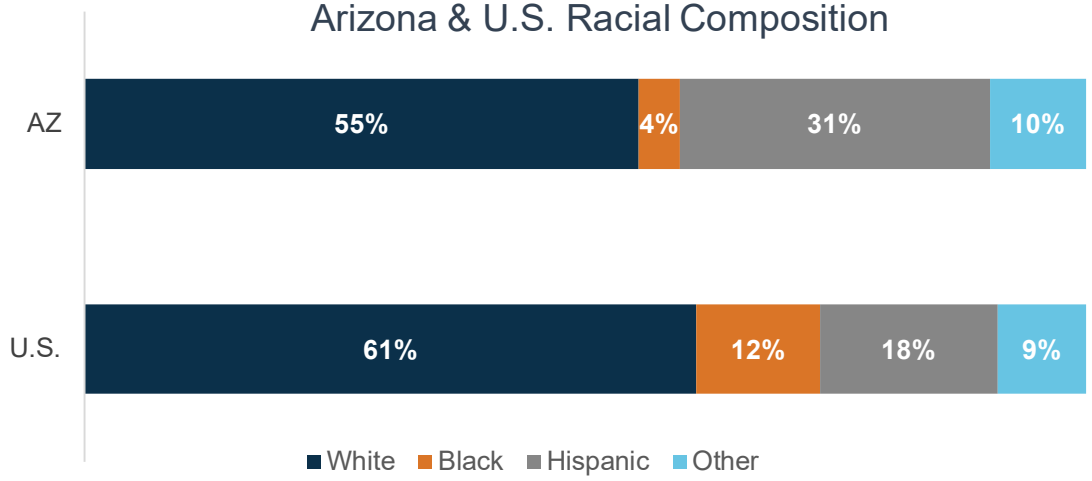
Median Income
Arizona $53,510
U.S. $57,617

*Due to rounding numbers do not add up to 100%

Population Distribution By Age



Arizona & U.S. Racial Composition



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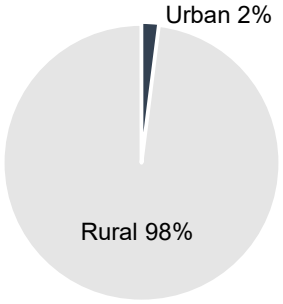
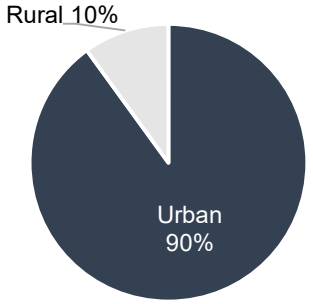
B.2. Population Centers

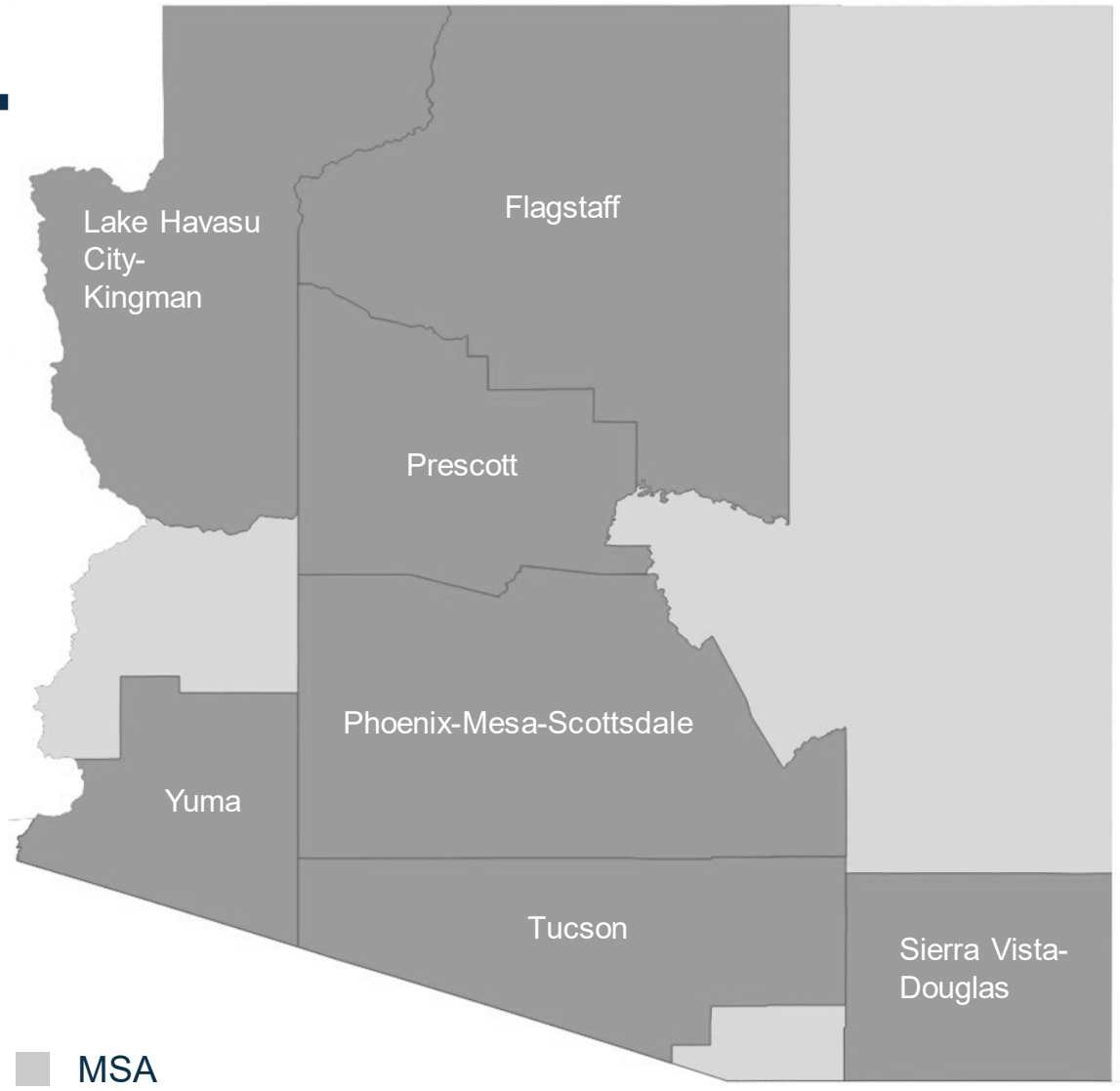
MSAs		
MSA	**CA Residents**	**Percent Of Population**
Total MSA Population	**6,463,394**	**92%**
Flagstaff, AZ	138,639	2%
Lake Havasu City-Kingman, AZ	204,691	3%
Phoenix-Mesa-Scottsdale, AZ	4,561,038	71%
Prescott, AZ	220,972	3%
Sierra Vista-Douglas, AZ	126,516	2%
Tucson, AZ	1,007,257	16%
Yuma, AZ	204,281	3%

Distribution Of Land Area



Distribution Of Population





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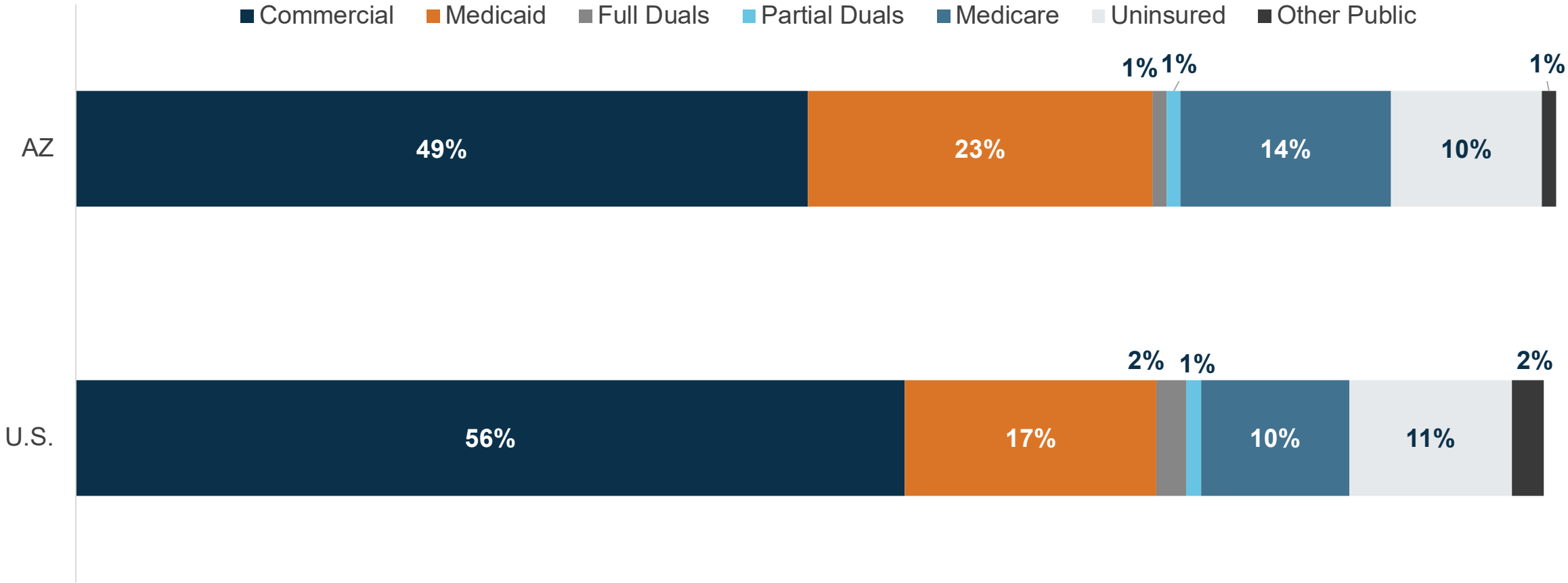
B.3. Population Distribution By Payer

National vs. State



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B.4. Largest Health Plans By Enrollment

Plan Name	Plan Type	Enrollment*
BCBS Of Arizona	Commercial ASO	903,101
Arizona Medicare FFS	Medicare	650,786
UnitedHealthcare Community Plan	Medicaid Managed Care – ACC	366,401
BCBS Of Arizona	Commercial	359,535
Mercy Care Plan	Medicaid Managed Care – ACC	352,353
UnitedHealth	Commercial ASO	333,268
UnitedHealthcare Insurance Company	Commercial	283,444
Cigna	Commercial ASO	273,820
Aetna	Commercial ASO	242,530
Medicaid FFS	Medicaid FFS	234,851

* Medicaid enrollment as of January 2019; Commercial as of 4th quarter 2017; Medicare as of November 2018

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B.5. Largest Health Plans By Estimated SMI Enrollment

Plan Name	Plan Type	Enrollment*	Estimated SMI Enrollment
Medicare FFS	Medicare	650,786	71,586
BCBS Of Arizona	Commercial ASO	903,101	20,771
UnitedHealthcare Community Plan	Medicaid Managed Care – ACC	366,401	17,954
Mercy Care Plan	Medicaid Managed Care – ACC	352,353	17,265
AARP MedicareComplete	Medicare Advantage	140,214	15,424
UnitedHealthcare Dual Complete	Medicare Advantage	50,283	15,085
Medicaid FFS	Medicaid	234,851	11,508
TRICARE	Other Public	204,609	11,458
Steward Health Choice Arizona	Medicaid Managed Care – ACC	221,283	10,843
Arizona Complete Health	Medicaid Managed Care – ACC	195,803	9,594

*Medicaid enrollment as of January 2019; Commercial as of 4th quarter 2017; Medicare as of November 2018

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B.6. Health Insurance Marketplace

Health Insurance Marketplace	
Type Of Marketplace	Federal
Individual Enrollment Contact	https://www.healthcare.gov/
	1-800-318-2596
Small Business Enrollment Contact	No small group plans are available through the marketplace; employers must purchase coverage directly from an insurance carrier, or through an insurance broker

2018 Individual Market Health Plans
1. BCBS Of Arizona, Inc.
2. Bright Health Insurance Company
3. Cigna HealthCare Of Arizona, Inc.
4. Health Net Of Arizona, Inc.
5. Oscar Health Plan, Inc.

2018 Small Group Market Plans
None

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B.7. ACOs

Commercial ACOs	
ACO	**Commercial Insurer**
Arizona Care Network, LLC	• Aetna Whole Health • UnitedHealthcare
Arizona Community Physicians	• Cigna
Arizona Connected Care, LLC	• Cigna
Banner Health Network	• Aetna Whole Health • BCBS Of Arizona • Cigna
Cigna Medical Group Of Arizona Collaborative Accountable Care	• Cigna
Commonwealth Primary Care ACO, LLC	• Cigna

Medicare ACOs
1. Abacus Health
2. Arizona Care Network, LLC*
3. Arizona Connected Care, LLC
4. Arizona Priority Care Plus
5. ASPA Connected Community, LLC
6. Banner Health Network
7. Commonwealth Primary Care ACO, LLC
8. John C Lincoln ACO, LLC
9. North Central Arizona Accountable Care
10. Optum Accountable Care*
11. PathfinderHealth, LLC
12. Physician Performance Network of Arizona, LLC
13. Revere Health*
14. Scottsdale Health Partners

* Denotes Next Generation model ACOs; all other Medicare ACOs listed operate under the Shared Savings Model

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C. Medicaid Administration, Governance, & Operations

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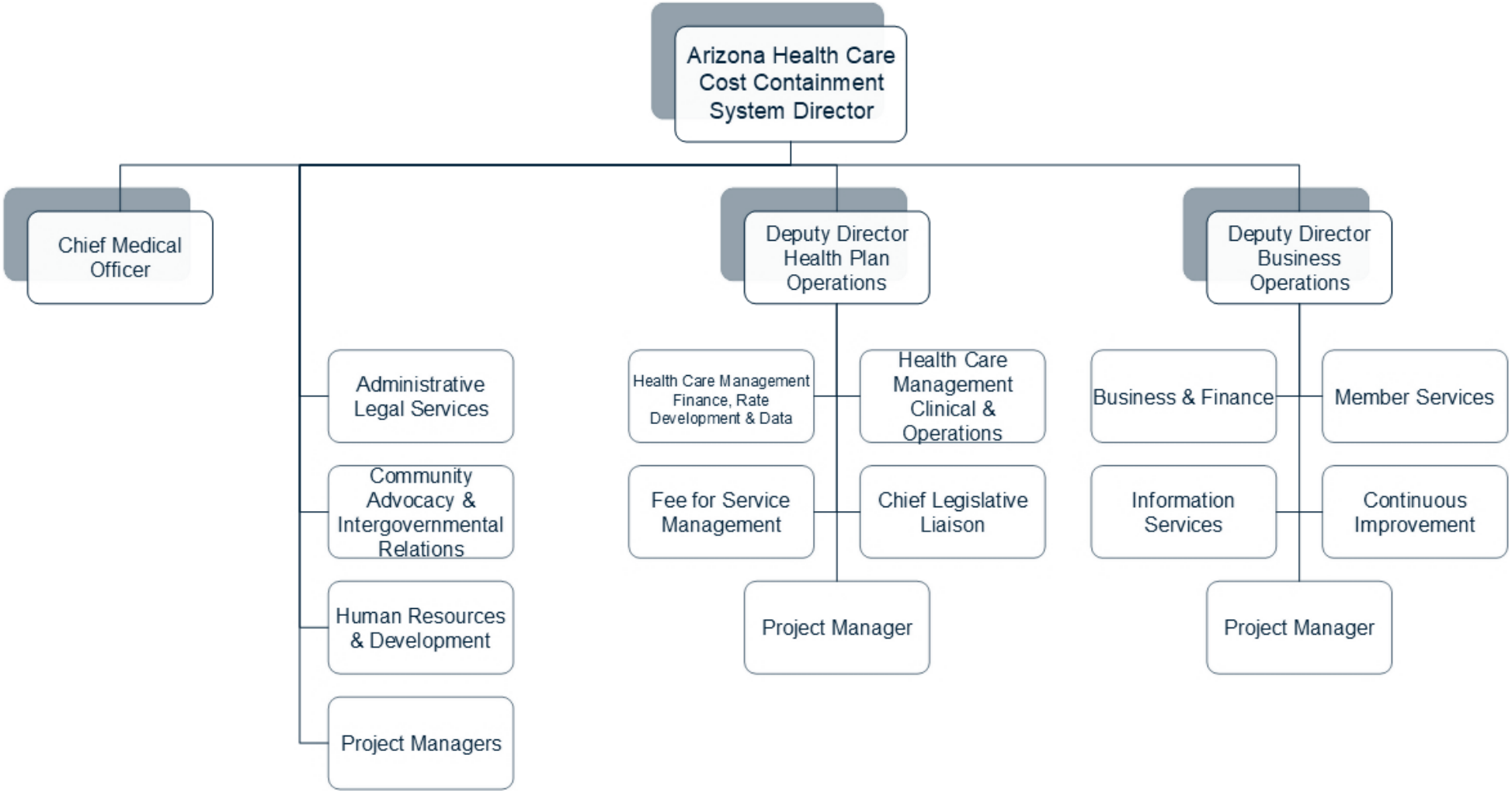
C.1. Medicaid Governance

Organization Chart



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C.2. Medicaid Governance

Key Leadership

Name	Position	Department
Jami Snyder	Director, State Medicaid Director	AHCCCS
Vacant*	Deputy Director Health Plan Operations	AHCCCS
Vacant*	Deputy Director Business Operations	AHCCCS
Sara Salek, MD	Chief Medical Officer	AHCCCS
Dana Hearn	Community Advocacy & Intergovernmental Relations	AHCCCS
Shelli Silver	Health Care Management Finance, Rate Development, & Data	AHCCCS
Virginia Rountree	Health Care Management Clinical & Operations	AHCCCS
Joni Shipman	Member Services	AHCCCS
Jami Snyder	Director, State Medicaid Director	AHCCCS

*The two Deputy Director positions are new and were announced in January 2019; the state is actively recruiting for these positions

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C.3. Medicaid Expansion Status

Medicaid Expansion	
Participating In Expansion	Yes
Date Of Expansion	January 2014
Medicaid Eligibility Income Limit For Able-Bodied Adults	133% of FPL; Note: The PPACA requires that 5% of income be disregarded when determining eligibility
Legislation Used To Expand Medicaid	House Bill 2010, 51st Legislature
Number Of Individuals Enrolled In The Expansion Group (September 2017)	430,795
Number Of Enrollees Newly Eligible Due To Expansion	112,408
Benefits Plan For Expansion Population	The alternative benefit plan is identical to the state plan

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C.4. Medicaid Program Benefits

Federally Mandated Services

1. Inpatient hospital services other than services in an IMD
2. Outpatient hospital services
3. Rural Health Clinic services
4. FQHC services
5. Laboratory and x-ray services
6. Nursing facilities for individuals 21 and over
7. EPSDT
8. Family planning services and supplies
9. Free standing birth centers
10. Pregnancy-related and postpartum services
11. Nurse midwife services
12. Tobacco cessation programs for pregnant women
13. Physician services
14. Medical and surgical services of a dentist
15. Home health services
16. Nurse practitioner services
17. Non-emergency transportation to medical care

Arizona's Optional Services

1. Podiatry
2. Optometry
3. Services of other practitioners
4. Private duty nursing
5. Clinic services
6. Dental services
7. Physical and occupational therapy
8. Services for individuals with speech, hearing, and language disorders
9. Prescribed drugs
10. Prosthetic devices
11. Diagnostic, screening services, and preventive services
12. Rehabilitative services
13. Inpatient services for individuals age 65 and over in IMDs
14. ICF / IDD and public institution services for individuals
15. Inpatient psychiatric services for individuals under age 22
16. Hospice care
17. Case management
18. Respiratory care
19. Nursing facility services for individuals under 21

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D. Medicaid Financing & Delivery System

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D.1. Medicaid Financing & Service Delivery System

Medicaid System Characteristics				
Characteristics	**FFS**	**Managed Care AHCCCS ACC**	**Managed Care Acute SMI**	**Managed Care ALTCS**
Enrollment (January 2019)	122,325	1,514,227	41,453	63,983
SMI Enrollment	• Arizona's only managed care exemption criterion is membership in an American Indian Tribe, with or without the presence of an SMI diagnosis; therefore, the majority of the SMI population is enrolled in managed care • Estimated 92% of SMI population is enrolled in managed care			
Management	• Acute Care: AHCCCS • Behavioral Health: RBHAs	Seven health plans that provide acute and behavioral health care services	Three health plans, operated by RBHAs	• Three health plans that provide acute and long-term care • Some populations served through Tribal and interagency agreements
Payment Model	• Acute Care: FFS • Behavioral Health: Capitated rate	Capitated rate	Capitated rate	Capitated rate
GSA	• Acute Care: Statewide • Behavioral Health: One RBHA per region	Statewide, plans available regionally	Statewide, one plan per region	Statewide, plans available regionally

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D.2. Medicaid Service Delivery System

Enrollment By Eligibility Group

Population	Mandatory FFS Enrollment	Option To Enroll In FFS / Managed Care	Mandatory Managed Care Enrollment
Parents & Caretakers			X
Children			X
Blind & Disabled Individuals			X
Aged Individuals			X
Dual Eligibles	Partial benefit dual eligibles		Full benefit dual eligibles
Medicaid Expansion			X
Individuals Residing In Nursing Homes			X
Individuals Residing In ICF/IDD			X
Individuals In Foster Care			X
Other Populations	• Emergency services for non-citizens • Presumptive eligibility	• Alaskan natives • American Indians	Breast and cervical cancer program

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D.3. Medicaid FFS Program
Overview

- FFS enrollment as of January 2019 was 122,325*
- Arizona calls its Medicaid program Medical Assistance
- The only full benefit population eligible to enroll in the FFS program is the American Indian population.
  - Of the 170,676 American Indians participating in Arizona's Medicaid program, 117,250 are enrolled in FFS
- The FFS program for American Indians is called the AIHP
  - American Indians are able to receive services from any AHCCCS provider organization, IHS facility, or tribally operated (638 contract designation) facility on an FFS basis
  - American Indians are able to switch back and forth from an AHCCCS managed care plan to AIHP at any time
  - In October 2017, the state began operating a voluntary PCMH program for the American Indian population called the AIMH
  - In areas with participating provider organizations, PCCM is available to AIHP enrollees through the AIMH program

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D.4. Medicaid FFS Program
Behavioral Health Overview

- Arizona transitioned to a new integrated delivery system for most Medicaid enrollees in October 2018
- As a result, the RBHAs no longer serve the AIHP population without SMI; services will be still be available through the T/RHBAs where available
- The AHIP population with SMI may choose to enroll in the RBHA for behavioral health services only and receive physical health services through the AIHP
- Most other FFS populations are those with presumptive eligibility or retroactive coverage and therefore, are not served by the RBHAs

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D.5. Medicaid FFS Program
Behavioral Health Benefits

FFS Mental Health Benefits
1. Inpatient services
2. Subacute facility services
3. Psychiatric residential treatment facility for individuals under age 21
4. Day programs
5. Counseling and therapy
6. Assessment, evaluation, and screening
7. Multisystemic therapy for juveniles
8. Rehabilitation services
9. Medication administration
10. Medical testing
11. Medical management
12. Electroconvulsive therapy
13. Support services, including case management
14. Crisis intervention services

FFS Addiction Treatment Benefits
1. Inpatient services, including medical detoxification
2. Subacute facility services
3. Day programs
4. Alcohol and drug assessment
5. Intensive outpatient
6. Comprehensive medication services
7. Crisis services
8. Support services, including case management

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D.6. Medicaid FFS Program

SMI Population

- Arizona's only managed care exemption criterion is membership in an American Indian Tribe, with or without the presence of an SMI diagnosis; therefore, the majority of the SMI population is enrolled in managed care
- OPEN MINDS estimates that as of January 2019, 8% of the SMI population was enrolled in FFS

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D.7. Medicaid Managed Care Program
Overview

- Managed care enrollment as of January 2019 was 1,514,227
- Arizona has two managed care programs to serve Medicaid enrollees:
  - **AHCCCS ACC**: Delivers acute care and behavioral health services to individuals who do not require LTSS
  - **ALTCS**: Provides acute care, behavioral health, and LTSS for those who require a nursing facility or ICF/IDD level of care
- Within these two programs, the state delivers services to populations with special needs through vertical carve-outs.
  - There are two ACC vertical carve-outs – one for individuals with SMI and one for the foster care population
  - There is an ALTCS vertical carve-out for the I/DD population
- The state has imposed minimum targets for health plan use of APMs based on a percentage of total payments made
  - **ACC**: 50% in calendar year 2019, increasing to 70% in 2021
  - **ACC Integrated Plans For Individuals With SMI**: 35% in calendar year 2019, increasing to 60% in 2021
  - **ALTCS For The Non-I/DD Population**: 50% in calendar year 2019, increasing to 70% in 2021
  - **Other Carve-out Population Services**: Percentages depend on the population and type of service; the calendar year 2019 targets range from 10% to 35%; the 2021 targets range from 25% to 60%

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D.8. Medicaid Managed Care Program
ACC

- On October 1, 2018, Arizona implemented the AHCCCS ACC, which integrates behavioral health and physical health services for Medicaid beneficiaries who do not require LTSS
  - Enrollment as of January 2019 was 1,514,227
- The main ACC program provides integrated physical and behavioral health services to all individuals enrolled in managed care through seven capitated health plans
  - Health plans are available by GSA, which refers to either one specific county or a grouping of counties
  - Enrollees can choose any health plan available in their GSA
- In 2016, the state added premium requirements for the Medicaid expansion population and in January 2019 received approval to add work requirements for most non-disabled populations
- In addition to the main ACC program, there are two vertical carve-out programs for special populations:
  - **Integrated Plans**: Individuals eligible for the ACC program with a diagnosis of SMI receive services through the RBHAs; enrollment as of January 2019 was 41,453, or 3% of the ACC population
  - **Comprehensive Medical & Dental Program**: Children eligible for the ACC program and who are in foster care receive services through this statewide program, which is operated by the state Department of Child Safety; enrollment as of January 2019 was 12,892 or 1% of the ACC population

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D.9. Medicaid Managed Care Program

Medicaid Expansion Cost Sharing

- In September 2016, CMS approved an amendment to the state's section 1115 demonstration waiver authorizing cost sharing for Medicaid expansion enrollees with incomes between 100% and 133% of the FPL
- The cost sharing program is called CARE; under CARE, these members are required to pay monthly contributions of up to 2% of household income, as well as co-payments for some services
  - The aggregate cap on cost sharing is 5% of household income
  - The payments are made from the member to the health plan based on a quarterly invoice, with a 60-day remittance term
  - There is no lock-out period for failure to pay premiums. Individuals who are disenrolled for failure to pay may be reenrolled at any time without settlement of arrears
- An incentive component to the program called Healthy Arizona allows individuals who meet healthy behavior targets to be exempt from their monthly contributions for six months; examples of healthy behaviors are annual physicals, flu shots, and tobacco cessation
  - Individuals who meet healthy behavior targets may use their previous CARE payment funds to access services not covered by Medicaid, or may apply them to subsequent year invoices
- American Indians, medically frail individuals, persons with SMI, and individuals with incomes below 100% of the FPL may voluntarily enroll in CARE, but are not mandatorily enrolled

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D.10. Medicaid Managed Care Program

Medicaid Expansion Community Engagement Requirements

- In January 2019, CMS approved an amendment to the state's section 1115 demonstration waiver authorizing cost sharing for Medicaid expansion enrollees between the ages of 18 and 49
- The cost sharing program is called AHCCCS Works; under AHCCCS Works, on or after January 1, 2020, these members will be required to spend at least 80 hours per month:
  - Working (including self-employment)
  - Participating in employment readiness activities (including full-time education, job or life skills training, and health education classes)
  - Searching for jobs
  - Completing community service
- Pregnant women, women up to 60 days post-partum, former foster youth up to age 26, individuals with SMI, individuals receiving disability benefits, medically frail beneficiaries, individuals undergoing active SUD treatment, full-time students, victims of domestic violence, homeless individuals, caregivers of individuals under age 18 or individuals with disability, individuals with an acute medical condition, individuals with a disability as defined by federal disabilities rights laws, individuals receiving SNAP or Cash Assistance, individuals receiving Unemployment Insurance income benefits, and all American Indian/Alaska Native beneficiaries will be exempt from the AHCCCS Works requirements
- The AHCCCS Works implementation plan is due to CMS by 150 days after its January 18, 2019 approval
- Enrollees will have a three month grace period after the program start date to comply with AHCCCS Works community engagement requirements

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D.11. Medicaid Managed Care Program

Integrated Health Plans For The SMI Population

- The transition to the ACC program in October 2018 did not effect the delivery system for the SMI population
- Persons with an SMI determination are automatically enrolled in the integrated care plan operated by the RBHA serving their county, but may opt-out for cause
  - The three RHBAs also operate ACC plans for the non-SMI population and manage behavioral health benefits for the safety-net population
- Enrollment as of January 2019 was 41,453, or 3% of the ACC population
- In addition to managing the delivery of physical health and behavioral health services, the RBHAs must provide care coordination, comprehensive care management, and a treatment team to each member
- Persons with SMI who require long-term services and supports are enrolled in the ALTCS program, and receive behavioral health benefits through the ALTCS health plans

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D.12. Medicaid Managed Care Program
ALTCS

- The ALTCS program provides acute care and LTSS for individuals who require a nursing facility or ICF/IDD level of care
  - Enrollment as of January 2019 was 63,983
  - The ALTCS program was not effected by the move to ACC on October 1, 2018
- Services are provided to 28,229 members through three capitated health plans that are available by ALTCS service area
  - Enrollees have a choice of health plan only if more than one plan is available in their service area
- Individuals with I/DD eligible for the ALTCS program receive acute care and LTSS through an intergovernmental agreement with the Department Of Economic Security, Division Of Developmental Disabilities
  - Enrollment as of January 2019 was 33,143
- As an option for American Indians, eight Tribes have entered into agreements with AHCCCS to deliver ALTCS services
  - These organizations served 2,611 individuals as of January 2019

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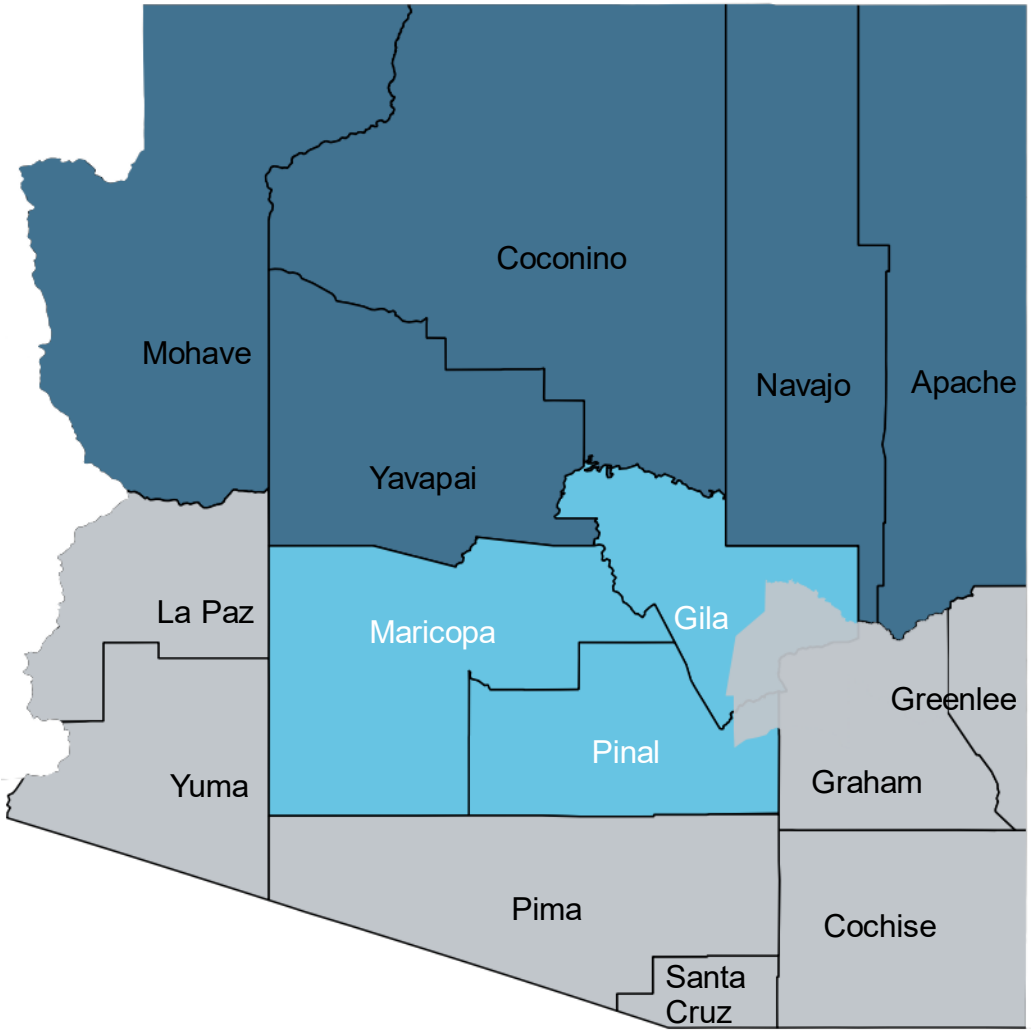
D.13. Medicaid Managed Care Program

ACC & ALTCS Service Areas



Region	Counties	ACC Health Plans	ALTCS Health Plans
North	• Apache • Coconino • Mohave • Navajo • Yavapai	• Steward Health Choice AZ* • Care 1st	• UHC Community Plan
Central	• Gila • Maricopa • Pinal	• AZ Complete Health • Banner • Care 1st • Magellan • Mercy Care* • Steward • UHC Community Plan	• Banner University Family Care • Mercy Care • UHC Community Plan
South	• Cochise • Graham • Greenlee • La Paz • Pima • Santa Cruz • Yuma	• AZ Complete Health* • Banner • UHC Community Plan (Pima County only)	• Banner University Family Care • Mercy Care (Pima County only)

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D.14. Medicaid Managed Care Program
Behavioral Health Overview

- On October 1, 2018, Arizona implemented the ACC program, which integrates behavioral and physical health benefits; the new program effectively ended the carve-out to the RHBAs
- Both the ACC and ALTCS populations receive all behavioral health benefits and behavioral health pharmacy through the Medicaid health plans; there are two exceptions to this:
  - The RHBAs will continue to serve foster care children enrolled in the CMDP and individuals with I/DD enrolled in the DES/DD plan
  - The state has plans to transition these populations to integrated models in the future
- The RBHAs will also continue to offer integrated health plans especially for the SMI population; the SMI population was not effected by the transition to the ACC model
- Each RBHA is responsible for one of three GSAs
  - Additionally, four American Indian Tribes have agreements with the state to deliver Medicaid behavioral health services to individuals living on their reservations through TRBHAs

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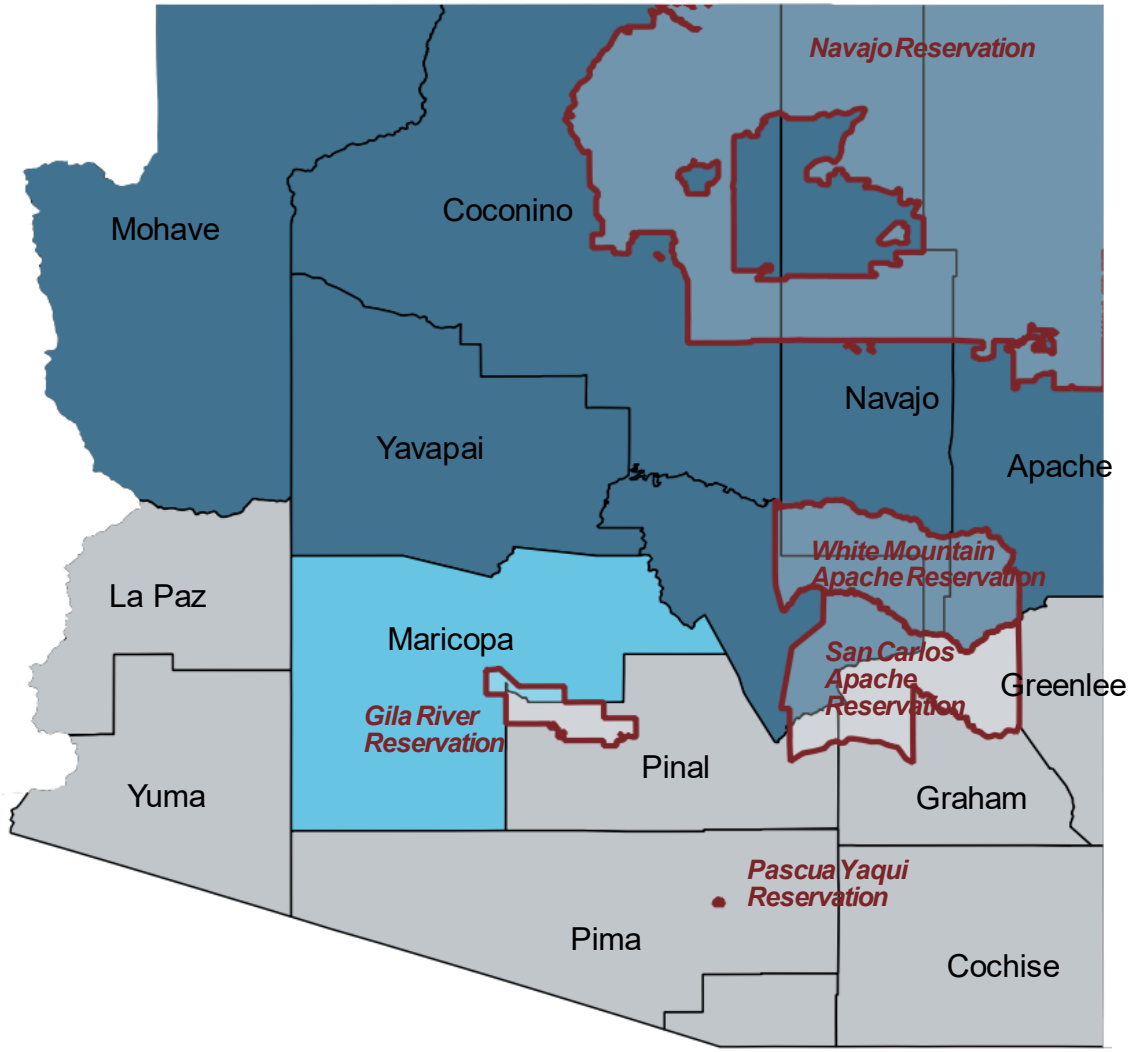
D.15. Medicaid Managed Care Program

RBHA Service Areas

As part of the transition to integrated care in October 2018, the RBHAs changed their names to align with the ACC plans they offer

GSA		RBHA	Counties
	North GSA	Steward Health Choice (formerly Health Choice Integrated Care)	• Apache • Coconino • Gila* • Mohave • Navajo • Yavapai
	Central GSA	Mercy Care (formerly Mercy Maricopa Integrated Care)	Maricopa
	South GSA	Arizona Complete Health (formerly Cenpatico Integrated Care)	• Cochise • Graham • Greenlee • La Paz • Pima • Pinal • Santa Cruz • Yuma



Tribal RBHA

*Zip codes in Gila County containing the San Carlos Apache reservation are included

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D.16. Medicaid Managed Care Program

Behavioral Health Benefits

Managed Care Mental Health Benefits

1. Inpatient services
2. Subacute facility services
3. Psychiatric residential treatment facility for individuals under age 21
4. Day programs
5. Counseling and therapy
6. Assessment, evaluation, and screening
7. Multisystemic therapy for juveniles
8. Rehabilitation services
9. Medication administration
10. Medical testing
11. Medical management
12. Electroconvulsive therapy
13. Support services, including case management
14. Crisis intervention services

Managed Care Addiction Treatment Benefits

1. Inpatient services, including medical detoxification
2. Subacute facility services
3. Day programs
4. Alcohol and drug assessment
5. Intensive outpatient
6. Comprehensive medication services
7. Crisis services
8. Support services, including case management

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D.17. Medicaid Managed Care Program

SMI Population

- Arizona's only managed care exemption criterion is membership in an American Indian Tribe, with or without the presence of an SMI diagnosis; therefore, the majority of the SMI population is enrolled in managed care
  - OPEN MINDS estimates that as of January 2019, 92% of the SMI population was enrolled in managed care
- Persons with SMI in the ACC program receive their physical and behavioral health Medicaid benefits through one of the three integrated health care plans operated by the RBHAs
- Persons with SMI who require long-term care services are enrolled in the ALTCS program, and receive behavioral health benefits through the ALTCS health plans

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D.18. Medicaid Program

Care Coordination Initiatives

ACO Program

- None

ACA Health Home

- None

PCMH

- The AIMH program was implemented in October 2017

Other Care Coordination Initiatives

- The state's section 1115 demonstration waiver authorizes incentive payments made to provider organizations for the integration of physical and behavioral health services

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D.19. Medicaid Program

AIMH Characteristics

AIMH Program	
Target Population	American Indian FFS enrollees
Enrollment Model	Voluntary
GSA	• Program is authorized statewide • As of January 2019, there are four participating AIMHs: Phoenix Indian Medical, Navajo Area Indian Health Service – Chinle Comprehensive Health Care Facility, Winslow Indian Health Care Center, Whiteriver Indian Hospital
Care Delivery Model	• HIS and Tribal facilities may serve as medical homes • PCCM model of care
Payment Model	AIMHs may qualify for one of four PMPM payment levels based on the types of services they have available: • Level 1: $14.51 PMPM; PCCM and 24-hour telephone line • Level 2: $16.70 PMPM; PCCM, 24-hour telephone line, and diabetes education • Level 3: $22.71PMPM; PCCM, 24-hour telephone line, and participation in state health information exchange • Level 4: $24.90 PMPM; PCCM, 24-hour telephone line, diabetes education, and participation in the state health information exchange
Practice Performance & Improvement	AIMHs must demonstrate that they meet the criteria for the program in one of two ways: 1. Achieve national level PCMH accreditation 2. Submit a PCMH assessment to IHS annually, submit quality measures data to IHS monthly, and submit narrative summaries on improvement projects to IHS quarterly

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D.20. Medicaid Program

Demonstration & Care Management Waivers

Waiver Title	Waiver Description	Waiver Type	Enrollment Cap	Effective Date	Expiration Date
AHCCCS	• Authorizes mandatory managed care enrollment for all Medicaid populations except American Indians • Includes $300 million in funding between FY 2018 and FY 2022 for the state's DSRIP Program called the Targeted Investments Program	1115	None	10/22/2011	09/30/2021

- The purpose of the Targeted Investments Program is to make incentive payments to Medicaid provider organizations that adopt processes to integrate physical and behavioral health services
- One amendment to the AHCCCS waiver is pending CMS approval
  - In May 2017, the state submitted an amendment request to receive federal financial participation for inpatient stays exceeding 15 days in IMDs provided to individuals between the ages of 21 and 64, regardless of delivery system
- In January 2019, CMS approved two waiver amendment requests:
  - Request to implement work, education, or community engagement requirements as a condition of Medicaid eligibility for childless adults between the ages of 18 and 55, with exemptions for persons with disabilities
  - Request to reduce the retroactive eligibility period from three months to one month

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E. State Behavioral Health Administration & Finance System

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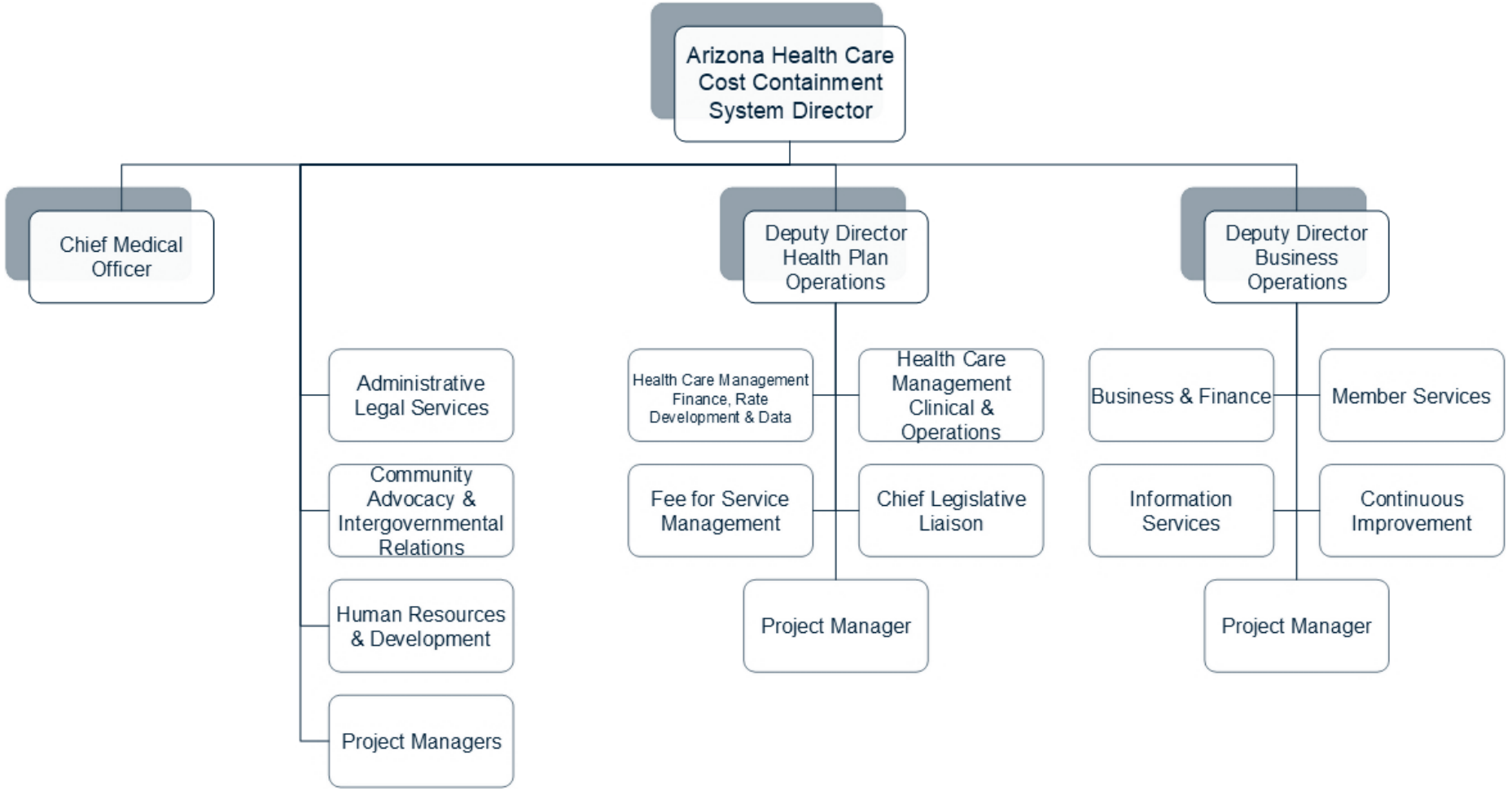
E.1. AHCCS

Organization Chart



Note: Behavioral health administrative functions are integrated throughout the AHCCCS.

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E.2. AHCCS

Key Leadership

Name	Position	Department
Jami Snyder	Director, State Medicaid Director	AHCCCS
Vacant	Deputy Director Health Plan Operations	AHCCCS
Vacant	Deputy Director Business Operations	AHCCCS
Sarah Salek, MD	Chief Medical Officer	AHCCCS

*The two Deputy Director Positions are new and were announced in January 2019; the state is actively recruiting for these positions

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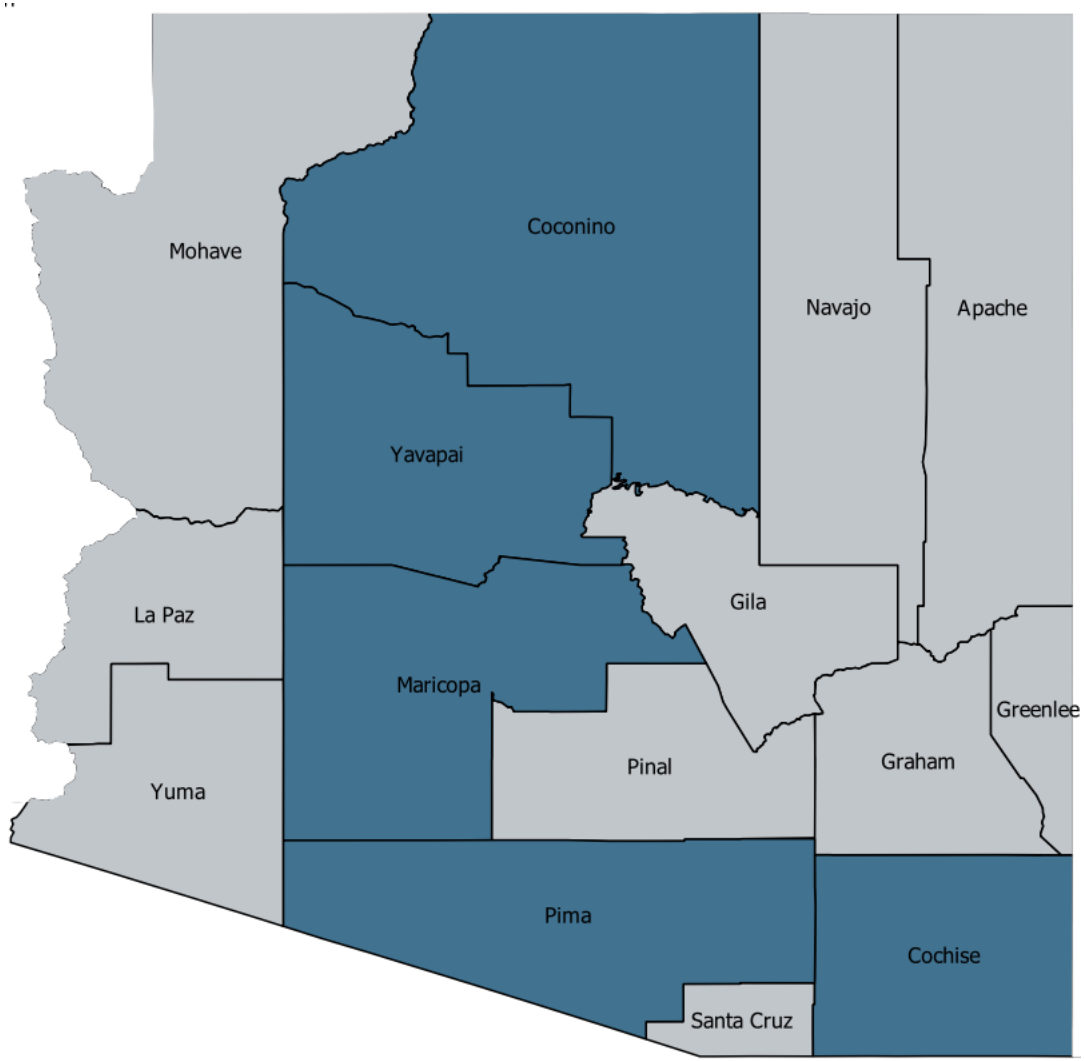
E.3. Mental Health & Addiction Bed Distribution

Mental Health & Addiction Treatment Bed Capacity	
Total number of hospitals with mental health and addiction beds	35
Number of mental health and addiction beds	1,155
Number of mental health and addiction beds per 100,000 population	16.66

Mental Health & Addiction Hospital Beds Per 100,000 Population

- 0.00
- 0.01 to 10.00
- 10.01 to 30.00
- 30.01 to 50.00
- More than 50.00



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E.4. State Psychiatric Institutions

State Psychiatric Institutions				
Institution	**Location**	**Population**	**Beds**	**FY 2018 Average Daily Census**
Arizona State Hospital	Phoenix	Civil	116	96
		Forensic	143	113
		Sex offender	100	93
Total			**360**	**302**

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E.5. Behavioral Health Safety-Net Delivery System

- The AHCCS contracts with three RBHAs that—in turn—contract with a network of provider organizations to deliver behavioral health services to the safety-net population
- The state also has agreements with five American Indian Tribes to deliver safety-net behavioral health benefits to their reservation populations through TRBHAs
  - Members of Tribes not entering into a behavioral health agreement with the state receive care from their geographic RBHA
  - The American Indian population may also receive safety-net care through a behavioral health program operated by their Tribes or the Indian Health Service agency
- These entities also have at-risk contracts to provide Medicaid behavioral health services to the FFS population
- Non-Medicaid safety-net services are financed by state appropriations and federal block grants

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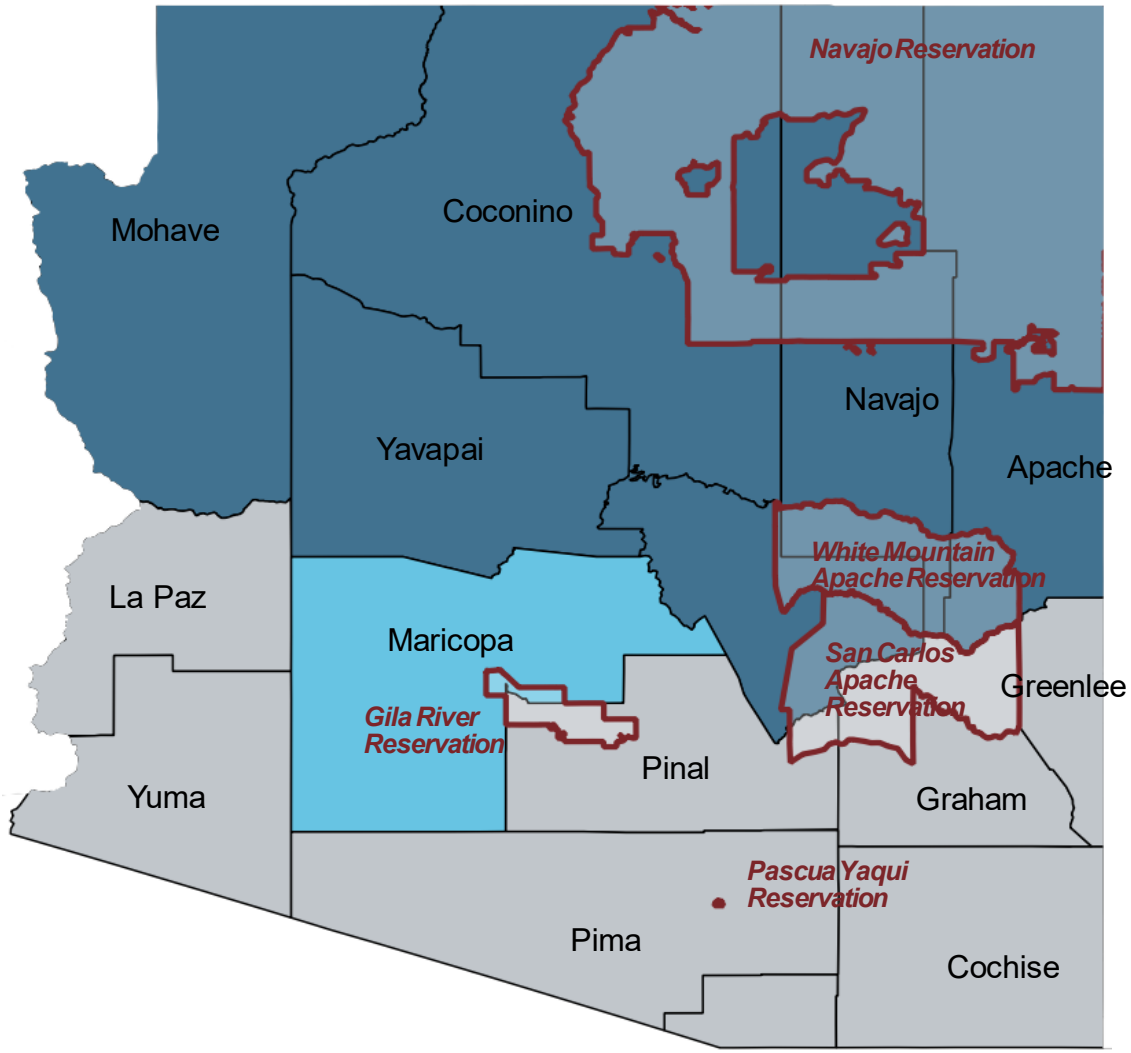
E.6. Medicaid Managed Care Program

RBHA Service Areas

As part of the transition to integrated care in October 2018, the RBHAs changed their names to align with the ACC plans they offer

GSA		RBHA	Counties
	North GSA	Steward Health Choice (formerly Health Choice Integrated Care)	• Apache • Coconino • Gila* • Mohave • Navajo • Yavapai
	Central GSA	Mercy Care (formerly Mercy Maricopa Integrated Care)	Maricopa
	South GSA	Arizona Complete Health (formerly Cenpatico Integrated Care)	• Cochise • Graham • Greenlee • La Paz • Pima • Pinal • Santa Cruz • Yuma



Tribal RBHA

*Zip codes in Gila County containing the San Carlos Apache reservation are included

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F. Appendices

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F.1. Acronym Legend

Acronym	Term	Acronym	Term	Acronym	Term	Acronym	Term
ACA / PPACA	Patient Protection & Affordable Care Act	BCBS	Blue Cross Blue Shield	GSA	Geographic Service Area	PMPM	Per Member Per Month
ACC	Arizona Complete Care	CARE	Choice Accountability Responsibility Engagement	I/DD / DD	Intellectual / Developmental Disability	RBHA	Regional Behavioral Health Authority
ACO	Accountable Care Organization	CMS	Centers For Medicare & Medicaid Services	ICF	Intermediate Care Facility	SMI	Serious Mental Illness
AHCCS	Arizona Health Care Cost Containment System	DSRIP	Delivery System Reform & Incentive Payment	IHS	Indian Health Services	SNAP	Supplemental Nutrition Assistance Program
AIHP	American Indian Health Program	EPSDT	Early & Periodic Screening & Diagnosis & Treatment	IMD	Institution For Mental Disease	SNP	Special Needs Plan
AIMH	American Indian Medical Home	FFS	Fee-For-Service	LTSS	Long-Term Services & Supports	SUD	Substance Use Disorder
ALTCS	Arizona Long-Term Care System	FPL	Federal Poverty Level	MSA	Metropolitan Statistical Area	TRBHA	Tribal Regional Behavioral Health Authority
ASO	Administrative Services Organization	FQHC	Federally-Qualified Health Center	PCCM	Primary Care Case Management	UHC	UnitedHealthcare
AZ	Arizona			PCMH	Patient-Centered Medical Home	US	United States

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F.2. Glossary Of Terms

Word	Abbreviation	Definition
Alternative Benefit Plan	**ABP**	State designed benefit package for the Medicaid expansion population (childless adults with income below 138% of the FPL). The benefit package must include the ten essential benefits as laid out in the PPACA. The Medicaid expansion population deemed medically frail (including those with SMI) are exempt from receiving benefits through the ABP.
Accountable Care Organizations	**ACO**	ACOs are groups of providers—such as physicians and hospital systems—that form an agreement to coordinate care for a set group of consumers. If the ACO delivers high quality care—measured through performance metrics—and lowers the cost of providing care against a baseline, then the organization receives a portion of the savings generated. ACOs can exist alongside all payment structures (fee-for-service and managed care delivery systems) and payers (Medicare, Medicaid, commercial).
Administrative Services Organization	**ASO**	An arrangement in which an organization hires a third party to deliver administrative services to the organization, such as claims processing and billing. The organization bears the risk for all claims.
Arizona Complete Care	**ACC**	Arizona's Medicaid managed care program that integrates physical and behavioral health services for individuals who do not need long-term services and supports.
Arizona Long-Term Care System	**ALTCS**	Arizona's Medicaid managed care program that provides acute care, behavioral health services, and home- and community-based services (HCBS) for those who require a nursing facility or ICF/IDD level of care.
Capitation		A set amount of money paid per enrollee per month to a health care entity to cover the cost of health care services. Generally the entity assumes full-risk for the cost of each enrollee's care.
Carve-Out		A Medicaid financing model where some portion of Medicaid behavioral health benefits— mental health outpatient, psychiatric inpatient, addiction treatment, pharmacy, etc. —is separately managed and/or financed. This can either be on an at-risk basis by another organization, or retained by the state Medicaid agency on a fee-for-service basis.

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F.2. Glossary Of Terms (Continued)

Word	Abbreviation	Definition
Certified Community Behavioral Health Clinic	**CCBHC**	Behavioral health clinics specially certified in a demonstration established by section 223 of the Protecting Access to Medicare Act of 2014. The clinics are designed to provide community-based mental health and addiction treatment services, to advance the integration of behavioral health with physical health care, and to provide care coordination across the full spectrum of health services.
Community Mental Health Center	**CMHC**	An organization that can demonstrate that it is actively providing all services in section 1913(c)(I) of the Public Health Services Act, including a.) Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of the CMHC's mental health service area who have been discharged from inpatient treatment at a mental health facility; b.) 24 hour-a-day emergency care services; c.) Day treatment, or other partial hospitalization services, or psychosocial rehabilitation services; and d.) Screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission. Additionally, the organization must meet the specifications for the state where it provides services.
Delivery System Reform Incentive Payment	**DSRIP**	A program that administers federal and state 1115 waiver savings to provider organizations to develop and implement transformative delivery systems through infrastructure development and innovative care models. The goals of these transformations is to improve care for individuals, improve care for populations, and lower costs through efficiencies.
Disproportionate Share Hospital	**DSH**	Hospitals that serve an above average number of low-income and uninsured patients. State Medicaid programs provide DSH payments to these hospitals to ease the burden of serving low-income and uninsured patients.
Dual Eligible		An individual who is eligible for Medicare (Part A and B) and Medicaid. Medicare serves as the individual's primary insurance, and Medicaid acts as a supplement. Dual eligibles are sometimes referred to as Medicare-Medicaid enrollees (MMEs).
Federal Poverty Level	**FPL**	The U.S. Department of Health and Human Services sets a standard level of income that is used to determine eligibility for services and benefits, including Medicaid. In 2018, the FPL is $12,140 for an individual and $25,100 for a family of four.

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F.2. Glossary Of Terms (Continued)

Word	Abbreviation	Definition
Fee-For-Service	**FFS**	A system in which provider organizations are reimbursed for each covered service such as an office visit, test, or procedure according to rates set by the payer.
Geographic Service Area	**GSA**	One specific county or a grouping of counties in Arizona that determine what health plans are available to Medicaid enrollees. There are three GSAs for physical health and three for behavioral health. The GSAs do not match.
Health Home		A "whole person" care coordination model that specifically targets populations with chronic conditions including those with SMI. Health homes provide six essential functions: 1.) Comprehensive care management; 2.) Care coordination and health promotion; 3.) Comprehensive transitional care from inpatient to other settings, including appropriate follow-up; 4.) Individual and family support; 5.) Referral to community and social support services; 6.) Use of health information technology to link services.
Health Insurance Marketplace	**HIM**	Created by the PPACA, the health insurance marketplace is an online service where individuals and small businesses can purchase health insurance. The federal government subsidizes coverage purchased on the marketplace through premium tax credits for individuals with income up to 400% of the FPL.
Home- & Community-Based Services	**HCBS**	Long-term services and supports provided in the home or community in order to avoid institutionalization. Traditionally provided through 1915(c) waivers, HCBS services are usually limited to specific populations and a specific number of people. HCBS services include skilled nursing care, personnel care services, assistance with activities of daily living, and custodial care.
Institutions For Mental Disease	**IMD**	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including addiction. Federal financial participation is available for Medicaid IMD services for individuals under the age of 21 and age 65 and over. In recent years, CMS has relaxed the rules prohibiting payments in IMDs for individuals age 21-64. Medicaid health plans may provide up to 15 days of IMD services per month in lieu of state plan services if medically appropriate, cost effective, and consented to by the individual. Additionally, states may be granted a 1115 waiver authority to allow individuals to receive residential addiction treatment in IMDs.

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F.2. Glossary Of Terms (Continued)

Word	Abbreviation	Definition
Long-Term Services & Supports	**LTSS**	Services provided in the home, community, or institutional setting to those who experience difficulty living independently and completing activities of daily living as a result of cognitive disabilities, physical impairments, disabling chronic conditions and/or age.
Managed Care/ Managed Care Organization	**MCO**	A health care delivery and financing system designed to manage cost, utilization, and quality. In Medicaid, states generally implement managed care through contracts with health plans, which provide a limited set of benefits to enrollees through a capitated or per person per month (PMPM) rate. The health plans generally assumes full-risk for the cost of treatment, and therefore usually contracts with a network of provider organizations to provide care at the most efficient rate possible while still maintaining member health.
Medicaid		Medicaid is a joint federal-state program that provides health coverage to economically disadvantaged populations, such as low-income adults, children, and aged, blind, and disabled (ABD) individuals. States establish their own eligibility standards, benefit packages, provider payment policies, and administrative structures under broad federal guidelines. Financing is a shared responsibility of the federal government and the states.
Medicaid Waiver		Granted by CMS, waivers allow states to make temporary changes to their Medicaid State Plan in order to test out new ways to deliver health coverage. Importantly, the waivers must be budget neutral.
Medicaid Waiver Section 1115	**1115 waiver**	Known as research and demonstration waivers, states can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.
Medicaid Waiver Section 1915(b)	**1915(b) waiver**	States can apply for waivers to provide services through managed care delivery systems, or otherwise limit people's choice of providers.
Medicaid Waiver Section 1915(c)	**1915(c) waiver**	States can apply for waivers to provide long-term care services in home and community-based settings, rather than institutional settings.

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F.2. Glossary Of Terms (Continued)

Word	Abbreviation	Definition
Medicaid Waiver Concurrent Section 1915(b) & 1915(c)		States can apply to simultaneously implement two types of waivers to provide a continuum of services to the elderly and people with disabilities, as long as all Federal requirements for both programs are met.
Medical Home		A medical home is not a physical place, but a model for care coordination. Medical homes provide primary care services, care coordination, enhanced access to care, and care that is culturally and linguistically appropriate. Medical homes exist across multiple payers.
Medicare		Federal health insurance for individuals over the age of 65, individuals with certain disabilities, and individuals with end stage renal disease. Medicare covers most acute care services (which may include psychiatric care), but does not cover LTSS or non-physician behavioral health services.
Medicare Advantage	**MA**	Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.
Medicare Advantage Special Needs Plan	**SNP**	A special type of Medicare Advantage plan that is designed to provide targeted coordinated care to individuals who are a) institutionalized; b) dual eligible; and/or c) meet the severe chronic disabled conditions set forth by CMS. Plans emphasize improved care primarily through continuity of care and care coordination.
Medicare Part A		Hospital Insurance: Covers hospital, skilled nursing care, hospice, and home health care for most eligible individuals at no cost. Financed through payroll tax and deductibles, copayments are only charged if a stay becomes long-term.
Medicare Part B		Supplementary Medical Insurance: Covers most outpatient services, and consumers pay a premium based on income level.
Medicare Part C		Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.

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F.2. Glossary Of Terms (Continued)

Word	Abbreviation	Definition
Medicare Part D		Outpatient Prescription Drug Benefit: Private plans contract with Medicare to provide coverage for prescription drugs. Most consumers pay premiums based on their income.
Metropolitan Statistical Area	**MSA**	An urbanized area of 50,000 or more population plus adjacent territory that has a high degree of social and economic integration as measured by commuting ties.
Patient-Centered Medical Home	**PCMH**	See Medical Home.
Patient Protection & Affordable Care Act	**PPACA or ACA**	U.S. health care reform signed into law in 2010. The legislation regulates certain aspects of private and public health insurance programs and authorizes an individual mandate to secure essential health coverage, premium tax credits for the purchase of private health insurance, and increased insurance coverage of preexisting conditions. In 2012 the Supreme Court ruled that state participation is optional for provisions of the law expanding Medicaid coverage to adults ages 18 to 64 with incomes under 138% of the FPL. In 2017, Congress repealed the tax penalties associated with the individual mandate essentially ending the mandate.
Pay-For-Performance	**P4P**	A health care payment model that offers financial rewards to organizations that meet or exceed pre-determined quality benchmarks. Typically, services continue to be reimbursed FFS.
Primary Care Case Management	**PCCM**	A health care delivery system model with limited utilization and cost control. Under the PCCM model, Medicaid enrollees choose a primary care physician who acts as a gatekeeper for more intensive services. The primary care physician generally receives a per person per month (PMPM) fee for care coordination, and is reimbursed fee-for-service for all medical services provided. Some states consider PCCM a managed care delivery model, while other states consider it an FFS delivery model.
Program Of All Inclusive Care For The Elderly	**PACE**	PACE serves populations over the age of 55 who are eligible for skilled nursing home care by utilizing a comprehensive delivery system of social, medical, and long-term care services to keep enrollees in the community for as long as possible. PACE is an optional state Medicaid program, and may only be available in certain states, or regions within states.

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F.2. Glossary Of Terms (Continued)

Word	Abbreviation	Definition
Regional Behavioral Health Authority	**RBHA**	Three regional prepaid inpatient health plans that provide some traditional and all specialty mental health services to some Medicaid members and the uninsured population. The RBHAs also operate integrated care plans that deliver all physical and behavioral health services to persons with SMI.
Serious Mental Illness	**SMI**	A mental, behavioral, or emotional disorder that lasts for a sufficient duration of time and causes impairment of major life activities. Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder.
Supported Employment		Provides services and supports to help individuals with disabilities become employed in an integrated or competitive work environment, and retain that employment.
Supported Housing		Housing provided for as long as needed at little or no cost to individuals with mental illness, or other vulnerable populations who are homeless or at-risk for homelessness. Mental health and social services are offered to participants, but are not a condition for participation in the program. The goal is to allow individuals to live as self-sufficient, independent lives as possible.
Tribal Regional Behavioral Health Authority	**TRBHA**	American Indian Reservation-based, prepaid inpatient health plans that provide some traditional and all specialty mental health services to the Medicaid and uninsured members of certain Tribes who have contracted with the state.
Value-Based Reimbursement	**VBR**	Reimbursement model in which payers financially reward or penalize health care provider organizations for performance on quality and cost of care. VBR payment mechanisms include P4P; capitation; shared savings models; shared risk models; and payments based on clinically-defined episodes, called episodes of care or bundled payments.

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F.3. Sources

A. Executive Summary
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   - A.2. Physical Health Care Coverage Map: Medicaid Managed Care Programs
     - Information compiled from sources provided throughout the profile.
   - A.3. Medicaid System Overview
     - Information compiled from sources provided throughout the profile.
   - A.4. Medicaid Care Coordination Initiatives
     - Information compiled from sources provided throughout the profile.
   - A.5. Behavioral Health Safety-Net Delivery System: Overview
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