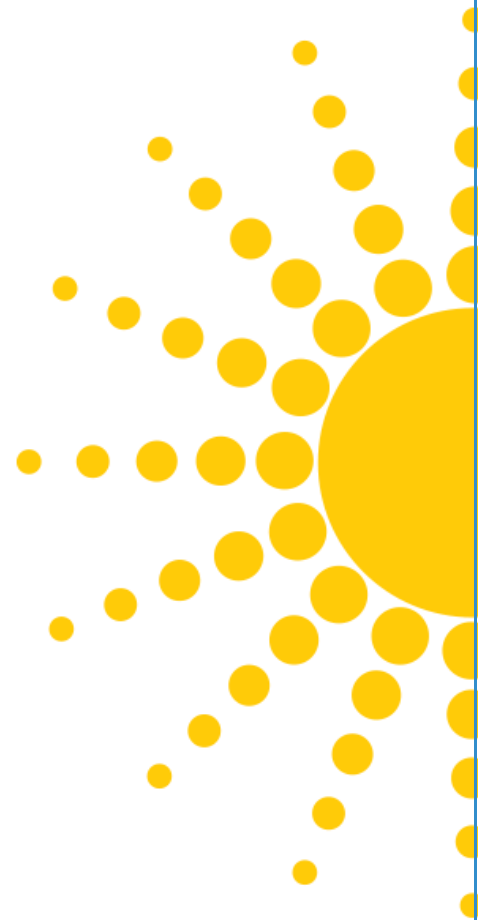




## SB1375 Report



October 1, 2015

## Introduction

Children involved with the foster care system have unique health care needs often characterized by significant risk of experiencing behavioral health conditions and concomitant chronic medical issues.<sup>1</sup> SB1375 requires the Department of Child Safety (DCS), in collaboration with the Arizona Department of Health Services (ADHS) and the Arizona Health Care Cost Containment System (AHCCCS) to:

- Determine the most efficient and effective way to provide comprehensive medical, dental and behavioral health services for children in foster care including the consideration of an administratively integrated system;
- Determine the number of disruptions of placements in foster care by age of child due to behavioral health management issues and the extent each child is receiving behavioral health services;
- Determine the number of adopted children who have entered foster care due to the adoptive parents' inability to receive behavioral health services to adequately meet the needs of the child and parents; and
- Submit a report of its recommendations to the Governor, the Speaker of the House of Representatives, the President of the Senate, and the Secretary of State on or before October 1, 2015.

This report will summarize the recommendations of the state agency collaborative including data analyzed to arrive at these conclusions. This report is organized into five sections:

- I. Healthcare needs of children in foster care;
- II. Current Arizona healthcare delivery system for children in foster care;
- III. Record review results for foster and adoptive disruptions;
- IV. Healthcare delivery system design options; and
- V. Recommendations.

For purposes of this report, the term “healthcare” is referring to the medical, dental and behavioral health needs of the child.

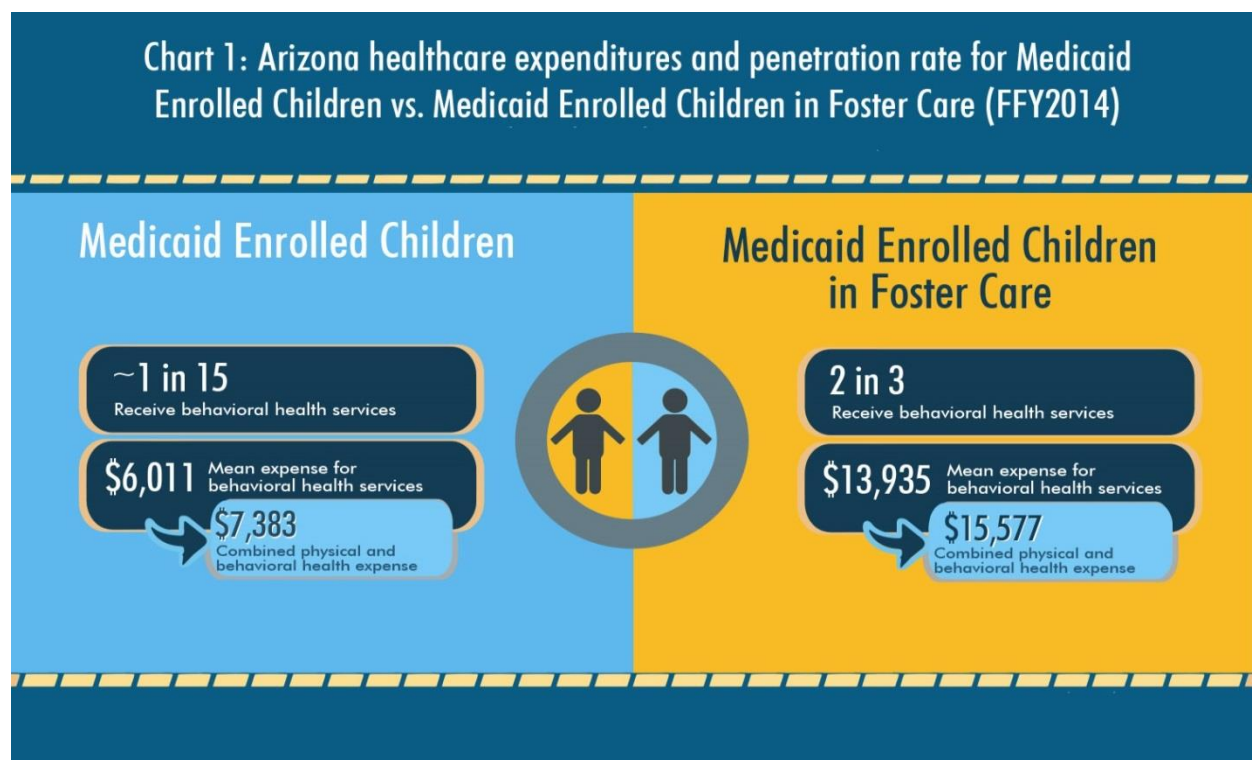
### I. Healthcare needs of children in foster care

As indicated in the most recent DCS Semi-Annual Report, the majority of the 25,508 Arizona Child Abuse Hotline communications during the 6 month reporting period were due to neglect (71.9%) or physical abuse (24.5%).<sup>2</sup> Depending on the outcome of the report investigation and identified protective factors, safety threats, and risk factors, cases might be closed with no further intervention, assigned to receive in-home services/interventions, voluntary placement, or the court may become involved through an in or out-of-home dependency. As of 3/31/2015, 17,592 children were in out-of-home care in Arizona.

Children involved with the foster care system have a high level of social needs and are more likely to have physical and behavioral health problems. It is well recognized that children in foster care experience trauma due to 1) maltreatment and/or neglect; 2) the actual removal process itself; and 3) being separated from their families, from their schools, from their friends, and from their community. A 2005 national study examining children entering foster care found that nearly 90% had physical health problems; the most common problems included asthma, vision and hearing problems, malnutrition, skin abnormalities, anemia, failure to thrive, and dental caries.<sup>3</sup>

Nearly half of children entering foster care have significant emotional and behavioral health conditions.<sup>4</sup> Children in foster care face tremendous ongoing emotional stress, often demonstrate what they need through behaviors adults find troubling, and how they are cared for directly contributes to placement stability and disruptions. A 2005 national study utilizing Medicaid claims data demonstrated that the most common behavioral health conditions identified for children in foster care are mood, anxiety and conduct disorders; the penetration rate for behavioral health services for children in foster care in this study was 32%.<sup>5</sup> The penetration rate for behavioral health services for children in foster care in Arizona for Federal Fiscal Year 2014 (FFY2014) was over double this national average at 67%.

In Arizona, the total physical health expenditures for children in foster care during FFY14 was \$34,077,043; in comparison, the behavioral health expenditures was nearly four times greater at \$131,125,986. Chart 1 compares Arizona penetration rates and expenditures for FFY2014 for Medicaid enrolled children to Medicaid Enrolled Children in Foster Care.



Studies have examined predictors of placement stability for children in foster care and four variables have consistently been linked to a higher number of placement changes: higher levels of behavioral or emotional problems, older age of the child, extended stays in care, and group home or residential care placement type.<sup>6</sup>

In 2011, a national study was published that analyzed predictors of placement disruption for youth in foster care.<sup>7</sup> The findings demonstrated a link between child problem behaviors and placement disruptions and the need for early interventions. This study demonstrated the following key findings:

- Approximately 95% of foster youth experience at least one placement disruption
- Problem behavior is an indicator of risk for placement disruptions
- Levels of externalizing behaviors and the number of problem behaviors were the strongest predictors of disruption

- Interventions mitigate these risks
- Training foster caregivers in behavioral management techniques reduces problem behaviors and disruptions

In 2012, the Child Welfare Information Gateway reviewed individual studies related to adoption disruption.<sup>8</sup> This review found that throughout the United States reports of adoption disruption rates ranged from 10-25%. In addition to youth factors identified below, key issues related to significant risk of adoption disruption included:

- Adoptive family factors including:
  - Lack of social supports
  - Unrealistic expectations
- Agency factors including:
  - Inadequate or insufficient information on the youth and his or her history
  - Inadequate parental preparation
  - Insufficient service provision
  - Inexperienced case manager involvement during the first year of adoption

## II. Current healthcare delivery system for children in foster care in Arizona

### Arizona Health Care Cost Containment System (AHCCCS)

Arizona's Medicaid agency, AHCCCS, uses federal, state, county, and provider assessed funds to provide health care coverage to the state's acute and long-term care Medicaid populations and low-income families. Since 1982, when it became the first statewide Medicaid managed care system in the nation, AHCCCS has operated under a federal Research and Demonstration 1115 Waiver which allows for the operation of a total managed care model. AHCCCS selects contracted managed care organizations (MCOs) via a highly competitive request for proposal (RFP) process; Chart 2 details the procurement cycle for the next 7 years. Prospective capitation payments are made to these MCOs which are responsible for the delivery of medically necessary care to members.

Chart 2: AHCCCS Procurement Cycle, 2016-2022

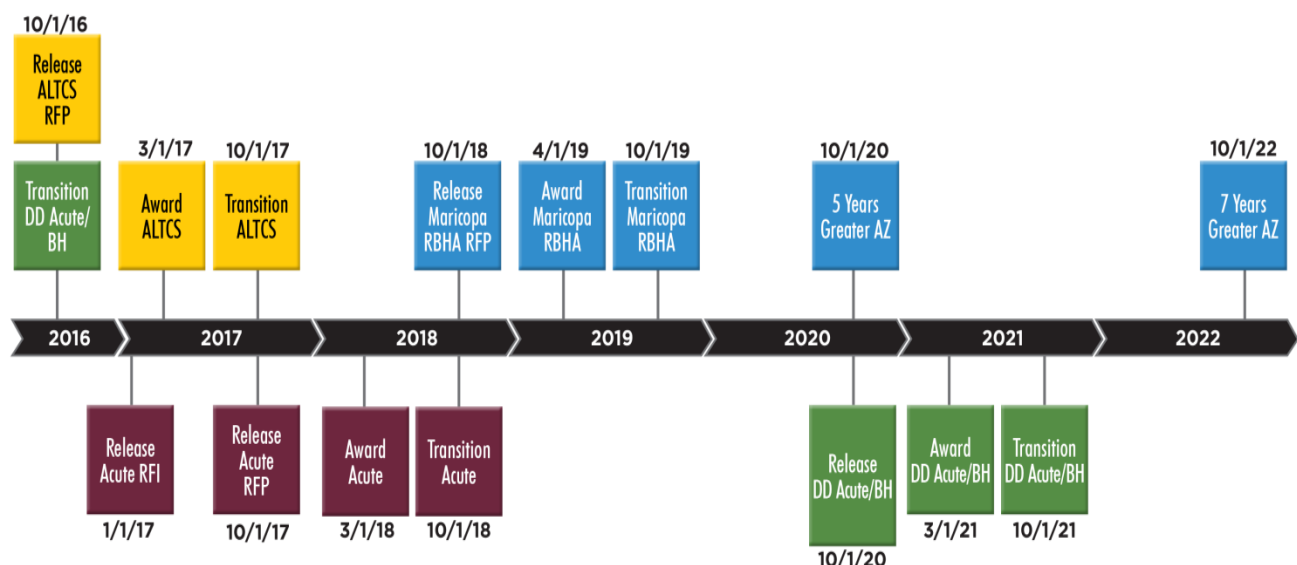
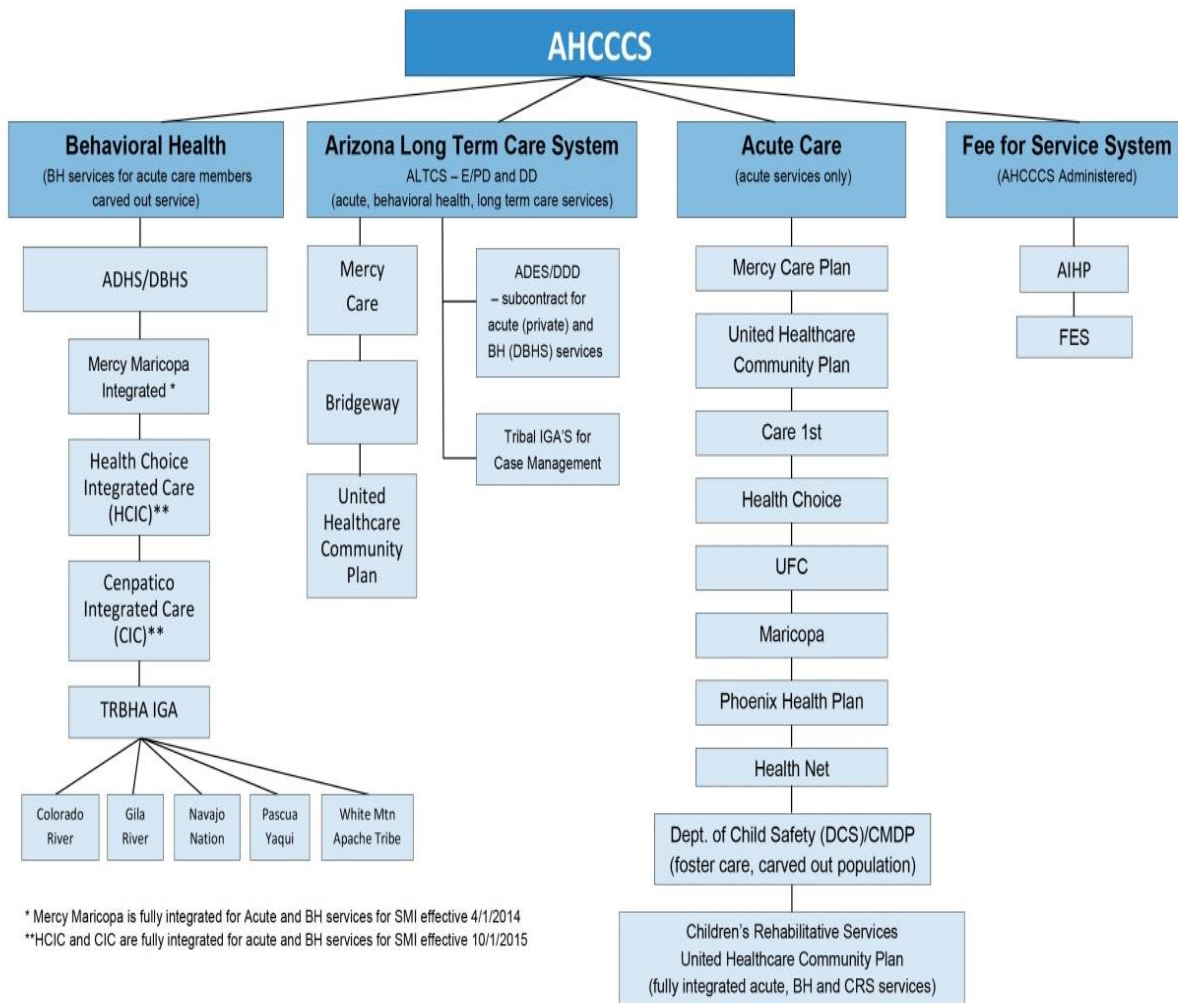


Chart 3 provides a high level overview of how the AHCCCS system is structured and identifies contractors as of August 2015. The current model of delivery of healthcare services to children in foster care is “carved-out” meaning that the behavioral health services are delivered through the Arizona Department of Health Services’ Division of Behavioral Health Services (AHDS/DBHS), whereas the physical health services are delivered through the Department of Child Safety, Comprehensive Medical and Dental Program (DCS/CMDP). Additionally, children in foster care who have a chronic and disabling medical condition that qualifies for Children’s Rehabilitative Services (CRS) are served by the CRS MCO for CRS-related and behavioral health services and CMDP for acute care services. Children in foster care who qualify for Arizona Long Term Care Services (ALTCS) due to a physical disability are served by the ALTCS contractor for all long term, acute, and behavioral health needs. Children in foster care who qualify for ALTCS due to a developmental disability are served by the Arizona Department of Economic Security, Division of Developmental Disabilities (ADES/DDD) for their long term care needs and DDD’s subcontractors for behavioral health services (ADHS/DBHS) and an MCO for acute care services. These services are further described below.

Chart 3: Medicaid Delivery System in Arizona



## Medical Services-Acute

CMDP was established in 1970 by the State to pay medical claims for children in foster care and was incorporated into Medicaid to leverage federal funds when Arizona adopted Medicaid in 1982. The AHCCCS Administration currently contracts with CMDP, which is located within the administrative structure of DCS, to provide medical and dental services to children in foster care who are Medicaid eligible. There were 16,507 Medicaid members enrolled with CMDP as of 8/1/15. The median length of enrollment in CMDP for children age 0 through 17 is 0.95 years.

Table 1: Average and Median Length of CMDP Enrollment by Age Group (as of point of time 5/12/15)

Age Group	Members	Percent of Membership	Median Length Enrollment (Years)	Average Length Enrollment (Years)
<1	1456	8%	0.39	0.42
1-5	6010	35%	0.99	1.08
6-13	6484	38%	0.99	1.20
14-17	3324	19%	1.07	1.61
Total	17274	100%	0.95	1.28

Under CMDP, foster caregivers can select any AHCCCS registered healthcare provider for dental or medical services (ARS § 8-512 C) which results in an open network of providers. Current statute also requires CMDP to reimburse providers at the AHCCCS fee for service (FFS) rate.

CMDP performance is measured on an annual basis by AHCCCS which includes access to primary care providers (PCP). As detailed in Table 2, CMDP exceeds AHCCCS minimum performance standards for FFY 2012 and 2013.

Table 2: CMDP Performance Measures

Performance Measure	FFY 2012 (10/01/11-09/30/12)	FFY 2013 (10/01/12-09/30/13)	AHCCCS Minimum Performance Standard
Children's Access to PCPs: 12-24 mo.	99.7%	98.8%	93%
Children's Access to PCPs: 25 mo.-6 yrs.	91.1%	93.5%	83%
Children's Access to PCPs: 7-11 yrs.	94.8%	94.8%	83%



<b>Children's Access to PCPs: 12-19 yrs.</b>	96.8%	98.1%	81%
<b>Well-Child Visits - 3-6 yrs.</b>	63.7%	71.8%	66%
<b>Adolescent Well Care</b>	63.9%	67.9%	42%
<b>Annual Dental Visits</b>	82.7%	81.8%	57%
<b>EPSDT Participation</b>	100.0%	92.6%	68%
<b>EPSDT Dental Participation</b>	79.0%	76.0%	46%

### ***Behavioral Health Services***

AHCCCS contracts with ADHS/DBHS to provide behavioral health services to children in foster care as part of AHCCCS' contract with ADHS/DBHS to deliver behavioral health services to the majority of children and adults who are Medicaid eligible. ADHS/DBHS contracts with managed care organizations referred to as Regional Behavioral Health Authorities (RBHAs). ADHS/DBHS also has intergovernmental agreements (IGAs) with the Tribal Regional Behavioral Health Authorities (TRBHAs).

ADHS/DBHS requires behavioral health staff that work with children and families to complete the training *Understanding the Unique Behavioral Health Needs of Children and Families involved with the Department of Child Safety*. This training is co-facilitated by RBHA and CMDP Behavioral Health Unit staff and is intended to increase clinical understanding of the DCS population in order to appropriately address their needs.

Referrals from DCS for behavioral health services are typically initiated through a DCS rapid response service request at the time of a child's removal from their home. The behavioral health system's rapid response intervention must occur within 72 hours of referral. This contract requirement is congruent with national best practice guidelines<sup>9</sup> and contribute to the overall higher penetration rates in Arizona compared to national data.

In 2015, ADHS/DBHS added the following requirements to the RBHA contracts: upon notification by DCS that a child has been taken into custody, the RBHA must ensure that each child and family is referred for ongoing behavioral health services for a period of at least six months unless services are refused by the guardian or the child is no longer in DCS custody. Services must be provided to:

- Mitigate and address the child's trauma;
- Support the child's temporary caretakers;
- Promote stability and well-being; and
- Address the permanency goal of the child and family.

A minimum of one monthly documented service is required. Additionally, RBHAs must designate a full-time Child Welfare Administrator within the organization, maintain a designated email for DCS to streamline communication, and reconcile the DCS removal list with individuals receiving a rapid

response on a monthly basis to identify individuals not referred to behavioral health services and initiate an engagement process.

The children's behavioral health system of care performance was measured in State Fiscal Year 2014 utilizing the System of Care Practice Review (SOCPR). The SOCPR tool was developed by the University of South Florida to measure how well a system is adhering to children's system of care principles.<sup>10</sup> The sample size for SFY14 was 195 children and 54.9% of cases (107 children) had child welfare involvement. The SOCPR utilizes both a qualitative and quantitative scoring system. Quantitative data are scored on a scale of 1-7; scores of 1-3 represent a lower implementation of the system of care principle measured and scores of 5-7 represent a higher implementation of the system of care principle measured. As indicated in Table 3, Arizona scored higher on implementation of system of care principles across all domains. Although the results of this review can not be generalized to the entire system based on sampling methodology, it provides feedback directly to providers on how they may continue to improve practice.

Table 3: SOCPR Quantitative Scores 2014

<b>All Cases: 5.35</b> <b>N=195</b> <b>Scores based on a 7 point scale (1-disagree very much to 7-agree very much)</b>	
<b>Domain I: Child Centered and Family Focused Domain Score: 5.34</b>	
Individualized	5.12
Full Participation	5.66
Case Management	5.25
<b>Domain II: Community Based Domain Score: 5.64</b>	
Early Intervention	5.47
Access to Services	6.04
Minimal Restrictiveness	5.82
Integration and Coordination	5.23
<b>Domain III: Culturally Competent Domain Score: 5.14</b>	
Awareness	5.26
Sensitivity and Responsiveness	5.03
Agency Culture	5.26
Informal Supports	4.99
<b>Domain IV: Impact Domain Score: 5.29 (1.37)</b>	
Improvement	5.40
Appropriateness	5.19



### ***Children's Rehabilitative Services***

The Children's Rehabilitative Services (CRS) program was started in 1929 to serve children with complex health care needs who require specialized services. CRS provides medical care, rehabilitation, and related support services to children diagnosed with one or more of the qualifying chronic and disabling conditions defined in state statute. As of 8/1/15, 16,739 children were enrolled with CRS.

Children in foster care who have a qualifying chronic and disabling condition receive behavioral health and CRS-related services from the CRS MCO (United Healthcare Community Plan as of 10/1/13) and acute care services from CMDP. As of 8/27/15, there were 550 children enrolled with CRS and CMDP, which is approximately 3.3% of the CMDP total.

### ***Arizona Long Term Care System***

The Arizona Long Term Care System (ALTCS) was implemented in 1988 under the existing 1115 Managed Care Waiver for members at risk of institutionalization. The Arizona Department of Economic Security (ADES) Division of Developmental Disabilities (ALTCS-DDD) is responsible for providing all the acute, long term, behavioral health, and case management services for members who have a DDD qualifying diagnosis as defined in state statute (epilepsy, intellectual disability, autism, and cerebral palsy) and who meet other eligibility requirements. ALTCS-DDD directly manages the long term care benefit through DDD support coordinators and direct contracts with long term care service providers. ALTCS-DDD contracts with three health plans to provide acute medical services. ALTCS-DDD contracts with ADHS/DBHS for behavioral health services for their members. The ALTCS program for the elderly or physically disabled (ALTCS-EPD) has three health plans, which integrates care by providing acute, long term, behavioral health, and case management services.

### ***System Changes since passage of SB1375***

Since the passage of SB1375, two major system changes have occurred:

- In May 2014, DCS was created as a permanent stand-alone agency
- In March 2015, ADHS/DBHS began activities to merge with AHCCCS for administrative simplification purposes. Following the completion of administrative simplification on July 1, 2016, the RBHAs will be directly contracted with AHCCCS.

## **III. Record review results for foster and adoptive disruptions**

In order to answer the questions posed by SB1375 regarding the number of disruptions of placements due to behavioral health management issues for children in foster or adoptive placements, the state agency collaborative conducted retrospective reviews of behavioral health and DCS records for a period of 6 months prior to disruption and 1 month post disruption. The data obtained from these record reviews were then cross-validated with AHCCCS claims and encounter data during the same time period. The chart review tool was developed by state agency subject matter experts and interrater reliability testing was conducted prior to the review.

### ***Foster Disruptions due to Behavioral Health Management Issues***

Cases for the foster care disruption review were pulled by utilizing the DCS database CHILDS for cases identified as "placement disruption" under the "placement move" field during State Fiscal Year 2014 (SFY2014). As the reason for placement move is not a required field in CHILDS, this method likely under-represents the number of foster care disruptions; however, there was no alternative methodology to

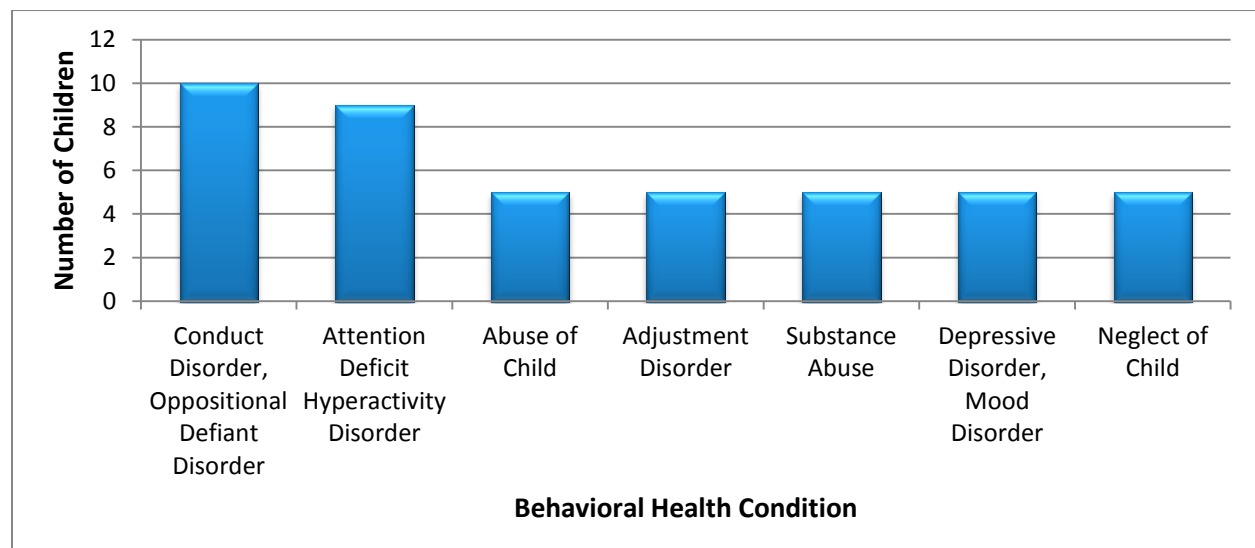
identify these cases. During SFY2014, 29,504 children were in foster care placement with 420 CHILDS system reported placement disruptions due to any reason. This translates into a disruption rate of 1.4% or 1 in 70 children experiencing a foster care placement disruption. A sample size of 68 children out of the 420 cases was determined by a biostatistician to be statistically significant for this study.

The findings of the reviews conducted for 68 children demonstrated that 34% (23 children) disrupted due to an identified behavioral health management issue. When this figure is incorporated into the overall foster care placement disruption rate, the result is a foster care placement disruption rate due to behavioral health management issue of 0.48% or 1 in 208 children in DCS custody. Additionally, 20% (14 children) were not receiving behavioral health services through the RBHA system; the reasons for this are unknown and as a result they were excluded from the analysis of disruptions. For the remaining 46% (31 children), there was no identified behavioral health management issues that contributed to the placement disruption.

Analysis of the 23 cases where disruption was attributed to an identified behavioral health management issue demonstrated the following:

- The majority (87%) of children were ages 6 through 18;
- Children did not have actively functioning CFTs that fully aligned to the model's fidelity in a majority of cases (83%);
- Behavioral health service unavailability was identified in 13% of the cases;
- Individualized service plans were completed for 100% of cases but often lacked necessary detail and rarely were revised in response to need;
- Individualized service plans were not typically updated in a manner consistent with established expectations; and
- Disruptive Behavior Disorders were the most frequent behavioral health condition identified (Chart 4).

Chart 4: Most common behavioral health condition in children in foster care who disrupted during SFY14 (N=23, duplicate member counts as children could have more than one diagnosis)



A potential concern is that trauma and the stressors related to trauma were not listed among the most frequent of the BH conditions identified. Maltreatment and trauma can lead to complex clinical presentations that may be difficult to differentiate from other behavioral health conditions.

### ***Adoptive Disruptions due to Behavioral Health Management Issues***

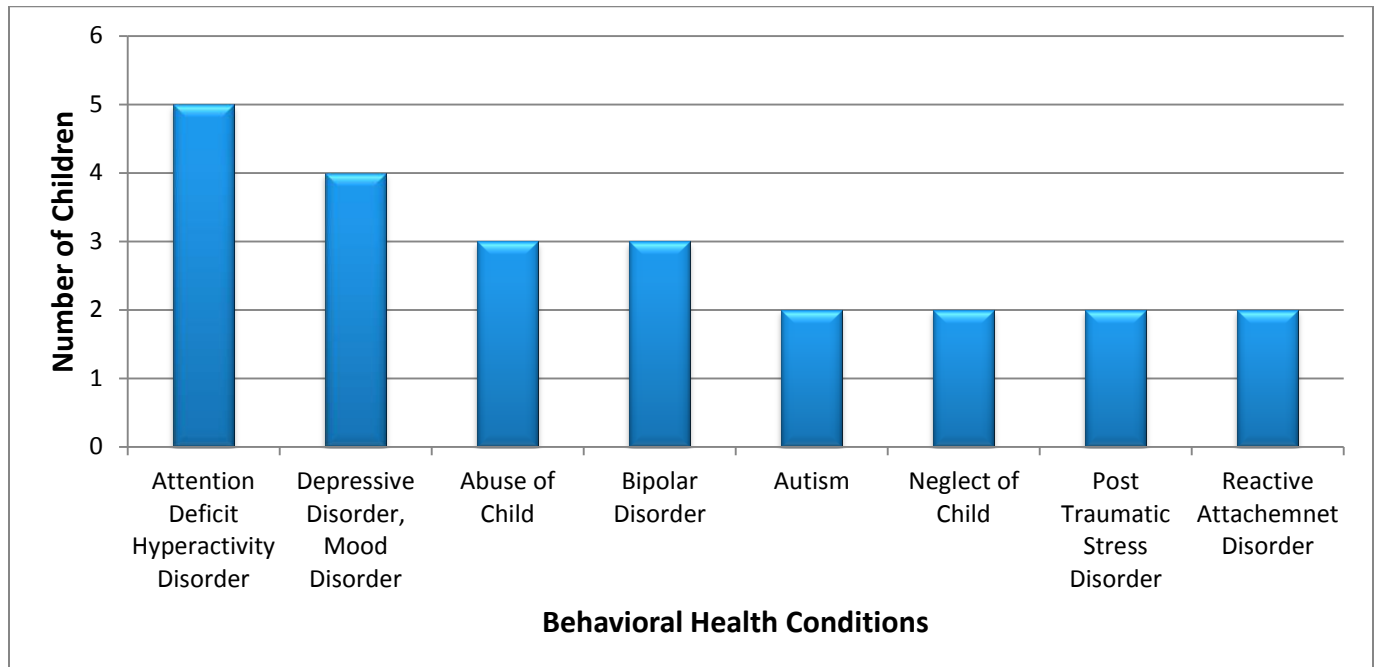
Cases for the adoption disruption review were identified through CHILDS system by identifying children who were removed into state custody who had previous adoption subsidy payment during SFY2014. In SFY2014, 19,647 children were connected to an adoption subsidy and 22 of those children experienced a disruption for any reason. This translates into a disruption rate of 0.1% or 1 in 1,000 children experiencing an adoption disruption. A sample size of 19 children out of the 22 cases was determined by a biostatistician to be statistically significant for this study.

The findings of the reviews conducted for 19 children who had experienced an adoption disruption demonstrated that 47% (9 children) disrupted due to an identified behavioral health management issue. When this figure is incorporated into the overall adoption placement disruption rate, the result is an adoption placement disruption rate due to behavioral health management issue rate of 0.053% or 1 in 1,885 children. Additionally, 16% (3 children) of the sample population of individuals with an adoption disruption were not receiving behavioral health services through the RBHA system; the reasons for this are unknown and as a result they were excluded from the analysis of disruptions. For the remaining 37% (7 children), there was no identified behavioral health management issue identified that contributed to the placement disruption.

Analysis of the 9 cases where disruption was attributed to an identified behavioral health management issue demonstrated the following:

- The majority (67%) of children were ages 13 through 18;
- Children did not have actively functioning CFTs that fully aligned to the model's fidelity in over half of the cases (56%);
- Individualized service plans were completed for the majority of cases but often lacked necessary detail and were not typically updated in a manner consistent with established expectations;
- Behavioral health service unavailability was identified in 1 of the 9 cases; and
- Attention Deficit Hyperactivity Disorder (ADHD) was the most frequent behavioral health condition identified (Chart 5)

Chart 5: Most common behavioral health diagnoses in children adopted who disrupted during SFY14 (N=9, duplicate member counts as children could have more than one diagnosis)



A similar concern to the foster disruptions is that trauma and the stressors related to trauma were not listed among the most frequent of the BH conditions identified. Maltreatment and trauma can lead to complex clinical presentations that may be difficult to differentiate from other behavioral health conditions.

#### IV. Healthcare Delivery System Design Options

The healthcare system design and delivery of services for children and families involved in foster care should be based on system of care values<sup>11</sup> in order to meet the specialized needs of this population; specifically:

- 1) *Preventative*: families are referred for needed healthcare services to assist in preventing the removal of a child
- 2) *Strength and solution focused*: children in foster care are resilient
- 3) *Family-Oriented*: children in foster care function in the context of their family unit
- 4) *Community-Based*: children in foster care should have access to a full continuum of care with a particular focus on community-based service delivery
- 5) *Integrated*: integration of medical, dental and behavioral services under a single health plan provides a single source of accountability which is widely viewed as a more effective and efficient delivery system
- 6) *Coordinated*: healthcare services are coordinated between the child and family service providers and with services provided through DCS
- 7) *Continuity of Healthcare*: child and family healthcare services are delivered by the same providers before entering, during, and after exiting foster care
- 8) *Access to Evidence-Based Healthcare*: children and families in foster care have access to evidence based healthcare services specialized to address the unique needs of children in foster care

- 9) *Outcomes-oriented*: children and families in foster care have access to healthcare services that improve outcomes including minimizing the number of placements and the time to achieving permanency.
- 10) *Trauma-Focused*: all services provided are consistent with the principles of trauma- informed care and include access to trauma specific interventions.

One major goal of the healthcare system design is to minimize the number of transitions for the child in foster care. This principle not only applies to the actual placement of the child, but also to the provider of services as well as the health plan. Thus, when considering healthcare system design, the cross agency collaborative assessed which design option would provide the best continuity of care for the child as they enter and exit the foster care system, as the healthcare needs of the child extend beyond the period of actual DCS involvement.

Approximately half of the children who enter foster care are enrolled in another Medicaid plan prior to entry into foster care. After exiting the foster care system, Arizona policy ensures that children are Medicaid enrolled for at least 60 days to ensure families have an appropriate timeframe to apply for Medicaid. During calendar year 2013, of those members who transitioned out of foster care, approximately half remained in Medicaid during that year. For this same cohort, 39% of members remained Medicaid enrolled as of 12-9-14; this percentage underrepresents the actual Medicaid enrollment since it does not capture those members who were adopted during this timeframe. Additionally, it is estimated that the actual percentages of children and families who qualify for Medicaid pre- and post-foster care is higher but economic and social factors likely contribute to families not pursuing Medicaid and other services.

### ***Summary of Models Considered***

The state agency collaborative evaluated the strengths and challenges of the following models for healthcare delivery design for children in foster care in Arizona:

- 1) Enhance the current system of service delivery
- 2) Integrated care through DCS/CMDP with an open network
- 3) Integrated care through DCS/CMDP with a contracted network
- 4) Integrated care through a single statewide MCO under AHCCCS
- 5) Integrated care through a single statewide MCO under DCS/CMDP
- 6) Integrated care through AHCCCS/RBHAs
- 7) Integrated care through AHCCCS Acute Care Contractors
- 8) Integrated care through AHCCCS Fee for Service

Based on this review, it was determined that the models that will best address the specialized healthcare needs of children in foster care based on system of care principles are:

- 1) Integrated care through DCS/CMDP with an open network
- 2) Integrated care through DCS/CMDP with a contracted network
- 3) Integrated care through a single statewide MCO under AHCCCS

The strengths and challenges of these models are detailed further below.

### ***Integration under CMDP—Open Network Model***

Arizona is unlike any other state’s healthcare delivery model when it comes to children in foster care since the physical health care carve-out component, CMDP, is part of, and directly reports into the state child welfare agency, DCS. This administrative structure reinforces the DCS mission within the healthcare delivery system. By carving in behavioral health under the current open network model, foster families and caregivers can continue to benefit from accessing any AHCCCS-registered provider who treats children in foster care.

Table 4: Summary Strengths/Challenges of Integrated CMDP Open Network Model

<b>STRENGTHS</b>	
1)	Historical performance for medical measures for children in foster care
2)	Alignment of DCS and healthcare mission and resources under one administrative agency
3)	Integration of behavioral and physical health services under a single payer
4)	Foster parents and caregivers can continue to seek care from any AHCCCS registered provider
5)	Maximizes continuity of care pre- and post- foster care through broad network
6)	Single plan retains the focus on children with special health care needs for easier tracking, monitoring and oversight of care delivery
<b>CHALLENGES</b>	
1)	State government recruitment and infrastructure challenges can impact operations routine to private MCOs
2)	Start-up resources are significant to expand CMDP staffing
3)	Provider reimbursement tied to AHCCCS FFS rates which will limit access to specialty and behavioral health providers
4)	Unable to establish value based purchasing arrangements
5)	Transition of care issues since median length of enrollment in CMDP is 0.95 years and children continue to have healthcare needs when exiting foster care
6)	Limited experience with reviewing for medical necessity for behavioral health services
7)	Expands model of one state agency funding and overseeing another state agency

### ***Integration under CMDP—Contracted Provider Model***

One of the alternative options for integrating behavioral health services under CMDP is to transition to a contracted network in order to leverage value based purchasing arrangements to drive improved outcomes. This model will also enable greater flexibility when accessing specialty healthcare services since some providers do not accept AHCCCS FFS rates.

Table 5: Summary Strengths/Challenges of Integrated CMDP Contracted Network Model

<b>STRENGTHS</b>	
1)	Historical performance for medical measures for children in foster care
2)	Alignment of DCS and healthcare mission and resources under one administrative agency



- 3) Integration of behavioral and physical health services under a single payer
- 4) Can leverage value based purchasing strategies
- 5) Single plan retains the focus on children with special health care needs for easier tracking, monitoring and oversight of care delivery
- 6) Change network and the services delivered to valued providers

### CHALLENGES

- 1) State government recruitment and infrastructure challenges can impact operations routine to private MCOs
- 2) State procurement, fingerprinting and background check requirements in statute are potential barriers to provider contracting
- 3) Start-up resources are significant to expand CMDP staffing capacity and to become compliant with managed care regulations
- 4) Transition of care issues since median length of enrollment in CMDP is 0.95 years and children continue to have healthcare needs when exiting foster care
- 5) Medical and dental health network would be more limited than currently available through CMDP
- 6) Lack of experience building a health care network to meet established sufficiency requirements
- 7) Limited experience with managed care application of medical necessity for behavioral health services
- 8) Expands model of one state agency funding and overseeing another state agency

### *Integration Under a Single Statewide MCO*

This model would integrate all medical, dental, and behavioral health services for children in foster care under a single statewide MCO. More than 30 states enroll foster care children in Medicaid managed care arrangements.<sup>1</sup> Three states have adopted a single statewide MCO model specifically designed for children in foster care: Texas, Florida, and Tennessee. The state agency collaborative conducted interviews with the Permanency and Well Being Manager at Florida Department of Children and Families/Office of Child Welfare, Division Administrator for Accountability in Texas, and Chief Medical Director at Superior HealthPlan in Texas to obtain additional data on how this model is performing to help inform the Arizona model design.

Table 6: States with Single Statewide MCOs for Children in Foster Care

States	Program Name	Statutory Authority	Geographic	Enrollment Type
Florida	Child Welfare Specialty Plan	1115(a)	Statewide	Mandatory
Tennessee	TennCare Select	1115(a)	Statewide	Mandatory
	TennCare Pharmacy	1115(a)	Statewide	Mandatory
Texas	StarHealth	1915(b)	Statewide	Voluntary

### ***Texas Model Overview***

Superior HealthPlan (“Superior”) is contracted directly with the state Medicaid agency, Texas Health and Human Services Commission (HHSC) to serve ~30,000 children in foster care through the STAR Health program. Texas implements a similar competitive process as Arizona to procure MCO services. Superior was initially awarded the STAR Health contract and began in April 2008; in 2015, Superior was re-awarded this contract. The state child welfare agency Department of Family and Protective Services (DFPS) has direct input on the performance of this MCO, although no formal intergovernmental agreement currently exists. DFPS was not involved in the original procurement process for the 2008 award but was subsequently involved for the 2015 RFP process.

Since implementation of this model, regularly scheduled meetings with leadership from DFPS, Superior, and HHSC occur to address any ongoing access to care or system level issues. Superior employs staff at each Regional DFPS office to coordinate care. Data exchange formally occurs through a daily file submission of new removals and demographic changes from DFPS to Superior. Superior has an internet-based electronic health record portal which provides access to healthcare providers and DFPS workers.

Since STAR Health was implemented in April 2008, there has been an increase in the outcomes for medical and behavioral health, especially in the area of dental providers for young children based on the federal Child and Family Services Review case review findings.<sup>12</sup>

### ***Florida Model Overview***

The Florida program is a joint program between a Managed Care Organization [Sunshine State HealthPlan (Centene)] and Community Based Care (CBC) agencies. Community-Based Care is a comprehensive redesign of Florida's Child Welfare System. It combines the outsourcing of foster care and related services to sixteen local and regional service agencies with an increased local community ownership of service delivery and design. The program has been in effect for approximately one year and there are no outcomes published to date regarding the impact of this system design.

Table 7: Summary Strengths/Challenges of Integration Under a Single Statewide MCO

STRENGTHS
<ol style="list-style-type: none"> <li>1) Single point of accountability for the State and DCS</li> <li>2) Integration of behavioral and physical health services under a single payer</li> <li>3) Single plan retains the focus on children with special health care needs for easier tracking, monitoring and oversight of care delivery</li> <li>4) Able to leverage value based purchasing strategies</li> <li>5) Able to select a contractor with a strong track record of positive outcomes in a managed care environment</li> </ol>
CHALLENGES
<ol style="list-style-type: none"> <li>1) Historical experience of CMDP would be lost</li> <li>2) Fingerprinting and background check requirements in statute are potential barriers to provider contracting</li> <li>3) Significant resources required for procurement and transition of care from current system</li> <li>4) Medical and dental health network would be more limited than currently available through CMDP</li> <li>5) Transition of care issues since median length of enrollment in CMDP is 0.95 years and children continue to have healthcare needs when exiting foster care</li> </ol>

## V. Recommendations

1. Institute continued improvement efforts through existing system structure until September 30, 2019:
  - a. Change Arizona policy to extend Medicaid enrollment for children exiting the foster care system from 60 days to 6 months to ensure families have an appropriate timeframe to apply for Medicaid.
  - b. Increase monitoring of behavioral health system to ensure that all children in foster care are served through a Child and Family Team (CFT) model to fidelity.
  - c. Integrate case planning activities between DCS and behavioral health by involvement of behavioral health in Team Decision Making (TDM) and/or DCS case planning in order to align case plans and position disciplines to provide their respective expertise in service of the child and family.
  - d. Update state agency policies and contracts to be congruent with the timeframes established for health care screening and evaluation by nationally recognized organizations including the American Academy of Pediatrics and Child Welfare League of America. This includes initiating a physical health screening within 72 hours of removal.
  - e. Ensure a trauma-informed care lens is utilized for all children involved with DCS throughout their engagement with the healthcare system, starting with the DCS Rapid Response. This includes:
    - i. Involvement of biological and/or foster family members;
    - ii. Engagement and development of a therapeutic relationship with the child and family;
    - iii. Consideration of the impact of trauma on assessment and diagnosis;
    - iv. Assessment to include a comprehensive focus on trauma including trauma history, child response, multi-generational trauma, effects of separation as well as other key trauma-related issues;
    - v. Understanding child adjustment to placement changes;
    - vi. Ongoing assessment to address needs in a timely fashion;
    - vii. Coordination of care with Primary Care Providers; and
    - viii. Coordination of care with Adult Behavioral Health and Substance Use Disorder Providers when applicable.
  - f. Leverage payment modernization strategies to increase timely access to evidence-based specialty services and improve outcomes. Evidence-based treatment options for children in foster care includes Multisystemic Therapy (MST), Functional Family Therapy (FFT), Dialectical Behavior Therapy (DBT), Brief Strategic Therapy, Trauma Focused Cognitive Behavioral Therapy (CBT) and DBT, Adolescent Community Reinforcement Approach (A-CRA), Motivational Interviewing, Seeking Safety, Dyadic/Relational Therapies, Seven Challenges, and Matrix.
  - g. Train and provide resources to foster caregivers on behavioral management techniques aimed at reducing problem behaviors and disruptions.

2. Develop system infrastructure to transition to the Integrated CMDP Contracted Network Model beginning on October 1, 2019:
  - a. Although the infrastructure to successfully integrate services is currently more readily available in the private sector, this model: supports recommendations provided by key stakeholders including child advocacy organizations; reinforces the DCS mission within the healthcare delivery system to serve the unique needs of children in foster care; integrates all healthcare services; and leverages payment modernization strategies within a contracted network to maximize access to specialized trauma informed services focused on improved outcomes.
  - b. Given the many factors that will be necessary to assure a successful transition of the service delivery system for CMDP members, including required legislation, funding and contract changes, the recommended timeline for such a transition is no sooner than October 1, 2019.
  - c. In order for this model to be successful, the following must occur:
    - The Legislature must:
      - i. Change statute to allow CMDP to contract their network to quality providers rather than utilize any AHCCCS registered provider;
      - ii. Change statute to provide flexibility on CMDP rate reimbursement structure (i.e., provider rates no longer tied to AHCCCS fee schedule); and
      - iii. Sufficiently fund the development of CMDP infrastructure to function as a health plan (estimated to be tens of millions of dollars) as CMDP will be overseeing nearly five times the services/expenditures that they currently do based on FFY2014 data (\$34,077,043 physical health expenditures vs. \$165,203,029 combined physical and behavioral health expenditures). Approximately 95% of CMDP children are Medicaid-eligible, therefore funding for these enhancements includes federal Medicaid matching funds.
    - DCS/CMDP must:
      - iv. Invest sufficiently in CMDP staff in order to function as a health plan. This includes developing the capacity to competitively recruit, hire, and retain CMDP staff with the appropriate health plan and managed care training and experience and allowing for salary compensation at or near the market rate for key positions, including but not limited to the Chief Executive Officer (CEO), Chief Operations Officer (COO), Chief Financial Officer (CFO), Chief Medical Officer (CMO), and medical management staff including Registered Nurses (RNs) and Licensed Behavioral Health Professionals.
      - v. Invest sufficiently in business operations infrastructure including information technology/data systems in order to function as a health plan. This includes the ability to process claims accurately and timely, develop a sufficient network of providers, track and trend utilization data, and provide care management to their members.
    - AHCCCS must:
      - vi. Provide the necessary technical assistance and expertise to assist DCS/CMDP with transition to a fully integrated health plan.

Without the aforementioned elements, this integration effort will fail.

3. Addressing the needs of the family involved with DCS: as children in foster care function in the context of their family, the state agency collaborative also recommends a similar re-evaluation of the healthcare system design for families involved with the foster care system in Arizona. This includes designing a system that:

- a. Assists with completion of application for services and benefits (i.e., Medicaid, cash assistance, nutrition assistance, etc.) to maximize resources for parents with healthcare and other needs;
- b. Provides timely and evidence based preventative and treatment services to parents with healthcare needs prior to a child's removal; and
- c. Engages parents in behavioral health services within 5 days of a child's removal.

4. Leveraging other state resources: meeting the specialized healthcare needs of children and families involved with DCS also extends beyond medically necessary preventative and treatment services delivered through Medicaid. Preventing removals and achieving permanency and successful reunification, guardianship, and adoption are supported through other state agencies, public and private programs including:

- a. Arizona Department of Health Services (ADHS) and County Health Departments provide home visiting programs and other preventive services through Title V and other funding sources.
- b. DCS receives state and grant funding for Families FIRST and SENSE Programs to provide services to parents with substance use disorders.
- c. Never Shake a Baby Program, Triple P, and other private and public programs provide important statewide prevention programs.

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