

# Arizona 1115 Waiver Amendment Request

## Integrating Care for Children's Rehabilitative Services (CRS)

### I. Summary

Arizona is requesting an amendment to the language found in Waiver #1 (and corresponding STC #19) as it relates to the carve out of services provided to children enrolled in Children's Rehabilitative Services (CRS) as found in its current 1115 Research and Demonstration Waiver List. Waiver #1 waives the State from requirements found in Section 1902(a)(4) of the Act and corresponding regulations as found in 42 CFR 438.52 and 438.56. This existing authority permits the Arizona Health Care Cost Containment System (AHCCCS), Arizona's single state Medicaid agency, to direct acute care and Arizona Long Term Care System (ALTCS) enrollees' to a single managed care organization (MCO) – Children's Rehabilitative Services (CRS) – *only* for the treatment of their CRS conditions.

The State's current Waiver authority reflects a health care delivery system that has carved out services for children with a CRS-qualifying diagnosis. The State seeks to amend Waiver #1 to create one single, statewide integrated CRS MCO that will serve as the only managed care plan for acute care and KidsCare enrollees<sup>1</sup> with a CRS qualifying condition. The CRS MCO will manage acute, behavioral health and CRS conditions for AHCCCS acute care and KidsCare enrollees with a CRS diagnosis.

The request is intended to allow the State to:

- Transform care for children with special healthcare needs by operating a fully integrated health care system that would enroll CRS-eligible children into one MCO that would manage their CRS, physical and behavioral health care needs.
- Improve care coordination for children with special healthcare needs.
- Increase the ability of the integrated CRS MCO to collect and analyze data to better assess the health needs of their members with a CRS condition from a holistic approach.
- Streamline the current fragmented health care delivery system, which has caused inefficiencies and led to challenges with care coordination for the families of CRS-eligible children.
- Improve health outcomes.
- Promote the sharing of information between CRS, acute and behavioral health providers and allow for greater collaboration in designing a treatment plan to address an individual's whole health needs.

This request follows recommendations made by Secretary Sebelius in a letter to Arizona Governor Jan Brewer dated February 15, 2011 wherein she recommended that the State explore integration of carve-out programs, including behavioral health services. The State agrees with the Secretary's recommendation and is pursuing this course for children with special healthcare needs.

---

<sup>1</sup> KidsCare is Arizona's Children's Health Insurance Program (CHIP) under Title XXI. Children with CRS conditions enrolled in the ALTCS program are excluded from this Demonstration since MCOs in the ALTCS program are largely integrated already and manage acute, behavioral health and long term care needs of their members. CRS-eligible children in ALTCS will continue to access the CRS MCO for the treatment of their CRS conditions.

# Arizona 1115 Waiver Amendment Request

## Integrating Care for Children's Rehabilitative Services (CRS)

### II. Overview

#### *The Basic Issue*

Arizona's public system of care for the treatment of children with special healthcare needs, CRS, pre-dated the State's participation in the Medicaid program. CRS was originally created in 1929 to serve children with special healthcare needs by a multidisciplinary team. When the State joined the Medicaid program in 1982, it incorporated the CRS program as a stand alone program, which remained under the management of the Arizona Department of Health Services. However, the services designed to treat the CRS condition remained "carved out" of the AHCCCS managed care model, a model designed to facilitate accessibility to quality, integrated care.

This fragmentation causes confusion among families and providers, creates boundary issues between delivery systems and impacts the ability of health plans to strengthen the provider network across service types (CRS, acute and behavioral health) to allow for greater choice and flexibility for families. Improving the current situation requires a model that ensures optimal access to specialty care and offers effective coordination of all service delivery.

#### *Background on CRS*

CRS provides medical care, rehabilitation, and related support services to over 25,000 AHCCCS-enrolled children diagnosed with one or more of the qualifying chronic and disabling conditions defined in state statute.<sup>2</sup> The services, with an annual cost of approximately \$100 million in total funds, are delivered via a network of providers that includes primarily Multi-Specialty Interdisciplinary Clinics (MSICs).

Until recently, the CRS program served both Medicaid and non-Medicaid children, and the Arizona Department of Health Services (ADHS) managed the care delivered to both populations. In 2008, following a competitive bid process, ADHS sub-contracted management of the entire CRS program to Arizona Physicians/IPA (APIPA). APIPA already served as a contractor for three AHCCCS programs (the Acute Care program, the Arizona Long Term Care System Division of Developmental Disabilities (ALTCS DDD) program, and the ALTCS Elderly and Physically Disabled (ALTCS EPD) program (under the name Evercare). The current APIPA-CRS contract expires in 2012.<sup>3</sup>

In 2010, because of budget constraints, funding for non-Medicaid eligible children was eliminated. As a result, the CRS program now serves only Medicaid eligible children. Given this fact, as well as the fact that APIPA has contracts and a working

<sup>2</sup> See Arizona Revised Statutes § 36-261 et. seq.

<sup>3</sup> The State is currently seeking to extend that contract for one additional year to accommodate this integration proposal in the new bid process.

## **Arizona 1115 Waiver Amendment Request Integrating Care for Children’s Rehabilitative Services (CRS)**

relationship with AHCCCS, administrative oversight of the CRS program was transferred from ADHS to AHCCCS effective January 1, 2011. The transition was a seamless one for CRS members and their families, and the changeover has simplified operations and reduced administrative costs.

### *Current Challenges*

Services required by AHCCCS children to treat CRS-eligible conditions are “carved out” of the responsibility of AHCCCS managed care plans. They are delivered and reimbursed by CRS. This means that AHCCCS children receiving CRS services are enrolled in a minimum of two separate systems of care – acute and CRS. They access preventive and primary acute care through their respective AHCCCS MCO and specialty care related to their CRS-eligible condition through the CRS system. Children with behavioral health needs are forced to navigate a third separate system of care since behavioral health services are carved out of the AHCCCS acute care program to ADHS; behavioral health services are provided through a Regional Behavioral Health Authority (RBHA).

The irony is that the State is asking its most challenged children and their families to navigate multiple systems of care and manage the overall coordination of that care. Obviously the burden on members and families is significant. Negotiating and navigating the appropriate care from the appropriate provider in the appropriate network is a daunting undertaking. Families confirmed this concern during the State’s extensive outreach efforts.

The burden on providers is also considerable. Providers serving CRS-eligible children may not contract with all nine AHCCCS acute care MCOs or they may be uncertain of which contractor to bill. In addition, providers are subject to multiple contractors’ varied medical management and billing policies for the same small, medically fragile population. All of these factors can impact prompt and/or accurate payment. These concerns were also raised by providers during the State’s stakeholder engagement process. Moreover, providers as well as members and their families are asked to address denials of service requests or claims because of disputes over boundaries (i.e. which system is responsible for providing and paying for which services).

Under the guidance of the Secretary and national support for integration of care, this waiver amendment seeks to address these long-standing issues.

### *Amending Arizona’s 1115 Waiver to Achieve Integration*

AHCCCS proposes an alternative to the current “carve out” model of payment for services provided to CRS-eligible individuals. Specifically, the current model would be replaced by a payer integration model that requires one MCO to assume responsibility for the delivery and payment of multiple services (i.e. services related specifically to CRS conditions as well as services related to primary care and other acute care needs and behavioral health). Ultimately, the purpose of such a model is to

## **Arizona 1115 Waiver Amendment Request**

### **Integrating Care for Children's Rehabilitative Services (CRS)**

ensure optimal access to important specialty care and effective coordination of all service delivery.

Under this model, **one single MCO** statewide would enroll all CRS-eligible children statewide and integrate their care for CRS, acute and behavioral health. The single MCO assumes responsibility for all service delivery, reimbursement, and care coordination (i.e. CRS-specialty care as well as acute care and behavioral health services).

Integrating CRS into one system of care would not be a new concept. Since AHCCCS was established, Arizona's managed care model has evolved and matured, providing quality care at a modest cost. The State currently uses an integrated managed care model in its ALTCS program, which serves members at-risk of institutionalization. ALTCS MCO serving the elderly and physically disabled (EPD) manage the physical and behavioral health care needs of their members, while also serving as Special Needs Plans, allowing ALTCS contractors to coordinate care for those dually eligible in Medicaid and Medicare. The ALTCS system, which has over 72% of its elderly and physically disabled members living at home or in the community, has served as a national model for quality, cost efficiency and integration of care.

In addition, without aligning the financial incentives, there simply will not be an adequate connection between the CRS, acute care and behavioral health delivery systems. This means that integration must be achieved at the administrative level, by making one entity – the single, statewide MCO – responsible for the CRS, acute and behavioral health needs of acute and KidsCare children with special healthcare needs. This type of structure leverages the State's managed care infrastructure and maximizes care coordination allowing one responsible entity to have access to all of the necessary data to target best practices for ensuring care coordination and improving the health outcomes within the identified population.

Finally, limiting this integrated CRS plan to one statewide-MCO is the best approach for maintaining and building upon an important but fragile provider network. There are a limited number of physicians trained to work with the CRS population. Requiring this provider network to contract with multiple MCOs and likewise requiring multiple MCOs to build a CRS-specific network is simply not feasible. Moreover, after engaging the families of CRS members as well as the provider community, there was broad consensus that one integrated MCO for CRS children was the right approach.

Therefore, this amendment to the current Waiver is needed in order to end the current carve out model and instead fully integrate services for acute care enrollees with a CRS condition. This means that children with CRS conditions would only be able to receive their acute care and behavioral health services through one CRS MCO, which is an expansion of the State's existing waiver authority.

## **Arizona 1115 Waiver Amendment Request Integrating Care for Children’s Rehabilitative Services (CRS)**

All of these factors outlined above – confusion for families, challenges to coordination of care, the need for alignment at the health plan level, and others – support Arizona’s request to move toward integration of CRS, acute and behavioral health by making one MCO statewide responsible for the CRS, acute and behavioral healthcare needs of AHCCCS acute care enrollees with CRS conditions.

For these reasons, Arizona seeks to be waived from the provisions found at Section 1902(a)(4) of the Act and corresponding regulations as found in 42 CFR 438.52 and 438.56.

### **III. Public Process**

The goal of designing an integrated system is to improve the overall health care and outcomes for AHCCCS members with CRS conditions. In order to achieve this goal, obtaining input from CRS families was critical to the State. Also important was a process to obtain input from not only providers that specifically treat CRS conditions, but also pediatricians, behavioral health providers and others that may interact with children with special healthcare needs.

To assist in this process, the State engaged St. Luke’s Health Initiatives (SLHI), a Phoenix-based public foundation focused on Arizona health policy and strength-based community development. For the consumer engagement process, SLHI also worked directly with Raising Special Kids, a non-profit organization of families helping families of children with disabilities and special health needs in Arizona. Raising Special Kids connected with MSICs across the State who identified 18 families of varying geographic and racial/ethnic backgrounds as well as levels of CRS use. Raising Special Kids and SLHI conducted one-on-one interviews with these families, including several interviews that were conducted in Spanish.

SLHI also conducted focus groups and individual interviews with the provider community that included CRS, primary/pediatric care and behavioral health providers. SLHI’s outreach also included community and advocacy groups. In all, over 60 providers and individuals representing advocacy groups were contacted as part of the outreach process. The results of this engagement were summarized by SLHI and their reports can be found on the AHCCCS website.<sup>4</sup> In addition, AHCCCS has an online survey accessible through the website and available to any individual who wishes to provide feedback throughout this process.<sup>5</sup>

It is best to review the SLHI reports as they fully capture the sentiments and thoughts of those who participated. However, the State does believe the public engagement process demonstrated support for a more holistic approach to healthcare, improving communication amongst the team of providers that work with children in CRS, and achieving greater accountability for the healthcare outcomes of this population.

<sup>4</sup>See [http://www.azahcccs.gov/reporting/Downloads/Integration/CRS\\_Input%20Summary\\_021012.pdf](http://www.azahcccs.gov/reporting/Downloads/Integration/CRS_Input%20Summary_021012.pdf).

<sup>5</sup>Additional information can be found at: <http://www.azahcccs.gov/reporting/legislation/Integration/CRS.aspx>.

## **Arizona 1115 Waiver Amendment Request Integrating Care for Children’s Rehabilitative Services (CRS)**

Additionally, the public engagement process confirmed that consumers’ primary concern is care coordination between CRS and primary care, as well as maintaining or expanding choice of providers who are able to treat children with CRS conditions. Choice of acute care health plan was not a priority. In fact, it is believed both by organizations representing families as well as the provider community that one MCO statewide for CRS is the best model. Raising Special Kids and the Tucson area MSIC have provided letters of support to that point; these are attached.

Overall, the public engagement process supports the approach the State is seeking in this waiver request. In addition, the State is committed to an ongoing dialogue with stakeholders and maintaining sufficient flexibility to incorporate feedback, particularly from CRS families where possible and appropriate. The State is also committed to maintaining that open dialogue with families and providers throughout the transition process to the new integrated CRS MCO.

The State has also introduced this concept at numerous tribal consultations.<sup>6</sup> The State views tribal consultation on this matter to be ongoing as issues related to American Indian children with a CRS condition are unique since these members cannot be compelled into managed care. However, the State is interested and committed to working with tribal stakeholders to develop practices and policies that can achieve the same or similar benefits that members will obtain through the CRS integrated health plan. The State will include tribes, Native American enrollees and their families, as well as Indian Health Services and tribally operated 638 facilities to gain their input on designing care coordination policies that will support tribal members with CRS conditions who receive services through the AHCCCS fee-for-service program, known as the American Indian Health Program.

### **IV. Data Analysis- “With Waiver” vs. “Without Waiver”**

The State does not anticipate any change to budget neutrality since the same services will be provided and the same populations are being served.

### **V. Allotment Neutrality**

<sup>6</sup> On 1/18/12, reference slide #s 28, 32:

[http://www.azahcccs.gov/tribal/Downloads/consultations/meetings/2012/1\\_18\\_12TribalUpdate.pdf](http://www.azahcccs.gov/tribal/Downloads/consultations/meetings/2012/1_18_12TribalUpdate.pdf)

On 12/14/11, reference page 18 of the PDF presentation:

[http://www.azahcccs.gov/tribal/Downloads/consultations/meetings/2011/December14/Presentation\\_AHCCCS\\_Update\\_12\\_14.pdf](http://www.azahcccs.gov/tribal/Downloads/consultations/meetings/2011/December14/Presentation_AHCCCS_Update_12_14.pdf) as well as the GRP tracking document. On 8/24/11, reference page 11 of the PDF presentation: [http://www.azahcccs.gov/tribal/Downloads/consultations/meetings/2011/Aug23/PowerpointPresentation\\_AHCCCSUpdate.pdf](http://www.azahcccs.gov/tribal/Downloads/consultations/meetings/2011/Aug23/PowerpointPresentation_AHCCCSUpdate.pdf). On 6/8/11, reference the GRP tracking document (item #14):

<http://www.azahcccs.gov/tribal/Downloads/consultations/meetings/2011/June08/Tracking%20Document%20-%20Arizona's%20Medicaid%20Reform%20Plan%20-%20AHCCCS%20Activities.pdf>

On 3/31/11, reference slide #25:

[http://www.azahcccs.gov/tribal/Downloads/consultations/meetings/2011/March31/Presentation\\_AHCCCS\\_Budget\\_Overview.pdf](http://www.azahcccs.gov/tribal/Downloads/consultations/meetings/2011/March31/Presentation_AHCCCS_Budget_Overview.pdf).

# Arizona 1115 Waiver Amendment Request

## Integrating Care for Children's Rehabilitative Services (CRS)

The State does not anticipate any change to allotment neutrality since the same services will be provided and the same populations are being served.

### VI. Details

Currently, AHCCCS acute care members with CRS conditions up to age 21 are enrolled with the CRS plan only for their CRS conditions. The State is seeking to allow members to remain in the new, integrated CRS MCO at age 21 and beyond.

In addition to extending the age limit for the CRS MCO, the State is seeking to expand the provider network serving this population. Most services are delivered through the MSIC. The State intends to preserve the MSIC model, but expand the availability of services in local communities. Stakeholder feedback shows that building the provider network is critical to providing better care and greater accessibility of services for CRS children. The State will work with the CRS MCO on ways to achieve a balance that provides families with greater access while still preserving the MSIC model, a direction supported by feedback obtained through consumer and stakeholder engagement.

Certainly, this waiver request represents a departure from the previous philosophy in the State of maintaining a separation of the CRS program from acute and behavioral health. However, the approach of one MCO for CRS will allow: for this specialized population to be appropriately served; the State to build upon best practices in care coordination; and the MCO to develop a health information technology infrastructure to support better communication and coordination in a team approach to care delivery. These efforts are costly and these investments are best leveraged where there is only one statewide MCO.

#### *Timeline*

At this time, the State has a broad estimated timeline, which is subject to change depending on approval of this waiver request and other factors.

Sept. 2011:	Commence stakeholder engagement
April 2012:	Submit Waiver amendment
Nov. 2012:	Release Acute Care RFP incorporating CRS Integrated Model
March 2013:	Announce contract award
Oct. 2013:	Implement fully integrated CRS model

### VII. Evaluation Design

**Arizona 1115 Waiver Amendment Request**  
**Integrating Care for Children’s Rehabilitative Services (CRS)**

The State would apply the same evaluation criteria to this proposal that it applies to the rest of its 1115 Demonstration. The evaluation would show that requiring one single entity (the integrated CRS MCO) to be responsible for the CRS, acute and behavioral health care needs of acute and KidsCare enrolled children with CRS conditions will improve health outcomes, service delivery and care coordination.