

February 15, 2018

The Honorable Douglas A. Ducey
Office of the Governor
1700 West Washington
Phoenix, Arizona 85007

Subject: Network Adequacy Study of Behavioral Health Services to Children Enrolled in the Comprehensive Medical and Dental Program (CMDP)

Dear Governor Ducey:

On March 24, 2016, Laws 2016, Chapter 71 (House Bill (HB) 2442) was enacted. Also known as Jacob's Law, this legislation mandates a number of requirements for purposes of ensuring easier access to behavioral health services for children in the legal custody of the Department of Child Safety (DCS) and adopted children who are Medicaid eligible under Title XIX or XXI. Jacob's Law outlines the following requirements:

- The out-of-home placement or adoptive parent may directly contact the Regional Behavioral Health Authority (RBHA) for a screening and evaluation of the child if it is identified a child is in urgent need of behavioral health services
- An assessment team must be dispatched within 72 hours of a child entering into out-of-home care
- An assessment team must be dispatched within 2 hours after being notified that the child has an urgent need
- An initial evaluation should be provided within seven calendar days after a referral or request for services
- If it is determined the child is in need of behavioral health services, an initial behavioral appointment should be provided within 21 calendar days after the initial evaluation
- If services are not received within 21 days, the out-of-home placement or adoptive parent shall contact the RBHA and AHCCCS customer services to document the failure and the child may access services directly from any AHCCCS registered provider regardless of whether the provider is contracted with the RBHA. In these situations the provider must submit the claim to the RBHA and accept the lesser of 130% of the AHCCCS FFS rate or the provider's standard rate
- If the child is in need of crisis services and the crisis services provider in the county is not being responsive to the situation, the out-of-home placement or adoptive parent may contact the RBHA to coordinate crisis services for the child
- The RBHA shall respond within 72 hours to a request to place a child in residential treatment due to displaying threatening behavior. If the child is hospitalized due to the threatening behavior before the RBHA responds, the RBHA shall reimburse the hospital

for all medically necessary services, including any days of the hospital stay during which the child did not meet inpatient criteria but there was not safe and appropriate place to discharge the child

Children in the legal custody of DCS are enrolled with CMDP for the provision of physical health care services and the majority of these children receive behavioral health care services through the RBHA in their geographical area. The Arizona State Health Care Cost Containment System (AHCCCS) holds Contracts with three RBHAs for the provision of behavioral health services throughout the state of Arizona. For those children enrolled with CMDP who have a Children's Rehabilitative Services (CRS) eligible condition, behavioral health services are provided through AHCCCS' statewide CRS Contractor.

Jacob's law requires AHCCCS to complete a network adequacy study for behavioral health service providers that provide behavioral health services to children enrolled in CMDP. In response to this requirement, AHCCCS submits the attached Behavioral Health Network Assessment report.

In March, 2017, AHCCCS awarded a contract, through a competitive bidding process, to Mercer Health & Benefits, LLC (Mercer) to conduct the network adequacy study required by Jacob's Law. To conduct this study, Mercer:

- Analyzed three years of service utilization data to identify the most prevalent behavioral health services and behavioral health providers utilized by members enrolled with CMDP,
- Mapped service locations against member locations to determine provider availability,
- Reviewed and synthesized behavioral health data reports submitted to AHCCCS from the Contractors for the CMDP population,
- Analyzed requests for assistance with accessing behavioral health services received by CMDP staff,
- Reviewed and analyzed RBHA and CRS behavioral health network availability, and
- Interviewed clinical leaders representing CMDP.

The Behavioral Health Network Assessment report determined, through a multi-faceted network adequacy analysis, that a comprehensive and responsive behavioral health network is available to Arizona's children in foster care. In response to Jacob's Law, the RBHA and CRS Contractors engaged in a systematic campaign to educate the community about provisions within the legislation, procedures to access behavioral health services, and the availability of resources for foster parents to assist if barriers were encountered when attempting to secure behavioral health services. A geospatial mapping analysis was completed to evaluate the extent contracted providers were available to meet the needs of the CMDP membership. While certain provider types for some Contractors did not meet these standards, the analysis identified a majority of the CMDP population has timely access to all covered behavioral health services across the state. In addition, the penetration rate of members enrolled with CMDP, for behavioral health services, has increased incrementally over the three year study period (+2%). Over 2,500 additional

children received behavioral health services between the first and the third year of the study period.

While the report concludes that a comprehensive and responsive behavioral health network is available to members enrolled with CMDP, opportunities exist to develop and expand the capacity of provider networks in the following areas of the state:

- Western Maricopa and Pima Counties,
- A large portion of La Paz County,
- Greenlee County, and
- Northern frontier regions of Mohave, Coconino, Navajo and Apache Counties.

AHCCCS will review all recommendations outlined in the Behavioral Health Network Assessment report for improvements in Contract and Policy requirements, as well as reporting requirements imposed on RBHA and CRS Contractors.

Sincerely,

A handwritten signature in black ink, appearing to read 'T. Betlach', with a large, sweeping flourish extending to the right.

Thomas J. Betlach
Director

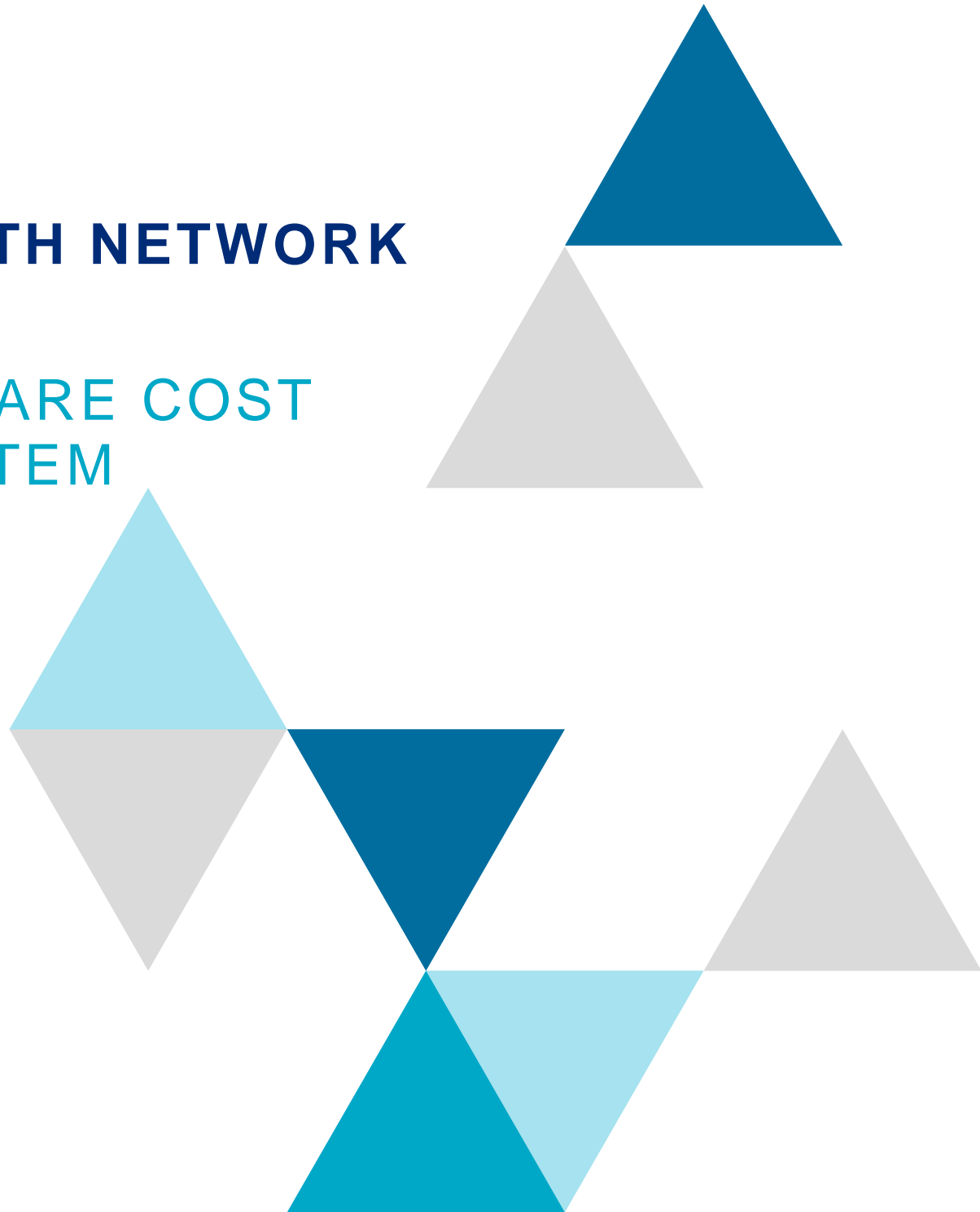
cc: The Honorable Steve Yarbrough, President, Arizona State Senate
The Honorable J.D. Mesnard, Speaker, Arizona House of Representatives
Matthew Gress, Director, Governor's Office of Strategic Planning and Budgeting
Richard Stavneak, Director, Joint Legislative Budget Committee

HEALTH WEALTH CAREER

BEHAVIORAL HEALTH NETWORK ASSESSMENT

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

FEBRUARY 1, 2018



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EXECUTIVE SUMMARY

The Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid Agency, engaged Mercer Government Human Services Consulting (Mercer) to conduct a behavioral health (BH) network assessment for children in foster care enrolled in the Comprehensive Medical and Dental Program (CMDP). The behavioral health network assessment is intended to fulfil the requirements of House Bill 2442¹; legislation enacted in 2016 designed to enhance access to behavioral health services for Arizona's foster child population.

The BH network assessment included an evaluation of the adequacy of the BH network to meet the BH needs of youth in the custody of the Department of Child Safety (DCS) and enrolled in the CMDP and children who are adopted. Several factors can influence the adequacy of a provider network and the network's ability to support members' timely access to care. One factor is availability, which addresses whether provider networks are sufficient to meet the needs of members and is a function of the number of providers and their ability to offer timely appointments. Another factor is accessibility which involves the proximity of providers to enrollees, based on geographic time and distance.² To conduct the assessment, Mercer applied a geospatial mapping analysis and reviewed other summary level data from AHCCCS' behavioral health Contractors, the statewide Children's Rehabilitative Services (CRS) Contractor, DCS/CMDP and AHCCCS administrative data.

¹ State of Arizona, Laws 2016, Chapter 71, House Bill 2442. Also known as Jacob's Law, this legislation required the administration (AHCCCS) to complete a network adequacy study for behavioral health service providers that provide behavioral health services to children enrolled in the CMDP.

² Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability. Center for Medicare and Medicaid Services & Mathematica Policy Research, April 2017.

To assess the availability of behavioral health providers to meet the needs of CMDP members, Mercer analyzed the following information:

- *Trended analysis of CMDP service utilization data:* The analysis of service utilization data was targeted to identifying the most prevalent BH services utilized by CMDP members and identifying BH providers used by CMDP members across a successive three-year period.
- *Geo-spatial mapping analysis:* BH provider categories and their service locations were mapped against member locations (i.e., where the member has been placed in the community following removal by DCS) to determine the extent to which the Contractor's network is in compliance with established distance standards based on AHCCCS requirements, when available, as AHCCCS has not delineated time and distance standards for all BH provider types and/or services.
- *Review and analysis of AHCCCS required reporting for the CMDP population:* A review and synthesis of Contractor data reports required by the AHCCCS Contractor Operations Manual (ACOM), Chapter 400, Policies: 415 (Provider Network Development and Management Plan; Periodic Network Reporting Requirements), 417 (Appointment Availability, Monitoring and Reporting), 436 (Network Standards), and 449 (Behavioral Health Services for Children in Department of Child Safety Custody and Adopted Children).
- *Review and analysis of requests for assistance with BH service access directed to CMDP and complaint data collected by the Regional Behavioral Health Authorities (RBHAs):* The review analyzed a tracking log of requests for assistance with accessing BH services from DCS field offices and from foster parent and kinship caregivers. The log is managed by CMDP and includes a summary description of the type of barrier that was being encountered when trying to access BH services. In addition, access to care complaints involving CMDP members and directed to each RBHA were analyzed.
- *Review and analysis of RBHAs and the CRS Contractor BH network documents and data:* Documents reviewed included the Contractors' network development plans, network-related data (i.e., services most utilized, penetration rates), complaint data, single case agreements, feedback and minutes of various meetings between the RBHAs and CRS and DCS/CMDP and stakeholder groups (e.g., foster parents), training logs and results of performance measures.
- *CMDP key informant interview:* An interview was conducted with clinical leaders representing the CMDP.

OVERVIEW OF FINDINGS

The BH network assessment revealed several important findings related to the accessibility and availability of Medicaid covered BH services to children in foster care. The service delivery system has recently intensified efforts to promote and educate community stakeholders, including foster parents and BH service providers, regarding the availability of a wide array of innovative BH programs, services and supports available to children enrolled with CMDP. Mercer reviewed a large volume of materials and information describing stakeholder outreach efforts, training initiatives and network development activities across the State of Arizona. In response to the passage of House Bill 2442, the RBHAs and the 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.

As the State's administrative oversight entity and designated Medicaid agency, AHCCCS has established a clear and coherent set of expectations through contractual agreements and policy requirements that help support CMDP members with access to BH screening and evaluation services immediately upon awareness of a youth's placement in an out-of-home setting. Based on the results of that initial evaluation, additional expectations are in place for the timely provision of initial and ongoing BH services as needed. AHCCCS currently requires CMDP member specific reporting and tracking of BH appointment standards and monitors time and distance standards for designated provider types that serve children in the foster care system. AHCCCS' RBHA and CRS Contractors are required to develop, monitor and periodically evaluate a comprehensive network development and management plan that includes targeted network development areas to promote and expand BH programs and services available to CMDP members.

As part of a statewide geospatial mapping analysis, Mercer examined seven distinct BH provider type categories and evaluated if the three RBHA's and the CRS Contractor's provider network could accommodate CMDP members' BH service needs. The geospatial mapping analysis evaluated the extent that contracted providers were available to meet established distance standards in relation to the proximity of the CMDP membership. While some provider type categories for some Contractors did not meet the minimum distance standards, the geospatial analysis confirmed that a majority of the CMDP population has timely access to all covered BH services across each of the three RBHAs and the CRS Contractor. In addition, service utilization trends demonstrate that a high percentage of CMDP members access a wide array of BH services and that the overall provision of BH services have increased proportionately in the past 12 months keeping pace with the total number of CMDP eligible members over that same time period. The data indicates that the annual statewide penetration has

incrementally increased over the three year period (+2%) and that over 2,500 additional children received behavioral health services between year one and year three of the study period.

BEHAVIORAL HEALTH NETWORK ASSESSMENT CONCLUSIONS

Through the multi-faceted network adequacy analysis, Mercer is able to confirm that a comprehensive and responsive BH network is available to Arizona's children in foster care. As with any dynamic and complex service delivery system designed to meet the needs of children in foster care, opportunities exist to enhance the availability of select services that are critically important for a population of children that have a demonstrated need for timely and responsive BH interventions, including evidence based practices and specialty services. Through Contractor self-identified network deficits and development plans, suggestive trends in complaints and CMDP inquiries, reported experiences by stakeholders, interviews with key informants from the CMDP and quantitative data derived through the geospatial mapping analysis and service utilization analysis, Mercer has identified BH services that should be examined further to determine the need to expand availability and accessibility. The RBHA and CRS Contractors utilize single case agreements and other expedited provider contracting strategies when periodic network gaps are identified; ensuring that highly specialized BH services are readily available to CMDP members even in remote regions of the State.

A summary of findings derived from the analysis of the varied data sources that informed the BH network assessment, as well as the identification of BH services that should be considered for continued development, are detailed in the report that follows.

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INTRODUCTION AND BACKGROUND

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 BH services to manage stressful circumstances surrounding the child’s removal from the home, separation from siblings and associated trauma. Factors contributing to the mental 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

Children in foster care have a disproportionately higher incidence of BH needs compared to the general population. A Substance Abuse and Mental Health Services Administration study of a large cohort of Medicaid enrollees found that children and adolescents in foster care have a mental health services utilization rate of 52.2%.⁴ In another national survey, an assessment was completed regarding the relationship between the need for and use of mental health services among a nationally representative sample of children who were investigated by child welfare agencies after reported maltreatment. Nearly half (47.9%) of youths aged 2–14 years included in the study had clinically significant emotional or behavioral health problems. The authors of this study suggest that routine screening for mental health needs and increasing

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 Center for Mental Health Services and Center for Substance Abuse Treatment. Diagnoses and Health Care Utilization of Children Who Are in Foster Care and Covered by Medicaid. HHS Publication No. (SMA) 13-4804. Rockville, MD: Center for Mental Health Services and Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2013.

access to mental health professionals for further evaluation and treatment should be a priority for children early in their contact with the child welfare system.⁵

When examining the need for BH services for children in foster care, the presence of one or more BH diagnoses can confirm the need for timely access to a comprehensive set of BH services. One large study of the prevalence of mental health diagnoses in 14 to 17 year old adolescents in foster care reported that approximately three out of five adolescents (63.3%) had a mental health diagnosis, and about one in five (22.8%) had three or more mental health diagnoses.⁶ As of February, 2018, AHCCCS reports there were 14,349 Arizona children in enrolled with the CMDP.⁷

The CMDP Service Delivery System

AHCCCS, Arizona's Medicaid agency, works with the Arizona DCS and CMDP to provide a full array of health care services to children placed in Arizona's foster care system.

CMDP is the health plan responsible for ensuring the provision of health care services for Arizona's children in foster care. CMDP provides medical and dental care for each child who is:

- Placed in a foster home; or

⁵ *Mental Health Need and Access to Mental Health Services by Youths Involved with Child Welfare: A National Survey*. Burns, Phillips, Wagner, Barth, Kolko, Campbell, Landsverk, J. Am. Acad. Child Adolesc. Psychiatry, 43:8, August 2004.

⁶ White, CR.; Havalchak, A.; Jackson, LJ. O'Brien, K.; Pecora, PJ. *Mental health, ethnicity, sexuality, and spirituality among youth in foster care: Findings from the Casey Field Office Mental Health Study*. Seattle, WA: Casey Family Programs, 2007.

⁷ Arizona Health Care Cost Containment System, AHCCCS Population by Health Care Contractor, February, 2018

https://www.azahcccs.gov/Resources/Downloads/PopulationStatistics/2018/Feb/Members_by_Contractor_Report.pdf

- In the custody of DCS and placed with a relative, in a certified adoptive home prior to the final order of adoption, or in an independent living program; or
- In the custody of the Arizona Department of Juvenile Corrections (ADJC) or the Administrative Office of the Courts/Juvenile Probation Office (AOC/JPO) and placed in foster care.

Once placed in foster care, children are enrolled with CMDP and, when medically necessary, receive Title XIX (Medicaid) covered BH services through a RBHA or CRS Contractor. Health care services must be rendered by providers that are appropriately licensed or certified, operating within their scope of practice, and registered as an AHCCCS provider. According to the *AHCCCS Enrolled in an Episode of Care – Penetration Report*, over 17,000 youth statewide were assigned to the CMDP health plan in June 2016; 61.5% of whom were receiving behavioral health services.⁸ The Arizona children in foster care rate of utilization is substantially higher than the approximately 50% mental health service utilization rate as reported in two national studies (see page 5).

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 for a listing of all Title XIX (Medicaid) covered behavioral health services available to children enrolled with CMDP.

AHCCCS has contracted with three RBHAs that are assigned to specified geographic service areas across the State of Arizona. The table below depicts the RBHAs as well as the CRS Contractor that is responsible for the provision of Title XIX covered BH services to children enrolled with CMDP or children who are adopted that meet eligibility criteria for the CRS program.

⁸ Arizona Health Care Cost Containment System, Enrolled in Episode of Care – Penetration Report, June 2016.

<https://www.azahcccs.gov/Resources/Downloads/BehavioralHealthReports/enrollment-penetration.pdf>

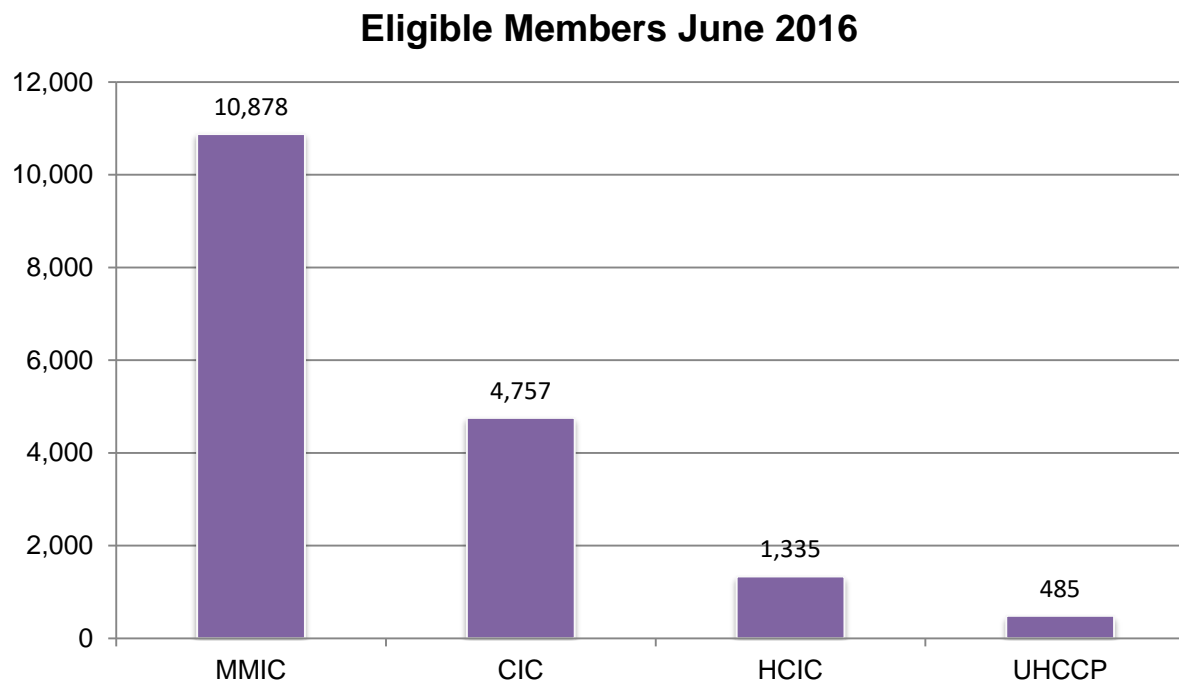
AHCCCS CONTRACTOR	COUNTIES SERVED
Mercy Maricopa Integrated Care (MMIC)	Maricopa
Cenpatico Integrated Care (CIC)	Pima, Pinal, Yuma, Cochise, Graham, Greenlee, Santa Cruz, La Paz
Health Choice Integrated Care (HCIC)	Coconino, Yavapai, Apache, Mohave, Navajo, Gila*
UnitedHealthcare Community Plan CRS (UHCCP)	Statewide

*Gila County includes designated zip codes that are assigned to the South Region (CIC)

In some cases, a member assigned to a particular RBHA may be temporarily placed outside of the RBHA’s designated geographic service area and may be in need of and/or accessing BH services. In these instances, the out-of-area care remains the responsibility of the original or designated “home” RBHA.

Each RBHA and the CRS Contractor must manage a network of providers to deliver all covered BH services to CMDP eligible and adopted children and adolescents. The RBHAs and CRS Contractor contract with BH providers to provide the full array of covered BH services available to children and youth in foster care or adopted. CMDP is responsible for timely care coordination with the RBHAs and CRS Contractor for members receiving BH services.

Per the *AHCCCS Enrolled in an Episode of Care-Penetration Report*, each RBHA and the CRS Contractor were responsible for ensuring the provision of medically necessary covered BH services to eligible CMDP members as presented in the graph below.⁹



⁹ Arizona Health Care Cost Containment System, Enrolled in Episode of Care – Penetration Report, June 2016.

<https://www.azahcccs.gov/Resources/Downloads/BehavioralHealthReports/enrollment-penetration.pdf>

House Bill 2442

On March 24, 2016, State leaders in Arizona took an important step towards addressing the needs of Arizona's children in foster care through the enactment of House Bill (HB) 2442 (i.e., Jacob's Law) with the goal of ensuring easier access to BH services for children in the foster care system. The law, in part, adjusted existing response timelines following requests for behavioral health services (i.e., 21 days as opposed to 23 days following the initial assessment), permits foster parents to have direct access to the BH 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 BH services for children in foster care.

AHCCCS and Contractor Response to House Bill 2442

Following the enactment of HB 2442, AHCCCS held a series of meetings with the RBHAs, the CRS Contractor and system stakeholders (e.g., DCS/CMDP, foster care families, and aged-out foster care youth) that were designed to increase public awareness of the law's requirements. Informed by stakeholder input, informational materials were developed and distributed to system stakeholders that summarized the key provisions of Jacob's Law. The legislation's requirements were conveyed and disseminated across the BH network, with AHCCCS requiring each Contractor to submit regular updates regarding outreach activities, training initiatives and highlights of foster care stakeholder meetings.

Through AHCCCS' leadership, the BH delivery system increased awareness of the availability of BH services to CMDP children. In the months leading to the passage of Jacob's Law and through its' enactment and implementation, RBHAs and the CRS Contractor demonstrated significant increases in the numbers and percent of CMDP children that were screened, assessed and subsequently accessed needed BH services. These increases can be attributed to the comprehensive outreach, training and public engagement by AHCCCS and the agency's Contractors that followed the passage of HB 2442. Contractor reported increases of CMDP members that accessed a Medicaid covered BH service is summarized below¹⁰.

- CIC: Increased the percentage of CMDP members that received BH services by 31% between March 2016-December 2016;

¹⁰ As reported by each AHCCCS Contractor in April 2017.

- HCIC: Experienced a 15% increase in the percentage of CMDP members who accessed a BH service between October 2015 and March 2017;
- MMIC: Increased the percentage of CMDP members that received BH services by 9% between June 2015 and December 2016; and
- UHCCP: Experienced a 22% increase in the percentage of CMDP members who assessed a BH service between March 2016 and December 2016.

Enhanced Ad-Hoc Reporting Specific to the CMDP Population

Following the implementation of HB 2442, each AHCCCS Contractor responsible for the provision of Title XIX BH services to children enrolled in foster care collected and presented data for the following metrics:

- Trended CMDP member penetration rates (the rate that children eligible for CMDP receive one or more BH services over a designated time period).
- The Contractor's five highest utilized BH services for CMDP members.
- The volume of calls received via the Contractor's dedicated foster care hotline and/or directed to the Contractor's DCS liaison (required as part of ACOM 449).
- The volume of CMDP members who received services through the Contractor from an out-of-network provider.
- Contractor performance in meeting rapid response timeframes.

Contractor's Stakeholder Engagement Activities

Within the few months following the execution of HB 2442, each AHCCCS Contractor engaged relevant foster care system stakeholders and reported ongoing activities and accomplishments. Highlights of stakeholder engagement activities by geographic service area (GSA) are presented here.

North GSA

- Initiated quarterly foster and adoption network meetings on the BH system in HCIC's GSA and shared information regarding how to access services;
- HCIC established the Member Advisory Council for Foster Families (includes representation from five foster families and three health homes);
- HCIC collaborated with Coconino Coalition for Children and Youth to improve outcomes for individuals in foster care and for foster care parents including community engagement, development of foster mentorship programs and bridge child abuse prevention with foster care outcomes;
- HCIC facilitated monthly process improvement meetings with CMDP to collaborate on resolving issues at a system level as well as bi-weekly case specific consultations;
- HCIC held quarterly meetings with local DCS and Home Care Training to Home Care Client (HCTC) providers to address questions and concerns;
- HCIC hosted regional foster family forums to address needs and to query foster families about their concerns navigating the BH system. The forums took place in Payson, Globe, Prescott, Flagstaff and Kingman. Foster family forum results and improvement opportunities were subsequently presented to HCIC contracted BH homes.

Central (Maricopa County) GSA

- MMIC developed and implemented a comprehensive communication plan to target kinship, foster care and group home placements and DCS;
- A social media campaign was launched on Twitter and Facebook about requirements for children's BH, prohibition of wait lists and foster family forum announcements;
- MMIC initiated focus groups with DCS to discuss needs for transition age youth (TAY);

- MMIC created a mechanism for foster parents to call a designated number to directly access and request a rapid response assessment and/or DCS stabilization team;
- In collaboration with providers, MMIC developed a check-in tool to assist in providing a meaningful minimum outreach to out-of-home placement providers to assess needs of children in the child welfare system;
- MMIC established DCS and stakeholder collaboration forums with workgroups represented in the following areas:
 - Foster, adoptive and kinship oversight
 - TAY
 - Juvenile justice
 - Safe reduction
 - Rapid response in detention
 - Birth to five
 - Autism spectrum disorder workgroup

South GSA

- Ten Foster Parent Forums were facilitated by CIC. The primary issues that arose out of these forums included the need to:
 - Consistently engage foster, kinship and adoptive placements in the Child and Family Team (CFT) process;
 - Educate foster parents about how to access the continuum of services;
 - Improve collaboration between foster parents and DCS Specialists;

- Better coordinate services for children placed out of area; and
- Expand crisis system responses that support foster homes to prevent placement disruptions.
- CIC worked collaboratively with MMIC and HCIC to convey a shared understanding of Jacob's Law and to develop unified initiatives to facilitate the provision of services to children in foster, kinship and adoptive placements.
- CIC facilitated a Jacob Laws Work Group during May 2017. DCS, CMDP, the Office of Individual and Family Affairs (AHCCCS), foster care licensing agencies, kinship support agencies and BH agencies were invited to attend. The purpose of this work group was to educate attendees about Jacob's Law, identify and overcome barriers and to develop committees to plan cross-system training and education. The cross-system trainings create a forum to have a dialogue between systems and collaboratively identify strategies to better meet the needs of foster parents and children in care.
- Information about Jacob's Law was shared with CIC's contracted providers during April and May 2017. In addition, CIC collaborated with system partners to develop a collective knowledge base about BH services and the rights of foster, kinship and adoptive placements.
- In a series of collaborative stakeholder meetings, CIC discussed the unique needs of children in foster care, Jacob's Law, collaboration with foster and kinship placements, Rapid Response Assessments, and the importance of providing high quality, clinically appropriate services to DCS-involved members.

CRS Contractor

- UHCCP hosted the CRS foster, adoptive, kinship parent advisory council which was initiated in April 2017 and meets monthly. The council includes five CRS family members, CRS BH providers and community advocacy groups.
- New content about HB 2442 and the DCS points of contact was incorporated into the UHCCP Summer Symposium Provider Forums. Presentations were completed in the communities of Flagstaff, Lake Havasu, Show Low, Tucson, Phoenix and Yuma.
- UHCCP initiated discussions with the Community of Practice Coordinator at the Arizona Department of Education regarding opportunities to partner and disseminate information about HB 2442 and DCS points of contact.

- UHCCP discussed updating the CRS/DCS collaborative protocol and rapid response process/forms during the CRS/CMDP/DCS Collaborative Monthly Meeting.
- UHCCP contacted every CRS/CMDP members' DCS case worker and out-of-home placement to identify if the member was in need of BH services, is currently receiving care and if there were any barriers with accessing care.

Contractor's Training Initiatives

The AHCCCS RBHA and CRS Contractors developed and facilitated trainings for foster care families, providers and other system stakeholders following the enactment of HB 2442 in an effort to promote awareness regarding the legislation's key requirements. Examples of training activities conducted in each GSA within the initial six months following the execution of HB 2442 are presented below.

North GSA

- HCIC health homes and community providers sponsored a webinar that focuses on living and working with traumatized children.
- HCIC developed dialectical behavior therapy training and certification for health homes.
- HCIC facilitated ongoing training for HCTC providers, foster families and kinship families that included:
 - Attachment based family therapy
 - Youth mental health first aid
 - Co-parenting as a mission of HCTC
 - Effective Interventions for grief and loss (as requested from foster family forums)
 - Assessment, interventions and techniques for sexualized behavior
 - Family therapy: theory and interventions

- Ongoing training in trauma informed therapy techniques
- Expressive arts for BH, empowerment and integration

Central (Maricopa County) GSA

- Monthly foster, adoptive and kinship navigation forums were organized and held
- Onsite community trainings for group home and foster care providers were provided
- MMIC scheduled presentations and discussions at each DCS office on navigating the BH system and presented an overview of BH services in partnership with co-located providers
- All MMIC contracted providers were required to attend training on the following topics:
 - Meeting the unique needs of children involved in DCS
 - Child and family team practice
 - High needs case management
 - › Stakeholder case management collaboration
 - › Advanced child and family team facilitation
 - › Transition to adulthood
 - Court partnerships
 - Out-of-home levels of care

- Out-of-home care targeted treatment goals
- Functional behavioral assessment and behavior plan training

South GSA

CIC training topics included:

- BH and Jacob's Law 101 for court appointed special advocates of Pima County
- Family support partner training
- Unique needs of children involved with DCS
- Trauma informed care
- Trauma focused cognitive behavioral therapy
- Rapid response assessor training for BH providers
- Jacob's Law training at the Kinship and Adoption Resource and Education Family Center
- Overview of Jacob's Law during the CIC All Staff Meeting
- Updates on Jacob's Law to the following groups:
 - Foster Parent Forum and Regional Foster Care Focus Groups
 - Pinal Best for Babies Meeting
 - Southeast Region DCS Leadership

- Foster Adoptive Council of Tucson
- Kinship Support Agency Meeting

CRS Contractor

- UHCCP developed a new training module to address the BH needs of children involved with DCS.
- A training flyer regarding care for individuals with intellectual and developmental disabilities was developed and shared with the Foster, Adoptive, and Kinship Parent Advisory Council (FAKPAC).
- UHCCP developed CRS statewide directory of community resources for members, families and care providers.
- UHCCP held community WebEx training forums covering the following topics:
 - Stage 1: Newborns and early intervention
 - Stage 2: Young children
 - Stage 3: Teens
 - Stage 4: Pediatric to adult transition
 - Stage 5: Adulthood and aging caregivers

AHCCCS Oversight

Beginning July 1, 2016, the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) joined AHCCCS to administratively streamline monitoring and oversight of the RBHA Managed Care Contractors throughout Arizona.

In its role as an oversight entity, AHCCCS has established a defined structural and organizational approach that includes the following components:

- Development of efficient Contractor monitoring teams.
- A flexible organizational structure/model that supports effective communication and contract oversight.
- Ongoing training and technical assistance to AHCCCS personnel responsible for contract oversight.

In addition, AHCCCS has optimized the use of contracts, policies and procedures and managed care standards to support the agency's oversight role. Written agreements are in place with managed care organizations that include explicit requirements and contract standards across key operational functions (e.g., clinical and quality management, access to care, network sufficiency, financial sustainability, reporting). AHCCCS has also identified and implemented contractual remedies that allow for a flexible response to substandard Contractor performance. Responses include technical assistance, training, performance improvement activities, corrective action plans, notice to cure provisions and sanctions.

To support oversight of the Contractors responsible for the health care needs of children in foster care, AHCCCS has developed a comprehensive set of policies that include standards and reporting requirements for the timeliness of responses to requests for services, access to care standards and provider network development activities. Through these policies, AHCCCS requires Contractors to track, monitor and report important access to care and BH network capacity issues affecting CMDP members. A summary of selected policies from ACOM is presented below.

ACOM 417 — Appointment Availability, Monitoring and Reporting

ACOM 417 includes the following appointment standards applicable to all RBHAs and the CRS Contractor:

General BH Appointment Standards

- For BH provider appointments:
 - Urgent need appointments as expeditiously as the member's health condition requires but no later than 24 hours from identification of need
 - Routine care appointments:

- › Initial assessment within seven days of referral or request for services
 - › The first BH service following the initial assessment as expeditiously as the member's health condition requires but no later than 23 calendar days after the initial assessment
 - › All subsequent BH services, as expeditiously as the member's health condition requires but no later than 45 calendar days from the identification of need
- For psychotropic medications:
 - Assess the urgency of the need immediately
 - Provide an appointment, if clinically indicated, with a Behavioral Health Medical Practitioner within a timeframe that ensures the member a) does not run out of needed medications; or b) does not experience a decline in his/her BH condition prior to starting medication, but no later than 30 days from the identification of need.

Additional BH Appointment Standards for CRS and RBHA Contractors

- For BH Appointments for persons in legal custody of DCS and adopted children:
 - Rapid response when a child enters out-of-home placement within the timeframe indicated by the BH condition, but no later than 72 hours after notification by DCS that a child has been or will be removed from their home.
 - Initial assessment within seven calendar days after referral or request for BH services.
 - Initial appointment within timeframes indicated by clinical need, but no later than 21 calendar days after the initial evaluation.
 - Subsequent BH services within timeframes according to the needs of the person, but no longer than 21 calendar days from the identification of need.

The appointment standards for members in legal custody of DCS and adopted children are intended to establish expectations for appointment accessibility and availability among the RBHA and CRS Contractors' network of providers. The Contractor is required on a quarterly basis to conduct provider appointment availability reviews to assess the availability of routine and urgent appointments with BH providers for persons in the legal custody of DCS.

The Contractor must conduct provider appointment availability reviews in sufficient quantity so that results are meaningful and representative of the services provided by the Contractor's network. Appropriate methods include:

- Appointment schedule review where the Contractor independently validates appointment availability;
- Secret shopper phone calls, where the Contractor anonymously validates appointment availability; and
- Other methods approved by AHCCCS.

ACOM 415 — Provider Network Development and Management Plan: Periodic Network Reporting Requirements

AHCCCS requires Contractors to develop and maintain a Provider Network Development and Management Plan which assures AHCCCS that the provision of covered services will occur as stated in the contract. The Network Development and Management Plan outlines the Contractor's process to develop, maintain, and monitor an adequate provider network that is supported by written agreements and is sufficient to provide access to all services covered under the contract and satisfy all service delivery requirements.

The Network Development and Management Plan must be evaluated, updated and submitted along with the following:

- Appointment availability provider report as delineated in ACOM Policy 417 (these reports are submitted to AHCCCS quarterly as well as annually)

ACOM 436 — Network Standards

AHCCCS has established the following network standards that must be monitored and adhered to by each Contractor (the following standards are applicable to all RBHAs and the CRS Contractor):

Network Standards for Maricopa County and Pima County

The Contractor must ensure that 90% of its membership does not need to travel more than 15 minutes or 10 miles from their residence for the following provider types:

- Pharmacy
- BH Outpatient (only applicable to RBHAs)
- Integrated Clinics (only applicable to RBHAs)
- Crisis Stabilization Facilities (only applicable to RBHAs)
- Hospitals — four in Maricopa County, two in Pima County (designated by districts)

Network Standards for all other GSA/Counties (outside Maricopa and Pima Counties)

ACOM 436 includes network standards for CRS and each RBHA for hospitals and pharmacies, these requirements vary by specific numbers per city, groups of cities and/or county.

RBHA Contractors serving counties outside of Maricopa and Pima Counties must document a sufficient network to meet the needs of its membership based upon the following requirements:

- BH Outpatient and Integrated Clinic Standards

RBHA Contractors must have a network that provides access so that 90% of their membership does not need to travel more than 15 minutes or 10 miles from their original residence:

- Crisis Stabilization Facility Standards¹¹

RBHA Contractors must have a network that provides crisis stabilization services so that 90% of their membership does not need to travel more than 60 miles from their residence

Contractor Reporting Requirements

CHAPTER NO.	CHAPTER TITLE	RELEVANT REPORT(S) ¹²
415	Provider Network Development and Management Plan; Periodic Network Reporting Requirements	Network Development and Management Plan Network Attestation Statement Network Development and Management Plan Checklist Appointment Availability Provider Report (417) Provider Terminations/Diminishment Due to Rates
417	Appointment Availability, Monitoring and Reporting	Appointment Availability Provider Report
436	Network Standards	BH Outpatient and Integrated Clinic Time and Distance Crisis Stabilization Facility Time and Distance BH Residential Facility Time and Distance
449	BH Services for Children in Department of Child Safety Custody and Adopted Children	Access to Services Calls and Reconciliation Member Advisory Council Plan

¹¹ The analysis of service utilization data revealed that 654 unique members accessed a crisis stabilization service (procedure codes S9484 and S9485). Mercer has determined that the service is primarily targeted to adults (age 18 and older) due to facility licensing requirements and that alternative services are often used as interventions for children experiencing a behavioral health crisis (e.g., emergency respite).

¹² Includes only those reports required for CMDP members and BH services.

The following reporting requirements apply to RBHA Contractors in all GSAs and, when applicable, the CRS Contractor. Contractors providing BH services must report time and distance that the 90th percentile of their membership must travel in each county within the Contractor's GSA. In addition, it should be noted that the RBHA Contractors must report separately for specified populations served under the contract, including members enrolled in CMDP.

BH Outpatient and Integrated Clinic Reporting

The CRS Contractor must report in the Contractors' Annual Network Development and Management Plan the time and distance from their original residence that the 90th percentile of their membership must travel to reach a contracted clinic with this provider type.

RBHA Contractors must report in the Contractors' Annual Network Development and Management Plan the time and distance from their original residence that the 90th percentile of their membership must travel to reach a contracted clinic for members enrolled in CMDP.

Crisis Stabilization Facility Reporting

RBHA Contractors must report in the Contractors' Annual Network Development and Management Plan (ACOM 415) the time and distance from their original residence that the 90th percentile of their membership must travel to reach a contracted facility that provides crisis stabilization services for members enrolled in CMDP. It should be noted that the RBHAs are responsible for the timely delivery of crisis stabilization services to CMDP CRS members within the RBHA's designated geographic service area.

Behavioral Health Residential Facility Reporting

The CRS Contractor must report in the Contractors' Annual Network Development and Management Plan the time and distance from their original residence that the 90th percentile of their membership must travel to reach a contracted facility that provides BH residential facility services.

RBHA Contractors must report in the Contractors' Annual Network Development and Management Plan the time and distance from their original residence that the 90th percentile of their membership must travel to reach a contracted facility that provides BH residential facility services for members enrolled in CMDP.

AHCCCS Network Oversight Requirements

ACOM 436 requires CRS and RBHA Contractors to take steps to meet and maintain network standards. If established network standards cannot be met, the Contractor is required to identify gaps and address short-term and long-term interventions in their Annual Network Development and Management Plan.

ACOM 449 — Behavioral Health Services for Children in Department of Child Safety Custody and Adopted Children

Applicable to the CRS and RBHA Contractors, ACOM 449 requires the timely provision of medically necessary BH services to children eligible for services who are in out-of-home placements and in the legal custody of the DCS and to adopted children. The requirements of ACOM 449 are directly related to the provisions outlined in HB 2442.

Under ACOM 449, AHCCCS requires the timely provision of all BH services including crisis services, 72-hour rapid response, urgent need response and ongoing BH services, including screening and evaluation, for adopted children and children in out-of-home placements.

ACOM 449 requires that an assessment team is dispatched within two hours of notification for screening and evaluation of any member in urgent need of BH services.

Triage Lines

AHCCCS' Contractors are required to ensure the availability of a telephone line, with designated staff, that is responsible for handling incoming calls after business hours related to the delivery of crisis services, including failure of an assessment team to respond within two hours.

There shall be processes in place for staff to:

- A. Address barriers to care,
- B. Directly contact the crisis services vendor and/or provider,
- C. Track and report calls as indicated, and
- D. Report specified information to the Children Services Liaison.

72-Hour Response

ACOM 449 specifies the notification of the need for 72-hour rapid response may be requested by DCS, law enforcement or other individuals including the out-of-home placement or adoptive parent.

The Contractor shall dispatch an assessment team to complete a rapid assessment within 72 hours after being notified that a member has been taken into the custody of DCS.

BH Out-of-Home Treatment Setting Dispositions

The Contractor shall make a determination, as expeditiously as the member's health condition warrants but no later than, 72 hours after a request is made by the out-of-home placement or adoptive parent for placement of the member in a BH out-of-home treatment setting due to the child displaying dangerous or threatening behaviors.

These settings include, but are not limited to, Residential Treatment Centers, BH Residential Facilities, and BH Therapeutic Homes.

Use of Non-Contracted Providers

Upon notification from an out-of-home placement or adoptive parent that a recommended BH service is not provided to a member within 21 calendar days from the initial assessment, the Contractor is required to:

- Notify the caller of the requirement to also report the failure to receive the approved BH services to AHCCCS Customer Service.
- Notify the caller that the member may receive services directly from any AHCCCS-registered provider, regardless of whether the provider is contracted with the Contractor.

For services provided by a non-contracted provider, the Contractor shall:

- Not deny claims submitted based solely on the billing provider being out of the Contractor's network, and
- Reimburse clean claims at the lesser of 130% of the AHCCCS fee-for-service rate or the provider's standard rate.

The member may continue to receive services from the non-contracted provider regardless of the availability of an in-network provider.

Children's Services Liaison

Under ACOM 449, each Contractor must designate a key staff person whose primary role is to:

- Serve as the member's single point of contact,
- Accept and respond to:
 - Inquiries from the out-of-home placement, adoptive parent, or providers, and
 - Issues and concerns related to the delivery of and access to BH services for members in out-of-home placements or with adoptive parents.
- Collaborate with the out-of-home placement and adoptive parents address barriers to services, including nonresponsive crisis providers, and
- Resolve concerns received in accordance with grievance system requirements.

Member Advisory Council

To promote a collaborative effort to enhance the service delivery system for members in out-of-home placement and adoptive care, AHCCCS requires Contractors to establish a Member Advisory Council to provide input and feedback on policy and programs focused on addressing the needs of members in out-of-home placement and adopted members.

Education

Each Contractor is responsible for ongoing education to providers, members, families, and other parties involved with the member's care, including but not limited to the following:

- Rights and responsibilities,
- Trauma-informed care,

- Navigating the BH system,
- Coordination of care,
- Covered services,
- Referral process,
- The role of the Contractor,
- The role of DCS, and
- Additional trainings identified by the Member Advisory Council.

Tracking and Reporting Requirements under ACOM 449

ACOM 449 requires Contractors to monitor the following indicators and submit results to AHCCCS monthly or quarterly, depending on the indicator. (At the time of this report, the policy was being revised and under review via public comment):

Quarterly Reports:

- Access to Services:
 - 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 the 21 calendar days after the initial assessment, and
 - Number of times recommended and approved BH services were accessed directly by an out-of-home or adoptive parent that were provided by a non-contracted provider.
- Provider terminations:

- List of providers that were formerly contracted with the Contractor but terminated their contract and provided services at the lesser of 130% of the AHCCCS fee-for-service rate or the provider's standard service rate, and the amount spent on those services.

Monthly Reports:

- Calls received by the Children Services Liaison:
 - Number of calls,
 - Types of calls including but not limited to:
 - › General information and education,
 - › Request for crisis services because a crisis service provider was unresponsive,
 - › Calls received due to no crisis services provider available in area,
 - › Notification of initial BH services not provided within 21 calendar days,
 - › Request for BH out-of-home treatment due to the member displaying dangerous or threatening behaviors, and
 - › Request for continuation of care.
 - Number of calls responded to within one business day.
- Calls received by the after-hour line:
 - Number of calls,
 - Types of calls including but not limited to:

- › General information and education,
- › Request for crisis services because a crisis service provider was unresponsive,
- › Calls received due to no crisis services provider available in area,
- › Notification of initial BH services not provided within 21 calendar days,
- › Request for BH out-of-home treatment due to the member displaying dangerous or threatening behaviors, and
- › Request for continuation of care.

DCS provides a monthly listing to each Contractor of children placed in DCS custody. The Contractor is required to report to AHCCCS information on a monthly basis regarding members in DCS custody who have not received rapid response services. The Contractor performs a reconciliation of members placed within DCS custody against those who have received a rapid response service.

For any identified members in DCS custody who have not been engaged in BH services, the Contractor is responsible for ensuring that a rapid response service is delivered. The Contractor submits a DCS Rapid Response Monthly Reconciliation Report to AHCCCS which includes the following elements:

- The number of members removed by DCS,
- The number of members referred by DCS for a rapid response service,
- The number of members who received a rapid response service,
- The number of members placed in DCS custody who were not initially referred by DCS for a rapid response service, and
- The number of members receiving a BH service after being assessed by rapid response following reconciliation of the monthly list.

Member Advisory Council Plan

On an annual basis, AHCCCS requires each Contractor to submit a Member Advisory Council Plan. The plan includes the schedule of council meetings, council membership, trainings completed, goals and objectives to achieve under the plan and an evaluation of the previous year's goals and accomplishments.

GOALS AND OBJECTIVES OF ANALYSES

The purpose of this study is to conduct a statewide and Contractor-level (RBHAs and the CRS Contractor) network analysis and network sufficiency evaluation to assess the availability of BH services to children enrolled in CMDP and children who are adopted. In order to achieve that goal, this network adequacy study includes a comprehensive statewide analysis of the BH network providers available to children in CMDP and children who are adopted. A core component of the analysis of BH network providers is a geo-spatial mapping analysis.

An additional goal of this study is to review and analyze utilization, penetration, and timeliness of services as well as training and public engagement activities conducted by the RBHAs, the CRS Contractor and AHCCCS to enhance CMDP members' access to BH services. Mercer has used a multi-faceted approach, with an examination of a wide array of data sources, in order to explore emerging themes, identify challenges, and to validate findings and trends.

Based on the study's synthesis of data, the final goal of this study is to propose recommendations for sustaining current network strengths, identify potential opportunities to build the capacity of the network (including strategies for rural and remote areas), increase the efficiencies of the current network, and/or enhance the current provider network structure. Mercer's recommendations seek to positively impact access to the full continuum of BH care available to children and youth in the foster care system.

Limitations and Conditions of the Study

The network assessment conducted for this geospatial analysis is based on data provided by AHCCCS and CMDP. A robust data validation process was conducted by Mercer and supported by AHCCCS. Potential sources of error were addressed, though some discrepancies remain between other data sources that Mercer reviewed (e.g., Contractor self-reported data) as part of the overall network assessment. As a result, the validity of the behavioral health network assessment is contingent on the accuracy and completeness of the utilization and CMDP member eligibility data received by Mercer.

The data validation process applied to the CMDP membership file used in the utilization analysis and the geospatial analysis revealed some limitations that were addressed to minimize potential impact on the overall validity of the data. The file contained information for 17,519 members. Sixty-eight percent of the members included the member address and a designated code that identified the member's assigned Contractor. Thirty-two percent of the cases included the member address only. To address this finding, members missing an assigned Contractor were attributed to the Contractor responsible for the GSA as determined by the member's address on record. However, a small percentage of members may be temporarily placed outside of the assigned Contractor's designated GSA. In these cases, the member may have been originally assigned to a different Contractor, including the CRS Contractor. As a result, a small volume of members used in both the geospatial mapping and service utilization analyses are unable to be definitely assigned to a Contractor.

3

METHODOLOGY

To assess the availability of BH providers to meet the needs of CMDP members, Mercer analyzed the following information:

- *Trended analysis of CMDP service utilization data:* The analysis of service utilization data was targeted towards identifying the most prevalent BH services utilized by CMDP members and identifying BH providers used by CMDP members across a successive three-year time period.
- *Geo-spatial mapping analysis:* BH provider categories and their service locations were mapped against member locations (i.e., where the member has been placed in the community following removal by DCS) to determine the extent to which the Contractor's network is in compliance with established distance standards based on AHCCCS requirements (when available).
- *Review and analysis of AHCCCS required reporting for the CMDP population:* Review and synthesis of BH Contractor data reports required by ACOM, Chapter 400, Policies: 415 (Provider Network Development and Management Plan; Periodic Network Reporting Requirements), 417 (Appointment Availability, Monitoring and Reporting), 436 (Network Standards), and 449 (Behavioral Health Services for Children in Department of Child Safety Custody and Adopted Children).
- *Review and analysis of requests for assistance with BH service access directed to CMDP:* The review analyzed a tracking log of requests for assistance with accessing BH services from DCS field offices and from foster parent and kinship caregivers. The log is managed by CMDP and includes a summary description of the type of barrier that was being encountered when trying to access BH services.

- *Review and analysis of RBHAs and the CRS Contractor BH network documents and data:* Documents reviewed included the Contractors' network development plans, network-related data (i.e., services most utilized, penetration), complaint data, single case agreements, feedback and minutes of various meetings between the RBHAs and CRS and DCS/CMDP, and stakeholder groups (e.g., foster parents), training logs and results of performance measures.
- *CMDP key informant interview:* An interview was conducted with clinical leaders representing the CMDP.

A description of the methodology utilized for each evaluation component is presented below.

SNAPSHOT ANALYSIS OF BH PROVIDERS

Mercer initiated a request to AHCCCS for a comprehensive service utilization data file. The service utilization data file included all adjudicated BH service encounters for any CMDP member between October 1, 2013 and September 30, 2016. Because encounter submission lag times can impact the completeness of the data set, the utilization data included six months of claims runout through April 1, 2017.

Specific queries were developed to identify the number of BH providers who filed a claim within the most recent 12-month timeframe. Due to the critical importance of a subset of BH services, a follow up analysis was conducted to evaluate the number of providers of respite, HCTC, crisis and non-emergency transportation services. Each of these analyses was conducted for the entire state as well as by each of the RBHAs and the CRS Contractor.

A list of all providers was then extracted corresponding to the third and most recent year of the service utilization data file. This list of child and adolescent BH providers was subsequently used in the geospatial mapping analysis as the list represented the most recent and active BH providers rendering services to the CMDP population.

Because this list of child and adolescent BH providers was developed from service utilization data, it included providers that are registered with AHCCCS but may not have been contracted with a RBHA or the CRS Contractor as of the date of service. This latter group was included in the statewide geospatial mapping, but not the attributed to any of the Contractor specific geospatial mapping analyses.

TRENDED ANALYSIS OF CMDP SERVICE UTILIZATION

Utilizing the same comprehensive service utilization data file noted in the previous section, Mercer developed data queries to identify and evaluate the volume of unique users and billing units for all covered BH services. The number of unique CMDP individuals receiving services was trended by age band and by RBHA/CRS Contractor across three successive years. An additional analysis identified the top five services utilized by the highest number of unique users.

To support an analysis of service utilization trends for a subset of key services, a more specific analysis was conducted for HCTC, respite, non-emergency transportation and crisis services. This subset of services was initially identified based on the perceived importance to promote timely access (e.g., crisis responsiveness), the critical role the service performs (e.g., reliable transportation to access services) and were further emphasized due to the results of the analysis of summary level data from AHCCCS' Contractors and the CRS Contractor that suggested that there may be issues with consistently accessing these services.

Ages were determined by the last date of service included in each 12-month service utilization data file, and age bands were designated as follows:

- 0 to 2.999 years
- 3 to 5.999 years
- 6 to 12.999 years
- 13 to 17.999 years

The same set of analyses was conducted for service penetration, a measure obtained by dividing the number of unique users by the total number of eligible CMDP members. Mercer performed penetration rate calculations consistent with the formulas depicted below:

- Monthly penetration rates (for 36 months) = Number of monthly unique BH users/Number of monthly unique eligibles (see Appendix I);
- Quarterly penetration rates (for three years) = Quarterly unique BH users/Quarterly unique eligibles (see Appendix H); and

- Annual penetration rates (for three years) = Number of unique users in contract year ending (CYE)/Unique eligibles in the CYE.

The application of normalized data such as penetration rates creates more meaningful measures as it includes the relationship between the number of users and the number of total possible users and can, consequently, be used to compare results across populations that vary in size.

An additional analysis was conducted to evaluate the extent that CMDP members access behavioral services within an emergency department setting. The number of CMDP members who received BH services in an emergency room was determined by identifying all members whose BH claims had an assigned place of service (POS) code in the emergency room (i.e., POS 23).

GEO-SPATIAL ANALYSIS

BH provider types were organized into one of seven categories. Generally, provider types were categorized based on type of provider (i.e., prescribing, therapy, support services) to make the results more consistent and meaningful. BH outpatient clinics were placed in a category distinct from outpatient providers as BH outpatient clinics can offer prescriber appointments as well as psychotherapy and support services. The BH provider type categories utilized for the geospatial mapping analysis are presented on the following table:

Behavioral Health Provider Type Categories

FACILITY-BASED SERVICES	PRESCRIBERS AND PHYSICIAN EXTENDERS	SUPPLEMENTAL	OUTPATIENT CLINIC	LICENSED INDEPENDENT PRACTITIONERS – NON-PRESCRIBERS	SPECIALIZED SERVICES
02 Level I Hospital	08 Physician (Allopathic)	03 Pharmacy	29 Rural Health Clinics (RHCs)	11 Psychologist	39 Habilitation Provider
71 Level 1 Psychiatric Hospital (IMD)	19 Nurse Practitioner	04 Laboratory	72 RBHA	85 Licensed Clinical Social Worker	A5 BH Therapeutic Home
78 Level 1 Residential Treatment Center-Secure (non-IMD)	31 Physician (Osteopathic)	28 Non-emergency Transportation	77 BH Outpatient Clinic	86 Licensed Marriage/Family Therapist	A8 IHR Individual Home Respite

FACILITY-BASED SERVICES	PRESCRIBERS AND PHYSICIAN EXTENDERS	SUPPLEMENTAL	OUTPATIENT CLINIC	LICENSED INDEPENDENT PRACTITIONERS – NON-PRESCRIBERS	SPECIALIZED SERVICES
B1 Level 1 Residential Treatment Center-Secure (IMD)			C2 Federally Qualified Health Centers (FQHCs)	87 Licensed Professional Counselor	BC Board Certified Behavioral Analyst (BCBA)
B2 Level 1 Residential Treatment Center-Non-Secure (non-IMD)			A3 Community Service Agency	A4 Licensed Independent Substance Abuse Counselor	
B3 Level I Residential Treatment Center-Non-Secure (IMD)			IC Integrated Clinic		
B5 Level Subacute Facility (non-IMD)			05 Clinic		
B6 Level 1 Subacute Facility (IMD)					
B8 BH Residential Facility					
A6 Rural Substance Abuse Transitional Agency					

Crisis service providers were identified separately due to the variation in the continuum of crisis services and the types of providers that can render crisis services. Services and providers can range from facility-based crisis stabilization units, to community-based mobile teams and

emergency transportation. To identify crisis providers, service claims were queried by procedure codes for crisis stabilization (S9484, S9485)¹³, mobile crisis (H2011) and emergency transportation (A0382, A0389, A0420, A0422, A0888, A0426, A0427, A0428, A0429, A0434, A0430, A0431, A0435, A0436). Rendering providers linked to these service codes in the utilization data file were deemed to be crisis providers.

Utilizing the list of child and adolescent BH providers constructed from the final 12 months of the three-year utilization data, service locations were identified from the rendering provider’s place of service address for each service claim. In those cases in which a provider renders services in multiple locations, all locations were assigned to that provider and each location was noted as providing access to the identified service in the geo-spatial mapping analysis.

BH provider categories and their service locations were then compared with member locations¹⁴. In order to assess accessibility, the following distance standards for rural and urban providers were determined for each provider type. AHCCCS distance standards were applied when available. When distance standards had not been established for some provider types, Mercer established distance standards comparable to the standards established by AHCCCS. Per AHCCCS’ designation, “urban service area” was defined as Maricopa and Pima Counties. All other counties statewide were considered “rural”. The distance standards for each provider type are noted in the table below.

Distance Standards by Provider Type

PROVIDER TYPE	URBAN DISTANCE	RURAL DISTANCE
Facility-Based Service Providers	30 miles	60 miles
Prescribers/Physician Extenders	10 miles	10 miles

¹³ The analysis of service utilization data revealed that 654 unique members accessed a crisis stabilization service (procedure codes S9484 and S9485). Mercer has determined that the service is primarily targeted to adults (age 18 and older) due to facility licensing requirements and that alternative services are often used as interventions for children experiencing a behavioral health crisis (e.g., emergency respite).

¹⁴ Member locations were not placed on the geospatial maps to preserve the confidentiality of CMDP members, particularly those in rural areas.

PROVIDER TYPE	URBAN DISTANCE	RURAL DISTANCE
Supplemental Service Providers (Pharmacy*, Laboratory, Non-emergency Transportation)	10 miles	30 miles
Outpatient Clinics*	10 miles	10 miles
Licensed Independent Practitioners – Non-prescribers	10 miles	10 miles
Specialized Services (Habilitation, HCTC, Respite, BCBA)	10 miles	30 miles
Mobile Crisis	10 miles	30 miles

*Indicates AHCCCS established distance standard

The AHCCCS established distance standard of each provider type being within the required distance of 90% of the CMDP membership was adopted to evaluate compliance for each provider grouping.

A separate geo-spatial analysis was conducted for each of the following services.

- Crisis response services.
- Respite Services.
- Home Care Training to Home Care Client (HCTC).
- Medically necessary non-emergency transportation services.

Minimum, maximum and average distance was calculated for each provider grouping as well as for the specific services noted above.

Provider services location maps were constructed for each provider category, with a radius appropriate to its type of service, to provide a visual guide of BH services coverage statewide and within the Contractor's GSA.

AHCCCS REPORTS

Relevant chapters from the ACOM were reviewed, and any reports applicable to CMDP BH network adequacy were analyzed:

CMDP Log of requests for Assistance with Accessing Services

CMDP retains a log of all requests from foster and kinship placements as well as DCS field office staff for help with accessing BH services. This review analyzed 73 requests for assistance for five months (October, 2016 through February, 2017). Based on a content analysis of the information, requests for assistance were grouped into the following categories.

- *Higher LOCs.* These requests were typically generated by either foster or kinship placements, or DCS staff requesting a higher level of care for the foster child or youth.
- *Specialty/Assessment.* These requests were for treatment requiring providers with specialty training such as trauma focused therapy; or assessments such as a psychological or neuropsychological assessment, and/or Functional Behavioral Assessment (FBA).
- *BH services.* These requests were related to help with initiating any BH services, and did not specify specific services.
- *Crisis related services.* Services requested included the crisis stabilization team and access to a crisis center.
- *CFT.* These log entries noted that the member could not access BH services until a CFT was conducted.

RBHA and CRS Contractor Network Data

A request for information was distributed by Mercer to the RBHAs and the CRS Contractor. Requested documents are associated with Contractor related monitoring of network adequacy and BH service access specific to the CMDP population. The information request included the Contractors' network development and management plans, network-related data (e.g., BH services most utilized, penetration rates), complaint data, single case agreements, training logs, results of performance measures, and feedback and minutes of various meetings between the RBHAs and CRS and CMDP, AHCCCS and stakeholder groups.

A follow-up request was issued that requested additional information following the analysis of the initial submission of documents. Mercer reviewed and summarized a separate set of documents that described activities designed to increase awareness of how to access BH services as a result of HB 2442, including stakeholder engagement, training initiatives and Contractor network development activities.

CMDP Key Informant Interview

An in-depth interview was conducted with clinical and administrative leaders representing CMDP to gather additional information regarding system strengths and potential barriers to accessing BH services for children placed in foster care. Themes from this interview are used to supplement the other data sources applied as part of the BH network assessment and are described in the findings section of this report.

4

FINDINGS AND RECOMMENDATIONS

The findings and recommendations are organized in four sections. The first section presents the results of a geospatial mapping analysis based on location of service rendered as determined from the utilization file. The second section includes a utilization data analysis trended across three successive years. The third section summarizes the information provided by the Contractors as it pertains to network monitoring and management. The final section summarizes findings, system strengths and proposes high-level recommendations designed to enhance the overall BH network.

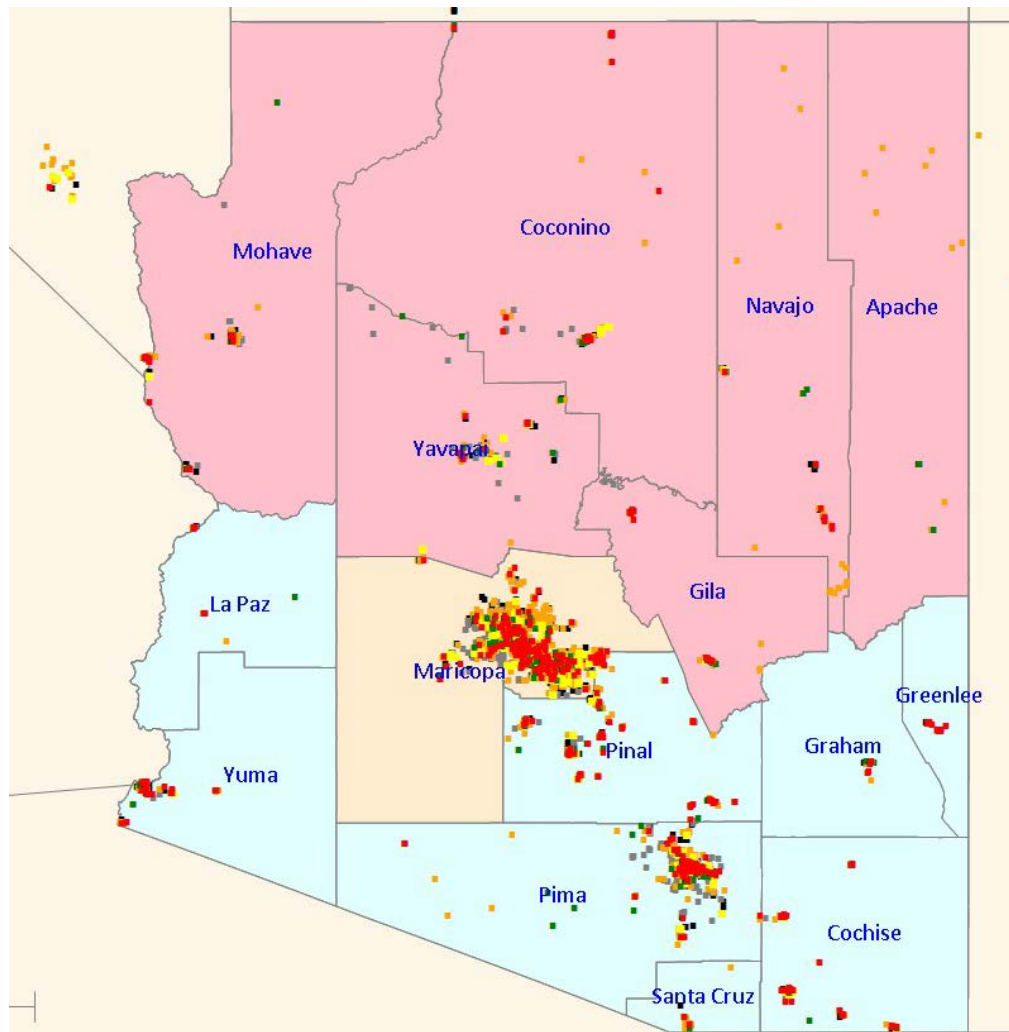
GEOSPATIAL MAPPING ANALYSIS

As noted in the methodology section, a statewide geospatial map was created that identifies all providers, both contracted and non-contracted, for each of the provider categories except for crisis services (separate statewide geospatial maps are presented for two categories of crisis services).

The locations of all the provider type categories are identified in the following statewide map.¹⁵

¹⁵ In order to protect the identity of CMDP members in rural areas, only provider locations are noted on the network analysis maps.

ALL PROVIDER TYPE CATEGORIES STATEWIDE



Map Legend

- BH Outpatient
282 providers at 502 locations
- BH Outpatient Clinic
306 providers at 411 locations
- Facility Based
132 providers at 207 locations
- Prescribers and Physician Extenders
741 providers at 1,866 locations
- Special Services
238 providers at 373 locations
- Supplemental Services
805 providers at 875 locations

Crisis Services

The continuum of crisis services available for CMDP members includes crisis stabilization services¹⁶, mobile crisis intervention services, and telephonic crisis intervention services. In order to avoid duplication, a separate statewide map for mobile crisis service providers is included, as many of the mobile crisis service providers offer other BH services as well.

The following provider types were determined to deliver mobile crisis services based on a review of the service utilization data file. Mobile crisis distance standards, as established by Mercer for purposes of the BH network assessment, are urban 10 miles/rural 30 miles.

06 Emergency Transportation

77 BH Outpatient Clinic

B5 Subacute Facility

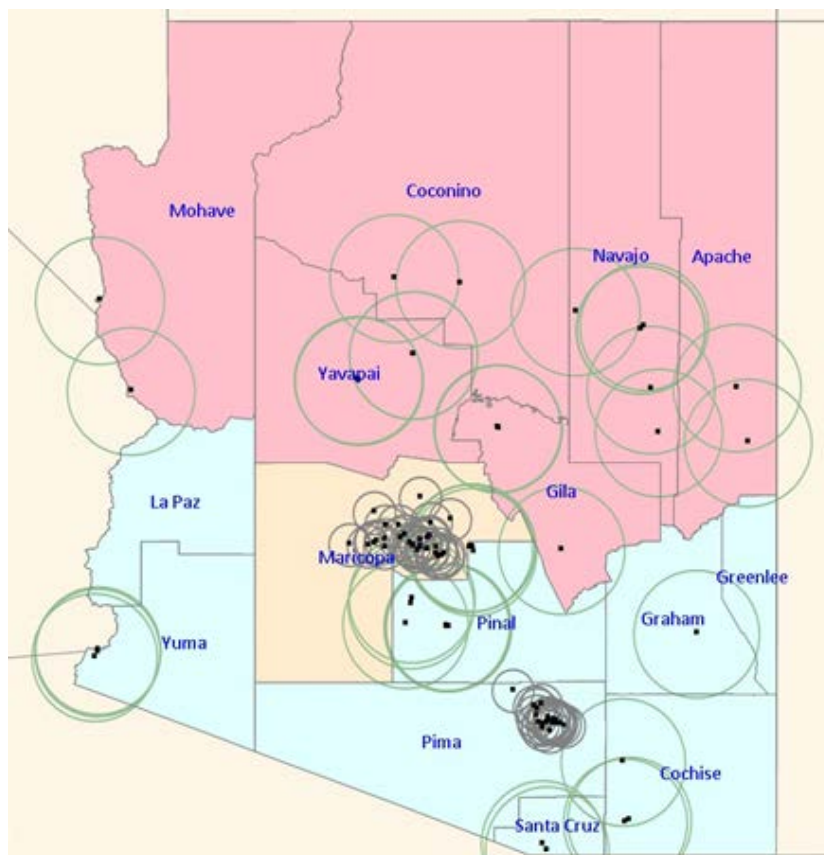
C2 FQHC

IC Integrated Clinic

The following map identifies the location for each mobile crisis provider type with both urban and rural distance standards indicated with circles, the smaller circles indicating the urban distance standard and the larger circles indicating the rural distance standard.

¹⁶ The analysis of service utilization data revealed that 654 unique members accessed a crisis stabilization service (procedure codes S9484 and S9485). Mercer has determined that the service is primarily targeted to adults (age 18 and older) due to facility licensing requirements and that alternative services are often used as interventions for children experiencing a behavioral health crisis (e.g., emergency respite).

MOBILE CRISIS PROVIDERS WITH URBAN/RURAL DISTANCE REQUIREMENTS



Although crisis services are available throughout much of the state, as noted in the Contractor specific analyses, members in the rural areas have less immediate access to these services. Specifically, coverage appears to be less robust in the following regions:

- Western Maricopa and Pima Counties (MMIC and CIC)
- A large portion of La Paz County (CIC)
- Greenlee County (CIC)
- Northern frontier regions of Mohave, Coconino, Navajo and Apache Counties (HCIC)

Contractor Specific – Geospatial Analysis Results

A geospatial mapping analysis was conducted for each of the Contractors. The Contractor geospatial maps can be found in Appendices D, E, F and G. The Contractor specific geospatial analysis does not include out of state members or providers. In addition, the geo-mapping software utilized by Mercer is unable to produce separate provider counts by urban and rural designations. Therefore, the number of providers and number of provider locations reflect the total number of providers for both urban and rural service areas for each provider type category.

Central (Maricopa County) GSA

Geospatial mapping analysis results for the Central GSA are summarized in the table below. Because the GSA is designated as an urban area for purposes of the BH network assessment, rural provider statistics apply to out-of-area members (982 members, or 9% of the total eligible members) who are not placed in Pima County (another urban designated area).

Central GSA (MMIC) Member Access — 10,914 Total Eligible Members (9,932 Urban/982 Rural)

PROVIDER TYPE CATEGORY	% MEMBERS WITHIN DISTANCE REQUIREMENT	90% STANDARD MET	NUMBER OF PROVIDERS (TOTAL)	NUMBER PROVIDER LOCATIONS (TOTAL)	AVERAGE DISTANCE (MILES)	MAXIMUM DISTANCE (MILES)
Facility-Based Services Urban	99.7%	Met	72 ¹⁷	128	2.7	54.4
Facility-Based Services Rural	90.3%	Met	--	--	18.6	148.3
Prescribers/Physician Extenders Urban	99.3%	Met	459	1,442	1.2	28.6
Prescribers/Physician Extenders Rural	93.2%	Met	--	--	2.8	44.0
Supplemental Services (RX, Laboratory, Transportation) Urban	99.1%	Met	676	729	1.2	50.8
Supplemental Services (RX, Laboratory, Transportation) Rural	97.0%	Met	--	--	4.2	112.2
Outpatient Clinics Urban	96.9%	Met	132	207	3.0	50.5
Outpatient Clinics Rural	77.0%		--	--	11.2	127.7

¹⁷ The number in the “number of providers” and “number of provider locations” columns represents both urban and rural providers.

PROVIDER TYPE CATEGORY	% MEMBERS WITHIN DISTANCE REQUIREMENT	90% STANDARD MET	NUMBER OF PROVIDERS (TOTAL)	NUMBER PROVIDER LOCATIONS (TOTAL)	AVERAGE DISTANCE (MILES)	MAXIMUM DISTANCE (MILES)
BH Outpatient Providers Urban	95.0%	Met	60	143	3.9	52.5
BH Outpatient Providers Rural	56.9%		--	--	14.2	127.7
Specialized Services (Habilitation, HCTC, Respite, BCBA) Urban	97.7%	Met	118	197	2.3	53.4
Specialized Services (Habilitation, HCTC, Respite, BCBA) Rural	81.2%		--	--	17.4	208
Crisis Mobile Services Urban	75.6%		16	31	7.4	68.2
Crisis Mobile Services Rural	81.6%		--	--	28.7	173.2

North GSA

Geospatial mapping analysis results for the North GSA are summarized in the table below. Because the North GSA is designated as a rural service area, urban distance standards only apply to out-of-area members (69 members, or 6.6% of the total eligible members) placed in Maricopa or Pima Counties.

North GSA (HCIC) Member Access — 1,107 Eligible Members (1,038 Rural/69 Urban)

PROVIDER TYPE CATEGORY	% MEMBERS WITHIN DISTANCE REQUIREMENT	90% STANDARD MET	NUMBER OF PROVIDERS (TOTAL)	NUMBER PROVIDER LOCATIONS (TOTAL)	AVERAGE DISTANCE (MILES)	MAXIMUM DISTANCE (MILES)
Facility-Based Services Urban	100.0%	Met	51	53	6.2	27.1
Facility-Based Services Rural	83%		--	--	34.2	159
Prescribers/Physician Extenders Urban	100.0%	Met	140	908	1.8	8.4
Prescribers/Physician Extenders Rural	82.9%		--	--	6.3	86.2
Supplemental Services (RX, Laboratory, Transportation) Urban	97.1%	Met	173	187	2.4	11.7
Supplemental Services (RX, Laboratory, Transportation) Rural	94.5%	Met	--	--	7.6	113.3
Outpatient Clinics Urban	91.3%	Met	114	164	4.7	16.1
Outpatient Clinics Rural	83.2%		--	--	6.6	110.1
BH Outpatient Providers Urban	78.3%		52	170	6.1	17.6

PROVIDER TYPE CATEGORY	% MEMBERS WITHIN DISTANCE REQUIREMENT	90% STANDARD MET	NUMBER OF PROVIDERS (TOTAL)	NUMBER PROVIDER LOCATIONS (TOTAL)	AVERAGE DISTANCE (MILES)	MAXIMUM DISTANCE (MILES)
BH Outpatient Providers Rural	67.4%		--	--	15.9	120.7
Specialized Services (Habilitation, HCTC, Respite, BCBA) Urban	88.4%		48	77	6.1	20.2
Specialized Services (Habilitation, HCTC, Respite, BCBA) Rural	69.1%		--	--	24.2	139.2
Crisis Mobile Services Urban	68.1%		28	46	8.1	21.7
Crisis Mobile Services Rural	67.3%		--	--	22.0	146.4

South GSA

Geospatial mapping analysis results for the South GSA are summarized in the table below. The South GSA includes Pima County, which is considered an urban service area. All remaining counties in the South GSA are considered rural service areas. Of the 309 out-of-area members, 264 reside in Maricopa County (designated as an urban service area).

South GSA (CIC) Member Access — 4,484 Eligible Members (3,059 Urban/1,425 Rural)

PROVIDER TYPE CATEGORY	% MEMBERS WITHIN DISTANCE REQUIREMENT	90% STANDARD MET	NUMBER OF PROVIDERS (TOTAL)	NUMBER PROVIDER LOCATIONS (TOTAL)	AVERAGE DISTANCE (MILES)	MAXIMUM DISTANCE (MILES)
Facility-Based Services Urban	99.1%	Met	68	90	4.6	79.5
Facility-Based Services Rural	90.4%	Met	--	--	15.3	117.0
Prescribers/Physician Extenders Urban	98.0%	Met	275	1,272	1.9	32.8
Prescribers/Physician Extenders Rural	95.1%	Met	--	--	2.3	43.0
Supplemental Services (RX, Laboratory, Transportation) Urban	97.6%	Met	298	329	2.2	65.9
Supplemental Services (RX, Laboratory, Transportation) Rural	98.5%	Met	--	--	4.1	66.5
Outpatient Clinics Urban	95.9%	Met	199	258	3.2	38.4
Outpatient Clinics Rural	92.8%	Met	--	--	3.4	37.9
BH Outpatient Providers Urban	93.9%	Met	111	310	3.7	57.9

PROVIDER TYPE CATEGORY	% MEMBERS WITHIN DISTANCE REQUIREMENT	90% STANDARD MET	NUMBER OF PROVIDERS (TOTAL)	NUMBER PROVIDER LOCATIONS (TOTAL)	AVERAGE DISTANCE (MILES)	MAXIMUM DISTANCE (MILES)
BH Outpatient Providers Rural	93.2%	Met	--	--	3.3	73.6
Specialized Services (Habilitation, HCTC, Respite, BCBA) Urban	98.1%	Met	133	213	2.3	77.9
Specialized Services (Habilitation, HCTC, Respite, BCBA) Rural	85.3%		--	--	13.2	103.6
Crisis Mobile Services Urban	83.6%		37	52	5.7	72.1
Crisis Mobile Services Rural	92.8%	Met	--	--	11.5	104.3

CRS Contractor

Geospatial mapping analysis results for the CRS Contractor are presented in the table below. Since the CRS Contractor is statewide, the GSA includes urban and rural service area designations.

CRS Contractor (UHCCP) Member Access — 450 Eligible Members (368 Urban/82 Rural)

PROVIDER TYPE CATEGORY	% MEMBERS WITHIN DISTANCE REQUIREMENT	90% STANDARD MET	NUMBER OF PROVIDERS(TOTAL)	NUMBER PROVIDER LOCATIONS (TOTAL)	AVERAGE DISTANCE (MILES)	MAXIMUM DISTANCE (MILES)
Facility-Based Services Urban	99.7%	Met	49	123	3.3	40.2
Facility-Based Services Rural	96.3%	Met	--	--	16.6	118.6
Prescribers/Physician Extenders Urban	98.6%	Met	563	1,586	1.5	15.0
Prescribers/Physician Extenders Rural	89.0%		--	--	4.3	44.7
Supplemental Services (RX, Laboratory, Transportation) Urban	99.5%	Met	546	582	1.3	11.2
Supplemental Services (RX, Laboratory, Transportation) Rural	96.3%	Met	--	--	5.9	70.4
Outpatient Clinics Urban	89.1%		63	84	5.1	40.4
Outpatient Clinics Rural	47.6%		--	--	15.8	128.9
BH Outpatient Providers Urban	89.1%		117	288	4.4	47.5

PROVIDER TYPE CATEGORY	% MEMBERS WITHIN DISTANCE REQUIREMENT	90% STANDARD MET	NUMBER OF PROVIDERS(TOTAL)	NUMBER PROVIDER LOCATIONS (TOTAL)	AVERAGE DISTANCE (MILES)	MAXIMUM DISTANCE (MILES)
BH Outpatient Providers Rural	76.8%		--	--	7.9	70.3
Specialized Services (Habilitation, HCTC, Respite, BCBA) Urban	97.0%	Met	101	171	3.0	38.8
Specialized Services (Habilitation, HCTC, Respite, BCBA) Rural	76.8%		--	--	18.1	169.2

GEOSPATIAL MAPPING ANALYSIS FINDINGS

To reiterate, in order to assess accessibility, distance standards for rural and urban providers were determined for each provider type. AHCCCS distance standards were applied when available. When distance standards had not been established for some provider types, Mercer established distance standards comparable to the standards established by AHCCCS. However, it is important to note that the distance standards established by Mercer for purposes of this analysis are not currently required of the AHCCCS Contractors.

The distance standards for each provider type are noted in the table below.

Distance Standards by Provider Type

PROVIDER TYPE	URBAN DISTANCE	RURAL DISTANCE
Facility-Based Service Providers	30 miles	60 miles
Prescribers/Physician Extenders	10 miles	10 miles
Supplemental Service Providers (Pharmacy*, Laboratory, Non-emergency Transportation)	10 miles	30 miles
Outpatient Clinics*	10 miles	10 miles
Licensed Independent Practitioners – Non-prescribers	10 miles	10 miles
Specialized Services (Habilitation, HCTC, Respite, BCBA)	10 miles	30 miles
Mobile Crisis	10 miles	30 miles

*Indicates AHCCCS established distance standard

Per AHCCCS’ designation, “urban service area” was defined as Maricopa and Pima Counties. All other counties statewide were considered “rural”. The distance standards for each provider type are noted in the table below. The AHCCCS established distance standard of each provider type being within the required distance of 90% of the CMDP membership was adopted to evaluate compliance for each provider grouping.

The results of the geospatial mapping demonstrate that, while some provider type categories for some Contractors did not meet the minimum distance standards, the geospatial analysis confirmed that a majority of the CMDP population has accessibility to all covered BH services across each of the three RBHAs and the CRS Contractor.

All of the RBHA and CRS Contractors met standards for facility based service providers (urban); prescribers/physician extenders (urban), and supplemental service providers [pharmacy, laboratory, non-emergency transportation (urban and rural)].

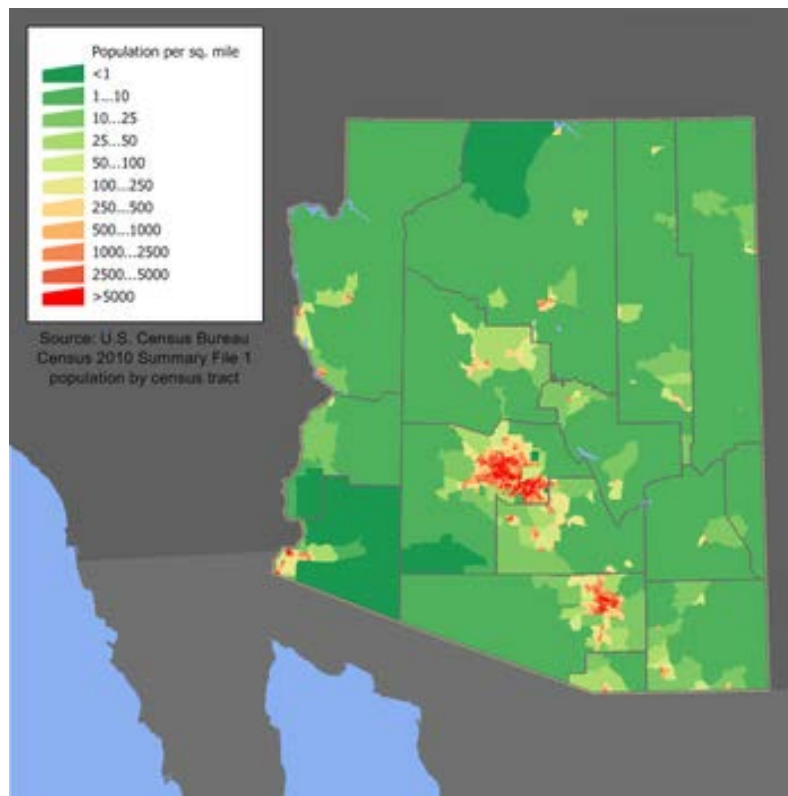
Opportunities for each Contractor based on provider types with AHCCCS established distance standards include the following:

Central GSA – Outpatient clinics (rural) and specialized services [habilitation, HCTC, respite, BCBA (rural)]. Based on Maricopa County's designation as an urban service area, the identification of potential deficiencies for accessing these services in rural service areas is due to assigned members that are placed outside of MMIC's geographic service area (n = 982).

North GSA – With the exception of facility based service providers (urban), prescribers/physician extenders (urban), and supplemental service providers [pharmacy, laboratory, non-emergency transportation (urban and rural)]; HCIC did not meet established distance standards for the remaining provider groupings.

The North GSA is an expansive frontier territory with only a few population centers. Much of the service area is national forest service land and other Bureau of Land Management administered lands. The territory also includes two large American Indian reservations; the Hopi and Navajo reservations.

The illustration below depicts the population per square mile and visually conveys the population density of the North GSA. The large geographic area and the relatively sparse population provide important context to the results of the geospatial mapping analysis for the North GSA.



South GSA – Specialized services [habilitation, HCTC, respite, BCBA (rural)]. CIC met all other geospatial distance standards for the remaining provider groupings with the exception of mobile crisis service providers (see note below regarding mobile crisis providers).

CRS Contractor - Prescribers/physician extenders (rural), outpatient clinics (urban and rural), and specialized services [habilitation, HCTC, respite, BCBA (rural)].

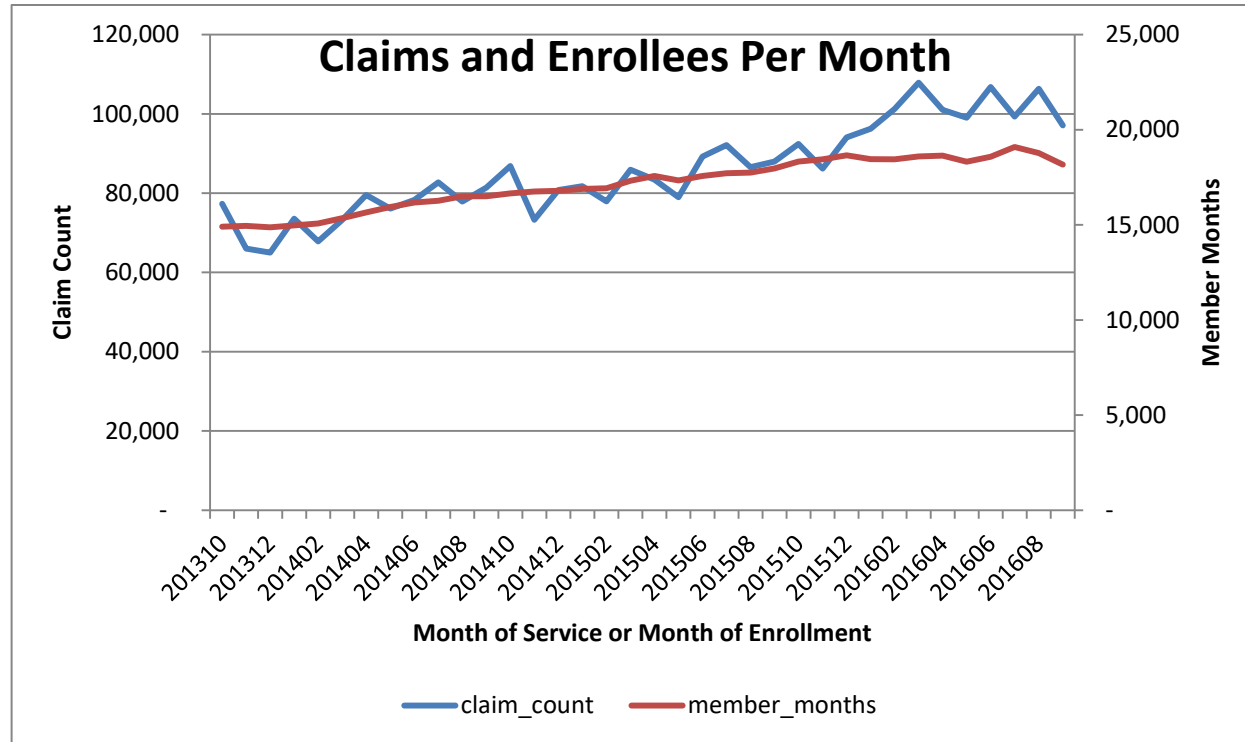
Mobile crisis services – Most of the RBHA Contractors did not meet established distance standards for mobile crisis services. However, there are some inherent limitations with applying the geospatial mapping analysis to mobile crisis providers as noted below.

Crisis mobile services are, by their nature, mobile services that travel to the location of the member in crisis. As such, the identified physical location of the provider for billing purposes is less relevant when the mobile crisis team may be dispatched from another location in the community. In addition, the prevalence of rural service areas across the state and episodic demand for the services pose challenges for Contractors to develop sufficient capacity to meet established distance standards.

UTILIZATION TRENDS

The following chart depicts the trend in claims over the three year period analyzed. The number of eligible CMDP members per month increased from 14,902 as of October 1, 2013 to 18,165 members in September 30, 2016, a 22% increase in the number of eligible members. During this same time period, the number of claims submitted during this time period increased from 77,331 to 97,113, a 26% increase in claims volume. The increase in the number of claims appears to align with and exceed the increase in the monthly eligible membership. The trend in this graph suggests that, when monthly variability is taken into account, statewide BH services have more than kept pace with the growth in eligible members over the past three years.

Monthly Number of Claims and Eligible Members



The table below presents an analysis of unique users of BH services, organized by Contractor. The tables also depict annual penetration rates, a measure that reports the percentage of CMDP eligible members who have received BH services during the specified time period. Appendix H displays penetration rates by quarter over the same time period (i.e., October 1, 2013–September 30, 2016) and Appendix I presents penetration rates by month over the same time period.

Trended Number of Unique Users of All BH Services by Contractor

GSA	YEAR ONE ¹⁸			YEAR TWO			YEAR THREE		
	Unique Users	Total Eligible	Penetration	Unique Users	Total Eligible	Penetration	Unique Users	Total Eligible	Penetration
Central GSA ¹⁹	10,518	14,746	71.3%	11,568	16,211	71.4%	12,119	16,765	72.3%
South GSA ²⁰	6,431	7,707	83.4%	6,739	7,726	87.2%	6,797	7,731	87.9%
North GSA ²¹	1,288	1,583	81.4%	1,560	1,845	84.6%	1,810	2,158	83.9%
CRS (All GSAs)	640	772	82.9%	666	763	87.3%	666	754	88.3%
Total Users/Eligible Members ²²	18,877	24,808	76.1%	20,533	26,545	77.4%	21,392	27,408	78.1%

The data indicates that the annual statewide penetration has incrementally increased over the three year period (+2%) and that over 2,500 additional children received behavioral health services between year one and year three.

¹⁸ Year One: Oct 1, 2013 - Sep 30 2014; Year Two: Oct 1, 2014-Sep 30 2015; Year Three: Oct 1, 2015-Sep 30 2016.

¹⁹ Maricopa County (GSA-6) transitioned from Magellan to MMIC on April 1, 2014.

²⁰ La Paz and Yuma Counties (GSA-2), Graham, Greenlee and Cochise Counties (GSA-3), Gila and Pinal Counties (GSA-4), Pima County (GSA-5) transitioned to CIC (GSA-8) on October 1, 2015.

²¹ Apache, Navajo, Coconino, Mojave, Yavapai Counties (GSA-1) transitioned from NARBHA to HCIC (GSA-7) on October 1, 2015.

²² Unique user and eligible member counts do not reconcile as some members moved between Contractors during the course of the year.

BH service utilization across age bands is presented in the table below and includes unique users and penetration rates for each designated age band. The 0 to 2.999 year old age band has the lowest penetration rates and the 6 to 12.999 age band has the highest penetration rates. Penetration rates increased significantly year to year for all age bands.

Trended Number of Unique Users of All BH Services by Age Band

Age Band	YEAR ONE ²³			YEAR TWO			YEAR THREE		
	Unique Users	Total Eligible	Penetration	Unique Users	Total Eligible	Penetration	Unique Users	Total Eligible	Penetration
0 to 2.999 years	4,095	6,024	68.0%	4,394	6,367	69%	4,623	6,582	70.2%
3 to 5.999 years	3,410	4,640	73.5%	3,640	4,799	75.8%	3,805	5,031	75.6%
6 to 12.999 years	6,556	8,032	81.6%	7,328	8,946	81.9%	7,557	9,117	82.9%
13 to 17.999 years	4,817	6,112	78.8%	5,173	6,433	80.4%	5,410	6,678	81.0%

The BH network assessment includes a special analysis of the following BH services: Crisis Services, Respite, HCTC and Non-Emergency Transportation. The following table presents the penetration rates for each service. Utilization of these services appears to be consistent from year-to-year, although noted increases in the penetration rates for HCTC and non-emergency transportation services was observed.

Trended Number of Unique Users for Specified Services

Service	YEAR ONE (15,510 TOTAL ELIGIBLE)		YEAR TWO (17,157 TOTAL ELIGIBLE)		YEAR THREE (18,409 TOTAL ELIGIBLE)	
	Unique Users	Penetration	Unique Users	Penetration	Unique Users	Penetration
Crisis Services	1,706	6.9%	1,670	6.3%	1,714	6.3%

²³ Year One: Oct 1, 2013-Sep 30 2014; Year Two: Oct 1, 2014-Sep 30 2015; Year Three: Oct 1, 2015-Sep 30 2016.

	YEAR ONE (15,510 TOTAL ELIGIBLE)		YEAR TWO (17,157 TOTAL ELIGIBLE)		YEAR THREE (18,409 TOTAL ELIGIBLE)	
Respite	837	3.4%	874	3.3%	852	3.1%
Home Care Training to Home Care Client	322	1.3%	323	1.2%	383	1.4%
Non-Emergency Transportation	4,363	17.6%	4,691	17.7%	5,403	19.7%

The following two tables depict the top five services by unique users. Case management and non-emergency transportation services constitute the highest volume of services units for the CMDP population during the period of October 1, 2015 and September 30, 2016.

Top Five Services by Units by Ages/All Ages

0 TO 2.999 YEARS	3 TO 5.999 YEARS	6 TO 12.999 YEARS	13 TO 17.999 YEARS	0 TO 17.999
Case Management (T1016)	Case Management (T1016)	Non-emergency transportation mileage, per mile (S0215)	Non-emergency transportation mileage, per mile (S0215)	Case Management (T1016)
Non-emergency transportation, per mile, vehicle provided by individual (family, neighbor, etc.) with vested interest (A0090)	Non-emergency transportation mileage, per mile (S0215)	Case Management (T1016)	Case Management (T1016)	Non-emergency transportation mileage, per mile (S0215)
Behavioral Health Counseling and Therapy (H0004)	Behavioral Health Counseling and Therapy (H0004)	Skills Training and Development (H2014)	Skills Training and Development (H2014)	Skills Training and Development (H2014)

0 TO 2.999 YEARS	3 TO 5.999 YEARS	6 TO 12.999 YEARS	13 TO 17.999 YEARS	0 TO 17.999
Non-emergency transportation mileage, per mile (S0215)	Non-emergency transportation per mile – case worker or social worker (A0160)	Behavioral Health Counseling and Therapy (H0004)	Behavioral Health Counseling and Therapy (H0004)	Behavioral Health Counseling and Therapy (H0004)
Skills Training and Development (H2014)	Skills Training and Development (H2014)	Unskilled Respite (S5150)	Non-emergency transportation per mile – case worker or social worker (A0160)	Non-emergency transportation per mile – case worker or social worker (A0160)

Top Five Services by Unique Users by Ages/All Ages

0 TO 2.999 YEARS	3 TO 5.999 YEARS	6 TO 12.999 YEARS	13 TO 17.999 YEARS	0 TO 17.999
Case Management (T1016)	Case Management (T1016)	Case Management (T1016)	Case Management (T1016)	Case Management (T1016)
Mental Health Assessment – by Non-Physician (H0031)	Mental Health Assessment – by Non-Physician (H0031)	Behavioral Health Counseling and Therapy (H0004)	Behavioral Health Counseling and Therapy (H0004)	Mental Health Assessment – by Non-Physician (H0031)
Behavioral Health Counseling and Therapy (H0004)	Behavioral Health Counseling and Therapy (H0004)	Mental Health Assessment – by Non-Physician (H0031)	Mental Health Assessment – by Non-Physician (H0031)	Behavioral Health Counseling and Therapy (H0004)
Home Care Training, Family (Family Support) (S5110)	Skills Training and Development (H2014)	Skills Training and Development (H2014)	Skills Training and Development (H2014)	Skills Training and Development (H2014)
Behavioral Health Screening to Determine Eligibility for Admission (H0002)	Home Care Training, Family (Family Support) (S5110)	Home Care Training, Family (Family Support) (S5110)	Home Care Training, Family (Family Support) (S5110)	Home Care Training, Family (Family Support) (S5110)

More CMDP children receive case management, mental health assessment, BH counseling and therapy, skills training and development and family support services than any other BH services. Case management is the most utilized service when examining the total number of unique users. Established AHCCCS policies that require children removed from their home to receive a screening and assessment within 72 hours is likely responsible for the high utilization of mental health assessment services. Once placed in foster care, CMDP children appear more likely to access counseling and therapy, skills training and development and family support services.

An additional analysis was conducted to evaluate the extent that CMDP members access BH within an emergency department setting. The number of CMDP members who received BH services in an emergency room was determined by identifying all members whose BH claims had an assigned POS code in the emergency room (i.e., POS 23).

Unique Users Receiving BH services in an Emergency Room Setting²⁴

	YEAR ONE	YEAR TWO	YEAR THREE
Unique Users	2,155	2,331	2,519
Eligible Members	24,808	26,545	27,408
Penetration	8.69%	8.78%	9.19%

BH utilization in emergency rooms ranges from 2,155 members in year one to 2,519 in year three, an increase of 17%. However, the number of eligible members also increased during this same time period (+10%). Overall, the penetration rate for emergency room utilization increased between year one and year three. In some BH service delivery systems, high utilization rates in emergency rooms can infer that accessibility, availability and/or accommodations (e.g., provider hours of operation) are compromised in some way within the BH provider network.

²⁴ The results are based on all unique users in the BH utilization file and included all of the BH services and codes that were applied as part of the utilization analysis.

SUMMARY LEVEL INFORMATION AND REPORTS

The following information is derived from AHCCCS RBHA and CRS Contractor required meeting minutes, network reports, network development and management plans; an AHCCCS-generated quality measure that assesses the timeliness of services, complaint data and a log of requests for assistance accessing BH services managed by the CMDP. Mercer reviewed and summarized the information to inform the overall analysis of the BH provider network available to children and youth in foster care.

Access to Care Reports

Three reports were reviewed that assess different aspects of access to care: the access to care report associated with ACOM 449, a survey based access to care report associated with ACOM 417, and a statewide, claims-based quality management report on the percentage of newly enrolled CMDP members receiving BH services within 7 and 21 days. Each access to care report is summarized below.

Contractor Access to Care Report

ACOM 449 requires that the Contractors submit a monthly access to services report every quarter in which the number of times the following incidents are identified.

1. The Contractor coordinated crisis services because a crisis service provider was unresponsive,
2. Initial BH services were not provided within the 21 calendar days after the initial evaluation.
3. Initial BH services were accessed directly by an out-of-home or adoptive parent that were provided by a non-contracted provider.

ACOM 449 does not specify the range of dates reported, other than that data be reported by month. Consequently, the Contractors' Access to Services Reports submitted in January 2017 cover a variety of date ranges:

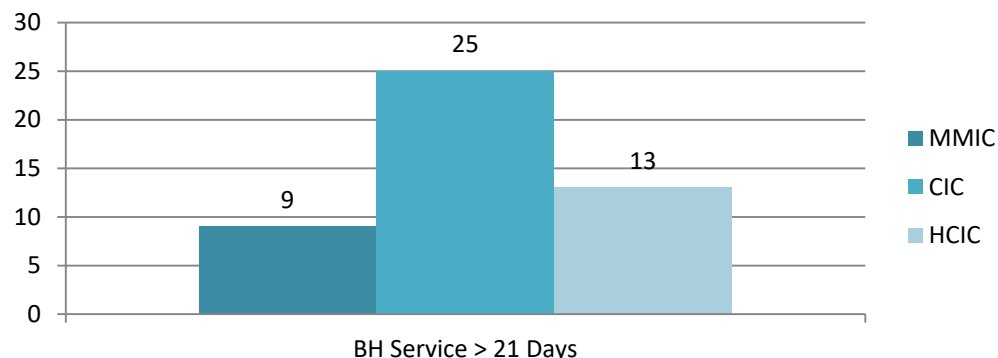
- September 2016 through November 2016 (MMIC);
- July 2016 through December 2016 (UHCCP);
- April 2016 through June 2016 (HCIC); and

- October 2016 through December 2016 (CIC).

Mercer’s analysis determined that during September 2016, MMIC reported that one foster parent or adoptive parent contacted a non-contracted BH outpatient clinic directly for services. This was the only reported occurrence across all Contractors for this incident type.

In addition, Mercer found that the CRS Contractor reported no instances in which initial BH services were not provided within 21 calendar days after the initial evaluation. However, the RBHAs reported multiple occasions in which BH services were not provided within 21 calendar days as presented in the graph below.

Number of Cases in which BH Services were not initiated within 21 Days²⁵



Overall, the number of reported instances in which BH services were not provided within 21 calendar days of an initial evaluation was low, but the differences between the Contractors were not correlated with the number of members enrolled in each Contractor. For example, the largest RBHA, MMIC (with 12,703 eligible members in Q3 2016), had the fewest number of cases in which services were not provided within 21 days. CIC, with 5,851 eligible members in Q3 2016, reported the highest volume of cases.

²⁵ The specific three month period represented in this chart varied across the RBHAs.

Interpretation of this report could be enhanced with a standardized approach to collecting data, including specifying the reporting time periods and the methods of data collection.

Contractor Appointment Availability Report

The Contractor appointment availability report is generated by the Contractors per specifications outlined in ACOM 417. This report monitors appointment availability with quarterly appointment availability reviews. Acceptable methods to conduct the reviews per ACOM 417 include:

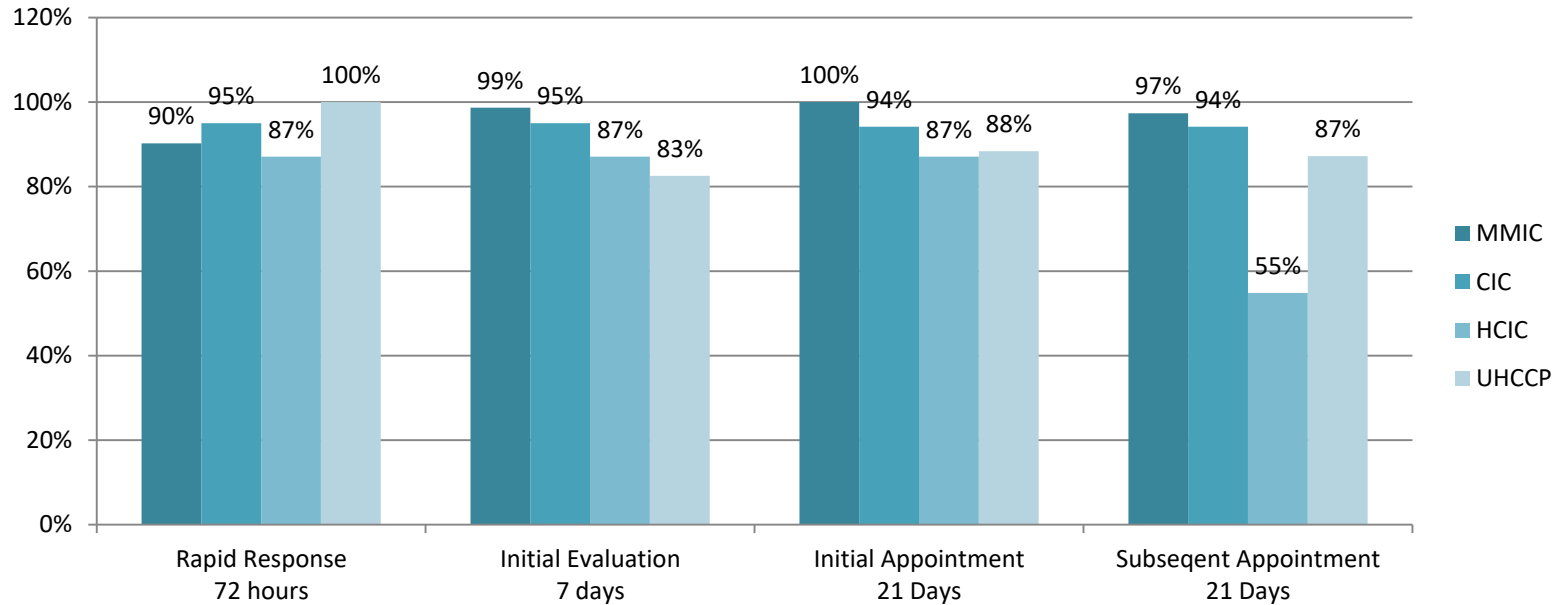
Appointment scheduling reviews in which the Contractor independently validates appointment availability;

Application of secret shopper surveys or proxy calls to determine when a provider can accommodate an appointment, or

An alternative approach approved by AHCCCS.

The Contractors submitted the following results for January, February and March (Q1) 2017.

Appointment Availability Report: January, February and March 2017



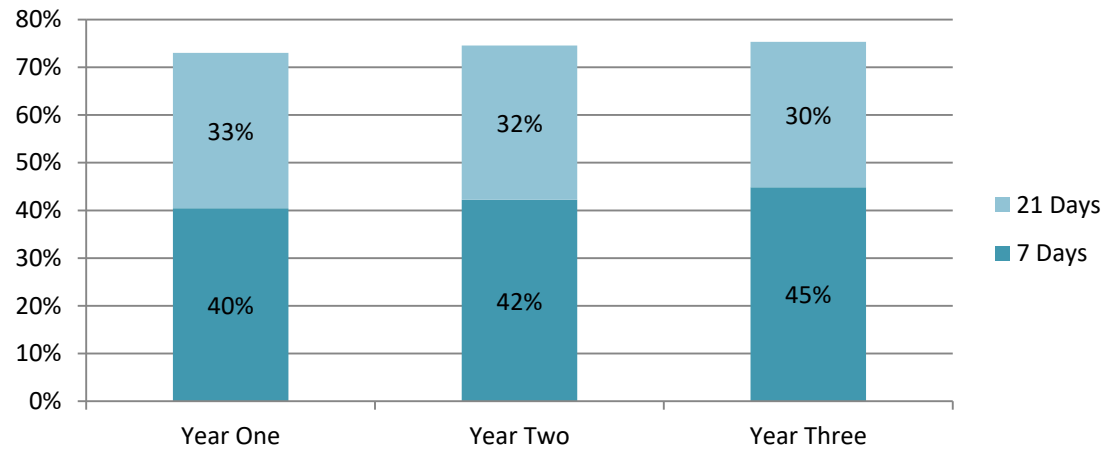
All of the Contractors responses ranged from 83% to 100% for the rapid response, initial evaluation and initial appointment standards. However, HCIC’s performance on the subsequent appointment standard (subsequent BH services no later than 21 calendar days for identification of need) was 55%. Mercer noted variations in the sample sizes utilized by each Contractor to calculate the access to care measures. Therefore, the results may not be representative of the population served by each Contractor.

The appointment availability report would be more meaningful if the sample sizes were specified and standardized to reach a particular confidence level or margin of error. The current approach does not necessarily produce representative information about the population.

Percentage of Newly Enrolled CMDP Members receiving BH Services within 7 and 21 Days

Mercer reviewed data from an AHCCCS-generated quality measure that represented a statewide snapshot of CMDP members receiving BH services within the first 7 and 21 days of CMDP enrollment. The measure uses administrative claims data to calculate the duration of time it takes for a member to record receipt of a of an allowable BH service as delineated within the measure specifications. The following statewide results were reported across three year time periods: Year One: October 1, 2013–September 30 2014; Year Two: October 1, 2014–September 30 2015; Year Three: October 1, 2015–September 30 2016.

Percentage of Newly Enrolled CMDP Members Receiving BH Services²⁶ within 7 and 21 Days



²⁶ Measure includes at least one unit of the following procedure codes: H0031,H0001,H0002,90791,90792,96101,96102,96103,96110,96111,96116,96118,96119,96120, 99241, 99242,99243,99244,99245,H0004,90832,90833,90834,90836,90837,90838,H2014,97532,H0025,H0034,H2025,H2026,H2027,99201,99202,99203,99204, 99205, T1016,T1019,S5109,S5110,H0038,S5150,S5151,98966,98967,98968,99367,99368,99441,99442,H2011.

Less than half of all new CMDP members accessed a BH service within the initial 7 days following enrollment with CMDP. Close to three out of four members access a BH service within 21 days following enrollment with CMDP. In some cases, the BH Contractors are not notified timely that a child has been removed from the home by DCS which can result in delays with initial response times.

Complaints and Inquiries

Mercer reviewed complaints reported by the BH Contractors and a log of requests for assistance accessing BH services maintained by the CMDP.

The CMDP requests submitted to Mercer covered six months from October 1, 2016 through February 29, 2017. The entries record staff and/or foster family/ kinship family requests for help in accessing BH services as well as a summary of the resolution.

The results from each data source are noted in the table below.

Complaints and CMDP Requests for Assistance

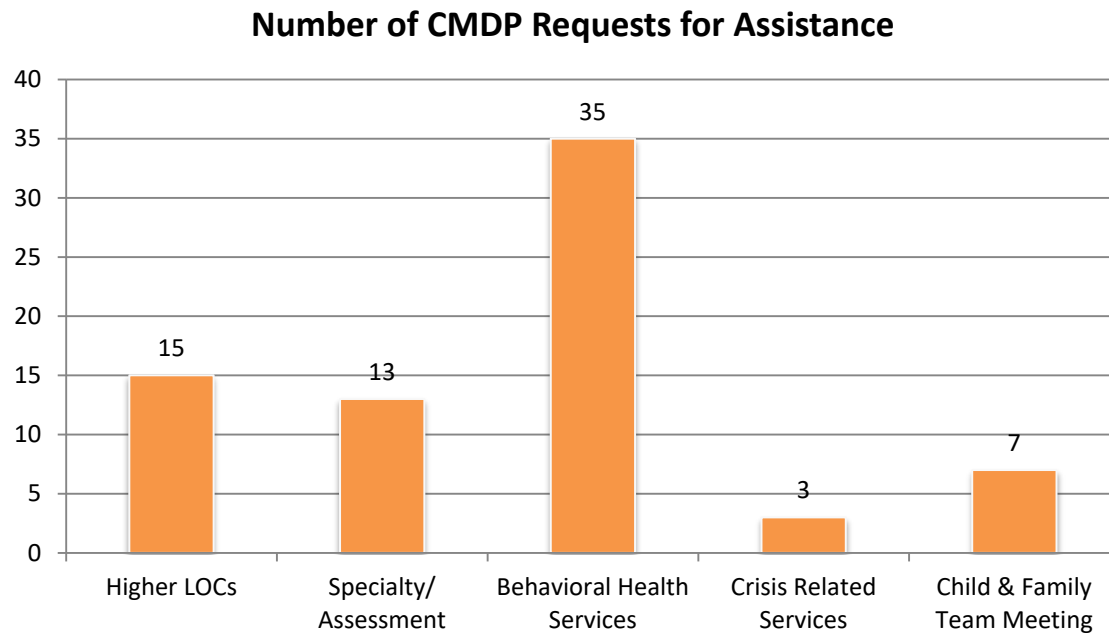
CONTRACTOR	% OF ENROLLED CMDP MEMBERS	CONTRACTOR REPORTED COMPLAINTS	ASSISTANCE REQUESTS TO CMDP	COMPLAINT/INQUIRY % FOR CONTRACTOR'S CMDP POPULATION
HCIC	6.5%	0	8	0.7%
CIC	26.4%	20	48	1.5%
MMIC	64.4%	2	15	0.16%
UHCCP/CRS	2.7%	NR	1	0.22%

Mercer noted that CIC reports the highest number of complaints and CMDP noted the highest requests for assistance despite an eligible CMDP membership that numbers less than half of the largest Contractor. Mercer requested additional detail from CIC to review the nature of the complaints filed. It was noted that the most frequent complaint types included extended wait times for services, concerns with discharge

planning when leaving an out-of-home treatment setting and issues related to accessing services, such as HCTC services and functional behavioral assessments.

In general, a low number of Contractor-reported complaints are difficult to interpret because of differing methodologies to recording member complaints. For example, members may have limited access to filing complaints, or the Contractor may only keep a record of those complaints that have not been immediately resolved, resulting in a lower number of reported complaints.

Each category had the following number of queries:



Mercer identified the following issues when the CMDP request for assistance log was analyzed.

Higher Levels of Care. In these instances, foster parents or DCS workers recommended that the child access a higher level of care for effective treatment, and requested CMDP to mediate with the Contractor to get the youth placed in what those individuals deemed a more appropriate placement.

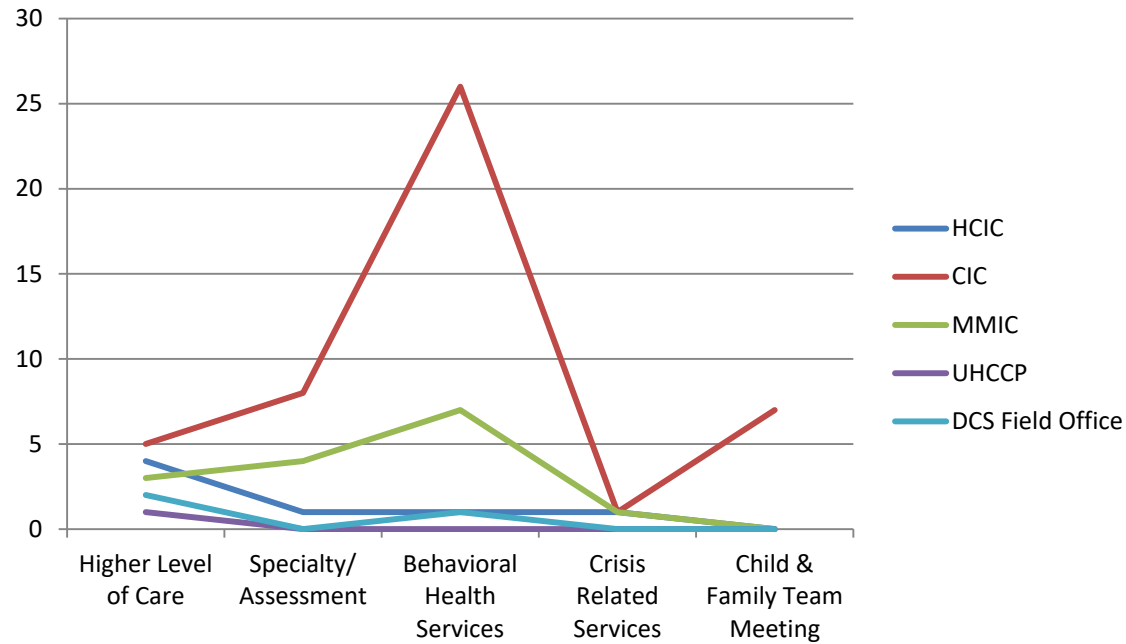
Specialty Service or Assessment. This category reflected when a CMDP enrollee needed a specialty service or assessment that was not immediately available, such as Eye Movement Desensitization and Reprocessing (EMDR) therapy, trauma focused therapy, and psychological and neuropsychological assessments.

BH Services. This category of request for assistance was the most frequent. Typically, the youth was identified to need BH services by the foster/kinship family and/or the DCS worker, and yet had not yet been able to access those services.

Crisis-Related Services. The log indicated one request for help for a crisis related service.

CFT Meeting. All of these requests for assistance were associated with CIC. The absence of a CFT meeting was noted to be a barrier to accessing BH services.

Reasons for CMDP Requests for Assistance with BH Service Access



Given the high number of requests for assistance, a root cause analysis to determine the cause(s) for CIC’s outlier status is recommended.

Community Collaboration and Stakeholder Feedback

Member Advisory Council

In accordance with standards outlined in ACOM 449, each of the Contractors established a Member Advisory Council (MAC) to provide input and feedback with the goal of promoting timely access to BH services for CMDP members.

MMIC developed a Foster/Adoptive/Kinship Oversight Workgroup, a TAY subcommittee as well as a Youth Leadership Council to fulfill the MAC requirement. Among other goals, this group provides review, discussion and recommendations on a) increasing awareness of how to

access BH services; and b) increasing accessibility of information and guidance on how to advocate for resolution of BH delivery challenges. MMIC has implemented the following initiatives in response to the workgroups recommendations:

- Conducted a Twitter campaign to advise members and families that waiting lists for BH services are not permitted.
- Notified providers, members and families of the timeliness requirements for BH services for CMDP members through public advertising and provider notifications.
- Created and implemented a new training requirement for Qualified Service Providers (QSPs) on timeliness standards and the internal escalation process for the required 21 day service delivery.
- Employed a child welfare liaison who reaches out directly to kinship families to help them access any needed BH services.
- Issued a Request for Proposal for an integrated health home in Maryvale.

CIC established a quarterly Foster Care Advisory Council that is supported by regional foster care focus groups in Yuma, Sierra Vista, Safford, Casa Grande, Nogales and Tucson. The Foster Care Advisory Council reviews local issues identified in the regional focus groups.

The primary issues identified included.

- Lack of Crisis Mobile Team (CMT) being dispatched following triage and a need for more in depth understanding of crisis response to DCS involved children and youth. CIC responded to this issue by a) requiring all crisis calls to the foster care hotline to include a dispatch of a CMT; and b) CMT training in de-escalation and evaluation.
- Insufficient numbers of licensed therapists and specialty providers in rural area. The Council also noted that the centralized ISP requirement is a barrier to timely access to services. CIC has responded to these issues by a) conducting outreach to recruit licensed and specialty providers who are registered with AHCCCS, but not contracted with CIC; and b) review of the service referral process with AHCCCS.

HCIC conducted five forums across the HCIC area to identify issues and concerns, and to initiate the MAC. Findings relevant to access and adequacy of BH services from the Kingman, Flagstaff and Prescott forums included the following.

- The need for additional respite services.
- Additional education on services available.
- Expand BH service availability, target schools for outreach and assist foster families with accessing services when needed.

UHCCP/CRS established a FAKPAC. Issues pertaining to access and adequacy of BH services included the following.

- Providers lack information or resources to access services for individuals with complex needs such as intellectual developmental disorders and BH needs.
- Family knowledge of how to access respite services, and BH respite providers reluctance to deliver services to individuals with cognitive disabilities.

Care Coordination

Each of the Contractors has developed venues to enhance care coordination and promote BH service access for CMDP members.

MMIC has improved their network of care for CMDP members through the following ongoing groups and processes.

- The High Need/High Cost Program coordinates between MMIC, CMDP and BH Providers to provide coordinated care to CMDP members and makes BH services available when and where they are needed.
- A monthly meeting between MMIC, DCS, and CMDP addresses BH service delivery issues as well as reviewing issues pertaining to physical health and BH care coordination.
- Weekly meetings between the MMIC Child Welfare Team and CMDP (including any involved providers) are conducted in which participants review placement dispositions of individual CMDP members.

CIC meets with CMDP weekly for care coordination. Topics for discussion have included availability for HCTC placements, prior authorization processes, and the need for residential programs to serve children with sexually-maladaptive behaviors. These meetings typically focus on the needs of specific CMDP members. CIC also meets monthly with CMDP for a High Needs/High Cost meeting designed to increase care coordination for high needs individuals.

HCIC participates in bi-weekly meetings with CMDP for issues associated with individual CMDP members, and either monthly, bi-monthly or quarterly to identify and address system barriers to BH access. Topics include foster/kinship family training needs and rapid response delays.

UHCCP meets with CMDP and DCS monthly to promote optimal health outcomes and regulatory compliance for CRS/CMDP members.

Contractor Behavioral Health Network Management

Two approaches to network management were analyzed: each of the Contractors' Single Case Agreements (SCAs) and the Contractor's annual network development plan and evaluation.

SCAs and Providers not Accepting New Members

SCAs are executed when a Contractor does not have access to a provider type within the contracted network or close to a member's geographic location. SCAs that are maintained with one provider for multiple members, or for particular provider types in specific areas, can suggest gaps in a provider network. However, when CMDP members are placed outside of their geographic area, the assigned Contractor continues to provide care to that individual. Some of the Contractors utilize SCAs to access services outside of the Contractor's designated geographic service area.

Two of the Contractors report a limited number of SCAs. UHCCP reported three SCAs, all for Level I Residential Treatment Facilities. CIC reported obtaining twelve SCAs since April 2016, nine for various types of Residential Treatment Centers and three for BH Outpatient clinics.

The remaining two Contractors report a higher number of SCAs. HCIC reported a total of 81 SCAs composed of the provider types noted in the accompanying chart. HCIC assists contracted health homes in creating SCAs when CMDP members are placed out of the HCIC GSA by DCS. Additionally, HCIC reports meeting with HCTC licensing agencies to shape HCTC service delivery and to recruit and expand HCTC services.

MMIC reported 80 SCAs for the following provider types: Outpatient Clinic, Nurse Practitioner, Licensed Professional Counselor, Licensed Clinical Social Worker, Habilitation Provider, and Hospital. MMIC policy is to reach out to providers and attempt to establish a full contract when the provider has over 25 SCAs.

MMIC reported that 30% of the SCAs were with providers of specialized services (e.g., sexual maladaptive behavior outpatient therapy, treatment of eating disorders, music and equine therapy, cultural based therapy and continuity of care) and 61% of the SCAs were executed to provide services to CMDP members placed out of MMIC’s geographic service area. MMIC reported expanding contracts with specialty providers as a result of an analysis of the types and volume of SCAs.

An additional approach to evaluate the capacity of an existing provider network is to monitor the number of providers who no longer accept new members. HCIC and MMIC report that all of the providers in their network currently accept new members. The CRS Contractor reported that five outpatient providers are not currently accepting new members. CIC reports that six providers in their network do not accept new members. All six are low volume providers and include four psychiatrists, one pediatrician and one provider affiliated with an HCTC.

PROVIDER TYPES FOR HCIC SCAS	NUMBER SCAS
B8 Behavioral Health Residential Facility	23
77 Outpatient Clinic	15
02 Level I Hospital	8
08 Physician-MD	8
71 Psychiatric Level I Hospital	6
11 Psychologist	5
87 Licensed Professional Counselor	4
85 Licensed Clinical Social Worker	3
B1 Level I Residential Treatment Center - Secure IMD	3
19 Nurse Practitioner	1
28 Non-Emergency Transportation	1
31 Physician-DO	1
78 Level I Residential Treatment Center - Secure Non-IMD	1
B2 Level I Residential Treatment Center - Non-Secure	1
B5 Level I Subacute Facility Non-IMD	1

Contractor Network Development Plans

AHCCCS requires each Contractor to develop and maintain a Provider Network Development and Management Plan, which supports the provision of covered services consistent with the AHCCCS contract. The Network Development and Management Plan describes each Contractor's approach to develop, maintain, and monitor an adequate provider network that is supported by written agreements and is sufficient to provide access to all covered services.

Excerpts of each Contractor's network development activities relevant to the CMDP population are summarized below. The information is summarized from each Contractor's Provider Network Development and Management Plan submitted to AHCCCS on November 15, 2016.

North GSA

HCIC and the DCS meet formally every other month to coordinate services and discuss system issues and opportunities, and to discuss issues surrounding HCTC homes. A separate DCS and HCIC meeting was planned to occur monthly between HCIC, DCS and CMDP to discuss and coordinate care for high-need CMDP members.

A pilot program, "Project Connections" was initiated by an HCIC contracted provider. Project Connections was developed to promote permanency for children dually enrolled in the Child Protective and Behavioral Health systems. Additional initiatives reported in the network development plan are as follows.

- Expansion of respite services based upon input from CMDP families and development of specialized residential facilities for members with both BH and personal care needs based upon provider input.
- HCIC implemented a new mobile crisis team system in Flagstaff through Terros, Inc. Terros' staff respond to the needs of all individuals in crisis, regardless of enrollment or eligibility status, including adults, youth and children, and individuals with developmental disabilities. The teams also respond to hospital rapid response calls in the emergency room or acute medical floor. Implementation for the Prescott/Prescott Valley/Chino Valley and Mohave County are expected for FY2017. In addition, Spectrum Healthgroup initiated a new approach to Mobile Crisis Teams specifically oriented to rapid response for First Responders in Eastern Yavapai County.
- In all northern Arizona counties, telemedicine systems are used to enhance the delivery of behavioral health services by allowing consumers to access psychiatric services in their own communities.

- A contract was established with a family-run provider for the Family Support Now pilot program. This pilot program is a partnership between the Mohave County Courts, BH providers, HCIC, and the DCS and immediately places a Family Support Partner with a parent who has had a DCS removal of a very young child (below age 5). Expansion of Parent Support Now in Yavapai County to continue to pair Family Support Partners with DCS-involved families to reduce the length of time where re-unification or permanency is achieved.
- HCIC developed Value-Based Payment contracts with network providers to shorten the length of time children are in DCS custody.
- The development of HCTC Homes or other out-of-home placements within the North GSA, the development of crisis services, and collaboration with DCS and the justice system continues.
- HCIC plans to continue to develop and expand respite services to strengthen and support the family and reduce the need for out-of-home placements. In addition, HCIC has developed new clinic-based respite services, consistent with new licensing regulations for this service that were released in 2016. As a result, day respite at a clinic is available in Mohave County and is under development for Yavapai, Coconino and Gila counties.
- HCIC is developing a residential treatment facility for adolescents in Kingman and to continue to recruit family-based HCTC homes and offer families intensive-in home supports.

Central (Maricopa County) GSA

MMIC leadership and CMDP leadership hold recurring meetings to address strategies for improving coordination of care and services for the CMDP Population.

Over the past year, MMIC has established expectations for provider agencies to have a minimum of one contact each month with all assigned CMDP youth. In addition, the assigned qualified service provider will offer ongoing BH services and assessments to CMDP youth for a period of at least one (1) year from the date of the BH enrollment.

MMIC has children's provider staff co-located at twelve DCS/DES offices to assist with enrollment and coordination of care and are working with DCS to have the ability to place co-located staff in an additional locations over the next year. In order to enhance services through the

co-located offices, MMIC initiated the DCS Co-location Project. This is a project outlining a comprehensive BH program model that meets the needs of the children, youth, families and caregivers that are involved in the child welfare system and enrolled in CMDP.

MMIC is outreaching the caregivers of youth that are in an out of home setting and funded by CMDP through monthly Navigation Forums and the Foster/Adoptive/Kinship Care Training Series. Direct referrals are now received from caregivers for both Rapid Response and DCS Stabilization Services, enrolling the child in services if not enrolled.

MMIC has established Birth to Five Learning Consortium which consists of representatives from the Birth to Five Specialty Programs, Cradles to Crayons and the Deputy Juvenile Court Administrator of Dependency. The purpose of this workgroup is to focus on the following:

- To identify of the needs for this population.
- To identify and establish partnerships between community stakeholders such as AzEIP, DCS and the Courts.
- To identify and develop educational materials, tools, and training for staff and families targeted towards assessment and treatment of the birth to five populations.
- To identify potential barriers to treatment and develop recommendations of strategies on how to overcome these barriers.
- To develop tools to support children and their families who need behavioral treatment in this specialty area.

Over the past year, MMIC allocated additional funding to the DCS co-located providers to expand service capacity and access to care for youth in the custody of the DCS. This includes three pilot projects targeted to engage the families of youth removed from their homes by DCS. The project has case managers co-located at eight of the DCS sites to assist in coordination of care activities. The providers were also allocated funding to provide supportive services as needed to the biological families/caregivers. The goal of this project is to provide supports to the entire family system in order to reduce the length of stay for youth in DCS custody and decrease the number of children in DCS custody.

MMIC also implemented co-located crisis providers at the DCS after-hours office and placement centers and additional funding was allocated to the qualified service providers to enable CMDP youth to receive a minimum of a year in treatment and to assess for ongoing needs.

MMIC allocated additional funding to children's providers for new programs and to expand capacity of existing programs. The expansion dollars provided additional services in the following areas:

- Improve access to care
- Services targeting specialty populations (CMDP, youth on the ASD spectrum, Birth to Five and TAY)
- Meet Me Where I Am, Trauma-focused CBT and respite services.

MMIC continues to expand and enhance the service delivery of specialty services, including:

- Trauma-informed care
- Youth with Sexually Maladaptive Behaviors
- Services for youth who are Developmentally Delayed or on the Autism Spectrum
- Sex trafficking

Over the past year, MMIC has expanded services for youth with Sexually Maladaptive Behaviors and for youth who are developmentally delayed or on the Autism Spectrum. MMIC has expanded contracts for services for developmentally delayed youth or children on the Autism Spectrum.

MMIC collaborated with co-located providers at three DCS model offices to implement a pilot project targeted to engage the biological parents of the youth taken into DCS custody. The Pilot Projects include: the expansion of parent mentors and/or family support partners to engage parents more effectively, attendance at Team Decision Making Meetings and/or joint planning with DCS prior to the PP5, service

coordination between parent and child, extended family-focused assessment and planning, trauma-informed assessments and interventions using appropriate tools, and ongoing monitoring of effectiveness and partnerships with Family Involvement Center and a Provider for family engagement and navigation. Funding has been made available to the each co-located providers to assist in parent engagement in services and coordination of care.

South GSA

In order to address the needs of children at risk of placement disruption, CIC developed BOOST, a secondary responder program. The Pima County-based program provides crisis stabilization and is available to support the child and placement 24 hours a day. This short-term placement stabilization program includes therapeutic intervention and staff trained to provide effective trauma-informed family support. CIC is in process in developing similar programs to support members in other counties within the South GSA.

Best practices for family support partner services have been incorporated into a guidance document and CIC is working with providers to offer family support services to families.

Jacob's Law work includes: implementation of the AHCCCS policy, increased collaboration with system partners, increased efforts to engage foster, kinship and adoptive placements, and a no-wrong door policy for accessing services for children involved with DCS system.

CIC continues to work with the courts and DCS to identify and develop more evidence based practices and programs to serve the specific needs of children and families in the foster care system. Parent Child psychotherapies, Parenting Programs and trauma focused CBT are all areas where focused development work has occurred.

CRS Contractor

UHCCP CRS is making the following additions to the CMDP BH network:

- Monitoring the need for additional intermediate/residential levels of care.
- Continuing to negotiate with Flagstaff Medical Center

- Continuing to negotiate with Maricopa Integrated Health Services
- Expanding current support services with Mentally Ill Kids In Distress (MIKID)
- Expanding services utilizing MSIC Telemedicine capabilities with contracted CRS BH providers.
- Physician coverage/call availability after hours and on weekends;
- Same day BH prescriber appointments;
- Nurse call-in centers, information lines, member services;
- Urgent Care/Crisis facilities; and
- Expansion of support and rehabilitation services.
- Focus on increasing the number of contracted Residential Treatment Centers.

UHCCP has continued Implementation of a CRS High Risk Case Management Program, which includes twice a month case review rounds with DES/DDD and DES/CMDP, and monthly case review rounds with the MSICs.

RECOMMENDATIONS

Based on the results of the BH network assessment, Mercer proposes the following recommendations for sustaining current network strengths as well as addressing opportunities to develop and expand the capacity of each of the BH Contractor's provider networks to address the needs of CMDP enrolled children. Mercer's recommendations seek to positively impact access to the full continuum of BH services and supports available to children and youth in the foster care system.

Further analysis is encouraged when findings align with the Contractor's own results derived through internal monitoring activities and/or represent suspected or known network development opportunities. The structure of Mercer's assessment relies on an accumulation of information and evidence to support emerging themes that may require closer examination. As such, Mercer does not recommend

interpreting single data source findings and translating those results to a need to address a perceived network deficit. Rather, Mercer's intent is for AHCCCS and the Contractors to review the findings and recommendations described in this report and, when indicated and supported by the results of the assessment as well as other relevant knowledge of the provider network, engage in a thorough review of causative factors that may (or may not) support the need to take action.

Geospatial Mapping Analysis — Recommendations

Although a continuum of crisis services is available throughout much of Arizona, crisis service coverage appears to be less robust in the following regions:

- Western Maricopa and Pima Counties
- A large portion of La Paz County
- Greenlee County
- Northern frontier regions of Mohave, Coconino, Navajo and Apache Counties

Opportunities for each Contractor based on provider types with AHCCCS established distance standards include:

- Central GSA – Outpatient clinics (rural) and specialized services [habilitation, HCTC, respite, BCBA (rural)]. Based on Maricopa County's designation as an urban service area, the identification of potential deficiencies for accessing these services in rural service areas is due to assigned members that are placed outside of MMIC's geographic service area (n = 982).
- North GSA – With the exception of facility based service providers (urban), prescribers/physician extenders (urban), and supplemental service providers [pharmacy, laboratory, non-emergency transportation (urban and rural)]; HCIC did not meet established distance standards for the remaining provider groupings.
- South GSA – Specialized services [habilitation, HCTC, respite, BCBA (rural)]. CIC met all other geospatial distance standards for the remaining provider groupings with the exception of crisis based service providers.

- CRS Contractor - Prescribers/physician extenders (rural), outpatient clinics (urban and rural), and specialized services [habilitation, HCTC, respite, BCBA (rural)].

Mercer recommends that each Contractor review the results of the geospatial mapping analysis and assess the need to develop additional provider capacity with the provider types identified above.

Service Utilization Analysis — Recommendations

All RBHA and CRS Contractors should examine the sufficiency and diversity of BH services available to children ages 0 to 5. In particular, assess the sufficiency of network providers who are qualified to address the needs of this unique population and determine the extent to which evidence based practices and specialty services are available to meet the needs of these children.

All Contractors (including the CRS Contractor) should assess the sufficiency of the network to provide HCTC services and develop a sufficient number of HCTC providers that are accessible to CMDP members, including those targeted to serve older children (ages 12–17) and children with complex needs (e.g., intellectual development disabilities and mental health disorders).

All Contractors (including the CRS Contractor) should assess the sufficiency of the network to provide respite services.

All Contractors should carefully examine BH utilization in emergency rooms and determine if more appropriate alternatives are available to meet the needs of CMDP members.

Summary Level Reports and Data — Recommendations

Standardize measurement and reporting specifications for current contract deliverables for all required Contractor reporting. In those contract deliverables that determine access based on a sample of the total population, require Contractors to use a sample size that is statistically significant at the 95% or 99% confidence level. Alternatively, AHCCCS could require that the Contractors report the confidence level associated with the sample size, in order to evaluate the adequacy of the sample size and to estimate the true value of the population.

Because the North GSA has identified and initiated plans to further develop the provider network, AHCCCS may require an in depth network development strategy for CMDP members, with a particular focus on specialized services such as HCTC, respite and crisis services.

Consider requiring CIC to conduct a root cause analysis into non-network adequacy barriers to BH service access that includes an analysis of complaint data specific to the CMDP population.

APPENDIX A

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 Home Care Training Family (Family Support)

SERVICE CATEGORY	SERVICE
	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

INVENTORY OF PROVIDERS BY COUNTY

(AVAILABLE UPON REQUEST)

APPENDIX C

INITIAL AND FOLLOW UP REQUEST FOR INFORMATION



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Jay Dunkleberger
Network Administrator
Arizona Health Care Cost Containment System
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March 22, 2017

Subject: Behavioral Health Network Assessment — Request for information

Dear Jay:

The Arizona Health Care Cost Containment System (AHCCCS) has retained Mercer Government Human Services Consulting (Mercer) to conduct a behavioral health network adequacy assessment for providers who render behavioral health services to children enrolled with the Comprehensive Medical and Dental Program (CMDP).

Mercer is requesting AHCCCS' assistance with the provision of data to complete the network assessment. Mercer has included data file details to support the following data requests:

- Behavioral health service utilization data specific to the CMDP population (see Attachment A — utilization data);
- AHCCCS registered behavioral health service providers (see Attachment B — provider reference data); and
- Member demographic data specific to the CMDP population (see Attachment C — Client Information System (CIS) and member demographics).

In addition, Mercer is requesting the following AHCCCS contractor specific data elements. Please provide the following data, reports and/or information for each AHCCCS contractor that is the subject of the behavioral health network assessment (Cenpalco Integrated Care, Health Choice Integrated Care, Mercy Maricopa Integrated Care, and United Healthcare Community Plan).

For the data sources listed below (excluding Attachments A, B and C), please submit the most recent data available since April 1, 2016. When possible and applicable, include data and reports specific to the CMDP population.

- Numbers and types of contracted providers who are not accepting new members
- Customer satisfaction survey data specific to network access
- Complaint data specific to network access or timeliness of services

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December 2016



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AHCCCS

- Single case agreements (volume and provider type)
- Stakeholder feedback and relevant committee minutes follow – up actions and outcomes (e.g., Member Advisory Council)
- Contractor tracking and reporting deliverables as required by *AHCCCS Contractor Operations Manual (ACOM), Chapter 400, 449 – Behavioral Health Services for Children in Department of Child Safety Custody and Adopted Children*
- Number of days and volume of impacted members where behavioral health inpatient services medical necessity criteria were not met but there was not a discharge plan in effect to meet the needs and safety of the child (if tracked by AHCCCS contractors and available)
- Contractually required quarterly narrative and data summary that addresses successes and barriers associated with behavioral health service delivery to CMDP members
- Contractor care coordination meeting minutes with CMDP, including identified issues, interventions and outcomes
- A review of inquiries to CMDP regarding members who are in the Department of Child Safety custody or adopted members related to access to behavioral health services (CMDP may need to provide this information).
- Any performance measures related to appointment timeliness and/or access to care and results of proxy calls/surveys to assess the availability and timeliness of behavioral health appointments **that are in addition** to the requirements of *ACOM, Chapter 400, 417 - Appointment Availability, Monitoring and Reporting*.
- Contractor specific network deliverables **that are in addition** to the requirements of *ACOM, Chapter 400, 415 - Provider Network Development and Management Plan; Periodic Network Reporting Requirements* and *ACOM, Chapter 400, 436 - Network Standards*.

Please upload the data requested above to the appropriate, designated shared secure Connect site folder **by April 5, 2017**. In the event that you have questions regarding this data request, please contact me at +1 602 522 8578 or via email at dan.wendt@mercer.com.

Sincerely,

Dan Wendt
Principal

Copy:
Christina Quast, AHCCCS
Michal Anne Pepper, Mercer
Nicholas Petsas, Mercer

Page 3
 March 22, 2017
 Jay Dunkleberger
 AHCCCS

Attachment A, B and C

To facilitate the document collection process, Mercer will utilize an online shared secured site called Connect and will provide access to an AHCCCS designated contact person(s).

Questions related to the Connect site should be directed to Stacia Ortega at: stacia.ortega@mercer.com. Please contact Stacia with the name(s) of the staff requiring access to the Connect site as soon as possible. The link to the secure site will be provided along with separate IDs and passwords when access is established for your staff.

Using pipe “|” delimited text files, please upload the data requested below to the appropriate, designated Connect folder by **April 5, 2017**. Please provide valid values or a data dictionary for all codes contained in the data.

Attachment A: Utilization Data

Data Element/Field	Comments
Reporting Time Period	January 1, 2016 – April 1, 2017
Fund Source	If any combinations of IDs are a unique identifier of the member from the member data table then remove this field.
Behavioral Health Category	If any combinations of IDs are a unique identifier of the member from the member data table then remove this field.
Member ID/Client ID	
AHCCCS ID	
Member First Name	If any combinations of IDs are a unique identifier of the member from the member data table then remove this field.
Member Last Name	If any combinations of IDs are a unique identifier of the member from the member data table then remove this field.
Date of Birth	If any combinations of IDs are a unique identifier of the member from the member data table then remove this field.
Gender Identity	If any combinations of IDs are a unique identifier of the member from the member data table then remove this field.
Race Code	If any combinations of IDs are a unique identifier of the member from the member data table then remove this field.
Zip Code of Residence	Please Include if available. If any combinations of IDs are a unique identifier of the member from the member data table then remove this field.
County of Residence	If any combinations of IDs are a unique identifier of the member from the member data table then remove this field.
Contractor ID	One of three Regional Behavioral Health Authorities or the Children’s Rehabilitative Services Contractor
Rendering Provider ID	
Rendering Provider NPI	
Rendering Provider Name	If any combinations of IDs are a unique identifier of the provider from the provider reference table then remove this field.

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 March 22, 2017
 Jay Dunkleberger
 AHCCCS

Data Element/Field	Comments
Rendering Provider Type	If any combinations of IDs are a unique identifier of the provider from the provider reference table then remove this field.
Rendering Provider Specialty	
Rendering Provider Address Line 1	If any combinations of IDs are a unique identifier of the provider from the provider reference table then remove this field.
Rendering Provider Address Line 2	If any combinations of IDs are a unique identifier of the provider from the provider reference table then remove this field.
Rendering Provider City	If any combinations of IDs are a unique identifier of the provider from the provider reference table then remove this field.
Rendering Provider Zip Code	If any combinations of IDs are a unique identifier of the provider from the provider reference table then remove this field.
Rendering Provider County	If any combinations of IDs are a unique identifier of the provider from the provider reference table then remove this field.
Rendering Provider State	If any combinations of IDs are a unique identifier of the provider from the provider reference table then remove this field.
Service Begin Date	MM/DD/YYYY
Service End Date	MM/DD/YYYY
Admission Date	MM/DD/YYYY. For inpatient only.
Discharge Date	MM/DD/YYYY. For inpatient only.
Procedure Code	Include all available CPT, HCPCS codes.
Procedure Code Modifiers	Include all associated modifiers.
Revenue Code	
DRG	
DRG Indicator	Indicate the DRG type and version.
Encounter Form Type	Include all available types.
Type of Bill	
Place of Service	
Encounter Status	
Unit of Service	
ICN Number	
Claim Line Number	

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 March 22, 2017
 Jay Dunkleberger
 AHCCCS

Attachment B: Provider Reference Data

Data Element/Field	Comments
Reporting Time Period	January 1, 2016 – April 1, 2017
Contractor ID	One of three Regional Behavioral Health Authorities or the Children's Rehabilitative Services Contractor
Rendering Provider ID	
Rendering Provider NPI	
Rendering Provider Name	
Rendering Provider Type	Include all available provider types
Rendering Provider Specialty	Include all available provider specialties offered by the provider
Rendering Provider Address 1	
Rendering Provider Address 2	
Rendering Provider Zip Code	
Rendering Provider County	
Rendering Provider State	
Service Begin Date	MM/DD/YYYY
Service End Date	MM/DD/YYYY. If still in service put 12/31/9999.

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 March 22, 2017
 Jay Dunkleberger
 AHCCCS

Attachment C: CIS and Member Demographics

Data Element/Field	Comments
Reporting Time Period	January 1, 2016 – April 1, 2017
Fund Source	
Behavioral Health Category	
Member ID/Client ID	
AHCCCS ID	
Member First Name	
Member Last Name	
Date of Birth	
Gender Identity	
Race Code	
Contractor ID	One of three Regional Behavioral Health Authorities or the Children's Rehabilitative Services Contractor
Member Address Line 1	Please Include if available
Member Address Line 2	Please Include if available
Member City	Please Include if available
Zip Code	Please Include if available
County of Residence	
Member State	
Member Eligibility End Date	MM/DD/YYYY
Member Eligibility Begin Date	MM/DD/YYYY

Follow Up RFI Request



Dan Wendt
Principal

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Phoenix, AZ 85016
+1 602 622 8579
dan.wendt@mercer.com
www.mercer.com

Page 2
May 2, 2017
Jay Dunkleberger
AHCCCS

Jay Dunkleberger
Network Administrator
Arizona Health Care Cost Containment System
Division of Health Care Management, Operations
701 E. Jefferson Street
Phoenix, AZ 85034

May 2, 2017

Subject: Behavioral Health Network Assessment — Follow-Up Request for Information

Dear Jay:

The Arizona Health Care Cost Containment System (AHCCCS) has retained Mercer Government Human Services Consulting (Mercer) to conduct a behavioral health network adequacy assessment for providers who render behavioral health services to children enrolled with the Comprehensive Medical and Dental Program (CMDP).

Mercer has reviewed the data submitted by the Regional Behavioral Health Authorities (RBHAs) and the statewide Children's Rehabilitative Services (CRS) contractor and is requesting AHCCCS' assistance with a follow-up request for additional information based on our analysis of the submitted data. Specifically, we are requesting the following information:

All Contractors:

- Please confirm that the submitted customer satisfaction survey data specific to network access (Item C) is not available separately for the CMDP population.
- Please confirm that custodial inpatient days due to lack of a safe discharge plan is not being tracked and trended at this time.

CRS Contractor:

- Please confirm that medical record reviews are not currently conducted to evaluate access to care and timeliness and availability of covered behavioral health services to the CMDP population.
- Page 18 of the Network Development Plan notes that the CRS contractor requires RBHAs to notify the contractor of referrals and crisis calls. If these contacts are tracked and/or trended for the CMDP population, please provide summarized results and any follow-up actions taken in response to the information.
- Please provide trended appointment and availability survey data (see page 57 of the Network Development Plan presented in a chart format) separately for the CMDP population, if available.

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Mercy Maricopa Integrated Care:

- Please confirm that medical record reviews are not conducted to evaluate access to care and timeliness and availability of covered behavioral health services to the CMDP population.
- Please provide summarized results and/or trended data derived from a comparative analysis of the DCS Removal and the Rapid Response Monthly Reports.
- Please provide the results of the analysis for behavioral health provider gaps as noted on page 46 of the Network Development Plan.
- Please provide summarized findings from the focus groups referenced on page 64 of the Network Development Plan (i.e., "the forums held for Adoptive and Foster Care Families").

Cenpatco Integrated Care:

- Please provide the following additional information concerning the 40 complaints and 42 requests for assistance with access and timeliness to covered behavioral health services:
 - Summary description of the complaint or request for assistance (with personal health information omitted).
 - Provider types associated with the complaint or request for assistance
 - Physical location of the provider associated with the complaint or request for assistance; and
 - Identification of the behavioral health service that was affiliated with the complaint or request for assistance.
- Please confirm that medical record reviews are not conducted to evaluate access to care and timeliness and availability of covered behavioral health services to the CMDP population.
- Please provide any aggregated or trended data or summary reports based on the monthly rapid response tracking of crisis response timeliness.

Health Choice Integrated Care:

- Please include a summary of actions taken and/or planned interventions to address the utilization of single case agreements when providing covered behavioral health services to the CMDP population.
- Please provide any additional details (e.g., provider types, identification of covered behavioral health services, results of an analysis of causative factors contributing to inaccessibility or delays in accessing behavioral health services, etc.) related to the recorded results for provision of services (row 9) and access to care (row 13) as reported on the second tab (CMDP Overall) of the health home medical record review results.
- Please confirm that the Network Development Plan in track changes and submitted as part of the initial data request is the final version.

Page 3
May 2, 2017
Jay Dunkleberger
AHCCCS

Thank you for your attention to this follow-up data request. To help ensure that any additional information can be reviewed and incorporated into the behavioral health network assessment, Mercer is requesting that the information be provided by May 12, 2017.

Sincerely,

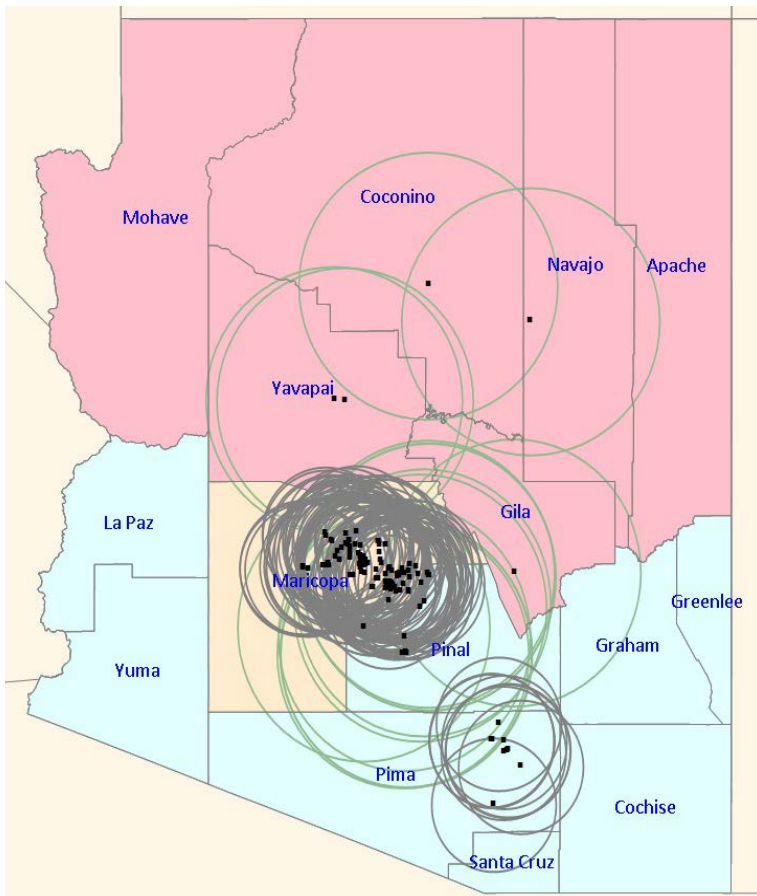
Dan Wendt
Principal

Copy:
Christina Quast, AHCCCS
Michal Anne Pepper, Mercer
Nicholas Petsas, Mercer

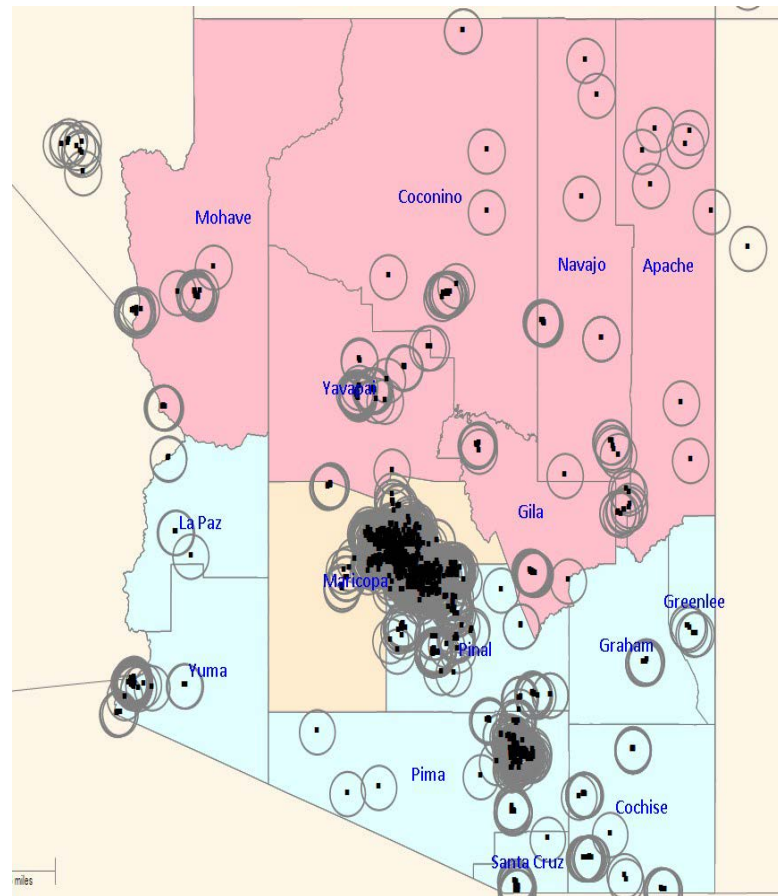
APPENDIX D

CENTRAL GSA (MMIC) PROVIDER CATEGORIES MAPS

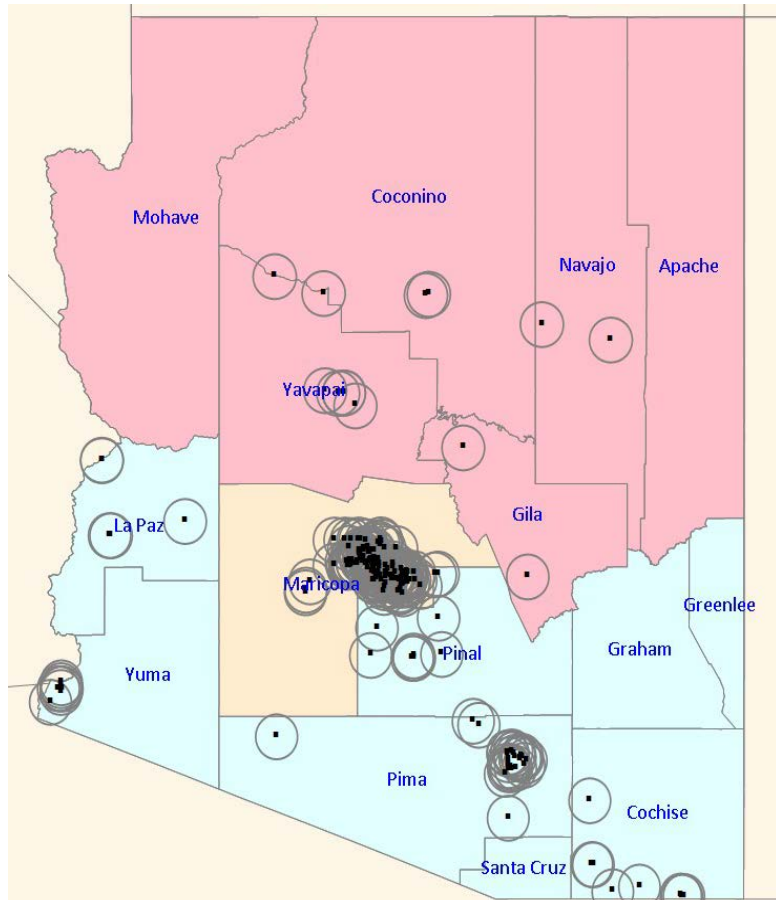
Facility Based Services Urban and Rural Standard



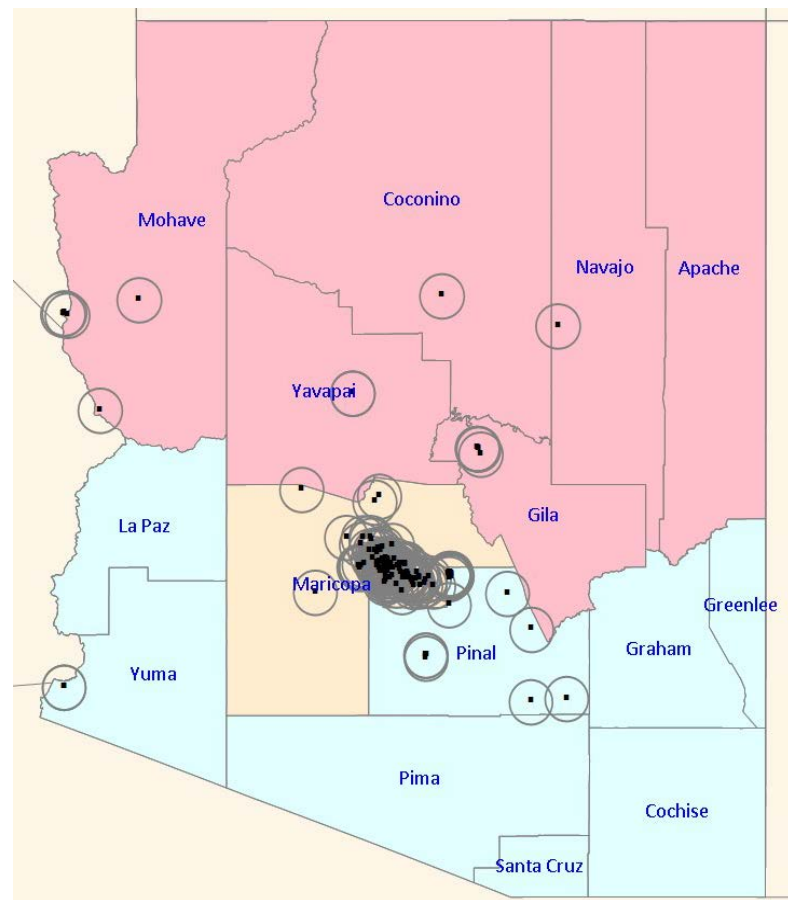
Prescribers, Physician Extenders



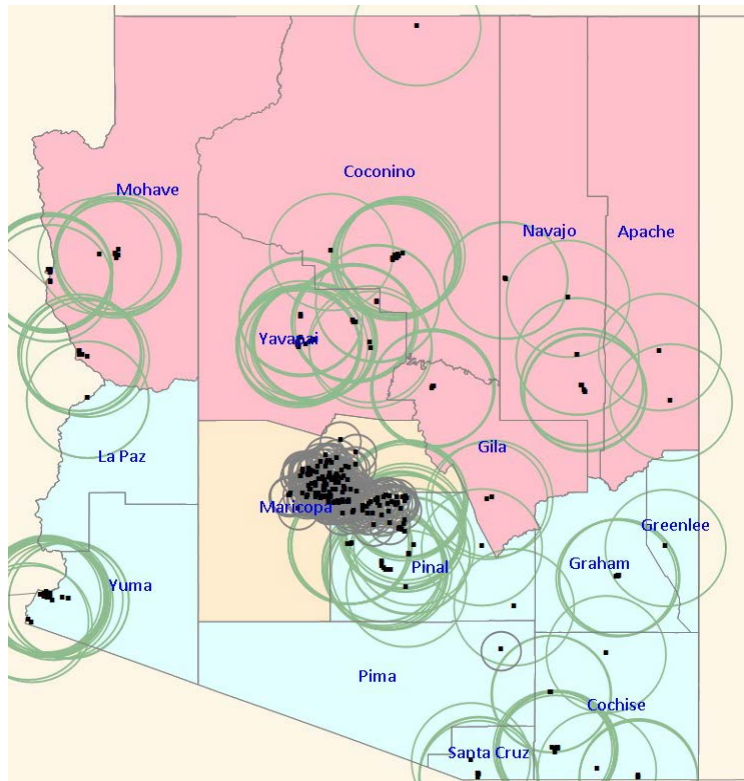
BH Outpatient Clinics



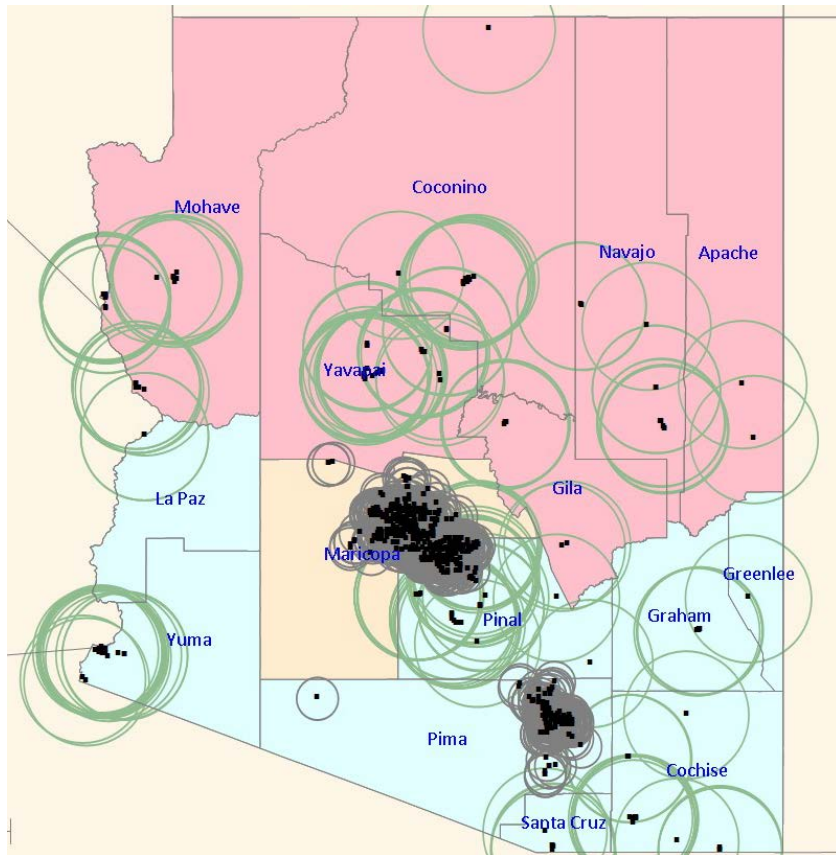
BH Outpatient Providers



Specialized Services (Habilitation, HCTC, Respite, BCBA) Urban and Rural Standard



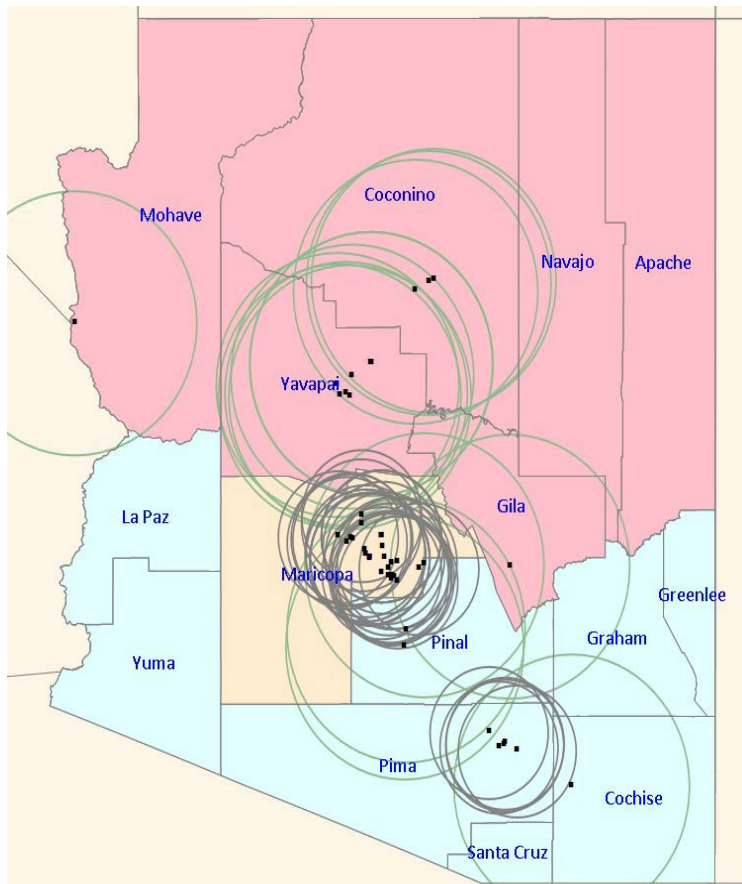
Statewide Access Supplemental Services



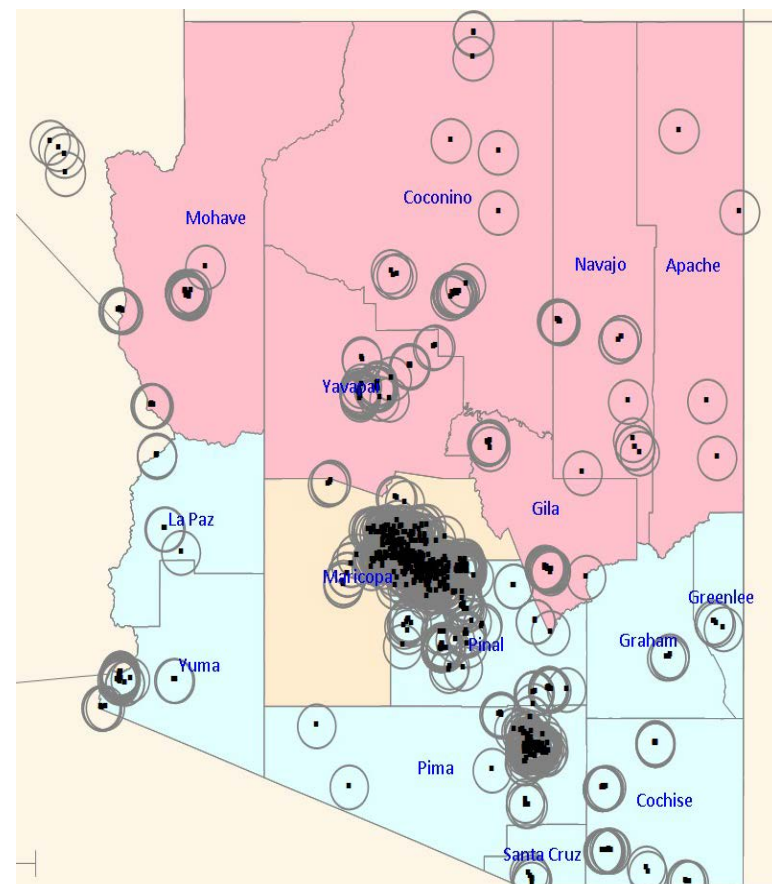
APPENDIX E

NORTH GSA (HCIC) PROVIDER CATEGORY MAPS

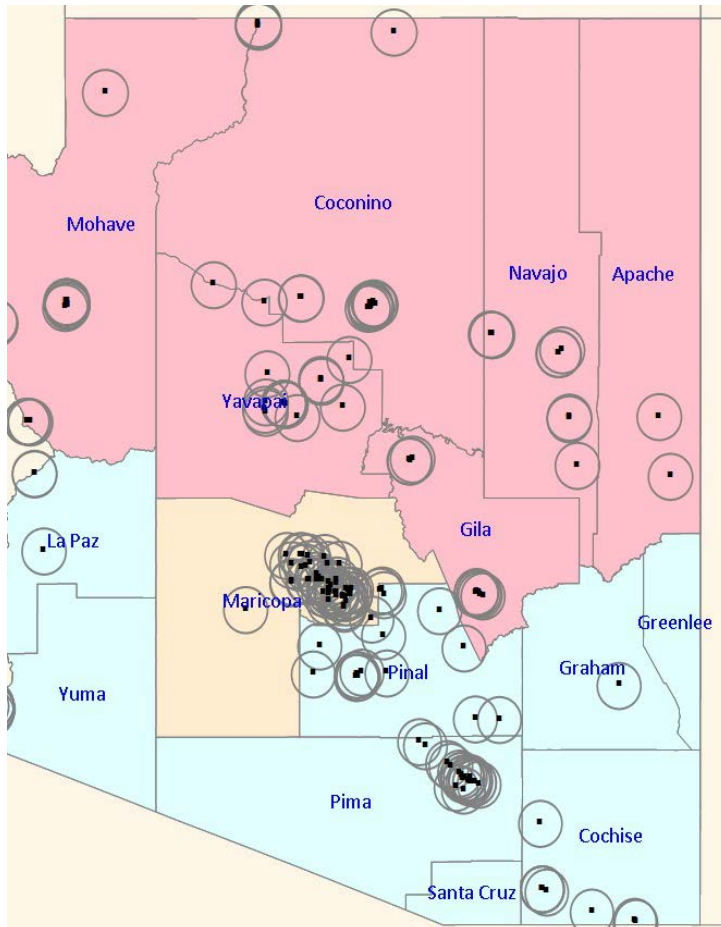
Facility Based Services Urban and Rural Standard



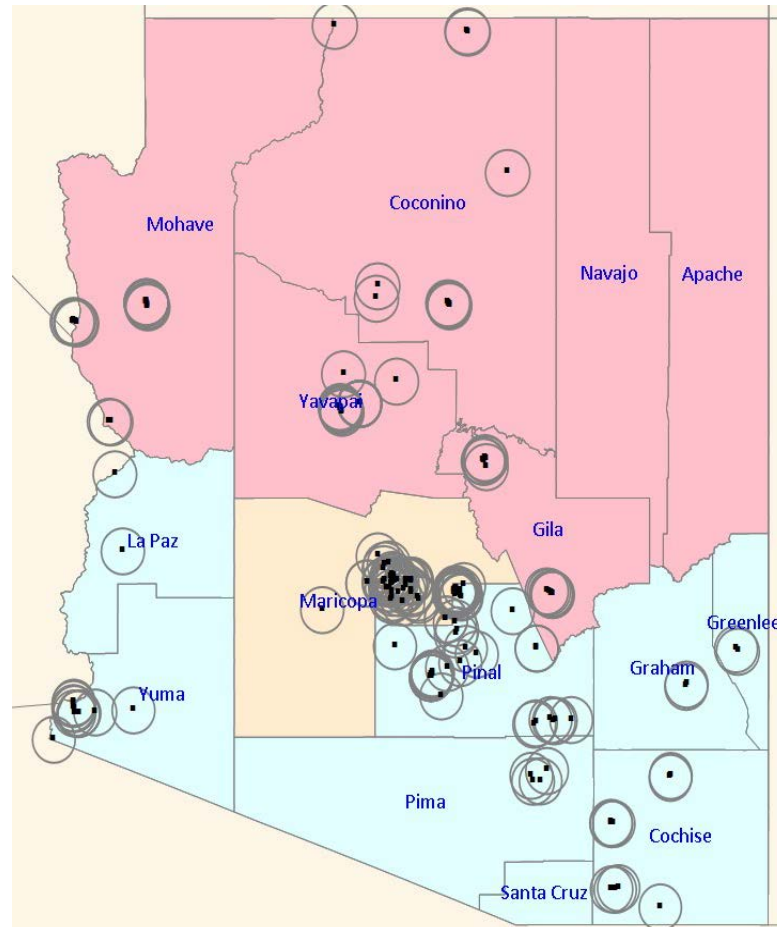
Prescribers, Physician Extenders



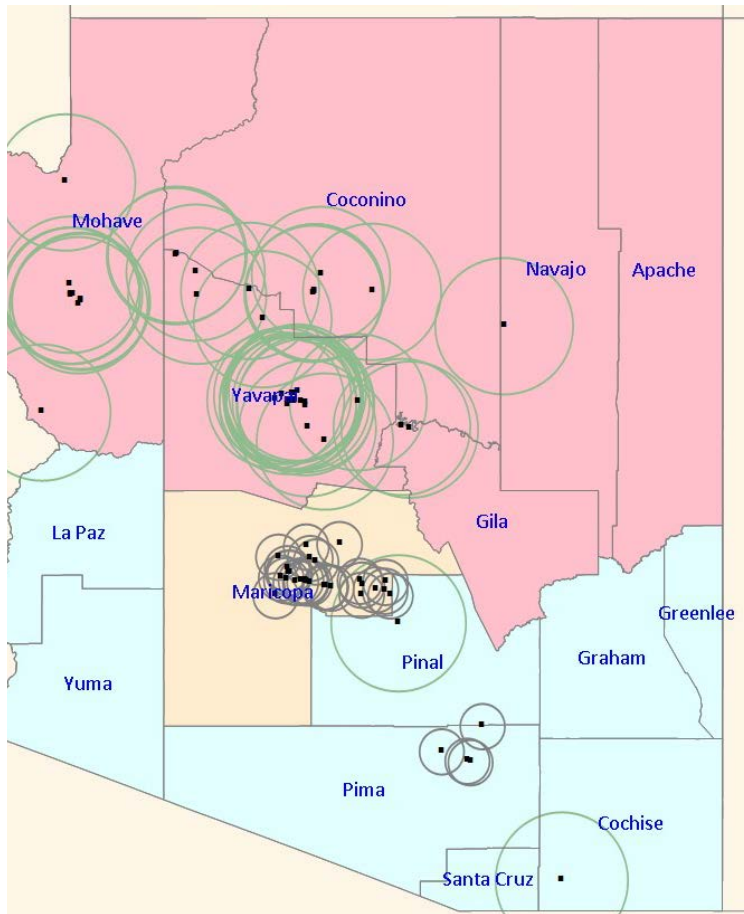
Outpatient Clinics



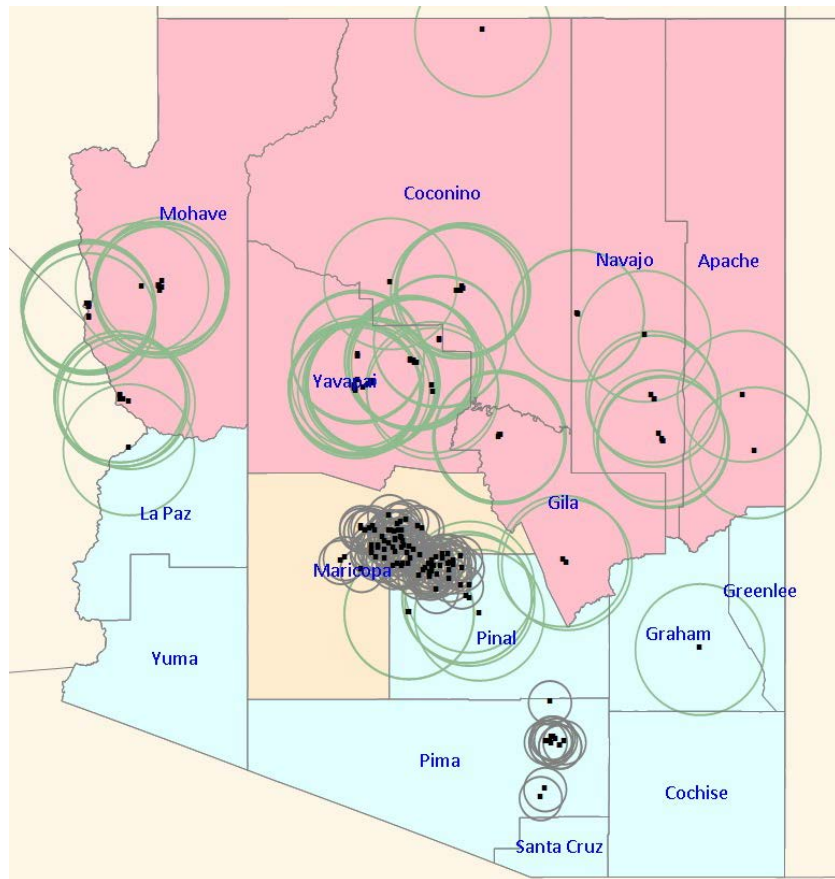
BH Outpatient Providers



Specialized Services (Habilitation, HCTC, Respite, BCBA) Urban and Rural Standard



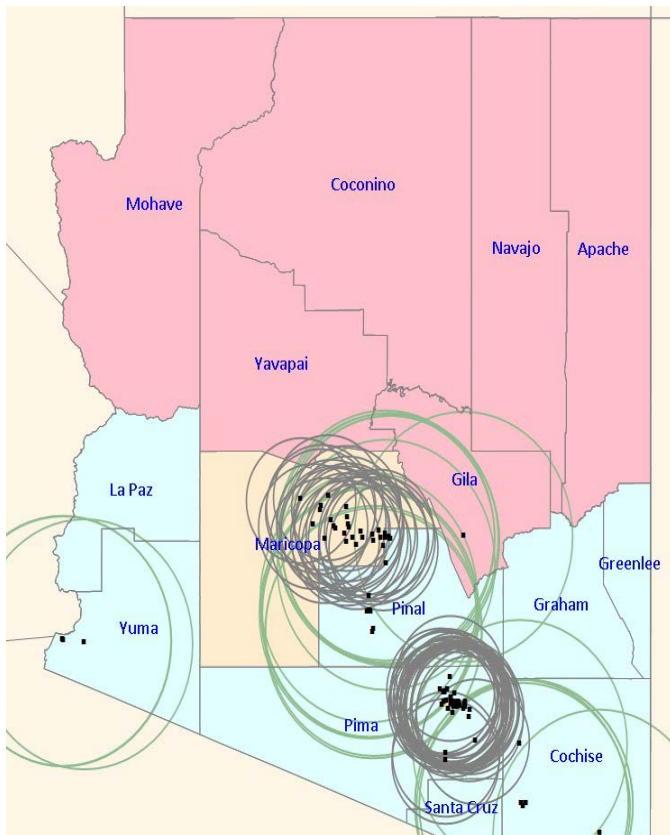
Statewide Access Supplemental Services



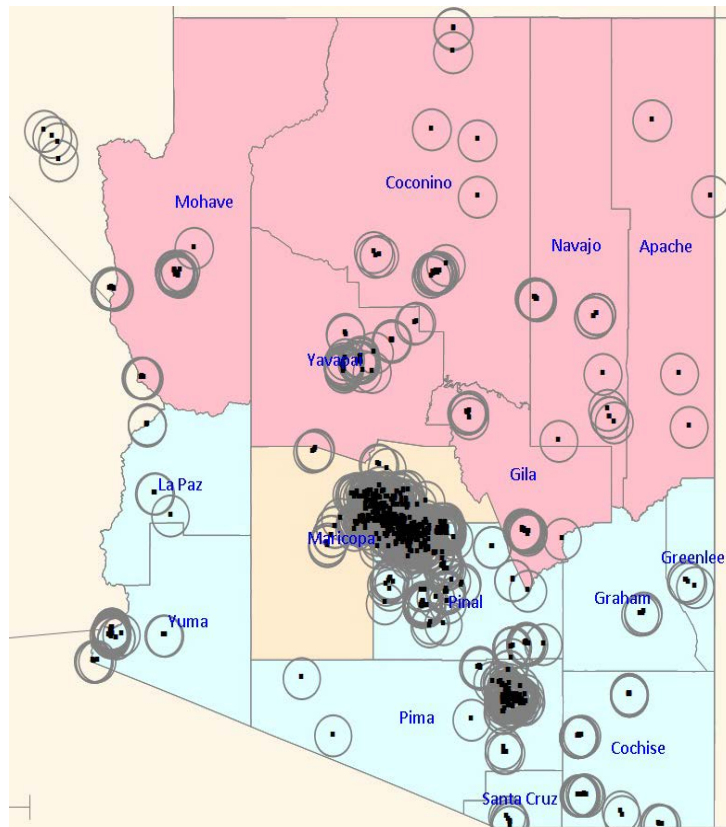
APPENDIX F

SOUTH GSA (CIC) PROVIDER CATEGORY MAPS

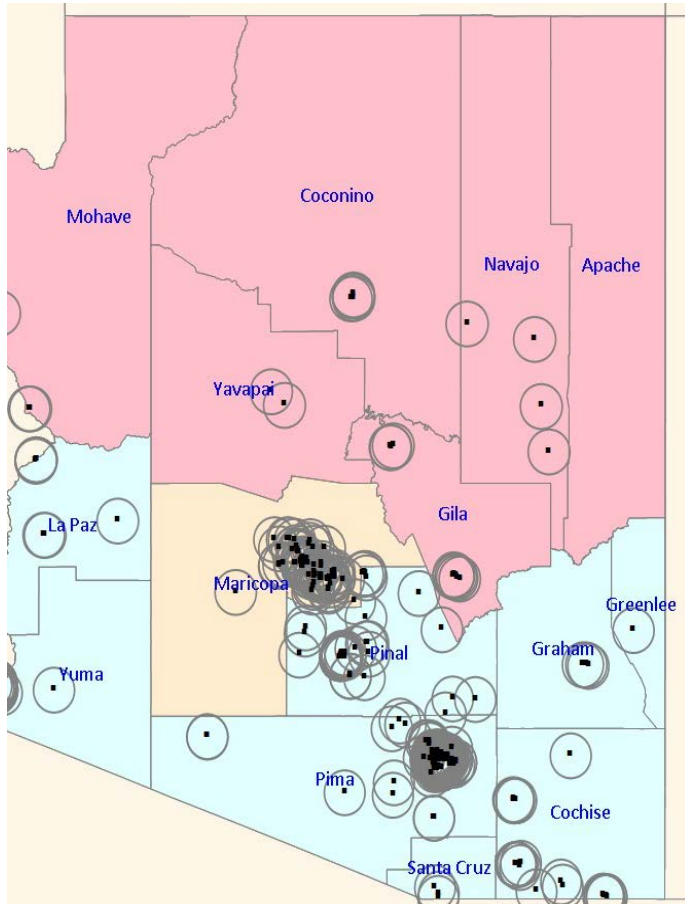
Facility Based Services Urban and Rural Standard



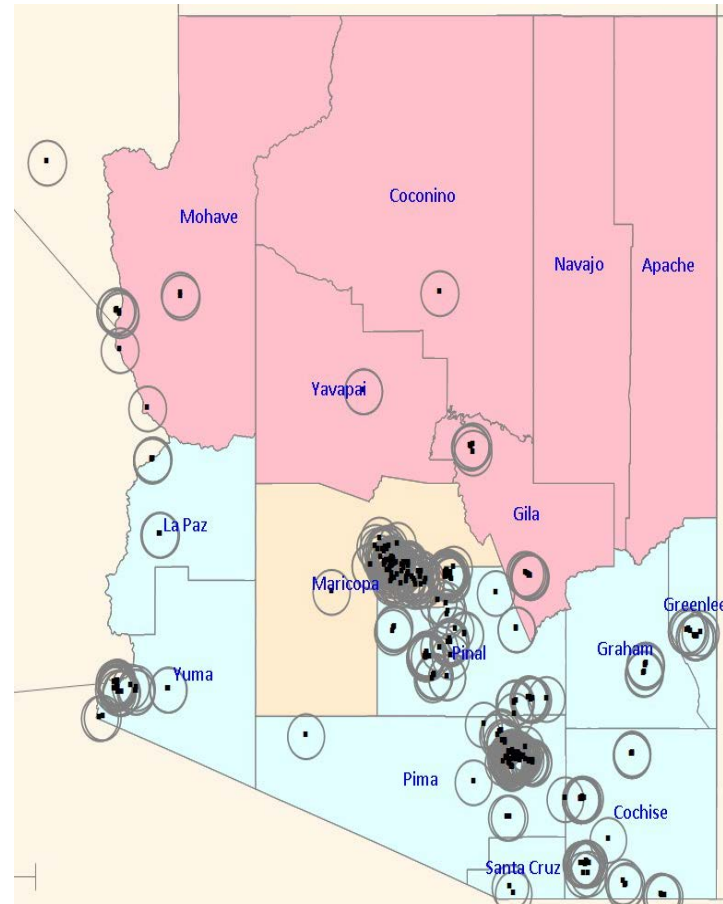
Prescribers, Physician Extenders



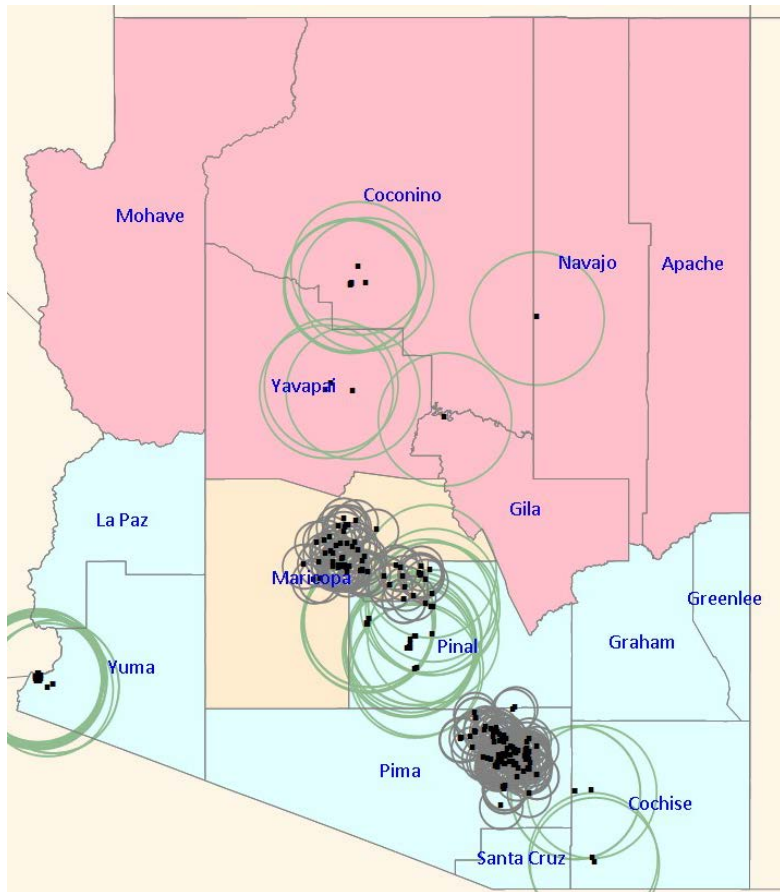
Outpatient Clinics



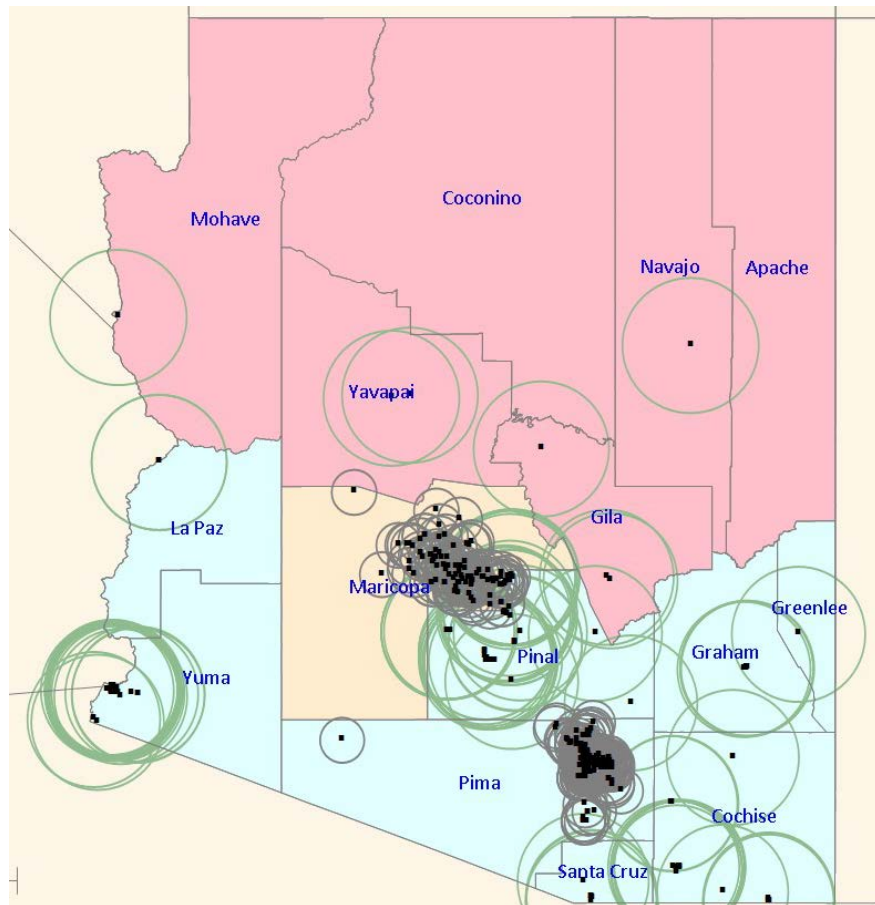
BH Outpatient Providers



Specialized Services (Habilitation, HCTC, Respite, BCBA) Urban and Rural Standard



Statewide Access Supplemental Services

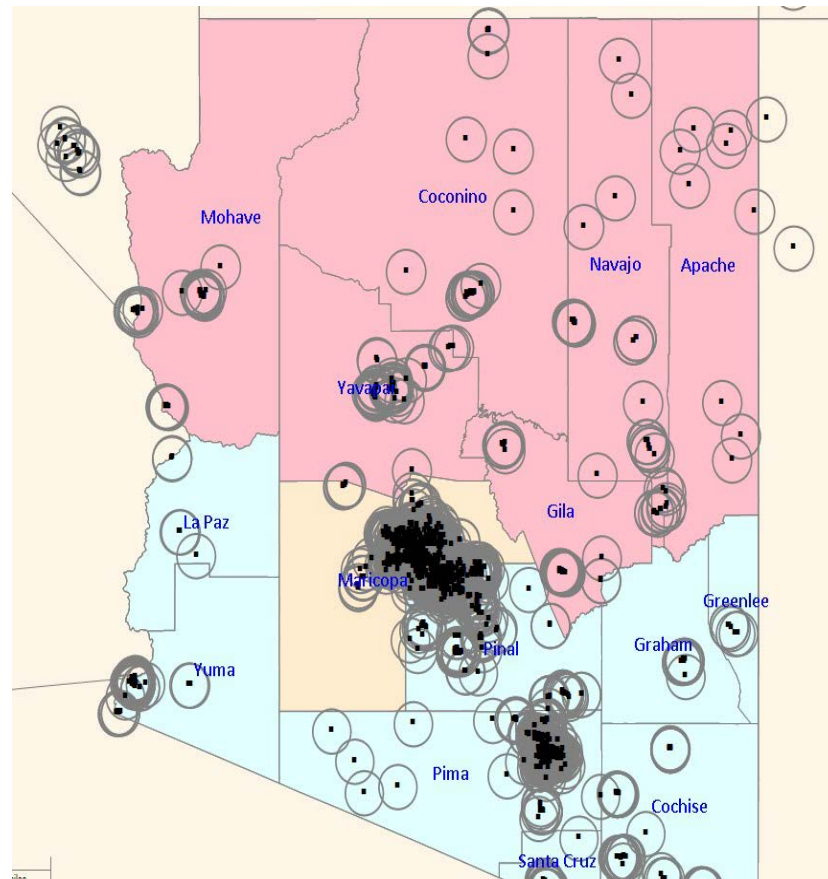
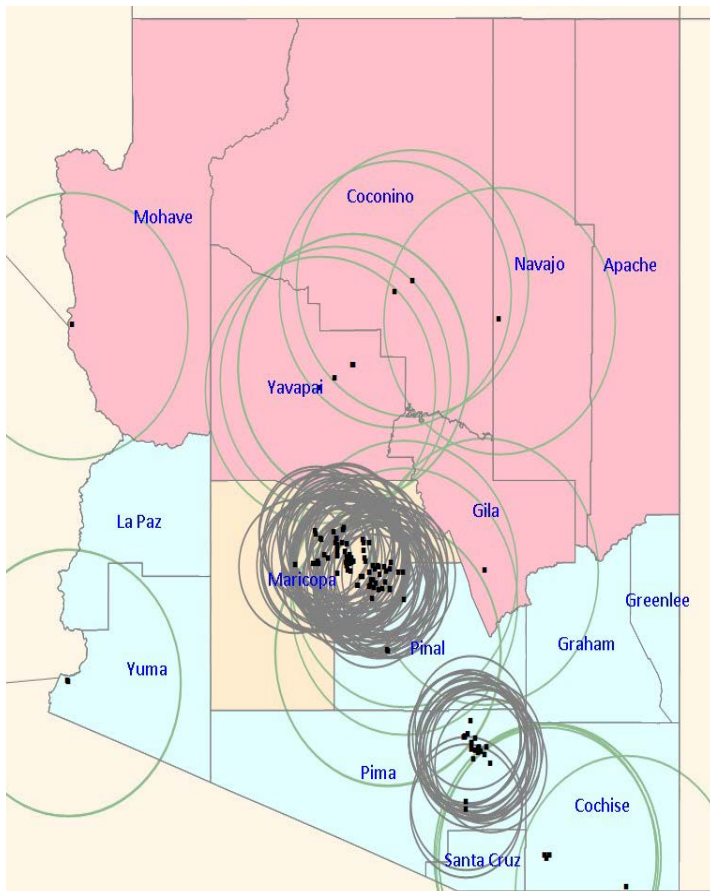


APPENDIX G

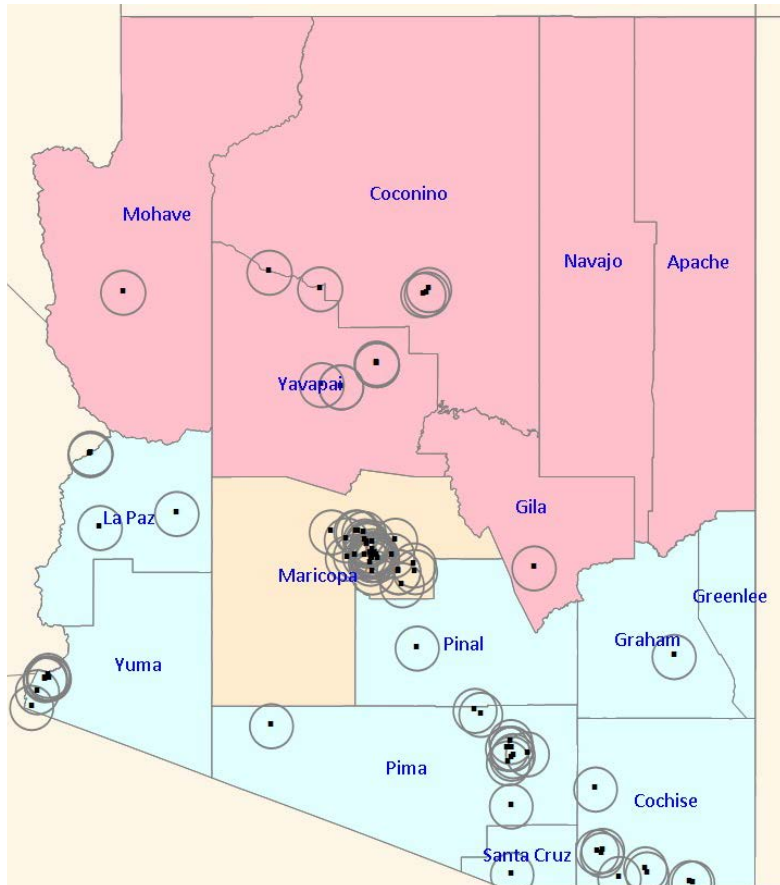
CRS CONTRACTOR (UHCCP) PROVIDER CATEGORY MAPS

Facility Based Services Urban and Rural Standard

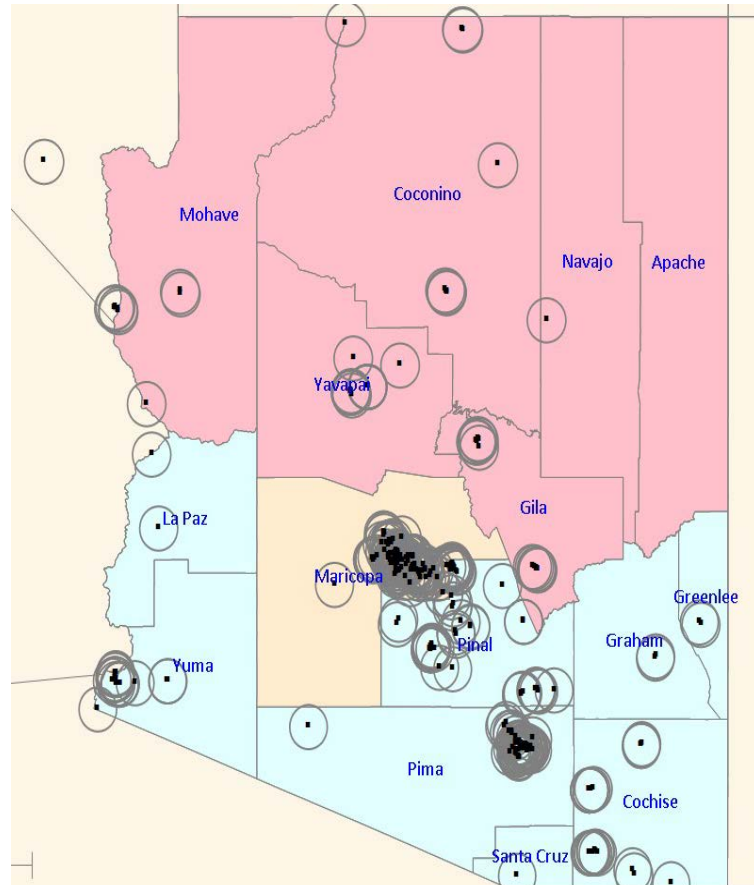
Prescribers, Physician Extenders



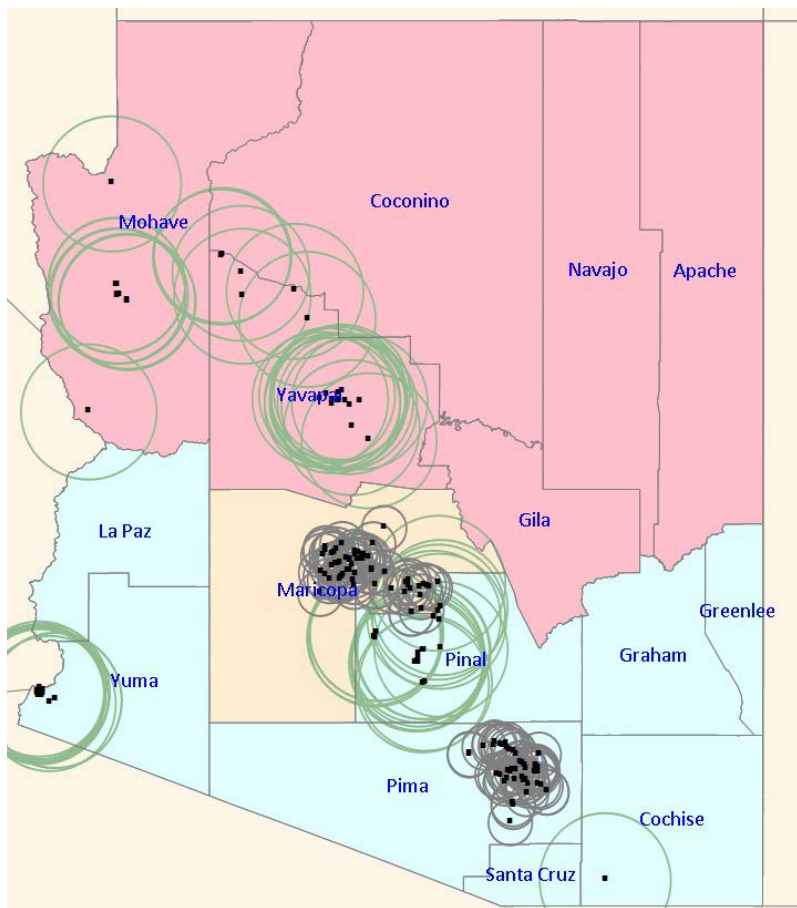
Outpatient Clinics



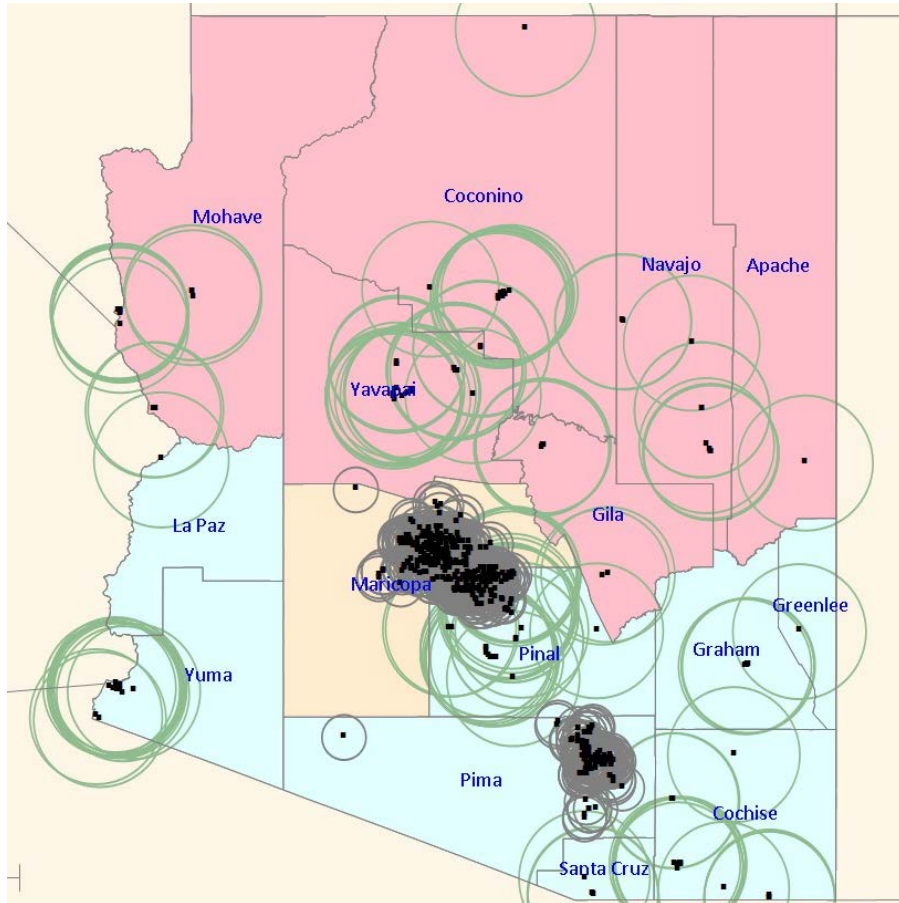
BH Outpatient Providers



Specialized Services (Habilitation, HCTC, Respite, BCBA) Urban and Rural Standard

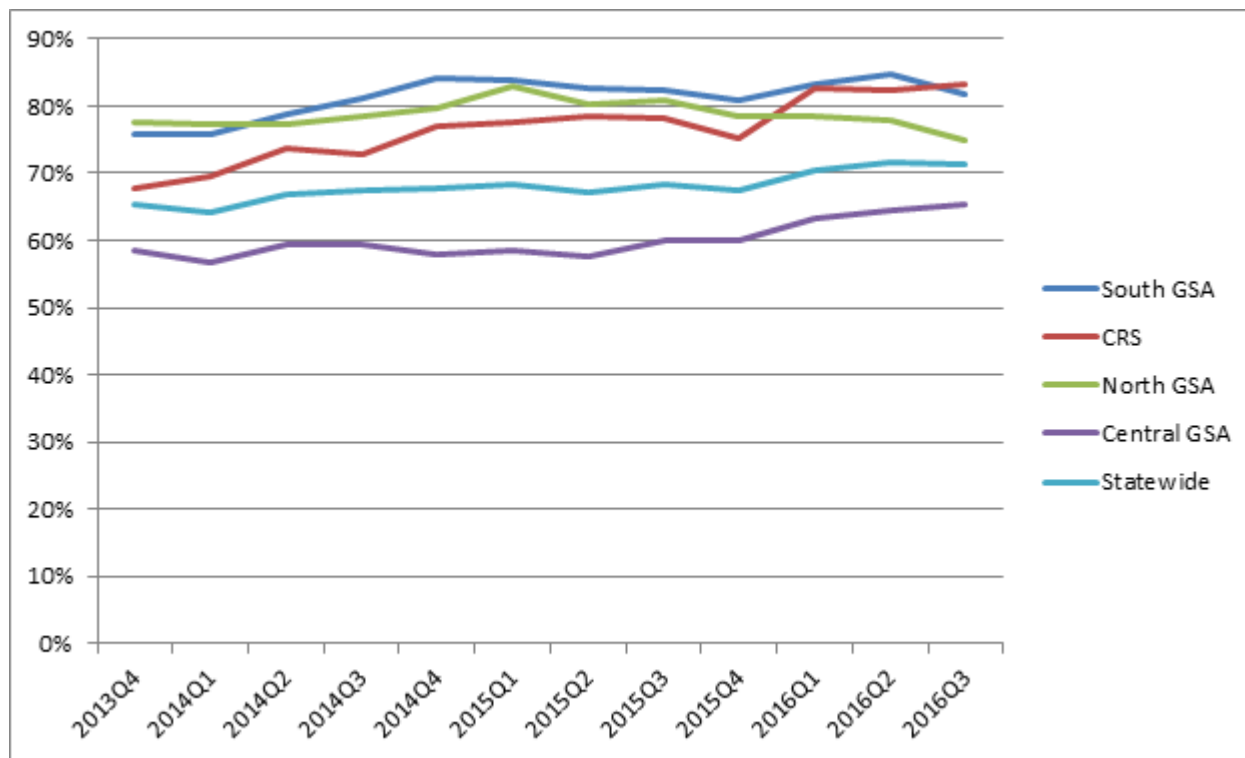


Statewide Access Supplemental Services



APPENDIX H

PENETRATION RATES BY QUARTER



Contract Year 2013-2014

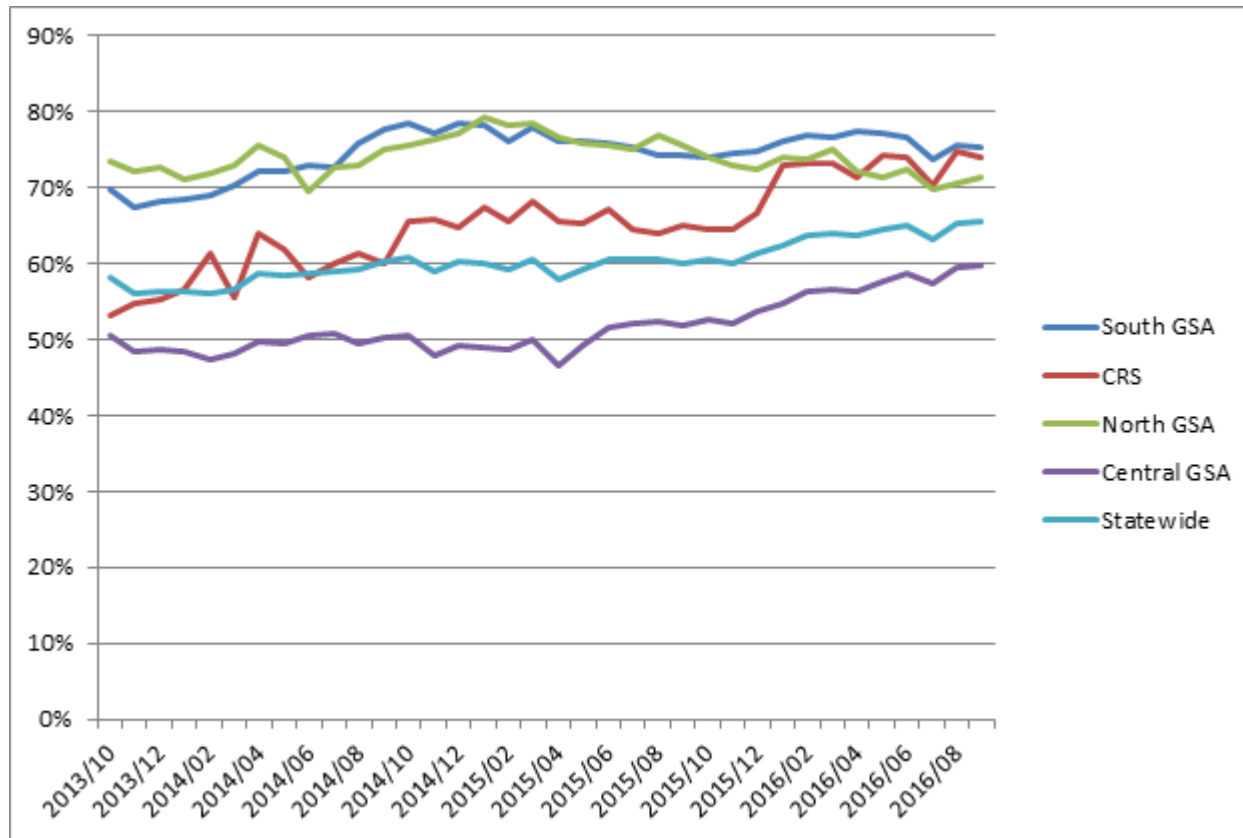
CONTRACTOR	Q1 2013	Q1 2014	Q2 2014	Q3 2014	Q4 2014
CIC	75.7%	75.8%	78.8%	81.0%	84.0%
CRS	67.6%	69.4%	73.6%	72.7%	77.1%
HCIC	77.7%	77.2%	77.3%	78.4%	79.6%
MMIC	58.4%	56.7%	59.5%	59.3%	57.9%
Total	65.4%	64.3%	67.0%	67.5%	67.6%

Contract Year 2015-2016

CONTRACTOR	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Q1 2016	Q2 2016	Q3 2016
CIC	83.9%	82.6%	82.3%	81.0%	83.3%	84.7%	81.7%
CRS	77.7%	78.3%	78.0%	75.2%	82.6%	82.4%	83.3%
HCIC	82.9%	80.4%	80.8%	78.4%	78.5%	78.0%	74.9%
MMIC	58.5%	57.7%	60.1%	59.9%	63.3%	64.4%	65.3%
Total	68.2%	67.1%	68.2%	67.5%	70.5%	71.6%	71.2%

APPENDIX I

PENETRATION RATES BY MONTH



Contract Year 2013-2014

CONTRACTOR	10/ 2013	11/ 2013	12/ 2013	01/ 2014	02/ 2014	03/ 2014	04/ 2014	05/ 2014	06/ 2014	07/ 2014	08/ 2014	09/ 2014
CIC	69.9%	67.5%	68.1%	68.5%	69.0%	70.3%	72.1%	72.2%	73.0%	72.5%	75.7%	77.7%
CRS	53.1%	54.8%	55.3%	56.5%	61.4%	55.5%	64.0%	61.8%	58.3%	60.0%	61.2%	60.1%
HCIC	73.5%	72.2%	72.6%	71.2%	72.0%	73.0%	75.7%	74.0%	69.4%	72.6%	73.0%	75.0%
MMIC	50.4%	48.3%	48.6%	48.5%	47.3%	48.1%	49.7%	49.5%	50.5%	50.8%	49.5%	50.2%
Total	58.1%	56.1%	56.4%	56.4%	56.0%	56.7%	58.6%	58.3%	58.8%	59.0%	59.2%	60.4%

Contract Year 2014-2015

CONTRACTOR	10/ 2014	11/ 2014	12/ 2014	01/ 2015	02/ 2015	03/ 2015	04/ 2015	05/ 2015	06/ 2015	07/ 2015	08/ 2015	09/ 2015
CIC	78.5%	77.0%	78.6%	78.1%	76.0%	77.9%	76.2%	76.0%	75.9%	75.3%	74.3%	74.1%
CRS	65.7%	65.8%	64.7%	67.4%	65.6%	68.1%	65.5%	65.2%	67.0%	64.6%	64.1%	65.2%
HCIC	75.6%	76.3%	77.3%	79.2%	78.1%	78.5%	76.5%	75.8%	75.5%	75.1%	77.0%	75.7%
MMIC	50.4%	48.0%	49.3%	48.9%	48.8%	49.9%	46.6%	49.2%	51.5%	52.0%	52.4%	51.9%
Total	60.9%	59.0%	60.2%	60.1%	59.2%	60.5%	57.8%	59.1%	60.6%	60.5%	60.5%	60.1%

Contract Year 2015-2016

CONTRACTOR	10/ 2015	11/ 2015	12 2015	01 2016	02/ 2016	03/ 2016	04/ 2016	05/ 2016	06/ 2016	07/ 2016	08/ 2016	09/ 2016
CIC	74.0%	74.5%	74.9%	76.0%	76.8%	76.7%	77.3%	77.1%	76.7%	73.7%	75.5%	75.4%
CRS	64.6%	64.5%	66.5%	72.9%	73.1%	73.3%	71.4%	74.3%	74.0%	70.4%	74.8%	73.9%
HCIC	74.1%	72.9%	72.5%	73.9%	73.8%	75.1%	72.2%	71.4%	72.4%	69.9%	70.5%	71.4%
MMIC	52.7%	52.0%	53.8%	54.6%	56.4%	56.5%	56.4%	57.6%	58.7%	57.5%	59.6%	59.8%
Total	60.4%	60.0%	61.3%	62.5%	63.7%	63.9%	63.7%	64.5%	65.1%	63.3%	65.3%	65.5%

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