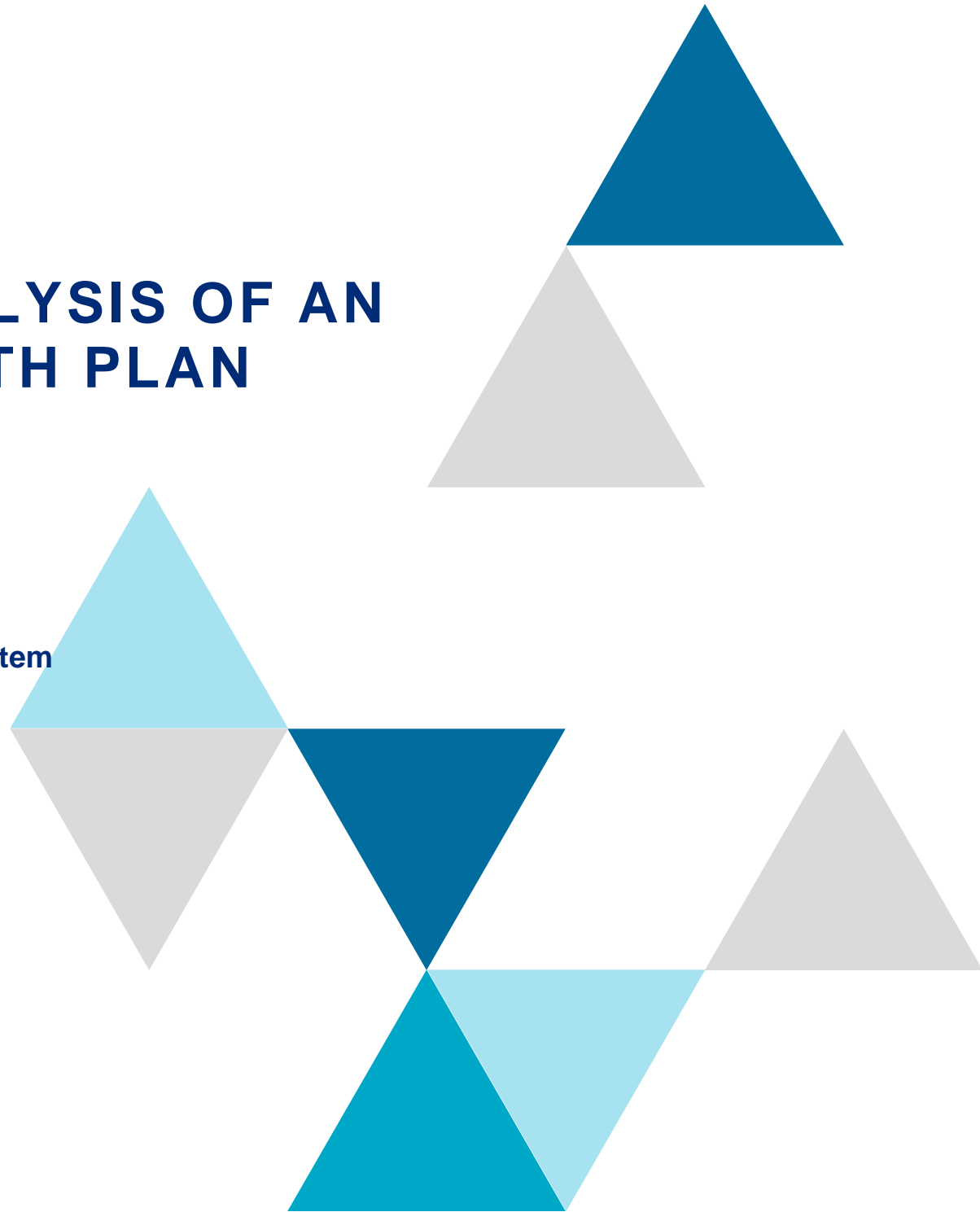


HEALTH WEALTH CAREER

INDEPENDENT ANALYSIS OF AN INTEGRATED HEALTH PLAN

FEBRUARY 22, 2018

Arizona Health Care Cost Containment System



CONTENTS

1. Executive Summary	1
• Summary of Findings – Legal Requirements	2
• Summary of Findings – Network Development.....	3
• Summary of Findings – Staffing Requirements and Organizational Infrastructure	4
• Summary of Findings – Enhanced Performance Measures	5
• Summary of Findings – Program Management and Transition Oversight Plan	5
• Summary of Findings – Cost Forecast.....	6
• Summary of Findings – Stakeholder Input.....	6
• Benefits of an Integrated CMDP Health Plan.....	7
• Risks and Challenges Associated with Transitioning to an Integrated Health Plan	7

2. Introduction and Approach	10
• Healthcare Needs of Children in Foster Care	11
• Methodology and Approach.....	11
3. Legal and Contractual Requirements	16
• CMDP Administration of Behavioral Health Services.....	17
• CMDP Administration of Benefits for CMDP Children with CRS Conditions	25
4. Provider Network and Provider Payments: Legal and Contractual Considerations.....	32
• Legal Challenges to Developing a Robust Provider Network and Pursuing VBP Strategies	32
• Additional Limitations Related to VBP	40
5. Network Development, Management and Expansion	45
• Current GSA Contractor Network Management.....	49
• Current CMDP Network Management	54

- Recommendations and Resources Required for the Development of a BH Network 55
- Summary of Key Findings and Recommendations 63
- 6. Staffing Requirements and organizational infrastructure 65
 - Existing CMDP organizational Resources 66
 - Infrastructure, Staff Experience, Operational Standards and Oversight Practices Required for the CMDP Integrated Health Plan 71
 - Recommended Staffing Resources for the Integrated Health Plan 86
- 7. Developing Enhanced Performance Measures 97
 - Analysis of Current AHCCCS Plan System Performance Measures 97
- 8. Program Management and Transition Oversight Plan 122
 - AHCCCS' Readiness Assessment Tool and Process 122
 - AHCCCS Member Transition Standards 123
 - Program Management and Transition Oversight Summary 126

9. Start Up and Ongoing Cost Forecast 134

10. Stakeholder Informational Meetings Summary 135

- Introduction 135
- Themes 136

11. Alternative Operational Models and Approaches 141

- Research – Other State Models 141
- Inventory of Key Considerations and Challenges – ASO Model 146
- Feasibility of Alternative Operational Models and Approaches 150

Appendix A: Title XIX Covered Behavioral Health Services 152

Appendix B: Cost Forecast Model 154

1

EXECUTIVE SUMMARY

The Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid Agency, hired Mercer Government Human Services Consulting (Mercer) to perform an analysis of implementing an integrated health plan for children in foster care. The analysis was designed to identify the operational and ongoing infrastructure requirements of an integrated health plan administered through the Arizona Department of Child Safety (DCS)/Comprehensive Medical and Dental Program (CMDP).

By securing this independent analysis of an integrated health plan, AHCCCS reinforces the organization's stated goals to reduce service delivery fragmentation and to create a more effective health care system. AHCCCS' efforts to further integrate care delivery systems and align incentives are designed to transition the structure of Arizona's Medicaid program to improve health outcomes and to effectively manage limited resources.

Mercer assisted AHCCCS with an objective organizational assessment of DCS/CMDP to identify structural and resource strengths and opportunities for enhancement. With the incorporation of behavioral health (BH) services into a fully integrated care contract, it is necessary to evaluate legal requirements, staffing resources, expertise, and roles, data system capabilities and tools that support monitoring and oversight of the service delivery system. AHCCCS provided a structured framework for the analysis that supported a comprehensive evaluation and incorporated key legal and infrastructure considerations necessary to evaluate CMDP's capability to successfully assume direct administrative oversight of Medicaid funded BH services.

SUMMARY OF FINDINGS – LEGAL REQUIREMENTS¹

Arizona Revised Statutes (A.R.S.) §8-512 creates the guidelines for the CMDP program including, but not limited to, (i) who is eligible for the program, (ii) identifying the benefits managed under the CMDP program, (iii) who may be a provider, and (iv) how to reimburse providers participating with CMDP. The current structure of A.R.S. §8 512 (A) is explicit that DCS shall “provide comprehensive medical and dental care, as prescribed by rules of the Department.” The verbiage suggests that DCS has discretion within rule to define the scope of “medical” care, and to determine that comprehensive medical care includes BH services. DCS’ current rule, A.A.C. R21-1-203(6), excludes coverage of the cost of care and services provided to CMDP members for BH services received through Medicaid BH contractors; however, it appears that DCS has the statutory authority to amend that rule to remove the exclusion.

Further supporting the interpretation that “medical” care may include BH services is A.R.S. §8-512(C), which states that “comprehensive medical and dental care consists of those benefits provided by AHCCCS as prescribed in title 36, chapter 29, article 1 and as set forth in the approved Medicaid state plan.” BH services are included in Title 36, Chapter 29, Article 1 [A.R.S. §36-2907(F)] and the approved State Medicaid Plan. While a statutory change is not necessary, DCS would need to amend its rule excluding coverage for BH services.

Even if DCS amends A.A.C. R21-1-203(6) to remove the exclusion of CMDP coverage of BH benefits that change alone will not likely be sufficient to modify the legal framework to support CMDP integration. Given that all of the existing statutes and rules currently require AHCCCS to contract with regional behavioral health authorities (RBHAs) to deliver BH services and regulate the regional behavioral health authorities (RBHAs) administration of BH services, additional changes will be necessary to ensure that CMDP has the appropriate authority to manage the BH benefit for its members. There are two options to transferring the necessary powers and duties to CMDP, (i) AHCCCS can change all of the statutes and rules to include CMDP as an entity that also has the authority to administer the BH benefits; or (ii) AHCCCS can designate CMDP as a RBHA under its intergovernmental agreement (IGA) with DCS. Given the administrative burdens and timing associated with amending existing statutes and rules, Mercer recommends designating CMDP as a RBHA (See Section 3, Legal and Contractual Requirements for additional information).

¹ AHCCCS understands that Mercer is not engaged in the practice of law and this report, which may include commenting on legal issues or regulations, does not constitute and is not a substitute for legal advice. Accordingly, Mercer recommends that AHCCCS secures the advice of competent legal counsel with respect to any legal matters related to this report or otherwise.

A.R.S. §8-512 includes subsections that may undermine the success of an integrated program and specifically impede CMDP's ability to develop a robust provider network and one that is capable of engaging in value-based purchasing (VBP) arrangements. The limitation that CMDP reimburse providers based on the AHCCCS fee schedule restricts CMDP's ability to negotiate competitive rates with providers and likely limits CMDP's ability to pursue value-based contracting strategies. Moreover, because CMDP is required to reimburse any willing provider, CMDP has limited power to negotiate contracts with quality providers who have experience with CMDP's specialized population. On its face, these two statutory requirements limit CMDP's purchasing power and the ability to enter into contracts with providers that pay for value over volume. Therefore, Mercer recommends that these provisions be removed from statute. See *Section 4, Provider Network and Provider Payments: Legal and Contractual Considerations* for additional information.

SUMMARY OF FINDINGS – NETWORK DEVELOPMENT

A Mercer analysis of CMDP utilization data indicates that over 2,200 providers are currently contracted with an AHCCCS BH Contractor to provide BH services to CMDP members. The current BH Contractors report a variety of health delivery and payment models, and noted that specialty providers are particularly challenging to secure for the CMDP membership magnified by the general challenges of locating specialty providers in rural and frontier areas of the state. In addition, many specialty providers demand higher fees. The current BH Contractors have access to skilled negotiators to initiate and sustain contracts with an adequate provider network that meets the needs of CMDP members. These Contractors noted that a full array of BH services, care coordination, and provider oversight resources are required to adequately manage and care for this population. Particular challenges include multiple stakeholders with differing opinions regarding the most appropriate care for the child, frequent member transitions that require high levels of care coordination, a demand for integrated information system resources, and accessing a wide variety of specialty providers.

The CMDP Provider Services Unit utilizes a fee for service network that is not contracted with CMDP. CMDP has developed a preferred provider network (PPN) of providers who have registered with CMDP, even though by law, CMDP provider fees are based on the AHCCCS established rates. CMDP Provider Service Representatives currently offer provider education and technical assistance to the PPN providers; but real limits exist for CMDP to actively manage the PPN.

Mercer recommends that the CMDP seek an exception to the State procurement rules and lift the restrictions on provider fees to the AHCCCS rate schedule. To develop an effective BH network for the short term, acute needs of CMDP members will require the ability to negotiate rates with a variety of BH providers throughout the state, and to be able to timely respond to emergent needs with single case agreements (SCAs) or similar expedited contracting options.

SUMMARY OF FINDINGS – STAFFING REQUIREMENTS AND ORGANIZATIONAL INFRASTRUCTURE

Mercer has recommended key functions, position titles, qualifications and projected grade levels for the proposed staffing model needed for CMDP to operate as an integrated health plan. Mercer designated position grade levels based on the Arizona Department of Administration (ADOA) salary schedule. However, an analysis of the ADOA salary schedule revealed that many of the recommended position salaries are not comparable to monetary compensation packages offered by commercial or private managed care organizations. Job titles were correlated with key staff positions required as part of AHCCCS' Complete Care Program Contract and supplemented with other necessary staffing resources deemed necessary to operate a fully integrated health plan. Mercer delineated positions that should be assigned regionally including care managers, transition specialists, support coordinators, clinical liaisons, CRS/CMDP support coordinators, family liaisons, provider representatives and provider contractors during the implementation stage of securing the provider network. All other health plan staff can be designated to the central CMDP office.

An area of concern noted through the Mercer analysis is the extent of manual involvement in generating and issuing service authorizations and notice of actions in cases of an adverse benefit determination. Given the expected increase in the volume of service authorization requests under the Title XIX BH benefit, manual tracking processes may not represent a viable or efficient approach as part of medical management functions. Mercer believes the added complexity and increases in workload will necessitate the use of automated systems to generate service authorizations as well as supporting other medical management activities such as tracking denials, issuing notice of actions and creating daily reports for internal management purposes. The integrated health plan should develop a provider portal in which providers can upload clinical information and initiate service authorization requests in a digital format that is automatically loaded into the updated QNXT care management module. Through this interface, notice of the authorization, service denial and status of the service authorization review is electronically transmitted to the provider. The medical management staffing model proposed by Mercer is based upon the assumption that current medical management manual processes will be automated under the integrated health plan.

BH services will be most efficiently managed by the creation of specific organizational units and staffing roles to support effective medical management of the covered services. The BH providers and the child and family team are advantageously positioned to further care coordination efforts and review possible treatment options and interventions. Current CMDP staff fulfilling advocacy roles, such as the BH clinical coordinators, should be considered placed within the DCS child welfare structure, but outside of the CMDP integrated health plan. Mercer's proposed staffing model eliminates this position entirely, although an alternative recommendation is to reorganize the BH clinical care coordinators teams to serve as care managers, transition specialists, or system of care support coordinators as deemed appropriate and determined qualified for these roles. *Section 6, Staffing Requirements and Organizational Infrastructure* identifies staffing requirements, clinical team design for care coordination, information technology needs and other operational requirements and challenges related to startup and sustained integrated health plan infrastructure.

SUMMARY OF FINDINGS – ENHANCED PERFORMANCE MEASURES

Mercer identified metrics that were supported by readily available data and that have the greatest impact on the children/youth's overall healthcare and permanency. In comparing national research, state examples and the current performance measures in Arizona, both required and not required by AHCCCS, Mercer outlined a summary of considerations in choosing which performance measures to prioritize as part of the transformation to an integrated health plan for children and youth involved in foster care.

Mercer recommends that AHCCCS partner with DCS to identify how the transition to an integrated health plan with integrated benefits can impact local and nationally reported outcomes for children and youth in the child welfare system. Mercer further recommends that a collaborative team comprised of representatives from DCS, AHCCCS, and CMDP come together to make recommendations on performance measures tied to impacting specified child welfare outcomes. This collaborative team will increase cross system support, which leads to a higher rate of success for performance measures.

Mercer recommends that AHCCCS and DCS/CMDP determine which social determinants of health impact the overall well-being for the children/youth and families involved in the child welfare system. Social determinants to consider are poverty level, school performance, social network and relationships, and trauma exposure for the parents (not just the children in care). In the past, Arizona collected data on National Outcomes Measures. However, AHCCCS encountered barriers with extracting data queries and relied on a manual process to generate reports. Reassessing the ability to collect these measures in the current system via electronic record systems would be advantageous.

Mercer also encourages AHCCCS and DCS/CMDP to consider monitoring health disparities for children/youth involved in foster care. Mercer recommends a requirement and process be put in place to trend and analyze aggregated outcome data by age, race/ethnicity, and geographic region. This will help to better inform where the system is succeeding and where there are opportunities for improvement. Specific measure recommendations are detailed in *Section 7, Developing Enhanced Performance Measures*.

SUMMARY OF FINDINGS – PROGRAM MANAGEMENT AND TRANSITION OVERSIGHT PLAN

To support the initial implementation and successful long-term outcomes, a detailed program management and transition oversight plan was developed by Mercer. An effective approach ensures the successful transition of the CMDP membership and maintains fiscal and programmatic stability across the behavioral health service delivery system. Mercer leveraged current AHCCCS contract requirements and policies that are in place to support the system transformation and presented a high level work plan, inclusive of key activities and timelines.

The transition should emphasize critical operational functions and data exchanges deemed necessary to successfully complete the transition and minimize disruptions in member care. Special attention should be directed to activities and data that ensure continuity of member care, tracking and monitoring of

service authorizations that carry over post transition and activities/data to ensure the timely and accurate adjudication of provider service claims before and after the contract implementation date.

Mercer's program management and transition oversight plan outlines the steps that the CMDP will need to take to ensure that the transition to an integrated health plan is successful. The transition plan describes the tasks, timelines, and a summary of considerations that should be addressed for each of the identified activities. See *Section 8, Program Management and Transition Oversight Plan* for more details.

SUMMARY OF FINDINGS – COST FORECAST

Mercer projected an estimate of startup and ongoing costs and the financial effects of required tasks for CMDP to operate as an integrated health plan. *Section 6, Staffing Requirements and Organizational Infrastructure*, identifies necessary personnel to accomplish the integration of behavioral health services within the CMDP organization and recommends necessary staffing. *Appendix B – Cost Forecast Model* utilizes those conclusions and calculates an aggregated estimate of the new costs (personnel and non-personnel related) necessary to successfully accomplish the transition to and sustainability of an integrated health plan.

The integrated health plan staffing positions as detailed in *Section 6, Staffing Requirements and Organizational Infrastructure* were compared to the ADOA's published job titles and pay ranges. Job codes were assigned to each position and the related "Hourly Mid" rate was used to calculate annual compensation amounts. Based on discussions with State staff, a tax and benefits burden rate of 42% of compensation was applied to arrive at the fully loaded cost of new personnel needed as part of the integrated health plan.

Assumptions used to estimate costs of supporting the personnel, which included items such as office space, technology, and travel costs, were based on available information, including cost per square footage reports for the Phoenix metropolitan area from outside sources. In addition, pre-implementation surge staffing costs were estimated which include costs to establish a statewide contracted network. The current forecast utilizes recent enrollment information to obtain annual membership, however the model is flexible to allow for changes in estimates as enrollment figures fluctuate. *Section 9, Startup and Ongoing Cost Forecast* and *Appendix B – Cost Forecast Model* includes additional information and cost estimates.

SUMMARY OF FINDINGS – STAKEHOLDER INPUT

Stakeholder informational sessions were held with providers, family members (biological, foster, adoptive and kinship) and youth/young adults currently or previously involved in the foster care system. Mercer facilitated a total of four stakeholder sessions during October 2017 - two in Maricopa County and two in Pima County.

The stakeholder meetings solicited input regarding the following themes related to the transition under consideration: transition of care and continuity of care, funding and oversight, network adequacy, medical management and care coordination, communication and system strengths that should be preserved under an integrated health plan. See *Section 10, Stakeholder Informational Meetings Summary* for more information.

BENEFITS OF AN INTEGRATED CMDP HEALTH PLAN

The CMDP was established in 1970 and has extensive experience collaborating with other child serving systems and possesses extensive knowledge of the unique needs of children and youth in the foster care system. Under an integrated health plan, CMDP will have close proximity and real time access to the child's DCS case worker to facilitate the gathering of information such as the outcome of the DCS safety assessment, the reason for removal, any known special needs of the child, any known supports for the child, the current disposition of siblings, any known needs of the new caregiver and the results of the initial preliminary protective court hearing.

Currently, a CMDP member may have multiple stakeholders involved in their care: the DCS case worker, the foster or kinship family, the member's primary care provider (PCP); a high needs case manager and the current BH Contractors. Due to the complexity of the service delivery system and the multiple entities and individuals involved the child's care and treatment; foster parents may be required to attend multiple meetings with a variety of agencies. During an interview with CMDP staff, it was conveyed that one foster parent recently reported that he is required to attend six meetings a week with four different organizations to oversee health and BH care to his foster children. By integrating BH into a CMDP integrated care health plan, fewer meetings, requirements and organizations will be involved with the child and foster family. This more streamlined approach removes the burden on foster and kinship families and facilitates care coordination activities.

A strength of the current CMDP staffing configuration is that many of the medical management team members are cross-trained and engage in care coordination and quality management activities as well as the review of requests for the authorization of services. Another positive outcome of CMDP's management of the integrated plan is that it may resolve delays that the BH Contractors experience with receipt of timely member enrollment information that has resulted in additional service claims denials and adjustments due to retroactive effective dates. Under an integrated health plan DCS/CMDP may receive member enrollment data more expeditiously for the fluid foster care population. Finally, efficiencies and expanded functions that the new version of QNXT, CMDP's integrated information technology solution, should provide CMDP the ability to sustain the current average of 10 to 14 days claims processing time due to the new system's automation despite an expected increase in claims volume.

RISKS AND CHALLENGES ASSOCIATED WITH TRANSITIONING TO AN INTEGRATED HEALTH PLAN

A substantial risk to assume operations as an integrated health plan is that CMDP's administrative cost allocation may not be sufficient to cover the expenditures to support the capital needed to manage and administer an integrated health plan. As recently reported by CMDP leadership, the existing health plan operations have been challenged to meet current contract expectations for the administrative cost percentage (no greater than 15%). Coupled

with declining trends of CMDP enrollment (down 18% in the past 18 months) and heightened expectations from AHCCCS to reduce the administrative cost percentage to 10% in future integrated care contracts, CMDP's membership may not be adequate to financially sustain the Plan's expenses and operations.

A correlated risk is that DCS/CMDP, as a state agency, must utilize the Arizona State Personnel Salary Schedule and Grade Listing. While an exception process exists, most salary ranges published in the salary schedule do not reflect market-based competitive pay for the staffing positions that the integrated health plan will need to be successful. Salary disparities or more pronounced for positions that require specialized clinical training, clinical credentials and/or extensive years of managed care experience. CMDP will need to secure the necessary staffing resources and the requisite funding to support ramping up personnel in advance of per member/per month (PM/PM) capitation payments to support the health plan's operations. Even if this obstacle is overcome, CMDP will be confined by the current ADOA salary schedule. This will likely limit CMDP's ability to attract qualified network staff that are necessary to oversee and implement a large scale procurement of a statewide network of behavioral health providers.

Typically when a health plan implements a new contract, employees from the relinquishing vendor are available for hire. This scenario affords the new health plan an available pool of qualified employees from which to hire. In the transition from the current BH contractors to the CMDP, a cadre of experienced employees will not be available to CMDP as the existing BH Contractors must retain most staff to support other children system lines of business. Recruiting a robust team of BH managed care personnel will be challenging due to both issues: relative low and non-competitive salaries and a lack of available, qualified and experienced talent.

Currently, CMDP is constrained by state procurement rules that require lengthy and cumbersome procurement processes to subcontract services. CMDP would have to obtain a procurement exemption in order to successfully contract with BH providers. The exemption would also ideally allow for SCAs which permits the health plan to expeditiously contract with a provider as needed. Instances in which this flexibility is required includes emergent situations, specialty services required in a rural or frontier areas, and other atypical circumstances for services that are not readily available as part of the established BH network.

Another restriction that must be removed is the mandate that the AHCCCS rate schedule be used for all provider rates utilizing a fee for service payment model. The current BH Contractors have discovered that a variety of payment models and negotiated rates are required to develop the necessary flexibility in providing services for the CMDP population. For example, the current North GSA BH Contractor pays higher rates for specialty providers such as Home Care Training to Home Care Client (HCTC), services provided through family run organizations, in-home intensive applied behavior analysis (ABA), and other specialized services necessary to support the needs of adopted children and children in foster care.

The current BH service delivery system has recently intensified efforts to expand services and promote and educate community stakeholders, including foster parents and behavioral health service providers, regarding the availability of a wide array of expanded behavioral health programs, services and

supports available to children enrolled with CMDP. The current BH Contractors have conducted stakeholder outreach efforts, training initiatives and network development activities across the state of Arizona. In response to the passage of House Bill 2442 (Jacob's Law), the RBHAs and the statewide Children's Rehabilitative Services (CRS) Contractor engaged in a systemic campaign to educate the community about provisions within the legislation, procedures to access BH services and the availability of resources for foster parents and CMDP to assist if barriers were encountered when attempting to secure BH services.

While a transition of the statewide BH network to CMDP may not have deleterious effects on the availability of covered BH services to children in foster care, it is reasonable to expect that there will be systemic lapses in the availability of innovative programming and services currently available to CMDP members. The current BH Contractor networks have been established for several years and require constant review and enhancement to keep pace with the emerging needs of children affected by trauma and life changing events. If BH benefit administration is transitioned to the CMDP, the short-term impact may be a reduction in the availability of a wide range of specialty services designed for these high needs children.

The implementation activities related to the transition of the behavioral health benefit administration to CMDP are extensive and will necessitate substantial time to execute. Relevant tasks include securing startup funds, easing procurement rules, and drafting amendments to administrative code, contracts and other necessary document development as well as network development activities and hiring a large number of staff. Mercer estimates that it will require at least 2+ years to execute the required actions, assuming that there are no delays in legislation or funding. If a decision is made to move forward with the integration of the CMDP health plan, Mercer is recommending that the implementation date be extended to at least October 1, 2020.

In addition to the risks and inherent challenges identified with the proposed transition to an integrated health plan; estimated costs related to the initial startup and expenses needed to sustain the integrated health plan operations will be considerable. Utilizing the ADOA's salary schedule and affiliated salary mid-point for each proposed staffing position, Mercer estimates that the initiative would require \$15.3 million in additional personnel costs. Another \$6.2 million is estimated to support non-labor costs, such as technology needs and other necessary supports for staff. In summary, Mercer estimates the total cost of the additional resources necessary to implement and maintain an integrated health plan under CMDP to be approximately \$21.6 million.

ALTERNATIVE OPERATIONAL MODELS AND APPROACHES

Given the range of considerations that must be examined in conjunction with this integration initiative, AHCCCS and DCS have jointly agreed that further evaluation is necessary to explore other operational models, such as an Administrative Services Organization (ASO), that may foster successful integration and decrease the risks and barriers a state agency faces in trying to operate as a Managed Care Organization (MCO).

Mercer has subsequently completed a high level analysis regarding the feasibility of an ASO model or similar types of models in facilitating the provision of high quality, integrated care to children enrolled in foster care. As part of the analysis, Mercer evaluated the benefits and challenges of CMDP implementing an ASO or similar model. The high level analysis can be found in *Section 11, Alternative Operational Models and Approaches*.

2

INTRODUCTION AND APPROACH

AHCCCS, Arizona's Medicaid Agency, engaged Mercer to conduct an independent analysis of an integrated health plan for children in foster care. The purpose of this analysis was to conduct an independent review of the implementation and ongoing infrastructure requirements of an integrated health plan under the DCS/CMDP for children in foster care.

CMDP is the health plan responsible for ensuring, in partnership with foster care providers, the provision of appropriate and quality health care services for children in foster care. Medicaid funded health care and dental services available to children in foster care are administered by CMDP, which serves as the contracted managed care organization for this population. AHCCCS also contracts with three RBHAs to provide BH covered services for Medicaid eligible children in foster care. Children in foster care who have a chronic and disabling medical condition that meet eligibility for CRS currently access BH services through a single statewide CRS managed care contractor. The analysis that Mercer performed assessed the existing AHCCCS BH service delivery system, including RBHA and CRS Contractor staffing, network composition, care coordination, monitoring and oversight and other managed care resources and practices to determine CMDP's capacity to serve as a fully integrated health plan, inclusive of physical health, dental, BH and CRS services administration².

On October 1, 2015, Arizona Senate Bill 1375 report was released. SB 1375 required the DCS, in collaboration with the Arizona Department of Health Services and AHCCCS, to determine the most efficient and effective health care delivery system providing comprehensive medical, dental and BH services for children and youth in foster care. The SB 1375 report recommended the development of system infrastructure to transition to an integrated CMDP contracted network model. Implementing this recommendation continues the provision of physical health and dental services by CMDP and shifts direct responsibility of behavioral health services from the RBHAs and statewide CRS Contractor to CMDP.

² AHCCCS Task Order #YH18-0013 for an Independent Analysis of an Integrated Health Plan for Children in Foster Care. July 25, 2017.

HEALTHCARE NEEDS OF CHILDREN IN FOSTER CARE

Children in the foster care system are among Arizona's most vulnerable populations with many having experienced significant trauma from abuse and/or neglect. Frequently, children placed in foster care and their families need access to urgent and routine behavioral health services to manage stressful circumstances surrounding the child's removal from the home, separation from siblings and associated trauma. Factors contributing to the mental and behavioral health of children and youth in foster care include a history of complex trauma, frequently changing situations and transitions, broken family relationships, inconsistent and inadequate access to mental health services and the over-prescription of psychotropic medications.³

Per a recent interview with DCS/CMDP leadership, approximately 15,255 children statewide are assigned to the CMDP health plan.⁴ Children in foster care have a disproportionate incidence of behavioral health needs compared to the general population, with some sources estimating up to 80% of children in foster care having significant mental health issues.⁵

On March 24, 2016, State leaders took an important step towards addressing the needs of Arizona's foster care children through the enactment of House Bill 2442 (i.e., "Jacob's Law") with the goal of ensuring easier access to behavioral health care for children in the foster care system. The law, in part, requires adherence to specific response timelines following requests for behavioral health services, permits foster parents to have direct access to the behavioral health provider network, and allows services to be provided by AHCCCS registered out-of-network providers when children do not receive services within prescribed timeframes. Jacob's Law furthers AHCCCS' goal of enhancing access to care and simplifying steps to secure needed behavioral health care services for children in foster care.

METHODOLOGY AND APPROACH

Mercer's analysis targeted eight distinct components that were determined to be critical to support an assessment of CMDP's ability to successfully implement and operate as an integrated health plan. Each component required extensive research, data collection and analysis to identify challenges with infrastructure requirements, timelines and resource investments necessary for CMDP to transition to an integrated health plan. In addition, Mercer met with

³ Mental Health and Foster Care, National Conference of State Legislatures. <http://www.ncsl.org/research/human-services/mental-health-and-foster-care.aspx>. May 2016.

⁴ Monthly Project Status Update Meeting, AHCCCS & DCS/CMDP, November 21, 2017.

⁵ National Conference of State Legislatures, Mental Health and Foster Care, May 9, 2016. <http://www.ncsl.org>.

AHCCCS weekly to review progress on the analysis and participated in two monthly progress update meetings with AHCCCS and CMDP leadership at the onset and near the conclusion of the review. Each evaluation component is described below:

1. Describe legal or contractual requirements in moving towards an integrated model and provide recommendations to address potential impediments.
2. Identify challenges with the current statutory requirement that CMDP pay the AHCCCS fee schedule, and make recommendations for what will be needed for CMDP to develop a contracted network, including value-based purchasing strategies when appropriate.
3. Provide an analysis of strategies CMDP will need to employ around network development, management and expansion to ensure adequate provider network capacity, timely access to care and appropriate service array that meets the needs of children and youth in foster care.
4. Identify staffing requirements, clinical team design for optimizing care coordination, information technology needs and other operational requirements and challenges related to startup and sustained integrated health plan infrastructure.
5. Assist in the development of enhanced performance measures that achieve or exceed the current AHCCCS minimum performance metrics related to acute and BH care access and foster child participation.
6. Design a program management and transition oversight plan for CMDP members receiving behavioral health services from the RBHAs into the integrated health plan.
7. Forecast startup and ongoing costs and the financial effects of the tasks necessary to implement and sustain operations as an integrated health plan.
8. Participate and facilitate up to four stakeholder informational meetings to gather input and recommendations regarding the potential transition to an integrated health plan.

Mercer utilized a team of clinical and policy consultants with knowledge of local and national regulations, statutes, and rules to analyze legal and contractual requirements. The legal and contractual review included the following activities:

- Review of each contract for compatibility with anticipated system design and national best practices as available.

- Review of related regulatory and contractual requirements with the goal of identifying inconsistencies and reducing administrative burden.
- Identification of explicit requirements that, if modified, may offer AHCCCS and CMDP more flexibility in service delivery design and program oversight.
- Leveraged Mercer's extensive in-house research of integrated behavioral health/physical health models of care in other states to determine the appropriate application of these models in regulations governing the care of children in foster care.
- Reviewed similar oversight entity regulations (e.g., pertaining to other agencies in Arizona, other states) to identify potential recommendations.
- Modeling provider financing arrangements and payment mechanisms with CMDP and conducting analysis of cost-savings to be achieved through new models of health care delivery.

Mercer's network development, management and expansion analysis considered the RBHA's and statewide CRS Contractor contracted behavioral provider networks, geo-spatial analysis, service utilization trends, active or planned network development initiatives, identified network gaps, and other available AHCCCS registered BH providers that could serve to supplement the CMDP BH network.

To assess staffing requirements under the integrated health plan, Mercer reviewed existing resources within CMDP, including supporting organizational structures, sufficiency of staffing resources, experience and expertise, and information systems and other technology that supports health plan operations. Through document reviews and interviews, Mercer identified strengths and opportunities in the current system and processes, and how these findings could be leveraged to address potential barriers and gaps. Mercer also assessed current RBHA staffing, oversight, and reporting responsibilities for the CMDP population. Effective operational standards and oversight practices were identified and evaluated to determine the feasibility for CMDP to replicate similar approaches.

Mercer leveraged knowledge regarding AHCCCS' current performance measures related to network access and adequacy and adopted the following approach to developing enhance performance measures:

- Mercer defined categories of performance measures with the State prior to beginning the analysis (i.e., system, plan, provider and member levels of performance).
- Mercer completed targeted research on national measures. Example resources included Agency for Healthcare Research and Quality (HEDIS measures), Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), Kids Count 2017 Report, National Outcome Measures, Child Welfare Information Gateway, and Adoption and Foster Care Analysis and Reporting System (AFCARS) data sets.

- Mercer leveraged experience from other states that have focused on the development and enhancement of performance measures and evidence-based practices.
- Mercer grouped and prioritized actionable versus non-actionable performance measures to allow AHCCCS to choose which performance measures will be most feasible from a data collection and monitoring perspective.

To complete the financial forecasting, Mercer identified personnel and systems currently in place with applicability to the integrated model versus necessary new one-time investments and startup costs, including legal costs and labor costs that will be incurred prior to commencing billable operations. Mercer identified new and existing costs, identified them as fixed or variable, and adjusted models accordingly based on current and forecasted membership.

The following report synthesizes findings and results derived through the analysis of the identified evaluation components. The report findings are organized in the following manner:

Section 1: Executive Summary

Section 2: Introduction and Approach

Section 3: Legal and Contractual Requirements

Section 4: Provider Network and Provider Payments: Legal and Contractual Considerations

Section 5: Network Development, Management and Expansion

Section 6: Staffing Requirements and Organizational Infrastructure

Section 7: Developing Enhanced Performance Measures

Section 8: Program Management and Transition Oversight Plan

Section 9: Startup and Ongoing Cost Forecast

Section 10: Stakeholder Informational Meetings Summary

Section 11: Alternative Operational Models and Approaches

3

LEGAL AND CONTRACTUAL REQUIREMENTS

AHCCCS contracted with Mercer to provide an independent analysis of developing an integrated health plan for children in foster care. As part of that analysis, Mercer was tasked with describing the legal and contractual requirements in moving towards an integrated model and providing recommendations to address potential impediments.

The current legal framework supports the existing model, where physical health and dental services are managed by the CMDP and BH services are managed by the RBHAs. In addition, presently CMDP children that have one or more qualifying CRS condition(s) are referred to a CRS contractor separately contracted by AHCCCS to provide physical health services for their CRS condition.⁶

Mercer reviewed existing statutes, rules and contracts to examine where modifications to the existing legal framework would be necessary to support integration. This section includes recommendations on mitigating potential legal and contractual issues, recommendations, and pros and cons for CMDP to administer behavioral health services. Additional discussion and recommendations concerning the current legal framework related to supporting a successful integrated delivery system [e.g., provider network development, provider payments and value-based purchasing (VBP)] is addressed in a *Section 4, Provider Network and Provider Payments: Legal and Contractual Considerations*.

⁶ According to AHCCCS' website posting of Major Decisions for the AHCCCS Complete Care RFP posted on May 2, 2017, effective October 1, 2018, "Members with a CRS designation who are also enrolled with CMDP will receive physical health services for their CRS condition from CMDP."

CMDP ADMINISTRATION OF BEHAVIORAL HEALTH SERVICES

Review of Applicable Statutes

Recommendation #1 – Amend DCS Rules under Arizona Administrative Code (A.A.C.), Title 21, Chapter 1, Article 2 to Reflect that “Medical” Care Includes Behavioral Health Services.

Arizona Revised Statutes (A.R.S.) §8-512⁷ creates the guidelines for the CMDP program including, but not limited to, (i) who is eligible for the program, (ii) identifying the benefits managed under the CMDP program, (iii) who may be a provider, and (iv) how to reimburse providers participating with CMDP. The current structure of A.R.S. §8-512 (A) is explicit that DCS shall “provide comprehensive medical and dental care, *as prescribed by rules of the Department.*” The italicized verbiage suggests that DCS has discretion within rule to define the scope of “medical” care, to include that comprehensive medical care includes BH services. DCS’ current rule, A.A.C. R21-1-203(6) excludes coverage of the cost of care and services provided to CMDP members for behavioral health services received through Medicaid behavioral health contractors; however, it appears that DCS has the statutory authority to amend that rule to remove the exclusion.

Further supporting the interpretation that “medical” care may include behavioral health services is A.R.S. §8-512(C), which states that “comprehensive medical and dental care consists of those benefits provided by the AHCCCS benefit as prescribed in title 36, chapter 29, article 1 and as set forth in the approved Medicaid state plan.” Behavioral health services are included in Title 36, Chapter 29, Article 1 [A.R.S. §36-2907(F)] and the approved State Medicaid Plan. While a statutory change is not necessary, DCS would need to amend its rule excluding coverage for behavioral health services.

Even if DCS amends A.A.C. R21-1-203(6) to remove the exclusion of CMDP coverage of BH benefits that change alone will not likely be sufficient to modify the legal framework to support CMDP integration.

Given that existing statutes and rules currently require AHCCCS to contract with RBHAs to deliver BH services and regulate the RBHAs administration of BH services (see e.g., A.R.S. Title 36, Chapters 5 and 34; and Arizona Administrative Code, Rule 9, Chapter 22), additional changes will be necessary to ensure CMDP has the appropriate authority to manage the behavioral health benefit for its members. There are two options to transferring the necessary powers and duties to CMDP, (i) AHCCCS can change applicable statutes and rules to include CMDP as an entity that also has the authority to administer the BH benefits; or (ii) AHCCCS can designate CMDP as a RBHA under its IGA with DCS. Given the administrative burdens and timing associated with amending existing statutes and rules, Mercer recommends designating CMDP as a RBHA.

⁷ <https://www.azleg.gov/ars/8/00512.htm>.

Recommendation #2 – Designate CMDP as a RBHA.

1) AHCCCS has the authority to designate CMDP as a RBHA because A.R.S. §36-3412(A) requires AHCCCS to procure for a “RBHA” pursuant to its authority under A.R.S. §36-2906. Under A.R.S. §36-2906(E), this includes the ability to enter into an IGA with the DCS. While designating CMDP as a RBHA may be the less administratively burdensome option, it is important to review some of the considerations of making this designation.

Table 1: Pros and Cons of Designating CMDP as a RBHA

RECOMMENDATION	PROS	CONS
<i>Designate CMDP as a RBHA</i>	- Likely requires fewer statutory, regulatory and contractual changes to explain that CMDP is also able to manage behavioral health benefits. For example, Jacob’s Law ⁸ that specifically references RBHAs would not need to be amended to also include CMDP.	- It is unclear if CMDP would have any challenges complying with A.R.S. §36-3410 (specifically, as a RBHA, CMDP would be prohibited from delivering any BH services). - It is unclear if CMDP can comply with all RBHA requirements currently in statute, rule, contract, and other documents incorporated by reference. For example - if CMDP is designated as a RBHA, would CMDP be subject to AHCCCS Contractor Operations Manual (ACOM) 322 ⁹ (which provides VBP strategies and requirements for RBHAs). If ACOM 322 applies to CMDP, CMDP would be required to have 35% of the value of the total payments to BH providers under a VBP arrangement by calendar YE 2020. ¹⁰

⁸ Jacob’s Law (A.R.S. §8-512.01), among other things, permits adoptive parents or out of home placements to directly contact RBHAs for behavioral health screenings/evaluations and includes timeframes for how quickly the RBHA must conduct the assessments. This law specifically references the RBHA as the entity providing behavioral health services to foster care youth. If CMDP is designated as a RBHA, no changes would be necessary. However, if CMDP is not designated as the RBHA, the references to RBHAs would need to be updated to support the integrated model where CMDP would now be providing those behavioral health screenings and services.

⁹ <https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/300/322CYE16-17v2.pdf>.

¹⁰ Note this assumes it would be subject to the non-integrated SMI rate for that calendar year.

RECOMMENDATION	PROS	CONS
		- If CMDP cannot meet all of the RBHA expectations, AHCCCS would be required to develop additional policies and/or exceptions for CMDP.

Review of Applicable Rules

As noted above, regulatory changes will be necessary to support an integrated CMDP delivery system. Rule changes take time (particularly in the absence of exempt rule-making authority) and resources.

The following outlines Mercer’s recommendations on rules that should be amended to ensure that CMDP can manage BH services.

Recommendation #3 – Amend A.A.C. R9-22, Article 12 to Support CMDP Management of Behavioral Health Services.

A.A.C. R9-22, Article 12, section 1202 entitled “ADHS, Contractor, Administration and CRS Responsibilities” should be updated to clearly identify the roles and responsibilities in managing and paying for BH services. This rule includes outdated references which could create confusion as to AHCCCS and contractor responsibilities and should be updated.

Recommendation #4 – DCS Amendment of A.A.C. R21-1, Article 2 to Support CMDP Management of Behavioral Health Services.

In general, this rule includes several references to medical, dental, or other covered services or medical, dental or other health providers. This language is sufficiently broad to include BH services and providers; however, AHCCCS may want DCS to include specific language to clarify and confirm that CMDP manages BH services and providers. In addition, we recommend the following changes to this rule:

201 – Definitions may need to be updated assuming changes are made to statutes as noted above, (e.g., to include BH services in the definition of “Covered Services”).

203(5) – States that the department shall not pay for a CMDP member “the cost of care and services provided to a behavioral health recipient received through Medicaid BH contractors.” As noted earlier, this section should be amended to remove the exclusion of CMDP coverage of BH services.

204 – Lists the prior authorization requirements. AHCCCS may want DCS to consider updating this section to include rules for BH prior authorizations (or reference the RBHA rules).

Review of Applicable Contracts

Recommendation #5 – Amend CMDP Contract to Include Behavioral Health Services and Update Existing RBHA Contracts to Effectively Remove the CMDP Population from their Responsibility.

Assuming rules can be amended to permit an integrated delivery system; contracts will also need to be amended to operationalize the integrated delivery system. Specifically, changes will need to be made to the current CMDP contract to ensure that CMDP can manage BH services to its members. In addition, the existing RBHA contracts will also need to be amended to make it clear that they will not be providing BH services to individuals receiving services from CMDP.

The following summarizes provisions that will likely need to be amended and/or added to the current CMDP contract to integrate BH services.

CMDP CONTRACT SECTION	TOPIC	RECOMMENDATION
CMDP Contract; D; 8	Transition Activities	- The contract includes specific language around transition of care requirements. It also specifically references ACOM 402. AMPM 330 will need to be amended to appropriately reflect the CMDP integrated model (see page 38). ¹¹ In addition, AHCCCS should consider language for implementation of the integration specifically around (i) prior authorizations and (ii) continuity of provider relationships.
CMDP Contract; D; 9	Scope of Services	- The contract will need to be updated to ensure it is clear which services are being managed by CMDP. - The contract will need to make sure the items that are incorporated by reference are appropriately amended and if CMDP is designated as a RBHA if any special exemptions need to be provided (see e.g., AMPM, ACOM and the AHCCCS Covered Behavioral Health Services Guide on page 41). - The behavioral health services included in the CMDP contract will need to be amended (see, e.g., behavioral health services on page 44).

¹¹ <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Policy330.pdf>.

CMDP CONTRACT SECTION	TOPIC	RECOMMENDATION
CMDP Contract D; 10	Special Health Care Needs	- This section will need to be amended to update references to RBHAs (see page 56).
CMDP Contract; D; 11	Behavioral Health Services	<ul style="list-style-type: none"> - Coordination of services may have to be updated (see page 59). - The BH standards for care delivery will need to be added specifically for: (i) referral expectations for individuals aged 17-½ for SMI eligibility, (ii) crisis services, (iii) community service agencies, (iv) psychiatric rehabilitation services, and (v) BH provider training and education. - With an integrated managed care contract, mental health parity will need to be reviewed by CMDP for its integrated model (see page 58). - Transfer of care will need to be updated to update references to RBHA (see page 61). - Expand upon training requirements to include the BH service package (for both CMDP staff and its subcontractors) (see page 61). - Specific Requirements for BH Services for persons in legal custody of the DCS will need to be updated to update references to RBHA (see page 62).
CMDP Contract; D; 15	Staff Requirements	- This section should be amended to include additional key staff requirements to support managing the BH benefit (see pages 64-69). AHCCCS should consider whether it is necessary to have a medical director/physician who is a psychiatrist.
CMDP Contract; D; 17	Member Information	- Requirements for the website and provider directory will not change but will need to be updated to reflect BH services and providers (see pages 71-73).
CMDP Contract; D; 22	Quality Management and Performance Improvement	- This section should be reviewed to include additional performance measures related to the BH services (see pages 75-84).

CMDP CONTRACT SECTION	TOPIC	RECOMMENDATION
CMDP Contract; D; 26	Network Development	- This section is drafted in a general manner that requires the contractor to have sufficient network that meets AHCCCS policies and refers to ACOM 415 and 436. While the contract does not need to be amended; AHCCCS should review ACOM 436 ¹² to either (i) ensure that CMDP as a designated RBHA can meet the BH requirements or (ii) develop BH network requirements that are specific to CMDP. In addition, AHCCCS should review ACOM 415 attachment B checklist to update it for CMDP requirements ¹³ (see page 87).
CMDP; Contract; D; 32	Appointment Standards	- Ensure that Network and Appointment standards include BH providers and standards (see page 94).
CMDP; Contract; D; 56	Reinsurance	- Reinsurance, financial viability standards, and performance bond values would need to be adjusted to reflect the added services/benefits and population (see page 113).
CMDP Contract; D; 76	Special Provisions for Payment	- To the extent there are changes made to the statute to provide more flexibility to CMDP to make payments to providers that are not tied to the AHCCCS fee schedule, the contract should be clarified to that effect (see page 141).
CMDP; Contract	NEW	- The standards for care coordination will need to be modified to state the expectations under an integrated model.
CMDP; Contract	NEW	- Consider adding provisions around collaborations with certain stakeholders such as AzEIP, Juvenile Probation, Juvenile Justice Division of the Arizona Office of Court, ADOC and ADJC; Arizona Department of Education, Schools or Other Local Educational Authorities (as necessary).

¹² <https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/436.pdf>.

¹³ https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/415_B.docx.

The following table summarizes provisions that will likely need to be amended and/or added to the current RBHA contract to integrate BH services. In general, these requirements should be reviewed to remove references to CMDP members (given that the RBHAs will no longer be managing their benefits) and to ensure that the transition of members occurs appropriately and efficiently (including the functions, data and records).

RBHA CONTRACT SECTION	TOPIC	RECOMMENDATION
RBHA Contract; Scope of Services; 1	Overview	The contractor responsibilities chart will need to be amended to clarify that the RBHAs will no longer have a role in providing BH services to CMDP members (see 1.1.9 on page 30).
RBHA Contract; Scope of Services; 2.1	Eligibility	The contract will need to be amended to clarify the RBHAs responsibility with respect to providing BH services to CMDP members (see page 33).
RBHA Contract; Scope of Services; 4.8.16 and 4.8.17	Specific Requirements for Services for BH Services for Persons in Legal Custody of the Department of Child Safety	The contract will need to be updated here to ensure that it is clear that CMDP will be managing the behavioral health services for the children in legal custody of the DCS. AHCCCS should consider also including transition language here to the extent children receiving services through the RBHA are then transitioned into CMDP (see page 49). If CMDP is not designated as a RBHA, ACOM 449 will also need to be amended to indicate that CMDP will be managing behavioral health services for its members. ¹⁴
RBHA Contract; Scope of Services; 4.9.8	Report on BH Utilization and Timeframes for CMDP Members	The contract can likely be amended to either (i) remove this quarterly report requirement or (ii) amend the report to be specific to CMDP transitions (see page 51; Exhibit 9 Deliverables page 333).
RBHA Contract; Scope of Services; 5	Care Coordination and Collaboration	The contract should be amended to clarify coordination efforts with CMDP (see, e.g., 5.1.14 on page 81).

¹⁴ <https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/449.pdf>.

RBHA CONTRACT SECTION	TOPIC	RECOMMENDATION
RBHA Contract; Scope of Services; 5	Coordination for Transitioning Members	The contracts all include specific transition requirements when a contract ends and when individuals move between contractors (including RBHAs, CRS and CMDP). The information should be sufficient to support the transition; however, AHCCCS may want to review the standards to ensure additional changes to the AMPM and/or ACOM policies are not needed (see 5.8.1. on page 93 and 5.8.12.7 on page 96).
RBHA Contract; Scope of Services; 8.12	Continuity and Care Coordination	The contract should be amended to clarify coordination efforts with CMDP (see, e.g., 8.12.10 on page 123). The high cost member chart will also need to be amended to remove CMDP members as such members will have all of their services managed by CMDP (see 8.12 page 124).
RBHA Contract; Scope of Services; 9.1.8	BH Screening Requirements for CMDP	This requirement can be deleted as it will now be a requirement for CMDP. Alternatively, AHCCCS can maintain this requirement to conduct a screening when an individual transitions to a RBHA when he/she is no longer eligible for CMDP (see page 129).
RBHA Contract; Scope of Services; 10.6.5	Performance Measures Reporting	This section can be amended to remove reference to CMDP members (see page 141).
RBHA Contract; Scope of Services; 15.6.8	Compensation	Can remove references to CMDP (see page 177).
RBHA Contract; Scope of Services; 18.7.7	CMDP Coordination	May want to amend the contract to amend the role of this coordinator. It is unclear if this role is no longer needed (given that there is a transitions coordinator) or if this role should be maintained to facilitate the churn that is likely occur as children move between CMDP and the RBHA (see page 230).

CMDP ADMINISTRATION OF BENEFITS FOR CMDP CHILDREN WITH CRS CONDITIONS

Review of Applicable Statutes

A.R.S. §36-2912 defines the CRS program and requires the AHCCCS administration to establish the CRS program, and to establish policies and rules to govern the program. A.R.S. §36-2912 that states, “Pursuant to the requirements of section 36-2903, the director shall prepare and issue a public request for proposals, including a proposed contract format, at least once every five years to contract for the care and treatment of children who have a chronic illness or physical disability.”

A.R.S. §36-2903 gives AHCCCS the necessary authorities to contract for the provision of medical care; however, A.R.S. §36-2906 describes the statutory requirements for contracting with qualified health plans or authorized agencies in the State. A.R.S. §36-2906(E) gives AHCCCS the authority to provide services through an interagency agreement with authorized agencies for specific populations or benefits. DCS is a state agency authorized to provide medical and dental care to CMDP members. As such, no statutory change is necessary to permit AHCCCS to enter into an interagency agreement to delivery services to CMDP members with CRS conditions.

A.R.S. §36-261¹⁵ requires the administration to establish the program for children who have a chronic illness or physical disability; however, it does not provide additional details around eligibility and services provided under the program. As such, integrating the CRS benefit package into CMDP for foster care youth who have a chronic illness or physical disability will not require a statutory change to A.R.S. §36-261. Similarly, Mercer does not believe any changes will be required to A.R.S. §8-512 to include the CRS benefit package under the management of CMDP. A.R.S. §8-512(C) references the services prescribed in title 36, chapter 29, article 1. Because the CRS program is included in this section of the statute, Mercer believes CMDP does not need any additional authority to manage the CRS benefit.

Review of Applicable Rules

Recommendation #6 – Amend A.A.C. R9-22, Article 13 to Support Integrating Benefits for CMDP Children with CRS Conditions.

Please see the discussion above regarding timing issues and constraints with respect to rule changes. Mercer believes that the following rule change will be necessary to support the integration of CRS:

A.A.C. R9-22, Article 13, section 1302 states “A member enrolled in CMDP shall also obtain CRS services through the CRS contractor.” This should be revised to indicate that CMDP will be managing the CRS benefit package to foster care youth that otherwise meet the CRS eligibility criteria.

¹⁵ Available at <https://www.azleg.gov/viewdocument?docName=https://www.azleg.gov/ars/36/02912.htm>.

Review of Applicable Contracts

Recommendation #7 – Amend CMDP Contract to Include benefits for CMDP children with CRS conditions and Update Existing CRS Contract to Effectively Remove the CMDP Population from their Responsibility.

As explained above, if CMDP will be providing the CRS benefit package to children with CRS conditions, the CMDP and CRS contracts will need to be amended accordingly. The following summarizes provisions that will likely need to be amended and/or added to the current CMDP contract to include the benefits for CMDP children with CRS conditions.

CMDP CONTRACT & SECTION	TOPIC	RECOMMENDATION
CMDP Contract D; 3	Enrollment	- Eligible populations will need to be updated to include individuals with CRS condition(s) (determined by AHCCCS) (see page 38).
CMDP Contract; D; 8	Transition Activities	- The contract includes specific language around transition of care requirements. It also specifically references ACOM 402. While the CRS Contractor should already have in place specific policies to address the transition to CMDP; AHCCCS should update ACOM 402 to delete the reference that CRS contractor will provide CRS benefit package to CMDP members. ¹⁶ Similarly, AMPM 330 will also need to be amended to appropriately reflect the CMDP integrated model (see page 38). ¹⁷ In addition, AHCCCS should consider language for implementation of the integration specifically around (i) prior authorizations and (ii) continuity of provider relationships.
CMDP Contract; D; 9	Scope of Services	- The contract will need to be updated to ensure it is clear which services are being managed by CMDP and that it includes the expanded benefit package for CRS-eligible members.

¹⁶ <https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/402.pdf>.

¹⁷ <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Policy330.pdf>.

CMDP CONTRACT & SECTION	TOPIC	RECOMMENDATION
		<ul style="list-style-type: none"> - The contract will need to make sure the items that are incorporated by reference are appropriately amended to reflect the ultimate decision on how BH services and the CRS benefit package are being managed by CMDP (see e.g., AMPM, ACOM, and the AHCCCS Covered BH Services Guide on page 41). - The contract will need to be amended to remove references to coordinating care with CRS except in the original transition when CMDP takes over (see, e.g., page 41, CRS on page 44). - The behavioral health services included in the CMDP contract will need to be amended (again depending on the ultimate decision of CMDP as a designated RBHA and whether there are one or two contracts to memorialize that arrangement) (see, e.g., behavioral health services on page 44).
CMDP Contract D; 10	Special Health Care Needs	<ul style="list-style-type: none"> - This section will need to be amended to update references to CRS and RBHAs (e.g., individuals will be determined to have special health care needs if they are determined to need the CRS benefit package and/or certain BH services) (see page 56).
CMDP Contract; D; 11	BH Services	<ul style="list-style-type: none"> - This section will need to be amended based on the decision to designate CMDP as a RBHA and whether that designation will be memorialized under a separate RBHA agreement (see page 58). - The references to CRS will need to be updated to explain that CMDP will manage the CRS benefit package for individuals who qualify (see page 58). - Coordination of services may have to be updated to reflect the decision on the designation of CMDP as a RBHA (see page 59). - Transfer of care will need to be updated to remove references to CRS and to update references to RBHA (see page 61). - Specific Requirements for BH Services for persons in legal custody of the

CMDP CONTRACT & SECTION	TOPIC	RECOMMENDATION
		DCS will need to be updated to remove references to CRS and to update references to RBHA (see page 62).
CMDP Contract; D; 15	Staff Requirements	<ul style="list-style-type: none"> - This section should be amended to include additional key staff requirements to support managing the CRS benefit package (see pages 64-69). - Consider also updating training requirements for CMDP and its subcontractors around the CRS benefit package (see page 70).
CMDP Contract; D; 17	Member Information	<ul style="list-style-type: none"> - Requirements for the website and provider directory will not change but will need to be updated to reflect the CRS benefit package (see pages 71-73).
CMDP Contract; D; 22	Quality Management and Performance Improvement	<ul style="list-style-type: none"> - This section should be reviewed to include additional performance measures related to the CRS benefit package and behavioral health services (see pages 75-84).
CMDP Contract; D; 26	Network Development	<ul style="list-style-type: none"> - This section is drafted in a general manner that requires the contractor to have sufficient network that meets AHCCCS policies and refers to ACOM 415 and 436. While the contract does not need to be amended; AHCCCS should review ACOM 436¹⁸ to either (i) ensure that CMDP as a designated RBHA can meet the behavioral health requirements or (ii) develop BH network requirements that are specific to CMDP. In addition, AHCCCS should review ACOM 415 attachment B checklist to update it for CMDP requirements¹⁹ (see page 87). - The contract will need to be amended to include the CRS requirements around Multi-Specialty Interdisciplinary Clinics (MSICs).

¹⁸ <https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/436.pdf>.

¹⁹ https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/415_B.docx.

CMDP CONTRACT & SECTION	TOPIC	RECOMMENDATION
CMDP; Contract; D; 32	Appointment Standards	- Need to add Network and Appointment standards for certain CRS providers, such as MSICs and field clinics (see page 94).
CMDP; Contract; D; 56	Reinsurance	- Reinsurance, financial viability standards, and performance bond values would need to be adjusted to reflect the added services/benefits and population (see page 113).
CMDP Contract; D; 57	Coordination of Benefits and Third Party Liability	- The contract will need to be amended to clarify that members who are eligible for the CRS benefit package will receive that package through CMDP (see page 119).
CMDP Contract; D; 76	Special Provisions for Payment	- To the extent there are changes made to the statute to provide more flexibility to CMDP to make payments to providers that are not tied to the AHCCCS fee schedule, the contract should be clarified to that effect (see page 141).
CMDP; Contract	NEW	- The standards for care coordination will need to be modified to state the expectations under an integrated model, and must include some unique requirements for the population that is CRS-eligible or has special health care needs, such as children with a serious emotional disturbance.

The following summarizes provisions that will likely need to be amended and/or added to the current CRS contract to integrate the CRS benefit package for CMDP members with a CRS condition(s). In general, the CRS contract should be reviewed to remove references to CMDP members (given that the CRS contractor will no longer be managing CMDP individuals with a CRS condition(s)) and to ensure that the transition of members occurs appropriately and efficiently (including the functions, data, and records).

CRS CONTRACT & SECTION	TOPIC	RECOMMENDATION
CRS Contract Section D; 3	Enrollment and Disenrollment	Update the contractor service responsibility grid to indicate that CMDP will be managing all services including CRS benefit package (see pages 40-41).
CRS Contract Section D; 6	Coverage Responsibility for Partially Integrated Members	Update this section of the contract to indicate that CMDP will be managing all services including CRS benefit package (see page 45).
CRS Contract Section D; 8	Transitions	The contract includes specific language around transition of care requirements even where CRS is relinquishing members to other contractors. It also specifically references ACOM 402. While the CRS contractor should already have in place specific policies to address the transition to CMDP; AHCCCS should update ACOM 402 to delete the reference that CRS contractor will provide CRS benefit package to CMDP members. ²⁰ Similarly, AMPM 330 will also need to be amended to appropriately reflect the CMDP integrated model (see page 46). ²¹
CRS Contract Sections D; 9	Scope of Services – Covered Services	Remove reference to CMDP. This benefit package will need to be included in the CMDP contract and available to CMDP members who have a CRS condition (see page 51).
CRS Contract Sections D; 11	Access to BH Services	This section can be amended to delete the reference to CMDP as CMDP members will not be enrolled with CRS pursuant to the integrated model (see page 68).
CRS Contract Section D; 22	Performance Measures	Remove CRS measures and consider including in the CMDP contract (see page 93-96).

²⁰ <https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/402.pdf>.

²¹ <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Policy330.pdf>.

CRS CONTRACT & SECTION	TOPIC	RECOMMENDATION
CRS Contract Section D; 32	Appointment Standards	(1) The behavioral health utilization and timeframes for CMDP members deliverable should be deleted; (2) Review whether this report should be included in the CMDP contract. (See reporting page 112).
CRS Contract Section F	Report - BH utilization and timeframes for CMDP members	(1) The behavioral health utilization and timeframes for CMDP members deliverable should be deleted; (2) Review whether this report should be included in the CMDP contract. (See page 222).
CRS Contract Amendment #16	Targeted Investments	While unlikely to have any material impact, AHCCCS may want to confirm whether transitioning CMDP members out of the CRS contractor's management will impact any CRS' providers' participation in the Targeted Investment Program.

4

PROVIDER NETWORK AND PROVIDER PAYMENTS: LEGAL AND CONTRACTUAL CONSIDERATIONS

Mercer has been tasked with identifying the challenges in the current statutory requirement that CMDP pay the AHCCCS fee schedule, as well as to make recommendations for what will be needed for CMDP to develop a contracted network, including VBP strategies when appropriate. This section addresses the current regulatory challenges for CMDP in developing a robust provider network and then specifically describes VBP challenges.

LEGAL CHALLENGES TO DEVELOPING A ROBUST PROVIDER NETWORK AND PURSUING VBP STRATEGIES

Statutory and Regulatory Framework Limitations and Recommendations

A.R.S. §8-512 includes subsections that may undermine the success of an integrated program and specifically impede CMDP's ability to develop a robust provider network and one that is capable of engaging in value-based arrangements. The limitation that CMDP reimburse providers based on the AHCCCS fee schedule, limits CMDP's ability to negotiate competitive rates with providers and likely limits CMDP's ability to pursue value-based strategies. Moreover, because CMDP is required to accept any willing provider, CMDP has limited power to negotiate contracts with quality providers who have experience with CMDP's specialized population. On its face, these two statutory requirements limit CMDP's purchasing power and the ability to enter into contracts with providers that pay for value over volume. Therefore, as further discussed below, Mercer recommends that these provisions be removed from statute.

To further support the development of a robust provider network and the ability to pursue VBP strategies, Mercer is also providing additional recommended changes to statutes and rules (and in some instances alternative options if our primary recommendation is not feasible). Below is a high-level summary of the recommendations followed by a detailed pro/con chart in Table 1 that describes specific considerations related to each recommendation.

Recommendation #1 – Amend A.R.S. §8-512 to delete requirement to allow any willing provider to participate in CMDPs network.

A.R.S. §8-512(D) allows any provider enrolled with AHCCCS to be eligible to provide services to individuals enrolled with CMDP. Children in the foster care system have unique and more intensive health care needs as compared to the general population, and are at significantly greater risk of experiencing concomitant BH conditions and chronic medical issues. Improved outcomes are dependent upon providers experienced in delivering evidence-based and trauma informed health care services. By allowing any provider to participate in the program, the agency loses leverage to engage high performing providers with the specific experience necessary to meet the unique needs of the foster care population. For that reason, we recommend deleting A.R.S. §8-512(D).

Recommendation #2a - Amend A.R.S. §8-512 to delete requirement that CMDP reimburse providers based on the AHCCCS Fee for Service (FFS) fee schedule.

A.R.S. §8-512(E) limits CMDP to paying providers according to the AHCCCS fee schedule. Paying according to a fee schedule creates barriers to competitive contracting, creating provider accountability, and establishing requirements and benchmarks that reward high performance. As such, we recommend deleting A.R.S. §8-512(E).

Alternative Option #2b – Obtain a Legal Opinion to Determine Whether Incentive Payments Can Be Made.

If it is not feasible to delete A.R.S. §8-512(E), we recommend that AHCCCS obtain a legal opinion to determine whether CMDP can still make incentive payments above and beyond the AHCCCS fee schedule. As highlighted above, A.R.S. §8-512(E) specifically states that providers be “reimbursed” according to the AHCCCS fee schedule. It is unclear whether once CMDP reimburses a provider based on the fee schedule if providers could also be paid an incentive amount tied to performance measures (e.g., meeting reporting requirements or achieving outcomes). If this payment arrangement would be permitted, CMDP could participate in certain VBP arrangements (akin to category 2 alternative payment models rather than risk based approaches – see below for a discussion regarding VBP options).

Even if this type of incentive payment arrangement would be permitted, CMDP would still be required to contract with any willing provider without corresponding amendments to A.R.S. §8-512(D). Nonetheless, by including an incentive payment amount linked to quality performance or quality reporting, CMDP could limit these incentive payments to those eligible high-performing providers that meet the quality performance measures.

Alternative Option #2c – Amend the AHCCCS Fee Schedule to Include Incentive Payments for Pay for Performance Measures.

If it is not feasible to delete A.R.S. §8-512(E), AHCCCS could amend the AHCCCS fee schedule to include a tiered payment structure where the tiered reimbursement payment includes a quality component. For example, if the fee schedule reimburses \$100 for a pediatric well visit for a newborn, pediatricians with higher immunization rates (or some other quality measure) could receive \$110 for a pediatric well visit. These tiered amounts can be included directly in the Medicaid State Plan. This would still allow CMDP to reimburse according to the fee schedule but would also permit CMDP to incentivize quality performance and reward high performing providers.

Alternative Option #2d – Create a stand-alone CMDP fee schedule.

If it is not feasible to delete A.R.S. §8-512(E), AHCCCS could attempt to develop a stand-alone fee schedule that only applied to CMDP (but still met the requirements of the statute that CMDP pay based on the AHCCCS fee schedule). While this may be an option, it is not clear that CMS would support a separate fee schedule for a different population.

CMS has typically viewed Medicaid reimbursement policy as paying for a specific service, not a specific population. Fee schedules are for specific services provided to individuals. Differentials in service value already have existing mechanisms through Current Procedural Terminology (CPT) codes that identify more complex visits and provide add-on funding.

Additionally, CMS is aware that there are different federal financial participation (FFP) rates for various populations and has generally not allowed fee schedules developed for specific populations to avoid potential state manipulation of FFP.

Lastly, CMS may also be concerned that providing specific fees by eligibility group or sub-population creates the potential that providers would only treat some populations, creating unequal access under the Medicaid state plan (non-comparability).

Recommendation #3a – Amend A.R.S. §41-2501.LL to Exempt Department of Child Safety (DCS) from the State Procurement Rules.

CMDP is subject to Arizona Procurement Code under A.R.S., Title 41, Chapter 23, without an exemption to the procurement process, CMDP would likely need to follow state procurement rules for every subcontracted provider. As such, we recommend DCS seek an exemption from following state procurement code for contracts with providers of CMDP medical and dental care.

Similar exemptions have been granted under A.R.S. §41-2501 to state agencies authorized and responsible for providing health care services, including:

- AHCCCS for provider contracts pursuant to A.R.S. §36-2904(A);
- Department of Health Services for domestic violence services and services of physicians at the Arizona State Hospital; and
- Department of Economic Security for Arizona Long Term Care System (ALTCS) services.

Alternative Option #3b: CMDP Could Contract with a Managed Care Health Plan.

CMDP could avoid the barriers posed by the State Procurement Rules by contracting with a managed care health plan that would in turn contract with providers to provide the CMDP benefit package to its members. Managed care health plans would not be subject to the Arizona Procurement Code when contracting with providers. In addition, managed care health plans may have the ability to scale and leverage their resources related to, among other things, (i) provider contracting, (ii) VBP options and (iii) infrastructure and data analytics.

Alternative Option #3c: CMDP could contract with an Administrative Services Organization (ASO).

CMDP could contract with an ASO to directly render designated administrative functions. For example, an ASO model in which CMDP contracts with an organization to provide:

- Network Development and Management
- Provider Services
- Provider Disputes and Appeals
- Claims/Encounters
- IT Solutions
- Reporting

Under this model, CMDP could maintain the functions for the direct management of more clinical components such as care coordination and utilization management.

The option may require legal authority by DCS to contract for ASO administrative functions, unless interpreted to be allowed under ARS 8-512(J). In addition, AHCCCS would need to consider what, if any, contractual limitations would be put in place for CMDP in terms of activities that would be permissible to delegate to an ASO versus what functions would need to be maintained by CMDP. However, under this model, CMDP would still need to have the resources and expertise necessary to conduct adequate oversight of the ASO.

Mercer completed limited research of select states to determine if a Medicaid ASO model was currently in place for the provision of services to children in foster care, but was unable to identify an existing ASO arrangement.

Recommendation #4 – Amend A.A.C. R21-1, Article 2 to be consistent with the recommended statutory changes noted above.²²

- A.A.C. R21-1, Article 2:
 - 203(4) – Currently limits cost of covered services to the AHCCCS fee schedule. To the extent changes are made to A.R.S. §8-512(E), corresponding changes should also be made to A.A.C. R21-1-203(4).
 - 212 – Specifically indicates that CMDP pay providers based on the AHCCCS fee schedule unless otherwise permitted by A.R.S. § 8-512 or in the contract between the Department and AHCCCS. If A.R.S. § 8-512 is updated to indicate that CMDP does not have to pay according to the fee schedule there is enough flexibility in the rules that would not require them to be updated. However, for clarity sake and to avoid confusion, it is recommended that the rule be updated.

Table 1: Summary of Pros/Cons of Recommendations to Mitigate Existing Legal Barriers to Robust Contracting and Utilizing VBP Models.

RECOMMENDATION	PROS OF RECOMMENDATION	CONS OF RECOMMENDATION
Delete A.R.S. §8-512(D)	<ul style="list-style-type: none"> - Allows CMDP to develop and shift service utilization to a network of providers best suited to meet the needs of their population. - Allows CMDP to establish specific performance standards for providers treating their members. - Gives CMDP greater authority to regulate providers to meet the needs of their members. - Establishes a mechanism for CMDP to implement VBP strategies or other special provisions for payment to incentivize providers to focus on service quality and outcomes over claims volume. - Allows CMDP to focus on contracting with providers 	<ul style="list-style-type: none"> - Using any AHCCCS provider in theory gives an expanded access to care as opposed to requiring members to use an in-network provider or obtain authorization to go outside of network. - CMDP does not currently contract with providers for the full array services. As such, it will likely be a large administrative effort to contract with an adequate network of providers (particularly with the inclusion of BH services and CRS-specific providers). This will be even more challenging in rural areas of the state - Will increase CMDP’s administrative expenses to handle the associated responsibilities with network

²² Please see discussion in Legal/Contractual Requirements and Barriers for an Integrated Delivery System for Children in Foster Care briefing paper for considerations around making rule changes.

RECOMMENDATION	PROS OF RECOMMENDATION	CONS OF RECOMMENDATION
	<p>who have experience with the unique needs of the foster care population.</p>	<p>development and management (e.g., likely require additional provider relations staff to, among other things, negotiate contracts, train providers, etc.).</p> <ul style="list-style-type: none"> - CMDP is not currently exempt from Arizona Procurement Code. Without an exemption to the procurement process, CMDP would need to follow the state procurement process for every subcontracted provider. - Currently, there is no other Arizona state agency that has contracted for a fully comprehensive provider network to meet physical, behavioral and dental care needs of its population. - Amending statute can be difficult unless there is political support.
<p>Delete A.R.S. §8-512(E)</p>	<ul style="list-style-type: none"> - Allows CMDP to negotiate rates above the AHCCCS FFS fee schedule when necessary and appropriate to contract with particular providers that are critical to the provision of services for their population. - Allows CMDP to negotiate rates above the AHCCCS FFS fee schedule when necessary to be able to contract with providers who have experience with the unique needs of the foster care population. - By not being limited to paying the AHCCCS Fee-For-Service (FFS) fee schedule, CMDP can explore alternative payment models. - Allows CMDP to compete in the marketplace for providers who otherwise prioritize the membership of other Plans who are offering higher rates. 	<ul style="list-style-type: none"> - Will likely require additional provider relations staff to, among other things, negotiate contracts. - Will likely require system changes and investment in infrastructure to pay providers based on contract rates rather than fee schedule. - Amending statute can be difficult unless there is political support.

RECOMMENDATION	PROS OF RECOMMENDATION	CONS OF RECOMMENDATION
<p>Alternative Option #2b – Obtain a Legal Opinion to Determine Whether Incentive Payments Can Be Made</p>	<ul style="list-style-type: none"> - If yes, no statutory amendment would be necessary. - If yes, CMDP could include specific pay for performance incentives that are tied to performance measures. The performance measures could be specific to quality goals for CMDP providers. 	<ul style="list-style-type: none"> - It is unclear if this option would be permissible under the limitations contained in A.R.S. §8-512(E).
<p>Alternative Option #2c - Amend the AHCCCS Fee Schedule to Include Incentive Payments for Pay for Performance Measures</p>	<ul style="list-style-type: none"> - This would not require a statutory amendment. - AHCCCS could amend its fee schedule to include a tiered payment structure that provides an incentive payment for high performing providers. AHCCCS would not have to amend every state plan service, but could target certain services that are more common for the CMDP population. - AHCCCS could simplify tiers based on meeting national quality measures. For example, pediatricians who meet the national average for immunizations get 10% above the standard fee schedule rate. 	<ul style="list-style-type: none"> - It will create an administrative burden on AHCCCS to amend the fee schedule and may not be completed timely to support the integration timetable. - It takes time to establish performance baselines and to re-measure provider performance in order to assign tiered payment levels. Timely access to accurate data is necessary to operationalize this option. - The State will need to meet public notice requirements to update the Medicaid State Plan. - If the AHCCCS fee schedule is updated it would apply to every provider who is paid according to the fee schedule and who meets the performance target (however, given that most providers are not reimbursed based on the AHCCCS fee schedule, this may not be a real negative).
<p>Alternative Option #2d –Create a standalone CMDP fee schedule</p>	<ul style="list-style-type: none"> - This would not require a statutory amendment. - AHCCCS could develop a fee schedule that encourages participation in CMDP. 	<ul style="list-style-type: none"> - It is not clear that CMS would approve standalone FFS rates that are different solely based on population. For example, it is not clear that CMS would support the same pediatrician receiving a different rate for a well-visit for a child enrolled in CMDP versus a child enrolled in an acute care plan. - It will create an administrative burden on AHCCCS

RECOMMENDATION	PROS OF RECOMMENDATION	CONS OF RECOMMENDATION
		<p>to develop the fee schedule and may not be completed timely to support the integration timetable.</p> <ul style="list-style-type: none"> - It takes time and there are public notice requirements to update the Medicaid State Plan.
<p>Amend A.R.S. §41-2501(LL) to exempt DCS from the State Procurement Rules</p>	<ul style="list-style-type: none"> - Offers a streamlined process for subcontracting for provider services. - Further supports CMDP's efforts to contract with high performing providers. - Further supports CMDP to focus on contracting with providers who have experience with the unique needs of the foster care population. 	<ul style="list-style-type: none"> - CMDP would need the authorities and rules to establish their own provider procurement process. - Amending statute can be difficult without political support. - Arizona currently lacks a model to demonstrate that a state agency can successfully contract for a comprehensive provider network of a full array of service providers.
<p>Alternative Option #3b: CMDP Could Contract with a Managed Care Health Plan</p>	<ul style="list-style-type: none"> - A statutory exemption from the State Procurement Code would not be necessary to contract with providers. - A managed care health plan could leverage its staff, technology, experience, etc. to develop a robust provider network and implement alternative payment models with providers. 	<ul style="list-style-type: none"> - Would require a competitive procurement process for a managed care health plan, which will take time. - CMDP infrastructure development would still be necessary to oversee the managed care health plan.
<p>Alternative Option #3c: CMDP could contract with an Administrative Services Organization (ASO).</p>	<ul style="list-style-type: none"> - A statutory exemption from the State Procurement Code would not be necessary to contract with providers. 	<ul style="list-style-type: none"> - CMDP infrastructure development would still be necessary to oversee the ASO.
<p>Recommendation #4 – Amend A.A.C. R21-1, Article 2 to be consistent with the recommended statutory changes noted above.</p>	<ul style="list-style-type: none"> - To the extent statutes are amended, amending the rules will be necessary to ensure clarity and consistency. 	<ul style="list-style-type: none"> - While amending rules does not require the same political support as amending statutes, it does take time. AHCCCS may be able to utilize the expedited rule making process if such exception is included when the related statutes are amended.

ADDITIONAL LIMITATIONS RELATED TO VBP

VBP and Alternative Payment Model Considerations

In addition to the statutory and regulatory requirements that present specific barriers to developing provider networks and VBP arrangements, there are also (i) challenges related to implementing VBP models in general and (ii) specific issues for CMDP to consider given its specialized purpose. In most instances the issues noted below would apply to both medical and behavioral health provider contracts that pursue value-based arrangements.





The core concept behind VBP is to encourage providers and purchasers to re-think and transform how care is delivered while at the same time achieving higher quality outcomes and controlling cost growth. Arizona is a national leader in pursuing VBP models to ensure it is paying for value over volume. Indeed, Arizona has had requirements for its acute care plans to pursue VBP models since 2013. Additionally, an 1115 Targeted Investment program was recently launched providing funding for specific activities to support integration and coordination between physical and behavioral providers leading to higher value and better quality.

AHCCCS defines VBP as “A model which aligns payment more directly to the quality and efficiency of care provided by rewarding providers for their measured performance across the dimensions of quality.”²³ This model works for the acute care plans and the RBHAs because, among other things, (i) each health plan has a sizeable membership allowing a movement towards VBP models that include risk, (ii) there are no statutory limitations on provider payments, (iii) there are no statutory limitations on provider contracting, and (iv) the health plans compete against each other based on quality performance for an incentive amount. Currently, these elements are not present in the CMDP contract leading to additional challenges (as discussed further below).

Arizona’s approach generally has been to provide broad guidance on acceptable VBP models and requiring that a percentage of payments each year must be considered “value-based.” Under this approach, the health plans have the flexibility to select VBP models that work for their networks and populations. As Arizona has approached VBP models with its contractors it has worked to advance alternative payments along a continuum of increasing provider accountability and risk as pictured below.²⁴

²³ See ACOM 322, available at: <https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/300/322CYE16-17v2.pdf>. For purposes of this document, references to value-based purchasing include the broad concept of alternative payment models.

²⁴ <https://hcp-lan.org/workproducts/apm-whitepaper-onepager.pdf>.

			
<p>CATEGORY 1 FEE FOR SERVICE – NO LINK TO QUALITY & VALUE</p>	<p>CATEGORY 2 FEE FOR SERVICE – LINK TO QUALITY & VALUE</p>	<p>CATEGORY 3 APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE</p>	<p>CATEGORY 4 POPULATION – BASED PAYMENT</p>
	<p>A</p>	<p>A</p>	<p>A</p>
	<p>Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for HIT investments)</p>	<p>APMs with Shared Savings (e.g., shared savings with upside risk only)</p>	<p>Condition-Specific Population-Based Payment (e.g., per member per month payments for specialty services, such as oncology or mental health)</p>
	<p>B</p>	<p>B</p>	<p>B</p>
	<p>Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)</p>	<p>APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)</p>	<p>Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)</p>
	<p>C</p>		<p>C</p>
	<p>Pay-for-Performance (e.g., bonuses for quality performance)</p>		<p>Integrated Finance & Delivery System (e.g., global budgets or full/percent of premium payments in integrated systems)</p>
		<p>3N Risk Based Payments NOT Linked to Quality</p>	<p>4N Capitated Payments NOT Linked to Quality</p>

Challenges Related to VBP

As Arizona and other states have continued to progress along the VBP continuum pictured above, some general themes and challenges for a successful VBP effort have emerged specifically around (i) developing quality measures, (ii) provider capacity, (iii) oversight concerns and (iv) data.²⁵

- **Quality Measures:** Generally, VBPs are linked to quality measures, improved outcomes and utilizing evidenced-based practices. For BH specifically, there are not as many nationally endorsed or recognized quality measures and there are challenges with accessing data.
- **Provider Capacity:** Changing provider payment terms and moving towards alternative payment models results in system changes related to billing, data collection, reporting requirements, etc. These changes require time, expense and personnel that are not always available to providers who would like to participate.
- **Oversight Concerns:** VBP models are often contingent upon reporting requirements, demonstrating outcome measures, etc. As such, it is necessary to have appropriate staff, expertise and data analytic capacity to know how to utilize and measure the data collected.
- **Data:** A key to successful VBP models is access to timely, accurate and complete data. Without appropriate requirements around access to timely, accurate and complete data – monitoring and paying in accordance with VBP models will be difficult.

Specific CMDP Considerations

In addition to the general challenges with undertaking VBP models, CMDP's unique plan (even without integrating BH services) faces additional barriers that should be noted:

- CMDP has limited purchasing power given the small size, approximately 15,255 members.
- Many children enrolled with CMDP are enrolled for a limited time and may churn between programs, making it challenging for providers to maintain patient relationships and develop meaningful VBP arrangements.

²⁵ See "Moving Toward Value-Based Payment for Medicaid Behavioral Health Services." CHCS Issue Brief, June 2017 available at: <https://www.chcs.org/media/VBP-BH-Brief-061917.pdf>.

- Many providers have contracts not only with CMDP and the other Medicaid plans but in most instances with commercial plans as well. In developing VBP strategies, CMDP will need to consider what quality measures should be used and what data and systems are available to support the measures. To the extent the acute care plans and RBHAs are utilizing different quality measures for their value-based arrangements; this may create confusion and additional administrative burdens for providers.
- There would be a learning curve for both CMDP and its providers that may also ultimately require investment in infrastructure for both CMDP and its providers to move toward VBP models. The extent of the changes recommended herein alone for CMDP to manage the behavioral health benefit will be challenging, much less adding in the necessary components to support VBP models. Further, given all the changes that providers have faced in recent years [e.g., the Affordable Care Act and repeal and replace efforts, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), and the Medicaid Managed Care Rule], CMDP is likely to face challenges of provider reporting-fatigue and reluctance to participate in meaningful change. These collective concerns realistically mean that establishing a VBP model for CMDP-managed benefits will take several years to develop.
- It will be difficult for CMDP to contract with existing CRS benefit package providers and BH providers if CMDP does not have the flexibility to enter into competitive contracts.
- CMDP has limited experience in negotiating provider agreements, especially with behavioral health providers. It will likely take not only additional staff but training and oversight to assist with negotiating these agreements.
- CMDP has no experience in developing and overseeing value-based arrangements with providers. Here too, CMDP will likely be required to hire and/or train staff to ensure they have the appropriate data analytic skills to evaluate providers' performance.
- CMDP and its providers will have to invest in infrastructure changes to support VBP models particularly around the ability to send and receive real-time data. Moreover, because CMDP is currently required to contract with any willing provider registered with the state, it may be challenging for CMDP to impose data requirements in its provider contracts.
- If CMDP is designated as a RBHA, it is unclear if AHCCCS will develop VBP targets that are specific to CMDP or whether CMDP will be required to comply with the existing RBHA targets (see additional discussion in Legal/Contractual Requirements and Barriers for an Integrated Delivery System for Children in Foster Care and AHCCCS Contractor Operations Manual (ACOM) 322²⁶)).

²⁶ <https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/300/322CYE16-17v2.pdf>.

Considerations to Mitigate Additional Challenges

While CMDP cannot change the size of its membership or its membership's special needs, there are some things to consider that might prove beneficial in mitigating provider network and value-based payment barriers and challenges for CMDP (please note some of these are dependent on whether legal framework is modified as identified previously):

- CMDP may want to discuss with AHCCCS lessons learned and best practice approaches to entering into VBP contracts given AHCCCS' experience in overseeing these arrangements.
- Assuming AHCCCS sets a target for CMDP that x% of payments be value-based, CMDP would have the flexibility to develop VBP models that are tailored to its provider network and are aligned with quality goals specific to CMDP's population.
- Even if CMDP is required to reimburse providers according to the AHCCCS fee schedule, AHCCCS may be able to amend its fee schedule to incorporate a tiered payment structure. The tiered structure could include incentives for meetings specific metrics that are determined to be high value/priority for AHCCCS and CMDP. However, this alternative will likely be administratively burdensome and require significant effort and time to develop.
- It may also be possible for AHCCCS to develop a stand-alone fee schedule for CMDP. While it is unclear if CMS will support such a construct, AHCCCS might be able to develop a fee schedule that encourages participation in CMDP.
- CMDP could slowly phase in VBP models and start with providers who may have some VBP experience.
- CMDP may also be able to leverage VBP strategies that providers may be currently using with the RBHAs or acute care plans. In the past, AHCCCS has sponsored learning collaboratives where its health plans discuss their VBP efforts. It may be that CMDP could learn from their past experiences. In addition, analysis could also be done to evaluate provider overlap with RBHA and acute care contracts to leverage alternative payment arrangements that providers may already be using.
- A large barrier to successful VBP methods is related to infrastructure (specifically that many providers often lack the technology, analytics and data availability to effectively participate VBP models), The Children's Clinics for Rehabilitation Services (Tucson MSIC) is in a VBP agreement with United Health Care Community Plan (UHCCP) and the membership includes CMDP members. In addition, the Tucson and Phoenix MSICs applied for Targeted Investment funding. CMDP could leverage or build upon UHCCP's experience. Nonetheless, addressing provider barriers will not in and of itself remedy CMDP's infrastructure and experience challenges.

5

NETWORK DEVELOPMENT, MANAGEMENT AND EXPANSION

In Federal Fiscal Year 2017, the cost for services associated with behavioral health utilization related to children in foster care enrolled in acute care equaled approximately \$180 million. The cost for medical and dental care equaled \$49 million²⁷. While the CMDP currently designates a preferred provider network of medical and dental providers; the network is not contracted or able to be effectively managed under the current regulatory requirements. Given the ratio of BH expenses relative to the medical costs, and CMDP's limited experience with BH network requirements, the focus of this section is on the following components:

- An in-depth description of the characteristics of the existing BH network that is undergoing constant evaluation, transformation and development. The intent of detailing the current BH Contractor's network development initiatives and achievements is to underscore the significant effort a nascent, statewide integrated health plan will expend to replicate the array of contracted providers and innovative programming that currently exists. A concerted, coordinated and financially supported pool of resources will be required to re-establish and maintain the existing comprehensive BH network.
- A description of the strategies and resources necessary for CMDP to successfully develop and manage the network; and
- A summary of key considerations and recommendations.

Currently, AHCCCS contracts with three RBHAs that are assigned to specified geographic service areas across the State of Arizona. The table below depicts the Geographic Service Areas (GSAs), the counties served and the GSA Contractor's reported average number of enrolled CMDP members.

²⁷ AHCCCS Task Order # YH18-0013 for an Independent Analysis of an Integrated Health Plan for Children in Foster Care. July 25, 2017.

GSA	Counties Served	Average Number of Enrolled CMDP Members
Central GSA	Maricopa	9,000 ²⁸
South GSA	Pima, Pinal, Yuma, Cochise, Graham, Greenlee, Santa Cruz, La Paz	4,600
North GSA	Coconino, Yavapai, Apache, Mohave, Navajo, Gila*	1,252
Statewide CRS contractor	Statewide	400

The BH Contractors initiate and maintain provider agreements with BH providers to provide the full array of covered BH services available to adopted children and children and youth in foster/kinship care.

Statewide Medicaid Children’s BH Providers²⁹

BH services include, but are not limited to, screening, evaluation, treatment and assistance in coordinating care among providers, and state agencies (e.g., juvenile justice, probation). See *Appendix A – Title XIX Covered Behavioral Health Services* for a listing of all Title XIX (Medicaid) covered BH services available to children enrolled with CMDP. AHCCCS maintains an inventory of providers who are registered as a Medicaid provider. This file includes all of the Medicaid providers in the state as well as out-of-state providers; although not all of the AHCCCS registered providers are currently contracted with the RBHAs or the statewide CRS Contractor. Provider specific identifying information includes specialty services, as well as designation as a BH provider. However, the inventory does not distinguish Medicaid registered providers who deliver BH services to children, nor does it identify if the provider is contracted with one or more of the BH Contractors.

²⁸ The Contractor reported 9,000 enrollees at “any point in time”, whereas a monthly average of 10,000 enrollees. The additional 1,000 enrollees are those individuals who move into and out of CMDP, demonstrating the program’s fluidity.

The Provider Affiliation Transmission (PAT) is required to be updated quarterly by all AHCCCS Contractors to support AHCCCS' oversight and monitoring of the Contractor's network. The RBHAs and the statewide CRS Contractor submit individual information about each BH provider in their network as part of a required quarterly update. Although BH providers are identified in the PAT file, provider demographics do not indicate if the provider renders BH services to children. Because the AHCCCS inventory of registered Medicaid providers and the PAT file does not delineate if the BH provider serves children, another approach was needed to identify children BH providers statewide.

Mercer recently evaluated the BH network currently available to CMDP members through the RBHAs and the statewide CRS contractor³⁰. In order to develop a list of providers who deliver BH services to CMDP members, an analysis was conducted of BH service utilization for three years from October 2013 through September 2016. The resulting list contains over 2,500 unique providers, 89% of which are contracted with one or more of the current BH Contractors.

The following table identifies provider types that constituted almost three quarters of the providers within the utilization data file.

Provider type	Number of Unique Providers
03 Pharmacy	733
08 MD Physician	530
77 BH OP Clinic	248
A5 BH Therapeutic Home	232
19 RN Practitioner	144

A separate analysis was performed using BH service utilization data during Fiscal Year Ending (FYE) 2016. The analysis demonstrated that 3.28% (88) providers accounted for 80% of the total claims volume during FYE 2016. The data included inpatient, outpatient, professional and prescription drugs claim form types. Additional follow up may be justified to determine the prevalence of provider types in this top tier provider grouping as well as the identification of specialty providers and their locations across the State for the remaining 20% of providers that are affiliated with lower service utilization rates. Both

³⁰ Behavioral Health Network Assessment 2017–2018.

provider groupings are necessary to ensure a sufficient BH statewide network is available to meet the unique needs of adopted children and children in foster care.

Fluidity of the CMDP Membership

Mercer evaluated the number of unique users by month and average tenure of the CMDP members. On average, 5% of the total CMDP membership enters and exits the program each month. The average tenure for CMDP membership is eight months. This appears to be a shorter than average tenure for Medicaid members in general. A high-level analysis of a variety of populations in various states estimated the average tenure to be a little over 10 months for Medicaid eligible members. The rapid enrollment and disenrollment cycle of the CMDP population can create challenges with maintaining continuity of care and necessitates an intensive care coordination effort to ensure access to needed health care services and successful transitions of care between contractors and providers.

Statewide Provider Fees

Mercer reviewed the number of claims and types of services relative to the AHCCCS fee schedule for one year (CYE 2016). Some of the higher volume providers had claims with fees below AHCCCS rates, other claims were paid at the AHCCCS fee schedule rate and some claims were paid above the AHCCCS fee schedule rate. The following table demonstrates claims from four claims form types, the number of claims analyzed, and the difference between the paid claims and the AHCCCS fee rate. Across all provider types, the BH Contractors paid almost 22% more for services than is supported by the AHCCCS fee schedule. The implications of this additional funding to develop and manage an adequate BH network for the CMDP population are addressed later in this section.

Claim Form Type	# of Claims	% Claims Paid Over Fee Schedule	Plan/AHCCCS Difference
Inpatient	6,447	61%	\$(6,791,134.53)
Outpatient services provided in a hospital facility	1,240	2%	\$(1,024,199.79)
Pharmacy	138,699	3%	\$(10,570,251.96)
Professional services (outpatient services provided in the community)	2,940,957	94%	\$83,255,987.42
Total Additional Provider Payment			\$64,870,401.14

CURRENT GSA CONTRACTOR NETWORK MANAGEMENT

Two of the current BH Contractors use a Health Home Model to deliver services and coordinate care. The two GSAs include large rural and frontier areas of the state. A third BH Contractor, that provides services in a primarily metropolitan area, focuses on the development of services specific to the CMDP population and fidelity to those treatment models. The CRS statewide contractor has developed four clinics as medical homes in which a variety of specialty services can be accessed in one location, including BH services and/or BH screening services available at four regionally-based MSICs.

Health Home Service Delivery and Payment Models

The North and South GSA BH Contractors assign CMDP members to health homes that are responsible for the provision of comprehensive BH services. The health homes reach out to the CMDP member and conduct the initial assessment, organize and facilitate the Child and Family Team (CFT), collaboratively develop the Individualized Service Plan and coordinate care with specialty providers outside of the health home. Each of these BH Contractors have used multiple approaches to expand their network to meet the unique needs of the CMDP population and each Contractors' network delivers Evidence Based Practices (EBPs) to meet the unique needs of children in foster care.

The South GSA health homes utilize high needs case managers and report that between 10% and 15% of CMDP members are currently assigned to a high needs case manager. The South GSA BH Contractor encouraged child-only providers to expand to include adults in order to provide and coordinate services to the parents of CMDP members. Aside from a few federally qualified health centers (FQHCs) in remote areas, the majority of the South GSA BH Contractor health homes have established a minimum enrollment of 1,000 members to leverage economy of scale at the provider level and to ensure that the provider has the capacity to render needed care coordination. When identified as a need, the health homes refer CMDP members out to specialty providers such as HCTC, ABA and intensive in-home services.

The South GSA BH Contractor reports that HCTC capacity is adequate, in part because overall CMDP membership has decreased, average lengths of stay in HCTCs have stabilized and foster care provider capacity has been increasing. This Contractor noted that Non-Emergency Medical Transportation (NEMT) is a cost driver, and must be coordinated when multiple children from one foster family have more than one medical appointment in one day. The South GSA BH Contractor described a full continuum of crisis services, from crisis telephone support, to mobile crisis teams, and facilities that provide brief crisis stabilization. In rural counties, members most frequently access crisis services through first responders and local emergency rooms. The member's assigned health home is expected to follow up with all members who have accessed a crisis service. The South GSA BH Contractor also provides "Second Responder" services, which are intended to help CMDP members remain in foster care placement. Offered in Pima and Pinal Counties, providers of second responder services work with the CMDP member and their foster/kinship placement to anticipate and address potentially escalating situations. Entry into these services may be triggered by calls to the BH Contractor's hotline, health home referrals or requests for assistance from the foster placement.

Like the health home model in the South GSA, the North GSA BH Contractor manages 12 health homes; with 11 of these health homes equipped to serve children. When services are not available within the health homes, the health home refers CMDP members to providers of specialty services (e.g., HCTC and ABA) in the community. In addition to health homes, the North GSA BH Contractor also contracts with three Family Run Organizations to provide support for the biological families, work with the courts and promote and support early reunification for children and their family of origin.

The North GSA BH Contractor reports recent challenges in contracting with respite services and HCTC homes in less populous regions of the state, as well as chronic shortages of inpatient bed capacity and commonly reported statewide shortages of psychiatrists and BH analysts. In one approach to overcome this barrier, the Contractor utilizes telemedicine to expand access and supplement the shortage of psychiatrists. The Contractor also uses inpatient beds in Maricopa County when no inpatient beds are available in the Contractor's assigned GSA. One of the North GSA health homes coordinates with CMDP to search for and identify additional family members to provide respite and placement for CMDP members.

Another challenge in the North GSA is establishing adequate crisis services. The current BH Contractor has recently recruited a Maricopa County-based provider to expand into the North GSA with mobile crisis services in Flagstaff, Western Yavapai County and Mohave County. This Contractor has also encouraged contracted health homes to develop mobile crisis services. Expanding current crisis stabilization centers has been challenging due to licensure requirements for separate child and adult facilities. In addition to licensure challenges, the low number of children requiring crisis stabilization in the North GSA does not tend to support the development of stand-alone child crisis stabilization facilities.

Both the North GSA and South GSA BH Contractors report utilizing a variety of payment models with the health homes and specialty providers, including capitation, block or network contract purchase payments³¹, and some VBP arrangements as well as fee-for-service and SCAs as needed. Reimbursement rates for the health homes are typically higher for CMDP members than for other children receiving care and provider payments are noted to be in excess of current AHCCCS rates. Both Contractors report that many of their providers report an inability to sustain financial viability with payments limited to the established AHCCCS fee rates. For example, the North GSA BH Contractor pays higher rates for specialty providers such as HCTC, services provided through family run organizations and in-home intensive ABA and other specialized services necessary to support the needs of adopted children and children in foster care. .

³¹ AHCCCS' Complete Care Program Contractor RFP released in November 2017 encourages Contractors to reduce the use of block purchasing models and is promoting the use of VBP arrangements.

Central GSA Service Delivery and Payment Models

The Central GSA BH Contractor maintains a large and comprehensive children's provider network for CMDP members and other lines of Medicaid business in Maricopa County. Provider network activities in the Central GSA include the development of dedicated programming to meet the behavioral health care needs of the CMDP population as well as the expansion of providers who deliver related EBPs. EBPs include Trauma Focused-Cognitive Behavior Therapy (TF-CBT); Family Functional Therapy (FFT), Eye Movement Desensitization and Reprocessing (EMDR), Birth to Five, Parent-Child Interaction Therapy (PCIT) and other family communication and resiliency-building approaches. The Central GSA BH Contractor reports that almost 80% of the CMDP population receives BH services, and 33% of them receive high needs case management.

Another focus of network development has been engaging providers who deliver services that treat individuals with sexually maladaptive behaviors as well as wrap around services that help stabilize children residing with foster and kinship families. The Contractor reports services with chronic limited capacity include neurological evaluations and ABA.

The Contractor reports a sufficient number of HCTC placements, although children with special needs may present challenges in finding a family with the skills and expertise to manage those needs (e.g., based on location, medically fragile conditions, and Autistic Spectrum Disorder). In some instances, the HCTC placement requires time to prepare for the child. In other cases, the Contractor may arrange for the provider to meet the child and/or engage in several visits before placement in order to avoid a later disruption of that placement. Crisis services are routed through the single integrated crisis response provider that includes a foster care hotline and provision of a rapid response within 72 hours of referral. Once the rapid response assessment has been conducted, the crisis team transitions care to an ongoing provider. The Contractor notes that the current children's network has been in development for over four years, and that it continues to require enhancements and ongoing expansion to adequately meet the dynamic needs of adopted children and foster care children.

Currently, most providers are contracted through block payment approaches, with some providers being reimbursed through fee-for-service arrangements. In aggregate, the Central GSA Contractor reimburses providers at 112% over the AHCCCS fee schedule for children's services. The Contractor has begun to enter into VBP arrangements with some providers. The Contractor has just completed negotiations for a Center of Excellence Family Center with specific goals to prevent or decrease time until permanency. The Contractor noted that BH providers tend to be less sophisticated in billing and claims processing than physical health providers. As a result, the BH providers require additional education and technical assistance, which may include face to face sessions.

Provider Services and Provider Oversight

The South GSA BH Contractor monitors provider performance across multiple departments, including the Contractor's quality department that conducts provider chart reviews. Because services are encouraged to be based upon an EBP, a designated provider services team routinely audits provider charts to ensure fidelity to the EBP. The quality department has a team of five staff who monitors and reports rapid response timeliness; meets with DCS pertaining to member or provider concerns and monitors the foster care hotline. In addition to the AHCCCS-required network deliverables and provider-related performance improvement programs, the South GSA Contractor tracks and trends provider complaints and offers provider training. The Contractor also provides member education pertaining to BH services and supports for CMDP members, and facilitates focus groups with foster/kinship families to capture complaints and unmet needs. The Contractor provides a direct telephone line and e-mail for CMDP BH clinical coordinators to identify any BH services concerns related to CMDP members.

In addition to provider services, the Central GSA BH Contractor utilizes a System of Care (SoC) team that provides a variety of monitoring functions, including provider oversight, provider delivery of EBPs and training related to fidelity to EBPs. In collaboration with the Quality Management (QM) Department, the Contractor's SoC team has developed provider monitoring tools and conducts regularly scheduled provider audits. The SoC team monitors network capacity, identifies network gaps and helps to secure potential providers to meet identified needs. In addition, the SoC team provides technical assistance with the implementation and performance of CFT teams for CMDP members.

The North GSA applies a decentralized approach to provider monitoring and oversight. The health homes are expected to perform needs assessments via the CFT process, recommend services to meet the identified needs, and develop a service plan. Some services are provided directly via the health home or referred to specialty providers (e.g., HCTC). The North GSA has established VBP arrangements for family support through a program referred to as Parent Support Now. Under the VBP model, a family support partner is paired with a family that has experienced a child being removed from the home. The family support partner engages with the parent and based upon the time the child achieves permanency within a designated time period threshold, the provider is then eligible for an incentive payment (in addition to the established provider reimbursement rate). The North GSA Contractor utilizes a dispersed organizational approach to monitoring and supporting providers coordinated through single points of contacts (provider service representatives), who can direct questions or issues to the appropriate BH Contractor staff for follow up and resolution. At other times, the providers will directly contact the appropriate BH Contractor staff for assistance. The North GSA Contractor reports that the provider network is stable with long-standing relationships between the health homes and the BH Contractor.

Since the passage of House Bill 2442 and its requirements for increased access to BH services, the BH Contractors have created multiple initiatives to enhance access to BH services. These initiatives include the development of foster care hotlines, foster and kinship family focus groups, and education on expectations concerning universal assessment upon entry into CMDP, identifying common BH issues and how to manage them, and how to access BH

health services. It is expected that for the first six months of CMDP enrollment, a child has a minimum of one BH service per month through at least the initial year of enrollment.

Children's Rehabilitative Services (CRS)

The statewide CRS Contractor provides CRS qualifying physical health services and BH services through four regional MSICs or health homes at which CMDP CRS members receive most specialty services in one location. The four MSICs are located in Phoenix, Tucson, Yuma and Flagstaff. The Tucson and Phoenix clinics also offer PCP services, and the Phoenix and Tucson MSICs provide BH services in addition to the specialty medical services (the Yuma and the Flagstaff MSICs conduct BH screenings). CMDP CRS members may also access services through any of the available specialty or BH service providers within the Contractor's statewide network. Services more likely to be accessed outside of the MSICs are BH services, occupational therapy, physical therapy, speech therapy and ear, nose and throat (ENT) specialists. On average, two to three CMDP CRS members a month are placed out of the state due to the complexity of their required medical care and related challenges with locating specialty providers. The Contractor and the MSICs provide care coordination during these transitions. In other instances the Contractor provides additional medical support to help members stay in an in-state placement. For example, many residential treatment centers (RTC) will not admit children with a medical port. In order to keep the child in the State, the CRS Contractor arranges to have a provider come into the RTC to support the child's special medical needs. These types of specialty arrangements and out of state placements require the Contractor to reimburse providers at higher rates in order to meet the child's complex medical and behavioral health needs, but only if a provider agency can be identified that is willing to accept the member for placement.

A CRS Contractor clinical liaison is assigned to each MSIC (two are assigned to the Phoenix MSIC). The clinical liaisons take the lead in coordinating care when a member has multiple care managers. A high risk case manager is assigned to those CMDP members who are determined to have high needs. The CRS/BH Contractor reports that this membership requires intensive care coordination and innovative strategies to provide the best care for the individual. The CRS/BH Contractor has a provider agreement with an integrated crisis response provider for statewide crisis services and a dedicated CRS foster care hotline, and receives daily utilization reports from the mobile crisis teams and crisis stabilization units. This information is made available to the MSICs to support coordination of care.

Using the AHCCCS fee schedule as a base, the CRS/BH Contractor negotiates rates with the providers, including direct contracts with the MSICs. The MSICs are responsible for credentialing and payment of its providers. The MSICs receive additional payment for each service rendered to support the facility and the varied specialists available within the clinics.

Challenges Delivering BH Services to the CMDP Population

All of the BH Contractors report obstacles specific to providing BH services to the CMDP population. Placement can be challenging due to the number and variety of stakeholders involved with the child, not all of whom agree about the best setting for the child. It was reported that, occasionally, a judge will

court order a child to an RTC, even when circumstances suggest that the level of care may not meet medical necessity criteria. BH Contractors offer area judges and courts with training pertaining to the clinical advantages of community based services and the use of medical necessity criteria in determining the appropriate level of care, though despite these efforts, the BH Contractors report limited influence over the court system.

Additional care coordination for children in the foster care system is required due to the fluidity of the CMDP population as it moves into and out of the health plan to ensure that the child and family continues to receive services during these transitions. Furthermore, coordination of treatment between the child and family members can necessitate that the BH Contractor deliver services to multiple Medicaid populations, though efforts focus on utilizing the same provider in these situations when possible and supported through provider contracting arrangements.

Because of the unique needs of the CMDP population, provider contracting with specialty providers requires skilled negotiators throughout the State. BH Contractors also enter into SCAs when a specialty service is needed immediately and the Contractor does not have access to an available service provider.

Oversight is required to ensure that providers are delivering EBPs to fidelity. This oversight requires groups of provider specialists dedicated to provider audits and chart reviews. These teams may reside in the Provider Services Department or in the QM Department. Each of the current BH Contractors emphasized that significant time and resources are required to build, maintain and monitor a robust provider network that can meet the needs of CMDP members.

CURRENT CMDP NETWORK MANAGEMENT

CMDP currently utilizes a non-contracted, fee-for-service network of physical health and dental providers who are registered with AHCCCS to provide physical health and dental services to the CMDP population. CMDP is currently restricted to reimbursing providers according to the AHCCCS provider fee schedule and is required to process claims from any AHCCCS registered provider. All CMDP members are assigned to a PCP and a Primary Dental Provider (PDP). Foster families and members are encouraged to choose from the PPN, which is composed of Primary Care Providers (PCPs), OB/GYNs, General and Pediatric Dentists, Pharmacies and specialist providers. These PCPs and PDPs serve as the CMDP member's medical home.

CMDP has encouraged a group of AHCCCS providers to register with CMDP to become part of their PPN. These providers receive referrals, educational materials and basic credentialing with CMDP. CMDP coordinates credentialing activities with the Plan's quality unit and the medical director. The CMDP credentials PPN providers and encourages them to participate in e-prescribe, share information regarding practice guidelines, and are loaded into QNTX system for tracking. These providers are primarily PCPs, and are encouraged to refer CMDP members with BH issues to RBHA contracted providers. As of July 1, 2017, the PPN included a total of 941 providers statewide out of total of approximately 60,000 AHCCCS registered providers.

The CMDP Provider Services Manager has a team of three Provider Service Representatives and one Provider Services Administrator. A Provider and Foster Caregiver Educator position is currently vacant. The Provider Services Representatives are dispersed across three regions: North, Central and South and conduct onsite visits with providers. One of the Provider Services Representatives assists with credentialing related activities, and another provides assistance to providers with claims issues. The providers are all reimbursed at the AHCCCS rate, which makes network development challenging and presents limitations for obtaining specialty provider services for CMDP members. Although CMDP creates an annual Network Management and Development Plan, CMDP currently has no means by which to incentivize providers to respond within service timeliness guidelines, participate in required training, submit data and reports or expand services.

CMDP reports that one of their biggest challenges is the lack of a contracted network and provider rates limited to the AHCCCS fee schedule. Despite these challenges, multiple advantages of an integrated CMDP health plan managed by CMDP are noted. Currently, the CMDP member may have multiple stakeholders involved in their care: the DCS case worker, the foster or kinship family, the PCP, high needs case managers and the BH Contractors. Due to the complexity of the service delivery system and the multiple entities and individuals involved the child's care and treatment; foster parents may be required to attend multiple meetings with a variety of agencies. During one interview with CMDP, it was conveyed that one foster parent recently reported that he is required to attend six meetings a week with four different organizations to oversee health and BH care to his foster children. By integrating BH into a CMDP integrated care health plan, fewer meetings, requirements, and organizations will be involved with the child and foster family. This more streamlined approach removes the burden on foster and kinship families and facilitates care coordination activities.

An additional advantage to an integrated plan managed by CMDP is more immediate access to information concerning removal from the home, the child's current location and disposition, thereby reducing the need for additional care coordination and communication between DCS and the healthcare delivery system. Yet another advantage is the elimination of current conflict between CMDP and the RBHAs about how services will be funded. CMDP reports that conflicts emerge between DCS case workers, CMDP BH clinical coordinators and the BH Contractors regarding appropriate treatment, placement and the funding source for placement.

RECOMMENDATIONS AND RESOURCES REQUIRED FOR THE DEVELOPMENT OF A BH NETWORK

Because of the particular BH and care coordination needs of members in the CMDP health plan, the BH benefit will be most effectively managed with a contracted network of BH providers that includes innovative payment models, telemedicine capabilities, specialty incentives and VBP initiatives. A contracted network will allow CMDP to manage providers with VBP arrangements and to ensure quality of care through oversight activities. Several key regulatory barriers will need to be removed to allow CMDP to have the authority to develop an effective BH network.

Currently, CMDP is constrained by state procurement rules that require lengthy and cumbersome procurement processes to subcontract services. CMDP would have to obtain a procurement exemption in order to successfully contract with BH providers. The exemption would also ideally allow for SCAs which permits the health plan to expeditiously contract with a provider as needed. Instances in which this flexibility is required includes emergent situations,

specialty services required in a rural or frontier areas, and other atypical circumstances for services that are not readily available as part of the established BH network.

A second restriction that must be removed is the mandate that the AHCCCS rate schedule be used for all provider rates utilizing a fee-for-service payment model. The current BH Contractors have discovered that a variety of payment models and negotiated rates are required to develop the necessary flexibility in providing services for the CMDP population.

As another state agency involved in the administration of Medicaid funded health care services, the Department of Economic Security/Division of Developmental Disabilities (DES/DDD or the Division) currently utilizes a procurement exemption for contracting Long Term Services and Supports (LTSS) that allows the Division to enter into a Qualified Vendor Agreement (QVA) with providers. The QVA contracting process requires minimally 60 days to execute, although the average contracting period can consume 4 to 6 months. The Division develops its own fee-for-service rate book which is revised every 5 years. Fees are negotiated and may include “special rates” and/or incentives. The Division currently contracts for 33 home and community-based service providers through 591 subcontractors and approximately 1,500 independent provider agreements. Although the Division has secured a network of LTSS providers, some aspects of the process of procuring providers has introduced challenges with obtaining adequate provider coverage and delays in members accessing needed services, resulting in the need to review and amend the process for improved efficiencies³².

Several significant differences between LTSS and BH services suggest that this approach should be considered as a loose approximation of an appropriate strategy to satisfy the needs for a robust CMDP BH network. LTSS are a limited number of non-medical services with non-licensed, non-clinical providers. The CMDP BH network, on the other hand, is highly complex with multiple specialty providers as well as routine clinical BH providers, many of whom may require multiple licenses, accreditations and experience. Additionally, the BH network contracting process will require the flexibility for SCAs in order to respond timely to emergent needs.

Differences between the DDD population and the CMDP population also may make this particular approach less feasible for the CMDP BH network. The DDD population is typically characterized with life long, chronic disabilities that require LTSS over long periods of time (years). DDD members may stay enrolled in the DDD plan for most of their lives. Consequently, contracting processes do not require the flexibility that a BH network for CMDP members necessitates.

³² AHCCCS has recently required that the Division review and enhance operational processes to address access to care issues and the vendor call process.

CMDP members have acute BH needs and are typically enrolled in the health plan for much shorter periods of time. The more fluid population, with its more acute needs, requires a comprehensive, statewide network of BH providers who deliver services to children, with a nimble contracting and credentialing process as well as a large enough staff to support and monitor the network. For these reasons, the CMDP approach to pursuing a procurement exemption must include consideration of these additional needs. An additional consideration is AHCCCS' intent to move away from block purchasing, which will require educating and supporting BH providers regarding the application of alternative reimbursement models.

Although this section addresses the development of a BH network, an integrated health plan will require a similar transition for medical and dental services, as well as integrated models of care delivery. For example, if restrictions for contracting a network are overcome by the CMDP, the current PPN will need to be contracted, trained and monitored. However, with the exception of the MSICs for the CMDP CRS members, the BH network will be larger, more complex and will require more rigorous oversight.

Step One: Contracting and Credentialing a BH Network

Using a regional staffing model, CMDP can outreach the child BH providers identified in the Mercer study and initiate contract negotiations. Having a list of current child BH providers will support the outreach activities. Mercer recommends that CMDP identify provider types and prioritize basic and routine BH services for contract negotiation, followed by specialty services. An analysis of current service utilization for the population will help target high volume and specialty providers. The exception to this approach is contracting with the MSICs for the CRS population, which is a current expectation emanating from the AHCCCS contract. The relatively small number of CMDP membership statewide may create additional challenges with provider contracting, who may not want to expend resources necessary to enter into and maintain a contract for two to three of members in rural/frontier areas. Just as the North GSA Contractor finds contracting for crisis stabilization services challenging, CMDP will also encounter this issue. Alternatively, providers may agree to contract with CMDP, but demand a higher fee due to the complexity of CMDP member needs.

The AHCCCS Complete Care Program Contract for Contractors states that AHCCCS intends to eventually eliminate block purchasing and transition to other payment models including value-based strategies. One option for VBP contracting is to identify services and outcome targets for which VBP contracts are to be negotiated in the initial contracting period. A second option is to acquire one or two years of experience with the network and member utilization before identifying areas for VBP contracting. The advantage of initiating immediate VBP contracting is to establish expectations and a pattern of VBP contracts. The advantage of the second option is that the CMDP network team will have sufficient time to establish the BH network and will gain experience specific to the new contracting expectations by which to target areas for VBP initiatives.

In addition to contracting a statewide BH network, providers will require credentialing. As an integrated health plan, CMDP will be contractually required to utilize the Credential Verification Organization (CVO) through the Arizona Association of Health Plans. The CVO is responsible for receiving completed applications, attestations and primary source verification documents. The CVO is also responsible for conducting annual entity site visits to ensure compliance with AHCCCS requirements. However, CMDP will still be responsible for completing the credentialing process consistent with AHCCCS

Medical Policy requirements. CMDP will require significant resources to oversee and coordinate the credentialing process for a statewide PH and BH network. The CMDP can consider different approaches to accomplish this substantial task. One approach is to accept the RBHA's credentialing of CMDP's newly contracted providers, when applicable and if permissible under AHCCCS requirements. This approach requires fewer immediate resources, and allows CMDP to stagger the number of providers that require re-credentialing in the future. However, CMDP also assumes liability for these providers without having conducted its own credentialing process under the direction of CMDP's Chief Medical Officer. A second option is to credential each of the providers as they are contracted. Although this approach mitigates the risk of increased liability, it requires significant effort and time as well as upfront capital and more initial staffing resources.

Required Resources

When commercial health plans transition to a new contract, they dispatch a national implementation team comprised of experienced staff to develop and establish the initial provider contracts and credentials and manage the input of those contracts and provider demographics into the claims processing information system. Although CMDP does not currently have access to these external resources, several options are available to contract a BH network. One option is to hire "surge staffing" to implement the BH network. Some of these staff may transition to permanent provider contracting and provider services staffing positions within the integrated health plan. The advantage of this approach is that it builds CMDP expertise and knowledge of BH contracting. A second option is to delegate this process to a subcontractor or an administrative services organization, preferably one familiar with CMDP program needs and BH network development. A third option is to purchase a network from an existing managed care organization.

The following table is a projection of the number of staff required to contract and credential a statewide BH network as well as the functions of these resources. Staffing needs are based upon contracting approximately 2,200 child BH providers across the state. Grade levels are provided as a general reference to determining employee costs. See *Section 9, StartUp and Ongoing Cost Forecast*, for a detailed financial forecast related to startup and ongoing costs and the financial effects of adding staffing resources. It is estimated that the accompanying position grades and associated salaries may be sufficient to hire staff interested in government employment, although they are not perceived to be comparable to commercial managed care organization salaries.

Surge Staffing for Initial Network Development

DEPARTMENT/STAFF FUNCTIONS	POSITION TITLE	POSITION QUALIFICATIONS	GRADE LEVEL
Manages Implementation of Network	1 FTE Network Contracting Manager	8 years in BH Network Development and Management, B.A.; 2-3 years implementation manager of large scale networks.	26 AUN04960
Initial contracting with approximately 2,200 BH providers and 941 PPN providers	12 FTE Provider Contract Specialists	3–5 years in contract negotiating, BH preferred.	24 AUN02035
Oversee and coordinate initial credentialing with new BH providers	12 FTE Credentialing Staff	3–5 years healthcare provider experience.	20 AUN08301
Upload provider contract information into IS	5 Data Entry Operators	HS diploma or GED; 1-2 years' experience healthcare data entry	16 AUN08003

Step Two: Sustaining, Monitoring and Supporting a BH Network

The CMDP network department will require immediate staff for ongoing network functions of contract maintenance, credentialing, and provider services; although some of the surge staff may ultimately be hired for permanent positions in the network department as provider contracts are established. In general, network staff should be regionalized by DCS districts, with centralized leadership. The network department has two general functions: 1) provider contracting and credentialing, and 2) provider monitoring/management and provider services (e.g., support, technical assistance). The provider contracting team manages provider contracts, develops processes and procedures by which to identify important provider information such as specialties, gender, race, languages and EBPs offered, and develops/maintains a provider network directory. This team also evaluates network sufficiency and access to care.

Currently, credentialing occurs within the CMDP Provider Services Unit. The placement of credentialing functions under the network department aligns with standard industry practice within and outside of Arizona and consequently has been recommended for the integrated health plan organizational model. However, the credentialing team can also report up through the quality department if it is deemed more appropriate. Robust credentialing/re-credentialing processes include not only a review of primary source verification, but also legal actions, malpractice allegations, complaints and

grievance data, quality of care concerns, utilization patterns and the number of denials associated with the practitioner. The resources available through the Arizona Association of Health Plans should serve to mitigate the credentialing effort.

Provider Services Representatives offer claims reconciliation and education, general technical assistance, as well as performing chart reviews to verify provider delivery of high fidelity EBPs and compliance with contract requirements. Given the intense monitoring and reporting requirements of rapid response timelines and the experience of the BH Contractors in dedicating staff required to meet those expectations, the following staffing table includes an additional five Provider Services Representatives to monitor and report rapid response timelines and reconciliations, monitor and follow up with calls to the foster care hotline, and process the AHCCCS Contractor Operations Manual (ACOM), Chapter 400 deliverables.

The following table depicts BH network functions and staffing requirements. Positions include key personnel that are required in AHCCCS' Complete Care Program Contract for Contractors and will most likely be required for the CMDP Integrated Health Plan. These positions may be used for BH, physical health and dental networks. Other positions pertain exclusively to the BH network. Position titles without "FTE #" indicate that this position is currently occupied on the current CMDP organizational chart.

Network Department Staff Requirements

DEPARTMENT/STAFF FUNCTIONS	POSITION TITLE	POSITION QUALIFICATIONS	GRADE LEVEL
Network Development & Management	1 FTE Network Administrator	8 years in healthcare network development and management, including BH networks and VBP contracting. B.A. Foster Care experience preferred. At least 3 years indirect managerial experience.	26 AUN04960
Provider Contracting/ Management	3 FTE Provider Contractors	3–5 years in contract negotiating, VBP experience, BH preferred.	24 AUN02035
Credentialing	1 FTE Credentialing Coordinator	3–5 years provider contracting or credentialing experience. BH preferred	21 AUN09027
Credentialing Staff	4 FTE Credentialing Staff	3–5 years healthcare provider experience.	20 AUN08301

DEPARTMENT/STAFF FUNCTIONS	POSITION TITLE	POSITION QUALIFICATIONS	GRADE LEVEL
Provider Management/Services	Provider Services Manager	2–4 years provider services experience; 5 years managerial experience	22 AUN04850
Provider education, services, monitoring, medical record reviews, EBP audits and monitor report rapid response timelines, monitor calls to foster care hotline and process ACOM, Chapter 400 deliverables	15 FTE Provider Representatives (5 of these dedicated to monitoring related activities)	1 year BH provider services experience	20 AUN09027
Provider Manual/ Communications and Provider Training	1 FTE Provider Communications and Training	1 year provider training, education; 3 years course development and design	21 AUN04866

Step Three: Development of a Provider Directory and Identification of Provider Specialties

A comprehensive, searchable online and hard copy provider directory with detailed provider information concerning specialties, locations, EBPs, hours of operation and status of accepting new referrals is essential to ensuring appropriate BH service access for CMDP members. The directory is typically developed over a number of years, with increasingly more detail added for each of the providers. Ongoing maintenance is required to monitor appointment availability, ensure that provider information is current and accurate, and includes regular assessments of the providers' capacity to accept new members. The directory is used by foster care and kinship family members, system stakeholders, CMDP staff as well as DCS staff. Although CMDP members may access any AHCCCS registered provider, not all BH providers deliver treatment to children. A Provider Directory of contracted providers ensures that foster and kinship families as well as CMDP and DCS staff have direct access to provider information relevant to providing services to children in the foster care system and adopted children.

SYSTEMIC ADVANTAGES AND RISKS OF A CMDP INTEGRATED HEALTH PLAN

As noted earlier, the development of a CMDP contracted BH network that is integrated with physical health and dental services decreases the number of stakeholders in each DCS case, resulting in fewer meetings and less time in reaching consensus on CMDP member services and placements. Another

advantage is the direct availability of DCS child specific information to care coordinators and providers. A final strength is the possibility of closer care coordination between DCS caseworkers and the healthcare delivery system.

Managed care organizations (MCOs) typically receive a capitated rate that is comprised of an administrative loss ratio (ALR) and a medical loss ratio (MLR). The MLR is the percentage of the capitated rate that is, by law, dedicated to paying for healthcare services and is expected to be at least 85%, but may be higher depending on member demographics. The ALR is the percentage of the capitated rate dedicated for the support of the organization's administrative functions. The MCO is expected to maintain annual profitability between 0 and 4 percent. Although the capitated rate can reflect costs, it is not cost based. The MCO is required to manage the benefit in a way that provides all needed medical services and the administrative functions are supported by the ALR. The Plan's administrative percentage based on total payments is capped at 15%, though CMDP has reportedly experienced periodic challenges meeting this expectation due to trends of declining CMDP enrollment (i.e., 18% decrease over the past 18 months).

The development and management of a network is a significant portion of administrative costs, particularly a statewide network that requires routine BH providers as well as specialty providers. Large commercial MCOs maintain statewide contracted networks for multiple lines of businesses. Using economy of scale, the MCO is able to staff for services for the higher need populations at a lower rate than if the organization were only managing high need individuals with complex cases, which is the scenario that would be in place if CMDP operated a fully integrated health plan.

If the intent of an integrated CMDP health plan is for the administrative costs to be covered by the ALR, the relatively limited and decreasing number of CMDP members (~15,255) combined with the requirement of a statewide network with multiple specialty providers raises the question of sustainability for the implementation and ongoing management of a network. Although beyond the scope of this analysis, it will be important to evaluate whether administrative costs in general, and network administrative costs required to fulfill contract specifications in particular, will exceed the ALR and require additional state funding to sustain the integrated health plan's ongoing operations.

A second area of possible risk derives from the fluidity of the CMDP membership. As a stand-alone health plan, foster care children and youth will rotate in and out of the CMDP health plan relatively rapidly. This movement carries the risk of disruption in BH care with possible changes in providers and services. Given the particular needs of CMDP members for stability and continuity as well as the complexity of many CMDP BH care needs, these rapid transitions could have a deleterious effect upon the child, including exacerbation of trauma related effects. One approach to mitigating this risk is to have the same provider requirements for all integrated plans. Another strategy to manage these concerns would be to require that all CMDP providers be contracted with the current BH Contractors, although the feasibility of the transfer of services from a CMDP health plan to a current BH Contractor will be limited to the extent that the CMDP health plan has services and providers specific to the CMDP population. The same provider may not be contracted

with the current BH Contractors for the same services. Nonetheless, similar requirements across all health plans will likely facilitate smoother care coordination and fewer disruptions in care³³.

SUMMARY OF KEY FINDINGS AND RECOMMENDATIONS

A Mercer analysis of CMDP utilization data indicates that over 2,200 providers are currently contracted to provide BH services to CMDP members. An analysis of provider fees across inpatient services, outpatient services provided in a hospital facility, pharmacy costs and professional services (outpatient services provided in the community) were 22% higher than the AHCCCS fee schedule. CMDP membership was noted to be more fluid than other Medicaid populations, with approximately 5% entering and exiting the plan monthly and an average enrollment period of eight months.

The current BH Contractors report a variety of health delivery and payment models, and noted that in some areas specialty providers are particularly challenging to secure for the CMDP membership coupled with the general challenges for specialty providers in rural and frontier areas of the state (e.g., Deaf or hard of hearing members who require residential treatment). In addition, many specialty providers demand higher fees. The BH Contractors have access to skilled negotiators to initiate and sustain contracts with an adequate network that meets the needs of CMDP members. These Contractors noted that significant behavioral health treatment, care coordination, and provider oversight resources are required to adequately manage and care for this population. Particular challenges include multiple stakeholders with differing opinions regarding the most appropriate care for the child, multiple transitions that require high levels of care coordination, significant information system resources and reporting demands and a wide variety of specialty providers.

The CMDP Provider Services Unit utilizes a fee-for-service network that is not contracted with CMDP. This unit has developed a PPN of providers who have registered with CMDP, even though by law, their fees are based on the AHCCCS rates. The Provider Service Representatives currently deliver provider education and technical assistance to the PPN providers, but real limits exist for CMDP to actively manage the PPN.

Mercer recommends that the CMDP seek an exception to the state procurement rules and lift the restrictions on provider fees to the AHCCCS rate schedule. To develop an effective BH network for the short term, acute health care needs of CMDP members will require the ability to negotiate rates with a variety of BH providers throughout the state, and to be able to timely respond to emergent needs with SCAs or similar expedited contracting options.

The contracting and credentialing of a statewide BH network is a significant undertaking that will require substantial resources. If CMDP opts not to delegate the task to a subcontractor, or purchase an intact BH network, surge staffing must be utilized to engage the new BH provider network. This surge

³³ AHCCCS has established an Enrollment Transition Information (ETI) Member Transition process (AMPM 520) to maintain consistency of service providers to the extent possible from the relinquishing contractor to the receiving contractor.

staffing is estimated to include 24 Provider Contract Specialists and Credentialing Staff with an implementation manager as well as 5 Data Entry Operations to upload provider contract information into the claims processing system. Ongoing maintenance, oversight and support of the contract will necessitate the development of a network contracting function that includes positions required in the newly released AHCCCS Complete Care Program solicitation.

Strengths of an integrated health plan for CMDP members managed by CMDP includes closer care coordination between DCS workers and health plan care coordinators, real time communication of information about removals, transitions and emerging needs as well as a reduced number of involved stakeholders and organizations.

Mercer prioritized the following risks associated with a CMDP integrated care health plan specific to network development, management and expansion:

- The management of a relatively small, high needs population may not be sustainable without supplemental state funding.
- The capacity for CMDP and the larger care delivery system to generate sufficient capital and resources to support anticipated startup costs and ongoing maintenance of the integrated health plan operations.
- The fluidity of the CMDP population and relatively short tenure of this stand-alone population may disrupt ongoing BH services and successful outcomes.

Mercer recommends that these risks be carefully evaluated and compared with the benefits of a CMDP integrated health plan before moving forward with implementation.

6

STAFFING REQUIREMENTS AND ORGANIZATIONAL INFRASTRUCTURE

The purpose of this section is to identify resources and operational standards to successfully implement and manage an integrated health plan. Sources that informed the analysis included interviews with the CMDP staff and current BH Contractor staff, reviews of submitted desk review materials and a review of published documentation on care coordination of children in foster care as well as consultation with Mercer's internal subject matter experts in managed care operations, claims processing, encounters and information technology resources. Topics addressed include the following.

- Existing CMDP organizational resources.
- Infrastructure, staff expertise, operational standards and oversight practices required for the CMDP Integrated Health Plan.
- Recommended staffing resources for the integrated plan.

The mission of DCS is to “successfully engage children and families to ensure safety, strengthen families, and achieve permanency.” DCS carries out its mission through preventive programs designed to strengthen families, investigating allegations of child abuse or neglect with subsequent removal from the home if the allegations are substantiated, licensing of foster families and other placements, and transition programs for young adults who are aging out of the foster care system. An additional component of DCS, the CMDP, functions as a health plan and manages physical health, dental and pharmacy services for adopted children or youth that have come under the custody of DCS.

Although some objectives may overlap, the operations of a Medicaid managed care health plan are distinct from the mission of DCS. The duties of a Medicaid managed care health plan are to manage the delivery of health care services to a defined population in such a way that furthers the Center for Medicare and Medicaid Services' (CMS') triple aim: 1) improving the patient experience of care (including quality and satisfaction); 2) improving the health of populations; and 3) reducing the per capita cost of health care.

The current CMDP organization and functions include roles designed to further the DCS mission as well as the health plan's responsibilities of supporting the provision and management of publicly funded health care services to adopted children and children in the foster care system. The management of an integrated health care plan that includes Title XIX funded behavioral health services will require that all DCS protective custody functions and activities pertaining to a CMDP member's health care (e.g., initiating a member grievance or appeal, member advocacy for a particular placement) be placed outside of the CMDP reporting structure in order to avoid the risk of DCS influence, or the appearance of DCS influence on benefit determination decisions. This is why, ideally, the CMDP structure should include functions that support the mission of the health plan, and all DCS child custody related functions operate outside of the CMDP.

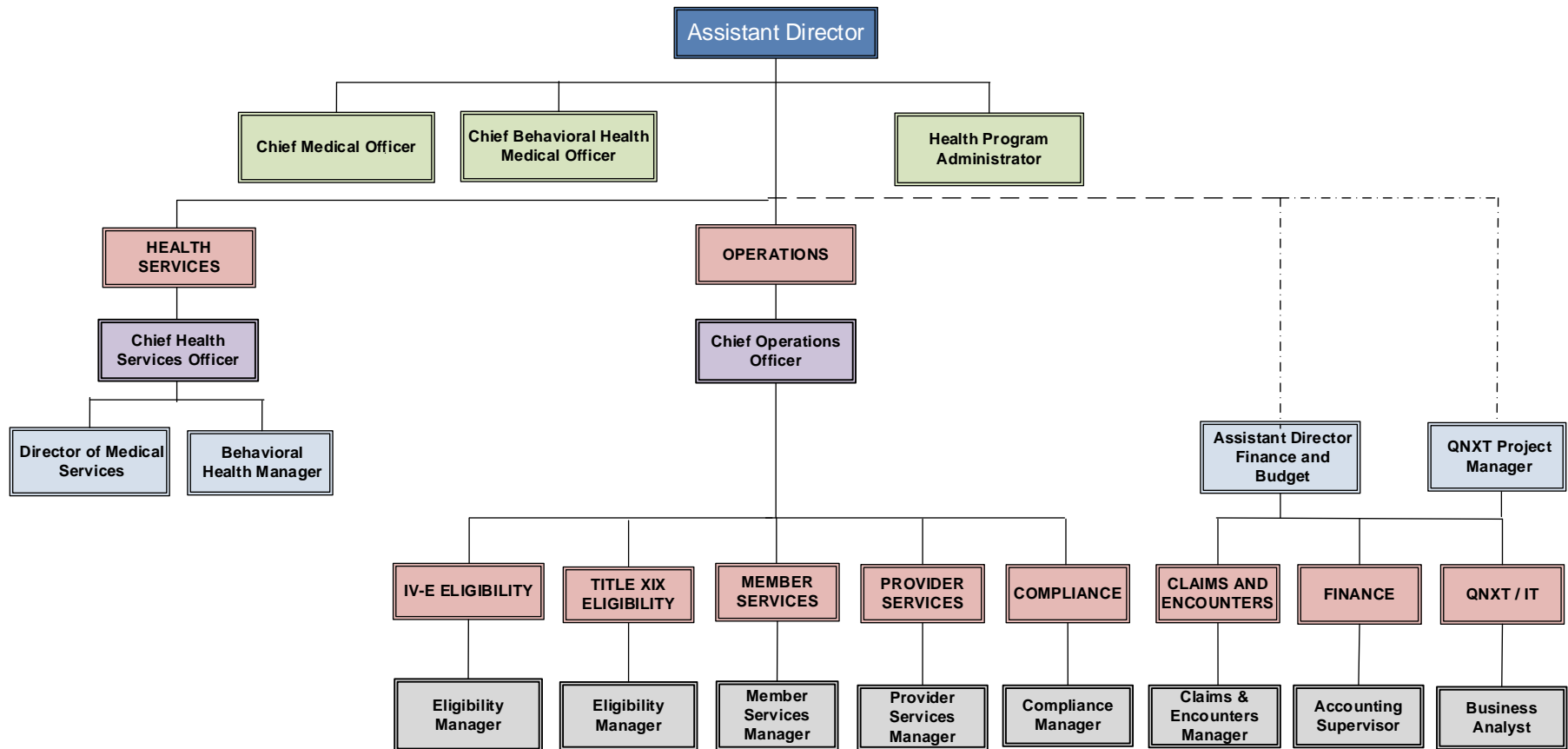
EXISTING CMDP ORGANIZATIONAL RESOURCES

A review of the current systems, staff, expertise and practice of the current CMDP management of physical health and dental services, including its strengths and weaknesses, is a fundamental building block for determining resources required for the management of an integrated plan. The following is a description of the current staffing structure and resources in the CMDP health plan.

The CMDP has two main functional areas: a Health Services Department that reports to the Chief Health Services Officer and an Operations Department that reports to the Chief Operations Officer. Both departments report up to the CMDP Assistant Director. A Chief Behavioral Medical Officer position is vacant, though active recruitment efforts were suspended several months ago. The Operations Department includes Title XIX Eligibility, Member Services, Provider Services and Compliance. Health Services includes a Medical Services Unit and a BH Services Unit.

Additional functional units include Claims and Encounters, Financial Services and an IT Unit. These teams have staff dedicated to the CMDP, but reporting relationships are with the DCS. Nearly half of the staff supporting these operations are designated as temporary contracted resources³⁴. The illustration below depicts the management levels of the current CMDP organization.

³⁴ Draft Comprehensive Medical and Dental Program Organizational Chart, effective September 20, 2017. Please note that the Title IV-E Eligibility Unit and Eligibility Manager are no longer assigned to the CMDP organization.



Health Services

The Medical Services Department is led by a Director of Medical Services who reports to the Chief Health Services Officer and has two direct reports: the Quality Management Manager and the Medical Management Manager. The Quality Management Manager leads a team of two nurses (EPSDT and Maternal Health), one care coordinator, one prior authorization technician and nine temporary contracted staff (these staff support member transitions and

reporting needs). The Medical Management Manager oversees a staff of two utilization review nurses, a behavioral health nurse, a prior authorization nurse, a dental care coordinator and a care coordinator for dental services and the Arizona Early Intervention Program (AzEIP). In addition, there is one temporary prior authorization nurse within the medical management unit.

Per interviews with CMDP leadership, all of the nurses in the unit conduct utilization reviews, although the utilization review nurses primarily focus on discharge planning due to the establishment of a diagnosis related group payment model with most participating inpatient providers. In the most recent quarter, Utilization Management staff reviewed 2,170 standard authorization requests (502 were expedited authorization requests) with an associated denial rate of 13.9%. Clinical information and authorization data is stored in QNXT; CMDP's information technology platform. The nurses are responsible for generating the notice of action letter when a denial is issued. All of the nurses on both teams perform a variety of roles, but each spends approximately 50% of their time performing utilization review related activities.

Providers submit hard copies of requests for authorizations of services via facsimile. Medical management team members authorize services, enter authorization data into QNXT, stamp the submitted materials with the authorization and fax it back to the provider. If a service request is denied, the medical management staff create the notice of action using a Microsoft Word template and manually record and track denials in a Microsoft Excel Worksheet.

Until recently, Health Services also included a part-time Medical Director Consultant that conducted peer reviews. Health Services nurses also provide care coordination and education for providers and placements. A significant commitment of CMDP's care coordination functions supports foster and kinship placements in the care and medical management of infants born to substance addicted mothers. Nursing staff and technicians also provide care coordination in response to requests from foster and kinship families, and follow up on referrals to programs such as AzEIP and Head Start.

CMDP has Collaborative Care Agreements with each of the current BH Contractors as well as care coordination goals described in the CMDP Medical Management Plan. However, Health Services staff report that currently, care coordination efforts are hindered by the limited number of available qualified staff. Salary levels of the department's support positions (e.g., prior authorization technicians) do not reflect the level of training, experience and expertise required to conduct complex care coordination activities for children in the foster care system.

Additionally, Health Services leadership report challenges with obtaining needed reports to manage member care and support care coordination activities. Per Health Services staff, current business analysts are not conversant with health plan data nor the data needs of the health plan. Further, requested ad hoc reports can be delayed when business analysts prioritize DCS report requests. Finally, the quality of the reporting is described by CMDP staff to be a common concern; with staff reflecting that data reports that appear to initially demonstrate outliers or atypical trends typically turn out to be issues with the integrity of the reporting outputs and/or accuracy of data query development.

Health Service staff expressed frustration with the RBHAs concerning coverage for BH services to CMDP members. As reported, the Health Service team encounter situations in which the RBHAs deny BH services that CMDP believes are needed by a CMDP member. Recently the BH Unit has implemented Clinical Case Reviews that include multi-agency staff members involved in the CMDP member's care and treatment, including the treatment team, a CMDP BH Clinical Coordinator, and, when assigned, a RBHA contracted provider high needs case manager. The goal of the clinical case review process is to gather treatment history and clinical information and reach consensus on the appropriate service array for the child or youth. The Health Services team has found the clinical case reviews to be an effective approach to resolving conflicts concerning appropriate treatment interventions and the funding of services.

The organization's quality management function is placed within Health Services. Current quality management activities and initiatives appear to be directed towards creating contract required reports and tracking and trending EPSDT and maternal health related performance measures. The current CMDP QM Committee Structure includes the following committees:

- Quarterly QM/Performance Improvement
- Quarterly Medical Management
- Quarterly Pharmacy and Therapeutics
- Monthly Policy Committee
- Monthly Credentialing Committee
- Compliance Committee Meeting

Responsibilities for the collection of data are dispersed across the medical management nurses and other functional areas of CMDP. The recently released AHCCCS Complete Care Program solicitation requires that the QM and Performance Improvement unit be separate and distinct from other organizational units, including Medical Management. The QM Manager has a direct reporting relationship to the chief medical officer.

Behavioral Health Unit

The CMDP BH Unit is led by a BH manager who oversees two teams of BH clinical coordinators. The BH coordinator teams are embedded in the DCS regional offices to ensure regional coverage across the State. Other personnel on the team include a BH appeals coordinator and a supporting BH clinical coordinator. The BH manager's job description requires that the incumbent meet standards as a BH professional. In addition to overseeing the BH unit, this staff person provides back-up for utilization review of non-Title XIX, state funded BH services.

The BH Clinical Coordinators serve as CMDP member advocates and respond to requests for assistance from various stakeholders. The BH Clinical Coordinators also serve as a resource for DCS staff, BH providers, and foster/kinship families by facilitating navigation of the BH delivery system. The BH clinical coordinators conduct various levels of advocacy for the perceived needs of the CMDP member by attending CFT meetings or resolving medication access issues.

Operations

Member Services is currently staffed by a manager and four member services representatives (CSRs). The unit is responsible for producing and revising member informational materials such as member identification cards, the member handbook and member newsletters. The unit's primary function is to answer incoming member and provider calls. The call center operates during regular business hours, Monday through Friday, supported by a Cisco Utility Platform. This platform generates standard call center reports as well as ad hoc reports. The system has the capacity to record calls, and a pilot project is currently in place to monitor live calls. The call center does not currently use standard scripts for responding to calls. Callers presenting with emergencies are asked to disconnect and call 911 at the initial call prompt. As reported by the CMDP, the call center currently answers approximately 2,000 calls per quarter.

Provider Services currently includes one manager, four provider services representatives, and a current vacant FTE responsible for caregiver education. *Section 5, Network Development, Management and Expansion* details additional resources that are required to implement and monitor a BH network.

The CMDP has an established foundation for compliance functions within the existing organizational structure. Currently, the CMDP's compliance staffing includes a Corporate Compliance Officer and a Compliance Manager that report up through the Chief Operations Officer and the Assistant Director. Functions carried out by this team include, but are not limited to, fraud, waste and abuse detection and contract compliance. The health plan's grievance and appeals function also reports up through the compliance unit. Current team members have behavioral health and child welfare experience. Compliance is responsible for coordinating and submitting all contract deliverables. Fraud, waste and abuse audits are completed on a quarterly basis (approximately 12 audits per quarter are completed). Audits are triggered by anomalies in the utilization data; provider claims disputes or identification of high dollar medical claims.

Claims/Encounters and Information Technology

Current resources include eight full-time employees in the Claims and Encounters Unit with 10 additional temporary staff. Work load distribution includes three staff for data entry of paper claims, five processors that also respond to provider calls, one trainer and the remaining team members support the claims processing function. Based on Mercer's statewide analysis of BH utilization data, CMDP can anticipate an increase of approximately 100,000 claims a month.

The CMDP uses the QNXT system for processing claims. CMDP is currently in the process of implementing an updated version of QNXT, which will be vendor hosted. User acceptance testing is in process with an expected implementation in February 2018. This upgrade will allow for automation of multiple areas including, but not limited to:

- Matching inbound claims systematically to the clinical authorizations. This match is currently done manually by processors since the authorizations are done in a separate system that is not integrated with the current QNXT version.
- Increase auto adjudication of claims from the current rate of approximately 32%. With the addition of the care management module, the rate should increase substantially and may be closer to the industry normal rate of 80% and above. This will allow for consistent processing and create more time for staff to handle more complex claims, such as inpatient services.

Finance

The CMDP Finance is a shared function which reports up to DCS. There are, however, dedicated personnel for the CMDP financial functions. The current structure includes an Assistant Director of Finance and Budget, an Accounting Supervisor, two accountants, a finance compliance auditor and a fiscal specialist. One of the accountant positions was showing as vacant at the time of this review.

INFRASTRUCTURE, STAFF EXPERIENCE, OPERATIONAL STANDARDS AND OVERSIGHT PRACTICES REQUIRED FOR THE CMDP INTEGRATED HEALTH PLAN

Medical Management and Quality Management

The CMDP currently has a robust medical management team supported by policies and procedures, ongoing supervision, an inter-rater reliability testing process, and an annual Medical Management Program Plan and Evaluation. The reported denial rate (13.97%) suggests that utilization management activities are adequately rigorous in comparison to other AHCCCS contractors. A strength of the current staffing configuration is that many of the medical management team members are cross-trained and engage in care coordination and quality management activities as well as the review of requests for authorization of services. The current volume of authorization requests does not appear to be substantial enough to support the number of full-time utilization reviewers. However, by requiring most of the staff to have multiple responsibilities, the medical management department is able to have enough qualified staff available to conduct utilization review when employees are unavailable due to vacations or illness and thus are able to backfill for staff vacancies.

The Integrated CMDP Plan will include the CMDP/CRS population, which will necessitate dedicated utilization review staff for this population. Although cross training will suffice for back-up staff and other duties as assigned; CRS medical management will require primary staff with special training, expertise

and experience with children with chronic medical conditions. Recruiting specialized nurses with the requisite qualifications that can perform utilization review may be challenging for CMDP due to current limitations with the compensation package offered through the ADOA.

In general, behavioral health conditions affecting children in the foster care are seldom straightforward and significant mental health issues can have several etiologies. Symptoms may suggest multiple, competing diagnoses; effective treatment of children in foster care is typically multi-faceted; and the level of functionality is predicted less by a particular diagnosis and more by co-morbidities and their interactions, including social determinants. For this reason, even Master of Arts (MA) level BH clinicians must obtain graduate level education for several years, followed by multiple years of supervised practice. A doctoral level BH clinician has the depth of training and experience to consider a variety of diagnoses, formulate case conceptualization from multiple theoretical orientations, and identify possible treatment trajectories. BH MCOs employ a full spectrum of licensed BH clinicians in addition to clinical social workers, psychiatric nurses, psychologists and at least one board certified psychiatrist. BH MCOs also provide ongoing clinical training and supervision and conduct daily clinical rounds based on the intensity of the level of care, the complexity of the case or evidence of a treatment-refractory psychiatric condition.

Although CMDP currently manages BH services for approximately 570 non-Title XIX CMDP members, the Health Services team includes only one MA level licensed BH clinician and one BH trained nurse for utilization review. With the exception of the BH manager, the remaining BH Unit personnel may only qualify as BH paraprofessionals. BH paraprofessionals are not trained or qualified to evaluate psychiatric conditions, do not possess the skills and training to identify appropriate BH treatment, and must be supervised by a BH professional.

The AHCCCS Complete Care Program solicitation requires a Children's Health Care Administrator and Medical Management Manager as well as Prior Authorization Staff and Concurrent Review Staff. Mercer's staffing model recommends a total of 16 prior authorization and 12 concurrent review staff. The estimate of medical management staff is predicated upon the assumption that the CMDP plan will require prior authorizations and concurrent reviews for the same array of BH services that are currently required for the non-Title XIX CMDP members.³⁵ The CMDP Medical Management team may also choose to require a prior authorization for psychological testing and evaluation as a means by which to leverage this service as an additional tool for assessing and recommending appropriate treatment planning for CMDP members with a history of complex BH challenges and/or co-morbid conditions. In addition to BH medical management, utilization review staff, and supervisors, this functional unit includes BH Pharmacy utilization review personnel.

³⁵ Non-hospital inpatient psychiatric facilities, behavioral health residential facilities, partial care (supervised day program, therapeutic day program, and medical day program); home care training to home care client (HCTC); psychotropic medication prescribed to CMDP members age 6 and younger; and AHCCCS designated controlled substances.

An area of concern noted through the Mercer analysis is the extent of manual involvement in generating and issuing service authorizations and notice of actions in cases of an adverse benefit determination. Given the expected increase in the volume of service authorization requests under the Title XIX BH benefit, manual tracking processes may not represent a viable or efficient approach as part of medical management functions. Mercer believes the added complexity and increases in workload will necessitate the use of automated systems to generate service authorizations as well as supporting other medical management activities such as tracking denials, issuing notice of actions and creating daily reports for internal management purposes. The integrated health plan should develop a provider portal in which providers can upload clinical information and initiate service authorization requests in a digital format that is automatically loaded into the updated QNXT care management module. Through this interface, notice of the authorization, service denial and status of the service authorization review is electronically transmitted to the provider. The medical management staffing model proposed by Mercer is based upon the assumption that current medical management manual processes will be automated under the integrated health plan.

BH services will be most efficiently managed by the creation of specific organizational units and staffing roles to support effective medical management of the covered services. The BH providers and the child and family team are advantageously positioned to further care coordination efforts and review possible treatment options and interventions. Current CMDP staff fulfilling advocacy roles, such as the BH clinical coordinators, should be considered placed within the DCS child welfare structure, but outside of the CMDP integrated health plan. Mercer's proposed staffing model eliminates this position entirely, although an alternative recommendation is to reorganize the BH clinical care coordinators teams to serve as care managers, transition specialists, or system of care support coordinators as deemed appropriate and determined qualified for these roles.

CMDP may choose nationally recognized evidence-based clinical guidelines such as BH Milliman Care Guidelines[®] for mental health medical necessity criteria and American Society of Addiction Medicine criteria for substance use disorder services guidelines. As the integrated health plan acquires experience in managing BH services for this population, it may choose to develop its own clinical criteria for designated levels of care.

As an integrated health plan, CMDP will need to develop BH clinical guidelines for providers to promote high quality behavioral health services. Recommendations for BH clinical guidelines include treatment protocols as well as preventative health guidelines. Although BH clinical guidelines do not substitute for BH professional judgement; the guidelines serve to clarify treatment standards and expectations of CMDP to BH providers. In addition to topics such as anxiety, depression and ADHD in children, the CMDP medical management team may choose to develop clinical guidelines for treatment interventions specific to the needs of the CMDP membership such as Trauma Focused-Cognitive Behavioral Treatment, Trauma Informed Care; Developing Resiliency in Children and Adolescents; Acute Stress Disorder and Post Traumatic Stress Disorder, and Treating Maladaptive Sexual

Behaviors. Alternatively, the CMDP may choose to utilize clinical guidelines available from national sources, such as the Agency for Healthcare Research and Quality (AHRQ) National Guidelines Clearinghouse.³⁶

Utilization review staffing resources represent the primary component of the CMDP medical management team and will help to shape and influence the care that CMDP members receive. Effective and active care management is a core component of effective BH medical management. Active care management is characterized by the following key elements and these recommendations should be adopted as part of the integrated health plan's approach to managing BH services.

- The BH medical management team will need to be properly trained to evaluate if the clinical assessment has sufficient information to support a benefit determination. Sufficient clinical information includes a clear diagnosis (or diagnoses) in which past “rule outs” have been resolved; the course of illness is clearly documented, including the onset, triggers, intensity, frequency, duration of symptoms and course of illness; multiple, incompatible or frequently changing diagnoses should not be used by the provider without explanation; and an assessment of co-occurring behavioral health and physical health conditions is present. Additionally, the mental status exam must be sufficiently detailed and supportive of the diagnosis; environmental and psychosocial factors potentially contributing to the member's functional status are identified and considered; and a thorough treatment history is documented and reviewed and identifies the types of interventions and services and the member's responsiveness to and engagement with prior treatment. If any of these elements are missing from the assessment, the integrated health plan reviewer reaches out to the provider for additional information prior to rendering an authorization decision.
- The medical management team makes a determination if the treatment plan is adequate to make a clinical benefit determination. The team reviews the treatment plan and the appropriateness of the plan (e.g., person-centered); that the plan is individualized based on the presenting problem(s) and stated goal(s); goals are realistic for the individual, and considered relevant, and includes recommendations for specific BH services. The treatment plan explores and addresses symptom-free or reduced symptom periods and addresses any co-morbid conditions. The treatment plan should go beyond symptom reduction and stabilization and include goals to increase functioning, independence, and quality of life (e.g., includes strategies to identify and establish alternative resources and supports). If any of these elements are missing from the treatment plan, the utilization reviewer discusses these issues with the provider and requests that the provider update the treatment plan accordingly.

³⁶ <https://www.guideline.gov/>.

- For CMDP members with a history of suicidal ideation, frequent decompensation or crisis system utilization, the reviewer requests that the provider develop a crisis plan in collaboration with the child and family team. For CMDP members with a history of aggression, self-injurious behavior, or crisis system utilization, the utilization reviewer should request that the provider develop a plan in collaboration with the member and the CFT that incorporates at least some of the following elements: early warning signs of relapse, replacement behaviors, calming techniques, de-escalation techniques, strengths of the individual and reinforcements. Older children and youth should be included in the construction of both a safety plan and a crisis plan in order to build a sense of self efficacy, independence and responsibility for managing disruptive behavior. If any of these elements are missing from the treatment plan, the reviewer contacts the provider for additional information.
- Medical management staff ensures that transition and discharge planning are addressed during the initial evaluation and throughout treatment. The team reviews the discharge plan and evaluates the appropriateness of the plan. The assigned utilization reviewer determines if there is adequate coordination with the caregivers as well as other providers and agencies to successfully plan for and implement the transition aftercare plan. For inpatient or residential placement discharges, utilization review staff, or another health plan designee, documents post discharge follow-up with aftercare services.
- The integrated health plan utilization review staff should be trained to recognize triggers that indicate a quality of care concern, including those that can be addressed by the reviewer (e.g., delays in access to approved provider services, lack of provision of approved services and or duration of service hours, lack of provider follow up on referrals or lab work; indications of engagement problems between the CMDP member and provider; lack of provider focus on environmental issues; lack of implementation of the treatment plan or the discharge plan) as well as quality of care concerns which should be addressed with a physician or psychologist consult with the provider (e.g., diagnostic issues such as multiple diagnosis, overreliance on diagnoses such as Intermittent Explosive Disorder, medication and polypharmacy issues, or confounding or life threatening medical issues; lack of responsiveness to medical management requests and suggestions, frequent readmissions and/or lack of progress). Utilization review staff should have a clear set of policies and procedures that identifies triggers and the procedures for follow-up on quality of care concerns.

Although the utilization review staff may coordinate efforts with support coordinators to target issues identified during service authorization reviews, the medical management team is ultimately responsible for ensuring that all aspects of clinical activity for an individual member are being implemented. The medical management team has immediate leverage via the issuance or withholding of an authorization to incentivize the provider's timely response to ongoing requests for service delivery that complies with established member care standards of treatment. When patterns of issues are identified for specific providers, Provider Representatives in the integrated health plan's Network Department may work with those providers to correct any systemic barriers to timely and effective BH service delivery.

AHCCCS QM requirements include a written QM and Performance Improvement Plan, work plan and an annual evaluation, the submission of performance measure results, multiple reports and other quality management activities that will require resources, including a full time QM Manager, a

Performance/Quality Improvement Coordinator and supporting staff. Placing the grievance and appeals function within the QM unit allows for tracking and trending of grievances and appeals and integration with other quality monitoring data (e.g., adverse incidents). Credentialing coordination and related activities can be embedded in the QM Unit or in the revamped Network Department.

In addition to required reporting and performance improvement activities, the QM Unit should also track and trend internal health plan activities (e.g., volume of service authorizations, care coordinator caseloads, daily inpatient census and readmissions reports, clinical staff documentation and telephone call audit reports) to support effective and efficient management of the health plan's operations. Because of the number and possible complexity of required reports and internal management reports, Mercer suggests that a full-time health care business analyst be added to the Quality Management Unit.

Member Services

CMDP can build on the current Member Services Unit in preparation for the management of an integrated plan. Although Member Services can reside in either Operations or Health Services, Mercer recommends organizing the unit in Health Services as it will require clinical oversight. The current call platform appears to be sufficient for future expansion in call volume. Although the number of members are the same in an integrated plan, the volume, types and complexity of calls (e.g., informational, referrals, clinical, emergency) will increase. Consequently, additional member services representatives and supervisors will be needed.

The following enhancements and resources will be required to manage the integrated plan.

- A comprehensive stand-alone CMDP website with member, provider and public information as well as the capacity to receive member and provider complaints and grievances. The CMDP website should provide access to the provider portal as well as a searchable online provider directory.
- A single direct telephone line, clearly identified on the opening page of the CMDP website, for members that is answered 24/7 with capacity for the warm transfer of calls to either a BH clinician in the Medical Management Unit or a triage nurse. BH clinicians in the Medical Management Unit can be used as clinical back-up for callers requiring access to a clinician.
- Increased FTEs (member services representatives and supervisors) during business hours and after-hours for an anticipated increase in call volume and to support 24/7 call center operations.
- The development of scripts to standardize appropriate and efficient responses to each type of call (e.g., benefit information, referral, crisis calls).

- Training in responding to each call type, including how to identify and respond to calls requiring an engagement with a clinician (e.g., calls concerning substance use disorders, callers in distress, callers expressing an intent for self-harm, callers who identify the situation as an emergency).
- Monitoring and supervision that includes monthly call monitoring and feedback and monthly or quarterly meetings with the BH Director or Medical director to review results of documentation audits, live-call monitoring and discuss clinical/crisis calls and interventions.
- A dedicated member services representative to develop digital and hard copy member informational materials, including materials for individuals with Limited English Proficiency.

Compliance

Building on the current CMDP Compliance Unit, the following reorganization, enhancements and resources are recommended to manage the integrated plan.

- Mercer recommends organizing the grievance and appeal function under other quality management activities within the Health Services Department. This change will support processing appeals as well as tracking and trending of member grievances.
- A separate Policy Coordinator position should be added to facilitate policy development, revision and review with the various functional leads in the organization, as well as track AHCCCS policy changes and timely update CMDP policies to reflect those changes. In preparation for the integrated care plan implementation, an analysis should be conducted of the applicable contract and policy standards and requirements. A significant effort will be required of both the Operations Department and the Health Services Department to identify all the policies and procedures required that address each of the AHCCCS contract and policy standards. CMDP's policies and procedures will be required as part of AHCCCS' readiness assessment tool and process during the pre-implementation period. Although policy and procedure software can expedite the policy development process (as will the development of standardized language), the development and upkeep of these documents will require significant time and resources. It will be important to have a Policy Coordinator position to track and coordinate the development of the new documents, and to track and arrange for updates as the policy and procedures require routine review or in response to changes with AHCCCS requirements.
- Mercer recommends that fraud, waste and abuse auditing and oversight be enhanced to ensure claims validation and auditing occurs across a significant sample of providers delivering BH services to children in foster care.

Claims/Encounters and Information Technology

A demonstration of the current system was not reviewed as part of the analysis because an upgraded system is planned and the current system will not be applicable for the BH integration effort. Efficiencies and expanded functions expected with the new version of QNXT, along with the care management

module, will provide CMDP the ability to sustain the current average of 10 to 14 days claims processing time due to the new system's automation, despite what is expected to be a significant increase in claims volume.

Mercer recommends that the CMDP take actions to address findings during the 2016 External Quality Review to update reason codes for adequate descriptions of all denials, adjustments with complete instructions for submitting corrected claims and for applying interest appropriately, including overturned provider claim disputes.

CMDP queries and produces reports as part of a shared service unit with DCS. Routine and ad hoc reports specific to compliance, QM and internal reports are generated by this unit. These reports include grievance system reports, claims, utilization, controlled substance reporting, prescribing practices, and fraud, waste and abuse (member abuse and provider abuse). There is a gap with information technology resources because of competing demands within DCS. In order to adequately handle expanded reporting, ad-hoc reporting and operational data needs, Mercer recommends establishing a separate reporting unit within the integrated health plan. Mercer recommends that the QNXT platform staff resources be staffed with business analysts with expertise in health care data. CMDP leadership should review all of the reports in the integrated contract, including clinical, operational and financial, and develop business requirements for report creation or modifications to current reports. These reports can then be generated in compliance with the AHCCCS contract deliverable schedule.

The expanded functions of the updated QNXT system will permit clinical Health Services staff to store clinical records, maintain records of care coordination activities and support other clinical functions in a single system. Encounters, authorizations, claims reports related to compliance and contract deliverables will be able to be generated from this new system. Many of the reports can be programmed for routine production on a daily, weekly, monthly or annual basis. With the planned QNXT upgrade, the information technology capabilities appear to be sufficient for the claims, reporting and clinical operations. However, a more thorough analysis should be conducted once the new system has been fully implemented.

Once the QNXT system is implemented, staffing resources may need to be enhanced. The Information Technology Unit currently has seven staff dedicated to CMDP. The Information Technology Unit may need to increase staff to have access to a dedicated business analyst for report development to perform data analyses of the BH authorization and service utilization data. CMDP staff will need assistance with linking business needs to identify procedures and reports to monitor and improve the integrated services delivered to CMDP members. In addition, information technology help desk services will be needed throughout business hours to support the integrated health plan employees.

Mercer analyzed the CMDP's current claims processing system for a transition to integrated BH service administration and identified the following recommendations:

- CMDP claims processing staff have knowledge of BH claims adjudication procedures as the existing staff currently process BH services covered under non-title XIX funding sources. Additional training may be needed for the specific BH services that would be integrated under the Medicaid benefit.
- The claims system contains national codes of HCPCS, CPT and diagnosis codes. Approximately two years ago, CMDP performed an evaluation to review BH services to ensure that the edits were aligned with AHCCCS' expectations, including services requiring prior authorization. System testing should be utilizing all codes for accurate benefit configuration.
- Newly contracted BH providers and the PPN, fee schedules and applicable demographics will need to be loaded into QNXT. CMDP uses the provider National Provider Identifier numbers and loads specialties, which is a standard practice of any Medicaid managed care health plan. .

Finance

During interviews, CMDP finance leadership reported that an expanded integrated care contract can be managed within the current staffing model as it was perceived that the expansion does not create additional financial reporting responsibilities. Temporary staff may be necessary during the pre-implementation period, but may not be necessary to retain once the expanded services and associated financial reports have been programmed.

Contract Management

Contract compliance and management is currently managed through the CMDP compliance unit. CMDP believes that an expanded contract can be managed with the current compliance staffing structure in place at CMDP. However tracking and monitoring of deliverables is currently administered manually. Therefore, Mercer recommends that CMDP consider the acquisition of an automated tracking software solution, such as "Compliance 360[®]", to track and monitor the expanded contract requirements and deliverables of an integrated Plan. Compliance 360[®] enables health plans to integrate and manage all compliance programs on a single system and helps maintain compliance with contract deliverables.

CMDP's Contract Compliance Officer will serve as the primary point-of-contact for all Contractor operational issues. The Contract Compliance Officer coordinates the tracking and submission of all contract deliverables, fields and coordinates responses to AHCCCS inquiries, and coordinates the preparation and execution of contract requirements such as AHCCCS' Operational Reviews (ORs), random and periodic audits and ad hoc visits. Contract compliance should create an inventory of all AHCCCS required deliverables and designate lead staff/departments/units within CMDP that are responsible for developing, analyzing and interpreting contract deliverables in advance of the deliverable due date.

In addition, MCOs typically employ a comprehensive quality management committee structure that reports to the health plan's governing board and/or executive management team and supports oversight of contracted providers as well as targeting quality improvement initiatives within the organization with the goals of improving processes and operating more efficiently. CMDP will need to designate staff responsible for provider monitoring, develop or

adopt existing monitoring tools, track and trend performance on pre-identified key metrics, and address substandard provider performance through direct technical assistance, performance improvement plans, corrective action plans and other contractual remedies.

Designated committees should include quality improvement, utilization management/medical management, network management, member services, corporate compliance, pharmacy and therapeutics and peer review/credentialing. Some, but not all of these committees, currently exist within the CMDP organization. Due to the high risk nature of BH conditions and related treatments, including seclusion/restraints, medication prescribing patterns, and the potential for adverse incidents, the Plan should develop a robust quality of care concern evaluation and resolution process consistent with the AHCCCS Medical Policy Manual, Chapter 900 requirements. Additional staffing resources will be required to support the committees (record keeping, meeting preparation and follow up), produce data and reports, conduct monitoring activities with providers and address quality of care concerns.

Behavioral Health Care Management

AHCCCS has defined members enrolled in the CMDP as having special healthcare needs and requires Contractor's to staff care management personnel who provide care coordination for members with special health care needs. The integrated health plan care managers will collaborate with other care coordinators and case managers that are responsible for the day-to-day duties of service delivery. The Contractor's care management staff's primary task is to identify and manage clinical interventions or alternative treatments for individual members to reduce risk, manage cost and help achieve better health care outcomes.

Mercer recommends that the integrated health plan's care management caseloads be tiered into three levels of acuity based on utilization and cost data (e.g., emergency room utilization, inpatient admissions and readmissions, multiple crisis episodes or out-of-home residential treatment placements or other indicators of acuity). An illustration of how the proposed care management tiers and corresponding caseload ranges is presented in the table below. Once the tier selection criteria have been established, a detailed policy and procedure should be developed that describes how a CMDP member is assigned to a care management tier and the circumstances in which a member may transition between levels. The model allows CMDP to comply with AHCCCS' standards for members with special health care needs, but allocates resources based on intensity of need and does not demand excessive staffing resources. Mercer further recommends that CMDP/CRS members (approximately 400) receive care management oversight from a staffing team through a proposed system of care functional unit and thus these members are not factored into the caseload calculations presented in the table below.

Care Manager Acuity Tiers and Recommended Caseloads

ACUITY	PERCENTAGE OF CMDP MEMBERSHIP	CARE MANAGER CASELOAD	NUMBER OF CARE MANAGERS
Tier One Care Management (intensive needs)	15%	1:200	12
Tier Two Care Management (moderate needs)	15%	1:400	6
Tier Three Care Management (less intensive needs)	70%	1:700	15

In addition to care management activities, the proposed BH Care Coordination Unit should include a Transition Coordinator to facilitate member transitions, ensuring that the member transition process between Contractors complies with procedures specified in the AHCCCS Medical Policy Manual, Chapter 520.

Behavioral Health Care Coordination

Multiple challenges are noted for children in foster care: the lack of a stable family arrangement to manage the high rates of acute and chronic physical and behavioral health conditions, the number of stakeholders involved in health care decision making, timely information sharing and the varying scope and capacity of available clinical services.³⁷

In one environmental scan of care coordination for foster children, a variety of health service delivery configurations was described that ranged from fee-for-service purchasing arrangements to managed care, and to subcontracted foster care agencies becoming health homes. However, several key elements were present in the different care coordination models for successful care.³⁸

³⁷ Medicaid Managed Care for Children in Foster Care (February 2013).

³⁸ Care Coordination for California's Children and Youth with Special Health Care Needs: Building Blocks from other States (June 2014). Health Management Associates.

- Timely initiation of contact with the child corresponding with an assessment and care plan development.
- Multiple contacts with the child/youth and caregivers. Many programs require that the care plan be reviewed and updated and that the foster family be contacted at certain intervals, such as every month or every six months.
- Care coordinator caseloads. Staffing ratios vary widely according to the characteristics of the target population. Programs focused on children with special health care needs that have caseloads as low as 1:40 and up to 1:60. The lowest caseloads are found in special needs populations such as foster care children, where the ratio is 1:22 for nurses and 1:25 for social workers.

Very little research exists on care coordination models for foster children. About half of the foster children have been moved under managed care in the United States, whereas 66% of the general Medicaid population was enrolled in a managed care program in 2014.³⁹ Much of the analysis and research has focused on the transition from fee-for-service to managed care payment models. However, a theme emerged in the literature regarding the importance of the stability of the foster or kinship family placement to support the child's mental health, resiliency and educational outcomes.⁴⁰ Consequently, care collaboration models that support the stability of the foster or kinship placement will contribute to positive outcomes.

Mercer reviewed information and conducted interviews with the current BH contractors related to care coordination staffing models, as well as provider monitoring and oversight resources and approaches. Though each Contractor is responsible for an expanded children's Medicaid population, the two illustrations presented below can be modified to target the specialized CMDP population that will constitute the integrated plan's membership.

BH Contractor – System of Care Team

The Central GSA BH Contractor oversees the BH delivery system for CMDP members through a Child Welfare Team in the System of Care Department. This team has a total of 11 full-time staff, including a manager, a liaison, a coordinator, four care coordinators, a transition age youth (TAY) coordinator and three special projects staff. The team collaborates with other resources within the RBHA as needed. When a CMDP member is initially enrolled with

³⁹ New Analysis Finds that More than Half of Foster Children Enrolled in Medicaid Managed Care. January 2016. *Open Minds*. Athena Mandros.

⁴⁰ Successful Academic Achievement Among Foster Children: What Did the Foster Parents Do? Anette Christine Iversen & Bente Moldestad Pages 356-371 | Published online: 13 Jul 2016.

the Contractor, the foster parent may be directly transferred to the System of Care Department for more immediate assistance. Three dedicated system of care team members respond to inquiries during business hours and are on call to support the Contractor's after-hours member services line.

The system of care team operates across multiple levels of the Children's BH delivery system identifying gaps in the provider network, providing technical assistance for CFTs, overseeing providers who work with the foster families and the DCS stabilization teams, and facilitating provider education and training. One example of a current initiative is to identify at-risk children and enroll them and their families before DCS must act to intervene. Other network development and enhancement activities include support for a birth to five initiative and the development of an assessment tool that evaluates safety and risk factors.

Consistent with AHCCCS policy, the system of care team ensures that a rapid response assessment is conducted via the contracted integrated crisis provider and that a warm transition is made between the rapid response team and the ongoing provider. The rapid response assessment may also generate a referral to another state agency (e.g., Department of Developmental Disabilities or AzEIP) or other needed resources in the community. The rapid response team also reaches out to the biological family and offers support.

The BH Contractor maintains a roster of providers who deliver EBPs specific to the CMDP membership and applies reinvestment funds to expand EBPs by training providers. The system of care team conducts chart audits of providers to verify that EBPs are being delivered appropriately and to fidelity. The BH Contractor has co-located personnel in DCS offices, which facilitates the initiation and ongoing work of child and family teams.

Children's Rehabilitative Services (CRS)

As a statewide contractor, service delivery and management occurs primarily in the four MSICs as described in *Section 5, Network Development, Management and Expansion*. The Contractor co-locates clinical liaisons (to assist with care coordination and address barriers to accessing care) and high risk case managers at each MSIC. The Contractor distributes daily utilization reports to the MSICs to further support effective care coordination for this high needs population. Penetration of behavioral health services has been increasing over the past 12 months, and the Contractor recently reported a 33% BH service penetration rate associated with the CRS/CMDP population. The Contractor notes that this population requires intensive and ongoing care coordination. During a recent interview, the CRS Contractor reported a current CMDP/CRS membership of 388, while noting a declining enrollment trend over the past two to three quarters.

The two BH Contractor examples of how each managed care plan has organized approaches to care coordination, monitoring, program development and contract oversight provides insight into the types of activities needed to manage the CMDP BH service delivery system and can serve as models for the CMDP integrated plan's staffing plan and approach to network management.

Child and Family Team Practice

The Child and Family Team (CFT) model is a version of the nationally recognized high fidelity wrap-around, an intensive case management approach for individuals with involvement in multiple government agencies and the health care delivery system. The current AHCCCS CFT Practice Protocol designates responsibility for facilitating the CFT to the BH provider or BH medical home with participation of all involved stakeholders. As the level of the child's complexity of needs vary, so does the intensity of the CFT involvement and corresponding treatment interventions. The CFT engages in the following activities

1. Engagement of the Child and Family,
2. Immediate Crisis Stabilization,
3. Strengths, Needs and Culture Discovery (SNCD),
4. CFT Formation/Coordination of CFT Practice,
5. Service Plan Development,
6. Ongoing Crisis Planning,
7. Service Plan Implementation,
8. Tracking and Adapting, and
9. Transition.

The training and skill level of the CFT facilitator is an important component of the success of the CFT team, the quality of the resulting treatment plan and service implementation, and successful utilization of crisis planning to de-escalate re-occurring crisis behaviors. Per the AHCCCS Medical Policy Manual, Chapter 1000, Policy 1060, AHCCCS Contractors are required to deliver training on CFT practice. Under the integrated health plan, CMDP Provider services may elect to specify CFT facilitator training requirements and competencies, or issue guidelines pertaining to expectations of facilitator competency in facilitating effective CFTs. Given the emphasis of the of the CFT model as a core component of the children's service delivery system, training and competency expectations should be a high priority. Oversight of the CFT process will include application of the Arizona Children's System of

Care Practice Reviews and the integrated health plan will require staffing to support the ongoing training and coaching of facilitators as well as the fidelity reviews of CFT practices.

Recommendations: CMDP Care Coordination

Mercer recommends the establishment of a BH system of care team within the integrated health plan that serves to monitor the BH health care delivery system, perform engagement and training with stakeholders, coordinate care and provides technical assistance to individual members and providers. The recommended staffing configuration for the system of care team includes 8 Support Coordinators who report to a System of Care Manager. The support coordinators are recommended to be regionally based and co-located at existing DCS offices. The support coordinators provide technical assistance to providers, intervene in CFT meetings as needed and function as BH consultants for DCS case workers. In addition, the support coordinators are responsible for identifying network gaps and/or provider performance issues. If confirmed, the concerns are brought to the attention of the System of Care Manager for elevation to the Network Administrator, as needed.

Under the proposed model, the four CRS/CMDP co-located clinical liaisons would be maintained at each of the MSICs. The clinical liaisons serve as the primary point of contact for the clinics and the integrated health plan. The clinical liaisons will provide care coordination for CRS/CMDP members and would be supported by up to 6 CRS/CMDP support coordinators, who may also be regionally located in the clinics or in the DCS offices.

Under the proposed care coordination staffing model, Mercer recommends several liaison positions: a Justice System Liaison, a Court Coordinator, and a Tribal Coordinator. Each of these positions interfaces with care managers and support coordinators; performing care integration activities related to the liaisons' specialty focus area. Another centralized function under the integrated health plan is cultural competency programming as well as various advocacy positions, including a member advocacy administrator, a CRS/CMDP member advocate, a child BH member advocate and an individual and family affairs administrator, who oversees up to five regional family liaisons. Family liaisons are individuals with lived experience with the CMDP as either foster/kinship, adoptive or biological parents and were recommended staffing positions within the integrated health plan by participants of the stakeholder informational meetings (*See Chapter 10, Stakeholder Informational Meeting Summary*).

Training Requirements

Staff in all functional units of the CMDP integrated health plan will require significant training in job related areas, including clinical and operational topics, as well as in managed care principles. Member services representatives will require training on the use of standard call scripts, inter-rater reliability for consistently categorizing grievances and inquiries, crisis response and warm transfers as well as policy updates on enrollment, benefits and referrals. Clinical supervision and training for the Medical Management Department should include a combination of rounds, group supervision and individual supervision as well as ad hoc consultation with doctoral level staff and supervisors. An annual BH training plan should be developed by leadership to capture emerging clinical BH topics and clinical staff should have access to online clinical training. Annual inter-rater reliability training and testing should

be required of all licensed utilization review and care management personnel to promote uniform application of medical necessity criteria and level of care guidelines for BH services. Providers will also require training and additional BH provider support including education, technical assistance, face-to-face meetings, and training regarding the purpose of claims edits, and claims processing.

RECOMMENDED STAFFING RESOURCES FOR THE INTEGRATED HEALTH PLAN

A substantial risk to assume operations as an integrated health plan is that CMDP's administrative cost allocation may not be sufficient to cover the expenditures to support the capital needed to manage and administer an integrated health plan. As recently reported by CMDP leadership, the existing health plan operations have been challenged to meet current contract expectations for the administrative cost percentage (no greater than 15%). Coupled with declining trends of CMDP enrollment (down 18% in the past 18 months) and heightened expectations from AHCCCS to reduce the administrative cost percentage to 10% in future integrated care contracts, CMDP's membership may not be adequate to financially sustain the Plan's expenses and operations.

A correlated risk is that DCS/CMDP, as a state agency, must utilize the Arizona State Personnel Salary Schedule and Grade Listing. While an exception process exists, the most salary ranges published in the salary schedule do not reflect market-based competitive pay for the staffing positions that the integrated health plan will need to be successful. Salary disparities or more pronounced for positions that require specialized clinical training, clinical credentials and/or extensive years of managed care experience.

Typically when a health plan implements a new contract, employees from the relinquishing vendor are available for hire. This scenario affords the new health plan an available pool of knowledgeable employees from which to hire. In the transition from the current BH contractors to the CMDP, a cadre of qualified employees will not be available to CMDP as the existing BH Contractors must retain most staff to support other children system lines of business. Recruiting a team of robust BH managed care personnel will be challenging due to both issues: relative low and non-competitive salaries and a lack of available, qualified and experienced talent.

The following staffing table includes key functions, position titles, qualifications and projected grade levels for the proposed staffing model needed for CMDP to operate as an integrated health plan. Grade level is based on expectations that the position can be filled per the corresponding ADOA salary schedule. However, an analysis of the ADOA salary schedule revealed that many of the recommended position salaries are not comparable to monetary compensation packages offered by commercial or private managed care organizations. Job titles presented in *italics* within the table are positions required as part of AHCCCS' Complete Care Program Contract. Please note that staff positions without a proposed number of FTEs indicate that a CMDP staff person currently occupies that position. Regionalized staff should include: care management, transition specialists, support coordinators, clinical liaisons, CRS/CMDP support coordinators, family liaisons, provider representatives and provider contractors during the implementation stage of securing the provider network. All other staff should be assigned to the central CMDP office.

Clinical Operations Reports up through the Chief Medical Officer

	KEY FUNCTIONS	STAFFING	QUALIFICATIONS	GRADE
Member Services	Manages a single toll- free telephone line for integrated services	Member Services Manager	Bachelor of Arts (BA) and call center experience in health services. 3–5 years managerial experience.	Gr.20 AUN06656
	Call Center with information for CMDP members regarding BH benefits; intake of grievances, provide referrals; warm transfer of BH crisis calls to Licensed BH clinicians in medical management or to a triage nurse	8 FTE Member Services Representatives during business hours. 12 FTE Customer Service Representatives to answer phones after hours and weekends.	BA strongly preferred. High school diploma or General Education Diploma (GED) required. A minimum of one year customer service experience or experience in health care services.	Gr.16 AUN08299
	Create member informational materials, including for members with Limited English Proficiency	1 FTE Member services specialist	BA and at least one year experience in health care member services.	20 AUN06921
Medical Management: BH Utilization Review	Medical BH Oversight	1 FTE BH Medical Director	Board certified. Arizona licensed Medical Doctor (MD) or Doctor of Osteopathic (DO). Preferred Child Psychiatry.	01 AUN03848
	Oversight of physical health (PH) and BH programs	Children's Health Care Administrator	Arizona Licensed Health Care Professional; expertise in Children's PH and BH health care systems. Must report to Chief Medical Officer (CMO).	26 AUN04960
	Management of all Medical Management functions	Medical Management Manager	Registered Nurse (RN) or Physician Assistant (PA); Experience in PH and BH UM, reports to Children's Healthcare Administrator.	25 AUN05490

	KEY FUNCTIONS	STAFFING	QUALIFICATIONS	GRADE
	Direct oversight of BH medical management teams	1 FTE BH Medical Management Manager	Independently Licensed BH clinician or RN with 5–8 years BH clinical experience, BH UM experience and management experience. Reports to Medical Management Manager.	24 AUN06475
	BH Prior Authorization, Concurrent and Retrospective Review	2 FTE UM Supervisor	Independently Licensed BH clinician or RN with 4–7 years BH clinical experience and BH UM experience. Reports to Medical Management Manager.	23 AUN04496
		16 FTE Prior Authorization Staff	Independently licensed BH clinician or RN with at least 3 years clinical experience, 0–2 years' utilization management experience. Reports to UM Supervisor.	22 AUN04883
		12 FTE Concurrent Review Staff	Independently licensed BH clinician or nurse with at least 3 years clinical experience, 1–2 years utilization management experience. Preferred: inpatient experience. Reports to UM Supervisor.	22 AUN04883
	Clinical Leadership, BH Clinical Guideline Development	Chief Medical Officer, BH Medical Director and Medical Management leadership		E1
	BH Pharmacy Management	Pharmacy Coordinator/Pharmacy	May be employee or subcontractor. Requires Doctor of Pharmacy and experience in BH related medications. Reports to CMO.	E1 or subcontractor
	BH Pharmacy Technician provides support to pharmacy program	1 FTE Program Specialist	At least 2-3 years pharmacy experience, Bachelor's degree preferred.	18 AUN01774
Medical Management: BH Care Coordination	Administers all disease management and acuity based care coordination	1 FTE BH Care Coordination Manager	Master of Arts (MA) level BH professional with managerial experience. Medicaid experience. Reports to Medical Management Manager.	24 AUN06475
	Supervises all disease management and acuity	2 FTE Care Coordination Supervisors	(MA) level BH professional with supervisory and managerial experience. Preferred: Medicaid experience.	23 AUN07500

	KEY FUNCTIONS	STAFFING	QUALIFICATIONS	GRADE
	based care coordination		Reports to the BH Care Coordination Manager.	
	Care Management for children with acuity or special needs	33 FTE Care Management Staff	A bachelor's degree in a health or human services field or RN with one (1) year experience working directly with individuals with behavioral health issues.	20 AUN04075
	Oversee and coordinate all member transition issues	1 FTE Transition Coordinator	At least BA level healthcare professional with BH experience.	20 AUN04075
	Oversee/coordinate Transition Age Youth (TAY) transition	1 FTE TAY Care Coordinator	At least BA level healthcare professional with BH experience.	20 AUN04075
	Support all transition activities	3 FTE Transition Specialists	Provides supporting care coordination for ETI, out of state transitions, and TAY transitions	19 AUN03242
	Provide a 24/7 nurse triage line available for all members for PH and BH services	6 FTE Triage Nurses ⁴¹	BA and RN required, with 2–4 years' experience in PH and BH. Preferred: managed care or triage experience. Reports to CMO.	20 AUN04075
System of Care (SoC)	Oversee, monitor, and support the SoC at network level, provider level and individual level	1 FTE System of Care Manager	MA level BH professional with supervisory and managerial experience. Preferred: Medicaid experience. Reports to Children's Healthcare Administrator.	25 AUN05490
	Support provider education and intervene in CFT meetings as needed	8 FTE Support Coordinators ⁴²	A bachelor's degree in a health or human services field or RN with one (1) year experience working directly with individuals with mental health issues. Reports to SoC Manager.	20 AUN04075

⁴¹ Response guidelines will need to be developed.

⁴² Current BH Clinical Coordinators can be used in these positions.

KEY FUNCTIONS	STAFFING	QUALIFICATIONS	GRADE
Provide care coordination for Children Rehabilitative Services (CRS) members with clinical liaisons co-located at each of the MSICs	4 FTE Clinical Liaison (1 at each MSIC)	Licensed Bachelor of Social Work (LBSW), RN or a bachelor's degree in health services with experience working with medically fragile children. Reports to SoC Manager.	20 AUN04075
With Clinical Liaisons, provides care management services for CRS members	6 CRS Support Coordinators	LBSW, RN or a bachelor's degree in health services with experience working with medically fragile children. Reports to SoC Manager.	20 AUN04075
Communication with the Justice System; tracks and coordinates court ordered evaluation and treatment	0.5 FTE Justice System Liaison 0.5 FTE Court Coordinator	BA level healthcare professional with BH and justice system involvement. Preferred: Medicaid experience. Reports to Cultural Competency Coordinator.	21 AUN09027
Advocacy program that supports biological, kinship and foster families	0.5 FTE Member Advocacy Administrator	1-3 years' experience in healthcare advocacy, managerial experience. Reports Cultural Competency Coordinator.	21 AUN09027
	0.5 FTE CRS Member Advocate ⁴³	BA and 3 years health care experience or combination.	19 AUN03200
	0.5 FTE Child BH member advocate	BA level and 3 years of BH experience or combination. Both positions report to Member Advocacy Administrator.	19 AUN03200
Coordinate with AHCCCS Office of Individual and Family Affairs to promote	0.5 Individual and Family Affairs Administrator	Has lived experience of receiving BH services, navigating the public BH public health system. Preferred: family member of CMDP member. Reports to Cultural	21 AUN09027

⁴³ Current BH Clinical Coordinators can be used in these positions.

	KEY FUNCTIONS	STAFFING	QUALIFICATIONS	GRADE
	member and family support programs		Competency Coordinator.	
		5 FTE Family Liaisons Regionally based	Family members of CMDP members. Reports to Individual and Family Affairs Administrator.	17 AUN04071
	Promotes services and programs to improve the health of American Indian members	.5 FTE Tribal Coordinator	Experience providing leadership in one of the Arizona Tribes, preferred: experience in health care.	21 AUN09027
	Implementation and oversight of the Contractor's Cultural Competency Program, creation of the Cultural Competency Plan	Cultural Competency Coordinator	BA or MA degree in health related field with 3–5 years' experience with developing and implementing cultural competency assessments, monitoring and/or training. Reports to the System of Care Manager.	23 AUN04496
Quality Management (QM)	Ensures quality of care (QOC), conducts investigations and reviews. Implements process improvements. Resolve, track and trend QOC grievances	1 FTE Quality Management Manager (may not have more than one title)	RN, MD, PA or Certified Health Care Quality and Management (CHCQM) or Certified Professional in Health Care Quality (CPHQ) (contract requirement). 3–5 years behavioral health experience required. Reports to the Chief Medical Officer.	25 AUN04173
	Develop/implements performance improvement projects (PIPs), develops intervention, reports performance measures	1.FTE Performance/Quality Improvement Coordinator	CPHQ or CHCQM, comparable education/ experience in health plan data and outcomes measurement (contract requirement). 3–5 years behavioral health experience required.	23 AUN03124
	Managing and	Dispute Manager	MA; 3–5 years' experience or an equivalent combination	22

KEY FUNCTIONS	STAFFING	QUALIFICATIONS	GRADE
adjudicating all member grievances and appeals; provider disputes		of education and experience. Knowledge of Medicaid regulations. Preferred: BH experience.	AUN04496
Processes, investigates, resolves and tracks grievances. Coordinates appeals documentation, tracks and trends denials and appeals, and assembles materials and coordinates State Fair Hearings.	Grievances and Appeals Coordinator		21 AUN09023
Supports Quality, PIP, and Grievance and Appeals	5 FTE QM and PIP staff	BA in healthcare and 1-2 years healthcare experience. Quality experience preferred.	20 AUN08301
Responsible for the design, collection, compiling, validating, analyzing and reporting of various clinical and operational data sets; Supports clinical decision making through established teams and the analysis of relevant clinical and benchmarking data	1.FTE Health Care Analyst	Bachelor's Degree in computer science and mathematics. Plus experience in clinical or operational health care analytics and data management is required or an equivalent combination of education and experience is required.	23 S10073

Business/Administrative Operations Reports up through Chief Operations Officer

	KEY FUNCTIONS	STAFFING	QUALIFICATIONS	GRADE
Contract Management/ Compliance/ Policy	Implements and oversees the Contractor's Compliance Program. Monitors compliance with federal, state, and local regulatory requirements. Coordination of the tracking and submission of all Contract deliverables, fielding and coordinating responses to AHCCCS inquiries, coordinating the preparation and execution of Contract requirements such as Operational Reviews (ORs), random and periodic audits and ad hoc visits	Corporate Compliance Officer	Bachelor's degree in a related area. Typically requires at least 4–7 years of related experience in health care. Relevant license (i.e., law, MD) and Certified Professional Compliance Officer™.	01 AUN07373
	Responsible for policy tracking, facilitating policy review and maintaining current policies and procedures in coordination with other department leads	1 FTE Policy Coordinator	Bachelor's degree in related field. Experience with Medicaid program requirements, policy and procedure review and project management.	24 AUN09020

	KEY FUNCTIONS	STAFFING	QUALIFICATIONS	GRADE
Reporting/ IT/ Claims	Ensures the information technology technical functions are operating reliably and accurate for all data exchange elements	Information Systems Administrator (can be a shared service with DCS)	Master's degree with 10+ years of experience managing an IT Department.	26 S10078
	Ensures prompt and accurate claims processing	1 FTE Claims Administrator	BA with 8 years of experience with claims processing and policy and procedure development.	25 AUN05673
	Ensure that AHCCCS reporting requirements are met	1 FTE Encounter Manager (may be combined with claims administrator if qualified)	BA with At least 5 years' experience with 837 and NCPDP Medicaid encounter submissions.	25 AUN05673
	Provide and monitor routine and ad hoc internal and external reports; conducts data validation audits	1 FTE Health Care Information Specialist	Data analyst with 3–5 years of health care reporting experience and proven track record of working with clinical and business professionals.	23 AUN09042
	Educate providers of claims processes, resources. Tracks and trends provider calls, improves provider satisfaction	1 FTE Provider Claims Educator	BA and 3–5 years in providing provider claims education; tracking and trending data and provider services.	21 AUN06579

	KEY FUNCTIONS	STAFFING	QUALIFICATIONS	GRADE
Network	Network Development and Management	1 FTE Network Administrator	8 years in healthcare network development and management, including BH networks and VBP contracting. BA, Foster Care experience preferred. At least 3 years indirect managerial experience.	26 AUN04960
	Provider Contracting/ Management	3 FTE Provider Contractors	3–5 years in contract negotiating, VBP experience, BH preferred.	24 AUN02035
	Credentialing	1 FTE Credentialing Coordinator/manager	3–5 years provider contracting or credentialing experience. BH preferred.	21 AUN09027
	Credentialing Staff	4 FTE Credentialing Staff	3–5 years health care provider experience.	20 AUN08301
	Provider Management/Services	Provider Services Manager	2–4 years provider services experience; 5 years managerial experience. 1 year BH provider services experience.	22 AUN04850
	Provider education, services, monitoring, EBP audits and monitor report rapid response timelines, monitor calls to foster care hotline and process AHCCCS Contractor Operations Manual deliverables	15 FTE Provider Representatives (5 of these dedicated to RR related activities)		20 AUN09027
	Provider Manual/ Communications and Provider Training	1 FTE Provider Communications and Training	1 year provider training, education; 3 years course development and design.	21 AUN04866

	KEY FUNCTIONS	STAFFING	QUALIFICATIONS	GRADE
Surge Staffing for Network Development ⁴⁴	Manages Implementation of Network	1 FTE Network Contracting Manager	8 years in BH Network Development and Management, BA, 2-3 years implementation manager of large scale networks.	26 AUN04960
	Initial contracting with BH providers	12 FTE Provider Contractors	3–5 years in contract negotiating, BH preferred.	24 AUN02035
	Initial oversight and coordination of credentialing with new BH providers	12 FTE Credentialing Staff	3–5 years healthcare provider experience.	20 AUN08301
	Upload provider contract information into data system	5 Data Entry Operators	High School diploma or GED; 1-2 years' experience healthcare data entry.	16 AUN08003

⁴⁴ Options to surge staffing include delegating the task to a subcontractor or administrative services organization or buy/lease an existing network. CMDP may also accept credentialing from RBHAs in order to phase in credentialing tasks, although attendant risks should be evaluated.

7

DEVELOPING ENHANCED PERFORMANCE MEASURES

ANALYSIS OF CURRENT AHCCCS PLAN SYSTEM PERFORMANCE MEASURES

Mercer completed a comprehensive analysis of the AHCCCS contracts with CMDP and the RBHAs, the CMDP Medical Management Plan, the CMDP QM Plan, CMDP performance metric reports, RBHA QM Plans, RBHA performance metric reports, and the CRS statewide Contractor QM and evaluation reports.

AHCCCS sets forth its performance measure requirements in contract and policy. Certain requirements apply based on the services the contractor is providing (e.g., CMDP is measured primarily on access to physical health services, RBHAs are measured on AHCCCS to BH services). Across all performance categories, AHCCCS typically establishes minimum and targeted goal performance standards and dictates the calculation and reporting format of its required measures. Performance metrics are established to measure how well contractors are assuring the delivery of care to their members in accordance with AHCCCS requirements. This may include how well the plan is operating and ensuring the application of managed care principles, as well as assuring access to care through appropriate provider availability and member-level appointment access and service utilization (which includes traditional “performance measures” such as those that measure certain types of visits, immunizations, hospitalization, etc.).

Current metric categories being managed by CMDP include utilization management (i.e., prior authorization, concurrent review, discharge planning), provider/network availability and accessibility (i.e., appointment availability, follow-up, emergency department utilization), credentialing, claims validation, fraud/waste/abuse, Healthcare Effectiveness Data and Information Set (HEDIS) measures (i.e. well-child exams, immunizations), BH quality and coordination, and drug utilization (i.e. prescribing practicing against industry standards and expenditures).

The RBHAs and CRS statewide Contractor are responsible for a variety of metrics that apply to all the populations for which they provide services which are reported by line of business (including separately for CMDP children). Specific to individuals being treated for a BH or substance use disorder (SUD) conditions, current metric categories being managed by the RBHAs and CRS statewide Contractor include similar managed operational measures (e.g.,

utilization management, credentialing), Early and Periodic Screening, Diagnostic and Treatment (EPSDT) participation, appointment availability, accessibility and follow-up (i.e., inpatient, emergency department, BH provider), monitoring of psychotropic medication usage (i.e., utilization by drug class and tracking of the use of multiple concurrent antipsychotics). AHCCCS has also established some unique measures for the CMDP population within the RBHA and CRS Contractor contracts and policy. The AHCCCS Contractor Operations Manual (ACOM), Chapter 400, Policy 449 outlines additional requirements for BH services for children in the custody of DCS and adopted children. Measures required by AHCCCS policy, initiatives and state law unique to the foster care population and children include:

- Tracking completion of a BH assessment for children removed by DCS.
- Number of times the Contractor coordinated crisis services because a crisis service provider was unresponsive.
- Number of times initial BH Services were not provided within 21 calendar days after the initial evaluation.
- Number of times initial BH services were accessed directly by an out-of-home or adoptive parent that were provided by a non-contracted provider.
- Tracking of removal notifications monthly and year-to-date.
- Total number of calls and e-mails received by DCS Liaison related to foster and adopted children, by reason for the call, including notification of behavioral health services not provided within 21 calendar days after identified need, and a request for BH out-of-home treatment due to the member displaying dangerous or threatening behaviors.
- Children on the DCS removal list.
- Number of children referred for rapid response and number of children not referred (including number of children who were returned home within 72 hours and did not receive a rapid response and children already engaged in the BH system).
- Number of children who received rapid response within 72 hours after referral and number who received rapid response outside 72 hours.
- Number of children sent to DCS/CMDP requesting efforts to enroll in BH after reconciliation of the list.
- Total number of children on removal list and those identified as removed with no referral to rapid response, receiving a BH service
- Number of children receiving the required monthly service in the first six months after removal.

The following measures are AHCCCS requirements which apply to the broader children's population inclusive of CMDP. These have been called out because Mercer has identified these as particularly important for the CMDP population and the integrated health plan.

- Increase the number children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the 12 months preceding their first, second or third birthday.
- Increase the number of prescribers electronically prescribing prescriptions and increase the percentage of prescriptions which are submitted electronically in order to improve patient safety.
- Reduce the number of adverse outcomes related to over prescribing or medication errors by increasing the number of prescribers registered and accessing the Arizona State Board of Pharmacy Prescription Database prior to prescribing an opiate, benzodiazepine or muscle relaxer.

While AHCCCS generally mandates the form and methodology of the measures, based on this analysis of information submitted by the RBHAs and the CRS Contractor, there appear to be discrepancies in how the data is collected, aggregated and trended. For example, reporting on children receiving the required monthly service in the first six months after removal or not being able to disaggregate the data by the CMDP population. It is our understanding that AHCCCS is working to standardize reporting of these measures. Broadly, if the contractors do not calculate metrics the same way, this could negatively impact the ability for AHCCCS to have reliable data in which to assess the system of care for the CMDP population.

With the transition to an integrated plan, it will be important to consider how the change in system design impacts how measures are tracked and compared. The following considerations should be taken into account prior to the system transformation moving forward.

- Children/youth involved in the foster care system move in and out of the system of care. However, many of these children remain enrolled in AHCCCS.
 - Their physical health services are met by CMDP when engaged with the child welfare system or other AHCCCS acute plans (or, as of October 1, 2018, the AHCCCS Complete Care (ACC) Contractors).
 - Currently, the RBHAs and the CRS Contractor provide BH services regardless of whether the children are in out-of-home placement or returned to the home. With the move to an integrated health plan, BH services for those children will move between CMDP and the ACC Contractor. In addition, it is common for children in foster care to move to different regions of the state or between Plans. With the transition of non-CMDP children's BH services to new ACC contractors beginning October 1, 2018 and as part of the transition to an integrated plan for children in foster care under CMDP, it will be important to ensure consistency in the quality of care for children/youth by maintaining standard requirements for continuing and adding new performance measures across all Plans. AHCCCS should consider tracking service utilization and contractor performance for children who are identified to be at risk of removal, as well as for a defined period of time (e.g., 12 months) children who exit CMDP to ensure consistent and appropriate service utilization.

- AHCCCS also recognizes the risk of removal and importance of supporting parents, in addition to their children, needing BH and SUD services to ensure successful reunification. AHCCCS has established specific requirements for contractors to provide services to the parent, guardian or custodian of children at risk of removal by DCS with the goal of keeping the children in the home. AHCCCS could consider establishing performance metrics for this population related to whether those metrics are successfully meeting that goal. Metrics should collect data and monitor around parent service system enrollment, treatment participation and progress against needs.
- Based on follow-up discussions with CMDP and AHCCCS, it was reported that the current performance measures are primarily collected and trended manually. For example there is an information technology platform in place; however it is managed as a shared service with DCS. This causes delays in reporting and query development. Per AHCCCS, with the exception of claims related metrics, data is submitted via self-reported documents from the Plan. As CMDP takes on responsibility for a broader set of metrics, it will be critical for the integrated health plan to evaluate opportunities to improve the efficiency of reporting, where possible. A comprehensive information technology solution across the system will help to create efficiency in collecting, trending and monitoring performance measures across Plans for this population. In the short-term, Mercer recommends working with CMDP to ensure that the scheduled 2018 enhancements to the QNXT system are fully implemented prior to a transition to an integrated health plan. It is further recommended that the management and utilization of this system move into the CMDP operations from shared operations. More detail on the information technology system and proposed enhancements can be found in *Section 6, Staffing and Organizational Infrastructure*.

DEFINING CATEGORIES OF PERFORMANCE MEASURES (I.E., SYSTEM, PLAN, PROVIDER AND MEMBER LEVELS OF PERFORMANCE)

- AHCCCS regulates its managed care contractors, including CMDP, the RBHAs and the CRS Contractor. In turn, those contractors set expectations and monitor requirements for providers within their contracted provider networks. Contractors will often set those provider-level expectations to align with AHCCCS expectations because provider performance is critical to enabling contractors' success in meeting AHCCCS' expectations. Similarly, required AHCCCS initiatives such as VBP and Centers of Excellence are provider-specific and their success is dependent upon individual provider performance. Although CMDP currently has an open network and does not currently have similar provider-level expectations, its providers are participating in initiatives led by other contractors and therefore it is reasonable that the provider's membership (including CMDP members) would benefit. In addition, CMDP has historically performed well on its quality performance measures despite the absence of direct provider-level incentives, possibly because of CMDP's direct involvement in facilitating access to care for its members. As CMDP moves to a contracted network, the integrated health plan will need to enhance capabilities to engage in setting provider-specific performance expectations and monitoring those requirements.

For the purposes of this analysis Mercer is defining performance measures as follows:

- Macro-level measures, which generally measure system-wide (i.e., entire Medicaid populations) or large components of the system (e.g., all Medicaid adults, all Medicaid children, statewide hospital system). Performance measure categories may include quality of care (i.e., HEDIS immunization rates), access to care, financial performance, utilization and cost.
- Micro-level measures, which generally measure small groups (i.e., specific groups of evidenced-based providers) or individuals (e.g., sub-population of children in foster care by age). Specific to health care, comparisons are typically oriented to best practices or clinical guidelines. Performance measure categories may include quality of care (e.g., member experience at a provider), utilization, or satisfaction⁴⁵.

Targeted Research on National Measures/Research National Metrics Specific to the Foster Care Population

In addition to bringing the current RBHA measures into the requirements for an integrated health plan, there are unique measures that are specific to children/youth involved in foster care that impact their success and health outcomes. Mercer recommends these additional measures become requirements for the integrated health plan administered by CMDP.

- Placement stabilization – Collaboratively with DCS, measure and monitor placement disruptions on a quarterly and annual basis as part of the Plan’s QM plan⁴⁶. This is recommended because multiple placement disruptions exacerbate the experience of trauma and can impact the child’s overall health, creating barriers to the improvement of BH conditions.
- Appropriate level of care – continue to measure and monitor placement authorizations and associated approval and denial rates quarterly and annually to ensure appropriate service level match to the acuity of the child’s needs and BH conditions, and
- Individual health needs of children and youth in foster care – measure functioning and health outcomes in addition to participation. Consider the use of standardized tools to assess functioning, levels of risk, and acuity such as the Child and Adolescent Service Intensity Instrument (already part of the RBHA requirements), Early Childhood Services Intensity Instrument, Child and Adolescent Needs and Strengths (CANS) or the Adverse Childhood Experiences Study to address trauma.

⁴⁵ <http://www.hret.org/chmr/resources/cp19b.pdf>.

⁴⁶ This could be done similar to the review done as part of the joint *SB 1375 Report*, which can be found here: <https://azahcccs.gov/Members/Downloads/Resources/SB1375Report10-1-15.pdf>. There are opportunities to enhance the DCS data collection on disruptions that could provide additional detail on why placements were disrupted.

Moving to an integrated health Plan that is part of the State's child welfare system creates a unique opportunity for impacting the success of children/youth. As established through a collaborative consultation group and the Department of Health and Human Services, seven national outcomes have been developed for children/youth in the child welfare system⁴⁷. Those outcomes are as follows:

- Outcome 1: Reduce recurrence of child abuse and/or neglect.
- Outcome 2: Reduce the incidence of child abuse and/or neglect in foster care.
- Outcome 3: Increase permanency for children in foster care.
- Outcome 4: Reduce time in foster care to reunification without increasing re-entry.
- Outcome 5: Reduce time in foster care to adoption.
- Outcome 6: Increase placement stability.
- Outcome 7: Reduce placements of young children in group homes or institutions.

Based on the most current published *Child Welfare Outcomes 2010-2014 Report to Congress*⁴⁷, although improvement is noted across most measures, Arizona is ranked as performing at or worse than the national average for measures related to the rate of children entering foster care and the length of time in foster care. However based on follow-up with the CMDP leadership, DCS has demonstrated continued efforts to improve performance with these metrics through their local DCS-Dashboard. For example, the table below shows an improvement from the 2014 data on entry rate per 1,000 from 7% to 5.7%.

As DCS and CMDP take on the significant system transformation efforts of moving to an integrated health plan, it will be important to sustain this progress and keep a continued focus on these efforts. Mercer recommends continued focus on the processes that have been put in place to generate these results and to build those strategies into the system transformation plan to ensure that progress does not decline. Continued progress in this area will be important to ensure the overall success of the integrated health plan.

⁴⁷ https://www.acf.hhs.gov/sites/default/files/cb/cwo10_14.pdf#page=91.

ENTRIES INTO FOSTER CARE POPULATION ^{1,2}	FY17	FY18 YTD	JUL 2017	AUG 2017	SEP 2017
Removals	11,429	3,185	666	911	804
Removal Rate of Children from Home	9.9%	9.1	9.3	9.1	9.0
Entry Rate per 1,000 in AZ Population	5.7	4.8	4.0	5.5	4.8

Mercer recommends incorporating local and nationally-reported outcomes for children/youth in the child welfare system. Much like integrated health care, it is important to have a holistic view of children/youth in the child welfare system (i.e., not solely DCS-only and CMDP-only metrics) recognizing that all entities responsible for services to children contribute to positive outcomes children participating in the health care delivery system.

Importance of Prescribed Psychotropic Medication and the Impact on Children/Youth in Foster Care

It has been well documented that foster children are prescribed psychotropic medication at higher rates than other children enrolled in Medicaid. Psychotropic medications include antipsychotics (such as Risperdal or Seroquel), stimulants (such as Adderall or Ritalin), antidepressants (such as Prozac or Celexa) and mood stabilizers (such as Depakote)). Arizona’s own 2013 data showed that children in foster care were 4.1 times more likely to be on psychotropic medication compared to the general Medicaid population. Children in foster care were 9.5 times more likely to be on five concomitant medications than the general pediatric Medicaid population.⁴⁸ Disproportionate utilization of psychotropic drugs in foster children is concerning due to the limited available evidence on the safety and efficacy of drugs used in pediatric populations, particularly when the drugs are used in combination. While some foster children may indeed have mental health diagnoses requiring the utilization of psychotropic medications, such use must be accompanied with access to psychosocial therapies and an appropriate monitoring plan.

Arizona has implemented and continues to refine the monitoring of psychotropic drug utilization in the foster care population. The Division of Children Youth and Families (the predecessor to DCS) published a clinical guide for the use of psychotropic drugs in children.⁴⁹

⁴⁸ <https://www.azahcccs.gov/Members/Downloads/Resources/BHNeedsofChildren.pdf>.

⁴⁹ https://dcs.az.gov/sites/default/files/media/psychotropic_medications_guide_for_cps_licensed_caregivers.pdf.

AHCCCS has conducted system-level reviews of psychotropic prescribing, the most recent of which can be found here: <https://www.azahcccs.gov/shared/Downloads/News/BHNeedsOfChildrenInvolvedWithDCSPsychotropicPrescribingFINAL.pdf>.

In addition, AHCCCS has demonstrated a commitment to monitoring and reducing the prescribing of psychotropic drugs in children, particularly foster children. AHCCCS requires its contractors to track the use of multiple antipsychotic medications and report as part of its EPSDT quarterly monitoring. AHCCCS also required a clinician led medical record review of prescribers who are prescribing four or more concurrent psychotropic drugs for CDMP children as part of EPSDT reporting. These tracking requirements and monitoring activities should be continued.

Like Arizona, several organizations and states are concerned about psychotropic drug use in young children and have developed and implemented Drug Utilization Review (DUR) programs and quality measures in an effort to ensure that psychotropic drugs are prescribed and monitored appropriately for children enrolled in Medicaid, particularly foster children. Many of these measures are publicly available and could be incorporated into the AHCCCS performance metrics to enhance monitoring.

Multiple organizations have developed metrics which are available publicly for state implementation. Organizations with potentially useful metrics include: HEDIS; the Center for Health Care Strategies' quality improvement collaborative, Improving the use of psychotropic Medication among Children and Youth in Foster Care (PMQIC); the Pharmacy Quality Alliance (PQA); and homegrown state measures. Metrics related to utilization of psychotropic drugs in the foster care population fall into three general categories: low age/high dose; polypharmacy; and metabolic monitoring.

Low Age/High Dose

Metrics used in this group identify the portion of children either receiving psychotropic medications at a young age or receiving doses in excess of published guidelines. The measures can also be used to compare use of psychotropic medications in foster children with utilization non-foster children. Examples of low age/high dose measures include:

- HEDIS: the use of first-line psychosocial care for children and adolescents using antipsychotic medications.
- PMQIC: percentage of children in foster care on any psychotropic medication; percentage of children in foster care on a specific class of medication (states can choose to track antidepressant, antipsychotic, stimulant, or other classes); Percentage of foster care children under 6 years old on any psychotropic medication.
- PQA: percentage of children under age 5 using antipsychotic medications.
- Homegrown state measure examples:

- Indiana tracks the number of children using dosages that exceed the maximum FDA-approved labels and doses exceeding maximum standards as published in the medical literature (such as used in the Texas guidelines) and compares the high dose utilization in foster children to non-foster children.
- Indiana and Louisiana track prescriptions for antidepressants or antipsychotics for children less than 4 years of age and stimulants for children less than 3 years of age (IN) or less than 4 years of age (LA). Montana tracks the number of children under age 7 receiving prescriptions for atypical antipsychotics.

Arizona is currently tracking a number of low age/high dose metrics as part of the continuing efforts to monitor psychotropic drug utilization in the foster care population. Measures currently being tracked include:

- Rates of psychotropic prescription – ratio of foster to non-foster children, broken down into age groupings.
- Rates of children prescribed psychotropic drugs outside FDA-approved doses or standards published in medical literature – ratio of foster to non-foster children.
- Member and Rx Count by age group for use of drugs within psychotropic medication categories: antipsychotics, antidepressants, ADHD, mood stabilizers and anxiolytics.
- Percentage of children in foster care receiving psychotropic medication, by therapeutic class.

Polypharmacy

Metrics used in this group identify situations where young Medicaid enrollees are using multiple psychotropic medications concurrently. Use of multiple medications concurrently increases the risk for medication adverse events and may represent a coordination of care issue. The American Academy of Child and Adolescent Psychiatry (AACAP) recommends that polypharmacy regimens, particularly regimens containing multiple atypical antipsychotics should be avoided if at all possible, citing limited data on the safety and efficacy of long-term use of combination psychotropic regimens. Examples of polypharmacy measures include:

- HEDIS: Use of multiple concurrent antipsychotics in children and adolescents.
- PMQIC: Percentage of foster care children taking one or more psychotropic medications from the same class; Percentage of children on 2, 3 or 4+ psychotropic medications; Percentage of children under 6 years old on 2, 3 or 4+ psychotropic medications.
- PQA: Drug-drug interactions; could be modified to focus on mental health prescriptions.

- Homegrown measure examples:
 - Indiana tracks the number of children prescribed two or more antidepressants, two or more antipsychotics, two or more stimulants, or three or more mood stabilizers concomitantly and compares the polypharmacy utilization in foster children to non-foster children.
 - Montana tracks the number of children taking three or more psychotropic, two or more stimulants, or receiving psychotropic prescriptions from multiple prescribers.
 - Arizona is currently tracking polypharmacy metrics as part of the continuing efforts to monitor psychotropic drug utilization in the foster care population. The current report which is being updated with the most recent data includes the percentage of children in foster care taking two, three, four or five or more psychotropic medications.

Appropriate Monitoring

Metrics in this group help identify whether or not pediatric patients taking psychotropic drugs are receiving quality care, including appropriate monitoring through visits and recommended safety monitoring for adverse metabolic events, particularly for patients using atypical antipsychotics. There is a well-documented association between the development of diabetes and weight gain associated with the use of atypical antipsychotics, and regular assessments are recommended by the American Academy of Child and Adolescent Psychiatry and the American Diabetes Association to ensure that patients are not experiencing adverse metabolic changes. In addition, metrics in this group can be used to ensure that patients have appropriate access to medical and BH care in addition to prescribed medications. Examples of appropriate monitoring measures include:

- HEDIS: Follow-up care for children prescribed ADHD medication; Metabolic monitoring for children and adolescents on antipsychotics; Use of first-line psychosocial care for children and adolescents on antipsychotics.
- Homegrown measure examples:
 - California and Mississippi have measured whether or not children receiving antipsychotic medications are receiving appropriate metabolic monitoring. The HEDIS measure used is defined as the percent of children who have received two or more prescriptions for antipsychotic medications who have received blood tests for glucose/HbA1C and cholesterol/LDL-C.
 - Mississippi measures the percent of children taking antipsychotics who have not had a visit with the prescriber within a year of a prescription fill.

Experience from Other States that have focused on the Development and Enhancement of Performance Measures and Evidence-Based Practices for Children/Youth in Foster Care

There are several state examples that have implemented integrated healthcare Plan designs specific for children/youth involved in the child welfare/ foster care system. The table below lists the states with a brief description of the health Plan program. How Arizona should consider and leverage these examples is discussed in more detail later in this section.

STATE	INTEGRATED PLAN	PROGRAM DESCRIPTION
Florida	Sunshine Health Child Welfare Plan	Community based Care Integrated Health (CBCIH) was created for the specific purpose of integrating physical and BH services under the new Medicaid Child Welfare Specialty Plan with the privatized child welfare system. CBCIH has partnered with Sunshine Health to provide statewide care coordination for the health plan. The Child Welfare Specialty Plan (CWSP) is an integrated, holistic healthcare program designed specifically for foster children under Florida’s Statewide Medicaid Managed Care program. The CWSP combines physical, mental and social health care into a single, statewide integrated health solution for children involved in Florida’s child welfare system. ⁵⁰
Georgia	Georgia Families 360° SM	Georgia Families 360° SM , the state’s managed care program for approximately 27,000 children, youth, and young adults in foster care, children and youth receiving adoption assistance, and select youth involved in the juvenile justice system, launched on March 3, 2014. Amerigroup Community Care of Georgia, one of the state’s CMOs, provides health care coverage for these populations. ⁵¹

⁵⁰ <http://www.cbcih.net/>. <https://www.sunshinehealth.com/providers/quality-improvement.html>.

⁵¹ <https://dch.georgia.gov/foster-care-adoption-assistance-juvenile-justice-%E2%80%93-georgia-families-360>.

STATE	INTEGRATED PLAN	PROGRAM DESCRIPTION
New York	Bridges to Health (B2H)	The Bridges to Health (B2H) Home and Community-based Medicaid services waiver program is designed to provide children in foster care who have significant mental health or developmental disabilities, or health care needs, with services to help them live in a home or community-based setting. ⁵² New York is currently embarking on a Children’s System transformation which will bring all waivers and services (physical health, mental health, SUD and pharmacy) under a statewide integrated Plan model across 18 MCOs. Beginning in 2018 and finishing in 2019 B2H will not be separated into a separate waiver program.
Texas	STAR Health	An Integrated Medical Home where each child has access to PCPs, BH clinicians, specialists, dentists and vision services. The Plan additionally offers care coordination services to help individuals and families understand benefits, get help with appointments, find transportation assistance and identify local community resources. Training programs are also offered to provide clinical expertise and program information for families, caregivers, caseworkers and other child advocates. ⁵³

⁵² <https://dch.georgia.gov/foster-care-adoption-assistance-juvenile-justice-%E2%80%93-georgia-families-360>. <http://ocfs.ny.gov/main/b2h/>.

⁵³ <https://www.fostercaretx.com/for-members/about-star-health.html>.

STATE	INTEGRATED PLAN	PROGRAM DESCRIPTION
Washington State	Apple Health Foster Care	Coordinated Care of Washington (CCW) provides all physical health care (medical) benefits, lower-intensity outpatient mental health benefits and care coordination for all Washington State foster care enrollees through a single, statewide managed care plan called Apple Health Care Connections. Inpatient services and higher-level outpatient mental health services are provided by the Behavioral Health Services Organization in the SW WA region or the Behavioral Health Organization (BHO) in BHO regions. ⁵⁴

As part of Mercer’s national research, performance measures required for each of the state examples were compared and evaluated against current AHCCCS system performance measures. The summary below includes the categories of performance measures utilized by each State example.

Florida

Sunshine Health Child Welfare Plan

- Sunshine Health collects⁵⁵, trends and reports on pediatric and adult (those applied to the young adult population) HEDIS measures on an annual basis. The measures cover areas that include:
- Well visits by age
- Immunizations by age
- Effectiveness of care

⁵⁴ <https://www.coordinatedcarehealth.com/members/foster-care.html>.

⁵⁵ <https://www.sunshinehealth.com/providers.html>.

https://www.sunshinehealth.com/content/dam/centene/Sunshine/pdfs/Medicaid%20Provider%20Manual%20FINAL%20MASTER%20%20NG%20AHCA%20edits%20ACC EPTED%20%2012.13.17_06.05.2017.pdf.

- Access and availability of care
- Satisfaction and experience of care
- Utilization of services
- Cost of care
- Health Plan stability

Georgia

Georgia Families 360SM

- Georgia Families and Georgia Families 360SM are implementing a new contracting cycle in State Fiscal Year 2017. Based on this change, the State developed a quality strategic plan⁵⁶ outlining their targeted goals and strategies for the system. This plan covers a three year period to accommodate the contractual shift in 2017. Measures for the Georgia Families and Georgia Families 360SM program were selected from CMS' Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set), the Agency for Healthcare Research and Quality's (AHRQ's) Quality Indicator measures and HEDIS. A summary of the performance goals and strategies for Medicaid and PeachCare for Kids members include:
 - Improved Health
 - Improve access to high quality physical health, BH and oral health care
 - Increase appropriate utilization of PH and BH services
 - Improve chronic care conditions
 - Decrease low birth weight (LBW) rates
 - Use of rapid cycle process improvement/plan-do-study-act principles to achieve improvements in preventive care, birth outcomes, and chronic disease management for their enrolled members.

Smarter Utilization of each Medicaid dollar

⁵⁶ <https://dch.georgia.gov/sites/dch.georgia.gov/files/2016-Quality-Strategic-Plan-Final-6.17.16.pdf>.

- Improve member's appropriate utilization of services so that improvements will be documented in emergency room visit rates and utilization management rates.
- In collaboration with the Georgia Hospital Association's Care Coordination Council, reduce the all cause readmission rate.
- Continue payment denials for identified medically induced negative outcomes and measure effectiveness through claims auditing.
- Improve access to health care information through collaboration with the Georgia Health Information Technology Extension Center and the Georgia Health Information Network.

In addition to these goals and objectives the Georgia Families 360SM Program is required to meet the following performance measures.

- Access to care by age
- Child well visits by age
- Immunizations by age
- Sick child visits
- Dental visits by age
- Young adult access and screenings (asthma, diabetes, COPD)
- BH (7 and 30 day MH hospital f/u, utilization, depression screening, use of antipsychotics, initiation and engagement in alcohol and other drugs)
- Utilization (ambulatory, IP, readmission)
- Medication management
- Care transition
- Membership characteristics

New York State (NYS) Bridges to Health (B2H)

- The NYS B2H program has chosen to establish their performance measures to meet the CMS six assurances and related sub-assurances.
- Level of Care (LOC)
- Completed evaluation for LOC for individuals whom may be eligible.
- Reevaluate of LOC at least annually or approved in waiver.
- Evaluated with indicated and approved tools (NY-CANS).
- Service Plans (SP)
- SP address all participants' assessed needs.
- SP development is monitored by the State.
- SP is updated and/or revised at least annually.
- Services are delivered in accordance to the SP (type, scope, amount, duration and frequency).
- Participants are afforded choice.
- Health and Welfare
- On a regular and ongoing basis, the State addresses and seeks to prevent abuse, neglect and exploitation.
- Qualified Providers
- Verification of initial and ongoing of provider qualifications of required licensure and certification standards.
- P&P and verification of required provider training.
- Financial Accountability
- Financial oversight – correct coding, payment in accordance to approved waiver.
- Administrative Authority.

Texas
STAR Health⁵⁷

- Access to Care
- Access/Availability to Care by age group.
- Getting Needed Care (urgent, specialist, routine, BH Treatment, doctor rating, Plan rating, exam room wait times and experience).
- Network composition.
- Use of facilities for Ambulatory Care Sensitive Conditions (ACSC) – IP and ED.
- Use of Services.

Quality of Care

- Children’s Preventative Health (well visits by age).
- Agency for Health Care Research and Quality (AHCQR) Pediatric Quality Indicators <18 years old.

Care for Chronic Illness

- Asthma (appropriate medication and management by age group).
- BH (7 and 30 day f/u for MH hospital, prescribed ADHD Medication initiation and maintenance, antidepressants by age group).

Administrative Service

- Member complaints, appeals, member services hotline rates, nurse hotline rates, BH hotline rates.
- Network provider complaints, provider services hotline rates, clean claim adjudication rates.

⁵⁷ https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/10_1_8.pdf.

Efficiency measure of actual/expected health care use after risk adjustment

- Financial
- Revenue.
- Income as % of revenue
- Admin cost as % of revenue
- MLR

Medical Passport

- % of BH providers that treated a member and submitted monthly notes to passport (IT system).
- % of members that saw a provider that have a passport that reflects claims data.

Washington State Apple Health Foster Care

- Statewide Common Measures Set⁵⁸ goes across all populations but does not separate out child welfare children.
- Immunizations
- Primary Care and Prevention – Children and Adolescents (PCP, oral health, weight and nutrition, hearing screens, well child visits).
- BH (Mental health and substance use disorder service penetration, antidepressant medication management, MH hospital f/u, HEDIS, and medication adherence).
- Ensuring appropriate care – Avoiding overuse (appropriate testing for children with pharyngitis, emergency department visits, and avoidable use of the emergency department).

⁵⁸ <https://www.hca.wa.gov/assets/program/2016.12.20.Common-Measure-Set-Health-Care-Quality-Cost-Approved.pdf>.

- State Health Care Spending.

Apple Coordinated Care If not already included in the Common Measure Set applies all Pediatric Care HEDIS measures.

Apple Health Core Connections run by Apple Coordinated Care completed their first year. Based on their first annual report⁵⁹ additional initiatives with data measures not already mentioned include:

- BH and PH (including pharmacy) provider network expansion to address continuity of care.
- Call center metrics.
- Roll out of their Liaison program.
- Community Education Initiative for training foster parents, caregivers, social workers, BH and PH providers statewide.
- Specialized programs to impact key issues or needs being faced by the foster care population such as opportunities for encouraging prosocial behaviors, suicide and ED diversion, creating linkages for aging out youth, and addressing healthcare needs for homeless youth.

Value-Based Purchasing and Incentive Considerations

Arizona has a solid foundation and is looked to nationally for their VBP model. AHCCCS has an umbrella of VBP initiatives that can be leveraged. This includes a contract structure that has incentives and penalties tied to quality measures, identification of valued providers (based on participation in VBP initiatives), centers for excellence and E-prescribing. Utilizing this experience, possible areas to focus VBP for the integrated health plan include access to care across EPSDT requirements, rapid response, BH assessment tied to services, or improvement of the prescribing practices of participating providers.

To assist AHCCCS in considering initiatives specific to children/youth in the foster care system, there are three examples noted below from the integrated health plans previously referenced. Florida has an incentive program, Georgia has developed a VBP program being launched in 2017 and Washington has localized initiatives that could be considered for VBP arrangements in the future as the integrated health plan matures.

⁵⁹ https://www.coordinatedcarehealth.com/content/dam/centene/Coordinated%20Care/pdfs/508_AHCCYear1AnnualReport.pdf.

Florida

The Sunshine Health's Provider Quality Incentive Program⁶⁰ which is focused on increasing quality, member outcomes and closing gaps. The Plan allows providers to develop measures for this program, however providers have to support members having an active role in their care and they must address one of the six following areas:

- Access and counseling
- Routine physicals and immunizations
- Preventive and screening services
- Timely follow-up care
- Appropriate treatment
- Appropriate medication

The program is managed through the Sunshine Health Secure Provider Portal (sunshinehealth.com/login.html) which allows for progress tracking and identification of member gaps for the improvement of care.

Georgia

Georgia has been going through procurement in 2017, and as a part of this re-procurement they have identified requirements for the managed care organization to improve performance rates for at-risk performance targets. Foster care specific performance measures include⁶¹:

- Care Management – The percentage of members who received appropriate and timely contacts by their Care Coordinator according to intensity level (e.g., complex care--one face to face per month).
- Operations – percent of members with prior authorizations for PCP, dental and BH that are completed within five days of receipt.

⁶⁰https://www.sunshinehealth.com/content/dam/centene/Sunshine/pdfs/Medicaid%20Provider%20Manual%20FINAL%20MASTER%20%20NG%20AHCA%20edits%20ACEPTED%20%2012.13.17_06.05.2017.pdf.

⁶¹ <https://dch.georgia.gov/sites/dch.georgia.gov/files/2016-Quality-Strategic-Plan-Final-6.17.16.pdf>.

- BH – The percent of members readmitted to a BH facility (crisis stabilization unit, psychiatric residential treatment facility or inpatient acute care facility) within 30 days of discharge.
- BH – The percentage of enrolled members who experienced reduced BH acute care stays and increased functional status as determined according to an agreed-upon and validated instrument.

Georgia stipulated additional children’s measures, although they apply to children/youth in foster care, they are not specific to this sub-population.

Washington

The State of Washington developed specialized programs to impact key issues or needs being faced by their foster care population for the first year of the contract. As part of these initiatives, the Plan is working with providers and community organizations to create opportunities for encouraging prosocial behaviors, reducing suicide and emergency department diversion, creating linkages for aging out youth, and addressing health care needs for homeless youth. These specialized programs⁶² include:

- Care Grants – art program to support prosocial behaviors
- Zero Suicide & Emergency Department (ED) Diversion
- Adolescent 2 Adult – addressing needs for “aging out” youth
- “We Care” – Youth homeless shelter program

Recommended Performance Measures

This section outlines Mercer’s recommendations for additional performance measures as part of the transition to an integrated health plan for children/youth involved in the foster care system. In choosing the following recommendations, Mercer identified metrics that seemed to have the easiest or most feasible means for collecting the data and the greatest impact on the children/youth’s overall health care and permanency.

⁶² https://www.coordinatedcarehealth.com/content/dam/centene/Coordinated%20Care/pdfs/508_AHCCYear1AnnualReport.pdf.

Summary of Considerations

In comparing national research, State examples and the current performance measures in Arizona, both required and not required by AHCCCS, Mercer has outlined the performance measures to prioritize as part of the transformation to an integrated health plan for children/youth involved in foster care. Specific measure recommendations are then detailed below.

- Mercer recommends that AHCCCS partner with DCS to identify how the transition to an integrated health plan with integrated benefits can impact local and nationally reported outcomes for children and youth in the child welfare system. Mercer further recommends that a collaborative team comprised of representatives from DCS, AHCCCS, and CMDP come together to make recommendations on performance measures tied to impacting specified child welfare outcomes. This collaborative team will increase cross system support, which leads to a higher rate of success for performance measures.
- Utilize, to the extent practicable, nationally recognized measures that establish an existing benchmark to measure against. This allows Arizona to truly assess the individual year over year progress as well as performance against the national average. In keeping with this concept, continuing to apply adult, women (for the young adult population) and pediatric HEDIS measures is recommended. These are also measures that CMDP has experience in collecting and reporting. Other national measures to consider include:
 - Tobacco Use and Help Quitting Among Adolescents
 - Follow-up with Patient's Family After Developmental Screening
 - Pediatric All-Condition Hospital Readmission Measure
 - Continuity of Primary Care for Children with Medical Complexity
- Mercer recommends that AHCCCS and DCS/CMDP determine which social determinants of health impact the overall well-being for the children/youth and families involved in the child welfare system. Social determinants to consider are poverty level, school performance, social network and relationships, and trauma exposure for the parents (not just the children in care). In the past, Arizona collected data on National Outcomes Measures. However, AHCCCS encountered barriers with extracting data queries which resulted in utilizing a manual process to generate reports. Reassessing the ability to collect these measures in the current system which more Plans and CMDP in particular, have electronic record systems would be advantageous.
- Mercer also encourages AHCCCS and DCS/CMDP to consider monitoring health disparities for children/youth involved in foster care. Mercer recommends a requirement and process be put in place to trend and analyze all outcome data by age, race/ethnicity geographic region and as well as reporting aggregated data. This will help to better inform where the system is succeeding and where there are opportunities for improvement

Current Performance Measures

AHCCCS currently has a robust set of performance measures for all children enrolled in the Arizona Medicaid Program (which apply to children/youth in foster care) as well as measures specific to the CMDP population. In addition, there are measures currently being collected and reported by the RBHAs as a function of improving outcomes for children involved in foster care. Mercer recommends continuing these measures under CMDP to track how an integrated system is performing.

In general Mercer recommends that the current measurement of HEDIS measures for pediatrics, adults (for overlapping young adult population), and women (for overlapping young adult population) continue. All BH Contractor measures currently in place for children should be added to the integrated contract for CMDP. AHCCCS and CMDP should also continue efforts to track antipsychotic use among foster children/youth. Consistent with stakeholder feedback identified in *Section 10, Stakeholder Informational Meetings Summary*, metrics specific to the system transformation are recommended. All other metrics should be described in AHCCCS' contracts along with data collection and reporting requirements. Stakeholders further requested that monitoring and oversight during the transition continue to be managed by AHCCCS to ensure continuity of care for the children, system improvement and progress during and following the transition.

Recommended Macro-level Measures

- Measures that impact the permanency for children/youth in the child welfare system.
 - Developing a plan to address the seven national outcomes that have been developed for children/youth in the child welfare system.
 - Requiring CMDP to collect and track placement disruptions and changes (currently collected through DCS and the BH Contractor in the North GSA). Recommend this include DCS placement changes, case worker changes and service provider changes.
 - Require service plan measures to validate that the service plan address all participants' assessed needs, is updated/revised at least annually, and that the services are delivered in accordance with the service plan (type, scope, amount, duration and frequency) while still affording participants choice (youth, foster families, adoptive families and biological families as applicable per each child's situation). This measure would require tracking and trending of utilization management decisions compared against service utilization and data from randomized record reviews.
- Measures that ensure qualified providers to support the unique needs of children in the foster care system.
 - Community Education Initiative that tracks training foster parents, caregivers, social workers, BH and PH providers statewide (WA).
 - Verification of initial and ongoing of provider qualifications of required licensure and certification standards and verification of required provider training. In the case of Arizona, recommend collection and tracking of specialty services to support the complex needs of children in foster care. This could include the identification of and implementation of evidence-based practices.

- Measures that ensure that patients have access to integrated behavior health care
 - Ensuring the use of first-line psychosocial care for children and adolescents using antipsychotic medications (HEDIS)
 - Follow-up care for children prescribed ADHD medication (HEDIS)

Recommended Micro-level Measures

- Measures that ensure appropriate care would advance current system measure from access and participation to matching member need and outcomes.
 - Avoidable use of the emergency room
 - Service plan measures – assessment of need
- Measures that focus on member level improvement in their clinical conditions
 - Improvement of chronic care conditions
 - Satisfaction and experience of care
 - Measure of functioning via standardized tool (AZ can utilize the CASII and ECSII)
 - SAMHSA National Outcome Measures
 - › Abstinence from drug use and alcohol abuse
 - » Decreasing symptoms of mental illness and improved functioning
 - › Increased access to services for both mental health and substance abuse
 - › Retention in services for substance abuse or decreased inpatient hospitalizations for mental health treatment

- Measures that monitor the use of psychotropic drugs in the enrolled population
 - Continue Arizona measures outlined earlier in the report.
 - Percent of children in foster care using psychotropic medications, by class (PMQIC)
 - Polypharmacy: Percentage of foster care children taking one or more psychotropic medications from the same class (PMQIC)
 - › Monitoring: Metabolic monitoring for children and adolescents on antipsychotics (HEDIS)

- Measures that focus on social determinants of health which compliment improvement of clinical conditions.
 - Employ the collection of SAMHSA’s National Outcomes Measures (NOMs). Mercer recommends focusing on the following:
 - › Resilience and sustaining recovery
 - » Getting and keeping a job or enrolling and staying in school
 - » Decreased involvement with the criminal justice system
 - » Securing a safe, decent, and stable place to live
 - » Social connectedness to and support from others in the community such as family, friends, co-workers, and classmates

8

PROGRAM MANAGEMENT AND TRANSITION OVERSIGHT PLAN

To support the initial implementation of the integrated health plan and successful long-term outcomes, a detailed program management and transition oversight plan must be thoughtfully designed. An effective approach ensures the successful transition of the CMDP membership and maintains fiscal and programmatic stability across the BH service delivery system. In this section of the analysis, Mercer will leverage current AHCCCS contract requirements and policies that are in place to support the system transformation and present a high level work plan, inclusive of key activities and timelines.

The transition should emphasize critical operational functions and data exchanges deemed necessary to successfully complete the transition and minimize disruptions in member care. Special attention should be directed to activities and data that ensure continuity of member care, tracking and monitoring of service authorizations that carry over post transition, and activities/data to ensure the timely and accurate adjudication of provider service claims before and after the contract implementation date.

AHCCCS' READINESS ASSESSMENT TOOL AND PROCESS

AHCCCS has established a readiness assessment process and tool that serves as a monitoring and oversight mechanism when contractors are transitioning into new contracts and/or managing new populations to administer benefits. Contractor generated reports that document progress on specified evaluation elements are provided to AHCCCS periodically over the course of the transition. AHCCCS assesses the following evaluation element topic areas as part of the readiness assessment process:

- Administration Management
- Delivery Systems
- Medical Management
- Case Management

- QM/Quality Improvement
- EPSDT and Maternal Child Health
- Financial Reporting
- Claims – Provider Support
- Encounter
- Management Information Systems
- Member Services

Contractors must document progress on each evaluation element and include supporting documentation. AHCCCS monitors the Contractor's progress and indicates if each element is complete or pending (which may necessitate additional information from the Contractor). Contractors prepare status updates and present metrics and other information related to progress and challenges to AHCCCS during in-person meetings that occur periodically over the course of the transition. In addition, exchanges of critical information between the relinquishing and receiving Contractors are identified and documented on an AHCCCS Data Exchange Format (DEF) file, which includes required data formats and specifications specific to the AHCCCS eligible populations that are the subject of the transition.

The AHCCCS readiness assessment process and tool supports a standardized approach to prepare and implement successful transitions between Contractors. The process is typically activated six to eight months in advance of the scheduled effective date of the transition. However, in the context of transitioning the CMDP member population and BH benefits, additional time (up to a full 12 months) is recommended due to multi-Contractor involvement (i.e., three RBHAs and CMDP), the relative inexperience of CMDP in administering a full array of Medicaid covered behavioral health benefits, the substantial ramping up of infrastructure and staffing needed for CMDP to operate as an integrated health plan and the unique and intensive needs of adopted children and children in foster care.

AHCCCS MEMBER TRANSITION STANDARDS

AHCCCS has established a member transitions policy that requires Contractors to identify and facilitate coordination of care for members during transitions between Contractors, including changes in service areas, subcontractors, and/or health care providers. AHCCCS has identified members

enrolled in CMDP as persons designated as having special health care needs⁶³. Members designated as having special health care needs have serious and chronic physical, developmental or behavioral conditions requiring medically necessary health, and related services of a type or amount beyond that generally required by other Medicaid eligible members⁶⁴.

AHCCCS' Member Transitions Policy requires relinquishing Contractors to provide relevant information to the receiving Contractor within specified timeframes based on notification from AHCCCS. AHCCCS has established an Enrollment Transition Information (ETI) form that is utilized for the transfer of information for members with extenuating circumstances, including members enrolled in CMDP and/or those with significant medical or behavioral health conditions that require ongoing specialist care and appointments. The ETI form conveys comprehensive information to support the member's transition and, includes but is not limited to, member specific demographic and clinical data (e.g., diagnoses, medications) and the member's assigned service provider(s) and contact information. In addition, the policy includes requirements for the transfer of pertinent medical records. The policy calls for additional provisions for supporting transitions of children to adult behavioral health services, procedures for members hospitalized during an enrollment change, protocols for enrollment changes for members receiving outpatient treatment for significant medical conditions, processes for the transition of medically necessary transportation and procedures that address the dispensing and refilling of prescription medications during the transition period.

As currently required under contract, CMDP must designate a staff person with appropriate training and experience to act as a Transition Coordinator. The Transition Coordinator is required to interact directly with the Transition Coordinator of the relinquishing (or receiving) Contractor for a safe, timely and orderly transition. The role of the Transition Coordinator includes:

1. Ensuring that transition activities are accomplished in accordance with AHCCCS and Contractor policies and procedures,
2. Acting as an advocate for members leaving and joining the Contractor,
3. Facilitating communication between Contractors and with AHCCCS,
4. Assisting Primary Care Providers (PCPs), internal Contractor departments, and other contracted providers with the coordination of care for transitioning members,
5. Ensuring that continuity of care is maintained during transitions, and

⁶³ AHCCCS Medical Policy Manual, Chapter 500 – Care Coordination Requirements, Section 520 – Member Transitions.

⁶⁴ AHCCCS Medical Policy Manual, Chapter 500 – Care Coordination Requirements, Section 540 – Other Care Coordination Issues.

6. Participating in AHCCCS transition meetings⁶⁵.

AHCCCS' member transition policy and contract requirements establish a uniform and efficient process to facilitate coordination of care during member transitions between Contractors. Due to children entering the foster care system and the relatively brief enrollment tenures for children assigned to CMDP, it is a fairly regular occurrence for these members to transition between other AHCCCS acute care Contractors. In addition, it is estimated that 60% to 70% of children have established relationships with another AHCCCS health plan prior to being assigned to CMDP.

After the Complete Care Program Contract is implemented in October 2018 and, later when/if CMDP becomes an integrated health plan, members will be transitioning to and from fully integrated care Contractors. The Contractor responsible for the full array of covered benefits (medical, dental and behavioral health services) will change for these members, which may or may not result in changes to the member's service provider(s) depending on the composition of each Contractor's provider network. While today's current system design includes member transitions between CMDP and other AHCCCS health plans, provider changes are less likely to occur for members transitioning to CMDP because these members can currently access any AHCCCS registered provider and the current service array administered by CMDP is limited to medical and dental services - typically resulting in continuity with the member's current behavioral health provider. In addition, the current system design affords opportunities for children in foster care and their parents/caregivers/foster parents/kinship parents to receive behavioral health services from the same provider. When/if CMDP becomes an integrated plan for foster care children, network contracting arrangements may limit these opportunities as the CMDP population will be restricted to members ages 0-17 and CMDP will manage a provider network that will predominantly serve children.

To the extent that an integrated CMDP is able to contract with a comprehensive network of children behavioral health providers, disruptions for members who may be required to change providers can be minimized when children enter the foster care system. This will be contingent on a number of factors, including the capacity for CMDP to establish a sufficient provider network, the ability to negotiate rates with specialty providers, and overcoming lengthy delays in procuring and contracting service providers.

To help mitigate potential disruptions in services during member transitions, AHCCCS has established standards for network composition that are designed to result in uniform availability and access of covered services from all Contractors serving a specific geographic area. In addition, AHCCCS policy provides, at a minimum, a 90-day transition period for children who have an established relationship with a PCP that does not participate in the Contractor's provider network and requires the extension of previously approved prior authorizations for a minimum of thirty days from the date of the member's transition.

⁶⁵ AHCCCS Contractor Operations Manual, Chapter 400 – Operations, Section 402 – Member Transition for Annual Enrollment Choice and Eligibility Changes.

To support the CMDP transition, AHCCCS should consider expanding the circumstances in which a member may be granted an extended transition period to remain with an established provider. By broadening the current policy exception to include additional provider types beyond PCPs, such as specified behavioral health providers (e.g., specialty providers, EBP programs, therapeutic placements), continuity of care for children with behavioral health needs can be extended until such time the receiving Contractor can execute a single case agreement and/or add the provider to the contracted network.

PROGRAM MANAGEMENT AND TRANSITION OVERSIGHT SUMMARY

Mercer has developed a program management and transition oversight plan (“the transition plan”) that outlines the steps that the CMDP will need to take to ensure that the transition to an integrated health plan is effectively coordinated and ultimately successful. The transition plan describes the tasks, timelines, and a summary of considerations that should be addressed for each of the identified activities.

The transition plan and related action steps are intended to be coordinated with AHCCCS’ established readiness assessment tool and member transition protocols, which overlap with a number of the tasks identified in the transition plan. Please note that some of the tasks listed have overlapping timeframes and that the order of recommended activities is not intended to be sequential in terms of implementation. A summary of the general “task types” is presented below.

Funding and Regulatory Changes

Tasks associated with funding and necessary amendments to regulations include estimating startup and ongoing operational costs and implementing strategies to coordinate a significant effort at the legislature with the Governor’s Office’s backing and support. DCS budget projections must be finalized in September 2018 in advance of the 2019 legislative session. DCS would need to initiate amendments to applicable administrative rule packages beginning in July 2019.

Communications

The transition plan includes references to a communications plan and recommended timing to initiate communication protocols. Recommended communication methods include member and family member newsletters, provider newsletters, public forums, website postings, media announcements (e.g., press releases), talking points for DCS caseworkers, scripts for CMDP member services agents and provider bulletins. Targeted audiences include foster families/kinship families, parents with adopted children, advocacy groups, DCS administrators and caseworkers, CMDP staff, providers and system stakeholders. Mercer recommends that the communication plan be developed and activated at least one year in advance of the implementation date with scheduled releases of increasingly detailed information as the implementation date draws closer. For example, general announcements regarding CMDP’s intent to move to an integrated health plan could be disseminated initially, with more comprehensive descriptions and details released as transition milestones are achieved. Communications will need to encompass a variety of methods, written communications must be available in prevalent Non-English languages, and strategies need to consider and leverage available DCS and CMDP resources statewide.

Network Development

Network development activities represent one of the more significant challenges for CMDP to establish itself as an integrated health plan. Network development activities reflected on the transition plan include an upfront analysis of the existing BH Contractor's network currently in place to meet the BH needs of children in foster care and adopted children. Mercer recommends that CMDP obtain statewide utilization data for the CMDP population and analyze the data by provider type, volume of covered services, geographic service area and frequently accessed specialty providers.

In addition to the BH network development activities, CMDP will need to develop written agreements with the current preferred provider network for physical health and dental services, adding to an already enormous effort. CMDP will also need to develop model provider agreement templates that reflect AHCCCS' minimum subcontract requirements.

Staffing Resources

CMDP will need to secure the necessary staffing resources and the requisite funding to support ramping up personnel in advance of PM/PM capitation payments to support the health plan's operations. Even if this obstacle is overcome, CMDP will be confined by the current ADOA salary schedule that establishes uniform compensation ranges for all State personnel. This will likely limit CMDP's ability to attract qualified network staff that are necessary to oversee and implement a large scale procurement of a statewide network of behavioral health providers.

To address the transition period capital deficit, DCS can request pre-implementation funds as part the agencies annual budget proposal and/or AHCCCS may be able to pass through supplemental PM/PM payments in advance of the implementation date. In addition, while the ADOA publishes a personnel salary schedule, state agencies can exercise an exception process with sufficient justification for why the high point of the salary schedule should be exceeded. However, this process is intended to be applied on a case-by-case basis and may not be practical to secure the number of key staffing positions that the integrated health plan will require.

In similar large scale transitions, it is relatively common for managed care organizations to hire a group of temporary staff to support the intense effort needed at the front end of establishing a provider network. This pre-implementation staffing team includes staff to support provider rate negotiations, contracting, credentialing related activities and loading provider data into the claims processing system.

Documentation, System Testing and Training

A significant effort will involve the development and revision of key CMDP operational documents. Examples include the health plan's provider manual, member handbook, policies and procedures and work process flow charts. System testing should ensue several months in advance of the implementation date and should minimally include interactions between service authorizations and the claims processing system as well as testing the information system's capability to produce the multitude of additional reports that will be necessary to support internal operations and satisfy AHCCCS contract

deliverables. Finally, a comprehensive training program inclusive of AHCCCS required training topics will need to be initiated with existing staff, new hires, providers, foster/kinship family members and community stakeholders in the months leading up to the implementation date.

Transition Activities

Several key operational processes will require oversight to successfully transition from the existing BH Contractors to the CMDP integrated health plan. AHCCCS' member transition standards will be implemented to monitor the successful transition of open grievances and appeals, pending and active service authorization requests, service claims, and open quality of care concern investigations that will transcend the implementation date. Intensive attention will also be needed to ensure that CMDP members who are actively receiving behavioral health services are identified and successfully transitioned to the integrated health plan without interruptions in services.

Program Management and Transition Oversight Plan (based on an October 1, 2020 implementation date)

TASK TYPE	TASK DESCRIPTION	START DATE	END DATE	CONSIDERATIONS
Funding	Estimate costs for startup and ongoing operations to inform DCS budget	April 2018	September 2018	Leverage and supplement Mercer analysis, factor member enrollment trends and sustainability of operations
Funding and Regulatory Changes	Obtain Governor's Office support	July 2018	September 2018	In accordance with established DCS/Governor's Office operating protocols
Funding	Launch campaign with legislature	December 2018	May 2019	In accordance with established DCS legislative liaison procedures
Funding	Secure DCS budget approval for FYE 2020	July 2019	June 2020	Includes startup funding to support pre-implementation resources and activities
Regulatory Change	Initiate amendments to applicable Arizona Administrative Code (Rule Packages)	July 2019	January 2020	Per DCS' established AAC review and revision procedures

TASK TYPE	TASK DESCRIPTION	START DATE	END DATE	CONSIDERATIONS
Funding	Secure upfront capital and funding	July 2019	June 2020	As appropriated by legislature
Communication	Initiate communications plan and implement communication protocols	October 2019	October 2020	Mediums: provider alerts, member newsletters, provider newsletters. Audiences: foster/kinship families, internal CMDP staff, DCS staff, system stakeholders
Network	Obtain and analyze past three years of statewide utilization data for CMDP population from AHCCCS	October 2019	December 2019	Organize by provider type, covered service, geographic service area (county) and volume
Communication	Establish ongoing meetings with current BH Contractors	January 2020	October 2020	Inquire about staffing, placement and service needs
Staffing	Begin recruitment, hiring and training of temporary pre-implementation staffing team. Staffing should include a core team of experienced managed care professionals that can represent all health plan functional units	October 2019	April 2020	Includes network staff to support rate negotiations, contracting, credentialing and data entry into the claims processing system
Network	Conduct outreach to prospective providers	October 2019	August 2020	Prioritize providers that constitute 80% of the claims volume as well as specialty providers

TASK TYPE	TASK DESCRIPTION	START DATE	END DATE	CONSIDERATIONS
Network	Develop model provider agreement template	October 2019	January 2020	Inclusive of AHCCCS minimum subcontract provisions and includes review by DCS legal representatives
Network	Negotiate reimbursement rates, validate credentialing and execute provider agreements	January 2020	October 2020	Assumes flexibility to offer rates above AHCCCS fee schedule. Credentialing contingent on reciprocity agreements with current BH Contractors
Network	Input of provider demographics and contract terms into QNTX claims payment system	July 2020	October 2020	Leverages temporary data entry staff
Staffing	CMDP finalizes staffing reorganization plan with input from core team	January 2020	April 2020	Informed by BH Contractor meetings and Mercer analysis
Staffing	CMDP begins and completes recruitment and hiring of permanent staff (post-implementation)	April 2020	October 2020	Prioritization should consider the most challenging positions to recruit as well as expertise needed to support pre-implementation activities, such as provider contract negotiations, training and document development

TASK TYPE	TASK DESCRIPTION	START DATE	END DATE	CONSIDERATIONS
Documentation	Development and revision of key CMDP operational documents	July 2020	October 2020	Documents include, but are not limited to, job descriptions, provider manual, member handbook, policies and procedures, work process flows, provider agreement templates, medical necessity criteria and clinical guidelines, QM and UM program descriptions and work plans, committee charters and meeting minute templates
System Testing	BH authorization, reporting and claims processing system testing commences	July 2020	October 2020	Ensures that BH services claim types and forms can be processed and linked to service authorization IT solution. Develop mock reports (internal and AHCCCS deliverables) using QNTX data queries
Training	Initiate training program with existing staff, new hires, providers, foster/kinship families, and stakeholders	August 2020	October 2020	Reference AHCCCS AMPM, Chapter 1060 for requisite training topics. Staff to be educated on Title XIX BH benefit, policies and procedures, work flows and new employee orientation. Providers should include existing PPN to ensure understanding of expectations

TASK TYPE	TASK DESCRIPTION	START DATE	END DATE	CONSIDERATIONS
				for referrals and coordination of care
Transition Activity	In collaboration with existing BH Contractors, identify open appeals and grievances	September 2020	November 2020	Determinations need to be made regarding which entity (CMDP or BH Contractor) will follow through with resolution after implementation date (October 1, 2020)
Transition Activity	Transition of pending and active service authorizations that will transcend the implementation date, including inpatient and residential care	September 2020	November 2020	Decision regarding when the transition of new service authorization requests will move over to CMDP. Develop system to identify existing authorizations and input into QNXT system to ensure timely payment of claims
Transition Activity	Tracking of claims payment for services rendered prior to implementation date through pre-identified run out period	September 2020	TBD	Claims run out period to be defined by AHCCCS
Transition Activity	Development of a procedure for making direct payments to providers if the claims payment system is not functional	September 2020	TBD	Smaller providers may need timely payment to stay solvent. If the implementation encounters barriers in paying claims, a back-up system should be in place

TASK TYPE	TASK DESCRIPTION	START DATE	END DATE	CONSIDERATIONS
Transition Activity	Procedures to address the resolution of any open quality of care concerns or cases under investigation for fraud, waste and abuse	September 2020	November 2020	Determinations need to be made regarding which entity (CMDP or BH Contractor) will follow through with resolution after implementation date (October 1, 2020)
Transition Activity	Process to identify and transition members who are actively receiving BH services	August 2020	October 2020	In accordance with AHCCCS' member transition policy
Monitoring	Identify key performance metrics and/or data sources to assess the ongoing success of the transition	August 2020	April 2021	Consider metrics that provide real time information and feedback, such as complaints, adverse incidents, service authorizations, timely claims processing metrics, and service denials

9

START UP AND ONGOING COST FORECAST

The purpose of this section is to present an estimate of startup and ongoing costs and the financial effects of required tasks for CMDP to operate as an integrated health plan. *Section 6, Staffing Requirements and Organizational Infrastructure*, identifies necessary personnel to accomplish the integration of behavioral health services within the CMDP organization and outlines the departmental conclusions regarding necessary staffing. *Appendix B – Cost Forecast Model* utilizes those conclusions and calculates an aggregated estimate of the new costs (personnel and non-personnel related) necessary to successfully accomplish the transition to and sustainability of an integrated health plan.

The integrated health plan staffing positions as detailed in *Section 6, Staffing Requirements and Organizational Infrastructure* were compared to the ADOA's published Job Titles and Pay Ranges found at the following link: http://hr.az.gov/ClassComp/CC_Job_Titles_with_Ranges.asp. Job codes were assigned to each position and the related "Hourly Mid" rate was used to calculate annual compensation amounts. Based on discussions with State staff, a tax and benefits burden rate of 42% of compensation per position was applied to arrive at the fully loaded cost of new personnel needed as part of the integrated health plan.

Assumptions used to estimate costs of supporting the personnel which included items such as office space, technology, and travel costs were based on available information, including cost per square footage reports for the Phoenix metropolitan area from outside sources. In addition, pre-implementation surge staffing costs were estimated which include costs to establish a statewide contracted network. The current forecast utilizes recent enrollment information to obtain annual membership, however the model is flexible to allow for changes in estimates as enrollment figures fluctuate.

Mercer did not include full-time employee estimates in situations in which a contractually required key staff position was clearly occupied by an existing CMDP employee (same job title as the required key staff position). However, the staffing model did not include an exhaustive review of all current CMDP employees and temporary staff to determine the appropriateness of recommending those staff for new positions under the proposed integrated health plan.

10

STAKEHOLDER INFORMATIONAL MEETINGS SUMMARY

INTRODUCTION

Stakeholder informational sessions were held with providers, family members (biological, foster, adoptive and kinship) and youth/young adults currently or previously involved in the foster care system. Mercer facilitated a total of four stakeholder sessions - two in Maricopa County and two in Pima County. Attendees were also able to participate by phone which allowed individuals from all over Arizona to participate. The provider session in Maricopa County included 27 in-person attendees and approximately 10 individuals by phone. The provider session in Pima County included 15 in-person attendees and approximately 7 by phone. The family/youth/young adult session in Maricopa County included 6 in-person attendees and approximately 7 individuals by phone. The family/youth/young adult session in Pima County included zero in-person attendees and approximately 4 by phone.

Mercer provided a short introduction regarding the purpose of the stakeholder sessions and then facilitated an active discussion with attendees. During the sessions, attendees were provided with feedback sheets to provide additional written feedback and a time limited email address to submit questions directly to Mercer for inclusion in this report.

The information below summarizes the feedback and recommendations shared by attendees.

System Strengths

Attendees identified the following strengths about the current system of care for children/youth in foster care and indicated the importance of maintaining these system strengths under an integrated model of care:

- All attendees agreed that CMDP provides expedient and easy access to PH care services. All costs are covered and families appreciate the choice of providers. Providers noted that contracting with CMDP is preferable because in addition to timely access and choice, payments are also timely. If CMDP becomes an integrated plan, attendees would like to see these aspects of the system replicated for the BH network.

- The passage of Jacob's Law has resulted in an increased awareness of family and member rights and has improved access to BH services. Attending educational sessions on Jacob's Law has also helped families (including adoptive families) to navigate the system, particularly for children/youth with high needs. All attendees agree that ongoing education about Jacob's Law is critical for both families and any professionals who engage with children in foster care.
- The Central GSA BH Contractor employs a foster care liaison who is reported to be extremely effective at helping families connect families to services, addresses barriers to care and provides answers to questions that go unanswered elsewhere. The concept of employing a family liaison at the health plan is highly valued by both families and providers and should be replicated in an integrated design.
- The current BH Contractors provide family members direct channels to address concerns about BH services. Family members stated, "When I have needed additional care, I elevated my concern to the RBHA. They were very prompt and responsive". "The RBHA helped me to navigate the system when I didn't know what to do. "Having access to the RBHA has been essential." In an integrated system, it will be important for the health plan to maintain these direct pathways for families and members to address issues that arise.
- Both CMDP and the BH system provide services specifically tailored to the unique needs of children/youth. CMDP offers specialty services that are tailored to the unique and complex needs (e.g., trauma) of children/youth in foster care. The BH system has the children's system of care that is well established and family/child centered. Attendees felt strongly that these specialty services need to be maintained under an integrated design as core tenets of a system of care.
- Community-based organizations, including family and peer-run organizations, help families to feel supported. Family members felt strongly that these organizations remain a part of any new system.

Overall, family members did not appear to have significant concerns about the concept of an integrated system. One family member stated, "I think having one system will be great. Having only one place to access care will be helpful."

THEMES

The sessions also generated questions and/or concerns across several themes:

1. Transition of Care and Continuity of Care:
 - A. Providers and families highlighted the importance of transitions in the lives of children in the foster care system. As the system goes through a transformation to an integrated plan, attendees stated that current transitions in the lives of foster children cannot be forgotten. As a result

providers and families alike are concerned about the continuity of care when a child changes either physical health or BH plans. There is concern that providers may be required to change or if moving from one region to another there may be a loss services rendered. Such changes could exacerbate the trauma children have already experienced and impact their movement toward positive outcomes. Additional transitions pertaining to sub-populations identified by attendees include TAY and foster children who have been adopted.

- B. Attendees expressed the desire for AHCCCS to have focused oversight and manage accountability through the system transformation as well as transitions of care through contract requirements. Some areas include 1) requiring the maximum amount of time allowed under Medicaid to ensure smooth transitions for children and help ensure continuity of care during changes; 2) requiring all AHCCCS Plans to share information when a child moves in and out of foster care; 3) set up contracting to include a base set of benefits and services across all Plans to minimize service and provider disruptions when children move in and out of foster care.
 - C. Providers highlighted the need for permanency plans for TAY and for children going through adoption. This will allow for continuity of care as TAY move into adulthood and the adult system of care for PH and BH services. This will also allow for stability post-adoption to ensure access is available in schools, homes and the community.
2. Funding and Oversight:
- A. BH providers are anxious about the transition given that rates currently paid to CMDP are capped at the AHCCCS rate and BH services are more costly. Currently, CMDP is not permitted to pay above the AHCCCS rate per statute. Attendees questioned how this will be handled under an integrated plan.
 - B. Department of Child Safety (DCS)/CMDP is currently a state agency. Participants questioned how will CMDP will be financed and regulated under a new, integrated design.
 - C. Currently DCS funds non-medically necessary services (e.g., community supports, court-ordered services paid for by DCS that have been denied by the RBHA. Attendees asked how these services will be funded in the future under the requirements of Medicaid and how these services will be covered. Participants also questioned how the infrastructure will be designed to ensure continuation of services and how will block grant funds be administered.
 - D. CMDP does not have an electronic medical record. Participants questioned how CMDP will obtain the resources to finance an upgrade of their medical record system to accommodate the needs of administering a health plan.

E. BH providers in Southern Arizona expressed a concern specific to their region. Recently there have been funding reductions in BH from 25%–35% without much notice to adjust the system resulting in dramatic changes or cuts in services and to the network. Providers requested an assessment of current funding challenges in Southern Arizona prior to the integration of CMDP to help prevent further strain on the system.

3. Network Adequacy:

A. Participants reported that the current provider network lacks a sufficient number of specialists for children/youth in foster care (e.g., developmental pediatricians, trauma therapists, dental and orthodontic specialists), particularly in rural areas. This can result in significant delays in accessing services. Attendees questioned if the new system will have the adequate network capacity to provide the care children/youth need. They recommended that AHCCCS provide direct oversight to ensure system accountability for access to care. A new health plan will also need to consider geo-access and timeliness requirements that will meet the needs of children/youth in rural areas.

B. The current BH Contractors provide a concentrated set of resources and have worked hard to ensure network sufficiency. Under the new system, provider resources and funding will be spread out over multiple health plans and all network providers will be need to be educated and adequately equipped to provide care. Participants questioned how specialty BH care for children/youth in foster care will be maintained.

C. Participants noted that BH providers can bill for work associated with CFTs; however, PH providers cannot. Attendees recommended parity in billing policies for all providers who participate in care coordination related to child and family teams.

D. Currently CMDP is FFS and offers an open panel to children/youth in foster care. However, there are limitations BH and CRS service providers with the specialty expertise resulting in lengthy wait times. Attendees spoke at length about the need to consider the differences between managed care versus FFS and the impact this has on access to care. They questioned if CMDP will be required to have a contracted network and follow network management requirements of managed care systems.

4. Medical Management and Care Coordination:

A. Behavioral health providers expressed concern with the differences and variability in the development, application of and decision making related to medical necessity and PA. Key issues identified include a gap in placement decision from identified need, different requirements by Plan, not enough focus on discharge planning, and fail first approaches versus level of care matched to need. Participants reported that CMDP, in particular, currently requires an individualize education plan (IEP) as part of the PA process for physical, occupational and speech therapies. However, many children do not have an IEP or it is difficult to obtain a copy and can impact access to medically necessary services.

- B. Attendees want to ensure in a transformation to an integrated Plan that decision makers consider the experience of multiple placements for children in foster care and the families taking care of them. Further recommendations include requiring the same medical necessity criteria across Plans and statewide PA processes, assessment of current requirements and removal of any unnecessary requirements (i.e., IEP) that hinder access to care.
 - C. Families reported that they cannot access timely care on the weekends or get the assistance they need to address crises from either the high needs case managers or the crisis line on the weekends. Families are often asked to contact hospitals directly and/or seek services for a child/youth in the middle of a crisis. Access to adequate crisis services under an integrated system will be a critical component to consider as part of service delivery design.
 - D. Families highlighted that the involvement of foster care licensing agencies play a role in improving care coordination for children/youth in foster care. Licensing agencies assist families to navigate through the systems of care, attend meetings with families if needed and provide training on system-related topics. As the system transformation moves forward considerations for maintaining and increasing this involvement is requested.
5. Communication
- A. Communication was identified as critical in all provider and family stakeholder sessions. It was shared that this is important during a system transformation as well as during any other change that may occur within the day-to-day operations of the healthcare system.
 - B. Communication in advance of a change helps providers and members prepare for what is coming. However the timeframe given prior to change needs to be improved upon in order to allow providers to better plan, work with members and to ensure that there are not any unintended negative consequences. Providers specifically noted that communications about changes need to be given based on the application to current children in care versus children newly entering the system because this will impact the way in which providers need to plan and implement.
 - C. Attendees highlighted that two-way communication between BH workers that allow for dialogue and feedback has recently improved and increased. It is requested that such opportunities continue leading up to a transition to integration and going forward.
 - D. Attendees requested various modes of communication to help maximize the information reaching as many people as possible. Some ideas included the use videos and other informational graphics to educate families about changes to the system; trainings; use of social media (i.e., Facebook or Instagram); announcement through provider agencies, doctors' offices, family run organizations and licensing agencies; open feedback forums; email and text messaging. Attendees shared that for forums, in particular, the provision of transportation, childcare, food and/or more geographically centric locations would help to increase participation.

- E. Lastly, specific to the possible integration of CMDP, providers commented that the integration appears to be more of a contractual integration, not service integration. It will be helpful to provide clear communication about how integration is defined in the context of this integration effort.

11

ALTERNATIVE OPERATIONAL MODELS AND APPROACHES

AHCCCS and DCS have jointly agreed that further evaluation is necessary to explore other health care delivery models for children in foster care, such as the delegation of certain health plan administrative functions to an Administrative Services Organization (ASO), that achieves the end goal of integration while decreasing the risks and barriers that DCS/CMDP faces in trying to operate as a Managed Care Organization (MCO).

Mercer analyzed the feasibility of an ASO model or an ASO-like model designed to supplement DCS' operational capabilities to provide high quality, integrated care to children enrolled in foster care. Under an ASO model, DCS/CMDP could serve as the provider of clinical operations (i.e., utilization management, care management, care coordination and member services), while leveraging and overseeing a subcontracted entity's business, claims and provider network operations through an ASO agreement.

Below is a high level summary of considerations and potential challenges for DCS to implement and oversee an ASO model or ASO-like model to administer physical health and behavioral health services to children in foster care.

RESEARCH – OTHER STATE MODELS

In an effort to ascertain if an ASO or similar service delivery approach has been implemented in any other state, Mercer completed a nationwide review of state models targeting mandatory enrollment of the foster care population into managed care. A summary of findings derived from the analysis are presented below.

Comprehensive Managed Care Organizations (MCOs):

- The most prevalent design of health care delivery systems for children in foster care is mandatory enrollment under a comprehensive MCO. Under this model, children in foster care are integrated, along with other Medicaid-eligible children populations, into the MCOs. According to a 2014 CMS

report, “Medicaid Managed Care Enrollment and Program Characteristics,”⁶⁶ 21 managed care state programs utilize this model of care. Since 2014, two additional states, Virginia and Ohio, have moved children in foster care into managed care under a comprehensive MCO.

Stand-Alone MCO for Children in Foster Care:

- Five states; Georgia, Texas, South Carolina, Washington State and Florida require mandatory enrollment of children in foster care in a stand-alone MCO.
 1. Georgia’s program, Georgia Families 360^{67 68}, became effective in March 2014. The program serves approximately 27,000 children in foster care and select youth in the juvenile justice system. The State contracts with Amerigroup Community Care, a single care management organization (CMO), to coordinate care. Amerigroup provides case management and care coordination services, specialist referrals and utilization management (including precertification for inpatient admissions, some behavioral health services, psychological testing, certain prescriptions, rehabilitation therapies and out-of-network providers). The Plan utilizes a pharmacy benefit manager (Express Scripts) for pharmacy benefits. Initial credentialing and re-credentialing of providers is conducted through the State.
 2. Texas’ STAR Health Program^{69 70} is managed under the Texas Health and Human Services Commission which contracts with Superior HealthPlan (Superior) to manage health benefits. Managed care functions under Superior include member services, network management, billing and claims, prior authorization and grievances and appeals. Superior utilizes a pharmacy benefit manager (U.S. Script) for pharmacy management.

⁶⁶ CMS Medicaid Managed Care Enrollment and Program Characteristics 2014: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2014-medicaid-managed-care-enrollment-report.pdf>

⁶⁷ Georgia Families 360: <https://www.myamerigroup.com/ga/your-plan/georgia-families-360.html>

⁶⁸ Georgia Families 360: <https://dch.georgia.gov/foster-care-adoption-assistance-juvenile-justice-%E2%80%93-georgia-families-360>

⁶⁹ Texas STAR Health Program: <https://www.fostercaretx.com/for-providers.html>

⁷⁰ Texan STAR Health Program: http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-star.asp#glance

3. South Carolina's⁷¹ dedicated health plan for foster children is a collaborative effort between South Carolina Department of Social Services (SCDSS) and the South Carolina Department of Health and Human Services. SCDSS operates as the custodial agency for children in foster care. Under a foster care health initiative, children are either enrolled in an MCO (Select Health of South Carolina) or a Medical Home Network (South Carolina Solutions). The plan serves approximately 3,300 children in foster care.
4. Washington State⁷² contracts with Coordinated Care of Washington (CCW) to provide all physical health care benefits, lower-intensity outpatient mental health benefits and care coordination for children in foster care through a single, statewide MCO called Apple Health Core Connections (AHCC). Inpatient services and higher-level outpatient mental health services are currently provided by the Behavioral Health Services Organization in the southwest Washington State region or the Behavioral Health Organization (BHO) in BHO regions. AHCC will become a fully Integrated Managed Care Program (FIMC) across Washington in 2018. Apple Health Core Connections serves approximately 24,000 children in foster care.
5. Florida⁷³ contracts with Sunshine Health Child Welfare Specialty Plan to provide Medicaid benefits to children in foster care. Managed care functions under Sunshine Health include grievances and appeals, prior authorization, billing and claims, quality improvement and provider credentialing.

Primary Care Case Management (PCCM):

- Only one state, Idaho, requires mandatory enrollment of children in foster care in the State's PCCM. According to CMS⁶⁶, the number of state programs operating under a PCCM model of service delivery reduced in 2014 for all Medicaid-eligible populations. The authors believed this shift was primarily due to an increase in the number of managed care enrollees being enrolled in comprehensive MCOs.
- Idaho's model, Healthy Connections⁷⁴, was initiated in 1993. Under the model, the State requires enrollees to obtain medical care through the PCCM system or specialty physician services arrangements. Coordinated care is provided by a lead primary care provider or team of care

⁷¹ South Carolina: <https://www.scdhhs.gov/press-release/foster-care-health-initiative>

⁷² Washington State: <https://www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage/foster-care>

⁷³ Florida Sunshine Health: <https://www.sunshinehealth.com/members/child-welfare-plan.html>

⁷⁴ Idaho Healthy Connections: <http://healthandwelfare.idaho.gov/Medical/Medicaid/HealthyConnections/tabid/216/Default.aspx>

providers who deliver and coordinates primary care and authorizes referrals to specialty services. In 2013, the State moved outpatient BH service and case management into a limited benefit capitated managed care program (Idaho Behavioral health Plan)⁷⁵. Idaho Medicaid requires contractors to report on all aspects of programming including, network functioning, service delivery, participant response to services, operations, and claims processing as well as specific performance measures.

Mercer was unable to identify any state Medicaid system within the nation that has implemented an ASO model specific to health care delivery for children in foster care. As such, AHCCCS and DCS/CMDP will not have the benefit of reviewing another state's implementation and associated challenges and risks under an ASO arrangement.

⁷⁵ Idaho Behavioral Health Plan Waiver: <http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/IBHPWaiver.pdf>

Summary by State and Service Delivery Design Model

MEDICAID SERVICE DELIVERY DESIGN FOR CHILDREN IN FOSTER CARE	STATE
<p>Comprehensive Managed Care Organization (MCOs) – Provide all acute and primary medical services; some also cover behavioral health services and long-term services and supports. Entities that qualify as comprehensive MCOs include Health Maintenance Organizations and Health Insuring Organizations.</p>	<p>Delaware Hawaii Iowa Kansas Kentucky Maryland Missouri New Jersey New York North Dakota Ohio Rhode Island Tennessee Vermont Virginia</p>
<p>Comprehensive MCO + Behavioral Health Organization (BHO) – A comprehensive MCO and a managed care entity specializing in behavioral health (mental health and/or substance use disorder services). Services are covered on a prepaid basis.</p>	<p>Michigan Nebraska Utah</p>

MEDICAID SERVICE DELIVERY DESIGN FOR CHILDREN IN FOSTER CARE	STATE
BHO (carve-out model) – Separate entities providing physical health benefits and behavioral health services administration	Colorado Louisiana North Carolina Pennsylvania
Stand-Alone MCO for Children in Foster Care	Texas South Carolina Georgia Washington Florida
Primary Care Case Management (PCCM)	Idaho

INVENTORY OF KEY CONSIDERATIONS AND CHALLENGES – ASO MODEL

Based on results and findings derived from an independent analysis of an integrated health plan, AHCCCS and DCS/CMDP are exploring other health care delivery models for children in foster care, such as the delegation of certain health plan administrative functions to an ASO, that achieves the end goal of integration while decreasing the risks and barriers DCS/CMDP face in trying to operate as a MCO.

Mercer analyzed the feasibility of an ASO model or an ASO-like model designed to supplement DCS/CMDP’s operational capabilities to provide high quality, integrated care to children enrolled in foster care. Below is a listing of considerations and potential challenges for DCS/CMDP to implement and oversee an ASO model or ASO-like model to administer physical health and behavioral health services.

Option 1 - DCS/CMDP contracts with an entity for physical and behavioral health network development and maintenance, including a full array of specialty providers and provider services. Ideally, this would be an entity that has statewide access to comprehensive PH and BH networks for the population to be served (children with complex needs and multi-system involvement).

- Considerations include:
 - DCS/CMDP's PH and BH network require statewide coverage.
 - › Comprehensive BH networks exist and are potentially available via the Regional Behavioral Health Authorities (RBHAs) or the statewide CRS contractor (might need to enhance for unique CMDP population needs).
 - › By the time DCS/CMDP implements an integrated delivery system for CMDP enrollees, PH networks for children should be in place via AHCCCS' integrated care contractors (access to a state-wide network under a single contractor may not be available).
 - › DCS/CMDP could select one RBHA to administer a statewide PH and BH network; though a recent BH network assessment revealed that accessibility is less robust outside of the RBHA's assigned geographic service area. Alternative options include contracting with United Health Care Community Plan, which currently operates a statewide PH and BH network for the CRS population (network may need to be enhanced to meet the unique needs of CMDP members) or contracting with more than one RBHA to ensure adequate statewide coverage. However, multiple contractors would increase DCS/CMDP's oversight responsibilities and requires coordination for members moving between regions. Other national behavioral health entities (e.g., Beacon Health Options) have partnered with PH MCOs to provide a full array of integrated health services under a contract with a state Medicaid agency (e.g., New York).
 - DCS/CMDP would be required to provide oversight and ongoing monitoring for any delegated functions.
 - › DCS/CMDP would need to hire qualified staffing resources to support the monitoring and oversight role. CMDP is confined by the current ADOA salary schedule that establishes uniform compensation ranges for all State personnel. This could limit CMDP's ability to attract qualified staff necessary to oversee a statewide network of physical health and behavioral health providers.
 - › Per AHCCCS' requirements, DCS/CMDP is prohibited from delegating operational functions that inhibit integrated service delivery. Any subcontracted arrangement must be assessed to ensure that member care is integrated at the point of service delivery (e.g., same subcontractor furnishing PH and BH network).
 - › DCS/CMDP must retain the QOC investigations process and onsite quality of care visits, which are prohibited from being delegated under the current AHCCCS contract. To effectively perform these reviews, DCS/CMDP would need to have direct access to the subcontractor's provider network. If the provider network is delegated to another entity, it's unclear how DCS/CMDP would be able to impose corrective actions on providers as a result of QOC reviews/visits.

- DCS/CMDP must follow State procurement rules to solicit an ASO.
 - › DCS/CMDP would need to develop a request for proposal solicitation and conduct an evaluation process within the designated timeframe or they could pursue an exemption to the procurement rules.
 - › DCS/CMDP could design ASO compensation strategies that promote CMDP member access and facilitate ASO oversight to ensure service quality and positive member outcomes. However, VBP opportunities may be aligned with the delegated entity’s priorities which may not include initiatives involving children in foster care.
 - › Under this arrangement, DCS/CMDP would have limited influence due to the indirect relationship with service providers. Challenges may include implementing high fidelity evidence-based practices, meeting access to care requirements, and ensuring effective care coordination.

Option 1A – DCS/CMDP leverages AHCCCS’ claims platform for claims payment and PBM for pharmacy services through an inter-governmental agreement.

- AHCCCS would receive PH and BH claims from providers of DCS/CMDP’s subcontracted ASO.
 - › Prior to the merger between the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) and AHCCCS, ADHS/DBHS held an IGA with AHCCCS to be the Third Party Administrator (TPA) for FFS payments to tribal members (The IGA was expanded to include all BH and PH claims when integrated programs for SMI were initiated). As such, it is likely that AHCCCS is not precluded from serving as a TPA, but would need to confirm via a legal review.
 - › AHCCCS would need to assess staffing sufficiency and the capacity of existing AIHP staff to perform claims processing on behalf of DCS/CMDP.
 - › AHCCCS would need to leverage/establish electronic claim submission interfaces with the subcontractor as well as DCS/CMDP to link service authorizations to claims.
 - › AHCCCS would need ongoing access to current contracted provider network and pricing/reimbursement schedules.
 - › Protocols need to be in place to address out-of-network providers and capacity to initiate single case agreements.

- › DCS/CMDP's subcontractor would need timely access to eligibility data to identify and route claims to AHCCCS when a child is enrolled with CMDP.
- Legal Considerations and current statutory barriers or prohibitions that would have to be addressed for AHCCCS to pay CMDP claims (both physical health and behavioral health).
 - › CMDP would still need authority to administer behavioral health services. As such, Mercer's discussion and recommendations provided in *Section 3, Legal and Contract Requirements*, would still apply here (again assuming AHCCCS would be paying for both physical and behavioral health claims for services administered by CMDP).⁷⁶
 - › As was noted in that original assessment, "CMDP could contract with an ASO to directly render designated administrative functions" but, additional legal authority may be required for CMDP to enter into such arrangement.⁷⁷
 - › With respect to claims payment, ARS 8-512(E) requires the Department of Child Safety (DCS) to pay claims for services administered by CMDP.⁷⁸ However, 8-512(J) states that "The department [DCS] may provide for payment through an insurance plan, hospital service plan, medical service plan, or any other health service plan authorized to do business in this state, fiscal intermediary or a combination of such plans or methods." Arguably 8-512(J) would provide sufficient authority for CMDP to enter into an ASO-like arrangement to have AHCCCS pay CMDP claims; however, Mercer recommends that AHCCCS obtain a legal opinion. Mercer understands that the Division of Fee-for-Service Management (DFSM) is considered to be a health plan that, among other things, pays fee-for-service provider claims (including those for AIHP). Assuming DFSM (or other similar entity that would be used to pay claims) would meet the definition in 8-512(J) of "an insurance plan, hospital service plan, medical service plan, or any other health service plan authorized to do business in this state, fiscal intermediary or a combination of such plans or methods" a statutory change would not be necessary.

Option 1B - DCS/CMDP provides the clinical management, including prior authorization and concurrent review, care management, and member services, including member education and support.

⁷⁶ See Section 3 of the Independent Analysis of an Integrated Health Plan, Jan. 5, 2018.

⁷⁷ Ibid. at pg. 35.

⁷⁸ See ARS 8-512(E).

- Providers would need access to an electronic interface to submit service authorization requests to DCS/CMDP (i.e., provider portal).
- Upon receipt of a service authorization request, DCS/CMDP would follow established protocols to verify member eligibility, check provider contract status and render the authorization decision.
- DCS/CMDP would be responsible for generating notice of actions in the event of an adverse benefit determination.
- DCS/CMDP must have capability to electronically transmit service authorizations to AHCCCS to support claims payment.
- In the event of a provider claims dispute; authorization issues would be addressed by CMDP; DCS/CMDP would need to coordinate with the subcontractor for disputes regarding paid amounts (e.g., based upon a DRG, per diem, or other negotiated rates).
- Complexity of this model and handoffs create a heightened potential for breakdowns in the timeliness and accuracy of claims payment which may result in an increase of claims dispute/resolution issues.
- DCS/CMDP may lack tools, strategies and expertise to effectively medically manage BH service costs. Recruiting experienced BH professionals to assist with effective clinical management of the BH benefit would be necessary. Previously identified challenges with recruitment of qualified staff and ADOA compensation schedules would still present as potential barriers for DCS/CMDP to attract and retain personnel.

Option 2 - As an alternative to leveraging AHCCCS' claims payment platform, DCS/CMDP could include claims payment functions as part of the contract with an entity for physical health and BH network development and maintenance. The primary advantage of this model is that it consolidates network development and management with claims processing functions and reduces the number of entities involved with reimbursing and managing providers. A subcontracted integrated care contractor will possess a sufficient PH and BH network that includes negotiated contract rates, executed provider subcontract agreements and an efficient claims processing system.

FEASIBILITY OF ALTERNATIVE OPERATIONAL MODELS AND APPROACHES

The implementation activities related to the transition of the behavioral health benefit administration to CMDP are extensive and will necessitate substantial time to execute. Relevant tasks include securing startup funds, easing procurement rules, and executing amendments to administrative code, contracts and other necessary document development as well as network development activities and hiring and training a large number of staff. Mercer estimates that it will require at least 2+ years to execute the required actions, assuming there are no delays in enacting legislation or securing funding. In addition to

the risks and inherent challenges identified with the proposed transition to an integrated health plan; estimated costs related to the initial startup and expenses needed to sustain the integrated health plan operations will be considerable.

One reasonable alternative to approaching BH integration within CMDP is to utilize an ASO model in which designated health plan functions are delegated to a private sector vendor that DCS/CMDP could contract with to provide a robust statewide PH and BH network equipped to meet the unique needs of the CMDP population. In addition to network development, management and related provider services, CMDP could potentially access a claims processing platform via an IGA with AHCCCS or include claims processing functions as part of a broader agreement with a delegated entity.

The option to execute an ASO model still requires legal review to ensure that DCS/CMDP has the authority to administer the PH and BH benefit through a delegated party and revisions to administrative code and/or contracts may still be necessary to operate under the model. In particular, DCS/CMDP's ability to reimburse providers above the AHCCCS fee schedule, even thru a delegated entity, will require closer legal examination in light of the current statutory requirements. Ideally, the expertise of an experienced integrated care contractor with an established provider network that has demonstrated capabilities to serve the unique needs of children in the foster care system could be leveraged with appropriate oversight from DCS/CMDP. This approach retains DCS/CMDP's central role in meeting the holistic needs of children in foster care while mitigating the challenges of a state agency assuming the untenable role of operating as a fully integrated health plan.

While Mercer's national literature review results did not identify publicly funded service delivery systems specific to the provision of health care services to children in foster care that are supported by an agreement between a child welfare agency and an ASO; models do exist in which the designated child protective services agency actively collaborates with the state's Medicaid agency. These health care delivery systems include stand-alone MCOs dedicated to serving children in foster care (e.g., South Carolina) or comprehensive MCOs that provide a fully array of health care services to all Medicaid eligible children, including youth involved in the foster care system (e.g., Louisiana). Arizona could consider a similar arrangement and take the added step to grant DCS/CMDP the opportunity to retain a decision-making role in terms of access to care requirements, required reporting and other contract-based deliverables and expectations. The collaborative approach could also include DCS/CMDP's partnership with AHCCCS to provide oversight of a managed care health plan under a shared contracting arrangement or other legal mechanisms that effectuates DCS/CMDP's active involvement in the care and treatment of children in foster care while leveraging AHCCCS' experience and proven expertise in monitoring, oversight, cost-effectiveness and enhanced quality of care for Arizona's most vulnerable residents.

APPENDIX A

TITLE XIX COVERED BEHAVIORAL HEALTH SERVICES

SERVICE CATEGORY	SERVICE
Treatment Services	Behavioral Health Counseling and Therapy
	Assessment, Evaluation and Screening Services
	Other Professional
Rehabilitation Services	Skills Training and Development and Psychosocial Rehabilitation Living Skills Training
	Cognitive Rehabilitation
	Behavioral Health Prevention/Promotion Education and Medication Training and Support Services (Health Promotion)
	Psychoeducational Services and Ongoing Support to Maintain Employment
Medical Services	Medication Services
	Laboratory, Radiology and Medical Imaging
	Medical Management
	Electroconvulsive Therapy
Support Services	Case Management
	Personal Care Services

SERVICE CATEGORY	SERVICE
	Home Care Training Family (Family Support)
	Self-Help/Peer Services (Peer Support)
	Home Care Training to Home Care Client
	Unskilled Respite Care
	Supported Housing
	Sign Language or Oral Interpretive Services
	Transportation
Crisis Intervention Services	Crisis Intervention Services (Mobile, Community Based)
	Crisis Intervention Services (Stabilization, Facility Based)
	Crisis Intervention (Telephone)
Inpatient Services	Hospital
	Subacute Facility
	Residential Treatment Center
Behavioral Health Residential Services	Behavioral Health Residential Facility, without Room and Board
	Mental Health Services (NOS)
Behavioral Health Day Programs	Supervised Behavioral Health Treatment and Day Programs
	Therapeutic Behavioral Health Services and Day Programs
	Community Psychiatric Supportive Treatment and Medical Day Programs

APPENDIX B

COST FORECAST MODEL

CMDP
Integrated Health Plan

		Arizona Department of Administration				Bureau of Labor Statistics						
FTE	Staffing	Qualifications	Grade	Job Code	Hourly - Midpoint	Annualized	with 42% Burden	OCC Code	BLS Midpoint	with 42% Burden		
Member Services		<i>Member Services Manager</i>	BA and call center experience in health services. 3-5 years managerial experience.	20	AUN06656	\$ 24.6736	\$ -	\$ -	11-9151	\$ -	\$ -	
	8	8 FTE Customer Service Reps during business hours.	BA strongly preferred. High school diploma or GED required. A minimum of one year customer service experience or experience in health services.	16	AUN08299	\$ 18.2228	\$ 303,227.39	\$ 430,582.90	43-4051	\$ 243,440.00	\$ 345,684.80	
	12	12 FTE Customer Service Reps to answer phones after hours and weekends	BA strongly preferred. High school diploma or GED required. A minimum of one year customer service experience or experience in health services.	16	AUN08299	\$ 18.2228	\$ 454,841.09	\$ 645,874.34	43-4051	\$ 365,160.00	\$ 518,527.20	
Medical Management: BH Utilization Review	1	1 FTE Member services specialist	BA and at least one year experience in healthcare member services.	20	AUN06921	\$ 24.6736	\$ 51,321.09	\$ 72,875.94	13-1199	\$ 64,610.00	\$ 91,746.20	
	1	1 FTE BH Medical Director	Board certified. Arizona licensed MD or DO. Preferred Child Psychiatry.	1	AUN03848	\$ 67.2668	\$ 139,914.94	\$ 198,679.22	29-1066	\$ 183,780.00	\$ 260,967.60	
		<i>Children's Healthcare Administrator</i>	Arizona Licensed Health Care Professional; expertise in Children's PH and BH health care systems. Must report to CMO.	26	AUN04960	\$ 40.4631	\$ -	\$ -	11-9111	\$ -	\$ -	
		<i>Medical Management Manager</i>	RN or PA; Experience in PH and BH utilization management, reports to Children's Healthcare Administrator.	25	AUN05490	\$ 37.1884	\$ -	\$ -	29-1171	\$ -	\$ -	
	1	1 FTE BH Medical Management Manager	Independently Licensed BH clinician or nurse with 5-8 years BH clinical experience and BH UM experience. Reports to MM Manager.	24	AUN06475	\$ 34.2262	\$ 71,190.50	\$ 101,090.50	29-1171	\$ 104,770.00	\$ 148,773.40	
	2	2 FTE UM Supervisor	Independently Licensed BH clinician or nurse with 4-7 years BH clinical experience and BH UM experience. Reports to MM Manager.	23	AUN04496	\$ 29.0164	\$ 120,708.22	\$ 171,405.68	29-1141	\$ 145,360.00	\$ 206,411.20	
	16	16 FTE Prior Authorization Staff	Independently licensed BH clinician or nurse with at least 3 years clinical experience, 0-2 years' utilization management experience. Reports to UM Supervisor.	22	AUN04883	\$ 29.0164	\$ 965,665.79	\$ 1,371,245.42	29-1141	\$ 1,162,880.00	\$ 1,651,289.60	
	12	12 FTE Concurrent Review Staff	Independently licensed BH clinician or nurse with at least 3 years clinical experience, 1-2 years utilization management experience. Preferred: inpatient experience. Reports to UM Supervisor.	22	AUN04883	\$ 29.0164	\$ 724,249.34	\$ 1,028,434.07	29-1141	\$ 872,160.00	\$ 1,238,467.20	
		<i>Chief Medical Officer, BH Medical Director and Medical Management leadership</i>	Various	E1	AUN03561	\$ 67.2668	\$ -	\$ -	29-1066	\$ -	\$ -	
		<i>Pharmacy Coordinator/Pharmacy</i>	May be employee or subcontractor. Requires Pharm D. and experience in BH related medications. Reports to CMO.	E1	AUN06450	\$ 51.9799	\$ -	\$ -	29-1051	\$ -	\$ -	
	1	1 FTE Program Specialist	At least 2-3 years pharmacy experience, Bachelor's degree preferred.	18	AUN01774	\$ 20.8830	\$ 43,436.64	\$ 61,680.03	15-2031	\$ 62,760.00	\$ 89,119.20	
	Medical Management: BH Care Coordination	1	1 FTE BH Care Coordination Manager	Master of Arts (MA) level BH professional with managerial experience. Medicaid experience. Reports to Medical Management Manager.	24	AUN06475	\$ 34.2262	\$ 71,190.50	\$ 101,090.50	11-9111	\$ 92,000.00	\$ 130,640.00
		2	2 FTE Care Coordination Supervisors	MA level BH professional with supervisory and managerial experience. Preferred: Medicaid experience. Reports to the BH Care Coordination Manager.	23	AUN07500	\$ 31.5119	\$ 131,089.50	\$ 186,147.10	11-9111	\$ 184,000.00	\$ 261,280.00
33		33 FTE Care Management Staff	A bachelor's degree in a health or human services field or Registered Nurse (RN) with one (1) year experience working directly with individuals with mental health issues.	20	AUN04075	\$ 24.6736	\$ 1,693,595.90	\$ 2,404,906.18	29-1141	\$ 2,398,440.00	\$ 3,405,784.80	
1		1 FTE Transition Coordinator	At least BA level healthcare professional with BH experience.	20	AUN04075	\$ 24.6736	\$ 51,321.09	\$ 72,875.94	19-3031	\$ 61,260.00	\$ 86,989.20	
1		1 FTE TAY Transition Coordinator	At least BA level healthcare professional with BH experience.	20	AUN04075	\$ 24.6736	\$ 51,321.09	\$ 72,875.94	19-3031	\$ 61,260.00	\$ 86,989.20	
3		3 FTE Transition Specialists	Provides supporting care coordination for ETI, out of state transitions, and TAY transitions.	19	AUN03242	\$ 22.4153	\$ 139,871.47	\$ 198,617.49	29-9099	\$ 105,750.00	\$ 150,165.00	
6		6 FTE Triage Nurses	BA and RN required, with 2-4 years' experience in PH and BH. Preferred: managed care or triage experience. Reports to CMO.	20	AUN04075	\$ 24.6736	\$ 307,926.53	\$ 437,255.67	29-1141	\$ 436,080.00	\$ 619,233.60	
System of Care (SoC)	1	1 FTE System of Care Manager	MA level BH professional with supervisory and managerial experience. Preferred: Medicaid experience. Reports to Children's Healthcare Administrator.	25	AUN05490	\$ 37.1884	\$ 77,351.87	\$ 109,839.66	29-1171	\$ 104,770.00	\$ 148,773.40	
	8	8 FTE Support Coordinators	A bachelor's degree in a health or human services field or Registered Nurse (RN) with one (1) year experience working directly with individuals with mental health issues. Reports to SoC Manager.	20	AUN04075	\$ 24.6736	\$ 410,568.70	\$ 583,007.56	29-1141	\$ 581,440.00	\$ 825,644.80	
	4	4 FTE Clinical Liaison	LBSW, RN or a bachelor's degree in health services with experience working with medically fragile children. Reports to SoC Manager.	20	AUN04075	\$ 24.6736	\$ 205,284.35	\$ 291,503.78	11-9151	\$ 240,880.00	\$ 342,049.60	
	6	6 FTE CRS Support Coordinators	LBSW, RN or a bachelor's degree in health services with experience working with medically fragile children. Reports to SoC Manager.	20	AUN04075	\$ 24.6736	\$ 307,926.53	\$ 437,255.67	11-9151	\$ 361,320.00	\$ 513,074.40	
	0.5	0.5 FTE Justice System Liaison	BA level healthcare professional with BH and justice system involvement. Preferred: Medicaid experience. Reports to the Cultural Competency Coordinator.	21	AUN09027	\$ 26.8142	\$ 27,886.77	\$ 39,599.21	21-1022	\$ 20,345.00	\$ 28,889.90	
	0.5	0.5 FTE Court Coordinator	BA level healthcare professional with BH and justice system involvement. Preferred: Medicaid experience. Reports to the Cultural Competency Coordinator.	21	AUN09027	\$ 26.8142	\$ 27,886.77	\$ 39,599.21	21-1022	\$ 20,345.00	\$ 28,889.90	
	0.5	0.5 FTE Member Advocacy Administrator	1-3 years' experience in healthcare advocacy, managerial experience. Reports to the Cultural Competency Coordinator.	21	AUN09027	\$ 26.8142	\$ 27,886.77	\$ 39,599.21	19-3031	\$ 30,630.00	\$ 43,494.60	

	FTE	Staffing	Qualifications	Grade	Job Code	Hourly - Midpoint	Annualized	with 42% Burden	OCC Code	BLS Midpoint	with 42% Burden
Quality Management (QM)	0.5	0.5 FTE CRS Member Advocate	BA and 3 years healthcare experience or combination.	20	AUN08306	\$ 24.6736	\$ 25,660.54	\$ 36,437.97	21-1021	\$ 17,595.00	\$ 24,984.90
	0.5	0.5 FTE Child BH member advocate	BA level and 3 years of BH experience or combination. Both positions report to Member Advocacy Administrator.	19	AUN08296	\$ 22.4153	\$ 23,311.91	\$ 33,102.92	21-1021	\$ 17,595.00	\$ 24,984.90
	0.5	0.5 Individual and Family Affairs Administrator	Has lived experience of receiving BH services, navigating the public BH public health system. Preferred: family member of CMDP member. Reports to the Cultural Competency Coordinator.	21	AUN09027	\$ 26.8142	\$ 27,886.77	\$ 39,599.21	21-1021	\$ 17,595.00	\$ 24,984.90
	5	5 FTE Family Liaisons Regionally Based	Family Members of CMDP members. Reports to the Individual and Family Affairs Administrator.	17	AUN04071	\$ 19.4826	\$ 202,619.04	\$ 287,719.04	31-0000	\$ 147,650.00	\$ 209,663.00
	0.5	5 FTE Tribal Coordinator	Experience providing leadership in one of the Arizona Tribes, preferred: experience in health care.	21	AUN09027	\$ 26.8142	\$ 27,886.77	\$ 39,599.21	21-1021	\$ 17,595.00	\$ 24,984.90
		Cultural Competency Coordinator	BA or MA degree in health related field with 3-5 years' experience with developing and implementing cultural competency assessments, monitoring and/or training. Reports to the System of Care Manager.	23	AUN04496	\$ 29.0164	\$ -	\$ -	25-1062	\$ -	\$ -
	1	1 FTE Quality Management Manager (may not have more than one title)	RN, MD PA or Certified Quality (AHO) and/or Certified Health Care Quality and Management (contract requirement). 3-5 years behavioral health experience required. Reports to the Chief Medical Officer.	25	AUN04173	\$ 37.1884	\$ 77,351.87	\$ 109,839.66	11-9111	\$ 92,000.00	\$ 130,640.00
	1	1.FTE Performance/Quality Improvement Coordinator	Certified Professional in Healthcare Quality (CPHQ) or Certified in Health Care Quality and Management (CHCOM), comparable education/ experience in health plan data and outcomes measurement (contract requirement). 3-5 years behavioral health experience required.	23	AUN03124	\$ 31.5119	\$ 65,544.75	\$ 93,073.55	13-1199	\$ 64,610.00	\$ 91,746.20
		Dispute Manager	MA; 3-5 years' experience or an equivalent combination of education and experience Knowledge of Medicaid regulations. Preferred: BH experience.	22	AUN04496	\$ 29.0164	\$ -	\$ -	29-1199	\$ -	\$ -
		Grievances and Appeals Coordinator	Bachelor's degree from an accredited college, 2 years' experience in an Appeals and Grievance role within a healthcare provider or vendor, 2 year's experience tracking and trending data.	21	AUN09023	\$ 26.8142	\$ -	\$ -	13-1199	\$ -	\$ -
	5 FTE QM and PIP staff	BA in healthcare and 1-2 years healthcare experience. Quality experience preferred.	20	AUN08301	\$ 24.6736	\$ 256,605.44	\$ 364,379.72	21-1014	\$ 234,000.00	\$ 332,280.00	
Contract Management/ Compliance/ Policy	1	1.FTE Healthcare Analyst	Bachelor's Degree in computer science and mathematics. Plus experience in clinical or operational healthcare analytics and data management is required or an equivalent combination of education and experience is required.	23	S10073	\$ 32.6976	\$ 68,011.01	\$ 96,575.63	15-2041	\$ 73,390.00	\$ 104,213.80
		Corporate Compliance Officer	Bachelor's degree in a related area. Typically requires at least 4-7 years of related experience in healthcare. Needs to have skills to work independently and collaborative in nature. Relevant license (i.e., law, MD) and Certified Professional Compliance Officer™.	01	AUN07373	\$ 51.9799	\$ -	\$ -	11-9111	\$ -	\$ -
	1	1 FTE Policy Coordinator	Bachelor's degree in related field. Experience with Medicaid program requirements, policy and procedure review and project management.	24	AUN09020	\$ 34.2262	\$ 71,190.50	\$ 101,090.50	11-9111	\$ 92,000.00	\$ 130,640.00
Reporting/ IT/ Claims		Information Systems Administrator (can be a shared service with DCS)	Master's degree with 10+ years of experience managing an IS department.	26	S10078	\$ 39.4231	\$ -	\$ -	15-1121	\$ -	\$ -
	1	1 FTE Claims Administrator	BA with 8 years of experience with claims processing and policy and procedure development.	25	AUN05673	\$ 37.1884	\$ 77,351.87	\$ 109,839.66	29-2071	\$ 64,140.00	\$ 91,078.80
	1	1 FTE Encounter Manager (may be combined with claims administrator if qualified)	BA with At least 5 years' experience with 837 and NCPDP Medicaid encounter submissions.	25	AUN05673	\$ 37.1884	\$ 77,351.87	\$ 109,839.66	11-9111	\$ 92,000.00	\$ 130,640.00
	1	1 FTE Healthcare Information Specialist	Data analyst with 3-5 years of health care reporting experience and proven track record of working with clinical and business professionals.	23	AUN09042	\$ 31.5119	\$ 65,544.75	\$ 93,073.55	29-2071	\$ 64,140.00	\$ 91,078.80
Network	1	1 FTE Provider Claims Educator	BA and 3-5 years in providing provider claims education; tracking and trending data and provider services.	21	AUN06579	\$ 26.8142	\$ 55,773.54	\$ 79,198.42	21-1091	\$ 49,580.00	\$ 70,403.60
	1	1 FTE Network Administrator	8 years in BH Network Development and Management, including BH networks and VBP contracting. B.A. Foster Care experience preferred. At least 3 years indirect managerial experience.	26	AUN04960	\$ 40.4631	\$ 84,163.25	\$ 119,511.81	11-9111	\$ 92,000.00	\$ 130,640.00
	3	3 FTE Provider Contractors	3-5 years in contract negotiating, VBP experience, BH preferred.	24	AUN02035	\$ 34.2262	\$ 213,571.49	\$ 303,271.51	13-2053	\$ 204,660.00	\$ 290,617.20
	1	1 FTE Credentialing Coordinator/manager	3-5 years provider contracting or credentialing experience. BH preferred.	21	AUN09027	\$ 26.8142	\$ 55,773.54	\$ 79,198.42	23-2099	\$ 49,960.00	\$ 70,943.20
	4	4 FTE Credentialing Staff	3-5 years healthcare provider experience.	20	AUN08301	\$ 24.6736	\$ 205,284.35	\$ 291,503.78	23-2099	\$ 199,840.00	\$ 283,772.80
		Provider Services Manager	2-4 years Provider Services experience; 5 years managerial experience.	22	AUN04850	\$ 29.0164	\$ -	\$ -	13-2053	\$ -	\$ -
	15	15 FTE Provider Representatives:(5 of these dedicated to RR related activities)	1 year BH provider services experience.	20	AUN09027	\$ 26.8142	\$ 836,603.04	\$ 1,187,976.32	13-2053	\$ 1,023,300.00	\$ 1,453,086.00
Finance	1	1 FTE Provider Communications and Training	1 year provider training, education; 3 years course development and design.	21	AUN04866	\$ 26.8142	\$ 55,773.54	\$ 79,198.42	29-2071	\$ 64,140.00	\$ 91,078.80
	0.5	.5 FTE Finance Mgr	3-5 years accounting or finance experience.	23	AUN06912	\$ 31.5119	\$ 32,772.38	\$ 46,536.77	11-3031	\$ 48,630.00	\$ 69,054.60
	1	1 FTE Financial Analyst	0-2 years accounting or finance experience.	21	AUN04123	\$ 26.8142	\$ 55,773.54	\$ 79,198.42	13-2051	\$ 70,070.00	\$ 99,499.40
Subtotal	168					\$ 9,067,468.59	\$ 12,875,805.40		\$ 10,699,930.00	\$ 15,193,900.60	
Variable Staffing Costs	FTE	Staffing	Qualifications	Grade	Job Code	AZ Guide	Extended	with 42% Burden	OCC Code	BLS Equivalent	with 42% Burden

	FTE	Staffing	Qualifications	Grade	Job Code	Hourly - Midpoint	Annualized	with 42% Burden	OCC Code	BLS Midpoint	with 42% Burden
Surge Staffing for Network Development	1	1 FTE Network Contracting Manager	8 years in BH Network Development and Management, B.A.; 2-3 years implementation manager of large scale networks.	26	AUN04960	\$ 40,4631	\$ 84,163.25	\$ 119,511.81	11-9111	\$ 92,000.00	\$ 130,640.00
	12	12 FTE Provider Contractors	3-5 years in contract negotiating, BH preferred.	24	AUN02035	\$ 34,2262	\$ 854,285.95	\$ 1,213,086.05	13-2053	\$ 818,640.00	\$ 1,162,468.80
	12	12 FTE Credentialing Staff	3-5 years healthcare provider experience.	20	AUN08301	\$ 24,6736	\$ 615,853.06	\$ 874,511.34	23-2099	\$ 599,520.00	\$ 851,318.40
	5	5 Data Entry Operators	HS diploma or GED, 1-2 years' experience healthcare data entry.	16	AUN08003	\$ 18,2228	\$ 189,517.12	\$ 269,114.31	29-2071	\$ 181,900.00	\$ 258,298.00
Subtotal	30						\$ 1,743,819.38	\$ 2,476,223.51		\$ 1,692,060.00	\$ 2,402,725.20
Totals	198						\$ 10,811,287.97	\$ 15,352,028.91		\$ 12,391,990.00	\$ 17,596,625.80
PMPM								\$ 83.86			\$ 96.12
Non-Personnel Costs:								\$ 6,267,276.00			\$ 6,267,276.00
PMPM								\$ 34.24			\$ 34.24
Grand Total								\$ 21,619,304.91			\$ 23,863,901.80
PMPM								\$ 118.10			\$ 130.36

Notes:

- 1) Arizona Department of Administration job codes and hourly rates obtained at http://www.hr.az.gov/ClassComp/CC_Job_Titles_with_Ranges.asp.
- 2) Bureau of Labor Statistics obtained at <https://www.bls.gov/oes/special.requests/oesm16st.zip>.
- 3) Many of the positions were difficult to match up to either Mercer descriptions or the Arizona Department of Administration descriptions and may not fully align to the staffing positions as detailed in Section 6, Staffing Requirements and Organizational Infrastructure.
- 4) Non-Personnel Cost Assumptions include:

Members	15,255	
Member Months Annualized	183,060	
Total Personnel Needed	198	
Square Footage Needed	158,400	Assumes 800 sq. ft. per employee covers office and common area
Annual Rent	\$ 3,833,280	Avg rent times sq. footage
Annual Utilities	\$ 158,400	Utilities times sq. footage
Supplies	\$ 154,440	\$65 per employee per month
Other	\$ 766,656	20% of rent for other expenses such as insurance, etc.
Travel	\$ 198,000	\$1000 per employee per year for vehicle and mileage
Postage, Shipping, Other	\$ 305,100	\$20 per member
Equipment & Software	\$ 851,400	Assumes \$4,300/FTE for computer, phone, tablet
Total	\$ 6,267,276	
PMPM	\$ 34.24	

MERCER (US) INC.

2325 East Camelback Road, Suite 600

Phoenix, AZ 85016

www.mercer.com