Children's Action Alliance
A Voice for Arizona's Children since 1988

Response to SB 1372 Draft Report
September 21, 2015

Thank you for the opportunity to respond to the Draft SB 1375 Report dated September 4, 2015. In 2013, Children's Action Alliance supported the passage of SB 1375 that required the study and consideration of an administratively integrated system of comprehensive medical, dental and behavioral health services for foster children. We appreciate the thought and extensive examination of the system and administrative alternatives that went into the report.

Recommendation Summary

To summarize our recommendation, we are supportive of an **Integrated CMDP Contracted Provider Network Model**. Our recommendation incorporates a few additional suggestions for implementation. These include:

1. That CMDP be permitted to move from a fee-for-service model to a value-based contracted purchasing system during a two or three year transition period from accepting the responsibility for behavioral health services for foster children;

2. That there be an exemption in the law that would not require medical and dental providers under this value-based contracting system to go through the fingerprint clearance process required for other DCS contractors; and

3. That there is consideration given to allow CMDP (medical, dental and behavioral health services) health care coverage to a child transitioning to permanency for a period of six months **after** leaving foster care. *Note: We recommend this coverage no matter what entity ultimately is responsible for an integrated health care model for foster children.*

General Issues and Concerns Regarding the Report Content:

- We have come to understand that CMDP's performance measures are incorrectly displayed in the draft report. It is our understanding that the following is correct:

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CMDP Acute-Care Measure Performance: Measurement Period CYE 2013 (10/01/12-09/30/13)

Measure	*Minimum Performance Standard (MPS)*	*Denominator*	*Numerator*	CYE 13 Medicaid Rate	CYE 12 Medicaid Rate	Relative Percentage Change	Statistical Significance	All Contractor Medicaid Average	NCQA Medicaid Mean	NCQA Commercial Mean
Children's Access to Care (12-24 mo.)	*93%*	*745*	*736*	**98.8%**	99.7%	-0.9%	0.084	97.4%	96.1%	98.0%
Children's Access to Care (25 mo. - 6 yrs.)	*83%*	*2,360*	*2,206*	**93.5%**	91.1%	2.6%	**0.003**	89.2%	88.3%	91.9%
Children's Access to Care (7 - 11 yrs.)	*83%*	*497*	*471*	**94.8%**	94.8%	0.0%	0.975	91.4%	90.0%	92.5%
Children's Access to Care (12 - 19 yrs.)	*81%*	*901*	*884*	**98.1%**	96.8%	1.4%	0.085	89.4%	88.5%	89.9%
Well Child Visits (3-6 years of age)	*66%*	*1,854*	*1,332*	**71.8%**	63.7%	12.8%	**<0.001**	67.9%	61.6%	79.0%
Adolescent Well Care Visits	*42%*	*2,060*	*1,399*	**67.9%**	63.9%	6.3%	**0.008**	65.5%	71.5%	74.3%
Annual Dental Visits	*57%*	*6,101*	*4,993*	**81.8%**	82.7%	-1.0%	**0.272**	39.7%	50.0%	44.5%
EPSDT Participation	*68%*	*11,399*	*10,560*	**92.6%**	100.0%	-7.4%	**<0.001**	59.9%	*	*
Dental Participation**	*46%*	*14,275*	*10,854*	**76.0%**	79.0%	-3.8%	**<0.001**	62.3%	*	*

* This measure is not detailed in the 2013 State of Health Care Quality report

CMDP exceeds AZ Medicaid average, NCQA Mean & NCQA Commercial Mean
CMDP demonstrated a statistically significant increase in measure
CMDP demonstrated a statistically significant decrease in measure

- Page 2 of the draft report presents a chart comparing Healthcare Expenditures and Penetration Rates nationally to Arizona rates, both for children in the Medicaid population and for children in foster care. But comparing national 2005 numbers against FFY2014 Arizona numbers could certainly be misleading. Foster care populations in most states have gone down whereas in Arizona our number of children in foster care has increased dramatically. Also the comparison does not take into consideration increased national enrollment in Medicaid or inflation costs of medical care. It would be beneficial to update this chart with more accurate national and state comparisons.

- We understand it may be difficult to determine the number of disruptions of placements in foster care and disruptions of adoptive placements due to the inability to receive adequate behavioral services. The sample of cases examined here is too small to draw meaningful conclusions. Are these case numbers a statistically significant sample size?

Why We Support Recommendation #2 - Integration under CMDP - Contracted Provider Model.

- **CMDP Performance Measures Exceed Statewide Averages**: Despite the fact that the population is limited to children and youth in foster care and the system difficulties that this population represents, CMDP continues to perform very well on the required pediatric Medicaid/HEDIS Performance Standards. Data recently released by AHCCCS, demonstrates that CMDP exceeded the statewide average in nine (9) of the nine (9) required Performance Measures. In addition, CMDP exceeded the NCQA Mean & NCQA Commercial Mean for 7/9 measures, including:
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- **Children's Access to Health Care** by a primary care physician (PCP). CMDP exceeded the state & national means in all four age groups with scores of 93.5% to 98.8% of children receiving this service.
- **Annual Dental Care** includes both preventative and restorative dental care visits performed. For the last measurement year, 81.8% of CMDP children ages 1-18 received a dental service.
- **Dental Participation** includes only the percentage of children who had a **preventative** dental visit within the measurement year. This score was also quite high at 76.0%.
- **EPSDT Participation** calculates the age of the child and the required number of well visits/EPSDT visits that should have occurred during the measurement period. CMDP scored 92.6% for this measure.

- **CMDP serves children well by including foster parents, relatives and other care providers in the coordination of care.** The health management for children in foster care involves coordination with DCS staff and caregivers for children in foster care (responsible for day-to-day care and supervision), and in some cases, biological parents, Juvenile Court, attorneys representing the child, and other court appointed advocates. This additional coordination is not typically applicable to other Medicaid health plans. Working with all these caregivers and stakeholders, CMDP strives for the optimal provision of medically necessary health care services and appropriate, responsive and timely supports to the children in care. Ultimately, these assets position CMDP to provide the best continuity of care for children in the DCS system.

- **Children will be better served.** CMDP's only responsibility and interest is foster children. Other managed care agencies and providers have responsibility for large populations of people with various health needs and issues. Foster children are not the highest priority for these other entities and have often gotten lost in the shuffle.

- **If we can do things better, in a more fiscally responsible manner, we should.** There are numerous administrative layers in the current Behavioral Health Services system each taking dollars away from the service delivery system, which means less money is available for services to foster children. If Behavioral Health Services' responsibility is integrated with CMDP's other responsibilities for medical and dental care for foster children, administrative layers would be reduced. Federal dollars would go from AHCCCS to CMDP and then directly to providers. In addition, CMDP's primary focus is on the care of foster children and is not focused on corporate profit as the for-profit Managed Health Care Agencies are.

- **CMDP is a steady, reliable and responsible presence for foster children and caregivers in the state.** CMDP was serving foster children well before Title 19 dollars came to the state. Over the 20 plus years that Regional Behavioral Health Authorities (RBHAs) have been responsible for behavioral health services for foster children, RBHAs have been volatile with new ones emerging and others closing. The prominent JK Law Suit was a result of children statewide not receiving timely, adequate or quality services. Great variation remains among the RBHAs in the number of foster children who actually receive behavioral health services. The statewide RBHA structure is on the verge of changing again. The nation and

the state are moving toward integrated health care systems. CMDP is an established entity and we should support this stability in an integrated systems structure for our most vulnerable foster care population.

- **More providers throughout the state will be eligible to serve the health needs of foster children.** CMDP is currently not tied, as RBHAs or Managed Health Care Agencies are, only to providers who qualify for network contracts. A transition period from the open network model to the contracted network model would give providers who have experience and expertise in working with foster children the opportunity to respond to, and qualify for, contracts.

Recommendations and Logistics Considerations

Giving CMDP the responsibility for behavioral health services for foster children is well overdue. We are supportive of an **Integration under CMDP - Contracted Provider Model**. Our recommendation incorporates a few additional suggestions for implementation and transition. These include:

- We assume CMDP would need to ramp up its administrative capabilities and staffing. The proposal to implement an integrated system starting in October 2019 gives sufficient time to move in this direction.

- To assist CMDP in building a network and capacity to convert to a managed care model, we suggest creating an interagency workgroup with AHCCCS. This group can provide assistance with implementation. Federal-state matching funds should be available during this planning and transition planning.

- CMDP should be permitted to move from a fee-for-service open network model to a value-based contracted purchasing system during a two or three year transition period from accepting the responsibility for behavioral health services for foster children;

- There should be an exemption in state law that would not require medical and dental providers under a CMDP value-based contracting system to go through the fingerprint clearance process required for other DCS contractors. This is not a requirement for other Managed Health Care Networks and such a requirement would most likely be a barrier for health care providers to continue with the CMDP network.

- Consideration should be given to allow CMDP (medical, dental and behavioral health services) health care coverage to a child transitioning to permanency for a period of six months **after** leaving foster care. This would allow improved continuity of service, transition planning for the child's health care needs, and address any immediate health related concerns in the child's return to family or new permanent placement. Qualification to this extended coverage could allow for: (a) choice by the parent, guardian or custodian to determine whether their health insurance plan is sufficient to provide the needed services, or (b) that the child had to have been in care for a certain period of time (to be determined) prior to exiting foster care. *Note: We recommend this*

coverage no matter what entity ultimately is responsible for an integrated health care model for foster children.

- We recommend that Chart 1on page 2 of the draft report be updated with more current national numbers and cost estimates.

- We recommend that AHCCCS and DCS continue to provide the quarterly Program and Accountability Reports that are required under SB 1375, Sec. 7, (Laws of 2013) during this transition period.

- We also recommend that DCS and AHCCCS continue to work together to identify the children who are experiencing foster care and adoption disruptions due to behavioral health issues. What can we learn from these case histories identified in the draft report to improve current and future behavioral health system services? To begin,
    - For both children disrupted from foster care and adoption identified in the draft report, it would be good to know the ages of the children, how long they were in their placements, and how many placements each child had.
    - How does the lack of, or inadequate, Child and Family Team (CFT) meetings impact available and appropriate services for children? How can CFTs be improved? How can parents and other caregivers know when, and how, to access CFTs? Further research on these questions, could be helpful for those currently in the field, even before an integration of these health services is in place.

Please feel free to contact Beth Rosenberg, CAA Director of Child Welfare and Juvenile Justice, at 602.266.0707, ext. 206, or brosenberg@azchildren.org if you have any questions regarding these recommendations.

Thank you.